

Technical Brief Disposition of Comments Report

Research Review Title: Models of Cancer Survivorship Care

Draft review available for public comment from August 9, 2013 to September 5, 2013.

Research Review Citation: Viswanathan M, Halpern M, Swinson Evans T, Birken SA, Mayer DK, Basch E. Models of Cancer Survivorship Care. Technical Brief. No. 14. (Prepared by the RTIUNC Evidence-based Practice Center under Contract No. 290-2012-00008-I.) AHRQ Publication No. 14-EHC011-EF. Rockville, MD: Agency for Healthcare Research and Quality; March 2014. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Comments to Research Review

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The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Commentator & Affiliation	Section	Comment	Response
TEP reviewer 1	Overall Comments	<p>Thank you for the opportunity to review this technical brief. Overall, the report was well-written and organized, although at times somewhat repetitive. Much of the information gained came from key informant interviews as well as a scant literature evaluating different models of care. The definition of a model as providing at least two separate services seemed somewhat arbitrary, and did not really address some of the key concerns related to survivorship care described in the IOM 2005 report. In particular, an assessment of survivor needs (e.g., persistent post-treatment symptoms, psychosocial concerns, employment and insurance difficulties), education and monitoring related to late effects, health and wellness strategies, are some essential elements of survivorship care that need to be addressed, in addition to the disease recurrence surveillance that is the most common element of survivorship care. A focus on the specific model of care delivery (who is delivering and in what setting or time point), exclusive of the content of the care, seems artificial, because it is the content that is lacking in post-treatment survivorship care. In fact, as described in the IOM report, much of what survivors need going forward is for their treating clinician to either provide these assessments as part of routine care, or have another member of their staff provide care or perform appropriate referrals.</p>	<p>We are not sure what specific material appears to be repeated.</p> <p>Our report is based on the premise that a single service does not equate a model of care. In light of the limited evidence on this topic, we do not, however, require as exhaustive a list of services and components as suggested by the IOM definition. We disagree with the idea that we focus on the service provider rather than the content of the service – as noted in the methods section of our report – we make the distinction between providers and services for specific needs and include studies in which a single provider addresses multiple needs.</p>

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TEP Reviewer 1	Overall Comments	Some specific concerns/observations that might be addressed in the report: 1) It is only 7 years since the dissemination of the IOM report that called for the recognition of the distinct phase of survivorship care (recommendation 1), and in recommendation 5 that CMS, NCI, AHRQ and others should support demonstration programs to test models of care. The authors were surprised to find only 9 published studies on models of care. However, given that there have been no major funding efforts to follow-up on recommendation 5, it is not surprising that at this early time post IOM report, that there are so few studies.	Added to conclusions of GQ3
TEP Reviewer 1	Overall Comments	2) The report also seems to struggle with the heterogeneity and lack of systematic approaches to survivorship care delivery and models, yet this exactly reflects the heterogeneity of the cancer care delivery system, which may occur in single practitioner offices (e.g., surgeons, oncologists) or in large cancer centers with multi-disciplinary teams with many physician extenders/nurses. It is thus not surprising that those clinicians or institutions that have become early adopters in the implementation of survivorship care have not only adapted their models to specific disease sites (e.g., breast, childhood survivors), but also reflect the institutional resources and urban/rural community resources that are available. Just as there are huge community based and institution based variations in the delivery of hospice care, it is not surprising to have divergence in models of survivorship care.	Added to conclusions of GQ3

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TEP Reviewer 1	Overall Comments	3) I think what is also missing is the potential ability of the delivery of survivorship care to decrease fragmentation and increase coordination if the model is organic and integrated with oncology care rather than seen as an add on. This is discussed to some extent in the report, but not really highlighted. The current perverse financial incentives of care, focused on oncology clinician follow-up visits, with multiple providers duplicating surveillance, is wasteful, and in a accountable care organization or medical home environment, such waste would be channeled into provision of the missing survivorship care. Thus looking at the benefits of a model in terms of reduction in unnecessary services, and an increase in survivorship advised services would be a reasonable evaluation strategy.	Although multiple sources have discussed the potential ability of survivorship care to decrease fragmentation and unnecessary resource utilization and increase coordination, no data are available to demonstrate that this occurs (or conversely, that survivorship care programs increase care fragmentation). As such, we cannot comment on this in the report. This has been included in the gaps and future research needs section
TEP Reviewer 1	Page 18, line 7	4), the references for the first sentence do not seem correct. References 34 and 42 do not appear to be guidelines. Please clarify.	We corrected the references which were the 1) 2013 ASCO guidelines and 2) the clinical guidelines for Wood et al. 2006: Management of Prostate Cancer - Comprehensive Version.

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TEP Reviewer 1	Page 23, lines 25-27	5), it is not clear why there is a reference to genetic risk and genetic testing as part of risk stratification. While having a hereditary predisposition gene heightens the risk for a new cancer, this testing is often done now as part of the diagnostic and treatment work-up, and the findings are used to address preventive surgery or delineate more intensive cancer surveillance programs. I believe that is a different kind of risk than should be considered in the setting of models of care. For example, patients with DCIS may not need ongoing monitoring by an oncology specialist after a short period of follow-up, nor would early stage colon cancer, small low risk melanomas, early thyroid cancer, etc. In these low risk situations, development of a survivorship care plan by the oncology provider that is shared with the patient and his/her other physicians (PCP) can be sufficient, as long as access to the oncology provider is available as needed. A new survivorship care program is not necessary for this transfer to occur. On the other hand, patients treated for leukemia high dose chemotherapy and stem cell transplant therapy who have many morbid complications with GVHD, infection risk, etc., may need some form of ongoing follow-up by the transplant team indefinitely and may never have PCP shared care. The real problem for patients is that oncology providers tend to refer out to multiple specialists (for the heart, the lungs, the metabolic issues) when often a PCP may be able to handle common comorbid conditions. This is especially the case for low risk patients.	We dropped the sentence on genetic risk (the perspective of one KI) and added the phrase “risk of new cancers” to an existing sentence to account for the risk of new cancers. “KIs also noted that evidence-based guidelines for survivorship do not account currently for risk stratification and that physicians do not really understand risk of new cancers and risk of recurrence.” We agree regarding the idea of a continuum of need, hence the last paragraph in this section on categories of risk.

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TEP Reviewer 1	Page 23, lines 25-27	6) Finally, there is no mention of the fact that the vast majority of cancer survivors are over 65 years of age and many of these individuals already have established relationships with PCPs and often it is the PCP who discovered the cancer. Should we not consider a shared care model as being critical in this setting?	We are unable to identify the specific text in the draft report to which this comment relates, but we concur that models of care would benefit from accounting for existing care structures and relationships.
TEP Reviewer 1	Page 23, lines 25-27	7) In conclusion, where I am weighing in, is that developing “models of care” that are elaborate and add on to a complex health care delivery system may not be the solution. I would have liked to have seen more effort to examine how best to engage the current health care providers to deliver the components of survivorship care within existing settings, and to suggest incentives and strategies to make that happen, rather than focusing on entirely new programs and structures.	This tech brief was scoped to focus on survivorship care models. We agree with the reviewer that once there is a better understanding of survivorship care models, one next step would be to compare to “enhanced” usual care, focused on engaging current health care providers to deliver the components of survivorship care within existing settings, with separate survivorship care models.
Peer Reviewer 1	General Comments	This is a well-organized review of a challenging topic - models of cancer survivorship care. As the authors note, even the term “model” is rarely defined in the literature. My comments below are not critiques of the Technical Review but rather another perspective on a topic for which, as the review notes, while there is limited tangible evidence, strong opinions are not lacking.	Thank you. No change required.

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Peer Reviewer 1	Introduction	The Background section references the IOM Report Lost Transition and uses this as the basis for identifying the 4 key components (at a high level) of survivorship care: (1) prevention of new cancers and other late effects, surveillance for recurrence or second cancers, interventions of secondary illnesses and other late effects, and coordination of care. The IOM report is clearly the seminal report on the topic of cancer survivorship. However, it is probably worth noting that it is also not really based on any evidence on how the nature of survivorship care, for example differs from the care of other complex medical conditions that primary care providers care for. One critical question that the Report should probably be address, and is really implicit in having a review of models of cancer survivorship care, is what makes cancer survivorship unique so that it requires its own models of care?	Added to the Introduction and GQ4 Next Steps
Peer Reviewer 1	Introduction	In the third paragraph, the authors note several barriers to “optimal” survivorship care but it is not clear that “optimal” care has really been defined.	Added to introduction.
Peer Reviewer 1	Methods	The methods are clearly described and appropriate to the topic including discussions with KI, gray literature and literature review. From a total of 1248 articles identified, only 9 studies meeting the inclusion criteria were identified.	Thank you. No change required.
Peer Reviewer 1	Methods	The decision to define a “model” of survivorship care as a “program for cancer survivors that addresses two or more different health care needs” seems like a reasonable choice. It might also be worthwhile to have a definition of a “comprehensive model” that addresses all of the aspects of survivorship care recommended by the IOM - do any of the identified studies address this question?	Table 6 lists the IOM component addressed by each of the identified studies. Three studies addressed all four components

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Peer Reviewer 1	Results	GQ1: It is mentioned that several studies assessed interventions targeted at coordination and prevention such as SCP - since a SCP is a document that is designed to facilitate care within whatever model exists, I am not sure that if a “model” that consists only of a SCP meets the definition of a model for survivorship care that the authors state in the Methods. It would be helpful to clarify how a SCP would meet this definition if it in fact does. By analogy, one would not consider the near universal Hospital Discharge Summary a model for transitioning care from the acute setting to outpatient setting.	We agree that an SCP alone does not meet the definition of a survivorship care model that we provided in the methods section. To emphasize this point, we have rephrased text related to models in which SCPs are a key component. Specifically, instead of referring to “models that focus on SCP development,” we refer to “models in which SCP development is a key component.” This rephrasing indicates that SCPs are not the only component included in the models in question.
Peer Reviewer 1	Results	GQ2: Under payment considerations, what is highlighted is the lack of payment for preparing an SCP. There are other general comments from KI’s regarding whether or not insurance companies “cover services.” For this information to be interpretable it needs to be specific to the type of services. General medical care and counseling for cancer survivors is covered through E&M just like any other health care. In order to be able to understand how reimbursement policies may be limiting access to needed survivorship care, the types of services that are not currently covered need to be identified. The specific reference to the Oncology Medical Home outside of Pennsylvania (John Sprandio’s practices) is not actually relevant since the issue being addressed was Dr. Sprandio’s successful effort to reduce ER visits for patients ON TREATMENT decrease revenue for his practice but he did not get any additional reimbursement even though his efforts saved his payers money. ER visits are common for cancer patients on active treatment but this Technical Report is using as its definition of a Survivor, patients who have completed therapy.	We have clarified that the comment about lack of coverage related to survivorship care plans. We dropped the reference to the Oncology Medical Home Model

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Peer Reviewer 1	Results	GQ3: The Tables describing the studies are very helpful. A summary of the limitations of the studies/literature overall would be helpful.	As assessment of risk of bias of included studies is outside the scope of this literature review activity because we are not evaluating the validity of causal claims. We do describe heterogeneity in this body of evidence in Tables 2 - 5.
Peer Reviewer 1	Results	GQ4: It might be helpful to again highlight the variation in the recommended care according to the Guidelines which in and of itself is a gap in our knowledge base that needs to be addressed in order to develop models to deliver the care.	Added to GQ4 Summary and Implications.
Peer Reviewer 1	Next Steps	I agree with all of the next steps and do not really have any additional steps to add. One comment though -- Prior to agreement upon the best model which might best be done through further research, as a starting point, agreeing on a taxonomy alone, would be very useful. In addition, it would be helpful to have a broader based group involved in some discussions about the taxonomy and the models in order to tease out what is unique about cancer survivorship care vs. other types of complex care. How is cancer survivorship similar or different/unique compared with survivors of a kidney transplant? Post - traumatic brain injury? Endocarditis?	Added to GQ4 Next Steps.
Peer Reviewer 2	Overall comments	I felt that the report was somewhat empty -- largely because so little had been done in the area of survivorship care models. My area of research has been on the economic outcomes and employment possibilities for cancer survivors. There was very little in this section of the report. I am guessing that is because these concerns are not incorporated in survivorship models and survivors are left to their own devices to get the assistance they need. I spent quite a bit of time on the report, but in the end, had little to say about it.	We agree that the state of the science is nascent.

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TEP Reviewer 22	1-page 8 line 35	<p>I think the report is very good and very complete. I have 2 specific suggestions and 2 general suggestions</p> <p>In some systems of care it is likely that medical oncologists provide the primary longitudinal cancer followup care. however, in many systems the team of the medical oncologist, surgeon, and radiation oncologist do so, and for 5-10 years. Interestingly enough, in the breast cancer scenario, many patients thus followed have as their initial diagnosis stage 0 or 1 disease, thanks to early detection, and have a very low risk of recurrence, second neoplasms, or late effects. Thus we as a system of care are investing a large amount of resources in a setting where they might be less needed. Developing a system of gradual “tapering” of specialists providing such care based on cancer stage and recurrence risk, other risk factors such as family and genetic risk syndromes, ongoing late effects from therapy, etc may help to enhance care and preserve valuable resources for new patients or survivors at higher risk.</p>	Added to the Gaps and future research needs section
TEP Reviewer 2	Page 23 line 35	<p>2-page 23 line 35-The notion of either the cancer team or the PCP providing all of the elements of survivorship care as an “all or none” approach is in my mind a flawed notion. Depending on patient specific variables, I would think that the PCP could have responsibilities for wellness and monitoring for new cancer, while the oncologist could have responsibilities for disease monitoring and late effect monitoring. This could then transition further over time based on a set of risk variables including disease specific issues, patient risk, etc. These multiple and continuous transitions would certainly require optimal communication amongst patient and providers to ensure that no ball is dropped.</p>	Added to the Gaps and future research needs section

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TEP Reviewer 2	General Suggestions	1-It might be helpful if the authors provided a bit more of a “roadmap” outlining a specific research agenda.	The lack of evidence regarding survivorship care models and the high level of heterogeneity in this field prevent suggestions of a specific research agenda. As suggested in GQ4 Next Steps, item 1, general agreement on survivorship models and model taxonomies is needed before a specific research agenda can be proposed.
TEP Reviewer 2	General Suggestions	2-Another possible outcome of the excellent review might be a targeted meeting amongst key stakeholders to discuss the published work and derive a set of actions to move the field forward, collect recommended data elements in a uniform fashion, and assure an essential number of standards in survivorship research and reporting so that in 2-3 years we will have truly moved the field forward.	Added to GQ4 Next Steps.
Peer Reviewer 3	General Comments	This report aims to provide an overview of models of cancer survivorship care, including the benefits and limitations presented in the current literature and interviews with key informants, and outlines steps for future research. There are a number of concerns with the report, as described below. In general – (1) review of the literature seems incomplete as there are published studies and reports that were not identified, (2) the report seems to focus mostly on the reports of the key informants; (3) the inclusion of studies that have addressed at least two domains of cancer survivorship, as defined by the authors based on the IOM report, seems premature given the lack of empiric data in this field; and (4) directions for the future do not present truly novel suggestions, as some of the proposed areas have already been covered. Specific comments are included below:	<p>(1) Not all guiding questions were supported by a comprehensive search so we did not expect to conduct a complete review on GQ1, 2, and 4. We have added text in the structured abstract and methods to clarify this for readers.</p> <p>(2) That is indeed true, given the paucity of published literature</p> <p>(3) Our criteria were intended to be as inclusive as possible while maintaining a requirement that models of care extend beyond a single service</p> <p>(4) We disagree with the reviewer’s comments that the directions for the future do not present truly novel suggestions. Many of these, particularly those in the Next Steps section, have not already been attempted.</p>

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Peer Reviewer 3	Structured Abstract	The background section should answer the question of “why” this technical brief was conducted, other than there being “few publications” in this field. Was there a concern about the level of care provided for survivors, costs, other issues? Also, should state up front that this report focuses on adult survivors of adult cancers (as presented later in the report).	Text added to abstract
Peer Reviewer 3	Structured Abstract	The methods section should provide a more in-depth description of the process.	We are restricted to providing additional detail to the technical brief structured abstract based on the template that includes a word limit.
Peer Reviewer 3	Structured Abstract	The results section is good. Would suggest that the report use “oncologists or oncology providers” rather than oncologists only, as much of oncology care is provided by nononcologists, such as urologists, gastroenterologists, etc.	Revised
Peer Reviewer 3	Structured Abstract	The last sentence in the conclusions seems to reach beyond the findings of this report. The importance of type of cancer, treatment and clinical setting on the model of care to be implemented should be highlighted.	We have revised this statement
Peer Reviewer 3	Introduction/ Background	There should be a statement up front that this report focuses on adult survivors of adult cancers, as specified a bit later in the text.	This already stated in the 3rd sentence of the abstract and the 2nd paragraph of the Background section.
Peer Reviewer 3	Introduction/ Background	In the second paragraph, please clarify that comorbid medical conditions may be co-existing among adult survivors of adult cancers. Literature has shown that with regard to comorbidities among adult survivors, there are not major differences compared to non-survivors (at least among breast cancer survivors, but adult survivors of childhood cancers appear to have numerous comorbid conditions.	This statement in the introduction (page 1) was made condition to reflect the lack of specific information.
Peer Reviewer 3	Introduction/ Background	As noted above, would use the term “oncologists or oncology providers” rather than oncologists only, as much of oncology care is provided by non-oncologists, such as urologists, gastroenterologists, etc.	Added to Background section, page 1.

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Peer Reviewer 3	Introduction/Background	On page 2, the authors accurately note that there are no standards for describing models of cancer survivorship care in much of the existing literature. While seems logical, the inclusion of studies that have addressed at least two domains of cancer survivorship, as defined by the authors based on the IOM report, seems premature given the lack of empiric data in this field. At this time, would propose that the authors describe all the interventions in the field and then outline which/how many domains were addressed.	As noted above, the premise of our report is based on the idea that a single service does not constitute a model of survivorship care. Rather than requiring the full range of IOM components of care, we only require that at least two services be provided to the survivor.
Peer Reviewer 3	Introduction/Background	In addressing the gaps in knowledge (page 4), important to also acknowledge that most of items in 3 are also unknown.	We disagree. The items listed under #3, " <u>Current evidence on cancer survivorship care</u> ", include survivor, provider, and model characteristics as well as model outcomes. While these items are found in few studies and there is substantial heterogeneity, most of these items can be determined from individual published studies.
Peer Reviewer 3	Introduction/Background	Numerous background studies were not included and are of importance. Specifically, a number of studies from the NCI/ACS SPARCCS data have been published in 2011-2013 focusing on cancer survivorship related knowledge, attitudes and practices of oncologists and primary care providers.	This background section of this document is not intended to be a comprehensive review of all information regarding survivorship care. It is focused on existing or proposed models of survivorship care, and as such, the background is limited to this topic.
Peer Reviewer 3	Methods	While the authors present the methods for searching the data, they seem to have missed a number of studies that are relevant in this report. When was the data pull conducted, what years of studies were included?	We pulled the literature on March 12, 2013 for the draft and August 22, 2013 for the final report. We included all available years of studies.

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Peer Reviewer 3	Methods	A recent systematic review of models of cancer survivorship care noted below should be noted, including some additional studies that were analyzed in this review. Models of care for post-treatment follow-up of adult cancer survivors: a systematic review and quality appraisal of the evidence. Journal of Cancer Survivorship, December 2012, Volume 6, Issue 4, pp 359-371.	We pulled this article (Howell, 2012) for review.
Peer Reviewer 3	Methods	A recent intervention by Henderson et al. Breast Cancer Res Treat. 2013 Apr;138(3):795-806. doi:10.1007/s10549-013-2486-1. Epub 2013 Mar 31. Randomized controlled trial of a clinic-based survivorship intervention following adjuvant therapy in breast cancer survivors.	We pulled this article (Hershman, 2013) for review and it did not meet our inclusion criteria because it was a single service intervention.
Peer Reviewer 3	Methods	As mentioned earlier, would consider including studies that addressed less than 2 aspects of survivorship care, ie. Grunfeld et al in J Clin Onc and BMJ.	Based on the scope of this review, we retain our original exclusion criteria of studies that address less than 2 aspects of survivorship care.
Peer Reviewer 3	Methods	Also, while Key Informants input is important, it would then also be helpful to include case reports and opinion pieces, as these are essentially similar in strength – if not stronger as having been subjected to peer review - to the comments of KIs.	While the Reviewer suggests an alternative approach, we chose to stay consistent with the more stringent methodology of other systematic review products and not include these as part of the empirical evidence. In addition, we recruited a broad range of perspectives to inform the guiding questions. This approach is consistent with EPC methodology for development of a technical brief.
Peer Reviewer 3	Results/Findings	As noted earlier, this section seems to focus heavily on the key informants rather than the summation of the existing literature. Case reports and/or opinion pieces may be as strong (if not stronger) in this regard. Also, may have been helpful to review existing programs around the country to evaluate the types of models that currently exist and perhaps address the pros/cons with the program directors. Including community based programs is important.	Although reviewing existing programs may have been helpful, this would have involved activities beyond the available time and budget for this project. We were able to incorporate information on a small number of existing survivorship care programs through the key informant interviews. This has been added to the Discussion section.

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Peer Reviewer 3	Results/Findings	In the “organizational structure and setting” – would consider adding a published paper from integrated health care delivery sites. Specifically, this paper addresses that in this setting, a distinct cancer survivorship care program may not be needed, or seen as beneficial. The differences in the implications for cancer survivorship models based on clinical settings is critical. Chubak J. Providing care for cancer survivors in integrated health care delivery systems: practices, challenges, and research opportunities. J Oncol Pract. 2012 May;8(3):184-9. doi:10.1200/JOP.2011.000312. Epub 2012 Jan 24.	Integrated in report.
Peer Reviewer 3	Results/Findings	In the provider responsibilities and type – there have been other studies that have addressed patients’ perceptions of the role of PCP and/or oncologists. Specifically, DelGuidice in JCO, Sissler et al in J Cancer Survivorship 2012, and Cheung 2009 JCO, among others. There has also been extensive literature regarding health services among survivors cared for by oncology or primary care providers (Snyder et al – numerous publications).	The Del Guidice citation that we found is based on PCP, rather than patient, surveys, but we have incorporated this information and the information from from Cheung et al. The Sisler article includes patients who may not have been cancer-free, had recurrence, or new cancers
Peer Reviewer 3	Results/Findings	In that section, also note that the Casillas article (#49) focuses on young cancer survivors, most of whom have actually been diagnosed as children.	Based on the information available, the article met the criteria for inclusion: Participants included survivors diagnosed during the pediatric (0–14 years) or adolescent or young adult years (15–39 years).
Peer Reviewer 3	Results/Findings	In discussion of payment considerations, it is important to note that cognitive care is paid for and may be billed accordingly. May also reference the comparison between SCPs and hospital discharge summaries in that regard. Nekhlyudov L, Schnipper JL., J Oncol Pract. 2012 Jan;8(1):24- 9. doi: 10.1200/JOP.2011.000273. Epub 2011 Nov 22. Cancer survivorship care plans: what can be learned from hospital discharge summaries?	We have revised the text somewhat but did not find a good fit for the cited reference within the existing text.

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Peer Reviewer 3	Results/Findings	In the discussion of training and staffing needed (page 18), consider Cancer survivorship care: exploring the role of the general internist. Hong S. J Gen Intern Med. 2009 Nov;24 Suppl 2:S495-500. doi: 10.1007/s11606-009-1019-4. Review. Also, there have been studies in medical schools focusing on survivorship. Further, the ASCO report in 2012 by McCabe, JCO, outlines some specific elements of training in survivorship.	Added citations
Peer Reviewer 3	Results/Findings	As noted earlier, would suggest that studies of survivorship care models be expanded, to include additional studies that were not included.	We disagree. As the explicit focus of this technical brief is models of survivorship care, we feel that restricting included studies to those that meet the definition is survivorship care models is appropriate.
Peer Reviewer 3	Results/Findings	In the future research needs (page 29), please note that the breast and colon cancer guidelines are mostly evidence based. There are also guidelines for prostate cancer, bone marrow transplant.	Although this is true, there are also evidence based guidelines for other areas of medicine including cardiovascular disease and vaccination. However, as the focus of this technical brief is on cancer survivorship care, our focus is on the lack of evidence-based guidelines for survivorship care.
Peer Reviewer 3	Next Steps	There are some limitations in the next steps. Specifically (the numbers below pertain to the listed questions and suggestions): 1. The LIVESTRONG essentials of cancer survivorship care meeting took place in 2011. The meeting report outlined the elements of cancer survivorship care, that may be used for future development of programs and evaluation.	Added to Summary and Implications section.
Peer Reviewer 3	Next Steps	2. Lots of health services publications outlining current state of care for cancer survivors, not clear that more descriptive studies are needed.	Although there are health services publications describing cancer survivorship care, very few publications have provided outcomes from survivorship models as defined in this report.
Peer Reviewer 3	Next Steps	3. Not sure if we are proposing a “program” but rather a model of care. No suggestions listed for this question.	Thank you. No change required.
Peer Reviewer 3	Next Steps	4. No suggestion listed for this question.	Thank you. No change required.
Peer Reviewer 3	Next Steps	5. This will vary by cancer type and treatment	Added to Summary and Implications.

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Peer Reviewer 3	Next Steps	6. Evaluation elements have been proposed in the follow up to the IOM report on implementing cancer survivorship care planning, a chapter by Earle et al.	Thank you. No change required.
Peer Reviewer 3	Next Steps	7. No comment by reviewer	Thank you. No change required.
Peer Reviewer 3	Next Steps	8. No comment by reviewer	Thank you. No change required.
Peer Reviewer 3	Next Steps	9. Need to acknowledge that settings are important in the type of model that may be implemented.	Added to Summary and Implications.
Peer Reviewer 3	Appendix – Glossary of Terms	Would be helpful to include some of this information in the body of the report, specifically the types of models	Moved the description of types of models used in this report to the background section.
Peer Reviewer 3	Appendix – Glossary of Terms	Also, regarding models of care: Distinction between integrative care versus shared care?	We have revised definitions of shared and integrative care.
Peer Reviewer 3	Appendix – Glossary of Terms	Distinction between transition to primary care and consultative model?	Very similar, where consultative is on a periodic or on a as needed basis whereas transition to primary care is almost exclusively, but consultative extends more flexibility in the frequency of the oncology team referrals.
Peer Reviewer 3	Appendix – Glossary of Terms	Survivorship care plan is not a model of care, but rather a component of care that may/should apply to all models of care.	We recognize and understand this, but the various definitions reflect the use of model across the literature of which a survivorship care plan is defined as such in some literature.
Peer Reviewer 3	Clarity and Usability	The report is clear, however, has a number of limitations as outlined above. Would be helpful if it provided a deeper overview of the evidence, with less emphasis on the KIs, and was more forward thinking in terms of next steps.	As noted earlier, the nature of this product (technical brief) is such that we do not conduct a systematic review of all GQ and we include KI comments. Further, as noted earlier, we believe the Next Steps presented in the technical brief are forward thinking, and represent important activities for this area that have not yet been attempted.
TEP Reviewer 3	Overall Comments	Comments: Due to the heterogeneity of studies as well as study characteristics, it's understandable that only 9 studies were found that met the author's criteria. But even looking at the 9 studies there was significant variation. I feel that the authors did a good job summarizing their findings on a topic with has little agreement	Thank you. No change required.

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Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	Overall comments	This well-written, clearly organized, and thoughtfully planned review of survivorship care models is both much needed and long overdue. Overall, the report lays out a review of existing survivorship care models using peer-reviewed and gray literature sources and interviews with key informants (KIs). The authors made several review decisions that will aid in the further establishment of an evaluation framework for survivorship care models that can be used by AHRQ and others to continue to evaluate models as they are developed. These decisions include using the IOM framework established in Lost in Transition to identify key components of survivorship care, and only including models that contained at least two components, which supports the idea that survivorship care should be comprehensive. Comments and suggested edits are included below to help strengthen the brief.	Thank you. No change required.
Peer Reviewer 4	Structured Abstract	In the “Guidance for reviewing technical briefs,” it states that the brief should begin with an Executive Summary. The current manuscript contains a Structured Abstract, which arguably suffices, but I thought I would mention the discrepancy.	The guidance has since been updated – a technical brief does not require an executive summary
Peer Reviewer 4	Structured Abstract	The use of the term “physician extenders” reads a bit like jargon in the abstract and perhaps should be set off by quotation marks for varied readership.	We have replaced this phrase with “nurse practitioners and physician assistants”

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	Background	Right off the start, the brief should include a definition of “survivor” and “survivorship.” Many researchers/providers/patient advocates (and of course those with a history of cancer) define “survivor” differently, either from the point of diagnosis forward (the NCI Office of Cancer Survivorship definition) or from the conclusion of treatment, and some even begin with only 5 years recurrence-free disease status. These variations also vary by region: most European institutions do not consider patients undergoing treatment as “survivors.” The authors should lay out this issue in the Background before mentioning the inclusion of studies that only had individuals who completed active treatment (in the Methods) and before they revisit the varying inclusion definitions by differing models of care.	Added to Background
Peer Reviewer 4	P. 1, line 40	The brief cites Potosky et al., 2011, but might also consider: J Clin Oncol. 2012 Aug 10;30(23):2897-905. doi: 10.1200/JCO.2011.39.9832. Epub 2012 Jul 9. Who provides psychosocial follow-up care for post-treatment cancer survivors? A survey of medical oncologists and primary care physicians. Forsythe LP, Alfano CM, Leach CR, Ganz (TEP) PA, Stefanek ME, Rowland JH. This paper examined oncologists and PCPs use of treatment summaries and care plans and also looked at provider confidence in caring for posttreatment survivors.	Added to Background
Peer Reviewer 4	P. 1, line 47	There are additional references that cover more prevalent cancers that should be considered in addition to Nicolaije et al., 2011.	This report is not intended to be a comprehensive review of all aspects of survivorship care and therefore it is not necessary to consider all references to background topics.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	P. 1, line 47	The point about potential for care fragmentation in the absence of good communication and coordination among providers is a great one. Also suggest considering the point that effective survivorship care models need to face the challenges of over-utilization of resources and care delivery inefficiencies.	Added to Background
Peer Reviewer 4	P. 3, line 42:	Under “Guiding Questions, Overview of Survivorship Care,” it’s a bit confusing to see this question after reading the Brief refers to the IOM 4 components of survivorship care. If the brief also intends to provide an answer to the question, “What are the components of survivorship care,” it should make a reference to the IOM components here. Otherwise it looks like the brief does not consider the IOM’s components to be sufficient in some way (although how they are insufficient is unclear).	The Guiding Questions list the issues that will be explored in the technical brief. This has been clarified on page 3. The IOM components are an “answer” to one of the listed subquestions.
Peer Reviewer 4	P. 3, lines 44-45:	What exactly is “usual care” in terms of survivorship? I thought the brief was premised on the fact that even “usual care” is poorly tracked and understood.	As discussed for the previous comment, one of the topics explored in the technical brief is the nature of “usual care” for cancer survivors. We found that there is essentially no agreement regarding “usual care” for this population, but it is important to list this as an area of exploration for the technical brief. This has been emphasized in the “Summary and Implications” of the report
Peer Reviewer 4	P. 4, lines 9-10	Under “Guiding Questions, Context Under Which Survivorship Care is Used,” suggest also considering identifying cultural background and regional/geographical considerations under patient characteristics.	Added.
Peer Reviewer 4	P. 4, lines 9-10	It was surprising to see no reference to the impending effects of the American Affordable Care and how they might also have an effect on survivorship care.	Added.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	Methods	Under the “Discussions with KI” section, I was greatly surprised to see no oncologists, only one representative from primary care, and presumably no nurses. Some justification as to how these professions were chosen is clearly warranted, given the influence and implications of these discussions.	We provided additional detail in the report about the selection of the KIs and specify that there KIs representing oncology, nursing and primary care.
Peer Reviewer 4	Methods	Under “Gray Literature Search” suggest defining what was precisely included as “gray literature.”	This detail is included in the Appendix A.
Peer Reviewer 4	p. 6, Table 1, “Outcomes.”	Health outcomes researchers distinguish “Quality of Life” from “Health-Related Quality of Life.” Were both included or only QOL?	Only QOL.
Peer Reviewer 4	Table 1, “Timing.”	This needs better explanation. Timing of the study? Timing of the introduction of survivorship care?	Rephrased to “All timing related to the start of survivorship care”
Peer Reviewer 4	Table 1, “Timing.”	What were the dates of inclusion for all studies (including the studies that presented models of care, but also gray literature)? In addition, when were the KI discussions held?	We did not include any limits on the dates of the studies. KI discussions were held on May 16-29, 2013.
Peer Reviewer 4	p. 7, “Data Abstraction and Data Management”	Is there a citation for the “PICOTS” criteria reference?	Yes, we added citation.
Peer Reviewer 4	p. 7, “Data Abstraction and Data Management”	Unless it’s conventional not to, suggest reporting an interrater reliability statistic (like Cohen’s Kappa) for the independent reviewers’ inclusion decisions.	Historically, the RTI-UNC EPC systematic review methodology has not included this information and therefore is not included in this report.
Peer Reviewer 4	p. 8, Figure 1	Spelling inconsistency: Reference to “grey” literature, as opposed to earlier spelling of “gray” literature.	We corrected this inconsistency.
Peer Reviewer 4	p. 8, Figure 1	A footnote should explain what “EXC 1” etc. means	The reason for exclusion for each code are listed in Appendix C. We included a call out to make this more obvious.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	p. 8, Figure 1	Give the lack of a survivorship care model “taxonomy,” a listing of the main search terms used to identify the studies in the survivorship literature search is highly suggested. Not only does this make the search more transparent, it will also help future reviewers of this literature.	We listed the search terms in Appendix A, with a call out in the text associated with Figure 1.
Peer Reviewer 4	Findings	“Potential Disadvantages and Harms of Survivorship Care Models.” Lines 8-10 state that potential advantages or disadvantages of cancer survivorship care models compared with one another are not described, but no reasons or speculation are offered. Why not?	Survivorship care models were likely not compared with each other in the literature because, as we report, the literature relating to survivorship care models is quite sparse to begin with.
Peer Reviewer 4	p. 13, line 9:	“If insurance does not make the decision...” suggest rewording. “Insurance” does not “make decisions.”	Revised for clarity
Peer Reviewer 4	p. 13, line 52	although the study likely referred to “consultant-led care,” this term warrants definition in the report. Are consultants in the UK oncologists?	Revised for clarity
Peer Reviewer 4	p. 13, line 52	Although there is good coverage of supportive care needs there is little reference to information needs. One paper that may have been overlooked that was both population-based and included long-term cancer survivors is: Health information needs and health-related quality of life in a diverse population of long-term cancer survivors. Kent EE, Arora NK, Rowland JH, Bellizzi KM, Forsythe LP, Hamilton AS, Oakley-Girvan I, Beckjord EB, Aziz NM. Patient Educ Couns. 2012 Nov;89(2):345-52. doi: 10.1016/j.pec.2012.08.014. Epub 2012 Sep 28.	Added

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	p. 15 lines 32-33	Furthermore, p. 15 lines 32-33 mentions that none of the studies referenced on survivorship care programs was population-based. Suggest looking at the following study of unmet information and supportive care needs in adolescent and young adult survivors (which was population-based): Unmet adolescent and young adult cancer survivors information and service needs: a population-based cancer registry study. Keegan TH, Lichtensztajn DY, Kato I, Kent EE, Wu XC, West MM, Hamilton AS, Zebrack B, Bellizzi KM, Smith AW; AYA HOPE Study Collaborative Group. J Cancer Surviv. 2012 Sep;6(3):239-50. doi: 10.1007/s11764-012-0219-9. Epub 2012 Mar 29.	We have added references to other population-based studies but have not focused on the Keegan et al. study because of the mixed adolescent and young adult population.
Peer Reviewer 4	p. 16, lines 29-30, "Application of risk stratification to cancer survivor programs."	Suggest looking at the following manuscript which examined the impact of comorbidities among cancer survivors on health-related quality of life: Cancer, comorbidities, and health-related quality of life of older adults. Smith AW, Reeve BB, Bellizzi KM, Harlan LC, Klabunde CN, Amsellem M, Bierman AS, Hays RD. Health Care Financ Rev. 2008 Summer;29(4):41-56	Added citation
Peer Reviewer 4	p. 19, line 37, "Intervention Characteristics"	"The studies' settings primarily comprised cancer centers..." Did the authors mean "academic cancer centers" or "comprehensive cancer centers," as opposed to "community cancer centers"?	The text has been clarified to indicate that both academic and community cancer centers were represented. Table 3 has also been modified.
Peer Reviewer 4	Conclusions-p. 26, lines 26-28.	LiveSTRONG has led discussions regarding what the essential components of survivorship care should include, although I am not sure that these have been published yet.	Added text to the Summary and Implications section: "Other groups (e.g., LIVESTRONG) have also outlined elements of cancer survivorship care, which may be used for future development of care programs. However, differences among the specified components of survivorship care from differing sources may also increase model heterogeneity and thus increase challenges in understanding and evaluating care models."

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Peer Reviewer 4	Next Steps	Under some of these, including #3 and #4, there are no suggestions for addressing the questions. Was this an oversight?	The text following question 5 has been modified to clarify that it provides suggestions for questions 3, 4, and 5.
Peer Reviewer 4	Appendix	Advise rewording some of the exclusion categories, such as “Wrong Population” and “Wrong Outcome.” Out of context these labels seem a bit perjorative.	This is the standard exclusion titles that we use to describe the rationale for exclusion.
Peer Reviewer 5	P8, line 38.	The term “barriers to care” seems strong when no one is able to determine if any of the care is beneficial.	Changed to “Challenges
Peer Reviewer 5	P9, line 35.	Does prevention address other cancers as well as the one diagnosed? These recommendations can often be quite vague suffering from lack of evidence.	This is specified on page 8, “prevention of new (primary) and recurrent cancers and of other late effects”
Peer Reviewer 5	P12, line 42.	Very strong criteria for inclusion/exclusion. Although it limited the number of papers for review, the criteria are well conceived.	Thank you. No change required.
Peer Reviewer 5	P18, line 52.	The third theme was vague. How do new “modalities” decrease variation or lack of coordination? I didn’t understand this paragraph.	The reviewer refers to guiding question 1 section on the nature of current clinical practice. We have revised the paragraph in question to clarify the third theme. In particular, we believe that the term “modalities” was confusing, so we have omitted it from the paragraph and used more direct language. The revised text is “A third theme relates to new approaches to cancer survivorship care...”
Peer Reviewer 5	P14, line 54.	What does the KI mean when he says the patients “fade out?” Does this simply mean they are lost to follow up to the cancer clinic? How do these services help patients “fade in”?	We have revised the introduction to clarify that this quote relates to attention and resources expended on care
Peer Reviewer 5	P23, line 36.	Stratification is essential for future studies. A common methodology should be established. All of the literature in this area suffers from the tremendous variability of cancer patients depending on their diagnosis and stage.	This comment has been incorporated in the Summary and Implications section (page 39).

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 5	P25, line 5.	This is another essential question for any future program. If neither quality of life or overall survival are affected, why is this even a subject for study? The literature in this topic seems replete with assumptions that further follow up must be advantageous. It feel good for both provider and patient, but does it actually accomplish anything of lasting value?	Our section on summary and implications raises this issue
TEP Reviewer 4	General Comments	This Technical Brief does an excellent job of summarizing the current state of understanding regarding cancer survivorship care models, integrating existing evidence from the peer reviewed and grey literature and input from key informants. As is expected in a Technical Brief, it provides a description of the current state of the science of survivorship care models, identifies pertinent issues and provides guidance for future research. The Technical Brief is appropriate for varied audiences, including both oncology and primary care clinicians, policy makers, payers, patients and researchers. My specific comments, by section, are intended to enhance clarity of the report to enhance its effectiveness.	Thank you. No change required.
TEP Reviewer 4	Executive Summary	I did not see an Executive Summary so do not have comments on an Executive Summary. The document did include a Structured Abstract. It seems that it would be important to address in the Structured Abstract clarification of what is meant by “adult survivorship care” – that is, that this report is focusing on adult survivors of adult-onset cancer only, not on adult survivors of childhood cancer. It may also me important in the abstract to mention why this report is limited to this population.	Revised as suggested

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 4	Background	a. It seems important to start the report with several key definitions so that it is clear to the reader what is, and isn't, being addressed in this report (and refer to Appendix E here): i. what is meant by "survivorship" for this report, since different definitions are used both in practice and in the literature ii. what is meant by "adult cancer survivors" for this report – that is, adult survivors of adult-onset cancer (not adult survivors of childhood cancer). This information is in Table 1 (the inclusion/exclusion criteria), but should be stated early on in the report	Clarified.
TEP Reviewer 4	Background	b. It seems that it would strengthen the report to state what the problem is that needs to be addressed by these models of survivorship care. The background implies that there is a problem with the quality of care for cancer survivors, but doesn't explicitly make the case that there is a problem that needs to be addressed by new models for cancer survivorship care.	We have added to the Introduction, at the end of the penultimate paragraph describing challenges of survivorship care, the sentence, "All of these issues highlight the importance of developing and evaluating evidence-based survivorship care models to address the multiple health care needs experienced by cancer survivors and to coordinate health care services among this diverse population."
TEP Reviewer 4	Background	c. The Background mentions the potential challenge related to projected workforce shortage of oncologists. Are there any potential challenges related to documented workforce shortages of or access to PCPs as well?	Primary care shortages listed
TEP Reviewer 4	Background	d. The "We believe" language (line 24, page 2) weakens the statement. Consider revising to state instead, "For the purposes of this report, a program addressing a single need is not considered a model of survivorship care."	Changed as per reviewer's suggestion.
TEP Reviewer 4	Background	e. Page 3, line 9 mentions "the LIVESTRONG program" without specifying which one. Can more specificity be added to this statement?	Reference to LIVESTRONG removed.
TEP Reviewer 4	Guiding Questions	This section is clearly stated and consistent with the provided Technical Brief specifications.	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 4	Methods	a. The Discussions with KI section would be strengthened by referring to Appendix A and, either in the body or in Appendix A, describe how the KIs were identified.	We added a call out to Appendix A in this section.
TEP Reviewer 4	Methods	b. Table 1 – It may be helpful to explain the rationale for the inclusion and exclusion criteria that were used, especially since some definitions of cancer survivorship include the entire trajectory of cancer care, from time of diagnosis through progression and death for those who are not cured.	Added rationale for this aspect of the inclusion/ exclusion criteria.
TEP Reviewer 4	Methods	c. The Searching for the Evidence, Data Abstraction and Data Management and Data Synthesis sections are clearly explained with sufficient detail.	Thank you. No change required.
TEP Reviewer 4	Findings	a. The Tables are particularly helpful and useful.	Thank you. No change required.
TEP Reviewer 4	Findings	b. Components of Cancer Survivorship Care – It seems like an omission to not mention the LIVESTRONG Essential Elements in this section, as they were based on expert consensus regarding the core components of cancer survivorship care. [www.livestrong.org/What-We-Do/Our-Approach/Reports-Findings/Essential-Elements-Brief]	We added text to this section
TEP Reviewer 4	Findings	c. Page 13, line 25 – Can a KI really be a “dispassionate observer”?	Struck out phrase
TEP Reviewer 4	Findings	d. Page 13, line 31 – It would be helpful to have additional clarification regarding the statement that “the onus in such settings gets shifted to the patient”. Onus for what?	Revised for clarity. Text now states “Settings in rural areas have fewer resources but great need, and the onus for care coordination in such settings gets shifted onto the patient.”
TEP Reviewer 4	Findings	e. Page 13, line 41 – It may be helpful to explain the meaning or intent of the quote “it keeps them sane”. I believe that the KI is implying that seeing survivors helps make their job as oncologists bearable as otherwise they would only be seeing patients who die of their cancer, but the average reader may not discern this message.	Revised for clarity. Text now states “...as one KI noted, community oncologists like to continue to see survivors because “it keeps them sane,” to balance their case load of severely ill patients with a poor prognosis with cancer survivors. A qualitative study supports this perspective, noting that oncologist “feel protective of and possessive of some patients”.”

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Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 4	Findings	f. Page 13, lines 45 – 49 – I’m not sure that I understand the statement that “nurse practitioners may be more open to following an evidence-based approach than oncologists when interacting with patients and still possess the subject matter knowledge to allow them to be effective.” Can this be clarified?	Deleted sentence
TEP Reviewer 4	Findings	g. Page 14, lines 4 – 10 – There needs to be clarity of language, and intent, in this section. This section uses the language of “general practitioner” rather than PCP, which implies that these data all come from the UK or Australia or other countries where there are general practitioners. Caution should be taken in using these terms, as general practitioners in these countries are not necessarily the same with regards to training or scope of practice as PCPs in the US. Caution should be taken regarding extrapolating opinion regarding general practitioners in these countries and opinion regarding PCPs in the US.	We added a caveat regarding the geographic setting of the review
TEP Reviewer 4	Summary and Implications	This section does an excellent job of summarizing the most important issues related to cancer survivorship care models.	Thank you. No change required.
TEP Reviewer 4	Next Steps	a. #3 – Why is the caveat “following completion of active treatment” included in this statement? I recommend leaving the statement more general (i.e What is the opportune time to initiate....) as the survivorship community may identify that the opportune time is at a different point in the cancer trajectory.	This caveat is included to emphasize that for this report, cancer survivors are defined as individuals who have completed active treatment.
TEP Reviewer 4	Next Steps	b. Why aren’t there any Suggestions for addressing this question provided for items #3 and #4?	Clarified to indicate that suggestions are for items # 3, 4, and 5.
TEP Reviewer 4	Next Steps	c. Since #4 and #5 might differ for different risk groups, I recommend adding a question about risk stratification to both of these items.	Added to Next Steps section

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 4	Next Steps	d. #9 – Underserved populations include those in rural settings. Please consider adding specific mention of rural settings to this item.	Added to Next Steps section
Peer Reviewer 6	General Comments	This technical brief provides an excellent overview of the current provision of cancer survivorship care, focusing on the provision of at least two components of comprehensive survivorship care for people who have completed treatment for nonmetastatic disease. It presents a picture of a widely varying set of models of cancer survivorship care, with little awareness on the part of survivors or providers on what services are available. This will be a useful summary of existing research on programs, highlighting next steps for research and for improving survivorship care.	Thank you. No change required.
Peer Reviewer 6	Background	The authors provide a very good description of the problems to be addressed in survivorship care. This section may benefit from a brief description of the landscape of late effects. There is a range of lingering and late-occurring effects, and it is possible that this variety is a major source of the variation in services for survivors. For example, the needs of survivors with persistent neuropathies will differ from the needs of survivors at risk for life-threatening cardiovascular disease.	The Background section indicates that one of the IOM criteria for survivorship models is “prevention of new (primary) and recurrent cancers and of other late effects.” As late-occurring effects is one of multiple issues that are important for survivorship care, we do not feel that including a detailed description of these effects is needed for this technical brief.
Peer Reviewer 6	Guiding Questions	The guiding questions adequately capture the issues relevant to models of survivorship care. In general, it would be clearer to refer to these by a name (such as Overview, Context of care, Evidence, Gaps in knowledge) rather than GQ1-4.	ARHQ products require a consistent format across reports, hence our reference to the guiding question in addition to a short description of the focus of the question

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Methods	How were KI's identified? Did those who are involved in the provision of survivorship care come from different regions, institution types, etc.? After reading about the variation of services provided between and within institutions, the overwhelming impression is that few, if any, people know the entirety of models of survivorship care in existence. It would be helpful to know as much information as possible about the types of people who spoke as experts on this topic.	This information is described in Appendix A.
Peer Reviewer 6	Methods	Some description of the gray literature would be helpful – both how it was identified and at least what type of literature was found. Otherwise, the definition of cancer survivorship was clear and relevant, as was the description of the systematic review methodology.	This information is described in Appendix A.
Peer Reviewer 6	Methods	It would be clearer to organize the Methods around the four GQ's.	The report organization follows the format guidelines provided by the AHRQ EHC.
Peer Reviewer 6	Methods	Eligibility table is overall excellent and useful. My clarifying questions are: 1. How was "intermediate patient outcomes" defined?	Any outcomes that come after those attributable to the cancer treatment and before the mortality outcome.
Peer Reviewer 6	Methods	2. How were outcomes attributable to cancer treatment (but not late effects) determined?	The outcomes must have been explicitly described as such in the study.
Peer Reviewer 6	Methods	3. What is meant by "timing"? The year of the study, the timing relative to cancer diagnosis and treatment, the frequency and duration of follow-up?	Reworded text to state: "All timing related to the start of survivorship care".
Peer Reviewer 6	Findings	This was an excellent description of existing models, though there are, from anecdotal experience, exceptions to these categories. The comment that the categorization of the models is not exhaustive or mutually exclusive should precede the description of the categories.	We preceded the description of model categories with the following phrase: "Although these categories are neither exhaustive nor mutually exclusive..."
Peer Reviewer 6	Findings	The characterization of programs by the goals of care was interesting.	No change required.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Findings	The section on components of care was somewhat confusing. This could be clarified by referring to the IOM components with more descriptive wording, such as prevention of new cancers and recurrences, coordination of care, intervention for late effects, and surveillance for new cancers and recurrences (though these may be imperfect too). It would be helpful to refer to these components in the same order each time. The word “intervention” is particularly confusing, as it refers to one of the IOM components and, in this section, to coordination, prevention, and surveillance. Perhaps specific examples of each component would help. Did any components of care emerge from KI interviews or the literature that did not fit into the IOM framework?	Revised our definition of the components to be consistent with the IOM's definitions. Reordered references to the components so that they appear in the same order each time. No components of care that did not fit into the IOM framework emerged from KI interviews.
Peer Reviewer 6	Findings	The nature of current clinical practice is well described among the LIVESTRONG cites in the first paragraph, but this does not seem to describe all models of care and perhaps should be granted a less prominent spot in this section. The discussion of guidelines is interesting and critical. It would benefit from a brief description of how guidelines are defined (e.g., consensus of experts within professional society). There are more guidelines available for survivors (see NCCN and possibly ASCO).	As noted in the document, we cannot describe all models of care because of the heterogeneity in classification of models. As such, the presentation order is not an indication of greater relevance. We have added text describing consensus-based nature of guidelines
Peer Reviewer 6	Findings	The variation between programs, decisions based on feasibility, lack of integration into continuum of care, and the emergence of new care models are all well described.	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Findings	The financial incentives discussed under the potential disadvantages and harms of models of care is very important and nicely documented. However, there are also financial incentives for oncology providers to discontinue services for providers if they are reimbursed more lucratively for curative treatment. The growing number of survivors may also burden the oncologist's schedule, creating an additional incentive to shift patients to other models of care.	Added to Gaps and future research needs section
Peer Reviewer 6	Findings	There is a repeated sentence about the logistical disadvantage of non-integrated care. Some of the harms listed, such as low uptake and limited confidence among PCPs do not seem like harms, per se.	The themes of low uptake of new approaches in survivorship care and limited confidence among PCPs appear in the "Nature of Current Clinical Practice for Survivors of Cancer" section, not the "Potential Disadvantages and Harms of Survivorship Care Models" section.
Peer Reviewer 6	Findings	Patients' lack of autonomy in selecting a model of care is an excellent point, and the lack of awareness of existing programs among patients mirrors the lack of awareness of existing programs among providers and the KI's. All of this points to a disorganized set of programs and the need to document models of care. The study in this section (p. 12) describing receipt of treatment summaries in Canada does not fit in this section on patient awareness. (If this point of receipt of treatment summaries is moved elsewhere, there are other studies with similar findings that can be added to this.)	Added a sentence explaining the reason for citing this study. "Even treatment summaries, which can serve as a foundation for survivorship planning, are not commonly distributed."

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Findings	The section on organizational structure and setting accurately points out an understudied area of how models of care develop within different frameworks. The sentence containing “institutional variation” and “provider-level variation” is a little unclear – does this mean that variation between institutions is greater than the variation between providers within an institution? Also, there is a mention of online resources here, and the topic of how online resources can direct survivors to existing models of care or provide survivorship services may merit brief discussion.	Revised for clarity
Peer Reviewer 6	Findings	In the discussion on providers, there is no mention of the shortage of primary care providers in the United States. This parallels the impending oncology provider shortage, and survivorship models of care may need to bridge this gap as well. Also a study by Hudson et al. investigates survivor preferences for provider type.	Added some text about the predicted shortage of primary care providers
Peer Reviewer 6	Findings	The payment considerations section is very good.	Thank you. No change required.
Peer Reviewer 6	Findings	The section describing patient characteristics is a little bit confusing, as it seems to address predictors of patient needs for survivorship care, interest in and uptake of survivorship care, and presence of survivorship models of care. I think this section may best address predictors of presence of a model of care or use of a model of care. Cancer type seems to be a critical predictor of what care is available – perhaps cancers with large numbers of survivors or with more serious late effect profiles are more commonly addressed in existing models of care. Age, race, and other factors may predict uptake, or perhaps some models of care particularly focus on some subgroups. Alternatively, perhaps some racial or ethnic groups have limited access to survivorship care. The comment about rural and urban survivors may fit in this section.	We added an opening sentence to this section to explain the context, as suggested by the reviewer. The other predictors described by the reviewer are noted in the text.

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Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Findings	Well written section on supportive care. "Repurposing" existing services for survivors is an interesting point, and it is not clear whether this is generally done.	Thank you. No change required.
Peer Reviewer 6	Findings	Excellent points regarding risk stratification. Some institutions likely have an implicit riskstratified system in place that offers continued oncologic care to more high-risk patients and an alternative model to lower-risk patients.	Thank you. No change required.
Peer Reviewer 6	Findings	Excellent section on resources needed to share information, especially the point about how electronic systems are not structured for retrieval of information relevant to survivorship.	Thank you. No change required.
Peer Reviewer 6	Findings	Good section on evaluating survivorship programs, highlighting the need to determine useful outcomes. Study design is a key issue here, with unique models of care emerging at different institutions. Comparing between models and understanding usual care may hinder evaluation. Perhaps these may be mentioned in the section on future directions.	We note concerns regarding usual care in the Gaps and future research needs section
Peer Reviewer 6	Findings	The lack of information on uptake, frequency, and duration of survivorship care is described well.	Thank you. No change required.
Peer Reviewer 6	Findings	Regarding training and staffing needs, there is at least one study describing training programs for survivorship care, possibly through LIVESTRONG.	The LIVESTRONG position paper that we identified focuses on adolescents and young adults. www.ncbi.nlm.nih.gov/pubmed/20823410

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Findings	The systematic review of survivorship care models is overall well done and thoughtfully reported. The section on design characteristics should summarize the level of the intervention and comparison group in the studies, such as whether patients were randomized within a clinic or whether clinics were randomized. Along these lines, the only outcomes reported for these studies, with the exception of the few studies addressing costs, appear to be at the patient level. There seem to be no provider- or systems-level outcomes.	Added to the GQ3 section that all randomization was done at the patient level and that other than costs and resource utilization, no provider- or systems-level outcomes were included.
Peer Reviewer 6	Findings	I have a few comments regarding the clarity of the tables, which are overall organized and presented well. 1. Table 2. "Comparison among survivors" – does this mean between survivors receiving different types of care?	Yes; this has been clarified in Table 2.
Peer Reviewer 6	Findings	2. Table 2. For multiple stages, does NA mean hematologic malignancies?	Yes; this has been clarified in Table 2.
Peer Reviewer 6	Findings	3. Table 2. This is a stylistic choice, but it might be clearer to use descriptive table entries rather than X's for some columns. For instance, cancer types could be listed rather than described as multiple or not. In Table 3, start of survivorship intervention and duration of intervention could be described rather than categorized as <1 year or ≥1 year. There are many instances of this.	In order to facilitate comparisons across studies in this technical brief, we have elected to include categorical information rather than more specifics.
Peer Reviewer 6	Findings	4. Some typos: should be first author and year, check alignment of X's.	We have revised the citation format and corrected the alignment
Peer Reviewer 6	Findings	In the conclusions for GQ3, excellent points about the lack of research done, the heterogeneity of models, and the study design issues in evaluating care. Another theme that emerged in reading this, as mentioned above, is the lack of awareness of programs on the part of the KI's (of varying professions) and patients.	Added to the Gaps and future research needs section.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Findings	For GQ4, the gaps in knowledge are addressed well, although an understanding of late effects will likely emerge from survivorship studies in general, not studies of survivorship care. (The word “care” could be omitted.)	Added to the Gaps and future research needs.
Peer Reviewer 6	Summary, Implications, and Next Steps	Future research needs address important questions. “Oncology medical home” should be defined.	Added to the Gaps and future research needs section.
Peer Reviewer 6	Next Steps	Under the next steps section, it may not be necessary to define “survivorship model”, and expert consensus on defining this term seems like overkill. This technical brief is an excellent start to coming to an agreement on this term, and as programs evolve, this term may be defined through experience. On the other hand, describing “usual care” seems not only useful but relatively easy to achieve. Some studies have addressed this, but it is piecemeal. The other three questions I might add are about how to determine risk stratification for survivorship care, what study designs could address program evaluation, and what resources are needed to implement different models of care.	Added to the gaps and future research needs section
Peer Reviewer 6	Appendices	A. It is possible that the question on harms and disadvantages may not have had an appropriate probe, resulting in few comments on this topic. There may be harms such as allocation of resources away from curative treatment, additional worry and distress for patients, etc. It may be that KI's genuinely felt there were no harms, but this may be mentioned as a limitation if interviewers felt that KI's were unable to think of harms.	We included this limitation in the “Limitations” section.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Appendices	D. Some of the evidence tables were unclear in their presentation. Without listing all of the incidences, if there is more than one element in a column, it may be useful to list the lower element in parentheses or italics or separated by a line to distinguish rows of information within a cell. Some of the NR's are confusing (e.g., in Table 1, does this mean there is no trial name?) as are the NA's (e.g., in Table 1, under setting, not sure what this means). Table 2: it is unclear if the Gates study has multiple groups and what they are. Tables 5-8 have a lot of text, some of which can be greatly reduced and clarified, particularly eligibility. Level of detail should be parallel across studies. I think location and timing of study would be useful details. Sometimes assessments (like interviews) are listed under delivery agent; perhaps there should be a separate column for assessment and outcomes. Some acronyms (HL and SD, for example) should be defined. Table 9 has too much precision for percentages. Most importantly, table 10 (or a new table 11) should have study findings, not just outcomes assessed.	The evidence tables have been revised to clarify the issues raised by the reviewer. We disagree with the reviewer's comment regarding reducing information on eligibility criteria in Tables 5-8; this information is standard for systematic review evidence tables. Technical briefs do not include study findings; hence we have not modified the table to include these specifics.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 6	Overall Comments	<p>In this clear and well-written report, the authors attempt to define “models” of cancer survivorship care, and review the limited research that has been conducted related to evaluation of these types of programs. Because this is such a new--albeit fast moving --area, there is, not surprisingly, a paucity of data to analyze and present (N = 9 studies identified and reviewed). Overall, and despite this severe restriction, the authors have made a valiant effort to answer each of the guiding questions delineated to examine this topic. At times, they rely heavily on their Key Informants for answers to some of the specific questions posed. There were only 10 of these, in large part due to OMB constraints but also because the field of experts in this topic area is still relatively small. By consequence, all participants (although blinded as to who participated) were likely very familiar with one another and many hold strong shared opinions. Due to this, some concern is raised as to whether the authors have truly 'saturated' the potential field of viewpoints they might have solicited.</p>	<p>Addressed these limitations in Summary and Implications section.</p>

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 5	Overall Comments	<p>A significant product of this work is the attempt to actually define what is meant by a 'model' of survivorship care, at present an elusive entity. The definition provided by the authors that this concerns, "a program for survivors that addresses two or more different health care needs," is a welcome contribution to the literature. An even better one might be that it address at least two of the four areas of care deemed by the IOM Lost in Transition report as encompassing survivorship care (surveillance, prevention, intervention, communication). The only caution here is that the authors likely should also be sure to define who they mean by 'survivors' (understood here to mean those who are transitioning from acute care or are post-treatment for cancer -- in concordance with the IOM Lost in Transition definition) as this too is a relatively contentious term in the field. Other valuable contributions are: the clear recognition of and reminder that there is no 'one size that will fit all' in caring for the growing population of cancer survivors; the observation that while mentioned by many, triage to levels of care has not been systematically built into extant models (although the authors may want to review the work being done in the UK on risk stratification: www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/risk-stratification/); the articulation on pg 9 - 10 of our need for some schema by which we can classify and compare model; and the several thoughtful next steps delineated at the end of this document.</p>	Text regarding the definition of survivors has been clarified as suggested by the reviewer.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 5	Overall Comments	<p>There are a number of places where clarification/elaboration would be helpful. The first and most important of these, is the rationale behind our need to better understand cancer survivorship care models. The authors emphasize in particular the need for better coordination of care for and communication with survivors. However, in the background, the authors give insufficient emphasis to the real driver behind this effort, beyond noting that the population of survivors is growing; namely, survivors have unique care needs post-treatment. These include the fact that survivors: a) are at higher risk of recurrence/second cancers for which they need to be monitored; b) often experience chronic and late occurring effects of their disease and its treatment which need to be identified and treated or, when possible (as in the case of late effects) prevented; often have co-morbid conditions that may have been caused or exacerbated by treatment and need to be managed; and benefit from health promotion to reduce preventable morbidity and mortality. As noted in the Lost in Transition report, they are also poorly informed about what is supposed to happen after treatment ends. Further, there is lack of consensus about who should provide or coordinate all this care. Some reference to the literature about these very specific effects that make their care more complex to manage is warranted. Otherwise one could argue: why are they a special case? Why not just treat cancer survivors the way we do those with any other chronic health condition, like diabetes or heart disease?</p>	<p>Text in the Background section has been added to incorporate the reviewer's comments. The reviewer's comment on the lack of definition regarding outcomes for cancer survivorship care has been added to the Gaps and future research needs section. However, it is beyond the scope of this document to attempt to define the specific outcomes that survivorship care programs need to address. The need to define a minimum set of outcomes for survivorship models was listed in item #6 of Next Steps.</p>

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 5	Overall Comments	In the same vein, there was the sense in reading this document that insufficient focus was given to understanding not just how these programs are configured, but importantly to determining what impact they are having---if any---on patients, providers, systems, payors, policy. Efforts to design and evaluate survivorship care models must have assessment of outcomes/endpoints/determinants of success built into the process. This point is felt to be critical and warrants greater attention in this review. In this regard, the manuscript itself talks about 'outcomes' in many places but does not really define these. For example, on page 2 the header reads: "Models of Care Intended to Enhance Outcomes..." What outcomes?	Text in the Background section has been added to incorporate the reviewer's comments. The reviewer's comment on the lack of definition regarding outcomes for cancer survivorship care has been added to the Gaps and future research needs section. However, it is beyond the scope of this document to attempt to define the specific outcomes that survivorship care programs need to address. The need to define a minimum set of outcomes for survivorship models was listed in item #6 of Next Steps.
TEP Reviewer 5	Comments	In the section addressing nature of current practice, there appeared to be no inclusion of the handful of studies examining physician preferences for models of care, although citations were included on patients' experience with these. Is there some reason this literature is omitted? Similarly, there a few studies that also examine physician comfort with providing survivorship care, e.g., medical oncology vs. PCP, nurse practitioners. Inclusion of these references with some comment would enrich this report.	we have expanded some sections with additional references and added text to Gaps and future research needs section
TEP Reviewer 5	Abstract	In addition to these larger points, a number of minor edits are needed. --Abstract, under the background section, last sentence, there is a typo: "of" is left out in the phrase "...and proposed models OF survivorship care..."	Revised
TEP Reviewer 5	Methods	Discussion with KIs' need to add reference to Appendix A.	Added a reference to appendix A in this section.
TEP Reviewer 5	Published Literature reviewed	It is unclear if the search eliminated foreign publications? What search terms were used?	Added the search terms to Appendix A. The search included foreign publications, but had to be available in English language.

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Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 5	page 8 top, second sentence,	edit needed: "The responses to GQs 1 AND 2 (delete the 'and' after 2) were primarily..."	Edited the text: "The responses to GQs 1 AND 2 (delete the 'and' after 2) were primarily..."
TEP Reviewer 5	page 9	several citations to reference #32 (Campbell KL et al) did not seem to fit with or have a relationship to the statements being made? This was usually paired with #44 which, by contrast, seemed wholly appropriate.	Corrected
TEP Reviewer 5	page 10	Components of Care section, next to last sentence, omit 'both' as the reference is to multiple (more than two) effects of interventions: "...should address (omit 'both') patients' physical and emotional needs, address the needs of family...and be designed to..."	Omitted "both" from this sentence.
TEP Reviewer 5	page 15	While there may be more limited data on supportive care needs, there are a number of published studies on the information needs of cancer survivors (see work by Neeraj K Arora and colleagues at NCI); some of these are from population based (cancer registry) samples.	We included the Kent et al study on which Dr, Arora is a coauthor
TEP Reviewer 5	page 31, question 5	Suggestions for addressing this, third sentence, there is a typo: "...models should examine differenceS ('s' missing) in outcomes..."	Corrected in text as per reviewer's comment
TEP Reviewer 5	General Comment	Overall it is felt that this report will help guide a field that is at present blindly racing forward to build care programs for survivors but with very little thought to all of the salient issues so nicely articulated in this document. Its messages are timely and needed.	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 6	General Comments	This is an important topic in oncology and will serve to guide research and clinical practice in the future. It is additive to other reviews and publications and will be a definite contribution. One major issue to be addressed is the way the report goes back and forth between findings in the literature and key informant comments. It becomes confusing and one wonders whether the anecdote holds more weight than the data presented or fills in when there is limited data or when none exists. There are a number of places where one key informant is quoted, which reduces the credibility of the report. In addition, the quotes sometimes use jargon that is not clinically precise and, thus, not useful. Understandably, the many models of care are confusing, but the text in the report doesn't add the needed clarity to the discussion. It would be good to set out a framework by setting and principle provider.	<p>The intent of the technical brief is to provide an overview of the literature that integrates qualitative and empirical data. We recognize that in some instances, we had to rely on anecdote and personal experience and note the lack of data saturation from qualitative interviews as a limitation of this technical brief.</p> <p>Limitations on the number of key informants unfortunately result in single KI input on several issues.</p> <p>Regarding the issue of developing a framework, we attempted this exercise and found that no accepted framework, or even theoretical basis for a framework, exists.</p>
TEP Reviewer 6	Introduction	1. In the Background section, it is unclear why the authors propose that "it is reasonable to consider whether certain survivorship models, by involving additional clinicians in the health care of the individual, may themselves lead to greater fragmentation of care and potential harms..." This statement is made in more than one place and seems like speculation since there is no evidence to support it and the authors don't expand on the statement.	This statement has been made more conditional and a potential justification has been provided in response to the reviewer's comment.
TEP Reviewer 6	Introduction	2. In the second paragraph in the section, "Models of Care Intended to Enhance Outcomes and Provide Supports Among Cancer Survivors," the foot problem is an odd example and can easily be made cancer specific.	The example is cancer specific and illustrates the issue in defining "medical care needs". As other reviewers have not objected to this example, we propose to leave it in the report.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 6	Introduction	3. Since the LIVESTRONG at the YMCA only involves a limited number of Ys, might it be more useful to suggest that smaller communities partner with health clubs and exercise centers?	The text has been changed as per the reviewer's comment.
TEP Reviewer 6	Methods	1. In the criteria section, it states that the report only includes studies of individuals who have completed active treatment. It would be worth stating this definition of "cancer survivor" up front in the report.	Added this definition earlier in the report.
TEP Reviewer 6	Methods	2. In Table 1, one of the inclusion criterion for an intervention is whether it is intended to facilitate and survivors experience. What does this mean?	We define this as an intervention designed to address or support two or more services that address the patient's needs.
TEP Reviewer 6	Results	1. In GQ 1 and other places in the text, the observational study done by the LIVESTRONG Centers of Excellence is quoted. Be careful making general inferences since the study was conducted at academic medical centers and the patient population was young adults whose needs may differ from the majority of cancer survivors who are 65 and older.	Based on the information available, the article met the criteria for inclusion: Participants included survivors diagnosed during the pediatric (0–14 years) or adolescent or young adult years (15–39 years).
TEP Reviewer 6	Results	2. In GQ 1, the term "guideline should be defined. This section on guidelines is vague and could sue some specificity. For example, is the lack of clarity about roles with respect to surveillance guidelines?	To address this comment, we have included the following definition of guidelines: "statements that include recommendations intended to optimize patient care" (IOM 2011). Since the KI did not specify whether roles lacked clarity with respect to surveillance guidelines or otherwise, we are unable to respond to this comment.
TEP Reviewer 6	Results	3. In GQ 1, a second theme of coordination is mentioned but the text following the statement seems to focus on delivering formal guidelines.	It is unclear which guidelines to which the reviewer refers. The text in question relates to CMS benefit categories, not to guidelines.
TEP Reviewer 6	Results	4. In QC1, the statement that "many features of optimal cancer survivorship care are not covered currently" needs justification.	Addressed this comment by specifying gaps between guidelines and usual care.
TEP Reviewer 6	Results	5. In GQ1, there is the statement that patients may self-select out of new models of survivorship care? What does this mean?	Addressed this comment by using clearer language to indicate that some survivors may decide not to participate in new models of survivorship care.

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Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 6	Results	6. In GQ 2, there is a discussion of the organizational structure that is too anecdotal. The point that academic centers took the lead in developing models of survivorship care is missing.	We note that these anecdotal insights are all the information we have.
TEP Reviewer 6	Results	7. In GQ2, where the provider responsibilities is discussed, the quote, “keeps them sane” should be replaced with a useful statement, such as “emotional and financial benefits.”	We added more text to explain the statement
TEP Reviewer 6	Results	8. IN GQ2, the section on payment considerations mentions reimbursement difficulties without any evidence to support it. The example of the medical home in Pennsylvania is not relevant and should be deleted. The section on the insurance companies should be deleted unless there is evidence to support the statements.	The medical home example is deleted, Insurance company statement is based on KI comments and is retained
TEP Reviewer 6	Results	9. In GQ2, paragraph 2 includes a statement by a KI about longer chemotherapy and poorer quality of life and worse health status. This needs a publication reference.	We were unable to find a specific citation and have revised the sentence to drop the reference to publications
TEP Reviewer 6	Results	10. In GQ2, the transplant patient is given as being in a high-risk category. One needs to be specific about the type of SCT. Auto/allo? They differ in long term and late effects. Not all SCT patients are followed for life.	Although important distinctions exist within each group of patients, the KI offered this categorization as a framework, rather than as a settled hierarchy.
TEP Reviewer 6	Results	11. In GQ3 - the Findings from the KIs section - the comments are not always well informed and detract from the credibility of the report.	The KIs are well known experts in the field of cancer survivorship. While this reviewer may disagree with their statements, they are nonetheless relevant comments regarding models of cancer survivor care.
TEP Reviewer 6	Discussion and Conclusion	1. The Summary and Next Steps section is clear and well written.	Thank you. No change required.
TEP Reviewer 6	Clarity and Usability	The Brief needs considerable editing to make it clearer and not so anecdotal in the presentation of the issues.	We have edited the brief, but the nature of the product is such that it will include qualitative perspectives including anecdotes.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 7	Comments	An excellent statement of the state of survivorship care, both the diversity and the paucity. The summary queries are well-done. The report underscores the tremendous amount of work that still needs to be done in this area. Thank you.	Thank you. No change required.
Peer Reviewer 7	General Comments	Viswanathan, Halpern and Swinson present a Technical Brief assessing Models of Cancer Survivorship Care using literature review and key informant interviews as their main source of information. This is an outstanding assimilation to improve our current understanding of this increasingly important issue and this document will likely be used for years to come to influence future research as well as current and future model development and implementation.	Thank you. No change required.
Peer Reviewer 7	General Comment	There are a number of issues that the authors should address to improve the manuscript: 1) The term “gray literature” is jargon and would recommend defining this and/or stating the type of literature to which you are exactly referring instead	The RTI-UNC EPC uses the term “gray literature” to describe the sources that are not peer reviewed. We provide detailed explanation of the types of literature in Appendix A.
Peer Reviewer 7	p. 1, Background	2) 4th paragraph, the following should also be considered as barriers to optimal care for cancer survivors: lack of data for benefits from certain interventions (lack of a robust evidence base) or lack of knowledge of available evidence on the part of providers, patient non-compliance with recommended follow-up or even participation in a survivorship program;	Text in the Background section has been modified as per the reviewer's comments.
Peer Reviewer 7		3) End of same paragraph as 2 above, would modify last sentence to read “is not achieved among providers and patients.” If you address and don't act, where are you? Further, patients have a roll as well.	Text in the Background section has been modified as per the reviewer's comments.
Peer Reviewer 7	P. 2	4) Defining what a model is was an outstanding contribution of this manuscript. The authors should refer to this later when they recommend that what a model is be defined.	Thank you. No change required.

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Peer Reviewer 7	P. 3	5) first paragraph re: partnering with a local Y: would add, or refer to services offered outside of the program (e.g., weight management program, smoking cessation services, cardiology clinic for follow-up of cardiotoxicity)	Text in the Background section has been modified as per the reviewer's comments.
Peer Reviewer 7	P. 5	6) it is notable that no actual patients (advocates are not the same as regular patients) or oncologists were interviewed. I suspect that some of the researchers were oncologists, but what about oncologists in private practice who deliver the majority of cancer care in this country. It may be too late for this brief to do more interviews, and perhaps it was felt that such interviews would not add much (these people would know little about available models perhaps), but it is important to recognize and perhaps discuss why they were not included.	In our methods section, we note that we included oncologists and patients. Nonetheless, we are limited by Office Management and Budget guidelines and note as much in a new section on limitations of this brief.
Peer Reviewer 7	Table 1	7) The title for Table 1 is either incomplete and/or incorrect.	Title to Table 1 has been modified as per the reviewer's comments.
Peer Reviewer 7	p. 11	8) I am not sure that The comment is fully correct: "a consequence of this lack of clarity about roles is the over- and underuse of surveillance testing" and think that a lack of evidence or even consensus, and possibly knowledge or agreement, when evidence exists, surrounding what should be done is more likely to contribute to over and undertesting.	The original text did not explicitly state that this sentence reports on KI interview findings. We chose not to evaluate KIs' statements in the findings section of the technical brief. The revised text specifies that this sentence reports on KI interview findings.
Peer Reviewer 7	P.11, Same paragraph as 8	9) While there are no outcome data re: the models as noted in the last sentence, you might give a nod to the extensive prior data suggesting gaps in survivorship care and common sense strategies/approaches to filling those gaps in a efficient and effective manner which is what may programs are trying to do.	We note gaps in the evidence identified by us and others in several places in the report.
Peer Reviewer 7	p. 11	10) paragraph below, last sentence re: Another KI, this should be rephrased as right now it is not easy to read and understand the intended meaning.	We have addressed this comment by splitting the sentence in question into two clearer sentences.

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Published Online: March 18, 2014

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 7	P. 12	11) Under potential disadvantages and harms- I am surprised that there is no discussion of potential advantages and disadvantages of different care models in the literature and would submit that is there but not necessarily labeled as such. For example, studies regarding which models/providers patients find acceptable for follow-up care suggest that patients find some models unacceptable and this is likely because of concerns, either real or imagined, that care would be less, things would be missed, and outcomes would be worse. Isn't discussion of that, or discussion of the cost of various models, some more, some less or the lack of availability for providers (e.g., oncologists) for a various model, a discussion of the potential advantages and disadvantages of a model?	The studies that we identified on patient preference and satisfaction relate to providers rather than models of care and have been addressed in the relevant section
Peer Reviewer 7	Same paragraph as in 12	13) throughout the manuscript, there should be care taken regarding describing what was not discussed by the KI's given the investigators were following a script and KI's may have had a lot of opinions about a particular issue, but were not asked and thus did not address the issue. (e.g., again in first paragraph on p. 18, how can you possibly know if KI's were unaware if they were not asked about an issue?)	We have added a section on limitations that notes that we had not achieved data saturation from the qualitative evidence
Peer Reviewer 7	Same section as 11 and above	14) some oncologists question the PCP's ability and PCPs and oncologists question the midlevel's ability.	We have noted confidence or lack thereof in other providers in the section on providers
Peer Reviewer 7	Same section as 11 and above	15) last few sentences would clarify: ...if roles are not clearly delineated or communicated adequately... and the risk of poorly prevented or managed late effects....	We chose not to edit KIs' statements in the findings section of the technical brief. However, we agreed that the word 'latent' was likely an interview transcription error and have revised this text

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 7	P. 13	16) I think the comment regarding np's more open to following evidence-based approach is a little off, extremely subjective with very limited evidence to support this, and not reflective of the way patients are cared for in practices that have doctors and NPs in general, and the KI possibly meant that nurses are more likely to be wiling to follow a protocol or care plan that has been laid out given care planning is part of their training. In most practices, this is how nurses (even NPs) practice - the physician learns and decides whether the evidence base is robust enough to be followed or develops a consensus (that might be that physician in solo practice alone who decides) of what to do, and then the practice (including NPs providing care) follows it.	Revised by deleting the indicated sentence.
Peer Reviewer 7	End of page 13	17) would include in this discussion of patient preferences and concerns about different models, Mayer et al., Breast Cancer Survivors' Perceptions of Survivorship Care Options, JCO, 2011.	Included
Peer Reviewer 7	P. 16	18) Application of risk stratification section: it should be noted that de facto, and in some guidelines, risk based care is practiced and recommended particularly with regard to certain long-term and late effects (e.g., mammogram for young women treated with chest irradiation at a young age) as well as follow-up for disease recurrence- need for and frequency and duration of scans in a number of diseases varies with stage at diagnosis.	Added a parenthetical phrase, but the statement about risk stratification relates to cancer care models.
Peer Reviewer 7	P. 18	19) under Training and staffing: would clarify what a teach-the-teacher model entails.	Replaced this phrase with a more commonly used term "train-the-trainer"
Peer Reviewer 7	paragraph just below 19 above	20) would sound better to describe having the training and skills necessary than saying "at the right level" re: NPs addressing survivorship issues with patients.	Revised

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 7	P. 18	21) paragraph beginning, "Substantial heterogeneity", would omit saying "... in this systematic review of the literature for the Technical Brief" after "Three studies identified" given the who paragraph is about the lit review for this brief. Also, think you mean studies rather than models in the second to last sentence beginning: " In each of these three models."	Text modified as per the reviewer's comments.
Peer Reviewer 7	P. 20	22) I am not sure of the meaning of the last sentence that begins, "Interestingly" just before the section, Outcomes. Which clinicians are being discussed here?	This sentence has been clarified.
Peer Reviewer 7	P. 26, in Conclusions from the Lit review	23) would recommend further discussion of this field evolving, and note that in the section referencing the review and study of Salz et al published early 2012, two things: 1) what constitutes "addressing" all these issues may vary and 2) many large centers have survivorship programs where care plans are shared with select patients that to some degree cover each of the issues.	The text in this section has been clarified to better explain "addressed". However, as we do not have information on coverage of survivorship care plans provided by many large centers, it would be in appropriate for us to comment on this.
Peer Reviewer 7	P. 27	24) discussion re: barriers to participation, it would seem important to distinguish between barriers to participation in research vs. barriers to care including survivorship care and care programs which are likely related but separate and these appear to be conflated in this discussion.	The text in this section has been modified in response to the reviewer's comments.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 7	P. 28	25) Gaps in Knowledge section: I am not sure that the evidence base for what happens to cancer survivors and determination of the risk of problems, nor what should be done to prevent/mitigate long-term/late effects is likely (nor is it necessarily the best, most efficient and effective research model) to come from studies within survivorship care programs. More likely, data will and has come from large epidemiologic databases as well as clinical trials. Enhancing the trials follow-up for important but non-lethal long-term, late effects as well as adding research studies to evaluate optimal follow-up in certain populations (specific diseases, specific stages, following particular treatments) is more likely lead to important findings in this setting then trying to find relative needles in haystacks in more heterogeneous survivorship clinics in general.	The text in this section has been modified in response to the reviewer's comments.
Peer Reviewer 7	P. 29	26) first paragraph defining survivor, would modify to read "and is observation only, or preventative or maintenance therapy..."	The text in this section has been modified in response to the reviewer's comments.
Peer Reviewer 7	p. 29 3rd paragraph under barriers	27) acknowledgement of lack of patient awareness or interest/adherence to survivorship care visit or follow-up.	The text in this section has been modified in response to the reviewer's comments.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 7	p. 29, 3rd paragraph	28) while it is acknowledged identification of candidates for survivorship care is a barrier, nowhere in this document is the discussion of the current state that even at major centers where care plans are available in theory for everyone, usually if they show up at consultative survivorship model clinic, getting to the masses of cancer survivors with true survivorship care planning (beyond when their next oncology follow up visit is!) remains an elusive goal and a huge barrier to this is the sheer numbers and relative lack of prioritization of this issue (vs. trying to get more patients treated and to survivorship!) I think this needs to be discussed, and similar emergence of palliative care as an important component of cancer care, survivorship needs to be further prioritized by leadership.	Added to Discussion Points from Reviewers section.
Peer Reviewer 7	p. 30, #2	29) the discussion of what is standard or usual care and the need to define standard care seems unnecessary and a waste of space and effort if this recommendation were to be followed. The standard is heterogeneous and messy and this has been well-documented in the literature citing the many gaps in care of cancer survivors. (see IOM report Lost in Transition, cited previously).	Other reviewers have commented that this is a key issue. This comment has been added to the Discussion Points from Reviewers section.
Peer Reviewer 7	P. 30-31	30) Questions 3 and 4 have no suggestions following to address the questions.	Clarified that the suggestions following question 5 are for questions 3, 4, and 5
Peer Reviewer 7	P. 32, question 8	31) cost should be added to every future study assessing models of care.	This comment has been added to the Discussion Points from Reviewers section. However, we disagree with this comment for the reasons stated in Next Steps item #8.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	Structured abstract	<p>This report is timely and fills an important need in the areas of cancer survivorship research and delivery.</p> <p>1) Structured abstract is solid and fills the mission as outlined in review guidelines. The one suggestion I would make in this area is to reconsider the sentence beginning “Our systematic review of the literature for the Technical Brief...” since models might include nurse-led, physician-led, shared cared, the patient-centered medical home, and individual/group counseling models imbedded in those more macro models. I would question whether the survivorship plan is a model—and suggest that, rather, the survivorship care plan is a specific tool (or component, as organized in your findings section, though not in GQ3) used in care planning and delivery models to prepare patients, coordinate care, and promote communication. I would also suggest a broader scope in approaches that moves from thinking of which provider leads care to team-based care models. This shows up in the findings, but would be useful to indicate in abstract.</p>	<p>We have changed the text to reflect that one group of models included survivorship care plans as a key component rather than the survivorship care plans being the model. As much of the literature on survivorship care models focuses on the health care provider leading the provision of medical care, we have retained this terminology.</p>
TEP Reviewer 8	Structured abstract	<p>2) Process and continuity of care are not adequately addressed</p>	<p>This has been added to the abstract conclusions.</p>

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	Background	3) Background section/Increasing Population: Note that the IOMK report was based on consensus rather than evidence to a large degree. Barriers to optimal care include not only lack of clarity about roles, but also RESPONSIBILITIES. Inadequate care coordination not only may lead to duplication and omission, it may lead to lack of continuity, lack of process for coordinated teamwork. This lack of continuity (process issue) is as problematic as the duplications and omissions. Last paragraph before Models header: suggest adding lack of clear delineation of responsibilities after the shortage issue. Even without a shortage, there are significant problems because it is not clear who should be caring for which patients when on the continuum. As other providers are added to the mix, this issue will only become more important.	1) We have included a comment on the text that the IOM recommendations are consensus-based. 2) We have added a comment regarding lack of clarity about responsibilities. 3) The text already discusses that challenges in survivorship care may “result in inadequate care coordination, leading to the duplication or omission”; we therefore have not mentioned this again. 4) As we have added a comment on the lack of responsibility in earlier text, we have not added another mention of this issue in this subsequent paragraph.
TEP Reviewer 8	Background	4) Background section/Models of Care: this is an important point made about the fact care will not be one-size fits all, and thus models will be diverse and need to be tailored to survivor needs and provider resources/workflow/team membership. May want to mention patient-centered medical home models.	We have added text indicating that survivorship models will need to be tailored to these factors. As there is little agreement and essentially no evidence regarding patient-centered medical homes for providing survivorship care, we do not mention this model.
TEP Reviewer 8	Background	5) Background/overall: very strong and clear. Delineation of criteria for what constitutes a model and its components is clear and meaningful.	Thank you. No change required.
TEP Reviewer 8	Guiding questions	6) Guiding questions. I am unclear whether changes were made? Guiding question 2—org structure is important, may also want to consider type of delivery system (integrated, etc.). Also under Guiding question 2, it may be useful to consider what processes of care delivery (teamwork, decision-making, transitional care) are in place.	The revised guiding questions are available in Appendix A for comparison to the original guiding questions. We are unable to add these elements to the the guiding questions now because the project is completed but concur that these elements may be important to consider in an update.

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Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	Methods	7) Methods section. Type and number of KIs were indicated, how they were engaged was not discussed. Process for selection of literature is well-specified. Table 1: It is unclear why outcomes among healthcare providers were excluded, given that patient outcomes were included and system, outcomes (cost, utilization) were included. To gain a comprehensive understanding of the models, provider outcomes would be of interest.	Added information about how they were engaged. For the scope of this effort, we are focused on outcomes specific to patients and related system outcomes that they experience.
TEP Reviewer 8	GQ1	8) Findings GQ1: array of types of care is well-articulated, but an organizing strata and figure/table that indicates how these categories overlap might be helpful since the categories do not appear to be mutually exclusive (e.g. disease-specific vs. general clinics might be organized as separate or integrated models and any model could use a care plan. As you note, the lack of a schema to organize these models makes It very challenging to compare structures, processes and outcomes. Also important that this report notes the extant literature provides little information about which models are most widely used and KIs noted wide variations in practice and lack of clarity in roles and responsibilities. Potential disadvantages and harms listed make sense, lack of evidence- based guidance in constructing and delivering these models is a disadvantage that parallels the reimbursement issues noted in the GQ1 section.	In an earlier draft of the document, we included a table much like the reviewer recommends. We ultimately excluded the table given that we currently lack an organizing schema, and the table artificially imposed an organizing schema.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	GQ2	9) GQ2: Important to note that survivors are not given choices and information about survivorship care, and many are not even provided a treatment summary, let alone care plan. Also a very important statement (p 13) that no study described how models might vary based on organization or setting. This is a major gap. Context of payment considerations is important, as is lack of research on risk stratification and I would add: lack of literature assessing match between survivors' needs and services provided. Section on resources needed to share information (pg. 16) discusses SCPs and EMRs. But I would suggest we need to think more broadly to include processes, such as teamwork and team functioning, which will aid communication regardless of the platform used to store and transfer information. Absence of studies on training or staffing needed for survivorship care is important gap. Some discussion of workforce development could be useful here and that development might include teamwork.	Added to the GQ2 section on resources needed to share information
TEP Reviewer 8	GQ3	10) GQ3: As noted in my comments on the structured abstract, survivorship care plans might be better considered as a component of survivorship models, and especially as a component of transitional care models (which would be supported by your finding that transitional care was explicitly incorporated as a facet of survivorship care model only in the studies of SCPs). Models of survivorship care planning might include care plans, navigators, shared care, etc. as components or mechanisms for care planning. This is a suggestion about how to organize and present the content of the report versus a suggestion to change content. Heterogeneity of the literature is well articulated.	We agree and have changed the text to refer to "models in which SCPs are a key component".

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	GQ4	11) GQ4: structural and process barriers are noted as a gap. But science should also explore best processes for delivering coordinated care, including processes such as teamwork and planning. Very important that survivors' needs is identified as a gap area of research, as is barriers. For future research needs, I would suggest research is missing not just on models and their components, but also their context. In summary and implications, heterogeneity and paucity of research are noted as key issues. I would suggest that the lack of an organizing stratum or framework to understand the models and map it to evidence is a key gap (and one that you note in an earlier GQ). I would suggest reiterating this in your summary/conclusions. Without a conceptual model that maps these models and shows their overlaps, it will be difficult to make sense of this body of work and develop a cohesive body of science.	We have added text highlighting the lack of provider knowledge regarding best processes for delivering coordinated care as a gap. We have also included lack of information on the context for survivorship care models in the Future Research Needs section and questions regarding conceptual models in the Next Steps section.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	Next Steps	12) Next Steps. #1 is very important and I reiterate the point above re: how care planning might fit into models versus be considered a model itself. Need for taxonomy that is called for in next steps #1 is critical. #2 it's clear from this review that usual care varies so greatly that perhaps there is no standard usual care—perhaps comparisons of patterns of care is more relevant? #3: assumes that the time to begin survivorship care is after tx, when it may be that the optimal time to do so in terms of coordinating care and decreasing fragmentation is before care ends. May be useful to consider the role of preparation for end of treatment transition as part of survivorship care and think about how to integrate with existing care structures and patterns. If we do not consider the transitions from active treatment and to palliative care, then the models we will perpetuate fragmentation across the care continuum. #7: for models using SCPs, these are key questions, but it also may be useful to ask survivors if they find SCPs useful and if every survivors actually needs one. Other questions look good, would suggest adding a focus on the process of care involved in delivery of these models, as coordination and fragmentation are identified as issues.	We have added a mentioned on the need for conceptual model in Next Steps #1. “Usual care” as mentioned in #2 would likely involve patterns of care. We have included a question on the role of end-of-treatment transition care in #3. We have also added comments on care coordination/ fragmentation to #6 and on the perceived usefulness of SCPs to #7.
TEP Reviewer 8	General	Overall, this will be a fabulous resource in guiding a developing field with great variation in practice and a fledgling evidence base.	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 8	General	A side comment: I realize the focus on adult cancer survivorship was determined earlier conversations that we had with the panel about the focus of this report. In the interim, NCI released two FOAs (12-274 and 12-175) focusing on survivorship care planning in adult cancer survivors and have received significant feedback that the issues of care coordination and models of care post-treatment for survivors of childhood cancer face many of the same challenges and in fact, are not as well coordinated as assumed. We are learning from our experiences with these FOAs that it would have been better to include adult survivors of childhood cancers.	We have added a mention of these two FOAs at the end of the Future Research Needs section.
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	The American Society of Clinical Oncology (ASCO), with more than 30,000 members worldwide, is the leading medical professional oncology society committed to conquering cancer through research, education, prevention, and delivery of high-quality patient care. ASCO is committed to improving the care of cancer survivors, and we appreciate the opportunity to provide comments on the AHRQ Technical Brief on Models of Survivorship Care.	No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	<p>For the last several years, ASCO has worked with groups inside and outside ASCO to enhance the quality and quantity of initiatives addressing cancer survivorship. ASCO's Cancer Survivorship Committee, composed of clinicians and researchers from multiple specialties including primary care, has developed a comprehensive agenda to assist ASCO members in the delivery of quality survivorship care. This agenda includes developing guidance for oncology care providers on the clinical management of cancer survivors, increasing collaboration between oncologists and primary care providers (PCP) in the provision of cancer survivorship services, improving health professional education and training, increasing patient and family education and self-advocacy, supporting research on cancer survivorship, and promoting policy change to ensure cancer survivors have access to appropriate health care services, including improving the payment environment so that adequate, uniform reimbursement for prevention counseling, interventions, and therapies is provided by payers.</p>	No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	As noted in the AHRQ technical brief, optimal survivorship care requires a comprehensive, multidisciplinary care infrastructure or model of care. Evidence-based models are needed to stratify cancer survivors into different levels of intensity and settings for follow-up care. To ensure care coordination among oncologists, PCPs, and other providers, we also support the use of written treatment summaries and care plans, which communicate the survivor's health status, provide a care roadmap to ensure survivor-appropriate services, and clearly delineate which provider is responsible for which aspect of care. Survivorship care planning is a core measure of the ASCO Quality Oncology Practice Initiative (QOPI) and also a program standard of the American College of Surgeons Commission on Cancer. An important issue to address increased use of treatment plans and summaries, as well as increased integration into electronic health records.	No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	<p>The AHRQ Technical Brief on Models of Survivorship Care aims to provide an overview of models of cancer survivorship care, including the benefits and limitations presented in the current literature and interviews with key informants, and outlines steps for future research. We commend AHRQ for taking on this complex topic and bringing needed attention to it. In order for the report to fully meet its intended goals, we have the following recommendations:</p> <p>The paper seems to focus mostly on the reports of the key informants. As a result, there are too many quotes, especially from single informants that read like testimonials. Providing consensus comment is appropriate in instances when they give some context to the barriers and why there are so many different models being implemented. However we suggest that key informant quotes be used only when they fill in blanks in the literature.</p>	As noted above, a technical brief weaves information from the evidence and supporting perspectives from key informants. We used key informant insights to support or add perspectives to the literature where available, and relied on KI input exclusively where we found no empirical evidence.
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	<p>We agree with the main point in the draft report which states that there is significant heterogeneity in current models of cancer survivorship care and that there is a paucity of data evaluating outcomes of care provided in these models. The report suggests multiple possible outcomes to evaluate, however studies that included endpoints related to provider outcomes were excluded from consideration in the draft report. We think that provider outcomes (such as primary care provider satisfaction) may be important endpoints to consider when evaluating the success of a cancer survivorship program. In addition, other endpoints could include cost, patient satisfaction and patient adherence to surveillance recommendations among others.</p>	Added text to the report that clarifies that provider-level outcomes were not excluded from the report, but beyond costs and resource utilization, were not included in any of the identified studies.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	We also agree with the discussion in the AHRQ draft report regarding the potential role for risk stratification in individualizing survivorship care. However, the draft report did not address the role of long-term anti-cancer therapies, and this is another factor which will need to be considered when individualizing survivorship care. For example, recent data suggests 10 years of adjuvant tamoxifen is superior to 5 years, thus many breast cancer survivors will be receiving ongoing anti-cancer therapy up to 10 years after diagnosis. Who should monitor and provide such care has not yet been fully addressed. Certainly, primary care providers would need further education regarding the optimal duration of adjuvant endocrine therapy and its potential toxicities if they were to assume the primary role of care for patients on these long term anti-cancer therapies.	Added to Discussion section
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	It would be beneficial if the document addresses cultural-contextual dimensions of models of survivorship care, which in turn reflect on the model feasibility/applicability. For example, the issue could be raised on page 4, before areas of future research, as well as in the conclusion, as shown below: In item 2, “Context in which cancer survivorship care is used”: Add “cultural and socio-economic context” to the bullet: “Patient characteristics such as age, race/ethnicity, cancer type, stage of disease, another risk-stratification issues”	Added to Discussion section

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	In item 4, “Gaps in knowledge and future research needs” Add a bullet on how can we develop and implement culturally-sensitive survivorship care models that can be acceptable and feasible also for minority and underserved patients in the United States?	This has been added to the Gaps in Knowledge section on page 40.
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	Finally, we would like to refer you to our some of our colleagues at Cancer Care Ontario, who are very adept at these types of reviews and are doing similar work in this area. Please let us know if this is of interest to you, and we will provide you with names and contact information.	Thank you. AHRQ updates on this topic may wish to consider key informants from Cancer Care Ontario.
Public Reviewer 1 ASCO (Kevin Oeffinger)	General	ASCO appreciates the opportunity to comment on this important issue and would welcome the opportunity to provide additional feedback on its development in the future.	
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	On behalf of the American Physical Therapy Association (APTA), I would like to thank the Agency for Health Care Research and Quality (AHRQ) for the opportunity to comment on the draft technical report “Models of Cancer Survivorship Care.” APTA commends the United States Department of Health and Human Services and AHRQ for the effective healthcare initiatives and the impactful topics which aim to improve the quality of health of all Americans.	No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	APTA is a professional organization representing the interests of more than 85,000 physical therapists, physical therapist assistants, and students of physical therapy. APTA's goal is to foster advancements in physical therapy practice, research, and education and to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and function of members of the public. Physical therapists perform evidenced-based examinations, screenings, evaluations, and interventions for musculoskeletal, neurological, cardiovascular pulmonary, and integumentary conditions and provide patient centered care that focuses on function and mobility to improve an individual's quality of life (QOL).	No change required.
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	Role of Physical Therapists in Cancer Survivorship Care Physical therapists are essential members of health care teams who provide evaluation and treatment for individuals who are cancer survivors. Key roles have been described as preventative, restorative, supportive and palliative care. ¹ The conditions physical therapist address may include trismus/cervical dystonia, spasticity, impaired mental functions(chemo-brain), neuropathy/nerve disorders, lymphedema, aromatase-inhibitor arthralgias, radiation fibrosis syndrome, and numerous musculoskeletal conditions that can include impairment of flexibility, muscle weakness, pain, fatigue, impaired mobility including impaired activities of daily living, and impaired ability to perform major life functions of domestic, work, leisure and civic life. 1. Dietz J. Rehabilitation oncology. Wiley; 1981.	No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	Physical therapists manage the care and ongoing needs of cancer survivors in many settings including hospitals, skilled nursing facilities, inpatient rehabilitation facilities, outpatient practices, home health agencies, skilled nursing facilities, hospices and the community often playing an essential role in multidisciplinary programs.	No change required.
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	<p>Components of Cancer Survivorship Care</p> <p>Overall the report fails to recognize rehabilitation as integral components of a cancer survivorship program. There is literature supporting an impairment and disability based model and rehabilitation is an important component per Silver² and others. For example, Cheville et al. notes that functional problems are prevalent among outpatients with cancer and are rarely documented by oncology clinicians. A more aggressive search for, and treatment of, these problems may be beneficial for outpatients with cancer.”³ The American Society of Clinical Oncology(ASCO) Recommendations for High Quality Survivorship Care includes rehabilitation services as essential to survivorship care and educational efforts.^{4,5}</p> <p>4. McCabe MS, Bhatia S, Kevin Oeffinger KC, et al. American society of clinical oncology statement: Achieving high-quality cancer survivorship care. <i>J Clin Oncol.</i> 2013;31(5):631-640.</p> <p>5. Jemal A, Simard EP, Dorell C, et al. Annual report to the nation on the status of cancer, 1975-2009, featuring the burden and trends in human papillomavirus(HPV)-associated cancers and HPV vaccination coverage levels. <i>J Natl Cancer Inst.</i> 2013;105(3):175-201.</p>	<p>We included Verbeek et al. {#95} to address rehabilitation.</p> <p>– The components of survivorship care specified in the IOM report cited by this tech brief include “) interventions for illnesses secondary to cancer and cancer treatment (including physical consequences of symptoms such as pain and fatigue) ...” While this includes rehabilitative care, it is not limited to or specific to rehabilitative care. We agree that rehabilitation services may be essential to survivorship care efforts, depending on the needs and preference of individuals survivors, but it would therefore be inappropriate to focus on one type of care that falls in this broader category.</p>

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	<p>As noted by Silver et al in 2013 evidence suggests cancer survivors have a reduced health-related quality of life more so as a result of physical impairments than psychological ones. Research has also shown that a majority of cancer survivors will have significant impairments that go undetected and/or untreated, which may result in disability. Additionally, it has been shown that physical disability is a leading cause of distress in this population.² As noted above, this supports the need for an impairment/disability based model that included rehabilitation.</p> <p>2. Silver J, Baima J., Mayer RS. Impairment-driven cancer rehabilitation: An Essential Component of quality care and survivorship. Jul 15.2013 doi: 10.3322/caac.21186. [Epub ahead of print]</p> <p>As the authors of the report note, late effects of cancer treatments are well described for the adult survivor of childhood cancers, but such late effects are poorly documented in the adult survivor of adult cancers. There is also emerging data which demonstrates that survivors have significant downstream rehabilitation needs.^{6,7}</p> <p>Including rehabilitation in models of cancer survivorship care has the potential to significantly decrease downstream impairments and disabilities. For example, it is important to recognize pre-frailty in breast cancer survivors. Pre-frailty and frailty could be assessed in breast cancer survivors age 50 years and older in a clinical setting using a few questions about weight, fatigue, and activity levels, in addition to simple tests of walking speed and grip strength. The early screening can detect impending frailty that could lead to reduced physical functioning or poor health.⁸</p>	<p>We included Verbeek et al. {#95} to address rehabilitation.</p> <p>– The components of survivorship care specified in the IOM report cited by this tech brief include “) interventions for illnesses secondary to cancer and cancer treatment (including physical consequences of symptoms such as pain and fatigue) ...” While this includes rehabilitative care, it is not limited to or specific to rehabilitative care. We agree that rehabilitation services may be essential to survivorship care efforts, depending on the needs and preference of individuals survivors, but it would therefore be inappropriate to focus on one type of care that falls in this broader category.</p>

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	Physical therapy would play a key role in addressing the impaired body functions and mobility to prevent the progression to disability. “Even seemingly benign impairments warrant attention, given their capacity to erode diminishing functional reserve.” International studies have demonstrated the need for rehabilitation and its underuse as well. ² 6. Darby SC, Ewertz M, McGale P, et al. Risk of ischemic heart disease in women after radiotherapy for breast cancer. <i>N Engl J Med</i> . 2013;368(11):987-998. 7. Campbell KL, Pusic AL, Zucker DS, et al. A prospective model of care for breast cancer rehabilitation: Function. <i>Cancer</i> . 2012;118(8 Suppl):2300-2311. 8. Bennett JA, Winters-Stone KM, Dobek J, Nail LM. Frailty in older breast cancer survivors: Age, prevalence, and associated factors. <i>Oncol Nurs Forum</i> . 2013;40(3):E126-34.	We included Verbeek et al. {#95} to address rehabilitation. – The components of survivorship care specified in the IOM report cited by this tech brief include “) interventions for illnesses secondary to cancer and cancer treatment (including physical consequences of symptoms such as pain and fatigue) ...” While this includes rehabilitative care, it is not limited to or specific to rehabilitative care. We agree that rehabilitation services may be essential to survivorship care efforts, depending on the needs and preference of individuals survivors, but it would therefore be inappropriate to focus on one type of care that falls in this broader category.
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	Emerging data suggests that cancer and its treatment can 1) significantly and adversely impact patient functional capacity and 2) can result in premature aging i.e. chronologic age may underestimate physiologic age. 8 Findings recently published by Darby et al 6 raise the possibility that these late effects may emerge more quickly in the adult survivor. Also, because a majority of these survivors are older adults with age associated comorbidities, a gerontologist should be a part of the discussion regarding staffing needs for survivorship care.	Added to Gaps and future research needs section

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	Conclusion The findings we have discussed above strongly suggest the need to either include a rehabilitation professional in surveillance models or, at a minimum, include the recognition that referral for rehabilitation is an essential part of treating the sequelae of cancer and cancer treatment.	Added to Gaps and future research needs section
Public Reviewer 2 APTA (Paul A. Rockar, Jr.)	General	APTA appreciates the effort AHRQ is undertaking to gain a better understanding of models of care for this increasing population. APTA would like to thank AHRQ for the opportunity to comment on the draft technical report, "Models of Cancer Survivorship Care." We look forward to working with AHRQ in the future to ensure that this process is comprehensive and reflects best practices. If you have any questions, please feel free to contact Heather Smith, PT, MPH, Program Director of Quality, at 703-706-3140 or heathersmith@apta.org; or Lisa Culver, PT, DPT, MBA Senior Specialist, Clinical Practice at 703-706-3172 or lisaculver@apta.org.	Thank you. No change required.
Public Reviewer 3 University of Texas Medical Branch [UTMB] Galveston (Gail Kwarciany)	Structured Abstract	Well written, concise description of the brief.	Thank you. No change required.
Public Reviewer 3 UTMB Galveston (Gail Kwarciany)	Background	Structuring the brief report based on the IOM's report makes sense as a method of structuring this information. It's interesting that the IOM report is now 8 years old and we are still struggling to even define survivorship. This technical brief provides an excellent overview of the state of survivorship.	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 3 UTMB Galveston (Gail Kwarcianny)	Methods	I understand the rationale as stated for including only survivors who have completed active treatment and were in remission however I think there would be value in including those with stable disease as well as progressive and metastatic disease.	As discussed in the report, there is lack of consensus in the field regarding the definition of cancer survivors. We have selected a widely used and conservative definition for the purposes of this report.
Public Reviewer 3 UTMB Galveston (Gail Kwarcianny)	Findings	I was not surprised by the findings but am glad to see this document that summarizes the reality for cancer patients and providers who are struggling to address survivorship for cancer as a chronic disease. Determining who will pay for these services is truly a barrier to development of these programs.	Thank you. No change required.
Public Reviewer 3 UTMB Galveston (Gail Kwarcianny)	Summary	Well stated identifying the key findings.	Thank you. No change required.
Public Reviewer 3 UTMB Galveston (Gail Kwarcianny)	Next Steps	I like the format of not just identifying potential areas for future work but also the suggestions for addressing issues. I would like to see more about the payment issue. Perhaps as more research is done with defined outcomes payers will be more likely to include these services. Alternatively providers may incorporate a model that address survivorship from the point of diagnosis, which goes back to a common definition of the cancer survivor as anyone living with cancer, whether in active treatment or progressive disease.	An additional question regarding payment systems has been added to item #8 in the Next Steps section.
Public Reviewer 3 UTMB Galveston (Gail Kwarcianny)	References	Comprehensive reference list	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 3 UTMB Galveston (Gail Kwarciany)	Appendices	Appropriate	Thank you. No change required.
Public Reviewer 3 UTMB Galveston (Gail Kwarciany)	Tables and Figures	Useful, well done	Thank you. No change required.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 4 Eva Grunfeld	General comments	<p>Thank you for compiling a comprehensive report on this important topic. I have not yet had a chance to read the report in detail. However, on quick review, I believe you have missed two important studies which should be included in the tables under the category “Physician led survivorship care models”. You have included the study by Wattchow in this category, which was modelled on the study reported in the 1996 paper listed below. The 2006 paper reports a larger study with more clinically relevant outcomes. The inclusion of the Wattchow paper suggests to me that the two studies below should also be consistent with you inclusion criteria. I would be pleased to discuss further or provide other information, if you would like.</p> <p>Regards, Eva Grunfeld University of Toronto eva.grunfeld@utoronto.ca Grunfeld E, et al. Routine follow-up of breast cancer in primary care: a randomized trial BMJ 1996; 313:665-9. (results of the economic evaluation are published in: Br J Cancer 1999; 79: 1227-33.) Grunfeld E et al. Randomized trial of long-term follow-up of early-stage breast cancer: a comparison of family physician versus specialist care. J Clin Oncol 2006; 24:848-55.</p>	<p>Thank you for drawing our attention to these two earlier manuscripts. Neither study abstract specifically indicated that the intervention being examined attempted to address two different needs among cancer survivors, which was an inclusion criterion. We therefore did not include either study in the GQ3 section.</p>
Public Reviewer 5 Centers for Disease Control and Prevention	General	<p>This is well written and clearly captures in an organized fashion the content found in lit reviews and received from KI interviews. The rationale used to define a “model” seems logical. The eligibility criteria and the methodology appear appropriate.</p>	<p>Thank you. No change required.</p>

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 5 Centers for Disease Control and Prevention	Page 1	A few comments are suggested for increased clarity, with #1 and comments related to #1 considered major comments: 1. Suggest including the definitions of survivor--a person diagnosed with cancer from the time of diagnosis [this is the general one used by many in the field and adopted by NCI, American Cancer Society, and CDC] and a person who's completed an initial course of treatment etc, in the first paragraph on pg 1, and note which definition was utilized for this brief. This is currently defined on pg 5 under inclusion criteria, but because there are different "accepted" definitions, it is likely much better to be very clear about this as early as possible in the report to avoid confusion.	Definition of survivor has been presented earlier in the document as per the reviewer's suggestion.
Public Reviewer 5 Centers for Disease Control and Prevention	Page 7	2. On pg 7, is it possible to expand a little on what grey literature sources were consulted or used?	This information is available in Appendix A.
Public Reviewer 5 Centers for Disease Control and Prevention	Page 7	3. Suggest noting on pg 7 in the data abstraction section that the PRISMA statement checklist was followed to complete the systematic review (I'm assuming it was since a PRISMA flowchart is included on pg 8).	Noted this per the reviewers comment.
Public Reviewer 5 Centers for Disease Control and Prevention	Page 8	4. Related to #3, suggest changing the title of Figure 1 on pg 8 to either clarify what is meant by PRISMA, or include the fact that the PRISMA statement was used in the methods as suggested in comment #3.	Changed Figure 1 title per the reviewers comment.
Public Reviewer 5 Centers for Disease Control and Prevention	Page 12	5. On pg 12, third para that starts with "KIs identified..."--this info appears earlier and seems to be repeated here, not sure if that was intentional.	We have noted that the theme appeared earlier

Commentator & Affiliation	Section	Comment	Response
Public Reviewer 5 Centers for Disease Control and Prevention	Page 29	6. On pg 29, I like the inclusion of the heterogeneity of survivor definitions as a challenge; it also supports the need to mention these potential definitions in the very beginning of the brief (as noted in comment #1 above).	This has been mentioned earlier in the document.
Public Reviewer 5 Centers for Disease Control and Prevention	Glossary	7. In the glossary the definition of survivor might be better qualified as “for the purposes of this brief” and cite the source used for that definition.	Added qualifying text per the comment.