

Simmons Cancer Center Interdisciplinary Supportive Services Program: Lessons Learned

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The multidisciplinary patient education program at UT Southwestern's Simmons Cancer Center started as a weekly event for pancreatic patients in June of 2016. We offer this information as an example of the current version of our program. We have found that the number one need in offering group education for new patients/families is flexibility with families and within the team. Our program continues to adapt each week with the dynamics of new groups, but the following is our general structure at this time. The patients attending this program are having a "new patient" medical and/or surgical oncology evaluation. They may be newly diagnosed, or new to our center but with previous treatment elsewhere.

Context: Specialty consult service was established to streamline first visit for patients with pancreatic cancer. All appropriate appointments (medical oncology, surgical oncology, imaging, lab, etc.) for patients new to the Simmons Cancer Center with a diagnosis of pancreatic cancer are scheduled within one day to minimize delays in start of treatment and to decrease patient/family travel burdens. Due to the expectation that these high-medical acuity patients would also have intensive needs for supportive services, a one-hour program was established to introduce the Supportive Service roles. Peer volunteers and other resources from the Pancreatic Cancer Action Network (PanCan) are also part of the program.

Team Members: Social work, registered dietitian, music therapists, and students of those disciplines, along with trained patient or caregiver peer volunteers through PanCan lead the weekly program. The pancreatic program's nurse navigator is an essential part of the program's success as he encourages participation and sets an expectation for the integration of supportive services when scheduling new patients. However, the navigator is engaged in the tumor board discussion that happens concurrently with the patient/caregiver program. The navigator or the clinic nurse will typically escort patients to the group session but do not remain for the program. Clinic schedulers, MOA, and Guest Services staff assist in getting patients to the group room.

Goals:

1. Introduce the role of each discipline represented and the support/education resources of a national organization partner, with the hope that patients treated in community settings will be able to request services.
2. Build rapport with treating team for patients who will be treated at Simmons Cancer Center.
3. Assist patients and families in identifying initial goals for contact with supportive services staff.
4. Facilitate active patient/family engagement in identifying concerns and setting treatment goals.

Logistics:

1. Lunch is provided to all patients and family members to facilitate this appointment at noon, when multiple other appointments are also scheduled in that day.
2. Lunch was initially paid through the surgical department. It is now subsidized by philanthropic support from the spouse of one of the early patients. Lunch costs are about \$10 per participant.
3. Parking vouchers for the volunteers are provided by the surgical department. Parking vouchers for patients/family members is now offered through the philanthropic support. (Valet parking is \$5.)

4. Lunch is ordered and delivery is coordinated by the surgical department's administrative assistant. The registered dietitian has offered input into a menu appropriate for the common side effects of pancreatic cancer. The navigator asks for any specific dietary needs at the time of scheduling patients for the program. We have amended the menu over time in response to requests from patients who are struggling with digestion and new insulin management issues following the Whipple surgery to remove the pancreas. Lunch is typically an assortment of sandwiches, fruit, potato chips, and water from Jason's Deli.

Challenges to Education in the Group Setting:

1. Having an accurate count of participants ahead of time and having all participants show up on time. We have had to adapt the program to accommodate patients who are having multiple appointments in the same day and are running late, patients who bring more family members than expected, patients who get lost in the building, etc. Our clinic scheduler and clinic nurses, along with the navigator, have become essential to keeping patients and family members located and as close to on time as is controllable.
2. Language barriers. The group is conducted in English. Although interpreters are offered when language barriers are identified at scheduling, many patients find that interpretation in the midst of a group discussion is difficult to follow. Staff members may spend additional time in individualized discussions after the session with the assistance of an interpreter. PanCan materials are available in Spanish, which is the second most used language in our community. Spanish language materials are included in the packet when we know in advance of the need, or can be added before patients leave the cancer center.
3. Differing emotional needs for patients who are newly diagnosed with pancreatic cancer and are still very hopeful for cure vs those who are coming after unsuccessful treatment elsewhere and coming to consider clinical trial or hospice. Since the onset of the program, the navigator has started identifying those patients who will not likely have life-prolonging treatment options and scheduling them for the morning. The social worker offers scheduling flexibility to meet individually with those families to discuss home care options including hospice and provide emotional support for end of life grief needs. Families are then given an option to remain for the group session or go home for private family time.

Benefits to Education in a Group Setting:

1. Normalization of fears, anxieties, and symptoms.
2. Ability to mingle family caregivers and patients facilitates ability to identify responses common to each role and to support discussions about coping as a family unit.
3. Proactive connection to supportive services decreases stigma (Why do I need a social worker?) or lack of familiarity (What is a music therapist?)
4. Proactive explanation of other resources (palliative care, physical medicine and rehab) decreases resistance to staff-initiated referrals and may increase patient/family requests for specific support.

Structure:

1. Welcome with housekeeping comments regarding flexibility of program, intent to encourage group support, recognition of varying levels of comfort with disclosure regarding illness and treatment plan. We encourage participants to feel comfortable eating during the discussion with an explanation that some patients will also have afternoon appointments.
2. Depending on time (did we start on time, group size) and mood of participants, may start with icebreaker that connects to role of support services staff. (What do you do for fun?; OSW assessment of coping, physical functional capacity; What do you like to eat?; RD assessment for favorite foods and impact of cancer on diet; What type of music do you like? Music therapist's assessment of musical interests and receptiveness to using music in coping)
3. If time is tighter, we will generally start with each discipline and our volunteers giving a 3-5 minute explanation of our roles and then opening the floor for participant questions. When we need to skip the ice breaker, we have our music therapist lead the explanation of support services role with a brief demonstration of what a music therapy session might include. The music therapist leads a 1 minute guided imagery, encourages patients to settle in, and will often use the Ben E. King song "Lean on Me" which is widely recognized across generations and cultures as a springboard for acknowledging the role of family support and the addition of the treatment team to the family experience.
4. Each family receives a packet that includes information about the SCC supportive services staff (our background and contact information), disease information from PanCan, and information on palliative care and other consult services. We will pull out some of the information as we discuss it to demonstrate what is in the packet. However, we also verbally acknowledge that participants don't have the energy to absorb detailed information and affirm that the packet is ready for their review at home.

Staff experiences:

1. The group program was presented by the surgeon champion as a way to maximize staff efficiency and see more patients in the same amount of time. The dynamics of organizing a group, setting up group space and meal, etc. add a time burden. It can be difficult to balance the needs of existing pancreatic patients who are in clinic for treatment and the needs of patients from other diseases with the new patient emphasis. However, we do find that the proactive format of the group education allows us to identify patients who need additional support before a crisis.
2. Cooperatively presenting the program allows us to observe and appreciate each other's interventions with patients and families. We rarely co-treat, so this interdisciplinary experience has been helpful in increasing our ability to explain our partners' roles and encourage broader support to patients.

3. We try to have about 10-15 minutes of eating and decompressing together before the patients arrive. That brief connection of self-care is bonding time for our team.
4. Our RDs and music therapists have expressed that leading groups was not part of their formal training. The need to help support participant emotions in a group setting felt particularly intimidating to our staff who are more accustomed to 1:1 education. Therefore, the MSW takes the lead in watching group dynamics and providing some reflection and direction to keep all group participants engaged. Our other staff have expressed increased confidence in their skills in group education as we have worked together.

Volunteer role:

1. We count the PanCan volunteers as part of the multidisciplinary team, but want to highlight their role as an essential element in this program. Our local affiliate's PanCan chapter recruited among their patient survivors for volunteers for this program. We have four volunteers in a regular rotation who cover most of our sessions. PanCan provided peer support training to emphasize the role of volunteers as an empathetic listener and normalizer of experiences. Although our PanCan volunteers do share their experiences as asked, they are careful to express that every patient differs and redirect patients back to their medical teams for medical questions.
2. Our participants often have an overtly surprised and pleased facial response when our survivor volunteers introduce themselves and their length of survivorship. We often hear "I haven't seen anyone who has lived this long." One of the most important things our survivors offer is simply their existence as people who are alive and have a good quality of life, as a reflection of the possibility that treatment will offer the same to our new patients. Particularly for disease groups like pancreatic cancer that have a high mortality rate, seeing evidence that a good quality of life is possible makes a significant difference in expectations. Our volunteers are also very helpful in encouraging use of supportive services and ancillary programs such as palliative care and oncology rehabilitation.

Incorporating Students:

1. The interdisciplinary approach also allows students to observe the work of another discipline and better prepares them for interdisciplinary collaborations.
2. The weekly repetition of essentially the same material, adapted for the unique needs of a new patient/caregiver group, allows students to observe and then learn how to adapt teaching styles and resources.
3. Students of each discipline may observe the sessions. Social work students tend to have the longest rotation in our setting, so they are the most engaged in leadership of the program. My 2017-2018 second year MSW student had not had any classroom instruction in group therapy or dynamics. She also had not had any practical experience in program evaluation. We identified these areas as priorities in her learning contract. The student quickly learned the process of doing a chart review on all patients prior to the group to identify likely areas of social work need and potential issues for the group experience. The student continued to prepare the

MSW as well as the multidisciplinary team on each family throughout the academic year. The student started with observing the group structure and flow and the interdisciplinary process. She started leading the social work introduction in the second quarter of her first semester. In the second semester of her field placement, the student took a more active role in introducing the overall aims of the program and guiding group discussions. In several weeks of her last quarter, the student covered the MSW's absence by leading group without another staff social worker sitting in to provide supervision. Our student expressed that this was a significant step in her confidence that she is ready for entry level MSW work. Our student was also involved in the decisions about program evaluation for this poster (how do you recruit participants, creating the survey questions, gathering and interpreting data) to meet her learning objective.

4. For students of all disciplines, the ability to meet a new patient under the direction of their field supervisor and identify some preliminary goals seems to make the process of initial individual assessments easier. Our students have expressed increased comfort in assessment with patients with whom they have an established rapport. It is then easier for both the student and the supervisor to use students as an extender of staff time for routine follow ups.