**SHARED-CARE OF SURVIVORSHIP MODEL**

Care for all survivors is coordinated between oncology specialist, and PCP generalists

*Without Transition to PCP*

- Follow-up care occurs in oncology setting
- Can be implemented at a cancer center, community hospital, or private practice

*With Transition to PCP*

- Follow-up care occurs in oncology setting in coordination with PCP
- At a predetermined time, care is transitioned to the PCP only
- Consultation with the oncology specialists occurs as needed

| **Without Transition** | |
|---|---|
| **Advantages** | **Disadvantages** |
| • Survivor continues to benefit from specialists in managing long-term and late effects<br>• Works well for survivors with ongoing, complicated cancer-related health issues | • Resource intensive since survivors require time, expertise, and a strong infrastructure of communication between specialist and PCP<br>• Often roles are not clearly delineated resulting in care that is omitted or duplicated |
| **With Transition** | |
| **Advantages** | **Disadvantages** |
| • Survivor continues to benefit from specialists when at highest risk of recurrence<br>• Works well for patients with limited risk of late effects<br>• Focus is on wellness rather than disease<br>• Promotes independence and allows focus on co-morbidities—important in the elderly | • Late involvement of primary care with resulting loss of trust for primary are ability to manage beyond transition period<br>• Challenging to coordinate transition appointments<br>• Loss of expertise to manage late effects |