Mission

To promote excellence in oncology patient care by fostering collaborative relationships and professional development among oncology nurse navigators and all healthcare disciplines locally, regionally, and nationally

Vision

To be the national leader in establishing standards that define the oncology nurse navigator role by advocating for the oncology nurse navigator within the community and professional arenas

Quarterly Newsletter

National Coalition of Oncology Nurse Navigators

July 2012

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DEDICATED TO THE SUPPORT OF THE ONCOLOGY NURSE NAVIGATOR

Navigator Notes: Message from the President

The Trending of Navigation: Hospital vs. Private Practice

Sharon Francz, BHA
Executive Director,
President and Co-founder

The landscape of navigation continues to be diverse across various healthcare settings. Recently I had the pleasure of speaking to a large privately owned oncology practice that is adding navigation. When NCONN first formed in 2008, the majority of nurse navigators were employed by hospital systems; however, this trend is increasingly changing. More and more oncology and radiation practices are adding navigation as a service to their cancer program.

Based on NCONN's membership data most navigators are hospital based and their salary is paid by their employer, their hospital. In the December 2010 HRA syndicated research survey The Evolving Influence of Oncology Nurse Navigators 62% of ONNs are employed by a hospital or hospital system and the balance primarily work for an oncology clinic 22% or a medical oncology office 13%. The trend has been that breast navigator salaries have been supplemented or entirely grant funded. If more and more private oncology practices hire and pay navigators, is it reasonable to believe hospitals will abandon hospital, based navigators in lieu of relying on private practices to pay and hire navigators?

I pose these questions, will hospitals opt out of hiring and funding navigator positions if community oncology and radiation practices continue to hire and pay for their own navigators. Will patients only have access to a navigator if they have a designated medical oncology home? If hospitals opt out of hiring nurse navigators, will they fill the mandated ASoC COC navigator positions with lay or patient navigators to save money?

For additional comments or thoughts on this, please email me at

sfrancz@nconn.org

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IN THIS ISSUE

Member Spot Light

This is the first of a new feature in the NCONN newsletter. We would like to highlight the practice of our nurse navigator members to share specifics of how we function in our role so we can learn from each other. If you would be interested in being in the member spotlight, please contact the editor, Karen Masino @ kmasino@ingalls.org

This member spotlight is on: Jennie Boyer, BSN, RN

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Nursing has been a family tradition with generations of nurses in both my parents' families and a great aunt who served in WWI in the Pacific. While at Penn State University I enlisted for active duty with the Army Nurse Corps and following graduation, spent the next 7 years at wonderful assignments from Hawaii to Germany. On entering civilian nursing, I continued to travel due to my husband's active duty. My passion was obstetrics and I practiced in many different settings throughout the nation. I also spent several years as a nursing supervisor in home health care, developed a university nursing course for ROTC nursing cadets, volunteered for hospice care, and served two medical missions – one in South Africa and another in Guatemala.

My formal entry into navigation came by way of a desire to return to oncology nursing. I had worked the inpatient hematology unit at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins for 2 years following my husband's allogeneic transplant for MDS. After his death in 2003, I returned to Saint Agnes Hospital, working obstetrics as I had for the past 27 years. However, I longed for the new challenges that the field of Oncology had to offer. During my husband's diagnosis and treatment I had become fascinated with the progress which had taken place since I had briefly worked oncology in the 80's. Also, I had personally been involved with several family members who had been diagnosed with cancer. Developments in oncology treatments offered hope for cure in some areas and chronic management in others. New treatment side effect management provided an improved quality of life.

In 2005, my present position opened in our Cancer Institute for a Care Coordinator for GI/Lymphoma patients. Initially my activities included coordinating colonoscopy screening for the uninsured and providing navigation for newly diagnosed patients with colorectal cancer and lymphoma. The concept of navigation was not new to me as I had been navigating for friends and family for many years. Identifying barriers to treatment, providing education and connecting patients with resources has always been a part my role as a nurse. Like many navigators, this was a challenging role for which I had little definition in my job description. I began to develop this role with the support of the colorectal surgeon who became my champion for GI and our medical director who provided me with what I felt has been the best guidance—printing the NCCN guidelines and telling me in no uncertain terms that this was the pathway for patients receiving care and treatment in our cancer institute.

The challenge became how to identify patients and connect with them. I began by reviewing pathology reports daily to identify patients newly diagnosed with colorectal cancer. My benchmark for referral to the medical and/or radiation oncologist is about 6 weeks with start of treatment within 10 weeks. I can also identify patients through our GI tumor board which I coordinate. I always follow up on patients either through the tumor board or through telephone calls to physician offices as well as patients and maintain a database to track patients to assure timely treatment decisions. This database includes any further diagnostics that may be needed as well as additional treatment decisions including patients who have out-migrated. My goal is always the same-did the patient receive consult and treatment decision within the time frame?

This has helped to reinforce my core belief in clinical expertise and evidence based practice, which have always been the guiding principles of my nursing career. One of the strengths of my role as an oncology nurse navigator is in actively tracking the evidence-based practice, national guideline usage and tumor board activity. I feel that this provides clinical credibility as you develop your relationships with administration, oncologists and surgeons. I have been able to retrieve patients who have "fallen through the cracks" due to poor communication, no referral, transfer to extended care facilities, etc. Utilizing NCCN as well as other national standard guidelines as our baseline is a part of Saint Agnes Cancer Institute Cancer Committee Meetings to meet accreditation standards of the American College of Surgeons Commission on Cancer (ACoS CoC). I firmly believe that that tracking these patients in my database and demonstrating that we adhere to evidence-based guidelines has significantly contributed to helping our institution to achieve the 2011 ACoS CoC Outstanding Achievement Award.

Working with the social worker, the ACS patient navigator and the nutritionist, we developed a one hour appointment with the patient and their significant other(s) called the "New Patient Orientation Visit" prior to initiation of treatment. Each team member reviews the patient's treatment plan and provides education on services and resources available. At this time, the patient completes the NCCN Distress Screening Tool which the social worker and the navigator review during the meeting. I provide the patient with an individualized education resource book including NCI printed material, their specific treatment plan, prescriptions and side effect management tools. I review all of this information with the patient, including NCCN guidelines and emphasize those aspects which address their specific concerns. This team approach has resulted in a smoother initiation of treatment, greatly reduced anxiety for the patient and family, and improved communication between patient and providers.

I also facilitate a support group in cooperation with the Leukemia & Lymphoma Society which meets once a month in the local community. The Mid Atlantic ACS Chapter has developed a peer-to-peer local support program called *Recovery Coaches*. Twice a year, I teach and update the colon and rectal cancer survivors who participate as coaches through this program. It has been a pleasure to see one of my patients, now a 6 year survivor, choose to be a peer 'coach'.

This year I have been given the added responsibility to provide navigation for patients receiving chemoembolization of the liver as well as those identified to receive radiation infused microspheres called SIR-spheres. This has been a fascinating process to learn and facilitate.

I have to admit that at times it has been an uphill battle to convince my administration of the value of clinical services, even though I know my position generates downstream revenue. However, my greatest satisfaction lies in supporting and providing patients with information to make decisions for their lives. To give them the opportunity to be a full partner in their journey, and to be a liaison and advocate for them when they cannot be one for themselves.

On a personal note, Jennie is a novice rock climber, a voracious reader and loves to escape to the mountains whenever possible. She has two rescued dogs and two children who she calls "the jewels of her life"

Angel Bus: Hope on Wheels

Angel Bus is a 501(c)(3) nonprofit charity located in Virginia Beach, Virginia, that provides free medically-related long-distance ground transport for patients in need. Several options are available, depending on resources and the patient's specific requirements.

Volunteer drivers: Angel Bus has about 90 qualified drivers who use their own luxurious motorhomes and converted buses for medical travel. Typically the range is 70-300 miles one way, and trips are to clinics and hospitals, then back home again. Patient must not require medical assistance during transport.

Commercial bus and rail: Another resource that may be appropriate is for Angel Bus to provide patient with bus tickets on Greyhound or rail tickets on Amtrak.

Angel Bus is a program of Mercy Medical Airlift (www.MercyMedical.org), a national charitable organization that began in the mid-1970s and has earned Charity Navigator's 4-Star award for many years.

Patients may access help from Angel Bus by calling **1-800-768-0238** or by emailing info@angel-bus.org.

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Mailing Address: 4620 Haygood Road, Suite 1, Virginia Beach, VA 23455

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Welcome newly appointed NCONN Executive Board Officers

As NCONN continues to grow it is necessary to have leaders of the organization that share the passion to continue to promote excellence in oncology patient care and professional development of the oncology nurse navigator (ONN). Today, NCONN is pleased to welcome the following additions to our executive board. Please join me in welcoming President-elect Susan Keen, RN, OCN, Vice President-elect Cindi Cantril, RN, OCN, MPH, and Chairperson of Special Committees Susan Stary, RN, MSN, OCN, and Secretary Diane McElwain, RN, OCN, M.Ed, to the NCONN Executive Board.

Susan J. Keen, RN, OCN, is an oncology certified nurse with over 14 years of experience. She began her career as an oncology nurse navigator in January 2007 when she developed the program for CJW Medical Center. In the last couple of years, she has specialized as the thoracic nurse navigator.

She is the co-founder of Virginia Coalition of Nurse Navigator and served as the first president for three years. She then served on the executive board for VCONN. She also served as president and president elect for Richmond local Oncology Nursing chapter.

Cindi Cantril, RN, OCN, MPH, is an oncology certified nurse with over 40 years of nursing experience in surgical, medical and radiation oncology. She was founding Board member and first Vice-President of the Oncology Nursing Society. In 2010, she received the Distinguished Service Award from the Oncology Nursing Society recognizing her commitment in establishing and creating models for patient navigation. Cindi led the efforts to create a focus group, now active special interest group on patient navigation for the Oncology Nursing Society.

Susan Stary, RN, MSN, OCN, has been a nurse for over 35 years, which includes experience in obstetrics, gerontology, medical-surgical, and oncology. Over the last 29 years, she has been working at MD Anderson Cancer Center and has been involved in many clinical areas in a variety of roles. During this time, she facilitated the development of the Transplant Nurse Coordinator role to facilitate the overall care and navigation of the oncology patient through this process. She currently is a Quality Management Analyst with MD Anderson Physician Network working with affiliated sites to improve the quality of care to oncology patients.

Diane McElwain, RN, OCN, M.Ed, is currently an oncology coordinator/navigator for the York Cancer Center in York, PA. She is also a past Coordinator for the Prevention and Early Detection Special Interest Group within the Oncology Nursing Society and the program chairperson for the PA Capital Region ONS Chapter. Diane is committed to the support of nurse navigators, as this role designation will become more important to patients as the complexity of the cancer journey increases.

To contact the NCONN Executive Board email: executives@nconn.org

Distress and the Nurse Navigator

Part II of II

Kerrie L. Girard, RN, BSN, OCN Clinical Navigator at Banner M.D. Anderson Cancer Center in Gilbert, AZ

Karen Masino, MS, CNP, ACNP-BC, AOCNP, RN, RD, LDN
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Introduction

Over the past several decades there have been many advances that have offered new treatment options to patients and added to the ever increasing numbers of survivors. However, with advances in treatment, therapies have become more complex and have increased the long term side effects thereby increasing the distress and potential for distress in patients with cancer. Several studies have documented that cancer and its treatment creates or aggravates psychosocial distress, while unresolved physical and practical problems can also add to the distress of patients attempting to complete their treatment and recovery.

While intuitively oncology nurses know that addressing distress issues can improve quality of life, unresolved distress can lead to additional problems for patients with cancer such as: non-adherence to therapy (Partridge, 2003; DiMatteo, 2000), increased medical costs and have a negative impact on survival. Addressing distress concerns in patients with cancer can have a positive impact in reducing distress and improving quality of life (Adler, 2008; Jacobsen, 2008; Breitbart, 2012).

This article will discuss sources of distress in patients with cancer the pros and cons of various instruments for measuring distress, barriers to addressing distress, strategies for implementation of distress screening and management programs and the role of the oncology nurse/ navigator in screening and managing distress.

In 1999 the National Comprehensive Cancer Network (NCCN) established a panel to investigate and evaluate the issues that contribute to distress in patients with cancer. That same year they developed the first set of guidelines to screen for and treat distress in patients with cancer. The term distress was chosen because it didn't have the stigma associated with a psychiatric diagnosis and also encompassed recognition of the physical, social, emotional and practical issues that can contribute to anxiety and distress (NCCN, 2012). The NCCN has defined distress as

"Distress is a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and spiritual crisis" (NCCN, 2002).

In 2008 the need for addressing psychosocial issues and distress in cancer patients became more prominent with the publication of the Institute of Medicine (IOM) report entitled "Cancer Care for the Whole Patient: Meeting psychosocial Health Needs." (Adler, 2008) Many prominent organizations have now produced position papers and incorporated distress management and screening into guidelines for clinicians. Most recently the American College of Surgeons Commission on Cancer incorporated a standard for distress screening into their cancer program accreditation standards (ACOS, COC, 2011).

Sources of distress

Many factors contribute to distress in patients with cancer. Several studies have evaluated the incidence of distress with a meta analysis indicating that up to 47% of patients have a significant level of distress and overall approximately 30-40% of patients have some combination of mood disorder (Mitchell, Bhatti, 2011). It has been further noted that the incidence of major depression increases with increasing levels of physical disability, advanced illness and pain (Sellick, Crooks, 1999). Physical symptoms can also contribute to distress with fatigue, sleep disturbance and pain being the most commonly reported physical symptoms (Carr, Goudas, Lawrence, et al., 2002), (Sarna, Brecht, 1997), (Oh, Seo, 2011), (Dy 2010), (Berger AM, Visovsky C, Hertzog M, Holtz S, Loberiza F. Jr, 2012) More recently, distress research has evaluated the impact of caregiver burden on the distress level of the patient with cancer. The stress of caregiving can negatively impact the ability of the caregiver to provide for the needs of the patient thereby adding to the distress of the patient with cancer (Northouse, 2012).

Although the need for distress screening is documented in a number of studies, routine screening to identify needs of patients remains less than optimal.

Distress screening should occur on the first visit and at interval visits as clinically indicated throughout the patient's cancer journey, particularly at times when increased distress is likely. Distress for patients can include external or internal sources such as cognitive, social and spiritual components. Distress can present at any point during the cancer diagnosis and treatment. Therefore, identifying barriers along the continuum of care, by all health care providers, is necessary. Patients are often hesitant about discussing stressful events whether it is their own cancer diagnosis, stressful family dynamics, financial issues or even their lack of knowledge or low education level. The NCCN guideline has incorporated a list of psychosocial distress characteristics. This list identifies patients at increased risk for distress as well as periods of increased vulnerability for patients. Patient characteristics that increase the risk for distress can include; psychiatric disorders, substance abuse disorders, poor social support, inadequate resources, communication barriers, uncontrolled symptoms and severe comorbid illnesses (NCCN). The NCCN further identifies periods of increased vulnerability which can include; staging and work-up, when informed of the diagnosis, when a change in treatment is indicated because of disease progression, recurrence of disease or advancing cancer to end of life care, as well as discharge from the hospital, transition to survivorship, and ongoing medical surveillance. This reinforces the importance of screening on a periodic basis as once a patient is diagnosed with cancer they will likely continue to face these periods of vulnerability.

Barriers

Barriers to care can impact quality of life and increase the distress in patients with cancer. Screening can identify many of these barriers so that appropriate management can be implemented. However, frequently there are barriers to providing the support indicated.

Barriers to screening for distress can arise from: either the healthcare team, the health care system or from the patient. Patient barriers include psychiatric disorders and the stigma that may be attached to psychological issues, substance abuse, cognitive impairment, depression with or without suicide attempt, communication/language barriers, financial limitations, insurance problems, work or transportation issues, cultural or spiritual concerns. The patient may also be hesitant to discuss their concerns with healthcare team members for various reasons. Healthcare team/system barriers include time constraints in oncology offices, lack of knowledge on how to screen for and manage distress issues, scheduling delays, lack of community resources or lack of knowledge regarding resources, inappropriate use of specialized staff, technological factors, communication/language barriers and other uncontrolled factors. The time and effort required to fill out and then discuss the results of the screening tool can feel overwhelming and exhausting to patients who are already feeling fatigued.

Regardless of the numerous barriers to distress screening, the patient needs to be assessed and evaluated both psychologically and physically in order to be treated appropriately throughout the cancer journey.

Screening tools

Screening tools are important as they assist the health care provider in identifying distress issues so that management of these problems can be quickly implemented to resolve existing or potential problems. There are multiple evidenced-based screening tools with what appears to be a trend toward the use of a simple instrument such as the distress thermometer and the distress problem checklist (NCNN, 2012). This tool has been validated to indicate distress in patients if the score greater than or equal to 5 on the distress thermometer (Craike, 2011, Wang, 2011). Other widely used tools include the Hospital Anxiety and Distress Scale (HADS) (Wang, etal, 2010) and instruments that have been developed for specific disease sites such as breast, as well as automated touch-screen computerized technology that appears to be at least as well accepted as a paper version (Dinkel, 2010). It is beyond the scope of this article to discuss these tools in depth. The reader is referred to Carlson, 2012 for a more in-depth discussion of various tools. The ideal screening tool should be brief and scoring results should be both simple and efficient. The tool used may evaluate distress experienced in the past day, week or within the patient's lifetime. Stressors, once identified, should be monitored, documented and treated promptly.

Building a distress screening and management program

Screening for distress is considered only the first step in identifying factors that contribute to a poorer quality of life. Just as important as completing the screening, is having processes in place to address the issues that confront patients.

It is recommended to have a multidisciplinary team selected for implementing and monitoring distress management. While the primary oncology team which typically consists at a minimum of an oncology physician and oncology nurses can address many patient concerns, it is important to include other disciplines and community resources to provide the full spectrum of services patients may require. For example including therapists, social work, nutrition services, chaplaincy services, psychiatric and mental health services, palliative care and hospice services, as well as community agencies providing support groups and assistance with practical problems such as transportation and financial concerns should also be included in the team. Many facilities already have representation from these areas on their cancer committees. Formalizing these resources into a subcommittee of this group may be one approach that helps to develop a distress management program. The team should determine the tool and the process that will be implemented to develop a distress screening and management program. The tool selected may be determined by the staff appointed to do the screening. In some facilities a social worker may be designated to meet with the patient or may review the screening and make referrals to other professionals. In other facilities, the screening may be done as part of a routine office visit with the physician and staff in which case a very fast tool such as the distress thermometer (NCCN) may be more appropriate for screening. The process needs to identify how the screening will be completed and at what points screening will occur. It is very important that good communication be a priority in addressing concerns of patients. Acknowledging the patient's concerns and providing adequate time to explore the patient's issues can help to develop a trusting relationship between the patient and the healthcare team and can set the stage for a positive relationship in the future.

Each facility or physician practice needs to identify available resources and staff available to address and manage distress issues. It is important to emphasize that all services do not have to be housed within a facility, but resources that are available by referral or connecting with a community resource also need to be included. Therefore, networking with community groups and developing partnerships with outside organizations is strongly recommended. The listing of resources should be formalized and disseminated throughout the institution and treating physician facilities so that patients within the treatment area have access to support services.

Since distress issues can affect patients throughout the cancer trajectory, it is necessary to have the resources to address all of the issues that can cause or exacerbate distress from diagnosis through survivorship and into end of life care.

Carlson (2012) outlines key points for successful implementation of a distress screening program:

Adequate time needs to be allocated to lay the groundwork

Gain support of hospital administrators and clinic coordinators prior to implementing screening

Provide appropriate staff training involved in screening, providing services and processing reports

Assess available support services to address psychosocial needs, practical support and physical problems to determine if additional services are needed

Triage guidelines and algorithms can be helpful

Perform ongoing evaluation and be sure to determine if the screening program addresses needs of the medically frail, minority and underserved populations and those with language barriers

Role of the Oncology Nurse Navigator in distress screening

The oncology nurse navigator is in an ideal position to be involved in screening for distress as well as providing management of distress issues. Oncology nurse navigators are involved in many duties in an effort the provide support as patients progress through the cancer trajectory. The oncology nurse navigator functions as an advocate for the patient to provide information explaining disease and treatment options, and linking the patient with resources that will enable them to complete their treatment and maintain or improve their quality of life. The oncology nurse navigator also is a primary point of contact to facilitate communication and act as a liaison with the health care team on behalf of the patient. The intervention of an oncology nurse navigator has demonstrated a positive impact on distress scores of selected groups of patients (Swanson, 2010). Since unresolved distress has been implicated in increased medical costs and possibly shortened survival (Partridge, DeMatteo), the impact of an oncology nurse navigator in lowering a patient's distress level is an area that warrants further study.

Nurse navigators can evaluate distress levels in patients and communicate these concerns to the healthcare team as an important step in the process of addressing and managing the patient's distress. Oncology nurses have been consistently involved in providing education to patients regarding their disease process and treatment, side effect management and in providing support. Because of the many sources of distress, the nurse navigator can also provide interventions to help guide patients on managing their symptoms as well as providing links to resources that can address their distress issues and help them with their coping skills.

The oncology nurse navigator is a key stakeholder in screening for distress and providing interventions to help manage distress in patients with cancer. Oncology nurse navigators are key stakeholders in developing distress screening and management programs within their facilities and are active participants in providing the interventions to provide support and improve the quality of life of patients with cancer.

Table 1. Sample process for developing distress screening

Committee on cancer acknowledged that distress screening will be a standard of care from the American College of Surgeons Commission on Cancer by 2015.

A subcommittee was developed to review available tools and present options to the committee.

The subcommittee consisted of an advanced practice oncology certified nurse practitioner, a psychologist with specialization in psycho oncology, a social worker, a case manager, a chaplain and a medical oncologist and consulting administrator.

The committee evaluated screening tools by reviewing the literature and recommended the NCCN distress thermometer and guideline for management. This was presented to the cancer committee and discussed. The committee endorsed implementing screening with this tool. This tool was selected because this is a community hospital with several independent physician offices caring for patients with cancer. They have limited time to screen patients and it was decided that because this tool was one page and able to identify important issues with minimal time being needed that this would be an appropriate tool.

Permission was obtained from the NCCN to utilize their distress thermometer.

The subcommittee decided to start a pilot program within the radiation therapy department because the oncology nurse practitioner who is a nurse navigator would be available to monitor the pilot closely and assist with providing management of patient concerns.

A policy was developed describing the procedure. See Table 2 as an example.

The subcommittee began developing a resource list of the various services and contact information for these services by reaching out to the various disciplines to provide this information.

The resource list was disseminated to all of the nursing units, the social workers, the case managers and physician offices.

At present, the oncology nurse practitioner assists the radiation oncology staff in providing interventions for the patients and providing triage for referrals.

At present database is being developed to monitor the distress screenings including the issues patients identify, the interventions provided. This information is reported to the cancer committee.

The plan is to move forward will implementation in the inpatient setting and into the medical oncology practices

Table 2. Sample policy and procedure for distress screening

Purpose:

The purpose of completing distress screening in cancer patients is twofold:

1). To identify psychosocial issues contributing to distress and provide appropriate management strategies to improve the quality of life of patients with cancer.

2). To meet the standard for providing distress management in patients with cancer as outlined by the Commission on Cancer of the American College of Surgeons.

Policy:

It is the policy of ____________________ hospital to provide distress screening and management to cancer patients initially and on a periodic basis as necessary to maintain or improve the quality of life of patients with cancer.

The distress screening thermometer as published by the National Comprehensive Cancer Network (NCCN) scale will be used to assess distress in cancer patients at the cancer care center. Permission has been granted to duplicate the distress thermometer for purposes of patient assessment and _____________________ hospital has agreed to abide by the following statement from NCCN as a condition to utilize this tool:

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Procedure:

The distress thermometer is an evidenced-based screening tool developed by the NCCN. This screening tool is incorporated within the distress management clinical practice guidelines in oncology. The cancer program of Hospital follows the clinical practice guidelines of the NCCN

1). Patients in the cancer care center will be given the National Comprehensive Cancer Network (NCCN) distress thermometer (NCCN) scale to complete with other paperwork at time of initial consult.

2) The patient responses are reviewed by the radiation oncology RN with the patient at the time the history is being obtained.

3) A score of 4 or greater on the distress thermometer requires documentation of intervention including referrals as appropriate.

4). All patients will be given information on support services available through organizations such as the American Cancer Society and the Cancer Support Center.

5). Patients indicating psychosocial distress issues will be evaluated by the nurse navigator and the cancer program assistant to evaluate for more specific support service needs.

6). The following criteria are indicative of increased risk for distress and these patients will be referred to the neuropsychologist for additional screening to determine if formal psychological evaluation is indicated:

Prior history of a psychiatric disorder

History of substance abuse

Cognitive impairment

Sexual abuse or emotional abuse

Patients expressing excessive worry or fear

Patients expressing sadness or hopelessness

Patients with uncontrolled pain

Patients expressing the absence of social support

7) Patients scoring 4 or greater on the distress thermometer scale will have documentation of follow up reevaluation within two weeks of starting treatment or sooner as indicated by the interventions recommended.

8) Patients will be routinely rescreened for distress at one to two week intervals while undergoing radiation treatment.

Table 2 continued:

Level of responsibility:

Radiation oncologist

Radiation therapy nurse

Cancer Nurse Navigator

1 NCCN clinical practice guidelines in oncology. Distress management version 3.2012

Table 3. Process and institution specific screening tool. Submitted by Margot Spies, BSN, RN, OCN.

The Distress tool in use in the radiation therapy department was updated.

Distress tool is provided to patient at first point of contact. The patient is assisted if necessary to complete the tool.

Positive screens are referred to the proper service or support service as indicated.

Patients are re-evaluated with the screening tool if they enter another cancer program service such as after completing chemotherapy and admitted to radiation services. They are also re-evaluated if need is suspected or identified by staff.

As our patients progress through the Cancer Program the paper Distress tool is Xeroxed and sent with the medical record to appropriate service and attending Oncologist.

A staff focus group is in place to improve patient flow.

On the following pages is a sample distress screening tool submitted by Margot Spies, BSN, RN, OCN, Oncology Nurse Navigator for Shore Health. 509 Idlewild Ave, Easton, Maryland 21601, Telephone 410-822-1000 x 5096

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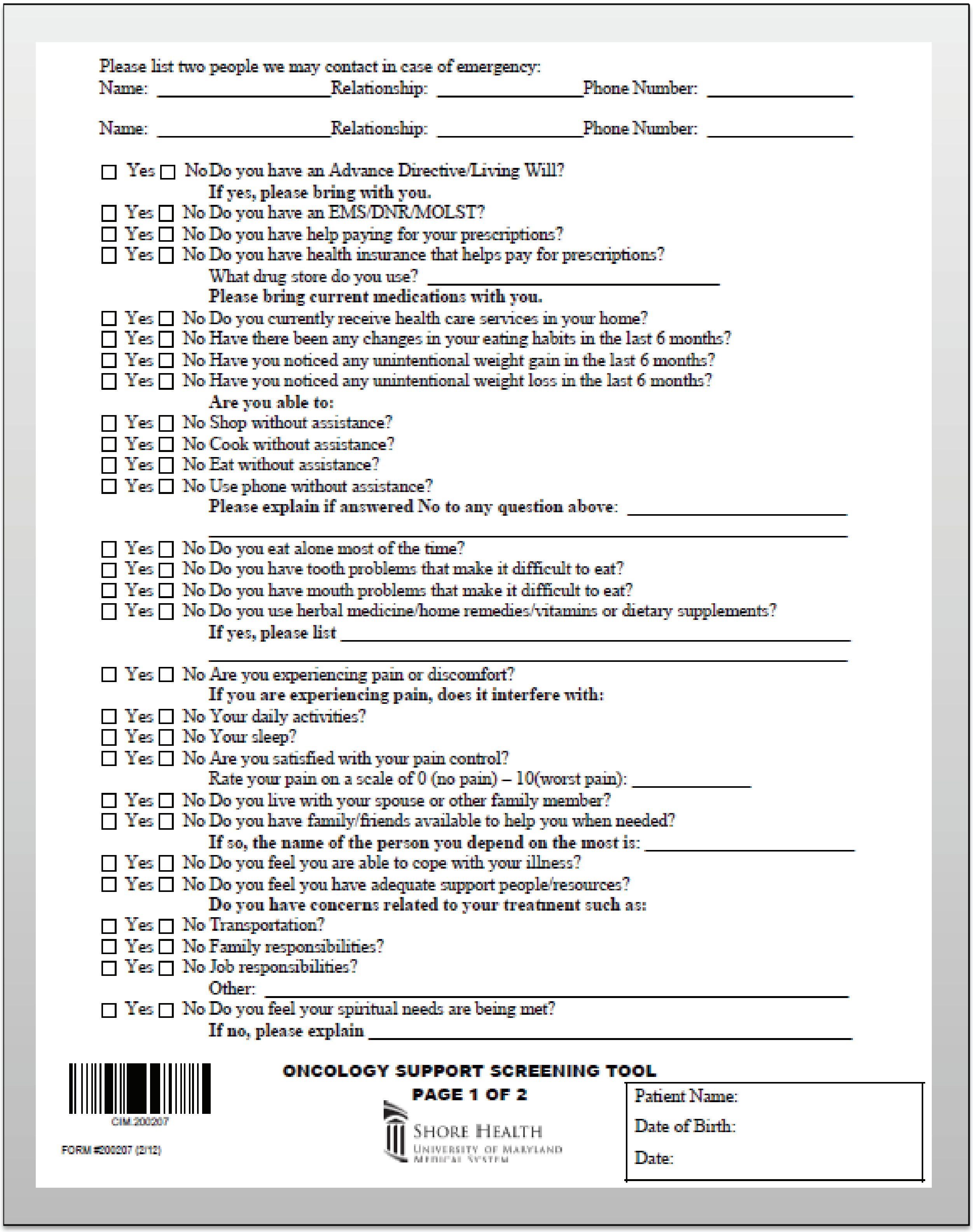
__SAMPLE:__

Oncology Support Tool – Page 1 of 2



Please list two people we may contact in case of emergency:
Name: ____________________ Relationship: _________________ Phone Number: _________________

Name: ____________________ Relationship: _________________ Phone Number: _________________

☐ Yes ☐ No Do you have an Advance Directive/Living Will?
If yes, please bring with you.
☐ Yes ☐ No Do you have an EMS/DNR/MOLST?
☐ Yes ☐ No Do you have help paying for your prescriptions?
☐ Yes ☐ No Do you have health insurance that helps pay for prescriptions?
What drug store do you use? __________________________________
Please bring current medications with you.
☐ Yes ☐ No Do you currently receive health care services in your home?
☐ Yes ☐ No Have there been any changes in your eating habits in the last 6 months?
☐ Yes ☐ No Have you noticed any unintentional weight gain in the last 6 months?
☐ Yes ☐ No Have you noticed any unintentional weight loss in the last 6 months?
Are you able to:
☐ Yes ☐ No Shop without assistance?
☐ Yes ☐ No Cook without assistance?
☐ Yes ☐ No Eat without assistance?
☐ Yes ☐ No Use phone without assistance?
Please explain if answered No to any question above: _________________________
____
☐ Yes ☐ No Do you eat alone most of the time?
☐ Yes ☐ No Do you have tooth problems that make it difficult to eat?
☐ Yes ☐ No Do you have mouth problems that make it difficult to eat?
☐ Yes ☐ No Do you use herbal medicine/home remedies/vitamins or dietary supplements?
If yes, please list ____
____
☐ Yes ☐ No Are you experiencing pain or discomfort?
If you are experiencing pain, does it interfere with:
☐ Yes ☐ No Your daily activities?
☐ Yes ☐ No Your sleep?
☐ Yes ☐ No Are you satisfied with your pain control?
Rate your pain on a scale of 0 (no pain) – 10(worst pain): ______________
☐ Yes ☐ No Do you live with your spouse or other family member?
☐ Yes ☐ No Do you have family/friends available to help you when needed?
If so, the name of the person you depend on the most is: ________________________
☐ Yes ☐ No Do you feel you are able to cope with your illness?
☐ Yes ☐ No Do you feel you have adequate support people/resources?
Do you have concerns related to your treatment such as:
☐ Yes ☐ No Transportation?
☐ Yes ☐ No Family responsibilities?
☐ Yes ☐ No Job responsibilities?
Other: ____
☐ Yes ☐ No Do you feel your spiritual needs are being met?
If no, please explain ____

CIM 200207

FORM #200207 (2/12)

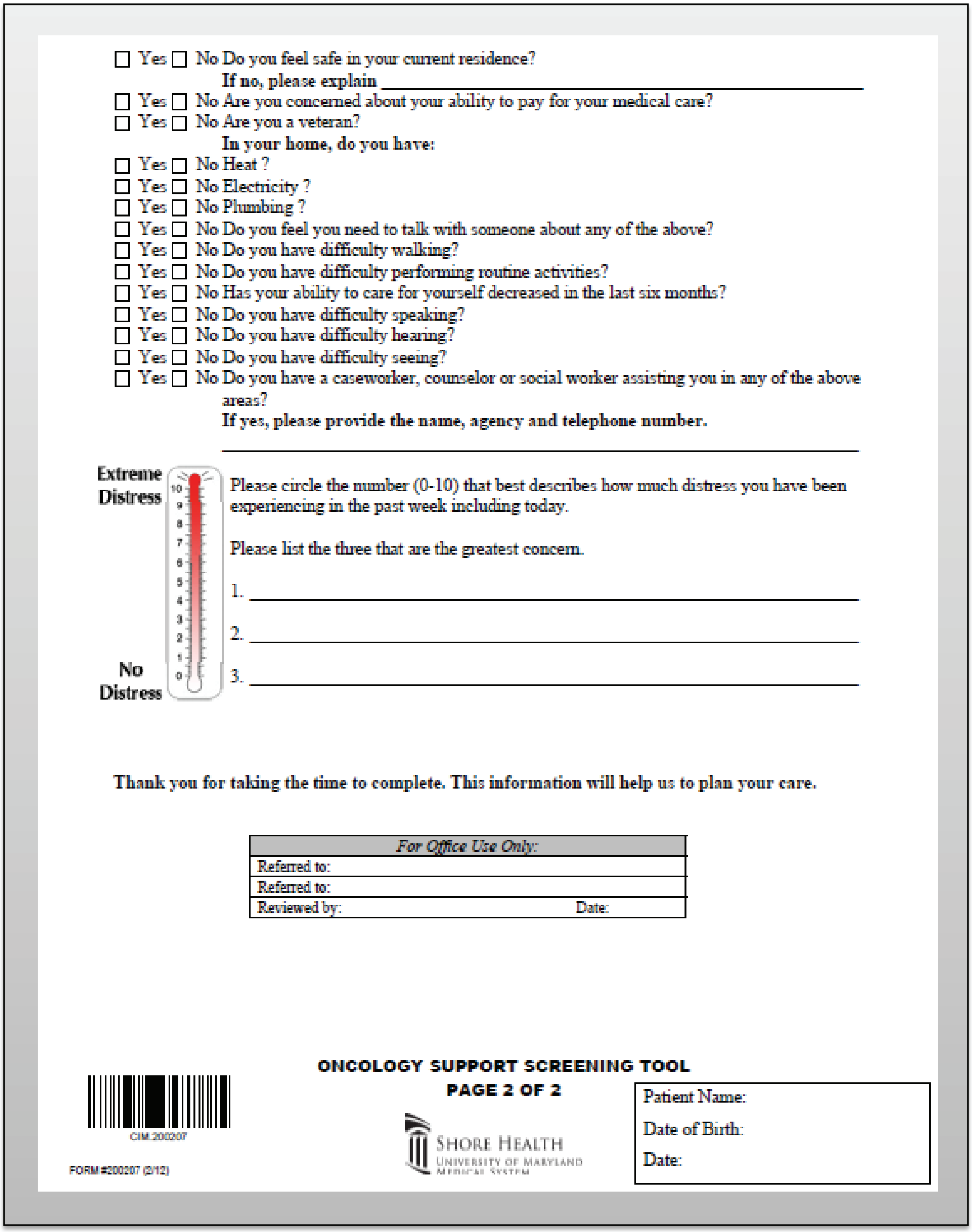
ONCOLOGY SUPPORT SCREENING TOOL
PAGE 1 OF 2

SHORE HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Patient Name:
Date of Birth:
Date:

SAMPLE:

Oncology Support Tool – Page 2 of 2



☐ Yes ☐ No Do you feel safe in your current residence?
If no, please explain ____________________
☐ Yes ☐ No Are you concerned about your ability to pay for your medical care?
☐ Yes ☐ No Are you a veteran?
In your home, do you have:
☐ Yes ☐ No Heat ?
☐ Yes ☐ No Electricity ?
☐ Yes ☐ No Plumbing ?
☐ Yes ☐ No Do you feel you need to talk with someone about any of the above?
☐ Yes ☐ No Do you have difficulty walking?
☐ Yes ☐ No Do you have difficulty performing routine activities?
☐ Yes ☐ No Has your ability to care for yourself decreased in the last six months?
☐ Yes ☐ No Do you have difficulty speaking?
☐ Yes ☐ No Do you have difficulty hearing?
☐ Yes ☐ No Do you have difficulty seeing?
☐ Yes ☐ No Do you have a caseworker, counselor or social worker assisting you in any of the above areas?
If yes, please provide the name, agency and telephone number.
____

Extreme Distress
10
9
8
7
6
5
4
3
2
1
0
No Distress

Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Please list the three that are the greatest concern.

1. ____________________
2. ____________________
3. ____________________

Thank you for taking the time to complete. This information will help us to plan your care.

For Office Use Only:	
Referred to:	
Referred to:	
Reviewed by:	Date:

CIM 200207
FORM #200207 (2/12)

ONCOLOGY SUPPORT SCREENING TOOL
PAGE 2 OF 2

SHORE HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Patient Name:
Date of Birth:
Date:

What is Dental Oncology? Why do I Need It?

Dennis M. Abbott, D.D.S

A diagnosis of cancer comes with many questions and emotions. "You have cancer." That one quick sentence made up of just three little words embarks a patient and his or her family on a journey down long roads of uncountable doctor visits, unknown terminology, and unwanted uncertainty. Few experiences leave their indelible mark on health, relationships, and spirituality as deeply as cancer. Often, in the midst of this storm, oral health and dental care are overlooked or placed on a back burner – until there is a problem.

Patients undergoing treatment for cancer present with an unique set of medical concerns and potential complications. Immunosuppression, radiation, and cytotoxic drugs can cause painful and debilitating side effects, increase the risk of infection, and alter the expected normal healing process. Unfortunately, these experiences are realized to some degree or another by patients with *all* types of cancer - not just patients with oral cancer. To care for these needs is the scope of dental oncology.

Dental oncology is a focus of dentistry dedicated to meeting the unique dental and oral health care needs that arise as a result of cancer therapy. It is an area of oral medicine devoted to improving the well-being and quality of life of people battling cancer. Dental oncology goes beyond the scope of general dental treatment to include management of the soft tissues of the mouth and care for oral side effects specific to cancer therapy. A dental professional knowledgeable in dental oncology plays an important role throughout cancer treatment by preventing and managing mucositis, xerostomia, osteonecrosis, restorative dental needs, oral pain and infections. As a member of the patient's oncology care team, the dental oncologist communicates directly with the medical oncologist, radiation oncologist and other team members to provide optimal comprehensive care before, during, and after cancer treatments.

Ideally, a patient's relationship with a dental professional begins as soon as possible after receiving the diagnosis of cancer. Most of the present-day treatments for cancer involve the administration of cytotoxic drugs, radiation, myelosuppressive treatments or some combination thereof. Having a baseline assessment completed before the implementation of immunosuppressive therapies allows the dental professional to have a pre-treatment reference point to compare oral and systemic health at future visits.

For the newly diagnosed patient with cancer who has not received regular dental and oral health care, a prompt visit to the dentist's office also allows for immediate attention to unaddressed periodontal issues and unresolved dental needs before immunosuppression begins. During cancer treatments, bacterial components of calculus, dental plaque and oral biofilm can easily become vehicles for bacteremia or the source of oral infections. Properly addressing these oral health concerns at this pretreatment stage can prevent or significantly reduce the severity of oral issues that could complicate or even interrupt the patient's cancer treatment schedule.

Sometimes, it is not possible for an individual to see a dental oncologist before beginning cancer therapy. There is still much that can be done at each stage of the battle to help diminish the severity of side effects and reduce the risk of infection. Even for the cancer survivor, a dental oncologist should be a member of an on-going care team. This is especially true for the head or neck cancer survivors or any patient that received bisphosphonate therapy for bone metastases.

An experience with cancer is a personal journey, and there is no single adage that applies to all. There are, however, recommendations that are applicable to most. A dental oncologist can customize a continuing care plan that is suited for the specific needs of the patient. Oral health is important - especially during the times of immunosuppression that comes with cancer therapy. Make a dental oncologist a part of your cancer care team.

DENTAL ONCOLOGY PROFESSIONALS
OF NORTH TEXAS

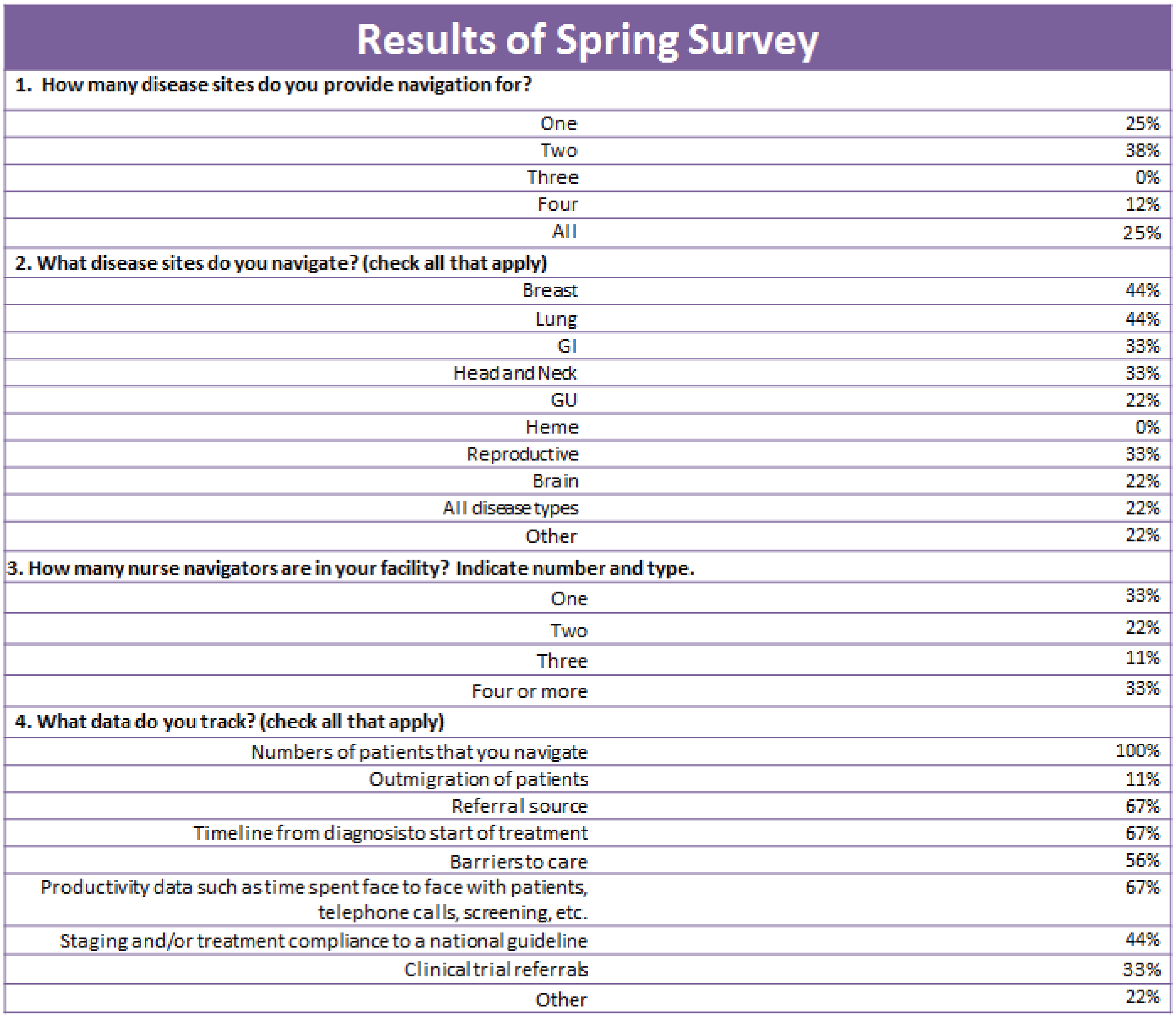
DENTAL ONCOLOGY PROFESSIONALS OF NORTH TEXAS
Web: www.dopnt.com
Twitter: @DentalOncology
Facebook: facebook.com/dentaloncology
Blog: dentaloncology.blogspot.com
News Feed: dentaloncology.tumblr.com/rss

Dennis M. Abbott, D.D.S. is the founder and CEO of Dental Oncology Professionals of North Texas, an oral medicine practice dedicated to meeting the unique dental and oral health needs of patients battling cancer. He holds a Bachelor of Arts in biology from Rice University in Houston, and is an honor graduate of Baylor College of Dentistry. After dental school, Dr. Abbott studied immunology, microbiology, and oral medicine at the School of Dental Medicine, State University of New York at Buffalo. In addition to private practice, he is a member of the dental oncology medical staff at Baylor Charles A. Sammons Cancer Center and Baylor University Medical Center in Dallas. Dr. Abbott also serves as a consultant to the national American Cancer Society in the development of oral monitoring guidelines for post-treatment cancer survivors.

Dr. Abbott has most recently conducted studies focusing on bisphosphonate-related osteonecrosis of the jaw and xerostomia in patients with cancer. He is the previous recipient of the Dentist Scientist Award and the National Research Service Award, both granted by the National Institutes of Health. Dr. Abbott has been a visiting faculty lecturer for the University at Buffalo School of Dental Medicine continuing education program and has lectured throughout the United States.

Featured Question:

What programs or procedures have you developed to increase the visibility of the navigator and increase your referrals for navigation services? Please send your comments to Karen Masino @ kmasino@ingalls.org. Responses will be posted in an upcoming newsletter.



Results of Spring Survey

1. How many disease sites do you provide navigation for?	
One	25%
Two	38%
Three	0%
Four	12%
All	25%
2. What disease sites do you navigate? (check all that apply)	
Breast	44%
Lung	44%
GI	33%
Head and Neck	33%
GU	22%
Heme	0%
Reproductive	33%
Brain	22%
All disease types	22%
Other	22%
3. How many nurse navigators are in your facility? Indicate number and type.	
One	33%
Two	22%
Three	11%
Four or more	33%
4. What data do you track? (check all that apply)	
Numbers of patients that you navigate	100%
Outmigration of patients	11%
Referral source	67%
Timeline from diagnosis to start of treatment	67%
Barriers to care	56%
Productivity data such as time spent face to face with patients, telephone calls, screening, etc.	67%
Staging and/or treatment compliance to a national guideline	44%
Clinical trial referrals	33%
Other	22%

ONN List-serv

Hot topics

by

ONNlistserv@nconn.org

What is a list-serv?

When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcast to everyone on the list. The result is similar to a newsgroup or forum, except that the messages are transmitted as e-mail and are therefore available only to individuals on the list. To join list-serv, contact lmercier@nconn.org

TOP 10

#1 Database Types and Use
#2 Art Therapy
#3 Navigation Program Staffing
#4 Focus Groups
#5 NCCN Distress Tool
#6 Head and Neck Cancer Navigation
#7 Chemo Consent
#8 ONN Job Descriptions
#9 Breast Health Navigators
#10 Cancer Care Guide app

YOUR ORGANIZATION NEEDS YOU!

Volunteer opportunities for the newsletter!

What opportunities?

Write an article

Be a reviewer for an article

Submit a best practice

Be in the Member Spot Light

Is there a topic you are interested in that you would like to share? If you have never written before, newsletter staff and peer reviewers will help you. Many of you are creating and using practices that can be shared with other members - submit your best practice. We can all learn from one another, so be in the spotlight.

We are only as strong as the members are active.

Contact:

Karen Masino

kmasino@ingalls.org

Feature: NCONN members in the news

When you make the news or know of another member who has made the news, please send the information to kmasino@ingalls.org and we will post it in the newsletter.

Register online now at:

www.nconn.org

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October 4-6, 2012

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