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An evaluation of a cancer survivorship education class for follow-up care

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ABSTRACT

The Wellness Beyond Cancer Program is part of a tertiary care hospital in Ontario, Canada. It provides cancer survivors with information and resources needed to self-manage their follow-up care (i.e., learn relevant information and skills to adapt to life with a chronic illness) after active cancer treatment (i.e., chemotherapy, radiation). A program evaluation was conducted on the two-hour survivorship education class (one component of the overall Wellness Beyond Cancer Program) with the purpose of evaluating whether attendance increased survivors' perceived knowledge and intent to self-manage follow-up care. Breast ($n = 107$) and colorectal ($n = 38$) cancer survivors who attended classes completed questionnaires on information needs and intent to self-manage pre- and postclass. Perceived increase in knowledge and intent to self-manage follow-up care were unrelated to age, gender, or time since diagnosis. After attending the class, survivors reported increased knowledge ($F_{(1,111)} = 144.6, p < .001$) and intent to participate in self-management of their follow-up care ($F_{(1,103)} = 57.3, p < .001$). Improvements in knowledge predicted

increased intent to self-manage ($R^2 = .64; F_{(4,86)} = 38.5, p < .001$). Colorectal cancer survivors showed greater improvement in intent to self-manage than breast cancer survivors ($\beta = .14, t = 2.2, p < .05$). These results can inform the development and implementation of future education classes for survivors.

Key words: survivorship, care transitions, education class, self-management, breast cancer, colorectal cancer

The Wellness Beyond Cancer Program (WBCP), established in 2012 at The Ottawa Hospital in Ontario, Canada, is offered to cancer survivors who have completed primary cancer treatment, and who are being discharged back to their primary care provider for follow-up care (Easley et al., 2017; Nekhlyudov et al., 2017; Rushton et al., 2015). Breast, colorectal, and endometrial cancer survivors are referred by their oncologists to the WBCP at the end of primary cancer treatment and complete both physical and psychological needs assessments and an empowerment scale. The WBCP aims to meet the individual's physical and psychosocial needs and to ensure appropriate access to resources (Rushton et al., 2015). For example, monitoring for cancer recurrence, management of late and long-term effects of treatment (e.g., cancer-related fatigue), healthy eating and exercise; and psychosocial aspects of survivorship care (e.g., fear of cancer recurrence, depression) are important survivorship needs to be addressed in follow-up care (Kotronoulas et al., 2017; Phillips & Currow, 2010).

One component of the WBCP is a two-hour disease-site-specific group education class provided by two oncology nurses called, "Living Well and Managing your Health After Cancer" (Rushton et al., 2015). The class provides information to equip cancer survivors (those who have completed primary cancer treatment and are discharged from tertiary back to primary care settings; Rushton et al., 2015) with the knowledge required to engage in the self-management of their follow-up care (i.e., learning relevant information and skills to adapt to life with a chronic illness; Howell et al., 2016). The classes have five main objectives: 1) to provide an overview of the WBCP; 2) to describe the purpose of follow-up care (i.e., follow-up tests to expect); 3) to review common survivorship concerns; 4) to review common late and long-term effects of treatment; and 5) to discuss risk reduction through healthy lifestyle behaviours (Rushton et al., 2015). Classes are offered in person at two alternating locations and available via live videoconference to the alternate campuses of The Ottawa Hospital and in three regional centres. Classes are disease specific, where the class content is tailored to either breast, colorectal, or endometrial cancer survivors.

This program evaluation had two evaluation questions: 1) Does the education class increase cancer survivors' knowledge about follow-up care and; 2) Does an increase in self-reported knowledge increase survivors' intent to participate in the self-management of their follow-up care?

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METHOD

Design

Given that the program was already established and has been in effect since 2012, the most appropriate type of program evaluation for the WBCP education class was an outcome evaluation. Outcome evaluations target the short-, medium-, and long-term goals of the program (Collins et al., 2017). In this case, this evaluation looked at the short-term outcomes related to perceived increase in knowledge and intent to manage follow-up cancer care after attending the one-time group education class. More specifically, the purpose of this outcome evaluation was to evaluate whether attending an education class increased the short-term outcomes of increased knowledge related to: a) the WBCP; b) the purpose of follow-up care; c) survivorship concerns; d) risk reduction and healthy lifestyle behaviours; e) signs of cancer recurrence, and f) attendees' *intent* to self-manage their follow-up care. Using a prepost design, attendees' self-reported knowledge and intent to self-manage were measured immediately before and after attending the education class.

Ethical Approval

As the present work was part of a quality improvement initiative, the Ottawa Health Science Network Research Ethics Board (OHSN-REB) provided a letter indicating that the project did not require REB approval.

Participants

Participants were breast and colorectal cancer survivors referred to the WBCP and attended the disease site-specific education class. Endometrial cancer survivors were not included in the present study due to an inadequate number of attendees, and less-frequent endometrial-specific classes held during the data collection period.

Procedure

Participants in two breast cancer classes and two colorectal cancer classes were included in this evaluation between January and April 2018. Class attendees were provided with a questionnaire package upon arrival to the class, which contained an information sheet explaining the program evaluation, the voluntary nature of the project, a description of the way the data would be used and two identical paper-based questionnaires (aside from demographic questions on the pretest only). Participants in the class were invited to complete one questionnaire prior to the start of the class (pretest) and the second identical questionnaire immediately after the class (posttest). The pretest questionnaires were collected from participants prior to the class starting. Participants were asked to complete the posttest questionnaire after the class (but before leaving). Those in the classes who did not wish to participate did not complete the questionnaires. The participants provided consent by submitting his or her completed questionnaires and was aware that their participation was completely voluntary.

Measures

The two main outcomes measured were self-reported knowledge about follow-up care and the intent to participate in self-management of their follow-up care.

Information Needs Questionnaire. An adapted version of the Information Needs Questionnaire was created for this study to measure changes in perceived knowledge before and after the class. It consists of 16 items rated on a three-point scale: "I need much more information," "I need some more information," and "I need no more information" (Beckjord et al., 2008). For the present evaluation, some items were removed or re-worded in consultation with the WBCP nurses to ensure: a) that the questionnaire was applicable to as many cancer survivors attending the class as possible; b) that the items were relevant to class content; and c) consistent language on specific topics presented in class, and to accommodate a breadth of reading level abilities among participants. Examples of items include needing information about "follow-up tests/procedures that you should have", "hereditary cancer concerns", and "managing your fear of recurrence". The final measure used in the present evaluation consisted of 11 items that were rated on the original three-point scale (range 11–33). In the present study, internal consistency of this measure was $\alpha = 0.89$.

Patient Activation Measure Short-Form. An adapted version of the Patient Activation Measure Short-Form (Hibbard et al., 2005) was created for this study to measure participants' intent to manage their follow-up care. This measure consists of 13-items rated on a four-point scale, where a value of one was attributed to the response option "strongly disagree," and a value of four was attributed to the response option "strongly agree" (Hibbard et al., 2005). Changes to the content and wording of items were again made in consultation with the nurses at the WBCP based on the reasoning described above. The adapted version used in this evaluation consisted of eight items (range 8–32), and the original four-point response options. Examples of items include: "When all is said and done, I am the person who is responsible for managing my cancer", "I am confident that I can tell my health care provider concerns I have even when he or she does not ask". The internal consistency of this measure was $\alpha = 0.86$ in the present study. The measure used in this study is a derivative work of the Patient Activation Measure Survey, and a research license was obtained.

At the end of the prequestionnaire only, participants were also asked to indicate their gender, age, treatment type (option to check all that apply: surgery, radiation, chemotherapy), and time since diagnosis.

Analysis

The Statistical Package for Social Sciences (SPSS Version 25) was used for the analysis.

Descriptive statistics. The frequencies were calculated for breast and colorectal cancer survivors, treatment type, and location of class attendance (i.e., in-person video conference within Ottawa, and video conference at regional locations). The mean and standard deviation were calculated for age, time since diagnosis, pre- and postclass total scores for the Information Needs, and the Intent to Self-Manage Follow-Up Care. These were calculated separately by disease site (breast or colorectal). For descriptive purposes, we also calculated the mean, median, and average pre-post difference for each

of the 11 items of the Information Needs Questionnaire and the 8 items of the adapted version of the Patient Activation Measure Short-Form (Hibbard et al., 2005).

Identification of possible covariates. Age, time since diagnosis, treatment type, and location of class attendance were correlated with total scores for knowledge and intent to self-manage follow-up care to identify variables that would need to be controlled in the subsequent analyses.

Testing for prepost differences in knowledge and intent to self-manage. Two separate 2X2 mixed ANOVA were conducted to compare breast versus colorectal patients on their pre- and postmean total scores on the 1) Information Needs Questionnaire, and 2) Patient Activation Measure Short-Form.

Regression analysis. Given the premise that cancer survivors need information to self-manage their follow-up care, a hierarchical regression analysis was used to examine whether a change in knowledge could predict changes in intent to self-manage, controlling for any relevant covariates and baseline level of intent to self-manage.

RESULTS

Participants

Most participants ($n = 145$) were women, diagnosed with breast cancer 3.8 years ago on average, with a mean age of 64 years, who had completed surgery, radiation, and chemotherapy ($n = 53$; 36.6%) or surgery and radiation ($n = 45$; 31%). Most participants ($n = 88$; 60.7%) attended the class

in person, while 46 (31.7%) attended via videoconference in Ottawa or at a regional satellite ($n = 11$; 7.6%). See Table 1 for a complete description of the sociodemographic and medical characteristics of the overall sample and subsamples of participants. There were significant differences between the breast and colorectal participants in terms of age, gender, treatments received, and mode of class attendance (see Table 1). Therefore, we decided to compare these two patient groups on their changes in knowledge and intent to participate in self-management.

Descriptive statistics and identification of potential sociodemographic and medical covariates

A total of 138 participants completed both pre- and postclass questionnaires. Pre- and postclass total scores of knowledge and intent to participate in self-management of follow-up care are reported in Table 2 for the overall sample and the subsamples of breast and colorectal cancer survivors. Table 3 reports the mean, median, and average pre/post difference for each of the 11 items of the Information Needs Questionnaire. There were no statistical differences between the breast and colorectal participants, so results are reported for the overall sample to facilitate interpretation of findings. Table 4 reports on the mean, median, and average pre/post difference for each of the eight items of the Patient Activation Measure Short-Form. Similarly, there were no statistical differences between breast and colorectal participants; therefore results are reported for the overall sample only.

The pre- and postclass total scores on knowledge and intent to self-manage follow-up care were not significantly correlated

		All participants N = 145	Breast n = 107	Colorectal n = 38	$p \chi^2$ test
Age		M = 63.9 SD = 10.1	M = 62.4 SD = 9.6	M = 69.1 SD = 10.3	.001
Years since diagnosis		M = 3.8	M = 4.1	M = 2.7	.13
		SD = 4.5	SD = 3.9	SD = 1.3	
		%	%	%	
Gender*	Male	82.1	0	36.8	.001
	Female	9.7	100	44.7	
Treatments*	Surgery only	12.4	6.5	28.9	.001
	Chemotherapy only	0.7	0.9	0	
	Surgery, radiation, chemotherapy	36.6	44.9	13.2	
	Surgery, radiation	31.0	41.1	2.6	
	Surgery, chemotherapy	11.0	1.9	36.8	
Mode of attendance	In person	60.7	66.6	44.7	.02
	Videoconference local	31.7	29.0	39.5	
	Videoconference regional	7.6	4.7	15.8	

*Totals do not equal 100% due to missing data

Table 2. Descriptive data (mean and standard deviation) for pre- and postclass Information Needs and Intent to Self-Manage Follow-Up Care total scores for the overall sample of participants as well as the breast and colorectal cancer subsamples

Measure and time point (possible range)	All participants N = 145	Breast n = 107	Colorectal n = 38	p
Preclass Information Needs (11–33)	24.8 (4.9)	24.8 (5.0)	25.6 (4.5)	.39
Postclass Information Needs (11–33)	30.2 (3.9)	30.2 (4.1)	30.4 (3.5)	.73
Preclass Intent to Self-Manage (8–32)	26.0 (3.2)	26.1 (3.0)	25.6 (3.7)	.43
Postclass Intent to Self-Manage (8–32)	27.7 (3.3)	27.5 (3.3)	27.9 (3.8)	.59

Note. Information Needs: adapted version of the Information Needs Questionnaire (Beckjord et al., 2008); Intent to Self-Manage: adapted version of the Patient Activation Measure Short-Form (Hibbard et al., 2005)

Table 3. Descriptive statistics for perceived change in knowledge measured with the Information Needs Questionnaire (Beckjord et al., 2008)

Item	Mean		Median		Average Prepost Difference
	Pre	Post	Pre	Post	
Follow-up tests/procedures you should have	2.36	2.71	2	3	0.382
Hereditary cancer concerns	2.46	2.82	3	3	0.372
What late and long-term side effects of cancer treatment to expect	2.13	2.66	2	3	0.541
Managing late and long-term side effects of cancer treatment	2.14	2.68	2	3	0.556
Managing your fear of recurrence	2.17	2.66	2	3	0.552
Finding support among family, friends, and coworkers	2.76	2.90	3	3	0.164
Reducing the risk of cancer recurrence	2.03	2.66	2	3	0.673
Nutrition and diet	2.22	2.79	2	3	0.568
Being physically active	2.46	2.85	3	3	0.424
Complementary and alternative treatments	2.28	2.72	2	3	0.516
Symptoms I should report to my doctor	2.01	2.74	2	3	0.748

Table 4. Descriptive statistics for change in intent to self-manage follow-up care measured with the derivative of the Patient Activation Measure Short-Form (Hibbard et al., 2005)

Item	Mean		Median		Average Prepost Difference
	Pre	Post	Pre	Post	
1. I am the person who is responsible for managing my cancer	3.24	3.45	3	3	0.150
2. Taking an active role in my own healthcare is the most important factor	3.47	3.59	4	4	0.102
3. I can take actions that will help prevent problems associated with my cancer	3.16	3.42	3	3	0.242
4. I can tell when I need medical care/when I can handle a health problem myself	2.95	3.29	3	3	0.0039
5. I can tell my health care provider concerns I have	3.28	3.44	3	3	0.167
6. I know what I can do to reduce the risk of cancer recurrence	2.67	3.23	3	3	0.541
7. I understand the importance of maintaining physical activity	3.39	3.64	3	4	0.260
8. I understand the importance of maintaining a healthy diet	3.40	3.63	3	4	0.240

These items are from the Patient Activation Measure Short-Form (Hibbard et al., 2005) with revisions for the present evaluation. The measure used in this work is a derivative of the Patient Activation Measure Short-Form (Hibbard et al., 2005).

with age, gender, or time since diagnosis. Independent t-tests showed that the pre- and postclass total scores for knowledge and intent to self-manage follow-up care did not vary by mode of class attendance or by type of treatments received. Therefore, we did not need to control for any of the sociodemographic or medical characteristics of the sample.

Testing for changes in knowledge and intent to self-manage follow-up care

We conducted two separate 2X2 mixed ANOVAs to examine changes in pre- and postscores in knowledge and intent to self-manage follow-up care with a Between Factor of cancer type (breast vs. colorectal). For knowledge, we found a significant effect of Time ($F_{(1,115)} = 144.6, p < .001$) but no significant TimeXCancer type interaction ($F_{(1,115)} = 0.9, p = .36$). This suggests that knowledge improved similarly from pre- to postclass for both breast and colorectal cancer survivors. In contrast, for intent to self-manage, we found a significant effect of Time ($F_{(1,103)} = 57.3, p < .001$) and a significant TimeXCancer type interaction ($F_{(1,103)} = 4.1, p < .05$). As can be observed in Figure 1, while both breast and colorectal cancer patients improved on their intent to self manage from pre- to postclass, this increase was greater for colorectal as compared to breast cancer survivors.

Multiple regression analysis

Hierarchical regression analysis was used to investigate if change in knowledge could predict changes in intent to self-manage. Entering in the first step preclass intent to self-manage follow-up care; in the second step cancer type; in the third step preclass knowledge; and in the final step, postclass knowledge. The final hierarchical regression model explained a significant amount of the variance of the postclass intent to self manage follow-up care ($R^2 = .64; F_{(4,86)} = 38.5, p < .001$). All the variables contributed significantly to the model: preclass intent to self manage follow-up care was a strong predictor ($\beta = .76, t = 11.4, p < .001$), while cancer type ($\beta = .14, t = 2.2, p < .05$), preclass knowledge ($\beta = -.18, t = -2.4, p < .05$), and postclass knowledge ($\beta = .23, t = 3.0, p < .01$) made smaller contributions. These results suggest that participants' postclass intent to self-manage was predicted by their baseline intent, and colorectal cancer patients reported greater postclass intent to self-manage. Additionally, participants who reported increased knowledge also reported greater postclass intent to self-manage.

DISCUSSION

The results of a program evaluation of a two-hour, nurse-led education cancer survivorship class showed that attendance increased survivors' self-reported knowledge and intent to self-manage follow-up care. This increase in knowledge was found to predict greater intent to self-manage follow-up care immediately after the class. Changes in perceived knowledge or intent to self-manage follow-up care were independent of the participants' gender, age, time since diagnosis, and treatments received.

Implications for Practice

Participants who received the class via videoconference reported similar results to those who attended in-person.

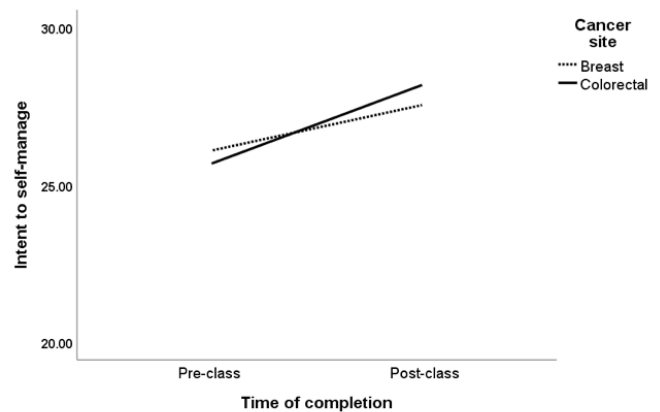


Figure 1. pre- and postclass changes in intent to self-manage for breast and colorectal cancer

There is a growing interest in online-based support for cancer survivors, and the results supporting the use of videoconference platforms could encourage the use of online platforms in a greater scale and to facilitate the provision of care to survivors living in rural areas. Additionally, a systematic literature review reported that cancer survivors found online interventions for distress after a cancer diagnosis helpful (Willems et al., 2020), and there is evidence that both live video-based programs and prerecorded content are comparable in reducing distress after a cancer diagnosis (Smith et al., 2019). Furthermore, a recent systematic literature review on the needs of American, rural, breast cancer survivors reported that these individuals are strongly interested in receiving information from their health care team (Anbari et al., 2020). Therefore, the provision of videoconference or other online-based survivorship education classes are likely to be effective and well received by cancer survivors. Interestingly, colorectal cancer survivors reported a greater improvement in their intent to self-manage their follow-up care. This may be due to different class content based on cancer type. Based on the literature, colorectal cancer survivors' most commonly reported supportive care needs were the need for information and education, especially about coping with fear of recurrence, diet, and the self-management of ongoing symptoms (Kotronoulas et al., 2017), which are covered in the WBCP education class. Given these cancer-specific differences, one strength of this work is the inclusion of more than one cancer type.

Limitations

The use of self-report measures and a prepost design may limit the interpretations of the findings due to the subjective nature of the responses. No objective measure of increased knowledge (i.e., a quiz) was utilized in this evaluation. It was not feasible to objectively determine behaviour change regarding self-management as the evaluation was confined to class time. Participants may have completed the first but not the second questionnaire, arrived late to the class, or skipped multiple questions. Survivors may have chosen not to participate based on language barriers, or possible illiteracy. The findings

are based on those who attended the class and chose to participate. Given that only 43.3% of those invited to the class attend (as shown in a previous evaluation by Jones et al., 2017), the results of the evaluation may not be generalizable to all breast and colorectal cancer survivors. Therefore, the results must be interpreted within this context of self-reported information needs and intent to self-manage immediately following the class rather than actual self-management. Finally, the psychometric properties of the measures and their performance in prepost contexts are currently unknown. Nonetheless, this outcome evaluation suggests that the WBCP education class is meeting its objectives.

Future Research

Future research should include longer-term follow-up and an experimental design to empirically support the effectiveness of the WBCP education class. As self-management has been identified as a skill that cancer survivors must develop (Howell et al., 2016; Sussman et al., 2017), future research is needed: a) to determine if education increases self-management behaviours over time and; b) to investigate

cancer survivors' attitudes toward self-management, and the barriers and facilitators to doing so. For example, this could involve looking at differences in the number of visits to health care services among those who did and did not attend the WBCP education class. Additionally, further research on the online delivery of education and other supports for follow-up cancer care is needed to better meet the needs of cancer survivors in urban, rural, and remote areas (Anbari et al., 2020; Smith et al., 2019; Willems et al., 2020).

Conclusion

A one-time, nurse-led cancer survivorship education class offered both in-person and remotely via videoconference significantly increased attendee's perceived knowledge and intent to manage their follow-up care. Information provision is an important first step in empowering cancer survivors to be active members of their healthcare team (Howell et al., 2016; Rushton et al., 2015). Increasing the accessibility (i.e., through cancer survivorship programs, videos, or online platforms) of pertinent and high-quality information about survivorship care is a key area for future research.

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