

Managing Late Effects of Breast Cancer Treatment

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This article illustrates the authors' participation in the ONS Foundation–supported Breast Cancer Survivorship (BCS) Quality Measures Set pilot study at Southern Ohio Medical Center (SOMC) Cancer Center. The data collection, outcomes, and action plans based on results are described. Included are the SOMC distress tool, psychosocial assessment tool, a survivorship care plan, and a clinical vignette describing how the tools and implementation of the action plan improved care and facilitated connection to supportive community resources. The BCS Measures pilot study provided a learning opportunity in identifying important quality assessments early in the plan of care. These valuable measures are necessary to provide better care in breast cancer survivorship.

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The Southern Ohio Medical Center (SOMC) Cancer Center participated in the ONS Foundation–supported Breast Cancer Survivorship (BCS) Quality Measures Set pilot study. The SOMC Cancer Center is a small, rural community outpatient facility that offers both radiation and medical oncology services in the same location. In southeastern Ohio, breast cancer is the leading cancer diagnosed in women and accounted for 43% of cancer diagnoses in women at SOMC from 2010–2012 (SOMC Cancer Services, 2013).

SOMC submitted data for 26 patients to the BCS Measures pilot study. The data required on each patient were detailed and very specific. At the SOMC Cancer Center, all of the patient records are electronic. Although the electronic medical record was beneficial, significant time was invested gathering specific data components for the study. The information required was not segmented in certain sections for easy report retrieval, and some data elements were not captured. During the collection process, areas for improving collectability of information were

identified, and opportunities for streamlining data were discovered. These opportunities were realized for all clinical areas, including providers, nurses, social services, and the breast health navigator.

The staff at SOMC Cancer Center created action plans after the study was completed to address opportunities for improvement. One area of particular interest was the survivorship care plan. Improvements were made to the plan in an effort to add missing information and provide more information to patients. Psychosocial concerns are addressed by the social worker using a self-administered distress inventory (see Figure 1) on the patient's first visit to the center. The social worker receives the distress inventory information and meets with patients with emphasis placed on the score and criticality. After the visit, a note is documented in the chart informing other staff members of potential problems the patient is having or may face in the future as well as the plan to address the concerns. The social worker continues to address the patient's needs throughout his or her care and communicates with the team

Name: _____

Today's date: _____

First, please circle the number (0–10) that best describes how much distress you have been experiencing in the last week, including today.

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Second, please circle yes or no for the following issues that you need assistance with or have been a problem for you in the last week, including today.

Financial/Practical Needs

Medical equipment	yes	no
Home health care	yes	no
Insurance	yes	no
Transportation	yes	no
Disability/social security	yes	no
Medication assistance	yes	no
Living will/POA	yes	no
Meals on Wheels	yes	no

Emotional Concerns

Depression or sadness	yes	no
Fears or worry	yes	no
Nervousness or anxiety	yes	no
Anger	yes	no
Use of alcohol or drugs	yes	no
Past mental health Tx	yes	no
Suicidal thoughts	yes	no
Loss of faith	yes	no
Relating to God	yes	no

Family Needs

Spouse overwhelmed	yes	no
Children need support	yes	no
Child care	yes	no
Housing	yes	no
Medicaid	yes	no

Cancer-Specific Concerns

Coping with diagnosis	yes	no
Lack of hope/lost hope	yes	no
Fear of treatment	yes	no
Fear of disease or death	yes	no
Loss of sleep	yes	no

Support Group Interest

Look Good Feel Better	yes	no
Breast cancer support	yes	no
Man-to-man support	yes	no
Caregiver support	yes	no
Survivor support	yes	no
Smoking cessation	yes	no

POA—power of attorney; Tx—treatment

FIGURE 1. Distress Inventory

Note. Courtesy of Southern Ohio Medical Center Cancer Center. Used with permission.

regarding any issues or concerns that need attention. This process has helped tremendously in providing better psychosocial care to the patients.

The social worker for the SOMC Cancer Center depends on the results of the distress inventory to provide direction for meeting the needs of each new patient with cancer in a holistic approach. Maslow's Hierarchy Theory of Need (Taormina & Gao, 2013) states that self-actualization or acceptance cannot be reached unless physiologic needs, as well as safety, love, and esteem, are satisfied. If a patient's immediate concerns are not addressed, he or she may have difficulty focusing on coping with healing and acceptance of a cancer diagnosis. The following case study is a vignette that illustrates how the distress inventory tool helped identify the needs of one patient with cancer.

Case Study

A 55-year-old woman came to the cancer center with a diagnosis of invasive ductal carcinoma of the right breast. Her cancer was HER-2 positive and appropriate for high-dose rate radiation treatment. She came to her first appointment with the self-administered distress inventory that had been mailed to her in the new patient packet. The social worker was not available to meet that day but called the patient the

next day. The patient had a score of 7 on a 10-point scale on the distress inventory, specifically listing nervousness, anxiety, and fear of treatment as concerns. The patient voiced no concerns during the phone interview or at the follow-up visit. She informed staff that she was independent and had a spouse to assist as needed. The patient downplayed any emotional distress that the cancer was having on her life, and her family physician was helping her with medication. The patient's distress seemed to stabilize during treatment, but her distress level increased after treatment ended and she developed lymphedema in her arm. She had been referred to physical therapy and was having panic attacks from fear that the therapy would exacerbate an old shoulder injury. At this point, she felt comfortable with the social worker and called for assistance. The patient was in tears because she felt as if she was "falling apart." She explained that when anything new happens, it sends her "south into despair and panic." She was guided to speak to a psychiatric professional about medication adjustment and encouraged to attend "I Can Cope," an education class for people facing cancer and their family members, or a breast cancer support group. The patient still attends the monthly I Can Cope group, which discusses a new cancer topic each month on a one-year rotation. She was so appreciative that a social worker was there to help her through this time, and although she took a while to discuss her concern, the distress inventory was the key that unlocked the door to

communication about her needs and concerns. After a year of I Can Cope classes, the patient felt ready to transfer to a breast cancer support group.

Symptom Assessment

The SOMC Cancer Center identified that nurses were not documenting issues with sleep, fatigue, or neuropathy. This

was not an assessment question typically asked, and, even if discussions occurred, they were not documented in discrete fields for data mining in the future. These items were added to the electronic nursing assessment in each patient's medical record and are addressed during each visit to the center. When problems are identified, the physician is notified and documentation ensues related to the action plan to address the issue. In this manner, subsequent nurses can follow these areas on the assessment and ascertain improvement or decline.

Congratulations!

You have reached the end of your treatment. To assist you in the transition from treatment to surveillance, we have prepared this individualized Survivorship Care Plan for you. Your Survivorship Care Plan contains your personalized Breast Cancer Treatment Summary.

Your Breast Cancer Treatment Summary consists of:

- Healthcare team contact information
- Breast cancer treatment clinical summary
- Recommended surveillance schedule

This Breast Cancer Treatment Summary can be shared with future healthcare providers as needed. It has been our privilege to be your chosen healthcare provider. We look forward to remaining a partner in your health care as you transition back to a new "normal." Please do not hesitate to contact us if you have specific questions about information contained in this summary.

General Information

Patient name: _____
Patient ID: _____
Phone: _____
DOB: _____
Age: _____

Care Team

Clinical presentation: _____
Family history/genetic testing: _____

Major surgeries or health complications: _____
Diagnosis: _____
Definitive surgery date: _____
Surgical procedure: _____
Tumor type, histology, and grade: _____
ER/PR status: _____
HER2/neu: _____
Oncotype result: _____
TNM stage: _____
Group stage: _____

Treatment Plan and Summary

Pretreatment	Post-treatment

Patient's weight: _____

Medication administration

Start Date	Stop Date	Cycles	Regimen

Treatment-related admission(s): _____

Ongoing toxicities: _____

Radiation treatment period

Course	Site	Technique	Modality	Current Dose	# Fraction	Fraction Pattern	Fraction Number

Additional therapies planned/given: _____

Follow-up care: _____

Medical oncology visits: _____

Radiation oncology visits: _____

DOB—date of birth; ER—estrogen receptor; ID—identification; PR—progesterone receptor; TNM—tumor, lymph nodes, metastasis

FIGURE 2. Breast Cancer Treatment Summary

Note. Courtesy of Southern Ohio Medical Center Cancer Center. Used with permission.

Results

Results from the BCS Measures pilot study helped identify that the plan for post-treatment education was not assessed in a complete manner. After the study, an improved survivorship program was launched for all patients with breast cancer. The breast health navigator developed a breast cancer treatment summary for the patients with breast cancer that addresses all areas of the survivorship care plan after treatment (see Figure 2). The breast health navigator meets with every patient after treatment ends and educates them on important areas lacking in the past on post-treatment education. Handouts are provided on diet, exercise, and lymphedema. Patients are educated on late effects they may experience and are provided information on recurrence. The breast health navigator also provides information on community resources.

Community resources include the “Life Matters” program for all cancer survivors. This program provides information after treatment on diet, exercise, goal setting, survivorship, and psychosocial issues patients may encounter after treatment. The program is a free six-week course offered for one hour weekly at SOMC to any cancer survivor in the area. A variety of team members, including a dietitian, fitness expert, nurse, social worker, and a cancer survivor, educate the participants during the meetings. A breast cancer support group also meets monthly at the cancer center. This program provides information on all phases of cancer care. Patients are given the opportunity to speak about their issues and concerns during this support group, and professional speakers are also present at quarterly meetings. Another program offered is I Can Cope, which provides a holistic approach to newly diagnosed patients and those receiving treatment. The classes are led by a social worker, nurse, dietitian, financial expert, and hospice staff depending on the topic being covered. I Can Cope classes are offered to anyone who wants to attend.

Findings from the BCS Measures pilot study created many learning opportunities for the center. Public reporting of quality measures has shown to promote changes in healthcare providers (Agency for Healthcare Research and Quality, 2012).

Implications for Practice

- ▶ Add sleep, fatigue, and neuropathy to the nursing assessment done at each follow-up visit, and address any issues in those areas that are discovered.
- ▶ Recruit a breast health navigator to help develop and implement survivorship care plans.
- ▶ Provide distress inventory documents to new patients, and address any psychosocial issues that the patient reports with the help of a social worker.

The results helped the center to develop action plans that strengthen the care provided to people with breast cancer. With the support of the whole team, more aspects of the patient's care are addressed and symptom assessment and educational tools have been strengthened in the process. The community resource programs have made a difference in the rural community. They provide an outlet for cancer survivors to meet and get answers to difficult questions they may not feel comfortable speaking to their physicians about. At the SOMC Cancer Center, staff continue to look for areas that need improvement and are always researching for the best practice to provide evidence-based health care for the community.

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