PSYCHO-SOCIAL INTERVENTION MANUAL FOR PATIENTS IN CANCER TREATMENT: A COLLABORATION BETWEEN SOCIAL WORKER AND PHYSICIANS

By

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ABSTRACT

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People undergoing chemotherapy treatment for cancer will experience significant emotional and psycho-social distress. Current research supports psycho-social interventions for this population and shows that these interventions can improve the perception of quality of life (QOL) during medical treatment for cancer. This project was a collaborative process between a master’s level social work intern, oncology medical practitioners, and the cancer program area director to create a manual for a behavioral QOL intervention which will be made available for the St. Joseph Hospital Cancer Program. The psycho-social intervention is tailored to the unique challenges of rural cancer service delivery and can be integrated into patient care by the cancer program mental health practitioners and patient navigators. The intervention manual consists of a QOL questionnaire, local resources, and recommendations for implementation. Future data collection results from the intervention can be utilized for a client community needs assessment for the cancer program in order to provide a better quality of patient care and more comprehensive psycho-social services for clients.
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This project is dedicated to Dr. Mindy Ellen Green, 1977-2013, “Love wins.”
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INTRODUCTION

This community project is a collaborative effort between the master’s level social work intern and the community partner, St. Joseph Hospital (SJH) Cancer Program. The intern worked in collaboration with the area director of the cancer program, one oncology surgeon, and two oncology/hematology physicians. The purpose of the project is to describe the student and community partner’s process to create a strengths-based psycho-social intervention designed for clients of the cancer program who are undergoing chemotherapy treatment for cancer. Furthermore, the project will include the completed psycho-social intervention manual created for the oncology staff to implement with their clients, along with recommendations to increase patient care and supportive services in the cancer program. Psycho-social interventions for people in this demographic are limited, and this is a growing field of research.

The project will be informed by research on the topic of behavioral psycho-social interventions for clients undergoing chemotherapy. Additionally, it will contain an assessment of rural cancer program barriers. This rural cancer program barriers segment will provide information about the substantial challenges clients and providers in this field encounter in an effort to increase the effectiveness of the intervention. The intervention focuses on rural populations and the unique barriers they face. Furthermore, the project is focused on one patient demographic of the SJH cancer program and does not include the areas of radiation oncology or surgery which are the other main departments in the cancer program.
Cancer affects millions of Americans each year. According to the American Cancer Society, cancer is the second leading cause of death the United States, exceeded only by heart disease (American Cancer Society (ACS), 2009). There will be an estimated 1,658,370 cancer cases diagnosed in the United States in 2015, 172,090 of which will be in the state of California (ACS, 2015). From 2007 to 2011 there were 3,459 cases of cancer diagnosed in Humboldt County (Korsower, 2014). The most common cancers diagnosed in Humboldt, Del Norte, and Trinity, Curry, and Mendocino Counties in 2007-2011, are, in order of highest to lowest incidence: Prostate (73.7%), lung and bronchus (73.1%), breast (71.6%), colon and rectum (48.9%), and skin (31.8%) (California Cancer Registry, 2014).

The emotional and psychological toll of cancer on a person’s life is immense (Philip, Merluzzi, Zhang, & Heitzmann, 2013). An estimated 30% of cancer patients will experience significant emotional distress during their treatment for cancer (Philip et al., 2013). However, despite the high incidence of distress in this population, access to effective psycho-social services is limited (Turner et al., 2011). Reasons for this discrepancy include: lack of systemic approaches of assessment, reduced psycho-social services, the reluctance of patients to receive treatment due to the perception of stigma, lack of oncology providers, inadequate referral patterns, and limited access to psycho-oncology services due to barriers to care such as isolation or disease burden (Turner et al., 2011).

A summary of the population demographics of clients I will work with at SJH Cancer Program is as follows: 88% are over the age of 50, 52% are male, 48% are
female, and 94% are white (National Cancer Data Base (NCDB), 2011). Our population’s racial and ethnic profile has a higher proportion of people who identify as White, American Indian, or “two or more races,” and we have fewer Black, Asian, or Hispanics than California overall (Korsower, 2014). Most of the population served has some form of government insurance; the majority has a high school education and what is considered a low income (NCDB, 2011). Those treated at SJH travel considerable distances to get to treatment which is one of the largest barriers to care in this area (NCDB, 2011). Another substantial barrier to care is the fact that a significant number of people are living in poverty in the counties served by the SJH Cancer Program with 20.8% of clients living below the poverty level in 2010-2014 (American Community Survey, 2014). The cancer program is accredited by the American College of Surgeons (ACOS) and the Commission on Cancer (COC). It serves the rural counties of Humboldt, Del Norte, Trinity, Mendocino, and Curry. In 2014 the cancer program served 550 patients. (This figure relates to total analytic cases in one year).

Having already interned and volunteered in the cancer program with the cancer survivorship services, I have experience with oncology social work in the rural hospital setting. During my undergraduate BASW internship I designed and implemented a survivorship care plan program for the clients who have completed treatment for cancer that receive services in the Survivorship Training and Rehabilitation (STAR) program. I have completed the provider training and am a certified STAR clinician. I also have a certificate in oncology patient navigation from George Washington University Cancer Center. Additionally, I have attended the SJH Cancer Committee meetings during my
BASW internship where the community oncology leadership and practitioners meet to discuss local oncology services. I worked for a local oncology breast surgeon as well and completed a pilot study for various cancer survivorship plans under the surgeon’s guidance. I have also participated in various local community events such as health fairs and was part of the prevention and health education team for the SJH cancer program. In the future I hope to become a certified oncology social worker, (OSW-C), so this project will provide excellent experience for me in this practice area. Oncology social work is my passion, and I feel that this master’s project will serve to further expand upon my knowledge base, giving me more necessary experience in this field to be an effective oncology social work clinician.
REVIEW OF THE LITERATURE

Oncology social work began in the early decades of the 20th century with two medical social workers named Ida Cannon and Harriett Bartlett in Boston, Massachusetts (Fobair, 2009). Cannon developed the psycho-physiological approach to disease which is a medical, social, and psychological formulation of patient care (Bruno, 1964; Shaffer, 1989). In the 1950’s health professionals and oncology social workers began to describe the patient’s experience in medical journals, and the first research papers were published on the patient’s psychological reactions to cancer (Sutherland, Orbach, Dyk, & Bard, 1952). According to Fobair (2000) during the 1960’s cancer centers in Boston, New York, Texas, and California increased social work staff to keep up with the additional needs of pediatric and adult cancer patients in clinical and research settings. By the 1980’s oncology social work was considered a specialty within medical social work due to medical providers’ unique knowledge of patient needs and resources, relationship with patients and their families, and the positive treatment outcomes which resulted (Fobair, 2009).

History of Psycho-social Interventions for Cancer Patients

Psychological interventions for adult cancer patients have had a focus on reducing stress and enhancing quality of life for patients (Andersen, 2002). Moyer, Sohl, Knapp-Oliver, & Schneider (2009) discuss how meta-analysis of psycho-social interventions for cancer patients conducted in the early 2000’s showed that the intervention approach
which has been used most frequently used is cognitive behavioral (32.4% of all interventions), the treatment goal was often improving quality of life generally (69.5% of all interventions), and the total number of professionals delivering the interventions were typically nurses (29.1%) or psychologists (22.7%). According to Andersen (2002) in recent years there has been an increased focus on biobehavioral outcomes, health behaviors, compliance, biologic responses, and disease outcomes which are equivalent to the Biobehavioral Model. This model examines the course of the disease and the stress the patient experiences during the illness. Research and meta-analysis has shown conflicting results regarding the effectiveness of psycho-social interventions for cancer patients (Raingruber, Green, & Shin, 2011). Some of the factors shown to be important in developing interventions have been the assessment of need for normative responses, risk factors, and a broad range of specific skills in assessing patient and family needs (Christ, Messner, & Behar, 2015). Research has shown that when assessing patient and family needs it is vital for medical providers to pay special attention to the points of transition and change in the illness and treatment process which includes the patients’ support network (Christ et al., 2015).

Quality of Life Patient Interventions

According to Moyer et al. (2009) quality of life (QOL) interventions address seven dimensions affected by cancer and its treatment: (1) physical concerns, (2) functional ability, (3) family well-being, (4) emotional well-being, (5) treatment satisfaction, (6) sexuality and intimacy, and (7) social functioning. One study on QOL
interventions showed that interventions delivered by nurses comprised of information combined with supportive attention may have a positive impact on mood in newly diagnosed cancer patients (Galway et al., 2012). Information-based interventions seemed unable to provide meaningful benefits, and cognitive-behavioral interventions had some positive effects (Hersch, Price, Juraskova, & Mullan, 2009). According to the Institute of Medicine (IOM) (2001) patient-centered care is considered one of six key elements of high-quality care (as cited in Epstein & Street, 2011, p. 100). The IOM states that the primary goal of patient-centered treatment planning is to include the patients and their families in discussions about medical care with the medical staff. They should be part of the treatment plan, and the staff should involve the patient and their family in determining their social, medical, and cultural needs (Balogh et al., 2011).

A new term has been developed in the field of medicine called Biopsychosocial Screening, which identifies a person’s physical, psycho-social, spiritual, financial, and practical problems: it is designed to improve communication between the patient, family, and care team (Patlak, Balogh, & Nass, 2011). This model promotes an understanding of the patient within his or her social context, improves treatment adherence, quality of life, and overall satisfaction (Adler & Page, 2008; Bultz & Johansen, 2010; Carlson, Groff, Maciejewski, & Bultz, 2010). The National Comprehensive Cancer Network (NCCN) has endorsed comprehensive biopsychosocial screening guidelines since 1998 (Loscalzo, Clark, & Holland, 2011). Few published research studies have evaluated large scale clinical implementation of biopsychosocial screening (Grace, Messner, & Behar, 2015).
The intervention that was created through this project is considered a biopsychosocial screening and will contribute to the information on this topic.

According to the Association of Oncology Social Work (AOSW) (2012) completion of a psychosocial assessment of the patient and family’s response to cancer diagnosis and treatment should include:

- knowledge about cancer and its treatment including level of understanding
- characteristics of the patient’s support system
- patient and family psycho-social functioning
- race
- ethnicity
- religion
- culture
- language
- physical or mental disability
- socioeconomic status
- sexual orientation
- gender identity or expression
- identification of barriers to care
- source, availability, and adequacy of community resources
- patient and family level of interest in participation in care/decision making
- development of a case plan with patient and family based on mutual goals
Distress Screening

Oncology social workers are increasingly including distress screening in their practices as well as using screening as a way of identifying need and generating referrals (Jacobsen & Wagner, 2012). The distress thermometer screens patients’ distress level on a rating scale from 0-10, 0 being the least personal distress and 10 being the most personal stress. It also has additional categories for social, psychological, emotional, and spiritual need. My intervention will also include a distress thermometer which can be used as a distress screening tool. Pivotal times during cancer treatment that are considered to be the most stressful to varying degrees include cancer diagnosis, initial meetings and assessment, beginning treatment, finishing treatment, and survivorship (Lauria, Clark, Hermann, & Stearns, 2001). The NCCN (2013) recommends the utilization of distress screening tools at each transition time during cancer treatment as well as during remission, recurrence, and progression. Transition into survivorship is one of the most common points of psycho-social distress during cancer treatment (Christ et al., 2015). It is important to prepare a patient for this part of treatment so he or she isn’t caught off guard by feelings of vulnerability, fear, and for some, posttraumatic stress disorder (Waldrop, O’Connor, & Trabold, 2011). My project compliments and replicates current knowledge about psycho-social interventions with strengths based patient-centered approaches which includes a biopsychosocial and information/knowledge focus.
Defining Rural Cancer Care

The US Census Bureau defines rural regions as areas that are ‘not urban’ (USDA, 2012). Specifically, rural is defined as “all territory, population, and housing units located outside of urban areas (UA) or urban clusters” (USDA, 2012). According to the Office of Rural Health Policy (ORHP) all non-metro counties are considered as rural (U.S. Department of Health and Human Services, 2015). Meilleur et al. (2013) states that current literature in the United States comprises of a mixture of studies in which the word rural is defined multiple ways. This makes comparing the results of the studies a challenge, and thus their generalizability is unclear. Though Humboldt County fits under the USDA and ORHP definition of rural I have kept this definition discrepancy in mind.

Barriers to Rural Cancer Care

Barriers and disparities in rural cancer care in the United States have historically been a challenge for hospitals and cancer care programs for a variety of reasons (Chipp, Johnson, Brems, Warner, & Roberts, 2008). Though these barriers have been well documented less is known about strategies rural providers may use to overcome such barriers (Chipp et al., 2008). The development of a metric of defining rural cancer care and creating a common analytic approach is vital to determining disparities in rural cancer care, and at present no such model exists (Meilleur et al., 2013). Some of the main barriers to cancer care in rural communities in the United States include limited oncology staffing and reduced access to cancer care (American Society of Clinical
Access to health services impacts physical, social, and mental health status, prevention of disease and disability, detection and treatment of health conditions, quality of life, preventable death, and life expectancy (Probst, Moore, Glover, & Samuels, 2004). Transportation has consistently been another barrier to cancer care due to the distance people living in rural areas must travel to receive cancer care, but research in this area has received minimal attention and continues to be problematic (Zullig et al., 2012).

Another significant barrier to cancer care in rural areas is poverty. One prominent study was conducted in the Appalachian region of the United States which showed health disparities in people living in this area who had cancer. This study cited socioeconomic differences as one explanation for the disparity (Appalachian Community Cancer Network, 2009; Meilleur et al., 2013). According to Bennett, Lopes, Spencer, & van Hecke (2013) poverty, lack of insurance, and cultural beliefs are contributing factors to low medical screening rates. Additionally, fear, embarrassment, and health illiteracy may also be factors (Bennett et al., 2013). Rural residents who are older, represent minorities, or are of low-income status have been shown to use less medical screenings and early detection options which leads to late diagnosis and increase in mortality (Centers for Disease Control and Prevention (CDC), 2002). Mortality rates from cancer (and cardiovascular disease) have been shown to be higher in rural areas in certain regions of the country (The American Journal of Public Health, 2004). Some of the reasons for this disparity include the fact that even when insurance status, age, severity of disease, and health are comparable, racial and ethnic minorities tend to receive lower-quality health
care than Whites (CDC, 2002). Social inequalities, including discrimination, communication barriers, and provider assumptions, can affect interactions between patient and physician and contribute to miscommunication or delivery of substandard care (ACS, 2011).

According to the literature the main barriers to cancer care in rural areas include: lack of certified oncologists, reduced proximity to cancer care facilities and medical centers, transportation, and lack of or minimal cancer screening and medical care for populations who live in poverty and some minority groups including African Americans, Hispanics, and Native Americans (Chipp et al., 2008). Research has also shown that challenges to confidentiality, overlapping roles for patients and providers, and limitations in training and education result in lack of provision of ethical and effective health services in rural communities (Brems, Johnson, Warner, & Roberts, 2006). As a result, rural areas struggle with inadequate disease prevention, delayed detection of illness, misdiagnosis and late diagnosis, inadequate referral processes, and ineffective treatment (Chipp et al., 2008). One of the focuses of this project is addressing barriers to cancer care in rural areas, and it will build on and complement the existing literature on this topic.

Lack of certified oncologists

The American Society of Clinical Oncology (2014) states that one of the main barriers in rural cancer care is the lack of certified oncologists. The report goes on to say that only 3% of oncologists are based in rural areas where 20% of Americans live (American Society of Clinical Oncology, 2014). One study estimated that there would be
a 48% increase in the demand for oncology services and stated that a shortage of 2,500 to 4,000 oncologists is expected over the next 15 years in the U.S., (according to projected statistics for oncologist to patient ratios), (Erikson, Salsberg, Forte, Bruinooge, & Goldstein, 2007). Fortunately, all medical and radiation oncologists employed by St. Joseph Health Humboldt are certified.

Proximity to cancer care

The lack of proximity to cancer care contributes to reduced access to state-of-the-art treatments for rural residents (Celaya & Gibson, 2005). A census conducted by the American Society of Clinical Oncology, (ASCO), shows early results that point to the possibility of access to cancer care in some rural areas being drastically reduced, especially in smaller areas where the patients rely on community practices for most of their care (ASCO, 2014). Transportation was listed as one of the St. Joseph Cancer Support Services barriers to care (Korsower, 2014). According to the California Center for Rural Policy (2009) reduced public transportation, long distance travel for specialty care, challenging terrain, and weather are all barriers to rural health care access.

Transportation barriers and reduced access to care were considered in the creation of my intervention to enhance patient quality of life during chemotherapy treatment, and I will also provide clients with local transportation resources from Crescent City to Garberville.
Poverty and lack of medical insurance

Poverty has been linked to poorer health outcomes in cancer patients in urban areas, but less research has been focused on attributes of rural areas that may be associated with the same outcomes (Meilleur et al., 2013). Between 1994 and 1998 a study on cancer mortality in Appalachia found that the overall cancer mortality rate was higher among rural residents than the total US population (Huang et al., 2002).

Another study showed that rural residents in persistent poverty counties were less likely to be screened for cancer than those in urban counties (Bennett, Lopes, Spencer, & van Hecke, 2011). In Humboldt County 19.7% of people in 2008-2012 lived below the poverty level (Selected Economic Characteristics, 2012). Diane Korsower, MD conducted a cancer care community needs assessment in 2014 which showed that 32% of the 55 patients she polled had MediCare, 9% had MediCal or other public insurance, and 4% had no insurance. She also stated that the patients she polled in Humboldt County said they would like to have more information about available community resources and social services, (the need for information on community resources/social services ranked the highest), and assistance with medical bills (Korsower, 2014).

I have utilized local social services and financial assistance programs in my psycho-social intervention. I built upon the research in this area by contributing further financial and social services resources to meet this area of need which are included in the manual.
Disparities in health outcomes among minority populations

Discrepancies in health outcomes and mortality rates among African American, Hispanic, and Native American communities remain a troubling statistic. The study by Bennett et al. (2011) also showed that 18.3% of African Americans in persistent poverty in rural counties reported not having mammography screening in comparison to 15.9% of the urban African Americans, and Hispanics had low screening rates in rural counties across all service types. In Humboldt County 10.3% of the population identifies as Hispanic or Latino and 6.2% identify as Native American (US Census, 2012).

Native American populations with cancer present with higher rates of advanced-stage disease for screening-detectable cancers, have lower levels of basic cancer screening knowledge, and more negative attitudes about cancer treatment than White patients (Guadagnolo et al., 2009). Some of the areas which social workers are recommended to address Native populations receiving cancer care include: appreciating competing life issues, considering cancer conceptualizations, assessing perceptions of “dis-ease” and healing approaches, identifying spiritual supports, acknowledging the potential role of traditional medicines, cultivating a relational orientation, acknowledging cultural perceptions of responsibilities, assessing orientation toward death and dying, and recognizing strengths of survivorship (Christ et al., 2015). In order to address historical mistrust, culturally grounded oncology work is needed to bridge cultural healthcare barriers in Indian Country (Christ et al., 2015).

This project supports cultural and spiritual characteristics of the local minority populations by gaining insight into supportive interventions for these populations. I used
the research about rural cancer care nationally and locally in order to provide a framework of reference for the cultural barriers and challenges that clients in Humboldt County currently face. I feel that it is vital for cultural and spiritual differences to be taken into account when working with all clients, and I was culturally sensitive in this area by providing information on local cultural agencies and organizations, community supports, and tribal resources.
METHODS

The purpose of this project was to create a psycho-social intervention manual for clients of the St. Joseph Hospital Cancer Program. This section will cover the following categories: theoretical framework, methodology, population served, overview of materials and information, project overview, rationale, and community engagement.

Theoretical Framework

The strengths-based paradigm was utilized for my community project; this paradigm focuses attention on positive contextual, social, and individual variables which are called promotive factors (Zimmerman, 2013). Resiliency Theory informed the project by viewing research through a lens that considers positive social and individual protective factors of clients, and as a result risk factors are diminished as the protective factors are strengthened. The strengths-based perspective or paradigm gives a set of guiding principles which see human behavior through a new lens; the premise being that people will do better when they can identify, recognize, and use strengths and resources which are available in their environment and within themselves (Saleebey, 1992, 1997; Weick, Sullivan, & Kisthardt, 1989).

Resiliency Theory informs this project in that I used it as a framework for strengths-based interventions for clients of the Saint Joseph Hospital Cancer Program. This project also incorporates information on barriers to cancer service delivery in rural
areas. This helps to inform and provide insight into gaps in service which will improve the patient intervention manual.

Various protective factors and individual and social supports were researched and incorporated to create the data collection tools. The protective factors included focused on individual, community, family, cultural, spiritual, and environmental supports which were included in the qualitative and quantitative questionnaire.

This project is relevant to social work because it builds upon prior research within the medical social work field which focuses on strengths-based approaches and which encompasses social and individual resources. Furthermore, the project informs the cancer service delivery industry about how protective factors and individual and community supports and strengths can be utilized to improve clients’ quality of life and potentially subsequent long-term health outcomes.

The eco-systemic perspective was utilized and explored for this project. Data and knowledge was organized with an emphasis on interrelatedness and interdependency between individuals and social systems. People who are diagnosed with cancer may experience profound stress in many areas of their lives, therefore, strengths-based supports which connect them to the protective factors in their social systems will encourage and promote resiliency. Some of the information for the methods was taken from research which is founded on Resiliency Theory. Protective factors which are assets and resources in a person’s life, and which have been proven to provide resiliency and to oppose risk factors were utilized in the patient intervention manual.
I was accountable to St. Joseph Hospital and Humboldt Medical Specialist’s medical staff and the community partner who was the oversight during the writing of this project. I stayed open to input into my work by my community partner and medical staff, ensured that this project wasn’t being motivated by personal gain or for reasons that would benefit the organization monetarily, and remained accountable to the (National Association of Social Work) NASW Code of Ethics and therefore the clients I work with. By incorporating the strengths-based paradigm into this area of my project it supported the strengths within individuals and communities and not the profit of the organization. Additionally, I was accountable to the Humboldt State University Institutional Review Board, the Social Work Department, and to my project committee chair for the ethics of this project.

Ethical consent and confidentiality practices among individuals and groups were ensured through communication, signed consent, documentation, and ensuring that all documentation remains confidential. The physicians and community partner involved with the project were invited to voice concerns and objections at any point about the consent process, confidentiality, or other elements of the project. Another important aspect of ethics for this project was to ensure that all participants could choose to discontinue being part of this process at any time.

Methodology

The methodology for the intervention manual incorporates strengths-based qualitative and quantitative questions. Literature on strengths-based social work
interventions in this field informs the writing of the manual as well. Individual and community strengths and protective and risk factors were taken into consideration when constructing the methodology portion of this project in order to provide optimal interventions for the clients of Saint Joseph Hospital Cancer Program. This portion of the project was developed and informed by the interviews with the physicians.

Information from qualitative interviews with the community partner, St. Joseph Hospital, (Cancer Program), a non-profit Catholic charity, and the medical director and oncologists contributed to the section on cancer care barriers which were informed by the strengths-based paradigm.

Population Served

The population served by this project includes the clients of St. Joseph Hospital Cancer Program. The specific department within the program which benefits from the research are the practitioners in the Peal’s Family Chemotherapy Clinic and Humboldt Medical Specialists (oncology). This is a rapidly growing program, and the clients have substantial psycho-social needs. The intervention manual will prospectively be utilized in the future by members of the multi-disciplinary team. This includes: oncology mental health professionals such as social workers, psychologists, counselors, and nurse navigators. The purpose of the intervention manual is to assess the client’s psycho-social needs and provide adequate resources, support, and referrals to the clients.
Overview of Materials and Information

This intervention manual is informed by scholarly research, the 2014 Cancer Care Community Needs Assessment for St. Joseph Hospital by Dr. Diane Korsower, HIPAA regulations, National Commission on Cancer (NCCN) guidelines, and interviews with specialists in the field of oncology. The manual is the result of review of scholarly literature about evidenced-based behavioral psycho-social interventions for oncology social work. Additionally, it includes client resources for people undergoing cancer treatment I compiled in my undergraduate internship year in the cancer program, binder sections, and recommendations for the intake, assessment, and referral processes. I utilized current research on best social work oncology practice, my own experience from interning in the Cancer Support Services for my undergraduate and graduate year(s), and previous experience in the medical field.

This manual is also informed by the interviews with Dr. Mahoney, Dr. Richa, Dr. Suryadevara, and Bruce Broswick. Dr. Mahoney is a local Stanford trained breast surgeon specialist. The Humboldt Medical Specialists physicians include: Dr. Richa who is an oncologist/hematologist from Stanford and Dr. Suryadevara who is an oncologist/hematologist. Bruce Broswick is the area director for the St. Joseph Hospital Cancer Program. The manual consists of: (a) a quality of life questionnaire, (the assessment), (b) local resources and referrals, (c) a detailed description of the patient organizational binder given to the patients during the intervention, and (d) a standard work process for the intervention with recommendations for implementation.
Project Overview

The project process was as follows: I interviewed the physicians and director about the intervention including the questionnaire, resource list, and resource binder, and recorded field notes from the meetings. The physicians and the director reviewed my project and quality of life questionnaire then offered feedback. Bruce Broswick, area director of the cancer program and my community partner, oversaw all aspects of the project including the literature review, theoretical framework, and methods sections. The doctors primarily oversaw the intervention manual details and reviewed the final documents. I included scholarly literature, interview results, and my own experience as a MSW student intern in the cancer program to create the quality of life questionnaire and intervention manual which includes the questionnaire, distress thermometer, binder resources and dividers, resource lists, and recommendations for intake and assessment. When the project was completed all of the physicians, the community partner, and my project committee chair and second reader reviewed the intervention, gave input, and edited for final approval and publication.

Rationale

I have chosen to create a psycho-social intervention manual because currently there isn’t a standardized psycho-social assessment and intervention process in the cancer program. Therefore, the clients lack access to needed psycho-social services and support, thus the goal of the manual will be to fill this gap in services. Involving the community
partner in the process of creating the manual incorporates the organization’s values of dignity, service, excellence, and justice so that the project will benefit the non-profit organization as a whole. As the physicians and director were part of the planning process for the manual, there was organizational buy-in to this process as well as a shared vision. This helps to support effective implementation of the intervention process in the program.

By explaining the process of collaboration between the physicians, director, and social work intern, this information can be used in the future potentially for collaboration on other projects. Additionally, future information gathered from this intervention can be used for a needs assessment for the cancer program to improve patient care and needed resources.

Community Engagement

The community partner, St. Joseph Hospital, was involved in all three areas of the editing process. The area director of the cancer program, Bruce Broswick, was integral to this process from start to finish. He gave input and advice into the direction the project will take, communicated which resources were helpful, and gave final approval of the project. There are three other doctors, Dr. Mahoney, Dr. Suryadevara, and Dr. Richa who are part of the cancer program who worked in partnership on the intervention as well. Their medical expertise and understanding of the clients’ needs while undergoing chemotherapy treatment was vital to the process.
Accountability

The accountability for my project includes the four R’s: relational accountability, respectful representation, reciprocal appropriation, and rights and regulations. In order to make sure that relational accountability is part of my project I honored and respected the community I worked with. This included a relational give and take within the relationships. On a practical level this meant that I took advice and input from my community partner. Additionally, I received input from the physicians I work with regarding my approach to intervention development. I was accountable to the NASW Code of Ethics, my faculty partners, the social work department, and Humboldt State University.

I incorporated respectful representation by ensuring to include the values of the organization, (justice, excellence, service, and dignity), and leaders who are involved with my project. Correctly and accurately representing these stakeholders was done in a respectful way through honest open communication that reflects the values of the organization and leaders.

Reciprocal appropriation occurred through doing research prior to starting my community project to ensure that all communities were incorporated and represented in the project. The questionnaires for the clients included questions that are relevant to the populations and have come from research within the oncology field of social work.

In order to make sure that I followed the proper rights and regulations, I used information from the cancer community needs assessment which has captured the voices
of the clients of the cancer program. I also referred to the NASW Code of Ethics, HIPAA regulations, and any other hospital regulations which must be followed in the process of creating the project.
I met with Dr. Mahoney, Dr. Richa, and Dr. Suryadevara over a two-month time frame to design the intervention manual. Additionally, I met with the area director of the cancer program, Bruce Broswick, to get his advice on the intervention process. Dr. Mahoney and I developed the questionnaire for the manual development and Dr. Richa, Dr. Suryadevara, and Bruce Broswick approved of the questions and gave advice on the intervention process. All physicians and the director were in agreement that the qualitative/quantitative questionnaire that had been created was fitting for the clients in the cancer program as well as the list of resources provided to accompany it. It was also agreed upon that the questionnaire could be administered before the clients began treatment for cancer and after their treatment had been completed to assess perception of quality of life and potential increase or decrease in QOL.

In designing the questionnaire for the manual I utilized the evidence based FAC-T questionnaire for cancer patients which assesses QOL. The questionnaire website gave permission to use the questionnaire and asked for the researcher to submit anonymous answers to their questionnaire via the website. I added questions about needed resources to the quantitative section of the questionnaire as well as additional qualitative questions. The questionnaire utilizes the strengths based paradigm by posing questions about the clients’ community, familial, cultural, spiritual, and environmental support systems which can serve as protective factors. I created a standard work process and included recommendations for administering the distress thermometer in order to ascertain the
level of distress. In addition, I included various community resource lists to increase the access to resources available for patients. The binder section recommendations are also included in the standard work process.

The manual addressed common rural barriers to cancer care by posing questions about these categories: transportation, (proximity to cancer care), financial need, (poverty), medical insurance, and minority status (to address care outcomes among minority populations), and other socio-economic and psycho-social needs. Resource lists with appropriate community resources for the above mentioned areas are included in the recommendations section of the manual.

Bruce Broswick advised that there should be appropriate clinical professionals such as psychologists or licensed clinical social workers who could counsel clients if the questionnaire elicited strong emotions or feelings. As there is currently only one part-time social worker in the department Bruce Broswick had concerns about potential lack of psycho-social resources for the clients as well. He also advised to include substantial categories as part of the patient resource binder such as sections for medical records, medical bills, nutrition and exercise info, and community resources: financial, social services, employment/career, home health and support services, support groups, transportation, integrative and complementary medicine, (it is imperative that all integrative and complementary medicine must first be approved by oncologists), cancer program practitioners, dieticians, estheticians, and religious/spiritual resource lists.
Advice from the oncologist physicians included the ethical concern of ensuring that all clients have access to the intervention regardless of cancer stage, type, or stage of treatment. Access to this intervention was of utmost importance if it were to be supported by the oncologist physicians and incorporated into the standard work process. Additionally, they requested that the interview process should be conducted face-to-face and that the mental health professional should check in regularly with the clients during their medical treatment to provide case management services.

The director and physicians also had advice for the recommendations section including how to incorporate the intervention into the standard work process of the cancer program. They suggested that each step of the intervention be documented and put into standard work formatting, which was added to the intervention manual. It was also suggested that a list of resources would be created or compiled to compliment the questionnaire so that clients would have adequate resources for their needs.

Notes were documented from the meetings with the physicians and community partner. All of the above recommendations were included into the intervention manual in the introductory information; all patients would have access to the intervention regardless of stage of disease, type of cancer, or stage of treatment, appropriate psychological services would be available either on site or via community referral for patients, the resource binder would include resources for each question which could elicit a referral, data would be collected from the questionnaires to be utilized in a potential needs assessment, and the intervention steps would be incorporated into a standard work process for the cancer program mental health practitioners.
Additionally, recommendations were made for collecting data for a needs assessment, data analysis, data reporting, and potential quality improvement and process and program evaluation, all of which will be discussed in the recommendations section.

The eighteen-page psycho-social manual which was created consists of the following sections:

(a) standard work process

(b) QOL Questionnaire (FAC-T for cancer patients and additional resource and qualitative questions I wrote).

(c) recommendations (Taken from the George Washington Cancer Institute Patient Navigation Training).

The methodology I had conceptualized for the project generally followed my proposed outline. The physicians and director provided feedback, advice, and support during the process of the creation of the manual. I was able to utilize the strengths based paradigm and protective factors into the intervention manual and find a quantitative QOL questionnaire which fit into my intervention parameters as planned. Additional recommendation categories for data, outcomes, and evaluations include:

- data collection
- data tracking
- data analysis
- data reporting
- process evaluation
- outcomes and measures
• enhancing practice

Bruce Broswick and the three physicians approved the psycho-social manual contents including the questionnaire, standard work process, and recommendations. It is yet to be determined if the manual will be implemented in the cancer program, and if so when this will occur. At the end of the community project creation process the manual will be printed and made available to the psycho-social staff in the program for their utilization.

The collaboration process for this community project between myself, (the MSW student intern), and the oncologists, surgeon, and area director of the cancer program was a successful one. Through the process of collaboration, the medical model and strengths-based theoretical frameworks were combined to design an effective psycho-social intervention manual complete with a standard work process and recommendations for patients undergoing chemotherapy treatment for cancer.
DISCUSSION

The purpose of this community project has been to describe the step-by-step process to create a strengths-based psycho-social intervention manual for the clients of the cancer program. The program manual development was informed by the strengths-based theoretical perspective, encompassing protective factors to increase the perception of QOL during treatment for cancer. Additionally, it was informed by feedback from staff working in the cancer program. As psycho-social interventions for people living in lower-income rural areas who are undergoing treatment for cancer is limited, this project aimed to expand prior program development in this area. Furthermore, since the cancer program at St. Joseph Eureka doesn’t currently utilize strength’s based psycho-social interventions, the project helps fulfill this unmet need and gap in services.

The community project resulted in the successful collaborative process between the student and the physicians and cancer program director to create a best practices strength’s based QOL psycho-social program manual specifically tailored to the unique strengths and needs of rural cancer programs. The intersection between the strengths-based and medical models showcases the blending of two distinctly different and seemingly apposing perspectives. This project demonstrates success in bridging the divide between these perspectives by providing supportive psycho-social services across systems to this unique and often under-served population.
The psycho-social manual includes a standard work process and recommendations sections which dovetail with the processes and programmatic nature of the cancer program, can be accessed by the mental health providers, and incorporates the physicians and director’s vision and the values of the community partner’s organization. This will help to ensure ‘buy-in’ from administrators and physicians and program sustainability. There is limited research about collaborative processes between social workers and physicians. This project is useful for expanding this area of research and program development and can be used as a model in similar rural cancer programs.

According to Turner et al. (2011) barriers to psycho-social support for people with cancer include: lack of systemic approaches of assessment, reduced psycho-social services, the reluctance of patients to receive treatment due to the perception of stigma, and lack of access to psycho-oncology services due to barriers to care such as isolation or disease burden. This intervention manual has created a systemic approach of assessment and standard work process for psycho-social services in the cancer program. It has also increased access to psycho-social services, and through the process of creating the manual the topic of barriers to care has been explored. The reluctance of patients to receive treatment and the lack of access to psycho-oncology services has not been addressed in the research which could be a result of limited substantial literature and practice models in this area to address these barriers.

QOL interventions address seven dimensions affected by cancer and its treatment (Moyer, Sohl, Knapp-Oliver & Schneider, 2009): (1) physical concerns, (2) functional ability, (3) family well-being, (4) emotional well-being, (5) treatment satisfaction, (6)
sexuality and intimacy, and (7) social functioning. The QOL intervention addresses all seven of these areas and supported current research in this field. The project goals of the psycho-social manual were to identify a person’s physical, psycho-social, spiritual, financial, and practical problems, but, it was not designed to improve patient, family, and care team interpersonal communication (Patlak et al., 2011). However, once the project is implemented this could be an unintended result.

This project may be utilized among other rural cancer programs to show how social workers can successfully collaborate with oncology physicians and administration to create a psycho-social intervention manual designed for a specific population of patients undergoing treatment for cancer. Furthermore, the successful relationship between the university, social work student intern, and medical staff could be used as a model for academic social science research and collaboration within the medical oncology setting.

Emerging Questions

Some of the most prominent questions which resulted from my project are whether the psycho-social intervention manual will be implemented in the cancer program, and if so, will it be effective for improving the perception of QOL in patients undergoing treatment for cancer? Secondly, will the collaborative process between social worker and physicians and medical staff continue as the manual is utilized? If so, what will the process implementation look like? Additionally, this project begs the following question; will the intervention improve communication between the patients and their
families as well as the medical staff and providers? The efficacy of the intervention in local rural cancer service delivery has yet to be tested; therefore, it remains to be seen if it will be effective in removing the barriers to care in this population. This includes minority populations such as Indigenous communities, Hmong, and Latino communities as well as other various disenfranchised populations. It also encompasses other people who are minorities, those living in poverty and addiction, and people who have mental illness that suffer health disparities across the board. When this intervention is implemented it may or may not be effective in reducing health disparities within these populations.

Some of the prominent challenges which face rural cancer service delivery include lack of certified oncologists, transportation barriers, reduced resources, and fiscal challenges. Since these are unknown elements in the implementation of the psycho-social intervention their impact is unknown at this time, therefore they could prove to be substantial barriers to successful implementation. Additionally, similar interventions have not been utilized in the program, and the ability to implement the intervention to all patients who have a cancer diagnosis may or may not be feasible due to staffing and time constraints.

Recommendations

The program manual outlining the protocol for the intervention should be implemented through the psycho-social assessment process in the social services or mental health services division of the cancer program. It is advised that the standard
work process described in the index should be implemented initially via a pilot study, and it should then be modified and tailored to meet the needs of the specific patient population. Pilot studies should assess effective implementation through patient satisfaction questionnaires, presentations to administration and physicians, (and should consider their subsequent recommendations), and review by the mental health practitioners. The recommendations section of the manual discusses data collection, assessment, tracking, analysis, reporting, and evaluation measures. If applicable the data can be used for a community needs assessment for the patients in the cancer program to improve services and help to develop further effective interventions. Additionally, these interventions could be used in a behavioral research study to increase the knowledge of research in this area of rural cancer service delivery. The results could also be utilized in future grants for the cancer program to increase access to healthcare and delivery of services. Results could be shared among community medical agencies to help educate providers about the psycho-social challenges of people undergoing chemotherapy as well as potential effective interventions for this population. Other community research and projects could potentially grow from this project. All of the above recommendations should be discussed and approved by the oncology leadership and physicians as well as any other mental health professionals on staff in the cancer program.

Limitations

This intervention is tailored for patients undergoing chemotherapy and is created to meet their unique psycho-social needs, therefore, it won’t address all of the same
concerns of clients who are undergoing oncology radiation therapy. Radiation oncologists were not part of the physician group collaborated with to create the intervention manual, so their voice is missing. Other staff such as oncology nurses and mental health professionals were not part of the collaboration process. The chemotherapy clinic does not allow for privacy for patients, so the qualitative portion of the questionnaire can’t be used in this location since it is facilitated in a verbal interview style which requires confidentiality. Additionally, it may not meet the same needs of people who have finished treatment for cancer who are in the “survivorship” stage. This intervention is created specifically for people who are undergoing chemotherapy treatment and is supposed to be implemented before, during, and after treatment, so the outcome may be different if it is implemented only in the middle of treatment. Since it has been designed for rural communities and their unique needs it may not be as effective in urban communities.

As this intervention is being used in the hospital and medical model environment, in order for it to be accepted and utilized in this field, some of the strengths-based elements and protective factors are minimized or non-existent. Clients of the cancer program were not interviewed or consulted prior to the creation of the intervention, so it has not been guided by their voice; this lack of participatory research does not support the strengths-based research paradigm. However, the 2014 Cancer Care Community Needs Assessment was utilized, and it does include patient interviews.

The interviews which took place with the physicians and director were not conducted with both parties present, therefore a collaborative meeting process is missing.
Since a surgeon and two oncologists assisted in the questionnaire process, the combination of these medical professional’s unique perspectives and expertise weren’t jointly discussed regarding implications for practice. Furthermore, it was challenging to schedule meetings with the physicians due to their busy schedules, so I was only able to meet with some of them a few times. Communication was also somewhat of a barrier due to the differences between the medical model and social work practice world views. Finding common ground and mutual understanding of terminology across practices was one of the biggest hurdles I faced while creating this project.

Lastly, the intervention has not been implemented yet within the cancer program, so its success or inadequacies have not been tested, data and results are not available, and outcomes remain unknown at this time.

Suggestions for Future Research

Future research could include studying the results of the intervention through needs assessments to look for gaps in cancer care in rural communities and how health disparities, barriers to care, and quality of life negatively impact patient outcomes. Alternately, the research could be used to show how QOL strengths-based interventions can be utilized in rural communities and could prove their effectiveness and sustainability. Other research could look at increased perception of QOL in cancer patients and how this affects health outcomes and life expectancy. This growing field of research has shown promising results. Future research could also include creating psycho-social interventions for radiation oncology patients. Radiation oncologists could
potentially partner with the oncologists and mental health professionals to create and assess psycho-social interventions for the patients who may be receiving radiation treatment only.

Since a professional relationship has begun between the social worker and the medical practitioners and administration in the cancer program through the process of this project, there is potential for future research in the St. Joseph Hospital Cancer Program which could encompass various theoretical perspectives and research models. Future research on psycho-social topics relating to rural cancer service delivery will be extremely valuable since this is a growing field of research due to the myriad of challenges and barriers to adequate medical care and services currently facing rural populations.
REFERENCES


Prentice-Hall.


Waldrop, D., O’Connor, T., & Trabold, N. (2011). Waiting for the other shoe to drop: distress and coping during and after treatment for breast cancer. *Journal of*


Appendix A

St. Joseph Hospital Cancer Support Services

Psycho-Social Intervention Manual

for Patients Undergoing Chemotherapy Treatment

May 2016

Author: April Alexander, MSW Student Intern

Edited by:

Ellen Mahoney, M.D., Bruce Broswick – SJE Cancer Program Area

Director, Elie Richa, M.D., and Uma Suryadevara, M.D.
With sincere gratitude and thanks to those who made this manual possible:

Humboldt State University Department of Social Work, St. Joseph Humboldt, Ellen Mahoney, MD, Marissa O’Neill, PHD, Bruce Broswick, Elie Richa, MD, Uma Suryadevara, MD, my family, and my fellow HSU MSW cohort

This manual is dedicated to the oncology staff and patients of the St. Joseph Eureka Cancer Program
Currently the Commission on Cancer (COC) requires a psycho-social assessment for distress during pivotal times during a patient’s treatment. Social work best practices and evidence based practice show that just as a patient is assessed for his or her vitals at every appointment so must distress (the “sixth vital sign”) be screened and followed up on by psycho-social practitioners to ensure the best patient care. This psycho-social intervention manual includes substantial follow-up and screening throughout the patient’s chemotherapy treatment for cancer.

**Purpose of the Intervention:**

- To help increase the perception of QOL of people going through chemotherapy treatment for cancer
- To reduce distress
- To remove barriers to care
- To determine which services and supports are most needed for the patient population

**Proposed Intervention Outcomes:**

- 1.) A change in distress level (documented by the distress thermometer) from initial visit to final visit and 2.) An increase in the perception of QOL/patient satisfaction shown by a decrease in areas of need/concern and an increase in areas of patient satisfaction (documented in the questionnaire).
- If this intervention is successful it could become the standard work for psycho-social interventions with patients in the chemotherapy clinic and potentially in other departments in the cancer program.
- The results of the intervention could be used for a comprehensive needs assessment.

**Referral Process:**

- All patients with a cancer diagnosis are referred to the oncology MSW social worker or other licensed mental health professional by physicians, RN Navigators, and RN’s.
- Timing for referral is before the patient has begun treatment for chemotherapy; preferably at their first appointment with the oncologist or around the same time they do their chemotherapy education with the RN Navigator.

**Proposed Intervention:**

- Initial Meeting with patient:
  Patient meeting requires confidentiality which is in accordance with the NASW Code of Ethics, also adopted by the Association of Oncology Social Work as part of their best practices. It is very important that patients should meet with the
social worker or mental health professional in a private room without interruptions or distractions.

- Practice ADIET with the patient and inform them of confidentiality. Approximate time for intervention: 1 hour.
- Use the strengths-based perspective/paradigm, person in environment perspective/paradigm or similar paradigm (further resources on these paradigms are available from the oncology social worker).
- Distress thermometer (unless the patient has recently done one during their chemo education already).
- Questionnaire to determine gaps in care and areas of needed support/concern (psycho-social assessment).
- Binder is given to patients with sections for: medical records, medical bills, nutrition and exercise info, and community resources: financial, social services, employment/career, home health and support services, support groups, transportation, integrative and complementary medicine (it is imperative that all integrative and complementary medicine must first be approved by oncologists), cancer program practitioners, dieticians, estheticians, and religious/spiritual/cultural resource lists.
- All patient data and results from the intervention are kept confidential in a HIPAA compliant location.
- If suicidal ideation is apparent contact the nurse manager or physician to determine next steps/follow hospital/cancer program protocol for suicidal ideation.
- Referrals for:
  - Understanding diagnostic treatment – medical personnel
  - Physical issues unrelated to cancer (to be determined by oncologist) – Oncologist or PCP referral
  - Psycho-social needs – support groups and/or counseling/spiritual services referral
  - Psychotherapy referrals (SJH’s LPCC, LCSW, or community clinical psychotherapists)
  - Social services
  - Community support
  - Cultural support
  - Financial counseling
  - Dietician (to be determined by oncologist)
  - Survivorship care plans (post treatment)

- Suggested resource lists which can be utilized during the intervention:
  - Humboldt County DHHS Resource List
  - SJE Cancer Support Services Resource List
  - Humboldt Resource Center Resource List
- SJE Cancer Support Services social worker resources
- Out of area Oncologist Referral Lists (for patients who need a second opinion or who can’t get an appointment with one in a timely manner)
- Northern California Tribal Resource List (created by MSW students)

- Two check-ins with clients during treatment:
  - Re-assessment, (Repeat distress thermometer)
  - Referrals and support as needed

- Final meeting with social worker or intern when treatment is completed:
  - Repeat questionnaire
  - Re-assessment
  - Referrals and support as needed
  - Follow up as needed

- Data collection, tracking, analysis, reporting, and evaluation measures are encouraged and will be discussed in the “recommendations” section at the end of the manual.
Questionnaire Part 1
(Information obtained from the FAC-T/Cancer Questionnaire with permission).

Name: __________________________________________________

Date of Birth: ____________________

Sex:  M      F

Ethnicity:  Hispanic or Latino □  Black □  Asian □  Native American □  Pacific Islander □  White □

Diagnosis: ______________________

Below is a list of statements that other people with your illness have said are important. Please circle or mark one number per line to indicate your response as it applies to the past 7 days:

Biological Needs

I have concerns about food for myself or my family…

getting food and/or paying for food (please circle if applicable)

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I have concerns about housing for myself or my family…

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I have concerns about finances…

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I have concerns about transportation…

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I have concerns about medical or dental issues that are not related to my cancer diagnosis…

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I have concerns about my physical or emotional safety…

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I have concerns about my work situation…

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I have concerns about obtaining disability…

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I have concerns about health insurance or medical bills…

Not at all  A little bit  Somewhat  Quite a bit  Very much
0  1  2  3  4

I need help with housework…

Not at all  A little bit  Somewhat  Quite a bit  Very much
0  1  2  3  4

I need help with grocery shopping…

Not at all  A little bit  Somewhat  Quite a bit  Very much
0  1  2  3  4

Social/Family Well-Being

I feel close to my friends…

Not at all  A little bit  Somewhat  Quite a bit  Very much
0  1  2  3  4

I get emotional support from my family…

Not at all  A little bit  Somewhat  Quite a bit  Very much
0  1  2  3  4

I get support from my friends…

Not at all  A little bit  Somewhat  Quite a bit  Very much
0  1  2  3  4
I have spiritual support…

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My family has accepted my illness…

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I have concerns about communication with my children about my illness…

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I am satisfied with family communication about my illness…

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I feel close to my partner (or the person who is my main support) …

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Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box □ and go to the next section…

I am satisfied with my sex life…

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Emotional Well-Being

I feel sad…
Not at all    A little bit    Somewhat    Quite a bit    Very much
          0         1           2                      3                      4

I am satisfied with how I am coping with my illness…
Not at all    A little bit    Somewhat    Quite a bit    Very much
          0         1           2                      3                      4

I feel nervous…
Not at all    A little bit    Somewhat    Quite a bit    Very much
          0         1           2                      3                      4

I worry about dying…
Not at all    A little bit    Somewhat    Quite a bit    Very much
          0         1           2                      3                      4

I worry that my condition will get worse…
Not at all    A little bit    Somewhat    Quite a bit    Very much
          0         1           2                      3                      4
Functional Well-Being

I am able to work (include work at home) …

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My work (include work at home) is fulfilling…

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<th>Quite a bit</th>
<th>Very much</th>
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<td>0</td>
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</table>

I am able to enjoy my life…

<table>
<thead>
<tr>
<th>Not at all</th>
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I have accepted my illness…

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I am sleeping well…

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</table>

I am enjoying the things I usually do for fun…

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</tbody>
</table>
I am content with the new quality of my life right now…

Physical Well-Being

I have a lack of energy…

Because of my physical condition, I have trouble meeting the needs of my family…

I have pain…

I am bothered by the side effects of treatment…
I feel ill…

<table>
<thead>
<tr>
<th>Not at all</th>
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<th>Quite a bit</th>
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I am forced to spend time in bed…

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I am limited in my normal daily activities…

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<th>Not at all</th>
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I have had difficulty performing the work or other activities (for example, it took extra effort.)

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I have concerns about understanding my diagnosis or treatment…

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</table>
Community Resources and Support

Do you need information about?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Veteran services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student services</td>
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<tr>
<td>Mental health services</td>
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<tr>
<td>Drug &amp; alcohol abuse services</td>
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<tr>
<td>Domestic violence</td>
<td></td>
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<tr>
<td>Cultural services</td>
<td></td>
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<tr>
<td>If yes, please specify ________</td>
<td></td>
<td></td>
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<tr>
<td>Respite services</td>
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<tr>
<td>Senior services</td>
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<td>Day Care services</td>
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<tr>
<td>Translation services</td>
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<tr>
<td>Support groups</td>
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</tr>
<tr>
<td>Service</td>
<td>Yes</td>
<td>No</td>
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<td>-------------------------------</td>
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<tr>
<td>Parenting groups</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>LGBTQ resources/support</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Transportation</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>
Questionnaire Part 2

1.) What are some areas in your life you feel that you could use more support in?

2.) How is your family supportive during your illness?

3.) How do you feel about communication with your family at the moment? Why?

4.) How are your friends supportive during your illness?

5.) What are some sources of strength in your life, and how do they support or encourage you?

6.) What do you do for yourself on a daily or weekly basis that you find enjoyable? (such as hobbies, sports, leisure, etc.) If not, what do you think you could do in the future?

7.) What are some positive things that have come from your experience with illness? Why do you think that is?

8.) What is a spiritual source of strength you draw from and how does that strength help you in life?

9.) What community support is in your life? In which ways does this support you?

10.) How is your medical team a support to you?

11.) How are you feeling about your physical health?

12.) How are you feeling about your life at this moment?

13.) How are you feeling about your future?
Recommendations

• Implementation
  o See standard work process

• Data Collection
  o Develop Excel sheet tracking tool to collect data from the intervention
  o Move data into the Access Program for easier manipulation
  o Track patient information from the questionnaire. Include both qualitative and quantitative sections during initial interview, check-ins, post-treatment interview, and follow-up

• Data Tracking
  o Keep accurate records
  o Track consistently and regularly
  o Ensure data accuracy
  o Ensure legibility

• Data Analysis
  o Look for trends from data collection
  o Determine areas in need of improvement/gaps in care
  o Determine strengths of the intervention/services

• Data Reporting
  o Potential use of data for needs assessment which is a COC requirement every three years
  o Potential use of data for grant purposes
  o Reports for Cancer Committee, oncologists, and cancer program management. Partner with oncologists and management, discuss recommendations, find middle ground, ensure buy-in.
  o Process Evaluation. Determine:
    ▪ What was done
    ▪ How the intervention was implemented?
    ▪ How well was the intervention implemented?
    ▪ If the intervention went as planned
    ▪ If the patients and providers were satisfied with the intervention
    ▪ How can we show that the outcome of our intervention has been implemented before its realized?

• Outcomes Evaluation
  o # of patients who did the intervention
  o # of patient barriers
- # of barriers resolved
- # of referrals
- Type of referrals
- Resources recommended
- Distress thermometer scores before, during, and after treatment
- QOL survey scores before, during, and after treatment
- Qualitative results before, during, and after treatment

- Questions to ask:
  - Did we reach our intervention goals?
  - How did the intervention impact the patient, i.e. was QOL increased?
  - What evidence demonstrates to our physicians and administrators that they should approve continued use of the intervention?

- Sample Outcomes Evaluation Measures:
  - Time from initial appointment to intervention
  - Time from initial intervention to check-in
  - Time from check-in to final intervention
  - Time from final intervention to follow-up
  - Patient adherence to scheduled intervention appointments
  - Patient satisfaction with intervention
  - Patient reported outcomes: Fatigue, distress, pain, quality of life, functionality
  - Physician satisfaction with intervention and outcomes

- Enhancing Practice – PDCA Cycle
  - Plan a change – new intervention
  - Do – Test/pilot intervention
  - Check/Study – Analyze results
  - Act – Make a decision, expand, alter, abandon

Appendix B

Informed Consent Form

Researchers at Humboldt State University study many topics. To do this, we need the help of people who agree to take part in a research study. We are asking you to take part in a research study that is called: *Psycho-Social Intervention Manual for Patients in Cancer Treatment: a Collaboration Between Social Worker and Physicians.*

The person who is in charge of this research study is **April Alexander**, MSW student. This person is called the Principal Investigator.

Her faculty supervisor is **Dr. Jennifer Maguire**, PHD, MSW.

This study is sponsored by: Humboldt State University.

You are being asked to participate because you are a physician or director in the Saint Joseph Hospital Cancer Care Program. The purpose of this study is to create a psycho-social intervention and manual for the patients undergoing chemotherapy treatment in the Cancer Care Program and for use of the practitioners in the CCP.

If you take part in this study, you will be asked to meet with the principle investigator for 1-4 hours per month for two months to help create the intervention.

You have the alternative to choose not to participate in this research study.

You should only take part in this study if you want to volunteer and should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty if you stop taking part in this study. Decision to participate or not to participate will not affect your job status.

We are unsure if you will receive any benefits by taking part in this research study.

This research is considered to be minimal risk.

We will not pay you for the time you volunteer while being in this study.

We will publish what we learn from this study. We will publish your name in the research project. We will not publish the notes from the meetings you will have with the principle investigator. The only people who will be allowed to view the notes the principle investigator records from the meetings with you are:
The research team, including the Principal Investigator, (April Alexander), and the Advising Professor, (Dr. Jennifer Maguire.)

April can be reached at: ada262@humboldt.edu or (707) 273-0976. Jennifer can be reached at: jennifer.maguire@humboldt.edu or (707) 826-4565.
The Investigator will answer any questions you have about this study. Your participation is voluntary and you may stop at any time.

If you have any concerns with this study, contact the Chair of the Institutional Review Board for the Protection of Human Subjects, Dr. Ethan Gahtan, at eg51@humboldt.edu or (707) 826-4545.

If you have questions about your rights as a participant, report them to the Humboldt State University Dean of Research, Dr. Rhea Williamson, at Rhea.Williamson@humboldt.edu or (707) 826-5169.

Would you like to participate in this study? If so, please sign and date here:

Name________________________________________________________

Date_________________________________________________________