

2019

AOSW 35th Annual Conference

Passion
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CREATING AN OASIS
IN CANCER CARE



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June 5-7, 2019

JW Marriott Tucson Starr Pass Resort & Spa

Tucson, Arizona USA

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PRE-CONFERENCE WORKSHOPS

***Indicates session is not eligible for CE*

PRE-CONFERENCE RESEARCH INSTITUTE (4.0 CE)

Title: Demystifying the Publication Process: Writing and Reviewing for Peer-Reviewed Journals

Author(s): *Karen Kayser, PhD, MSW; Daniela Wittmann, PhD, MSW*

Date Scheduled:

6/4/2019, 8:00am - Noon

Abstract Content:

Publishing articles for peer-reviewed journals and reviewing manuscripts as peer reviewers for journals are not only important professional activities for social workers but also shape the science that is published, disseminates evidence-based interventions into practice, and gives voice to research participants and patients. Most early career professionals and doctoral students receive little training on how to write articles and how to review for peer-reviewed journals. Even seasoned professionals may wonder about the publication process, what reviewers are looking for in a good manuscript and about how to write a good review. This workshop aims to provide guidance for writing articles and for reviewing manuscripts for peer-reviewed journals. This half-day workshop will take the participants through the writing and publishing process, from the initial writing of a manuscript to submission to a journal, through the revise-and-resubmit phase on to publication. It will focus on 1) how to write a variety of articles (original research, case study, book review, or commentary) and 2) how to be a peer reviewer for a journal such as the Journal of Psychosocial Oncology. Participants will learn specific steps for writing a manuscript, for attending to journals' author guidelines, working with co-authors and getting a manuscript ready for submission. Participants will also learn about how to write a good response when the journal asks for the author(s) to revise and resubmit the article. Ethical considerations related to plagiarism and human subjects in research will be addressed. Participants will learn about what editors look for in a peer review. The workshop will be interactive with breakout groups to review manuscripts using a checklist that will be provided. Handouts of recommended readings, tip sheets for writing articles and examples of reviews will be given to participants. The session will be helpful for intermediate social work professionals, doctoral students, and social work researchers/educators. It will also be of interest to seasoned researchers and practitioners who would like to become members of editorial boards.

Abstract Summary:

This workshop will take the participants through the writing and publishing process, from the initial writing of a manuscript to submission to a journal, through the revise-and-resubmit phase on to publication. It will focus on 1) how to write a variety of articles (original research, case study, book review, or commentary) and 2) how to be a peer reviewer for a journal such as the Journal of Psychosocial Oncology. Participants will learn specific steps for writing a manuscript and how to write a good response when the journal asks for the author(s) to revise and resubmit the article. The workshop will be interactive with breakout groups to review manuscripts using a checklist that will be provided. Handouts of recommended readings, tip sheets for writing articles and examples of reviews will be given to participants.

Learning Objectives:

1. Describe how the peer review editorial process works from manuscript submission to final decision and publication.
2. Identify the specific things that editors look for in a well-written manuscript and an informative review.
3. Critique and write a review of a manuscript, using a validated checklist.

Outline:

- 8:00 a.m. – 9:15 a.m. Describe how the peer review editorial process works from manuscript submission to final decision and publication.

- 9:15 a.m. – 10:30 a.m. Identify the specific criteria that editors look for in a well-written manuscript and an informative review:
 - Publication and dissemination of evidence-based practice in psychosocial oncology.
 - How social work practitioners and researchers to write for publication in peer-reviewed journals.
 - How social workers play an important role in writing and reviewing manuscripts by shaping the science that is published.
- 10:30 a.m. – Noon. Critique and write a review of a manuscript, using a validated checklist, in AOSW's Journal of Psychosocial Oncology.
 - How the articles relate to direct services to clients, individuals, families, and groups.

References:

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Lovejoy, T.I., Revenson, T.A., France, C.R. (2011). Reviewing Manuscripts for Peer-Review Journals: A Primer, Annals of Behavioral Medicine, 42: 1-13.

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Scholl, M.B. (2017). Recommendations for writing case study articles for publication in the Journal of College Counseling, 20, 81-93.

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Keywords: Research, Education
Course Designation: Clinical
Presentation Level: Intermediate

½ DAY CONFERENCE WORKSHOP (4.0 CE)

Title: Essential Skills in Collaborative Care in Cancer Treatment
Author(s): *Tiffany Courtnage, MSW, LICSW; Jesse Fann, MD, MPH*

Date Scheduled:
 6/4/2019, 1:00pm - 5:00pm

Abstract Content:

Psychosocial distress is associated with poor adherence to treatment, decreased functioning, more cognitive and somatic complaints and higher costs to care for people with cancer.[1] One quarter of all people with cancer have symptoms of major depression[2]; and survivors of cancer are at high risk of developing Post-Traumatic Stress Disorder (PTSD)[3] as a response to their illness, yet only one-quarter receive effective interventions for these psychosocial concerns within traditional referral systems. [4] Psychosocial distress is under-treated in cancer patients[5], despite efforts by the Commission on Cancer and other groups to encourage distress screening. According to the only national assessment of capacity for screening and intervening in psychosocial distress, only 21.4% of cancer treatment centers are functioning at the highest level in responding to psychosocial distress. [6] Collaborative care is a model which

integrates medical and psychosocial care by adopting a population-based, stepped approach to identifying and treating mental health problems. Social workers are at the core of this model acting as both care managers and brief intervention specialists. Collaborative care begins with population-based screening using standardized, validated instruments and repeated screening at regular intervals.[7] People with low levels of distress are provided with self-management information and access to community-based resources. For those with moderate distress, the social worker provides evidence-based practices such as motivational interviewing and behavioral activation, continuing treatment until the patient's level of distress has decreased, or intervention needs to be increased. People with severe distress receive psychiatric assessment, medications as needed and more intensive follow up. A robust body of evidence from primary care settings supports the use of collaborative care for the treatment of mental health concerns. Several studies with cancer patients have shown the collaborative care model to be more effective in reducing symptoms of depression and anxiety than usual care, yet few cancer centers have adopted the collaborative care approach [8]. One reason for the slow implementation of collaborative care is the lack of training some social workers have in evidence-based practices (EBPs). [9] The purpose of this half day workshop is to provide oncology social workers with an overview of the collaborative care model; information on effective, population-based screening instruments; and training in two core EBPs, motivational interviewing (MI) and behavioral activation (BA). We will provide training in population-based approaches to measurement-based-care, including monitoring symptoms using validated instruments and an electronic registry; training in team-based stepped psychosocial care; and effective collaboration with oncology teams and other support services, particularly psychiatry and psychology. Participants will actively engage in assessing demonstrations by the trainers of social work interactions with mock patients to identify EBP skills that are or could be used in these situations. Trainees will also practice skills with one another through experiential learning exercises, including "real" plays that draw from the participants' own experiences to try out new skills and obtain feedback. We will end with participant evaluation of the potential champions and challenges to implementing collaborative care in their settings.

Abstract Summary:

Collaborative care is a model which integrates medical and psychosocial care by adopting a population-based, stepped care approach to identifying and treating problems such as depression, anxiety and other concerns. Social workers are at the core of this model acting as both care managers and brief intervention specialists. This half day workshop will provide an overview of the collaborative care model, information on effective, population-based screening instruments and training in two core evidence-based practices (EBPs), motivational interviewing and behavioral activation. Participants will actively engage in assessing demonstrations and practicing skills with one another. We will end with participant evaluation of the potential champions and challenges to implementing collaborative care in their settings.

Learning Objectives:

1. Explain how the integrated collaborative care service model can be applied to provide a population based approach to evidence-based psychosocial oncology care.
2. Apply standardized psychosocial distress screening tools to evaluate the level of care a person may need.
3. Identify and practice key brief intervention skills related to motivational interviewing and behavioral activation in the context of cancer treatment.

Outline:

- 1:00 p.m. – 2:00 p.m. Overview of theory and research related to the structure and implementation of a collaborative care service to treat psychosocial distress among cancer patients.
- 2:00 p.m. – 2:30 p.m. Understand how the integrated collaborative care service model can be applied to provide a population based approach to evidence-based psychosocial oncology care.
- 2:30 p.m. – 3:00 p.m. Identify how social workers are the largest frontline group of mental health providers in the country, and identify how those in oncology settings will be at the forefront of efforts to expand the implementation of collaborative care models.
- 3:00 p.m. – 3:30 p.m. How to apply standardized psychosocial distress screening tools to evaluate the level of care a person may need

- 3:30 p.m. – 4:00 p.m. Ways to improve psychosocial oncology skills in engagement, assessment, planning, intervention and evaluation of services to treat mental, emotional and behavioral disorders among people with cancer
- 4:00 p.m. – 4:30 p.m. Skill development in the use of standardized assessments; practice key brief intervention skills related to motivational interviewing and behavioral activation in the context of cancer treatment.
- 4:30 p.m. – 5:00 p.m. How to increase the effectiveness of your clinical practice and how to advocate for more comprehensive models of care for your patient population.

References:

- [1] Adler, N.E. & Page, A.E.K. (Eds.). (2008). *Cancer care for the whole patient: Meeting psychosocial health needs*. Washington, DC, National Academies Press.
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Keywords: Clinical Practice/Skill Building, Leadership/Administration

Course Designation: Clinical

Presentation Level: Intermediate

FULL-DAY PRE-CONFERENCE WORKSHOP (8.0 CE)

Title: Navigating Cancer: Work & Insurance

Author(s): *Rebecca Nellis, MPP; Joanna Morales, Esq.*

Date Scheduled:

6/4/2019, 8:00 am - 5:00pm

Abstract Content:

Approximately 50% of cancer survivors are “working age” and, when faced with a diagnosis may find themselves confronting a variety of questions and challenges specific to their individual circumstances. Those who are employed must often address the central question of whether and/or how to continue working through treatment, take time off,

or return to work. Studies also show that a history of a cancer diagnosis is correlated with an overall increase in the likelihood of unemployment compared to healthy peers, with greater disparities among the less-educated, and racial and ethnic minorities; and that survivors' job search experience is often characterized by a specific and potentially hindering mindset unique to this population. Circumstances are often further complicated by realities of U.S. health insurance, which is frequently tied to (or lacking based on) an individual's employment circumstances. A drop in employment-related income and a loss in health insurance coverage are two of the most significant factors of financial toxicity. Fortunately, there is evidence in the literature that work-related support, advice, and services provided by oncology healthcare professionals play an overwhelmingly positive role in helping patients continue on-the-job during treatment and/or successfully return to work after time off for treatment. However, a meta-synthesis of 39 studies, conducted by Stergiou-Kita, et al. in 2014, found healthcare providers themselves indicate that they lack knowledge about how cancer treatment may influence work ability and job retention. For example, among a group of oncology social workers surveyed between 2009 and 2017, 92.8% indicated that their patients asked for guidance about working through treatment, 41.4% stated they were not familiar with the Americans with Disabilities Act (ADA), a law that is often key to allowing individuals diagnosed with cancer to identify solutions for remaining on the job, while also providing protections against workplace discrimination. This full-day workshop is a unique and innovative training specifically developed to address this gap in knowledge by providing up-to-date practical and legal information about the various issues that sit at the intersection of work and cancer. Topics include, helping survivors decide whether to disclose their diagnosis to an employer, working through treatment and/or taking time off, returning to the workplace, maintaining both income and insurance, and more. Interactive group exercises and case studies are used to simulate the experience of the patient to help attending oncology professionals put learning into practice. Oncology social workers who attend will leave equipped with tools and enhanced clinical skills to empower all patients in achieving positive work-related outcomes - regardless of race, ethnicity, socioeconomic background, current employment status, or where they are in their cancer journey.

Abstract Summary:

Approximately 50% of cancer survivors are "working age" and many find themselves confronting questions and challenges specific to their individual circumstances. Those who are employed must often address the central question of whether and/or how to continue working through treatment, take time off, or return to work. Additionally, studies show that history of a cancer diagnosis increases the likelihood of unemployment compared to healthy peers; and both a drop in employment-related income and a loss in health insurance coverage are significant factors of financial toxicity. This innovative, full-day training provides up-to-date practical and legal information about the various issues that sit at the intersection of work and cancer. Topics include working through treatment and/or taking time off, returning to the workplace, maintaining both income and insurance, and more. Attendees will leave equipped with tools and enhanced clinical skills to empower all patients in improving work-related outcomes.

Learning Objectives:

1. Describe techniques that can be used to help guide newly diagnosed patients through the process of balancing work and cancer treatment.
2. Identify practical suggestions and resource referrals that can help patients address needs that arise while dealing with employment after a cancer diagnosis.
3. Discuss key practical and legal considerations for individuals diagnosed with cancer deciding if, when, or how to disclose their diagnosis at work or online.

Outline:

- 8:00 a.m. – 8:45 a.m. Welcome and Introductions
 - Speaker introductions
 - Objectives and Agendas
 - Why talk about work and cancer
- 8:45 a.m. – 9:20 a.m. Newly Diagnosed Patients
 - Determining whether to continue on the job
 - The role of personal identity in work-related decisions

- Accessing rights and responsibilities under the Americans with Disabilities Act (ADA)
- 9:20 a.m. – 10:35 a.m. Working Through Treatment
 - ADA, including reasonable accommodations (space and schedule modifications)
 - Communication and on-the-job strategies
 - Family and Medical Leave Act (FMLA) as intermittent or short-term leave
- 10:35 a.m. – Noon Taking Time Off
 - FMLA
 - Disability insurance – SSDI and SSI
 - Practical tips for taking time off
- Noon – 1:00 p.m. Lunch on your own**
- 1:00 p.m. – 1:45 p.m. Returning to Work
 - Transitioning off disability insurance
 - Re-entry into a job
 - Changing perceptions of post-cancer abilities in the workplace
 - FMLA and ADA return to work requirements
 - Job search
- 1:45 p.m. – 3:15 p.m. Disclosure
 - Disclosure rights and decisions
 - Medical certification
 - Who, what, and when to tell at work and during a job search
 - Online brand, social media use, and privacy considerations
- 3:15 p.m. – 4:30 p.m. Health Insurance Options
 - Understanding health insurance options under the Affordable Care Act (ACA)
 - Consolidated Omnibus Budget Reconciliation Act (COBRA), Medicare and Medicaid
 - Updates on recent legislative changes and activities
- 4:30 p.m. – 5:00 p.m. Closing and Final Q&A

References:

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- (8) Stergiou-Kita, M., Grigorovich, A., Tseung, V., Milosevic, E., Hebert, D., Phan, S., & Jones, J. (2014). Qualitative meta-synthesis of survivors' work experiences and the development of strategies to facilitate return to work. Journal of Cancer Survivorship, 657-670.
- (9) Swanberg, J.E., Nichols, H.M., Ko, J., Tracy, K., & Vanderpool, R.C. (2017) Managing cancer and employment: Decisions and strategies used by breast cancer survivors employed in low-wage jobs. Journal of Psychosocial Oncology, 35:2, 180-201.

Keywords: Financial Toxicity, Patient Navigation

Course Designation: Clinical

Presentation Level: Introductory

FULL-DAY PRE-CONFERENCE WORKSHOP (8.0 CE)

Title: Becoming and Sustaining a Passionate Leader: To Be or Not to Be... A Manager

Author(s): Penny Damaskos, PhD, LCSW, OSW-C, FAOSW; Susan Hedlund, MSW, LCSW, OSW-C, FAOSW; Sage Bolte, PhD, LCSW, CST; Alison Mayer Sachs, MSW, LCSW, OSW-C, FAOSW

Date Scheduled:

6/4/2019, 8:00 am - 5:00pm

Abstract Content:

Have you ever wondered what it would take to be a manager or been told you have strong leadership skills and not sure where to apply them? Have you wanted to strengthen your leadership skills but not clear on where to turn? Many oncology social workers seek out growth opportunities as a leader both within the clinical area and in an administrative setting. In this growth trajectory there is a difference between becoming a manager, and management from a leadership perspective. Authors on leadership have identified there is an important distinction to be made that a good manager can be a good leader, but a good leader may not be may not want to be a manager (Behar, H., 2007; Jennings, K.R., 2016). Christ, G. Messner, C. Behar, L. (2015). More importantly, often a leader does not “manage” but rather guides and shapes the direction of a department or program (Jennings, K.R., 2016). Through personal examples and interactive discussion this institute will identify key aspects, informed by research, of what contributes to the making of a strong manager/leader, management styles and “ego ideal” for leading. What kind of leader are you? What kind of leader do you aspire to be? Do you aspire to be a leader through a management position? How can you get there?

The panelists will use lessons learned that led them to the positions they currently have and address strategies to identify, assessing and improving your leadership and management skills with focus on the following topics:

- Examples of how to approach your supervisor or boss for help with management growth opportunities.
- Identifying several leadership paths within an institutional setting for moving into or up the administrative (manager) level.
- Strategies of working with HR to identify “requirements” for managerial positions as well as how to approach key administrators within the organization that can contribute to your growth.
- Opportunities outside of institution/organization through several venues such as board work (e.g. AOSW, APOSW, NASW) and community involvement (e.g. political action, spiritual communities).
- Exploration of internal/personal barriers will be discussed, such as:
 - The roles of fear and guilt related to leaving clinical setting
 - How the crisis nature of the work takes precedence over strategies for moving into management positions or leadership priorities
 - The fear of not having the right “training” or experience
- Imagined/Real lack of support for professional development and recommendations for strategizing “workarounds”
- Recommendations on how to manage former peers
- The importance of creating and sustaining strong teams and advisory groups with an emphasis on how to grow effective leaders within our teams using our social work skills to do so
- The utilization of personality tools such as Strengths Finder, Myers Briggs, etc. to grow oneself as a leader and or manager as well as to grow ones team Much focus will be on the push to think creatively and how leadership opportunities might lead to opportunities outside of cancer and/or in the social work field.

Abstract Summary:

Many oncology social workers seek out growth opportunities as a leader both within the clinical area and in an administrative setting. In this growth trajectory there is a difference between becoming a manager and management from a leadership perspective. Authors on leadership have identified there is an important distinction to be made that a good manager can be a good leader, but a good leader may not be may not want to be a manager. More importantly, often a leader does not “manage” but rather guides and shapes the direction of a department or program. Through didactic, personal examples and interactive discussion this institute will identify key aspects, informed by research, of what makes a strong manager, management styles and “ego ideal” for leading. Opportunities within institutional settings for leadership, identifying champions outside of social work and how to become visible to key leaders in your organization will be explored. Having the right leaders in management influence every aspect of the patient and caregiver experience.

Learning Objectives:

1. Evaluate the career trajectory of oncology social workers focusing on leadership development and describe different career tracks/ methods to achieve professional development with an emphasis on establishing “next steps” in career path for social workers who want to have a greater influence on patient care throughout their organization.
2. Differentiate between "Leaders" and "Managers and identify and explore barriers (institutional, and internal to the oncology social worker) to achieving leadership development goals that impede growth, professional development and compassion for co-workers, patients and caregivers.
3. Identify and formulate individual plans on how to create support networks and strong teams that contribute to own leadership growth as well as that of the team including discussion on how to address management of former peers in order to provide the exceptional care and compassion for patients and caregivers.

Outline:

- 8:00 a.m. – 8:30 a.m. Introductions, review of learning objectives, ice breaker activity
- 8:30 a.m. – 9:00 a.m. Identification of key aspects to becoming a strong leader
- 9:00 a.m. – 9:30 a.m. Group discussion type of leaders and discussion on how to get there; Identification of what kind of management style you have and want to develop
- 10:00 a.m. – 11:00 a.m. Personal stories to outline different paths of panelists and how they contributed to leadership styles
- 11:00 a.m. – Noon. Review of opportunities within work settings to exemplify leadership growth and opportunities. Exercises to enhance thinking creatively about career trajectories will be discussed.
- Noon – 1:00 p.m. Lunch on your own**
- 1:00 p.m. – 2:00 p.m. Further discussion regarding leadership opportunities outside of work place: board work, community involvement etc. Panelists discuss lessons from their own stories to illustrate multitude of paths and approaches.
- 2:00 p.m. – 2:30 p.m. Exploration of internal barriers—what holds us back? Examination of fear, guilt leaving the clinical setting play in remaining at current level.
- 2:30 p.m. – 3:00 p.m. Complexities of leading former peers. Creating and sustaining strong teams.
- 3:00 p.m. – 4:00 p.m. Breakout Exercises using personality tools, such as Meyers Briggs and Strengths Finder.
- 4:00 p.m. – 4:30 p.m. Use of social work skills to build teams and develop leadership qualities in teams
- 4:30 p.m. – 5:00 p.m. Conclusion, Q&A and wrap-up

References:

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Keywords: Leadership/Administration, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

AOSW 35TH ANNUAL CONFERENCE ABSTRACT BOOK
WEDNESDAY, JUNE 5, 2019

OPENING KEYNOTE

Title: Valued-Based Strategic Clinical Care and Leadership: Compassion, Curiosity and Courage as the Foundation for Staff Leadership

Author(s): *Matthew Loscalzo, MSW, LCSW, APOS, FAOSW*

Date Scheduled:

6/5/2019, 9:30am - 10:30am

Abstract Content:

The Value of Values

Social work is an inherently value-based and powerful profession. Paradoxically, at a time when basic humanistic values are being challenged and undermined by putative leaders who manipulate the basest of instincts to divide and deflect from the systematic and insidious erosion of universal societal norms, there opens a wider space for compassion, curiosity and courage.

Health care settings are microcosms of society at large in which the complex battle for values and what is valued, plays out in the context of life-threatening disease for patients, and highly emotionally charged environments for social workers and other health care providers. Social workers may not be aware of, or are knowledgeable, about how to maximize the considerable influence they have. Values, as the foundation for clinical, communication and problem-solving related skills, are powerful instruments that can be deftly applied to create positive personal and societal change.

Personal Accountability

But it all starts with the personal accountability and skills that links to the team and ultimately may transform the entire setting. Supportive care, in general, and social work specifically, has evolved from the courageous struggles of leaders who were and are, deeply committed to democracy, honesty, fairness and profound respect for all people, especially the most vulnerable. The Vision has not changed.

There is an unspoken challenge to some in the helping professions who manifest: an overly narrow identification with and unconscious reinforcement of the victimized side of those we serve. The implications for this lack of mindfulness, given that victimhood may be linked to a sense of entitlement, for the social worker, patient/family and team, are significant. Not surprisingly, victims may make for poor clinicians, colleagues, educators and especially leaders. (We all deserve to treat others and ourselves, better.)

Strategically Expanding Clinical Skills

Strategically, whether it be patient care, managing conflict with colleagues or negotiating with institutional leaders, mindfully focusing on connection with the healthiest parts of the other person, sets the stage for mutually rewarding and self-reinforcing relationships. Judging or demonizing others is fast, easy, destructive and almost always based misperceptions with only negative implications that migrate well beyond those directly involved. Effective short and long-term strategies are all about creating healthy relationships (trust, conflict, disappointment, healing, growth). The relationship always matters. A guiding principle based on core personal values can be accessed by asking: In one minute, one hour, one week, one year from now, will I be proud of how I am showing up for others, right now!?

In addition to creating a relationship of mutual respect and action, even in or especially in the face of conflict, is the ability to identify: Core Values—Benefits— Desired Outcomes of the other. By simply knowing what others see as their core values can be a strong foundation for increased trust, confidence and generosity. Benefits refers to how the other clearly sees the benefit of your existence (and working with you) within the immediate context. Finally, Desired Outcomes relates to the bigger vision, measurable positive outcomes (the more practical/concrete the better).

Leadership Matters

Leadership is a function not bounded by a title or position. Leadership is to be encouraged and expected from every chair. Value-based clinical skills (communication, connection, engagement, motivation, problem-solving, activation, etc.) are the primary and most powerful of leadership skills. Be it programmatic growth or longer term strategic planning and implementation, a mental-shift reformulation of clinical skills into big picture thinking can be very effective. Leaders need to learn to: Think Like a Program.

Unifying Concepts

Emotional states cannot be trusted nor can thinking from the gut, to maximize the potential of being proud of actions taken today by the best future self. The long view, although slower is almost always wiser and more prosocial.

Regardless of the size of the team or institution, personal accountability in the service of core shared values creates a greater potential for healthier social contexts. The best clinicians have the capacity to be the best leaders as they strive (albeit imperfectly) to be: highly ethical, compassionate, curious and courageous.

Abstract Summary:

The Value of Values

Social work is an inherently value-based and powerful profession. Paradoxically, at a time when basic humanistic values are being challenged and undermined by putative leaders ...there opens a space for compassion, curiosity and courage. It all starts with the personal accountability and skills that links to the team and ultimately may transform the entire setting. There is an unspoken challenge to some in the helping professions who manifest: an overly narrow identification with and unconscious reinforcement of the victimized side of those we serve. The implications for this lack of mindfulness are significant. We all deserve to treat others and ourselves, better. Strategically, whether it be patient care, managing conflict with colleagues or negotiating with institutional leaders, mindfully focusing on connection with the healthiest parts of the other person, sets the stage for mutually rewarding and self-reinforcing relationships. Effective short and long-term strategies are all about creating healthy relationships (trust, conflict, disappointment, healing, growth). A guiding principle based on core personal values can be accessed by asking: In one minute, one hour, one week, one year from now, will I be proud of how I am showing up, right now!? Leadership is a function not bounded by a title or position. Leadership is to be encouraged and expected from every chair. Leaders need to: Think Like a Program. The long view, although slower, is almost always wiser and more prosocial. Regardless of the size of the team or institution, personal accountability in the service of core shared values creates a greater potential for healthier social contexts.

Learning Objectives:

1. Explain the power of value-based clinical care and leadership.
2. Discuss the value of and leadership potential of staff leadership models.
3. Apply their own curiosity, compassion and courage.

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Keywords: Leadership/Administration, Clinical Practice/Skill Building

Course Designation: Clinical

PAPER SESSION I

Title: Loaded Language: War and Other Cancer Metaphors and Their Impact on Patient Narratives

Author(s): *Margaret Price, LCSW; Jordan Bailey, LCSW*

Date Scheduled:

6/5/2019, 11:00am - Noon

Abstract Content:

Oncology social work practice involves attunement to the patients' stories of cancer and its impact. We bear witness to the reality that a diagnosis of cancer can heighten sensitivity to language, and greatly impact the patients' experience. Metaphors used by the culture, media and the medical community are some of the more meaningful messages in the language of cancer. Metaphors can assist in mediating between what is known and unknown, assisting in managing the complexity of a cancer diagnosis. The language used by the medical team to explain cancer to a patient may influence how they live the rest of their lives. They can inform a patient's expectation for treatment, course of disease, and totality of their cancer experience. We will draw from the literature on cancer and metaphor, to review the history of language, the military metaphor and alternatives, and the impact and implications this topic has in oncology social work practice. As far back as the 14th century, diseases were described using symbolic language evidenced in literature and the humanities. This practice continued into the 1700 and 1800s, gradually adopting terms and phrases often used in times of battle. These metaphors were then applied to a mysterious ailment, to help people make an unknown concept more manageable. Language has transitioned from cancer being a death sentence to a body at war with itself. In our culture, the military metaphor has dominated the way in which we think and talk about cancer. Although the language of war in conjunction with cancer has been used for centuries, the military metaphor received its' most famous boost in 1971 when Richard Nixon converted a biological weapons research facility into a cancer lab and consequently signed the National Cancer Act into law. This act created the National Cancer Institute (NCI). Military rhetoric energized public opinion against cancer, maximized public donations, and granted inspiration and optimism to patients and families. The use of the military metaphor stemmed from attempts to escape the stigma and mystery of cancer. Cancer had become equated with a societal evil. The more recent literature suggests the use of the military metaphor may be harmful for some patients. There is a growing sensitivity to the effect of imposing certain metaphors on patients, when it may not be reflective of the patient's reality. The focus is now on allowing the patient to set the tone of the language used when describing their cancer experience. Oncology social workers have long been in the pivotal position of creating a bridge between the narrative of patient experience and the delivery of cancer care. Understanding the history of metaphor in cancer narrative can increase our understanding of the importance of word choice when working with patients. It also allows us to educate others on the interdisciplinary team about sensitivity to language when describing the disease, treatment plan, and next steps. Awareness of these issues is instrumental in our role as advocates and result in patients' creation of their own narratives.

Abstract Summary:

Oncology social workers have long been in the pivotal position of creating a bridge between the narrative of patient experience and delivery of cancer care. We witness how metaphors can empower patients by illustrating their cancer experience. However, we also see how metaphors are capable of perpetuating stereotypes and stigma. The military metaphor has been the most prominent with the high profile use of the "war on cancer" and the imperative for patients to have a fighting spirit. Balancing the instinct to fight with words of healing remains a challenge. We will focus on the history of the military metaphor and the sometimes harmful impact of the rhetoric of war on cancer patients. We will present alternative metaphors shared by cancer patients through selected writings. As oncology social workers, awareness of these issues may be instrumental in our role as advocates, resulting in patients' creation of their own cancer narratives.

Learning Objectives:

1. Analyze the history of use of metaphor in disease, and describe aspects of metaphor in oncology, especially the military metaphor.
2. Discuss the benefits of using metaphors in cancer narrative, and empower patients to create their own based on unique identity and values.
3. Explain the potential impact of cancer metaphor in clinical practice, and create an open dialogue about potential interventions.

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Keywords: Clinical Practice/Skill Building, Education

Course Designation: Clinical

Presentation Level: Intermediate

Title: Drama Therapy as a Healing Art

Author(s): Catherine Paykin, LCSW-R

Date Scheduled:

6/5/2019, 11:00am - Noon

Abstract Content:

While storytelling, art, and music therapy are well-documented in the literature as clinical tools for people with cancer and other illnesses (Heiney, Darr-Hope, Meriweather, & Adams, 2017), there is less written about the value of acting and play-writing. This social worker shares her experience using a psychotherapeutic, drama-based intervention within a support group for cancer patients. The outcome was an emotional 15-minute play titled, "the Invitation," which opened

a large urban Cancer Center's annual Lung Cancer Awareness program to an audience of over 100 patients, family, hospital staff and community members. Characters were based on patients' own stories amidst a backdrop of songs, poems and artistic design. The play's premise of "how a support group helps" conveyed to the audience how powerful and healing group relationships can be for people experiencing cancer. The group distributed a playbill that included a synopsis of each actor's story. The idea for the play was born when the social worker was asked to find one patient to speak at the annual lung cancer awareness and clinical update program. She offered the play as an alternative to highlight the value of support groups. Taking a course about play writing at the local YMCA to learn the basics and develop competency was a necessary step. She recruited actors to prepare the patients for the stage. Forty-nine of 100 members of the audience completed a survey after viewing the play. Ninety-eight percent said the play accomplished its goal to inform the public that people can live well after a cancer diagnosis and have meaningful connections with others. Ninety-eight percent said the play accomplished its goal of giving a glimpse into the workings of a support group and how it can be an important resource for patients. Patients found this artistic experience fostered their individual strengths and group friendships, which is consistent with the literature (Kirshbaum, Gretchen, Nasreena, & Fiona, 2017).

Abstract Summary:

Drama can be an effective psychotherapeutic technique for empowering patients. Group facilitators with a conducive personality and expertise in cancer and drama are critical to successful implementation (Lidsle-Madison, Snickars-von Wright, Lindholm, & Faberstrom, 2007). This social worker's facilitation of a drama intervention with a lung cancer group culminated in patients writing and acting in "The Invitation" an original 15 minute play. Content focused on the complex roles of cultural heritage, family and caregivers in patients' management of their disease. Through the experience of writing and performing the play, patients addressed survivors' guilt, pending mortality, and the stigma of lung cancer. The experience strengthened the relationships within the group and the self-confidence of members to face an uncertain future (Redhouse, 2015). Support groups that galvanize members to work together toward a unique goal can provide meaning and purpose to patients who are struggling with terminal diagnoses.

Learning Objectives:

1. Apply strategies for developing a strength-based approach to an existing support group to fuel a specialty intervention.
2. Conceptualize a project with buy-in from group members and to implement the vision into a functional program.
3. Recognize and harness the influence and healing power of art, music, poetry and dance and mobilize these arts to improve patients' lives.

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Keywords: Clinical Practice/Skill Building, Disease Type (ovarian, lung, GYN, etc.)

Course Designation: Clinical

Presentation Level: Advanced

Title: Pathway to Professionalism for Social Work Interns: A Comprehensive Guide for Your Program

Author(s): Ashley Adams, MSS, LCSW; Sandra Blackburn, MSW, LSW

Date Scheduled:

6/5/2019, 11:00am - Noon

Abstract Content:

Our presentation will provide field instructors with a comprehensive and standardized student program for use at their facility. At our NCI-designated Comprehensive Cancer Center, we identified the need for oncology social work interns to have not only a structured orientation, but also a field curriculum to supplement and reinforce what is being addressed in individual supervision. More than a welcome packet, our curriculum bridges the gap between classroom learning and field instruction and also aligns with AOSW Standards of Practice. We will share, in digital form, our complete orientation and curriculum program for you to use. We will also provide this information in a template format for you to customize for your facility and program needs. This program can be used by the time-strapped field supervisor. It also can be utilized as a start-up kit if you are new to field supervision. Capitalize on this curriculum and empower your students to reach their full potential! We will share our thought process in creating this program, as well as our experience in usage. Our curriculum is composed of three components: The first component addresses the basic information a student needs to function in the work environment. It includes a half-day orientation to the student program and the institution in general. Students are also provided with a resource manual of local and national cancer resources and supports. The second component is a curriculum composed of educational modules designed to develop and refine professional skills. Modules are based on the AOSW Standards of Practice. Topics include receiving and making patient referrals, how to complete a thorough biopsychosocial assessment from an oncology framework, and how to document thoughtfully in a medical record. The third component is a format for group processing sessions with your cohort of oncology social work interns. These sessions include case discussion, role play, clinical skill-building exercises and peer support. Our anecdotal results found that students benefited not only from receiving feedback from each other but also from feedback from other oncology social workers, in addition to their field supervisor. There was noted improvement in clinical skill and level of professionalism demonstrated by the cohort following the implementation of the curriculum. Students reported higher levels of self-confidence in their abilities and viewed the curriculum as a beneficial learning tool. This curriculum is designed to supplement and enrich the students' experience and is not a substitution for the consistent individual supervision by one's field supervisor. This program will prepare the next generation of oncology social workers for success in the "real world."

Abstract Summary:

Our presentation will provide field instructors with a comprehensive and standardized student program for use at their facility. At our NCI-designated Comprehensive Cancer Center, we identified the need for oncology social work interns to have not only a structured orientation, but also a field curriculum to supplement and reinforce what is being addressed in individual supervision. More than a welcome packet, our curriculum bridges the gap between classroom learning and field instruction and also aligns with AOSW Standards of Practice. We will share, in digital form, our complete orientation and curriculum program for you to use. We will also provide this information in a format for you to customize for your facility and program needs. This program can be used by the time-strapped field supervisor, or as a start-up kit if you are new to field supervision. Capitalize on this curriculum and empower your students to reach their full potential!

Learning Objectives:

1. Implement a standardized orientation and curriculum for oncology social work interns. Our program model, created at our NCI-designated Comprehensive Cancer Center, will be shared with all attendees, along with a customizable template for individual use.
2. Align the Association of Oncology Social Work Practice Standards with field education and practice.
3. Discuss methods for ongoing assessment and innovation in their field education program.

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Keywords: Education, Leadership/Administration

Course Designation: Clinical

Presentation Level: Introductory

Title: Sick of Being Alone: The Intersection of Cancer Care and American Loneliness

Author(s): *Patrice Al-Shatti, LMSW*

Date Scheduled:

6/5/2019, 11:00am - Noon

Abstract Content:

“An enormous technology seems to have set itself the task of making it unnecessary for one human being ever to ask anything of another in the course of going about his daily business.” This statement was written forty eight years ago by a noted sociologist, who could not possibly have anticipated how accurate his words would become. (12) Today one of four people say they have no one with whom to share important news. (9) Researchers find that we spend less time with real people the longer we are on our phones, and it’s thought that we currently spend a sixth of the day checking them. Cigna Healthcare conducted a study this year warning that 18-22 year olds are the loneliest generation, that only 53% of Americans have meaningful social interactions on a daily basis, and that half of us sometimes or always feel lonely or left out. (10) One former Surgeon General recently warned that America is in the midst of a loneliness epidemic. An unfortunate outgrowth of this trend is that suicide is up 30% since 1999, particularly among midlife men. This presentation will investigate this public health crisis and help participants understand the problem and the societal influences that are eroding our social capital. Americans have an individualist cultural ideal which causes us to overvalue self-reliance. Our technology has made it so that our lives can, to a large degree, be conducted in the virtual world but human nature has not ceased to need the physical closeness and body language cues that are exchanged in the presence of another person. Technology is also distracting us and limiting our attention. Why call when you can text? We are hyper-busy as a virtue and prioritize anything over social engagement. With the background of these cultural shifts, our patients and family members often come to the cancer experience unprepared, without the ties that provide emotional support and practical assistance, without watchful communities, and without the strong mental health that comes from daily interaction with caring others. Many studies have noted that loneliness is associated with poor mental and physical health outcomes in cancer patients. (1) It’s also true that the cancer experience, itself, generates loneliness as patients are pulled from work and other routine social outlets, face symptoms and side effects existentially alone, and slowly realize that no one can do this for them or really understand what they feel. (2) We will discuss special

populations, such as young adults and midlife men, who are particularly vulnerable and explore the biological effects of loneliness, which are numerous and notable. Participants will also learn how to innovate in their practices by including loneliness assessment into the social work intervention. All signs point to the fact that our society is in a dramatic and progressive slide toward disconnection and perhaps, in the crucible of the cancer experience, the oncology social worker can facilitate reflection, allow space for redefinition of values, and collaboratively foster lasting and meaningful change.

Abstract Summary:

Today 25% of people say they have no one with whom to share important news and a recent study warned that only 53% of Americans have meaningful daily social interactions. One former Surgeon General urgently warned that America is in the midst of a loneliness epidemic. With the background of these cultural shifts, our patients often come to the cancer experience without the ties that provide emotional support and practical assistance. This presentation will discuss the societal influences that are eroding our social capital, the biological effects of loneliness, and special populations who are particularly vulnerable. Participants will also learn how to include loneliness assessment in the social work intervention. All signs point to the fact that our society is in a dramatic and progressive slide toward disconnection and perhaps, in the crucible of the cancer experience, the oncology social worker has an opportunity to facilitate meaningful change.

Learning Objectives:

1. Discuss the basic cultural dynamics that contribute the present epidemic of loneliness in the United States.
2. Describe the biological and mental health impact of chronic loneliness on the individual and will demonstrate an understanding of the unique developmental and cultural factors that put midlife men and young adults particularly at risk.
3. Assess individual patients and caregivers for chronic loneliness and will demonstrate an understanding of the unique ways in which cancer both causes and exacerbates this condition.

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Keywords: Clinical Practice/Skill Building, Specialized Needs

Course Designation: Clinical

Presentation Level: Intermediate

Title: The Role of Masculinity in Oncology Social Work: Decoding Masculine Gender Norms in the Changing Social Environment

Author(s): David Sarfati, MSSW, LCSW; Christopher Anrig, MSSW, LCSW-R

Date Scheduled:

6/5/2019, 11:00am - Noon

Abstract Content:

It is well established that cancer patients are faced with numerous physical, psychological, and social challenges that can impact their quality of life and overall well-being (Jacobsen & Andrykowski, 2015; Hoyt & Stanton, 2012). The way in which cancer affects men and women differently is an important topic, as research shows men have greater difficulty with certain aspects of psychosocial adjustment to cancer than women (Pudrovskaya, 2010; Peleg-Oren et al., 2003; Nicholas, 2000; Fife et al., 1994). It is important to consider how societal gender norms may influence male adaptation to cancer, and how oncology social workers can attempt to facilitate positive psychosocial adjustment for this population. Research by Love, Thompson and Knapp (2014) shows that men who are diagnosed with cancer want and need emotional support; however, cultural expectations of masculinity seem to serve as a barrier to accessing it. Their research found that men want to be honest about their emotions, but feel they cannot express their feelings because of expectations of masculinity. Their work demonstrates that men feel a need to appear "strong" in response to a cancer diagnosis, which many men interpret as unemotional. This barrier to emotional expression prevents men from receiving support, which can have important implications for their adaptation to cancer. The social-cognitive processing model suggests that people adjust better to their cancer diagnosis when they perceive their environment to be supportive and open to emotional disclosure (Lepore, 2001). Furthermore, research by Darabos and Hoyt (2017) shows that men report higher levels of depression when their support network is not receptive to their emotional needs. Oncology social workers are in a unique position to be change agents when it comes to this issue. They can create dialogue for men to discuss how their relationship to masculinity may impact their adjustment to cancer. Focus on how this relationship may shift over time, and on factors such as race and cultural heritage, family narratives of gender, emotional expression, and vulnerability may be helpful. Social workers who come from a non-conforming gender perspective can provide a unique lens of understanding and can expand the definitions about traditional gender norms and expectations around emotional expression when appropriate. Drawing upon theories of masculinity, gender, and psycho-oncology literature, this presentation will discuss how oncology social workers can promote emotional connection and expression with male cancer patients. Cases will be used to elicit examples of how men present to an outpatient oncology setting with symptoms of anxiety, social withdrawal, and isolation that affected their adjustment to their illness and treatment. Participants will gain knowledge and increase their skills in working with men throughout the trajectory of their illness course.

Abstract Summary:

The way in which cancer affects men and women differently is an important topic, as research shows men have greater difficulty with certain aspects of psychosocial adjustment to cancer than women (Pudrovskaya, 2010; Peleg-Oren et al., 2003; Nicholas, 2000; Fife et al., 1994). It is important to consider how societal gender norms may influence male adaptation to cancer. Research by Love, Thompson and Knapp (2014) shows that men who are diagnosed with cancer want and need emotional support; however, cultural expectations of masculinity seem to serve as a barrier to accessing it. Oncology social workers are in a unique position to be change agents when it comes to this topic. They can create space for men to discuss how their relationship to masculinity may impact their adjustment to cancer. This presentation will provide relevant case examples, interventions, and programming ideas.

Learning Objectives:

1. Identify psychosocial challenges for emotional expression in men.
2. Consider gender based barriers to help seeking behavior in men and apply them to clinical practice.
3. Demonstrate enhanced comfort level with gender norms in clinical practice.

References:

Darabos, K., & Hoyt, M. A. (2017). Masculine norms about emotionality and social constraints in young and older adult men with cancer. *Journal of Behavioral Medicine*, 40(2), 259–270. <http://doi.org/10.1007/s10865-016-9739-5>. Fife, B.L., Kennedy, V.N., & Robinson, L. (1994). Gender and adjustment to cancer. *Journal of Psychosocial Oncology*, 12(1-2), 1-21. doi: 10.1300/J077V12N01_01. Hoyt, M. A., & Stanton, A. L. (2012). Adjustment to chronic illness. In A. Baum, T. A. Revenson, & J. Singer (Eds.), *Handbook of health psychology* (pp. 219-246). New York, NY, US: Psychology Press. Hoyt, M.A. (2009). Gender role conflict and emotional approach coping in men with cancer. *Psychology & Health*, 24(8), 981-996. DOI: 10.1080/08870440802311330. Jacobsen, P. B., & Andrykowski, M. A. (2015). Tertiary prevention in cancer care: Understanding and addressing the psychological dimensions of cancer during the active treatment period. *American Psychologist*, 70(2), 134-145. <http://dx.doi.org/10.1037/a0036513>. Lepore, S. J. (2001). A social–cognitive processing model of emotional adjustment to cancer. In A. Baum & B. L. Andersen (Eds.), *Psychosocial interventions for cancer* (pp. 99-116). Washington, DC, US: American Psychological Association. <http://dx.doi.org/10.1037/10402-006>. Love, B., Thompson, C.T., & Knapp, J. (2014). The need to be Superman: The psychosocial support challenges of young men affected by cancer. *Oncology Nursing Forum*, 41(1), E21–E27. doi: 10.1188/14.ONF.E21-E27. Nicholas, D.R. (2000). Men, masculinity, and cancer: Risk-factor behaviors, early detection, and psychosocial adaptation. *Journal of American College Health*, 49(1), 27-33. doi: 10.1080/07448480009596279. Pudrovskaya, T. (2010). Why is cancer more depressing for men than women among older white adults? *Social Forces*, 89(2), 535–558. <http://doi.org/10.1353/sof.2010.0102>.

Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Cultural Competency

Presentation Level: Intermediate

Title: The Stretch Toward Resilience—A Different Look at Leadership

Author(s): Penny Damaskos, PhD, LCSW, OSW-C, FAOSW; Susan Hedlund, MSW, LCSW, OSW-C, FAOSW

Date Scheduled:

6/5/2019, 11:00am - Noon

Abstract Content:

Contributing factors of professional development for an oncology social worker has been the focus of many chapters and articles (Christ, et al, 2015; Hedlund, 2015; Jones et al, 2014). Leadership trajectories typically include the progression from front line social worker to supervisor to manager and ultimately departmental director. However, sustaining meaning and connection to the work throughout ones professional trajectory can be tenuous at times which can result in burn out and compassion fatigue. There have been many studies on the factors that contribute to burnout of clinicians working in oncology that examine why staff burn out (Cashavelly et al, 2008; Bowling & Damaskos, 2015). There have been far fewer articles and studies that examine the factors that keep oncology social workers engaged. Many oncology social workers accomplish so much in their professional life through the development of expertise in a particular clinical modality, patient population or disease site. Some focus on mentoring staff, some teach while others write to further their connection to the work and contributions. Yet, in our roles as supervisors and managers we are often at a loss when our staff come to us “maxed out” and unsure of their next steps on how to further stretch in their career. For many the extra step is difficult to ascertain in the face of crises and emotional strain inherent in the daily work. The focus of this talk will be to look at the mid-career oncology social worker that do not want to leave oncology but are looking at ways to renew their connection to the meaning of their work. Stretching and applying the skills we have has oncology social workers in other areas of care such as trauma and disaster relief, homeless shelters, community organizing and immigration work can present as opportunities to apply the skills we have mastered within a completely different area of need. The ability to look beyond the day to day can lead to renewal and resilience as the clinician experiences. Development of flexibility is the cornerstone to the development of resilience and subsequently longevity in the field. The presentation will use examples of leadership and mentorship experiences and unexpected opportunities to illustrate some paths that oncology social workers can take to develop as to reengage with the meaning

of their work. The talk will also make connections between these experiences and the development of leadership skills that can be applied in any setting.

Abstract Summary:

Contributing factors of professional development for an oncology social worker has been the focus of many articles. However, sustaining connection to the work throughout one's professional trajectory can be tenuous at times which can result in burn out and compassion fatigue. Many studies have focused on the factors that contribute to burnout of clinicians working in oncology that examine why staff burn out while fewer have examined the factors that keep oncology social workers engaged in the field. The focus of this talk will be to look at the mid-career oncology social worker that do not want to leave oncology but are looking at ways to renew their connection to their work and professional development. Cultivation of flexibility is the cornerstone to resilience and subsequently longevity in the field. Case examples include the application of clinical skills in other areas of care and connection to leadership opportunities will be presented.

Learning Objectives:

1. Examine the career trajectories of oncology social workers, including burnout and resilience.
2. Discuss what contributes to sustained meaning in one's professional life.
3. Identify the leadership and clinical skills that can be applied to other professional opportunities.

References:

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Keywords: Leadership/Administration, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Advanced

LUNCH PANEL I

Title: Massachusetts Social Work Schools Response to the Opioid Crisis: An Oncology Social Work Perspective

Author(s): *Katherine Walsh, PhD, MSW, LICSW, FAOSW*

Date Scheduled:

6/5/2019, 12:15pm - 1:45pm

Abstract Content:

Social workers in every realm of practice are being called upon today to join the multiple forces engaged in addressing the opioid crisis that has led to soaring rates of opioid use disorders and a two-fold increase in overdose deaths in the past decade. In 2015 Massachusetts had one of the highest rates of overdose deaths in the country, causing the Governor to initiate a multipronged approach to prevention, education and intervention. In 2016 all 9 schools of social work in the state established a set of core principles for the prevention and management of substance misuse reaching 4300 social work students each year.

As a practicing oncology social worker and a faculty member at Westfield State University, I have been involved in this educational initiative and simultaneously witnessed the impact on cancer patients and providers of new prescription monitoring laws and a public education campaign on opioid addiction that have changed patient perceptions and provider practices.

This presentation will review the Massachusetts Initiative and the education and training approaches Westfield State University department of social work has taken to equip students to bridge the worlds of pain management and substance misuse prevention and treatment. Some of these training methods are carried out in collaboration with other disciplines including the departments of criminal justice, nursing, physicians assistance and education. Course and conference learning objectives, teaching tools, and student case examples will be shared. The particular impact of the Governor's initiative on oncology social workers and their clients will be discussed.

Abstract Summary:

Social workers in every realm of practice are being called upon today to join the multiple forces engaged in addressing the opioid crisis that has led to soaring rates of opioid use disorders and a two-fold increase in overdose deaths in the past decade. In 2015 Massachusetts had one of the highest rates of overdose deaths in the country, causing the Governor to initiate a multipronged approach to prevention, education and intervention. In 2016 all 9 schools of social work in the state established a set of core principles for the prevention and management of substance misuse reaching 4300 social work students each year. As a practicing oncology social worker and a faculty member at Westfield State University, I have been involved in this educational initiative and simultaneously witnessed the impact on cancer patients and providers of new prescription monitoring laws and a public education campaign on opioid addiction that have changed patient perceptions and provider practices. This presentation will review the Massachusetts Initiative and the education and training approaches Westfield State University department of social work has taken to equip students to bridge the worlds of pain management and substance misuse prevention and treatment. Some of these training methods are carried out in collaboration with other disciplines including the departments of criminal justice, nursing, physicians assistance and education. Course and conference learning objectives, teaching tools, and student case examples will be shared. The particular impact of the Governor's initiative on oncology social workers and their clients will be discussed.

Learning Objectives:

1. Describe the purpose and scope of the Massachusetts Governor's Initiative to address the Opioid Crisis.
2. Discuss approaches Social Work training programs can take to equip students to assist clients with both pain management needs and opioid use disorders and their consequences.
3. Identify the challenges that initiatives to address opioid misuse present to oncology social workers and other oncology providers and patients.

References:

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Clark, M. and Lafond, P. (2018). An Introduction to Medication Assisted Treatment for Opioid Use Disorders
<https://www.youtube.com/watch?v=RPFnCUELcPU&feature=youtu.be>

Keywords: Leadership/Administration

Course Designation: Clinical

Presentation Level: Intermediate

SIG PRESENTATIONS I

Adolescent & Young Adult (AYA) SIG

Title: A Tale of Two Cancer Centers: When Adolescents and Young Adults Present Differently But Require Similar Support

Author(s): *Meghan Fitzgibbons, MSW, LICSW*

Date Scheduled:

6/5/2019, 2:00pm - 3:30pm

Abstract Content:

Approximately 72,000 adolescents and young adults (AYA) are diagnosed with cancer each year (National Comprehensive Cancer Network, 2017). A cancer diagnosis during this life stage generates unique medical and psychosocial needs as developmental milestones are simultaneously impacted (Institute of Medicine, 2013). Social isolation and alienation are commonly reported among AYAs (Zebrack, Hamilton, & Wilder-Smith, 2009). D'Agostino, Penney, and Zebrack (2011) note that financial challenges are common too. They also point out that having adequate information about the possible impact of cancer and treatment on fertility is important to AYAs. Clinical social work patient navigators (CSWPNs) at the Sidney Kimmel Comprehensive Cancer Center (SKCCC) at Johns Hopkins Hospital and the Murtha Cancer Center (MCC) at Walter Reed National Military Medical Center help AYAs cope with their diagnoses, treatments, and emotions, and with navigating medical systems and difficult decisions. For the purpose of this study, CSWPNs from SKCCC and MCC collected data between January 1, 2017 and June 30, 2018. A total of 287 unique patients were included in the data collection, which tracked patients via monthly Google Form submissions by the CSWPNs. This study tallied the incidence of barriers to care and intervention strategies. The average patient age at SKCCC was 19, with the five most common diagnoses as acute lymphocytic leukemia, Hodgkin lymphoma, osteosarcoma, brain cancer, and acute myeloid leukemia. At MCC, the average patient age was 31, with the most common cancers being breast, brain, non-Hodgkin lymphoma, testicular, and colorectal. Of note, all patients at MCC are Tricare beneficiaries who have no out of pocket medical costs. The data collection reflected that despite the apparent differences between the AYA patient populations at SKCCC and MCC, the CSWPNs observed many of the same barriers and employed many of the same interventions. Seven of the ten most commonly encountered barriers at the two cancer centers were the same. In order of highest incidence, they were: adjustment to illness and/or hospitalization, social isolation, understanding diagnosis and/or treatment, limited support, mental health, work and/or school, and communication with the medical team. Strikingly, the most common intervention used at both cancer centers, with tallies more than twice as high as the next on each list, was one on one emotional support. Completing the remainder of the shared top interventions employed by the CSWPNs, in order of frequency, were: encouragement, Ulman program referrals, referral to other staff or hospital resource, resources related to coping with diagnosis, treatment and side effects, logistical support, and fertility preservation education. This study indicates that AYA patients treated at SKCCC and MCC are receiving age-specific informational and psychosocial support. The differences in demographics at the two cancer centers may help to explain the slight variation in the frequency with which certain barriers and interventions were cited. Despite demographic differences, this study showed that AYAs require frequent emotional support and encouragement. This is profound, in that social workers with minimal AYA experience may already be equipped to provide the most commonly used interventions to address barriers to care and wellbeing.

Abstract Summary:

Adolescents and young adults with cancer have unique medical and psychosocial needs. Clinical social work patient navigators at two large cancer centers collected data on patients for an 18-month period, to identify the barriers to care that AYAs experienced and the interventions employed to address those barriers. Despite the differences in patient demographics at the two cancer centers, the challenges they faced and the intervention strategies used were frequently the same. The barriers and interventions that were not most commonly shared at the two cancer centers may be specific to patient age, and partially explained by civilian or military background. One striking conclusion is that all social workers are likely to be equipped to provide the most appropriate and commonly cited interventions, one on one emotional support and encouragement, without any formal AYA training.

Learning Objectives:

1. Identify the most common barriers to care that adolescents and young adults face, and will be able to describe the most commonly cited interventions used to address these barriers.
2. Distinguish the differences between the average adolescent treated at a civilian cancer center and the average young adult treated in a military treatment facility cancer center.
3. Apply appropriate age-tailored intervention strategies in their work with adolescents and young adults with cancer.

References:

- D'Agostino, N.M., Penney, A., & Zebrack, Z. (2011). Providing developmentally appropriate psychosocial care to adolescent and young adult cancer survivors. *Cancer*, 117(10), 2329-2334.
- Institute of Medicine (2013). Workshop summary. In *Identifying and addressing the needs of adolescents and young adults with cancer (Introduction)*. Retrieved from <http://www.nap.edu/read/18547/chapter/2#introx-ch1>.
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Keywords: Adolescent and Young Adult, Patient Navigation

Course Designation: Clinical

Presentation Level: Intermediate

SEXUALITY SIG

Title: Bringing Sex Into the Conversation: Understanding and Overcoming our Own Biases

Author(s): Sage Bolte, PhD, LCSW, CST; Jennifer Bires, MSW, LICSW, OSW-C

Date Scheduled:

6/5/2019, 2:00pm - 3:30pm

Abstract Content:

Sexual health is a critical aspect of quality of life. Cancer and its treatments have both acute and chronic impact on a patient's and partner's sexual health (Flynn et al., 2011), yet this critical assessment and conversation is all too often overlooked in medical assessments (Arora et al., 2013; Bdair & Constantino, 2017; Nusbaum & Hamilton, 2002). Barriers to more challenging conversations like sexual health can certainly be environmental including real time constraints, but many of the major barriers are our own internal barriers – perceptions, assumptions, discomfort, misinformation and fear (Bdair & Constantino, 2017). Oncology social workers are positioned to lead our colleagues in integrating sexual health conversations into quality of life assessments of patients and their partners. In order to lead, we must first acknowledge and look into our own biases, discomforts and perceived or real barriers that we experience when exploring the sexual health challenges our patients face.

Social workers have often paved the way on advocacy and empowerment for critical and often taboo topics like the end of life, financial toxicity and spirituality needs of our patients (Cagle & Bolte, 2009; Walters, 2011; Gwyther et al., 2005; Kalisiak et al., 2014). Sexual health is no exception. With an expected 19 million cancer survivors (Desantis, 2014) who will be living with the long term biopsychosocial consequences of their diagnosis, social workers are part of a critical juncture to advocate for the early and often assessment of sexual health concerns throughout the continuum of care into survivorship or end of life. To do this, it requires a level of comfort in raising the questions of sexual health along with a level of comfort in being open to whatever information or additional questions may arise once the topic is broached. For example, how might you respond to someone who relays to you that they have multiple partners that their primary partner is not aware of? How do you respond to a patient much older or younger than you when they speak of their sexual history or inquire on improving their sexual health? Exploring our own reactions is critical to providing the very best care possible and setting the example for our colleagues. Patients and caregivers continue to

report that health care professionals are not inquiring about sexual health or sexual changes (Burg, et al 2015), yet they want to be informed and be able to discuss. Health care providers often report that one of the barriers is level of comfort with discussing sexual health and fear of not having an answer to a question (NCI, 2018; Arora et al., 2013). There are several assessment models that can guide clinicians in the assessment of sexual health, but one must first evaluate and assess individual barriers and discomforts

This interactive presentation using didactic and experiential teaching methods, grounded in research and evidenced based interventions, will explore our own perceived and real barriers along with the discomforts we may experience in doing sexual health assessments so that we can be fully present and the best advocates for our patients and their sexual health and lead by example within our teams.

Abstract Summary:

Sexual health is a critical aspect of quality of life. Cancer and its treatments have both acute and chronic impact on a patient's and partner's sexual health (Flynn et al., 2011), yet this critical assessment and conversation is all too often overlooked in medical assessments (Arora et al., 2013; Bdair & Constantino, 2017; Nusbaum & Hamilton, 2002). Barriers to more challenging conversations like sexual health can certainly be environmental including real time constraints, but many of the major barriers are our own internal barriers – perceptions, assumptions, discomfort, misinformation and fear (Bdair & Constantino, 2017). Social workers have often paved the way on advocacy and empowerment for critical and often taboo topics like the end of life, financial toxicity and spirituality needs of our patients (Cagle & Bolte, 2009; Walters, 2011; Gwyther et al., 2005; Kalisiak et al., 2014)). Sexual health is no exception (Bolte & Anrig, 2015). To do this, it requires a level of comfort in raising the questions of sexual health along with a level of comfort in being open to whatever information or additional questions may arise once the topic is broached. This interactive presentation using didactic and experiential teaching methods, grounded in research and evidenced based interventions, will explore our own perceived and real barriers along with the discomforts we may experience in doing sexual health assessments so that we can be fully present and the best advocates for our patients and their sexual health and lead by example within our teams.

Learning Objectives:

1. Identify at least three barriers that influence sexual health assessments
2. Identify at least three evidence based solutions to overcome barriers
3. Identify at least three resources available to improve comfort and knowledge in sexual health

References:

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Lisa P. Gwyther MSW, LCSW, Terry Altilio ACSW, Susan Blacker MSW, Grace Christ DSW, Ellen L. Csikai BASW, MSW, PhD, Nancy Hooyman PhD, Betty Kramer PhD, Julie M. Linton BA, Mary Raymer MSW, ACSW & Judith Howe PhD (2005) Social Work Competencies in Palliative and End-of-Life Care, *Journal of Social Work in End-of-Life & Palliative Care*, 1:1, 87-120, DOI: 10.1300/J457v01n01_06

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Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Clinical

Presentation Level: Intermediate

BRAIN TUMOR SIG

Title: Returning to Work Post Treatment: Preparation is Key

Author(s): Hannah Smith, MSW, LCSW, OSW-C

Date Scheduled:

6/5/2019, 2:00pm - 3:30pm

Abstract Content:

It is a widely known fact that cancer diagnoses, cancer treatments and the emotional impact of both can play a role in decreased quality of life for cancer survivors (Bergo, et al., 2016). According to 2016 data from the National Cancer Institute, there are over 15.5 million cancer survivors living in the United States. With the majority of cancer survivors having received one or more treatments including surgery, radiation, chemotherapy, or hormonal therapy, it is important to note the impact that these have on a patient's future. For many, a return to normalcy is characterized by continuing to or returning to work after treatment is complete, which can boost a patient's sense of accomplishment and meaning (Liaset & Kvarn, 2017). It was found that one in six people with a history of cancer were unable to return to work due to physical, cognitive, and emotional changes (Nieuwenhuijsen, Boer, Spelten, Sprangers & Verbeek, 2009). Among cancer survivors with a history of brain tumors, the number of people who return to work is even fewer. Literature suggests that anywhere from 44-60% of brain tumor survivors will attempt a return to work within one to two years after diagnosis and treatment (Collins, Gehrke, & Feuerstein, 2013; Liaset & Kvarn, 2017). The question then becomes, what new cognitive deficits are present, and how are healthcare professionals better able to support these patients through it? The role of the healthcare team is to ensure that the patient is medically ready to return to work, emotionally capable of handling the new challenges he or she will face, and to help them understand their new abilities. In our work at outpatient cancer centers, patients often ask questions about their readiness to return to work and how

to navigate the system as they adjust to their new lifestyle. The use of a neuropsychologist may shed light on what to expect after diagnosis and treatment of a brain tumor (Vardy, Ahles, Tannock, & Schagen, 2008).

Neuropsychology evaluations and assessments in the role of cancer survivors' return to work can be a complicated yet necessary tool. Used at initial diagnosis, prior to surgery and standard of care, the assessment can be a baseline evaluation for the patient, as well as to his or her family. Emotionally, it can also play a role in how the patient perceives their diagnosis and its effect on their mind and body. Physically, it may help surgeons and physicians map out a surgical plan prior to resection. Neuropsychology follow-up evaluations and assessments after treatment can highlight any changes in executive function, cognitive deficits compared to baseline, and identify cognitive rehabilitation plans to help restore cognition as close to baseline as possible. This approach can serve as helpful and hopeful for patients in determining their readiness to return to work. However, many times baseline assessments are never done, and patients are left to return to work not knowing if it is too soon or what challenges may arise when he or she gets there. This can result in increased emotional and financial distress for patients and the family.

In a study done by Tucha, et al., 90% of 139 patients in a sample displayed impairments in at least one area of cognition, with additional deficits seen in executive functioning and memory and attention (Bergo, et al., 2016). These deficits are common and expected in patients with brain tumors. Another study conducted in 2017 by Liaset and Kvarn showed that patient's experience of returning to work were categorized using three different themes: easier said than done, from mastering to the feeling of inadequacy, and the environment's impact.

This talk will present the challenges faced by cancer survivors of brain tumors who have a desire to return to work following treatment. We will explore how neuropsychological testing can play a supportive role in helping the patient understand these changes, as well as ways in which social workers and supportive staff can assist the patient through the process. Caregivers and family members too, are included in this discussion, often times being the front lines of those who are forced to agree or disagree on a patient's decision to return to work. Finally, case examples will be provided to discuss the different outcomes that can come about from being prepared versus unprepared for this return. Recommendations on how to guide clinical practice, support the caregivers, and increase knowledge of the patient's individual challenges will be highlighted.

Abstract Summary:

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Learning Objectives:

1. Describe the challenges faced by patients and caregivers when the decision is made to return to work following treatment for brain tumor.
2. Express the impact that neuropsychological testing and follow up can have on a patient's readiness.
3. Compare ways in which oncology social workers and healthcare professionals can support patients and their loved ones through the process of retuning to work.

References:

1. Bergo, E., Lombardi, G., Pambuku, A., et al., "Cognitive Rehabilitation in Patients with Gliomas and Other Brain Tumors: State of the Art," *BioMed Research International*, vol. 2016, Article ID 3041824, 11 pages, 2016. <https://doi.org/10.1155/2016/3041824>.
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Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Clinical

Presentation Level: Intermediate

ETHICS SIG

Title: Pets are Wonderful Supports - Usually: Ethical, Legal and Practical Implications of Emotional Support, Service and Therapy Animals in Oncology Settings

Author(s): *Christina Bach, MSW, MBE, LCSW, OSW-C, FAOSW*

Date Scheduled:

6/5/2019, 2:00pm - 3:30pm

Abstract Content:

In 2017, it was estimated that 85 million families (68% of the population) in the United States own a pet. (<https://www.iii.org/fact-statistic/facts-statistics-pet-statistics>). Pets play a wide range of roles in our lives: they are our best friends; we may share our beds with them; they may protect our homes and property; they get us out of the house and socializing; they are our exercise partners. They are our constant companions, giving unconditional love and support, while asking so little in return.

As the number of household with pets has grown, so has the expectation of many pet owners to be able to include their pets in more aspects of their lives, from vacationing to dining out. However, it isn't always practical for pet owners to travel with their pets; and not all housing arrangements support pets in the home. Hence, the birth of the "emotional support animal" designation.

However, just what an emotional support animal is and where they can go continues to be confusing. As mental health practitioners, social workers are often placed in a difficult position of wanting to advocate for the patient's needs; while needing to respect other patients/staff and ultimately agency policy and federal law.

In this session, we will unpack the nuances between service animals, therapy animals and emotional support animals. We will explore the legal standing of all three through the lens of the Americans with Disabilities Act, the Air Carrier Access Act (ACAA) and the Rehabilitation Act of 1973. We will explore the rules for supporting patients requesting "emotional support animal" verification as well as the ethical challenges this poses for social workers. We will specifically focus on the core values of competency, integrity and the importance of human relationship and how these values can be compromised and embraced with these requests. Methods for addressing emotional support animal requests at the agency as well as the building of therapy dog programs in cancer settings will be discussed. Ultimately, the goal of this presentation is to understand the importance of the human animal bond while respecting the legal principles in place to protect public health and safety.

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Learning Objectives:

1. Differentiate between service, therapy and emotional support animals and provide education to patients, caregivers and staff about the important differences between each of these classifications.
2. Describe the ethical and legal challenges posed by emotional support animal verification letter requests.
3. Develop a plan for addressing emotional support animal requests with their own clients as well as work with their agency and the local veterinary community to build interprofessional relationships that support patient's needs and the human-animal bond.

References:

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Von Bergen, C. W. (2015). Emotional support animals, service animals, and pets on campus. *Administrative Issues Journal*, 5(1), 4.

Keywords: Ethics

Course Designation: Ethics

Presentation Level: Intermediate

PATIENT NAVIGATION SIG

Title: Working with the Metastatic Breast Cancer Patient—Navigating Recurrence and Quality of Life Issues

Author(s): *Cara Kondaki, MSW, LCSW, ACSW, CBPN-IC, OSW-C*

Date Scheduled:

6/5/2019, 2:00pm - 3:30pm

Abstract Content:

“Working with the Metastatic Breast Cancer Patient -Navigating Recurrence and Quality of Life Issues” will review a recent study from the National Cancer Institute reporting increased survival rates for women with Metastatic Breast Cancer. Angela Mariotto Ph.D. Chief of the data Analytics branch of the Division of Cancer Control at the National Cancer Institute related “ Even though this group of patients with Metastatic Breast Cancer is increasing in size, our findings are favorable...women are living longer with Metastatic Breast Cancer...longer survival means increased needs for services and research”. Cancer programs nationally have evolved and expanded to include support service teams to address this growth. Increased services addressing nutrition, body image, mindfulness, Art and Music interventions and strategies to address patient distress have prompted increased psychosocial support. There is also a focus on improving patient survivorship. While Survivorship care plans were designed to help patients address long term medical issues and lifestyle choices, patients with Metastatic Breast cancer patients are not typically provided with a survivorship care plan. Whereas Psychosocial Distress screenings are completed at pivotal visits throughout the Cancer Continuum, COC Standard 3.3 requires survivorship care plans for “Stage I,II, or III cancers that are treated with curative intent and have completed active therapy”. One would argue that Survivorship for patients with Metastatic Disease would be equally important to address. Patients diagnosed with Metastatic Breast Cancer have varying reactions to the need for ongoing surveillance and treatments and the need to palliate vs cure. Changes in treatment regimes, side effects of medications and treatments; increased trips for medical follow up and progression present unique challenges. Psychosocial stressors can surface including employment, insurance and financial issues and adjustment issues including depression, anxiety and difficulty coping. Over time these concerns can exacerbate and ultimately affect not only Metastatic breast cancer patients but their families and even the Breast care team. To accomplish this Johns Hopkins University and Comprehensive Cancer Center in March 2016 piloted survivorship care planning with the Metastatic Breast Cancer Patient to “address the evolving survivorship needs in their trajectory from initial diagnosis of advanced disease to end-of life care”. They are continuing to collect data with the goal of “promoting individualized services within the metastatic setting and improve the quality of life for this population”. This will certainly provide much needed information and guidance as the cancer community continues to define the meaning of survivorship for all cancer patients moving forward. This presentation will include case discussions of several Metastatic Breast cancer patients and how they managed their journey with Metastatic Breast cancer. The presentation will review individual Quality of Life issues, care coordination with oncology providers, psychosocial and support services interventions used to provide support and increased patient-centric care during their breast cancer journey. Finally, it will address the difficulty for the Breast care team when working with long term patients and ultimately having to consider alternatives such as Palliative Disease Management and Hospice. Presenter will discuss resources for Social Workers and Breast Patient Navigators and review caring for caregivers and dealing with loss.

Abstract Summary:

Many people living with advanced breast cancer describe the moment they learned of their diagnosis as “truly devastating”. Patients can feel betrayed by their bodies or angry. Some second guess treatment decisions they made when initially diagnosed. Coming to terms with a diagnosis of advanced breast cancer is very individual and affects each

patient differently. The reality is many women are living with Metastatic Breast Cancer and live long active lives during treatments. A recent study from the National Cancer Institute showed that despite a poor prognosis, survival rates are increasing and between 1992-1994 and 2005-2012 five year survival rates in women diagnosed with Metastatic Breast cancer from ages 15-49 are estimated to have doubled from 18 percent to 36 percent. Stage IV Breast Cancer can now be considered a chronic illness in many cases. While this is good news, there are many considerations for patients with Metastatic Breast Cancer. The Clinical Breast Team must address the management of the long term side effects of ongoing chemotherapy treatments; both oral and infused; radiation treatments, complications including secondary malignancies and distant recurrence. Oftentimes the oncology social worker is integral in addressing how these treatment related challenges affect the patient's quality of life. Longer survival with Metastatic Breast Cancer will certainly increase patient needs and affect family dynamics, employment and lifestyle choices; increasing the need for psychosocial interventions. While Metastatic Breast Cancer is not a curable condition, new treatments can prolong life, delaying the progression of cancer. Psychosocial support and interventions are crucial for these patients. Addressing long term cancer related symptoms and complications and how it ultimately relates to patient adjustment and quality of life will continue to be a challenge for Oncology social workers.

Learning Objectives:

1. Discuss increasing survival rates for patients with Metastatic Breast Cancer.
2. Describe Metastatic Breast Cancer as a "Chronic Illness" and options for ongoing treatment.
3. Evaluate the current concept of "Survivorship" in patients with Stage IV Breast cancer.

References:

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Keywords: Patient Navigation, Special Populations

Course Designation: Clinical

Presentation Level: Intermediate

RESEARCH SIG

Title: Want to Explore Your Interventions With Patients and Families? An Introduction to the Oncology Social Work Intervention Index (OSWii) Practice Version

Author(s): *Julianne Oktay, MSW, PhD*

Date Scheduled:

6/5/2019, 2:00pm - 3:30pm

Abstract Content:

Recent changes in cancer care standards have led to increased distress screening in oncology social work (Oktay & Zebrack, 2018). This has had many positive outcomes; however, screening itself, without effective follow-up services, is not enough (Zebrack et al, 2017). As primary providers of psychosocial care, oncology social workers can benefit from a tracking system that monitors the services they provide and their impact on patients (Zebrack et al, 2017).

Unfortunately, there is no widely-used and empirically-validated instrument that captures the range of interventions provided by oncology social workers. In response to this need, a team of researchers from the AOSW Research Committee developed a research instrument, the Oncology Social Work Intervention Index (OSWii) (Oktay et al, Navigator, 2018; Oktay et al, APOS, 2018). In response to great interest by AOSW members, we also developed a practice version of OSWii, known as OSWii-PV. The practice version, created using MS Excel, allows oncology social workers to enter data on the interventions they provide to patients and families. In this presentation, the OSWii Practice Version will be demonstrated. In addition, the AOSW Basecamp users-group will be introduced to participants, so that SIG participants can further explore the OSWii PV in their practice settings.

The Practice Version of OSWii allows an oncology social worker to enter data on each encounter with or on behalf of a patient or family member. When a user opens the Excel file, they will first enter the date, an ID for the patient, a worker ID and an undefined field, "type of visit". Then, they are asked to select one of five possible answers to the question, "What was the social worker's role in this encounter?" The answer category selected determines which follow up questions are asked. The five categories are: Category 1, where there was no direct contact (e.g., sending information, leaving messages); Category 2, where there was direct contact, but no clinical intervention was provided (e.g. assessment, monitoring, patient declined further social work services); Category 3 includes interventions that educate about resources, connect patients and families to services, and/or advocate for patients and families; and Category 4 includes interventions that provide emotional support and /or counseling to help patients/families adjust to and cope with diagnosis and treatment. Category 5 is for cases where both interventions in Category 3 and Category 4 were provided.

Following the selection of one of the five categories, the social worker completes information on the specific services provided. All categories include a text box labeled "other" where the social worker can enter interventions that are not part of the Index. Before submitting, the worker indicates who he/she worked with, patient, family member, and/or other. Also, he/she is asked how many minutes were spent on these interventions. The OSWii-PV also has some reports built in, and these will be demonstrated as well.

In addition to demonstrating the OSWii-PV, the SIG presentation will discuss additional things to think about before beginning using OSWii-PV, potential problems in downloading the file, and how to examine the data using basic Excel tools. In addition, an AOSW Basecamp users- group was created to encourage users to share experiences, problems and solutions using OSWii-PV. This will also be introduced to participants.

Future issues, such as adding additional variables, adding reports, integrating OSWii-PV with other data (e.g. EMR), and creating a network version will also be addressed. AOSW members who are currently using OSWii-PV will be invited to share their own experiences.

The OSWii-PV has the potential to enable oncology social workers to demonstrate what services they provide, assess their own practice, or demonstrate to administrators and/or professional colleagues the breadth and depth of services provided. They may also use the results of the OSWii to communicate with patients and families the wide range of psychosocial services available.

Abstract Summary:

As primary providers of psychosocial care, oncology social workers can benefit from a tracking system that monitors the services they provide. Unfortunately, there is no widely-used and empirically-validated instrument that captures the range of interventions provided by oncology social workers. In response to this need, a team of researchers from the AOSW Research Committee developed a research instrument, the Oncology Social Work Intervention Index (OSWii) (Navigator, Dec 2018). In response to the interest shown by AOSW members, we developed a practice version of OSWii (OSWii-PV). The practice version uses MS Excel, to allow oncology social workers to enter data on the interventions they provide. In this presentation, the OSWii - PV will be demonstrated

Learning Objectives:

1. Describe at least three features of the OSWii Practice Version.
2. Identify three reasons why an oncology social worker might want to explore using the OSWii-PV in their practice.
3. Discuss three issues they can anticipate having to resolve before incorporating OSWii-PV into their own practice setting.

References:

Okta, J.S., Rohan, E., Shapmire, T. J., Callahan, C., Burruss, K. & Zebrack, B. (2018) The development and testing of an instrument to describe oncology social work interventions. APOS, Tuscon, AZ.

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Keywords: Research

Course Designation: Clinical

Presentation Level: Introductory

SIG PRESENTATIONS II

INTEGRATIVE ONCOLOGY SIG

Title: Breathing in Wellness: A Novel 4-Week Mindfulness Session for Adult Cancer Patients/Survivors

Author(s): *Matthew Grossman, MSW/MPH Candidate; Erin Price, LGSW, MSW*

Date Scheduled:

6/5/2019, 4:00pm - 5:30pm

Abstract Content:

Mindfulness is shown through the medical literature to be beneficial to cancer patients in a variety of ways, improving quality of life (Rush & Sharma, 2017), symptoms of stress (Rush & Sharma, 2017), anxiety (Rush & Sharma, 2017; Zhang et al 2015), and depression (Rush & Sharma, 2017; Zhang et al 2015) (through self-report and and/or cortisol measures), lowering heart rate, respiration rate, and blood pressure, improving coping skills, and improving sleep quality (Rush & Sharma, 2017). Largely based on the Mindfulness Based Stress Reduction model created by Jon Kabat Zinn, mindfulness meditation interventions can be delivered in many ways, including through in person instruction, online video or audio, or through CDs; sessions typically occur weekly and last anywhere from 90-120 minutes, and include homework to complete between sessions. (Rush & Sharma, 2017, Haller et al 2017, Zhang et al 2015). Despite this, many limitations still exist through the current methods. In recent systematic reviews, the majority of the studies reviewed lacked diversity in cancer diagnosis (majority breast cancer patients), race, and gender (majority Caucasian females) (Rush & Sharma 2017, Haller et al 2017). The current intervention took shape as a 4-week long in-person mindfulness intervention for a diverse sample of adults, offered both at the Smith Center for Healing and the Arts and the Adult Oncology Clinic at the George Washington Medical Center (GW). Session 1 focused on Sitting Meditation, with emphasis on focused acceptance and attention on/to the breath, sensations in the body, and thoughts in the mind. Session 2 covered the Body Scan, which involves focused and nonjudgmental awareness and acceptance to specific parts of the body in sequential order (head, neck, chest, abdomen, etc.). Session 3 covered Visual Meditation/Guided Imagery practice, which involves picturing yourself in a physical place that makes you feel comfortable and happy. Session 4 covered Lovingkindness Meditation, which involves generating feeling of love and acceptance of yourself, people you are close to, and others you do not particularly like or know very well. All sessions were well attended, with between 11 and 16 participants attending all session at Smith, and between 8 and 12 attending each session at GW. Surveys were administered at the end of each session, with 5 questions assessing how valuable the workshop, facilitators, and lessons were. Additional short answer questions gauged for aspects of the class that were especially valuable or that needed improvement. Participants reported that the mindfulness sessions provided a practical way to reduce stress, helped to increase presence and well-being, and promoted better ways to relax and reduce anxiety. Participants also noted that they enjoyed the workshop facilitators, and would continue practicing the skills they learned in the workshop. This session will review the above intervention, describe session details and resources provided, share results, and provide information for future implementation at other institutions.

Abstract Summary:

Current medical literature shows that mindfulness meditation benefits cancer patients in a variety of ways, decreasing symptoms of stress, anxiety, and depression, and improving sleep and physical health. Despite this, current literature lacks diversity in cancer diagnoses, race and gender. The current intervention is a 4-week long mindfulness workshop administered in hospital and organizational spaces. Sitting Meditation, Body Scan, Visual Meditation/Guided Imagery, and Lovingkindness meditations were taught, and resource sheets were disseminated after each lesson. All sessions were well attended, with 8-16 participants per session. Participants felt the workshop taught them strategies to reduce stress, increase presence and well-being, and promoted better ways to relax and reduce anxiety. Participants also responded well to the program instructors and reported that they would continue to use the strategies they learned in the future. This session will review intervention details, resources provided, and results, and provide information for future implementation at other institutions.

Learning Objectives:

1. Define different components of a standardized mindfulness intervention and contrast different mindfulness methods from each other and from other psychosocial interventions.
2. Appraise the literature regarding mindfulness with cancer patients, distinguish specific pathways through which mindfulness interventions can especially benefit cancer patients, and explain why.
3. Express the mechanisms through which mindfulness affects cancer patients, and synthesize knowledge to plan their own mindfulness interventions.

References:

Effectiveness of Mindfulness-based Therapy for Reducing Anxiety and Depression in Patients With Cancer: A Meta-analysis. Zhang, Wen, Liu, Peng, Wu, Liu. (2015). Mechanisms of action in mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) in people with physical and/or psychological conditions: A systematic review. Modi Alsubaie, Rebecca Abbott, Barnaby Dunn, Chris Dickens, Tina Frieda Keil, William Henley, Willem Kuyken. (2017) Mindfulness-based interventions for women with breast cancer: an updated systematic review and meta-analysis. Heidemarie Haller, María M. Winkler, Petra Klose, Gustav Dobos, Sherko Kümmel & Holger Cramer, (2017) Mindfulness-Based Stress Reduction as a Stress Management Intervention for Cancer Care: A Systematic Review. Sarah E. Rush, Manoj Sharma (2017) Standardised mindfulness-based interventions in healthcare: an overview of systematic reviews and meta-analyses of RCTs. Gotink, Chu, Busschbach, Benson, Fricchione, Hunink (2015)

Keywords: Clinical Practice/Skill Building, Research

Course Designation: Clinical

Presentation Level: Introductory

PAIN, PALLIATIVE CARE, AND END-OF-LIFE (PPCEOL) SIG

Title: Even the “Sick” Care About Fertility and Sexual Health: Education and Support Interventions on an Inpatient Oncology Unit

Author(s): *Jennifer Bires, MSW, LICSW, OSW-C*

Date Scheduled:

6/5/2019, 4:00pm - 5:30pm

Abstract Content:

“The experience of a person who is given a cancer diagnosis is similar to that of a soldier who is given orders by his officers to parachute into a jungle war zone without a map, a compass, or training of any kind. . . Physicians often assume that the patient needs to know nothing except how to follow medical advice.” -Michael Lerner, PhD, Lecturer and Author of *Choices in Healing: Integrating the Best of Conventional and Complementary Approaches to Cancer* More and more cancer patients are not only willing to navigate the daunting territory of conventional oncology care, but are motivated if not insistent in finding complementary therapies to support them in their trek. Many patients have had to achieve this blend of therapies on their own, unaware of or without access to information and people resources who have the maps, compasses and training in navigating safely and wisely in the landscape of integrative cancer care. Beyond Conventional Cancer Therapies is a web-based open-access information service with the goal of helping people with cancer and their clinicians learn about integrative cancer care so that they may navigate wisely beyond conventional care. The ultimate goal is to provide information that will support a person’s decision-making to choose a blend of conventional and complementary care that will help reduce suffering and improve quality of life. We will chronicle the development of this information service, including how we: 1) identified gaps in information and access to integrative care, 2) curated the most promising and interesting complementary therapies; 3) solicited advice, guidance, and feedback from integrative oncology care experts, including Naturopathic Oncologists, people with cancer and their caregivers; 4) dealt with the challenges of presenting balanced, non-commercial information about therapies, clinics and clinicians; 5) came up with a plan to maintain, update and sustain the website. By the time of the conference, the website will have been launched to the public. We will provide a demonstration emphasizing the organization of and navigation through the content. We will suggest how to make the most use of this site for one’s own clinical practice and for patients. Bearing in mind that personal stories are powerful illustrators of what really matters to people now, we will

describe experiences of a person with cancer, a caregiver and of a clinician in going beyond conventional cancer therapies.

Abstract Summary:

Beyond Conventional Cancer Therapies is a web-based open-access information service with the goal of helping people with cancer and their clinicians learn about integrative cancer care so that they may navigate wisely beyond conventional care. Integrative oncology is a patient-centered, evidence-informed field of cancer care that utilizes mind and body practices, natural products, and/or lifestyle modifications from different traditions alongside conventional cancer treatments. Integrative oncology aims to optimize health, quality of life, and clinical outcomes across the cancer care continuum and to empower people to prevent cancer and become active participants before, during, and beyond cancer treatment. The ultimate goal is to provide information that will support a person's decision-making to choose a blend of conventional and complementary care that will help reduce suffering and improve quality of life. We will provide a demonstration emphasizing the organization of and navigation through the content. We will suggest how to make the most use of this site for one's own clinical practice and for patients.

Learning Objectives:

1. Discuss the current paradigm shift in North American oncology care toward an integrative approach.
2. List at least three key information needs about integrative oncology identified by patients and clinicians and describe one idea for providing their patients with access to quality information about integrative cancer care.
3. Describe gaps in scientific literature and clinical and educational resources regarding integrative oncology, as well as describe three challenges and three opportunities in consolidating and providing unbiased, non-commercial integrative oncology resources and information in a web-based platform.

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Keywords: Education, Survivorship

Course Designation: Clinical

Presentation Level: Introductory

SPIRITUALITY SIG

Title: Assessment: It's Our Bread and Butter, So Do It Well!

Author(s): Debra Mattison, LMSW, ACSW, OSW-C

Date Scheduled:

6/5/2019, 4:00pm - 5:30pm

Abstract Content:

The Council on Social Work Education (CSWE) released a 2018 report entitled "Envisioning the Future of Social Work" evoking a provocative call to action stating: "...the health/health care sector will continue to dominate the public's consciousness and governmental spending in the years ahead. Social Work needs to determine whether it will lead or following in this space." As oncology social workers, we are all called to be leaders whether in a formal leadership role, in advocating for clients and causes, or by demonstrating social work clinical competency to improve patient quality of care. This presentation focuses on contributing clinical leadership on our teams by articulating and demonstrating the clinical value of our long-held core social work competency of assessment. While all health care disciplines assess, none

assess with our unique bio- psychosocial-spiritual approach in the context of social work values and skillsets. CSWE describes social work assessment as an “ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations and communities.” Our professional values, skills sets and comprehensive holistic frameworks with attention to cultural humility are unique and thus highly valuable in complex oncology settings. Combining technical, theoretical and clinical skillsets in an ethical practice of use-of-self, social workers conduct assessments utilizing a highly complex, analytical process of gathering, analyzing and interpreting information which is vital to the interdisciplinary team in formulating effective care plans and interventions. Social Work assessments sort through layers of connections, influences, determinants of health using specific theoretical models related to illness, change and coping. We help the team see and understand interconnectedness between access to care and compliance, interrelatedness of spirituality and hope and the intersectionality of mental health and physical health as we assess the person in their environment. Prioritizing client self-determination, our assessments address patients’ own definitions and perceptions of their needs. Our strengths-based lens ensures that not only problems, but resilience is explored, while honoring patients as being their own experts of their lives. We embrace diversity, seek social justice and identify barriers in accessing quality care. We assess mothers and fathers; immigrants, migrants, refugees; the uninsured and the well-resourced; young and old; those who identify as LGBTQ, he, she, they or ze; those whose languages we do not speak and those we do, and those who will be cured and those who will die of their cancer. This session will focus on articulating the value of social work assessments and honing skill development for all levels of practitioners by exploring and utilizing diverse and emerging assessment approaches and models which can be readily implemented in daily clinical practice. Participants will leave with new assessment tools and ideas to add to their clinical toolbox along with a renewed sense of confidence to lead by excellence utilizing our core professional activity of assessment.

Abstract Summary:

While all health care disciplines assess, none assess with our unique bio- psychosocial-spiritual approach in the context of social work values and skillsets. Combining technical, theoretical and clinical skillsets in an ethical practice of use-of-self, social workers conduct assessments utilizing a highly complex, analytical process of gathering, analyzing and interpreting information which is vital to the interdisciplinary team in formulating effective care plans and interventions. This session will focus on articulating the value of social work assessments and honing skill development for all levels of practitioners by exploring and utilizing diverse and emerging assessment approaches and models which can be readily implemented in daily clinical practice. Participants will leave with new assessment tools and ideas to add to their clinical toolbox along with a sense of renewed confidence to lead by excellence utilizing our core professional activity of assessment.

Learning Objectives:

1. Express the value of articulating and demonstrating social work unique clinical assessment skills.
2. Identify at least three assessment models/tools to add to one’s clinical practice toolbox.
3. Discuss application of an assessment model/tool to a specific practice population.

References:

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Keywords: Clinical Practice/Skill Building, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Intermediate

BLOOD CANCER/BMT SIG

Title: Strengthening the Future of Psychosocial Care in Hematopoietic Stem Cell Transplantation (HSCT)

Author(s): *Nancy Boyle, MSW, LCSW, OSW-C; Erica Bryan-Wegner, MSW, LICSW*

Date Scheduled:

6/5/2019, 4:00pm - 5:30pm

Abstract Content:

For the past five years, a group of clinical social workers (herein referred to as “the work group”) from across the country, with years of experience in both adult and pediatric HSCT, have come together to create a legacy and to answer the question: “How can we ensure that social workers are equipped to provide the best psychosocial care possible to the increasing numbers of HSCT patients and their families?”

In 2016 there were 21,696 transplants performed in the United States. This number has increased by 16% in just four years, resulting in a greater need for psychosocial care, intervention and support to this vulnerable population of patients. HSCT is a rigorous, lengthy treatment that is often the last option for patients seeking curative intervention. Particularly for those with existing mental health conditions, substance use/abuse issues, work/financial issues, and/or lack of social support, intervention from a social worker is imperative for successful treatment outcomes. HSCT has become standard therapy for a number of high-risk malignancies as well as the recommended treatment for many non-malignant conditions. Beyond transplant, various targeted gene and immune therapies are emerging in many transplant centers. As a result, HSCT social workers must acquire more advanced and specialized skills and knowledge to meet the needs of a diverse patient population.

Social workers can provide a vast array of effective interventions to enhance the psychosocial health of patients and families. In addition to direct clinical work, they may serve as an intermediary between the family and the medical team. Social workers can enhance communication among multi-disciplinary team members and advocate for the importance of treating the whole person. As medicine in general moves away from its roots as a paternalistic, disease-focused profession, social workers should be leading the way towards a more holistic approach to patient care. In 2008, the Institute of Medicine highlighted the need for cancer care for the whole patient and emphasized the inclusion of psychosocial services. Unfortunately, while transplant centers have incorporated psychosocial providers, these providers are often underutilized.

A phone survey of HSCT social workers demonstrated that many are the sole practitioners within small programs and do not belong to either AOSW or APOSW. These social workers may be isolated, with little or no peer contact or peer-to-peer consultation opportunities. The work group identified a need for enhanced transplant-specific education for social work interns and other psychosocial professionals. Training modules were developed and designed to fill the identified gap that exists between practicing HSCT professionals and the knowledge they need to provide excellent psychosocial support.

Transitioning HSCT social workers from a “support function” to a more central role on the interdisciplinary team will take time and effort. In addition to creating educational tools, the work group has taken a significant step by creating a social work SIG within the largest professional medical organization for HSCT providers, the Association of Blood and Marrow Transplant. The goal is to make a global impact on the HSCT community by providing education, promoting the central role of social workers in HSCT and ensuring that clinical social workers are working at the top of their licenses and expertise.

HSCT is a difficult and complex treatment for patients and families that impacts every aspect of life. Social workers should be equipped with the training and skills to meet these psychosocial needs and inter-professional care teams at transplant centers should consistently utilize social workers’ highest level of expertise. The medical field and health care systems are also complex and can present barriers to social workers. The success of our work group highlights the opportunity for our profession to help patients at a macro level by collaborating, educating and advocating. By reaching beyond the walls of our institutions, social workers will strengthen psychosocial care for HSCT patients and their families.

Abstract Summary:

HSCT is a difficult and complex treatment that impacts every aspect of the patient’s and family’s life. Social workers should be equipped with the training and skills to meet these psychosocial needs. In addition, inter-professional care teams at transplant centers should consistently utilize social workers’ highest level of expertise. The medical field and health care systems are also complex and can present barriers to social workers. If social workers take on a leadership role in patient education and advocacy we could break down many of these barriers. The success of a nation-wide group of clinical social workers who created educational tools and advocated for the role of social work in transplant centers will be presented. Join us for an interactive, engaging presentation to learn how reaching beyond the walls of our institutions will allow social workers to strengthen the psychosocial functioning of HSCT patients

Learning Objectives:

1. Describe the complex issues facing HSCT patients and the interventions social workers use to improve psychosocial health.
2. Recognize educational gaps that exists between practicing HSCT social workers and the knowledge they need to provide excellent psychosocial support.
3. Identify opportunities to collaborate with other social workers to elevate our profession.

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Keywords: Clinical Practice/Skill Building, Specialized Needs

Course Designation: Clinical

Presentation Level: Intermediate

YOUTH, FAMILIES, & CANCER SIG (formerly Children & Cancer SIG)

Title: Working With Families When a Parent Has Cancer

Author(s): *Carissa Hodgson, MSW, LCSW, OSW-C*

Date Scheduled:

6/5/2019, 4:00pm - 5:30pm

Abstract Content:

At least 14 percent of cancer patients live with minor children, with an estimated 1.58 million U.S. cancer survivors living with minor children. This represents 2.85 million children (Weaver, et al., 2010). A parent's cancer diagnosis significantly affects children, teens, and the family system as a whole. A 2014 Cancer Support Community survey found that 66 percent of parents felt that their child(ren) did not talk openly with them or share their feelings about cancer. Additionally, 25-39 percent of children may experience adjustment disorders for up to five years after a parent's diagnosis (Nelson & While, 2002).

This presentation includes a literature review of families with a parent who has cancer and the best practices to support these families. It also includes results of a 2018 survey by the author at Gilda's Club Madison about families, cancer and resilience. Key aspects of child development and a child's understanding of and response to cancer at various stages along the developmental spectrum are addressed. Risk factors, protective factors, and key interventions are explored. Lastly, valuable resources for families and professionals are shared.

Abstract Summary:

At least 14 percent of cancer patients live with minor children, with an estimated 1.58 million U.S. cancer survivors living with minor children. This represents 2.85 million children (Weaver, et al., 2010). A parent's cancer diagnosis significantly affects children, teens, and the family system as a whole. A 2014 Cancer Support Community survey found that 66 percent of parents felt that their child(ren) did not talk openly with them or share their feelings about cancer. Additionally, 25-39 percent of children may experience adjustment disorders for up to five years after a parent's diagnosis (Nelson & While, 2002).

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Learning Objectives:

1. Review child and teen development in its relation to understanding cancer, separation, loss, death and grief.
2. Discuss common reactions of children and teens to a cancer diagnosis in the family and how to identify signs of distress.
3. Describe the most effective interventions and resources for children and teens, from the time of diagnosis through post-treatment or grief.

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Weaver, K.E., Rowland, J.H., Alfano, C.M. & McNeel, T.S. (2010). Parental cancer and the family: A population-based estimate of the number of US cancer survivors residing with their minor children. *Cancer*, 116 (18), 4395-4401.

Keywords: Patient Navigation, Special Populations

Course Designation: Clinical

Presentation Level: Introductory

RADIATION THERAPY SIG

Title: Being an Oncology Social Worker in a Proton Therapy Setting

Author(s): Lauren DeWitt, MSW, LCSW

Date Scheduled:

6/5/2019, 4:00pm - 5:30pm

Abstract Content:

The Radiation Therapy Special Interest Group through Association of Oncology Social Workers provides an opportunity for oncology social workers in the radiation setting to learn from each other and support each other in providing psychosocial resources to our patients and their families. This presentation will focus on informing fellow oncology social workers in the radiation setting of proton therapy and the unique challenges associated with this care. This will also provide an opportunity for those not in the radiation setting to learn about this field and advances in care provided. During this discussion I will discuss what proton therapy is and the benefits it presents to patients and physicians. Proton therapy is offered in few locations due to the size of the machine and the cost of the equipment. However, proton beam therapy can provide multiple benefits, some of which were recently described by Thomas Bortfeld and Jay Loeffler, "Protons can be targeted more precisely than X-rays, so the tissues around the tumour receive two to three times less radiation. This lowers the chance of causing secondary tumours or impairing white blood cells and the immune system. High doses of protons can be delivered safely to hard-to-treat tumours: for instance, those at the base of the skull or in the liver. Such accuracy is crucial when treating cancers in children." (2017).

While proton beam therapy provides benefits for patients, the cost of treatment and sparse treatment machines can bring a new set of challenges to oncology social workers. One common challenge is insurance coverage and associated financial toxicity, as not all major insurance providers cover proton therapy. We will explore specific ways to advocate for patients and the national resources available including the National Association for Proton Therapy. For oncology social workers, patient-centered care has always been a goal and a central principle for practice. This stems from our profession's ideals "including helping people, advocating on behalf of disadvantaged populations, and providing mental health services" as well as endorsing "a dual purpose, to promote both human well-being and social justice". (Keenan, Limone, & Sandoval, 2016). Part of encouraging patient-centered care is advocating for patients on many levels. We must advocate for patients in the community, with insurance, and often within our settings. As oncology social workers, we are our patient's first line of defense. We provide encouragement, assist them in getting transportation, and express their needs to our interdisciplinary team. As part of an interdisciplinary team, it is important for oncology social workers to show our worth and value to the team. We will discuss further ways to promote our profession and worth in our settings.

Oncology social workers are focused on providing services across the continuum of care which also includes being aware of how cancer impacts patient's lives on multiple levels. We are attuned to "patient values and concerns, such as pain and symptom management, psychological and emotional distress, future orientation, and attainment of goals and achievement (even short term ones)." (Zebrack, Jones, & Smolinski, 2015).

Being informed of treatment options makes us more aware of the issues and barriers patients are faced with, and make us more equipped to help. As Betty Ruth and Jamie Marshall state, "there is a growing understanding of how unmet social needs of humanity detract from health and produce inequitable health outcomes." (2017). Our roles as oncology

social workers allow us to identify these social needs, identify resources to combat them, and promote resiliency among our patients and their families.

A cancer diagnosis affects everyone differently. As elaborated in the Handbook of Oncology Social Work, Carolyn Messner, Caroline Kornhauser, and Rolaie Canosa, "A cancer diagnosis is a traumatic life event that may threaten one's physical, emotional, and social existence. For many people, the hallmarks of the cancer experience include feelings of vulnerability coupled with fears of recurrent disease, suffering, and death." (2015). These feelings can be exacerbated in the proton therapy setting as patients are often away from home and loved ones, which as we know impacts every level of Maslow's Hierarchy of Needs. We will explore ways for oncology social workers to provide support and unique groups to help provide a sense of belonging as well.

Abstract Summary:

The Radiation Therapy Special Interest Group provides an opportunity for oncology social workers in the radiation setting to learn from each other and support each other in providing psychosocial resources to our patients and their families. This presentation will focus on informing fellow oncology social workers in the radiation setting of proton therapy and the unique challenges associated with this care. This will also provide an opportunity for those not in the radiation setting to learn about this field and advances in care provided.

During this discussion I will discuss what proton therapy is and the benefits it presents to patients and physicians. While proton beam therapy provides benefits for patients, the cost of treatment and sparse treatment machines can bring a new set of challenges to oncology social workers. One common challenge is insurance coverage and associated financial toxicity. We will explore specific ways to advocate for patients in this setting and the national resources available including the National Association for Proton Therapy.

We will also discuss the clinical component of working in a proton therapy setting. Since many patients travel for this treatment loneliness and isolation become a major factor for patients. I will explore how my setting addresses these concerns through unique support programs and psychosocial interventions.

Finally, this presentation will also discuss ways to show our worth as oncology social workers in our settings. Oncology social workers have a major role in our patient's lives and are influential members of our interdisciplinary teams. I will review my experience showing my worth as an oncology social worker and build a discussion on how we can work together to provide the best psychosocial care to our patients.

Learning Objectives:

1. Identify challenges of working in a proton therapy setting.
2. Identify psychosocial resources to bring back to their own setting.
3. Identify ways to show your worth in your interdisciplinary teams.

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Keywords: Patient Navigation, Special Populations

Course Designation: Clinical

Presentation Level: Introductory

PAPER SESSION II

Title: Working With Grief and Loss in the Cancer Experience

Author(s): Michelle Bronzo, MA, LPC, CT

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

In 2018, an estimated 1,735,350 new cancer cases will be diagnosed in the United States and 609,640 people diagnosed with cancer will die. Adjustment to a cancer diagnosis includes a multitude of physical, cognitive, emotional, and spiritual changes. These changes—both big and small—often are accompanied by feelings of grief and loss. Functional losses are associated with distress and have a considerable effect on patients' quality of life, sense of self, roles and abilities, and relationships. Advanced (stage IV) cancer patients also contend with their own mortality and have grief reactions to perceived losses implicit in death, which can contribute to social withdrawal and detachment. Preparatory grief has been found to be correlated with psychological distress and hopelessness. Those living with advanced disease with a longer expected survival have the difficult challenge of balancing engagement in life with facing fears of death. Working from a thanatological perspective in clinical work can impact the loss-related, psychosocial issues that emerge in an oncology population. This case study presentation will depict the wide range of both experienced and anticipatory losses in a young adult living with metastatic colorectal cancer. We will discuss living with uncertainty and facing death, meaning making, suffering, quality of life, the installation of hope and leaving a lasting legacy through the lens of Stroebe and Schutt's Dual Process Model and other theoretical approaches.

Abstract Summary:

Adjustment to a cancer diagnosis includes a multitude of physical, cognitive, emotional, and spiritual changes that are associated with distress. These changes—both big and small—are often accompanied by feelings of grief and loss. Functional losses are associated with distress and have a considerable effect on patients' quality of life, sense of self, roles and abilities, and relationships. Those living with advanced disease have the difficult challenge of balancing engagement in life with facing fears of death. This case study presentation will depict the wide range of both experienced and anticipatory losses in a young adult living with metastatic colorectal cancer. We will discuss working from a thanatological perspective to address living with uncertainty and facing death, meaning making, suffering, quality of life, the installation of hope and leaving a lasting legacy.

Learning Objectives:

1. Describe how a cancer diagnosis can bring about feelings of grief of loss.
2. Identify the physical, cognitive, emotional, and spiritual changes associated with preparatory grief and distress.
3. Demonstrate the use of the Dual Process Model in clinical practice situations with an oncology population.

References:

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Keywords: Clinical Practice/Skill Building, Adolescent and Young Adult

Course Designation: Clinical

Presentation Level: Intermediate

Title: Responding to Cancer-Related Trauma

Author(s): *Sophia Smith, PhD, MSW; Susan Hedlund, MSW, LCSW, OSW-C, FAOSW*

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

The number of cancer survivors in the United States continues to increase as a result of earlier screening and detection as well as numerous new approaches to treatment. It is estimated that by 2024 there will be 19 million cancer survivors in the US living after treatment. Cancer survivors report that their lives are affected across several domains that include physical, social, psychological and spiritual functioning post-treatment. Psychologically, patients often experience anxiety, loss of control, fears of recurrence, depression, and at times, cognitive change. Additionally some patients have previous experiences with trauma. The cancer experience itself can re-traumatize those patients, and may cause trauma for those without previous trauma histories. The prevalence of Post Traumatic Stress Disorder (PTSD) in the general population is approximately 7% over a lifetime. For those serving in the military, it is 14%. The estimate of cancer patients experiencing full PTSD is 10%. Those who are at greater risk for developing cancer-related PTSD are patients who are younger, lower socioeconomic status, prior trauma, less social support, more intense treatment (e.g., transplant), and those with more advanced disease. Oncology social workers are often on the front line of care, and are well-positioned to identify those who are at risk for developing PTSD, and for assessing and treating these symptoms. The three main goals for treating PTSD include improving symptoms, teaching the patient skills to deal with it, and to restore the self-esteem of the patient. Presented by an oncology social work researcher, and a clinician-this interactive session will provide an overview of the incidence of PTSD in the oncology setting, a well as principles of crisis intervention, and PTSD treatment approaches. Evidence-based tools for assessing and treating PTSD will be presented and considered for their efficacy, including the ACT model of trauma treatment, the cognitive processing therapy model, Eye Movement and Desensitization and Reprocessing, and use of medication. Finally, the use of technology as one approach to delivering behavioral health interventions to the community will be considered.

Abstract Summary:

The number of cancer survivors in the United States continues to increase as a result of earlier screening and detection as well as numerous new approaches to treatment. It is estimated that by 2024 there will be 19 million cancer survivors in the US living after treatment. Cancer survivors report that their lives are affected across several domains that include physical, social, psychological and spiritual functioning post-treatment. Psychologically, patients often experience anxiety, loss of control, fears of recurrence, depression, and at times, cognitive change. Additionally some patients have previous experience with trauma. The cancer experience can re-traumatize those patients, and may cause trauma for those without previous trauma histories. The prevalence of Post Traumatic Stress Disorder (PTSD) in cancer survivors is

approximately 10%. Presented by an OSW researcher and an OSW clinician, this session will provide an overview of PTSD in the oncology setting, and assessment and treatment approaches.

Learning Objectives:

1. Discuss the prevalence of Post-Traumatic Stress Disorder in patients being seen in the oncology setting.
2. Evaluate assessment and treatment approaches for individuals experiencing PTSD in the oncology setting.
3. Describe a behavioral health technology approach to be used with cancer patients.

References:

<http://www.ptsd.va.gov/professional/> National Center for PTSD

<https://www.cancer.gov/about-cancer/coping/survivorship/new-normal/ptsd-hp-pdq> National Cancer Institute PDQ

<http://www.cancer.net/survivorship/life-after-cancer/post-traumatic-stress-disorder-and-cancer> American Society for Clinical Oncology

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Keywords: Clinical Practice/Skill Building, Survivorship

Course Designation: Clinical

Presentation Level: Advanced

Title: Veteran Identity: What Can We Borrow from the Research?

Author(s): *Karlynn BrintzenhofeSzoc, PhD, MSW, FAOSW; Louisa Daratsos, PhD, LCSW*

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

Much has been discussed about veteran identity and the cancer experience and the need to offer veteran centered care. This appears intuitively appropriate, but are these endeavors informed by research? Do these veteran centered programs adequately address the “so what” question. Oncology social workers who work with veterans, respond to a long list of questions continuously: Are there differences among war cohorts? Are there differences among members of the various branches of service? Are there differences between male and female veterans? Are there differences among veterans with multiple cancer diagnoses? Are there differences between veterans who experienced combat and those who did not? The questions keep coming, and until recently there has been little research to shed light on possible explanations and guidance for clinical practice for veterans (Locatelli, Turcios & LaVela, 2014; Di Leone, Wang, Kressin & Vogt, 2016) Knowing a client’s personal perspective is essential to providing patient centered care, in this case veteran centered care. Social workers caring for veterans should have objective data on which to base their interventions which are rooted in theory (Martin, 2017). Community social workers must gain more knowledge of veterans’ identity, culture, and services to better meet the needs of their veteran clients. There are an estimated 22 million veterans alive in the United States as of 2014 (Bagalmen, 2014; Unique Veterans User Report FY 2014, 2016). Only 5.8 million veterans were enrolled in VHA in 2014 (Bagalmen, 2014). The relative low VA use highlights the need for all medical and community social workers to have a working understanding of veteran identity. There is a large base of medical evidence that connects one’s military service and toxic exposures (e.g., Agent Orange) to cancer. Research continues to be conducted on the connection of other service related exposures and cancer, such as the recent announcement that the water at Camp Lejeune was contaminated between 1953 and 1987 (Institute of Medicine, 2015). According to the National Survey of Veterans – Final Report (2010), even in an era with wide access to information, over 40% of veterans were not aware they had access to health care services, and over 26% reported not knowing how to apply. Upon diagnosis, veterans need to be quickly connected to the VA so getting access to the resources that can be helpful to them and their families

are readily available. Once the veteran's cancer is presumed to be related to military exposure, what is the impact of that realization upon him or her? Does having a cancer presumed to be because of a long ago military exposure have a relationship with a veteran's quality of life now? This Learning Institute will review the latest research on veteran identity and help participants apply the findings to oncology social work practice, helping oncology social workers answer the "so what" question in their efforts to bring veteran centered care into their practice.

Abstract Summary:

Only 5.8 million of the 22 million veterans were enrolled in VHA in 2014 (Bagalmen, 2014; Unique Veterans User Report FY 2014, 2016). Lower VHA use demonstrates why social workers must understand veteran identity and resources. Professionals caring for veterans should have data to base their interventions which are rooted in theory (Martin, 2017). New research offers guidance for clinical practice with veterans (Locatelli, Turcios & LaVela, 2014; Di Leone, Wang, Kressin & Vogt, 2016). There is a large base of evidence connecting military service and toxic exposures (e.g., Agent Orange) to cancer. According to the National Survey of Veterans – Final Report (2010), over 40% of veterans were unaware they had access to health care services. This Learning Institute will review emerging research on veteran identity helping participants apply the findings to their practice and helping to answer the "so what" question about the importance of veteran centered care.

Learning Objectives:

1. Recognize one theory of veteran identity.
2. Describe the importance of including veteran status in the psychosocial assessment and the importance of integrating this content in the comprehensive cancer treatment plan.
3. Identify resources and interventions to facilitate connecting veterans to potentially eligible veteran services, on the local, state and national level.

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Keywords: Veterans, Clinical Practice/Skill Building

Course Designation: Cultural Competency

Presentation Level: Intermediate

Title: Empowering the Oncology Social Worker: The Challenge of Working With Intimate Partner Violence

Author(s): *Jacqueline LaGrassa, LCSW; Susan Glaser, LCSW-R; Barbara Mitchell, LMSW*

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

Recently, the world has been exposed to the personal experiences and high-profile accounts of sexual and domestic violence (Johnson, 2018). The “Me Too” movement has become a cornerstone and voice for men and women who have survived such violence (Johnson, 2018). Intimate partner violence (IPV) is broadly defined as abuse that occurs between two individuals in an intimate relationship (Johnson and Pieters, p. 88). According to the Centers for Disease Control and Prevention, IPV includes 4 types of behavior: physical abuse, sexual abuse, threats of physical or sexual abuse, and emotional abuse (Johnson and Pieters, p.88). More than one in five women and one in seven men have experienced severe IPV at some point in their lifetime (Johnson and Pieters, p. 88). Given the frequency of IPV among the general population, it can be assumed that a similar percentage of people diagnosed with cancer may be living with partner abuse. (Johnson and Pieters, p.88). Recent studies have described how a partner’s interfering behaviors impact a patient’s quality of life during cancer treatment (Coker, 2017; Medical Express, 2017). These behaviors include emotional and practical manipulations that increase stress, depressive symptoms and challenges to coping and compliance (Medical Express, 2017). This has important implications for patient care, as those with cancer may complain of symptoms that can be treated when arising from the disease or treatment, but less likely to have a positive treatment response when confounded with current IPV. (Johnson and Pieters, p. 88). The dual stress of cancer and IPV has not been widely studied nor written about in social work literature. Due to the specialized care provided by oncology social workers, we may not always feel prepared to assess for IPV or to address the manipulative or interfering behaviors that are witnessed in our clinics (MacMillan, 2009). The limited experience of our medical teams may also evoke strong reactions to observed or reported IPV. The oncology social worker is responsible for not only the assessment and support of patients and families, but also educating and managing the stress of our medical teams (Wilson & Webb, 2018). In addressing these interactive dynamics of patient, family and team, social workers are often met with limited community supports and resources as well (Wilson & Webb, 2018). Our talk will highlight the unique perspective an oncology social worker can provide when supporting IPV survivors and their families while simultaneously offering valuable educational and emotional support to team members. Case examples will provide the backdrop for frank discussion around the parallel process of counter-transference feelings, such as helplessness, powerlessness, anger and counter-identification (Keller, 1996). The experience of secondary trauma when working with these complex cases will also be addressed in the context boundary and self-care issues. Programming strategies and additional research areas will be proposed.

Abstract Summary:

Given the frequency of IPV among the general population, it can be assumed that a percentage of people diagnosed with cancer may be living with partner abuse. (Johnson and Pieters, p.88). Recent studies have described how a partner’s interfering behaviors impact a patient’s quality of life during cancer treatment (Coker, 2017). These behaviors include emotional and practical manipulations that can occur during a cancer experience and often increase stress, depressive symptoms, and create challenges to coping and compliance (Medical Express, 2017). As oncology social workers, we may not always feel prepared to assess for IPV or to address the interfering behaviors that may present in our clinics (MacMillan, 2009). The limited experience of our medical teams may also evoke reactions to observed or reported IPV. Our talk will highlight the unique perspective an oncology social worker can provide to survivors while offering valuable educational support to medical teams.

Learning Objectives:

1. Describe intimate partner violence (IPV) and to be able to define IPV and it's complexities.
2. Discuss common myths about IPV and how they can affect our practice as well as identifying assessment skills that are useful when dealing with IPV.
3. Describe ways that might improve screening and assessment of IPV cases. Empower social workers to feel more comfortable assessing and engaging survivors.

References:

Coker, A., Follingstad, D., Garcis, L., & Bush, H. (2017). Partner interfering behaviors affecting cancer quality of care. *Psycho-Oncology* 26, 1205-1214. Johnson, C., & Hawbaker, K. (August 20, 2018). #MeToo: A timeline of events. Chicago Periodical. Retrieved from <http://www.chicagotribune.com/lifestyles/ct-me-too-timeline-20171208-htlmstory.html> Johnson, W. A. (2017). Journey of decision-making among a sample of women diagnosed with breast Cancer and living with a non-supportive or abusive partner. UCLA. ProQuest ID: Johnson_ucla_0031D_15403. Merritt ID: ark:/13030/m55b4wtd. Retrieved from <https://escholarship.org/uc/item/14x4f4fz> Johnson, W. and Pieters, H. (2016). Intimate partner violence among women diagnosed with cancer. *Cancer Nursing* 39 (2), 87-96. Keller, E. L. (1996). Invisible victims: Battered women in psychiatric and medical emergency rooms. *Bulletin of the Menninger Clinic*, 60(1), 1-21. Massetti, G., Townsend, J., Thomas, C., Basile, K., and Richardson, L. (2018). Healthcare access and cancer screening among victims of intimate partner violence. *Journal of Women's Health* 27(5), 607-614. McMillan, H., Wathen, C., Jamieson, E., Boyle, M., Shannon, H., Ford-Gilboe, M., ...McNutt, L. (2009) Screening for intimate partner violence in health care settings. *JAMA* 302(5), 493-501. Researchers report connection between intimate partner violence and barriers to cancer recovery from Medical Express, University of Kentucky, February 23, 2017. Wilson, M. & Webb, R. (2018). Social work's role in responding to intimate partner violence. NASW: Social Justice Brief.

Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Clinical

Presentation Level: Intermediate

Title: Warm Calling as Clinical Intervention? Upended Assumptions and Unexpected Outcomes in Psychosocial Distress Screening

Author(s): Nancy Borstelmann, MPH, MSW, LICSW, PhD; Tricia Hughes, MSW, LICSW

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

Psychosocial distress screening within the practice of oncology has been met with mixed emotions. On the one hand, screening recognizes the critical psychological, social, financial, and spiritual impact that cancer and its treatment may have on patients and families. On the other hand, it can raise concerns for oncology social workers, who are often the primary responders to identified needs, and who may feel they have limited bandwidth to offer to more potential patients. Additionally, it may seem that screening itself is a blunt instrument by which to assess the complexities of an individual's life circumstances. Moreover, one might wonder what comprises an adequate or substantive response for those who endorse some degree of distress. With such concerns in mind, the Dana-Farber Cancer Institute (DFCI) launched a step-wise, clinic by clinic roll-out of distress screening in September 2017, and to date has screened approximately 1000 patients across two disease centers and two satellite locations in the community. In that time, both clinicians and patients have offered various responses, which have coalesced into some unexpected and surprising findings. These outcomes and developments have illuminated innovative ways of conceptualizing social work practice, understanding the nature of distress within cancer treatment, and reimagining the role of screening in the provision of patient care. This presentation will explore some of the initial lessons learned and the working assumptions that have been challenged and reconsidered. For example: ****Working assumption:** Therapeutic rapport-building requires multiple sessions and face-to-face contact for patients to gain comfort in sharing the intimate details of their lives. ****Lesson learned:** A one-time phone call can provide the forum for a meaningful clinical encounter, and the unexpectedness and anonymity of the contact via phone seems to allow for deeper sharing. ****Working assumption:** Patients who are distressed will endorse multiple indicators of distress. ****Lesson learned:** Clinically rich encounters have occurred when a patient endorsed a single area of impact (i.e., children or work) which, upon discussion evolved into a set of wider, interconnected concerns. ****Working assumption:** Patients who screen in for distress will require ongoing social work support. ****Lesson learned:** Many seem satisfied with the SW phone number and the invitation to call again if need be. The phone number seems to serve as transitional object. This presentation will illustrate these themes with clinical examples, supported by current literature and practice theory. It will also consider how the process of screening has revealed a population of sub-clinically distressed patients, the nature of their needs, and the approaches incorporated

for addressing them. Finally, it will demonstrate how screening has enabled DFCI to expand its circumference of care to include more patients without overtaxing current providers or overwhelming the current system.

Abstract Summary:

Psychosocial distress screening within the practice of oncology has been met with mixed emotions. On the one hand, screening recognizes the critical psychological, social, financial, and spiritual impact that cancer and its treatment may have on patients and families. On the other hand, it can raise concerns for oncology social workers, who are often the primary responders to identified needs, and who may feel they have limited bandwidth to offer to more potential patients. At Dana-Farber Cancer Institute (DFCI), the screening process has elicited several unexpected insights and outcomes, which have illuminated innovative ways of conceptualizing social work practice, understanding the nature of distress within cancer treatment, and re-imagining the role of screening in the provision of patient care. This presentation will explore these findings and their implications.

Learning Objectives:

1. Recognize psychosocial distress screening as a potentially more substantive clinical undertaking.
2. Evaluate assumptions about telephonic and single-session models of care in clinical social work practice.
3. Re-assess concerns and fears about the impact of psychosocial distress screening on uptake social work services.

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Keywords: Distress/CoC, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Introductory

Title: Trauma Informed Care: The Next Step in Addressing Distress in Cancer Care

Author(s): Eileen Joyce, LICSW, OSW-C

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

Did you know that according to SAMSA, 15-25% of women experience sexual assault in their lifetime. Did you know that according to studies of adverse childhood events, 64% of those surveyed experienced one or more adverse childhood events (ACE) such as physical or sexual abuse, neglect, or witnessing domestic violence. Did you know that having experienced trauma can make a person more likely to experience significant and long lasting trauma symptoms with subsequent traumatic life events such as a cancer diagnosis. Oncology social workers have been on the forefront of exploring and addressing the psycho-social, emotional, mental health and practical impacts of a cancer diagnosis on patients, families, treatment providers and communities. We have been a strong and unified voice advocating for distress recognition, screening, and support. But, what do we do when it is not just the cancer, but our own clinics, interventions, and good intentions that are contributing to and compounding the distress experienced by the people we are working to support? Trauma informed care, well known in behavioral health fields, but just gaining understanding and traction in health care settings, provides an approach to trauma from the individual interaction to the larger systemic view of and approach to people who have experienced trauma. Oncology social workers, with our grounding in systems theory, our training in interviewing, observation, and communication, and our work in both supportive counseling and psycho-education as well as teaching and advocacy are the perfect providers to champion a trauma informed approach within cancer care. This talk will move from previously presented information on trauma informed

care to providing a more in-depth exploration of addressing trauma's impact within our own practices, as well as how to foster a culture shift towards a more trauma informed practice environment within your clinic, center and institution as a means of reducing cancer related distress.

Abstract Summary:

Oncology social workers have been on the forefront of exploring and addressing the psycho-social, emotional, mental health and practical impacts of a cancer diagnosis. We have been a strong and unified voice advocating for distress recognition, screening and support. Studies have shown that trauma is more common than many providers recognize and that previous trauma may result in more significant and longer lasting trauma reactions for some cancer patients. Trauma informed care provides an approach to trauma, from the individual interaction to the larger systemic view of and approach to people who have experienced trauma. This talk will move from previously presented information on trauma informed care to providing a more in-depth exploration of addressing trauma's impact within our own practices, as well as how to foster a culture shift towards a more trauma informed practice environment as a means of reducing cancer related distress.

Learning Objectives:

1. Examine our own practice with a trauma informed lens, by exploring and identifying clinical tools to help patients who may have a trauma history build their trauma toolkit, understand and communicate their needs to providers and staff, and navigate their cancer diagnosis and treatment with the least amount of practice and treatment related distress as possible.
2. Describe how the treatment environment may contribute to triggering of previous trauma experiences and the resulting impact on patients' level of distress both during active treatment and beyond.
3. Discuss how to begin within our own clinics to introduce trauma informed ideas and practices.

References:

Clark, L., Holcombe, C., Fisher, J., & Salmon, P. (July 2014). Breast cancer survivors' perspectives on whether clinical staff should ask breast cancer patients about childhood abuse. *Annals Royal College of Surgeons of England*, 96(5), 364-368. ·

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Keywords: Clinical Practice/Skill Building, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Intermediate

Title: I'm Too Young For This: Challenges in the Unprecedented Rise of Early-Onset Colorectal Cancer

Author(s): *Fiona Begg, LMSW; Hadley Maya, LMSW*

Date Scheduled:

6/5/2019, 5:45pm - 6:45pm

Abstract Content:

Over the past several decades, advances in medical research and the development of successful prevention and diagnostic tools, have led to a decrease in cancer incidence and mortality rates. While the colorectal cancer (CRC) incidence and mortality rates in adults over the age of 50 has been following this downward trend, the incidence and mortality of early-onset colorectal cancer (diagnosis before age 50) has increased 51% since 1994 (1). Even though effective screening tools for CRC exist and some risk factors for CRC are known (smoking, diet, alcohol use, etc.), there are no universally effective prevention and diagnostic interventions for the young onset population. Additionally, young onset CRC patients are more likely to be diagnosed with late stage disease and a worse prognosis, as patients and physicians tend to ignore early symptoms. In fact, 82% of young onset patients were misdiagnosed at the first sign of CRC symptoms (1). In response to the puzzling trend in early-onset colorectal cancer, Memorial Sloan Kettering (MSK) launched the Center for Young Onset Colorectal Cancer, which is the first clinic of its kind in the world solely dedicated to the specific needs of CRC patients under 50 years of age. The center's mission is to uncover the factors contributing to this rise in early onset CRC, increase awareness of this trend, and address the unique clinical and psychosocial needs of MSK's younger CRC patients from diagnosis through survivorship (3). Research shows that young adult (YA) cancer patients report poorer quality of life and emotional outcomes following cancer treatment (4). They face a unique set of psychosocial challenges, including issues with fertility, sexual health and body image, intimate relationships and social life, education and employment, and premature confrontation with mortality. Additionally, young onset CRC patients can experience feelings of increased isolation from healthy peers, the general population of CRC patients, and other YA patients due to the stigma associated with CRC and its association with private bodily functions. They can also feel isolated even within the early onset population, as many 20 year old patients experience different challenges than the 40 year old patients based on their individual life stages. With the knowledge that this growing population faces a set of unique challenges, we now provide an assessment to every young onset patient, which has enabled us to learn more about this population and develop strategies to best support them. We use a combination of psychoeducation and counseling to strengthen coping, build self-esteem, decrease stigma associated with CRC, and improve connection and communication with loved ones about cancer related issues from diagnosis through end of life and/or survivorship. We connect these patients with age appropriate groups and peer-to-peer support specific to their life stages both at MSK and in the community. We have also established support strategies to combat the countertransference we experience as YA social workers working with this population. With our presentation we will share our response to this challenge so that it can be used by other oncology social workers.

Abstract Summary:

In response to the puzzling trend in early-onset colorectal cancer, Memorial Sloan Kettering (MSK) launched the Center for Young Onset Colorectal Cancer, which is the first clinic of its kind in the world solely dedicated to the specific needs of CRC patients under 50 years of age. The center's mission is to uncover the factors contributing to this rise in early onset CRC, increase awareness of this trend, and address the unique clinical and psychosocial needs of MSK's younger CRC patients from diagnosis through survivorship. We use a combination of psychoeducation and counseling to strengthen coping, build self-esteem, decrease stigma associated with CRC, and improve connection and communication with loved ones about cancer related issues from diagnosis through end of life and/or survivorship. With our presentation we will share our response to this challenge so that it can be used by other oncology social workers.

Learning Objectives:

1. Recognize the specific challenges caused by a young onset colorectal cancer diagnosis.
2. Develop skills for assessing the needs, providing support, and identifying resources for young onset CRC patients.
3. Discuss the work of the Center for Young Onset Colorectal Cancer at Memorial Sloan Kettering and how to incorporate aspects of this program into their own cancer psychosocial support programs. Participants will become more adept at discussing uncomfortable topics with CRC patients, such as bowel movements and body changes, that are part of a CRC patients treatment and support.

References:

1. Bhandari, A., Woodhouse, M., Gupta, S. (2016, October 24). Colorectal cancer is a leading cause of cancer incidence and mortality among adults younger than 50 years in the USA: a SEER-based analysis with comparison to other young-onset cancers. *J Investig Med.* p. 311-315.
2. Colorectal Cancer Alliance (2018). 2017 Young Onset Colorectal Cancer Survey Report. Retrieved from <https://www.ccalliance.org/colorectal-cancer-information/young-onset/2017-young-onset-colorectal-cancer-survey-report>
3. Memorial Sloan Kettering Cancer Center (2018). Colorectal Cancer Before 50. Retrieved from <https://www.mskcc.org/cancer-care/types/colorectal/colorectal-cancer-young-adults>
4. American Cancer Society (2016). Cancer Treatment & Survivorship Facts & Figures 2016 2017. Retrieved from <http://www.cancer.org/acs/groups/content/@research/documents/document/acspc048074.pdf>

Keywords: Disease Type (ovarian, lung, GYN, etc.), Adolescent and Young Adult

Course Designation: Clinical

Presentation Level: Introductory

**POSTER SESSION
WEDNESDAY, JUNE 5, 2017**

POSTERS**PO1**

Title: Complementary Therapy Impact on Quality of Life and Psychological Burden Among Advanced Cancer Patients and Survivors

Author(s): *Tabitha Brookins, BA, BS; MSW; PHD; ACSW; LGSW; Katina Lang-Lindsey, MSW; LGSW; PHD*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Abstract/Background: A cancer diagnosis is known to be associated with dying or the end of life phase. Epidemiological evidence suggests cancer patients face the challenges of psychological morbidity following a cancer diagnosis. This study examined the effects of complementary therapy utilization on quality of life and the psychological burden of patients diagnosed with cancer. **Methods:** Data was collected randomly from a set of cancer outpatient from hospitals listed as having an oncology department and support groups in three southern states (Alabama, Georgia, and Mississippi). A concurrent mixed method was used to access the quality of life and weight of psychological burden experienced by cancer patients using complementary therapy. Participants completed validated scales on several outcomes: quality of life (SF-8), Distress, (DT), anxiety (GAD-7), and Depression (PHQ-9). **Results:** Data was collected over a period of six months. A high commitment to this study was shown out of 390 surveys distributed to participants, 255 (65%) were completed and returned. Participant's ages ranged from 45 years of age and above. The most commonly used complementary therapies were Prayer, Walking, Music, Painting, Support Group, and Yoga. Approximately (92%; n=229) expressed a significantly high quality of life (SF-8) with use of complementary therapy. With respects to Quality of life sub-groups, (84.92%; n=229) expressed a control of anxiety and fear (GAD-7) while (89%; n=229) felt more hopeful with complementary therapy use. Helping alleviate the psychological burden, (79%; n=229) reported improved mental health and (89%; n=229) were able to function socially in society. Most cancer patients and survivors (78%; n=229) reported significantly lower distress (DT) with complementary therapy use. **Conclusion:** Results strongly suggest that complementary therapy plays a vital role in improving the quality of life and alleviating the psychological burden on patients diagnosed with cancer. The potential application of this research is vast. Given the high probability of quality of life improvement shown by a patient with cancer who use complementary therapy, education of social workers on complementary therapy and updating their knowledge on complementary therapy resources available to patients is essential for a holistic approach to cancer treatment. Also, Insurance policies can begin to explore policy options that

incorporate various types of complementary therapies helping patients not only afford treatment but reduce the psychological burden they face and improve their quality of life. Further research is needed to explore the impact of complementary therapy to the life expectancy of a patient with various forms of cancer.

Abstract Summary:

Abstract/Background: A cancer diagnosis is known to be associated with dying or the end of life phase. Epidemiological evidence suggests cancer patients face the challenges of psychological morbidity following a cancer diagnosis. This study examined the effects of complementary therapy utilization on quality of life and the psychological burden of patients diagnosed with cancer.

Learning Objectives:

1. Examine the quality of life and psychological burden in cancer patients and survivors during complementary therapy utilization.
2. Summarize research on the type of psycho-social factors that motivate patients' decision to use complementary therapies and the psychosocial needs that are fulfilled.
3. Cite examples using qualitative and quantitative research and provide a standard which to incorporate complementary therapies in oncology social work practice.

References:

1. Leroy T, Fournier E, Penel N, Christophe V. Crossed views of burden and emotional distress of cancer patients and family caregivers during palliative care. *Psychooncology*. 2016; 25: 1278-85.
2. Robinson J, Gott M, Ingleton C. Patient and family experiences of palliative care in hospital: what do we know? An integrative review. *Palliat Med*. 2014; 28: 18-33
3. Lee YJ, Kim JE, Choi YS, Hwang IC, Hwang SW, Kim YS, et al. Quality of life discordance between terminal cancer patients and family caregivers: a multicenter study. *Support Care Cancer*. 2016; 24: 2853-60.

Keywords: Research, Education

Course Designation: Clinical

Presentation Level: Introductory

PO2

Title: Caregivers CONNECT: Reducing Isolation and Meeting the Emotional Needs of Cancer Caregivers Through Solution Focused and Mindfulness Group Interventions

Author(s): *Michelle Rouse, LCSW; Nicole Peeke, LCSW-R*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

BACKGROUND: Caregivers are heavily relied on by the medical system to manage the complex needs of cancer patients (Lambert et al, 2018). The burdens associated with caregiving increase caregivers risk of anxiety, depression and other medical morbidity (Longacre et al., 2018; Lambert et al, 2018). Several studies report that caregivers are diagnosed with anxiety and depression at higher rates than cancer patients, which negatively impacts patient medical outcomes (Longacre et al., 2018; Lambert et al., 2013). A growing body of evidence reinforces the importance to attend to the psychosocial needs of caregivers (Applebaum & Breitbart, 2013). Group interventions are a popular modality for providing psychosocial support to caregivers. However, many caregiver group interventions are time-limited, diagnosis or stage specific, focused on couples, or practical education (Applebaum & Breitbart, 2013; Matson, et al., 2014). Caregivers Connect (CC) is an innovative caregiver-centered model focused on the impact of cancer on the caregiver, rather than disease or patient. CC utilizes a strengths-based framework and solution focused and mindfulness-based interventions to decrease participants stress and feelings of isolation, while increasing self-care behaviors and connection with caregivers. **METHODS:** CC is a weekly, 90-minute, open, process group for caregivers regardless of

cancer diagnosis or stage. CC is facilitated by Licensed Clinical Social Workers (LCSW). CC participants complete a 5-minute pre-group survey measuring level of stress. Facilitators orient participants to group processes and philosophy. Participants introduce themselves by answering three questions: name, self-care behavior, and one word or sentence describing how they are presently feeling. Facilitators transition to creating a supportive environment for caregivers to ventilate emotions typically kept to themselves including: feeling overwhelmed, guilty, fearful, and angry. CC concludes with a 5-minute stress reduction exercise utilizing a free web-based program. Participants complete a similar post-group survey at the end of CC. RESULTS: A paired t-test analysis was conducted on stress scores between pre-and post-intervention (N=216). Stress scores were significantly lower in post-study group (M=4.31, SD=2.2) than in pre-study group (M=6.6, SD=2.27), $t(215)=16.64, p<0.001$. A power > 80% was attained. Participants ranged in age: 5% 18-25, 11% 26-39, 48% 40-64 and 36% 65 and older. The majority of patients being cared for are in active treatment with a new diagnosis or relapsed disease, followed by patients in remission or nearing end-of-life. Participants report a decrease in anxiety, negative thoughts, and an increase in self-care behaviors and better sleep. Participants describe feeling empowered and more confident in their skills, and valued the connection with other caregivers. CONCLUSION: Evidence is clear that caregivers emotional well-being impacts cancer care. Caregivers have multiple demands and time limitations so it is essential that interventions are efficient, effective, and accessible to all caregiver populations. CC participants described the shared experience of “not feeling alone” helps alleviate stress and normalize feelings. Despite the heterogeneous make-up of CC; caregivers related to one another and expressed “comradery” as being a valuable intervention. CC study results are encouraging and further research about the benefits of developing caregiver-centered process groups and interventions.

Abstract Summary:

Caregivers of cancer patients are at higher risk than the patient themselves of developing anxiety and depression. Caregivers are often isolated and in need of emotional support and self-care. A variety of caregiver groups exist; however few focus on the psychosocial needs of the caregiver. Caregivers Connect (CC) is an innovative caregiver-centered model focused on the impact of cancer on the caregiver, rather than disease or patient. CC utilizes a strengths-based framework and solution focused and mindfulness-based interventions to decrease participants stress and feelings of isolation, while increasing self-care behaviors and connection with caregivers. CC provides both a process-oriented group and a stress reduction exercise intervention. Findings shows decreased anxiety, negative thoughts, and an increase in adaptive self-care behaviors and better sleep.

Learning Objectives:

1. Demonstrate effective facilitation of an open caregiver-centered group including: processes and philosophy, focusing on the caregiver not patient and utilizing strength-based and mindfulness-based interventions to decrease stress.
2. Identify commonalities between caregiver experiences, benefits of comradery regardless of their patient’s type of cancer or stage, using quotes from qualitative survey questions and case presentations.
3. Explain and share resources utilized to decrease caregiver stress and promotion of self-care behaviors.

References:

Applebaum, A., Farran, C., Marziliano, A., Pasternak, A., & Breitbart, W. (2014). Preliminary study of themes of meaning and psychosocial service use among informal cancer caregivers. *Palliative and Supportive Care, 12*(2), 139-148.

Lambert, S. D., Girgis, A., Lecathelinais, C., & Stacey, F. (2013). Walking a mile in their shoes: Anxiety and depression among partners and caregivers of cancer survivors at 6 and 12 months post-diagnosis. *Support Care Cancer, 21*, 75–85.

Lambert, S. D., Ould Brahim, L., Morrison, M., Girgis, A., Yaffe, M., Belzile, E., Clayberg, K., . . . Loiselle, C. G. (2018). Priorities for caregiver research in cancer care: An international Delphi survey of caregivers, clinicians, managers, and researchers. *Supportive Care in Cancer*. <https://doi.org/10.1007/s00520-018-4314-y>

Longacre, M. L., Applebaum, A. J., Buzaglo, J. S., Miller, M. F., Golant, M., Rowland, J. H., Given, B., . . . Northouse, L. (2018). Reducing informal caregiver burden in cancer: Evidence-based programs in practice. *Translational Behavioral Medicine, 8*(2), 145-155.

Matson, M., Song, L., & Mayer, D. K. (2014). Putting together the pieces of the puzzle: Identifying existing evidence-based resources to support the cancer caregiver. *Clinical Journal of Oncology Nursing, 18*(6), 619-621.

Keywords: Clinical Practice/Skill Building, Research

Course Designation: Clinical

Presentation Level: Introductory

PO3

Title: Lost & Found: Re-Establishing Intimacy after Cancer

Author(s): Jean Rowe, LCSW, OSW-C, CJT; Mallory Casperson, MS

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Background: Sex, intimacy and relationships after cancer can be scary, uncharted territory. It is normal for young adult cancer survivors (YACS) to not feel particularly sexual or physically attractive after treatment. This reduced or complete lack of interest in sex could be physiological or it could be psychological. Or both. Some YACS have expressed feeling like their bodies have betrayed them. Young adults ages 18 to 39 may still be coming into their own about sexuality when a cancer diagnosis shows up like a party crasher. Oncologists are not equipped to have conversations about how to sustain intimacy during or after cancer when a patient has an existing partner much less addressing this subject with single young adults. The realization that intimacy has skipped town may not show up until after treatment has finished. This can feel isolating, confusing and cause further isolation and fear. Questions like, "When do I tell someone about cancer?" often arise. The Young Survival Coalition, a nonprofit organization focused on the unique needs of young women diagnosed with breast cancer, and Lacuna Loft, an online nonprofit organization providing wellness support and resources to YA, partnered to pilot a six week online journaling workshop delivered via video chat to address these concerns. Participants were invited to join others who understand what they have experienced while learning how to reconnect with themselves, gain a more compassionate understanding of their bodies now and creating ways to open their hearts to intimate opportunities after cancer. Specific journal techniques were utilized for participants to be pioneers in reconnecting with themselves. Sessions completed live through video and audio, completed journal techniques in session and shared with one another. The workshop provided feedback to one another and also received encouraging feedback from the facilitator, a certified journaling instructor. Participants were encouraged to explore acceptance towards their bodies as they are now, knowing that the process may feel awkward and weird while also inviting opportunity and creativity. The workshop is ongoing and will conclude September 15th. Results from six young women are participating in the workshop. To discern behavioral and attitudinal changes/shifts regarding sex, intimacy and relationships before and after the workshop, a pre-workshop survey was distributed via SurveyMonkey to participants. We will survey participants at the conclusion of the workshop and again 3 months after the workshop to learn of the long-term impact of tools they learned. These survey results will inform both organizations of the impact of the workshop as an intervention and will inform future programs. Oncology social workers will benefit from learning about this intervention to be able to refer YACS to similar programs on a topic that is of great importance to this population.

Abstract Summary:

Sex, intimacy and relationships after cancer can be scary, uncharted territory. It is normal for young adult cancer survivors to not feel particularly sexual or physically attractive after treatment. Oncologists are not equipped to have conversations about how to sustain intimacy during or after cancer when a patient has an existing partner much less addressing this subject with single young adults. Young Survival Coalition and Lacuna Loft partnered to host a 6 week online video workshop called Lost & Found: Re-Establishing Intimacy after Cancer for young female adult cancer survivors. Specially crafted journal techniques were utilized to help them reconnect with themselves in a compassionate and loving way. Pre/Post and longer term impact results will be shared at the conference.

Learning Objectives:

1. Assess young female cancer survivors attitudes and behaviors regarding sex, intimacy and body image both before and after the intervention.

2. Utilize journal techniques as intervention addressing sex, intimacy, body image and reconnecting with oneself in order to promote change and shifts in behavior and attitude regarding these areas.
3. Participants formulate a plan of self-care to promote a more loving, compassionate self-image and to incorporate new skills regarding body image, sex and intimacy.

References:

Acquati C., Zebrack B.J., Faul A.C., Embry, L, Aguilar, C., Block, R.,...Cole, S. (2017). Sexual functioning among young adult cancer patients: A 2-year longitudinal study. *Cancer*, 124(2), 398-405. Cheung, C.K., & Zebrack, B. (2017). What do adolescents and young adults want from resources? Insights from a Delphi panel of AYA patients. *Support Care Cancer*, 25, 119-126. D'Agostino, N.M., & Edelstein, K. (2013). Psychosocial challenges and resource needs of young adult cancer survivors: Implications for program development. *J Psychosoc Oncol*, 31, 585-600. Dobinson, K.A., Hoyt, M.A., Seidler, Z.E., Beaumont, A.L., Hullman, S.E., & Lawson, C.R. (2016). A grounded theory investigation into the psychosexual unmet needs of adolescent and young adult cancer survivors. *J Adolesc Young Adult Oncol*, 5, 135-145. Geue, K., Schmidt., R., Sender, A., Sauter, S., & Friedrich, M. (2015). Sexuality and romantic relationships in young adult cancer survivors: Satisfaction and supportive care needs. *Psychooncology*, 24, 1368-1376. Rabin, C., Simpson, N., Morrow, K., & Pinto, B. (2013). Intervention format and delivery preferences among young adult cancer survivors. *Int. J. Behav. Med.*, 20, 304-310. Tindle, D., Denver, K., & Lilley, F. (2009). Identify, image and sexuality in young adults with cancer. *Semin Oncol*, 36, 281-288. Wettergreen, L., Kent, E.E., Mitchell, S.A., Zebrack, B., Lynch, C.F., Rubenstein, M.B., Keegan, T.H.,...AYA HOPE Study Collaborative Group. (2017). Cancer negatively impacts on sexual functioning in adolescents and young adults: The AYA Hope Study. *Psychooncology*, 26, 1632-1639. Wong, A.W., Chang, T., Christopher, K., Lau, S.C., Beaupin, L.K., Love, B., Lipsey, K.L.,...Feuerstein, M. (2017). Patterns of unmet needs in adolescent and young adult (AYA) cancer survivors: In their own words. *J Cancer Surviv*, 11, 751-764. Zebrack, B.J., Kent, E.E., Keegan, T.H., Kato, I., & Smith, A.W. (2014). Cancer sucks and other ponderings by adolescent and young adult cancer survivors. *J Psychosoc Oncol*, 32, 1-15.

Keywords: Adolescent and Young Adult, Specialized Needs

Course Designation: Clinical

Presentation Level: Intermediate

PO4

Title: The Development of an AYA Peer Match Program: PEEPS—Patients Encouraging and Engaging Peer Support

Author(s): *Amanda Trout, LMSW, LCSW, OSW-C*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

According to the Psychosocial Standards of Care for Children with Pediatric Cancer and National Comprehensive Cancer Network Adolescent and Young Adult (AYA) Guidelines, tailored psychosocial support, opportunities for social interaction, and availability of peer support for AYA patients are essential to comprehensive pediatric oncology care. Children's Mercy Division of Hematology/Oncology/Bone Marrow Transplant has had a well established Parent to Parent Program for over 25 years, offering peer match support for parents of children in treatment, but there was nothing similar in place for patients themselves. While we do have less formal ways for AYA patients to connect (a Teen Room on the inpatient unit, quarterly social events outside of the hospital, and a Teen Advisory Board), AYA patients expressed a desire to have a more formalized way to connect with other AYA who had already been through treatment. Collaborating with our hospital's Family-Centered Care Program, we developed an AYA specific peer match program with the goal of meeting the distinct psychosocial needs of our AYA patient population through peer mentorship. Overall, development and initiation of this program took approximately 18 months. A multidisciplinary working group met and researched existing peer match programs, created applications and training materials, and involved hospital leadership and teen/family advisory boards. Final drafts of materials were submitted to the hospital's Legal Department for approval, which took several weeks. Results: As of September 2018, we have held several mentor trainings, trained 12 mentors, and have had one successful match. Programs like this take much longer than you would expect to come to

fruition. It takes a step-wise, thoughtful approach to ensure that all pieces are in place to provide a safe and healthy environment for peer support to take place while simultaneously allowing it to feel as natural as possible for the participants. It has been a learning process at every step. Our mentors have a strong desire to “give back” and wished they had something like this during their treatment. We are hopeful that with ongoing and persistent staff and patient/family education, ongoing input from our mentors and AYA patients, and internal marketing efforts, this program will grow and be beneficial to all involved.

Abstract Summary:

It is well known that AYA patients experience unique psychosocial struggles, and that a diagnosis of cancer is a huge disruption, creating concerns about identity, loss of independence, educational and vocational struggles, and changes in family and peer relationships. The availability of peer interaction and support was identified as an area for improvement in AYA psychosocial programming at Children's Mercy. This poster will address how one pediatric hospital has worked to create a formalized peer match program for AYA patients in order to better meet the needs of this population, describe the process of developing such a program, and offer ideas that could be adopted in other practice settings.

Learning Objectives:

1. Describe the benefit of providing formalized peer mentoring for AYA oncology patients in a pediatric setting.
2. Illustrate how the Psychosocial Standards of Care for Children with Pediatric Cancer and NCCN AYA Guidelines have influenced development of this program.
3. Analyze challenges to developing this program and strategies to ensure ongoing program growth.

References:

Wiener, L. et al. (2015). Standards for the psychosocial care of children with cancer and their families: an introduction to the special issue. *Pediatric Blood Cancer*, 62, S585-S618
National Comprehensive Cancer Network. Adolescent and Young Adult Oncology (Version 2.2018).
<http://www.jnccn.org/content/16/1/66.full.pdf+html>. Accessed September 2, 2018.

Keywords: Adolescent and Young Adult, Survivorship

Course Designation: Clinical

Presentation Level: Intermediate

PO5

Title: A Standardized Methodology for Actively Engaging Patients in Advance Care Planning

Author(s): *Karen Stepan, MPH, RN, MCHES; Margaret Meyer, MSSW, MBA, LCSW, OSW-C; Wendy Griffith, MSSW, LCSW, OSW-C*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Without a standardized advance care planning (ACP) process in place, the University of Texas MD Anderson Cancer Center set out to develop, implement and evaluate an ACP methodology that would engage patients, caregivers and providers in a process of ongoing communication involving the sharing of knowledge related to disease prognosis, treatment options and potential care outcomes; and elicitation of the patient's values and goals as they pertain to medical decision making. A multidisciplinary team was formed to identify and build the infrastructure needed to support our ACP efforts. Key factors impacting ACP were determined and addressed. We aimed to increase the number of documented ACP conversations over a two-year period for new patients who had a diagnosis of advanced or metastatic disease by the 3rd office visit from 19.1% at baseline (FY16) to 50% (FY18) post-intervention. Data was obtained from electronic health record (EHR) ACP analytics. Plan-Do-Study-Act (PDSA) cycles were implemented based on identified improvement opportunities. Our study demonstrated a 16.2% increase in the number of documented ACP

conversations with new patients who had a diagnosis of advanced or metastatic disease by the 3rd office. However, the rate of ACP note documentation varied between ambulatory centers and ranged from 3% to 100%.

Abstract Summary:

Changing an organization’s culture and sustaining that change over time are two of the most difficult leadership challenges one can face. Like changing the course of a large ship, it takes time to maneuver. This presentation will demonstrate the steps taken by one health care organization to create a meaningful and sustainable Advance Care Planning Program.

Learning Objectives:

1. The learners will gain preliminary information about advance care planning.
2. The learners will gain knowledge related to the strategic steps designed to implement a sustainable advance care planning program.
3. The learners will have the opportunity to explore ideas surrounding the development of patient education materials.

References:

1. National Quality Forum. National Voluntary Consensus Standards: Palliative Care and End-of-Life Care - A Consensus Report. 2012. http://www.qualityforum.org/Publications/2012/04/Palliative_Care_and_End-of-Life_Care—A_Consensus_Report.aspx
2. The Quality Oncology Practice Initiative. QOPI® 2014 QCDR Measures: Measure 20; NQF 326. <http://qopi.asco.org/documents/QOPIQCDR2014.pdf>
3. The Institute of Medicine. Dying in America: improving quality and honoring individual preferences near the end of life. The National Academies Press. 2015.
4. The Advisory Board Company. The ABCDEs of advance care planning. 2014 Apr 25.
5. AMA Victoria: Advance care planning: have the conversation. <https://amavic.com.au/training/advance-care-planning--have-the-conversation>
6. Eggertson L: Doctors, patients urged to discuss advanced care plans. CMAJ. 2013 Sep 17; 185:E617-8.
7. Mylod D: Encouraging end of life discussions to improve care, enhance patient decision making and reduce suffering. The Institute for InnovationSM 2015 Mar 4.
8. American Board Company: Prompt palliative care consultations can save \$3,237 per patient, study finds. 2018 May 3.
9. Cancer in the News—For the Members of ASCO. EOL discussions with teenage kids of terminally ill patients linked to more trust in patient’s care. 2013: Monday, July 22.
10. Mack JW, Fascoano KM, Block SD: et al: Communication about prognosis with adolescent and young adult patients with cancer: information needs, prognostic awareness, and outcome of disclosure. Clin Oncol. 2018 Apr 23;JCO2018782128.
11. Enzinger AC, Zhang B, Schrag D, et al: Outcomes of prognostic disclosure: associations with prognostic understanding, distress, and relationship with physician among patients with advanced cancer. J Clin Oncol 2015 Nov 10; 33:3809-16.
12. Sudor RL, Fried TR, et al: Redefining the “planning” in advance care planning: preparing for end of life decision making. Ann Intern Med. 2010 Aug 17; 153:256–261.
13. Nalley C: Who leads end-of-life discussions matters, study reports. Oncology Times. 2016 10 July; 38:12.

Keywords: Pain, Palliative Care and End of Life, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Intermediate

PO6

Title: Using Metrics to Your Advantage: How a Department of End of Life Care Used Metrics to Improve Delivery of Patient Care

Author(s): Teresa van Oort, MHA, LCSW; Mary Jo Meyer, MBA, LCSW, OSW-C

Date Scheduled:

6/5/19, 7:00 p.m. – 8:00 p.m.

Abstract:

With improvements in preventative care, patient volumes are increasing at a rate that surpasses the growth in social



work positions. This creates an imbalance between patient needs and social work staffing available to address those needs. Creative thinking is required to manage the expectations of patients, caregivers, social work staff, and the health care system. Patients and caregivers want their needs addressed immediately, and simultaneously social workers want to deliver quality and safe patient care. These two areas of focus are then addressed by the health care system, whom expects quality and safety while reducing expenses. Having appropriate staffing levels to meet these expectations is key to the provision of quality patient care. Gaining additional staff requires converting social work terminology to language better understood by the health care system. The Department of Social Work at MD Anderson Cancer Center is using metrics to quantify social work activity as a link to demonstrate the workload of current staff and the need for additional staff. This poster will demonstrate how staff to patient ratios impact patient care by meeting needs reflective of time from consult to contact, current staffing trends and plans for the future.

Abstract Summary:

There will always be greater human need than social workers to address the need. How can the need be managed? How can the caseload or department? How can one gather the right information to communicate the need? How can one address the need to people who do not understand our work?

Learning Objectives:

1. Learners will be able to identify key metrics of their work and how to plot that activity.
2. Learners will be able to connect the metrics to the needs of patients, caregivers, social workers, and the health care system.
3. Learners will learn how to package metrics into a presentable format for justifying additional staff.

References:

Studer, Q. 2018. *Leading Excellence*. FL: Fire Starter Publishing.

Keywords: Leadership/Administration

Course Designation: Clinical

Presentation Level: Intermediate

PO7

Title: Developing Content and Resources for Parents Impacted by Breast Cancer

Author(s): *Ingrid Mapanao, BS; Arin Hanson, MPH; Becky Mastin, MPH*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Background: Young women who are diagnosed with breast cancer face a number of challenges that affect their parenting and the parent-child relationship (Tavares, Brandao & Matos, 2018). Newly diagnosed parents struggle with how to tell their children about their diagnosis (Forrest, Plumb, Ziebland & Stein, 2006; Rana et al., 2017; Tavares, Brandao & Matos, 2018). Additionally, aspects of their mother's treatment, such as hair loss and results of surgery can be stressful for children (Forrest, Plumb, Ziebland & Stein, 2006). **Objectives:** To address these challenges in parenting with a breast cancer diagnosis, Living Beyond Breast Cancer (LBBC), a national non-profit, developed educational programming and content to be available to young mothers who have been impacted by breast cancer. **Methods:** To identify resources and programs that would be most useful for mothers with breast cancer, LBBC staff collected qualitative data from a national online community of women diagnosed with breast cancer. Twenty-one individuals provided suggestions and insight into resources that would be useful to them while parenting through a breast cancer diagnosis. Analysis of the qualitative data revealed that books for children are especially useful for parents when talking to their children about their parent's cancer diagnosis. Respondents also reported a desire to hear advice from other parents, and a need for centralized resources for parents with a breast cancer diagnosis and their children. **Results:** As a result of this need, LBBC expanded the parenting information on the LBBC.ORG website. The expanded, medically

reviewed content includes articles on caring for one's own mental health, caring for the mental health of one's children, talking to children about a breast cancer diagnosis, and a resources list of national organizations, camps and other videos and online resources for children. LBBC held a Twitter Chat in May 2017 focused on parenting, in which mothers impacted by cancer discussed their experiences and offered advice. The Twitter Chat had a total reach of 487,651 and 2,588,047 impressions. The LBBC blog also featured a woman recounting her experience talking to her children about her breast cancer diagnosis. Finally, LBBC also created a page for Reading for Reassurance, a program that provides two to three free children's books about cancer to parents. Through spring and summer 2018, there were over 138 requests for books through the Reading for Reassurance Program. Preliminary analysis of the Reading for Reassurance evaluations suggest that the books are relevant, easy for children to understand, and are useful in helping parents have conversations about cancer with their children. Conclusion: The need for resources for young parents who have been diagnosed with breast cancer is high. Using qualitative data, LBBC was able to meet this need through online web content and continued programming. By providing these resources and support, LBBC intends that parents diagnosed with breast cancer who utilize these services, will have more tools and knowledge to effectively parent through their diagnosis.

Abstract Summary:

Young women who are diagnosed with breast cancer face a number of challenges that affect their parenting and the parent-child relationship. After analyzing qualitative data, Living Beyond Breast Cancer (LBBC), a national non-profit, developed educational programming and supportive content for young mothers with a breast cancer diagnosis. LBBC expanded the information for parenting on the website, created a resources list, held a Twitter Chat on parenting, and implemented a program that sends free children's books about cancer to parents. Through these efforts, LBBC has addressed the needs many young mothers face when parenting with a breast cancer diagnosis.

Learning Objectives:

1. Describe the unique needs of young parents with a breast cancer diagnosis and the gap in support that exists
2. Identify the educational support and resources developed to address this need
3. Discuss the practical use of these resources for social workers and their clients

References:

1. Ahmad, S., Fergus, K. & McCarthy, M. (2015). Psychosocial issues experienced by young women with breast cancer: the minority group with the majority of need. *Current Opinion in Supportive and Palliative Care*, 9(3), 271-278.
2. Forrest, G., Plumb, C., Ziebland, S. & Stein, A. (2006). Breast cancer in the family – children's perceptions of their mother's cancer and its initial treatment: qualitative study. *BMJ*, doi:10.1136/bmj.38793.567801.AE 3.
3. Rana, P., Ratcliffe, J., Sussman, J., Forbes, M., Levine, M. & Hodgson, N. (2017). Young women with breast cancer: Needs and experiences. *Cogent Medicine* 4(1). Accessed on 8/31/18 from <https://www.tandfonline.com/doi/full/10.1080/2331205X.2017.1278836>
4. Tavares, R., Brandao, T., & Matos, P. (2018). Mothers with breast cancer: A mixed-method systematic review on the impact on the parent-child relationship. *Psychooncology*, 27(2), 367-375.

Keywords: Survivorship, Special Populations

Course Designation: Clinical

Presentation Level: Introductory

PO8

Title: Supports for Collaborative Care in Cancer Treatment Centers in Five States

Author(s): Hazal Ercin, MSc; Taryn Lindhorst, PhD

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Half of all people with cancer report significant levels of psychosocial distress at various points during diagnosis, active treatment and survivorship periods [i]. In the only national study of the capacity to provide psychosocial care, only 21.5% of institutions rated themselves as having a high capacity for provision of psychosocial care [ii]. To date, little information is available on how cancer centres are implementing psychosocial care services. Collaborative care is a model which integrates medical and psychosocial care by adopting a population-based, stepped care approach to identifying and treating problems such as depression, anxiety and other concerns. The purpose of this study was to evaluate the capacity of Commission on Cancer accredited treatment centres in the Northwest region to provide collaborative psychosocial care. We conducted an interview-based survey with oncology social workers or other professionals at the centre and used secondary quantitative data from Hospital Value-Based Purchasing Program (HVBP) to assess staffing levels, psychosocial screening and treatment practices. We have completed interviews with 18 of 48 hospitals in Wyoming, Alaska, Montana and Idaho and present findings on these hospitals below. Data collection will be completed with Washington centres in fall, 2018, so complete findings will be available by the time of the AOSW conference. Currently, among the Northwest cancer care workforce, oncology social workers are the primary providers of psychosocial support and interventions. Of the 18 centres, 16 (89%) have at least one full-time equivalent oncology social worker, but of these, 6 (37,5%) have only one oncology social worker for all cancer patients. Additional psychosocial staff are limited – the majority (14 centers, 78%) have no access to a psychiatrist and even fewer (2 centers, or 11%) have access to a psychologist. Centers differ substantially in the ways in which they are implementing the Commission on Cancer requirement for psychosocial distress screening. Sixty percent are using some form of the Patient Health Questionnaire (PHQ) to assess for distress; 40% only assess psychosocial concerns at admission to the centre. 5 centres reported that they had no systematic method for assessing psychosocial distress. Interviewees reported that the top three barriers to the implementation of psychosocial and supportive care for people with cancer their families in cancer centres were financial resources, transportation for patients to the centres, and lack of available workforce. When they were asked about the greatest facilitators, almost all of them mentioned the importance of the team members and organizational culture. [i] Mehnert, A., Hartung, T. J., Friedrich, M., Vehling, S., Brähler, E., Härter, M., . . . Faller, H. (2018). One in two cancer patients is significantly distressed: Prevalence and indicators of distress. *Psycho-Oncology*, 27(1), 75-82. doi:10.1002/pon.4464 [ii] Zebrack, B., Kayser, K., Padgett, L., Sundstrom, L., Jobin, C., Nelson, K., & Fineberg, I. C. (2016). Institutional capacity to provide psychosocial oncology support services: A report from the association of oncology social work. *Cancer*, 122(12), 1937-1945. doi:10.1002/cncr.30016 [doi]

Abstract Summary:

Collaborative care is a model which integrates medical and psychosocial care by adopting a population-based, stepped care approach to identifying and treating problems such as depression, anxiety and other concerns. The purpose of this study was to evaluate the capacity of Commission on Cancer accredited treatment centers in the Northwest region to provide collaborative psychosocial care. Currently, among the Northwest cancer care workforce, oncology social workers are the primary providers of psychosocial support and interventions. However, centers differ substantially in the ways in which they are implementing the Commission on Cancer requirement for psychosocial distress screening and intervention. More capacity building efforts are needed to support cancer centers in their ability to engage in a collaborative care model.

Learning Objectives:

1. Provide an overview of the collaborative care model for responding to patient mental health needs.
2. Report on access to psychosocial and support services for cancer patients in Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) cancer care centers.
3. Describe barriers and facilitators to delivery of collaborative care.

References:

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., . . . Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane Database of Systematic Reviews*, 10, CD006525. doi:10.1002/14651858.CD006525.pub2

Fann, J. R., & Sexton, J. (2015). Collaborative psychosocial oncology care models. In J. C. Holland, W. S. Breitbart, P. B.

Jacobsen, M. B. Loscalzo, R. McCorkle & P. N. Butow (Eds.), *Psycho-oncology*, 3rd ed (11-21). New York: Oxford University Press. doi:10.1093/med/9780199363315.003.0099 Retrieved from

<http://dx.doi.org/10.1093/med/9780199363315.003.0099>

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Zebrack, B., Kayser, K., Padgett, L., Sundstrom, L., Jobin, C., Nelson, K., & Fineberg, I. C. (2016). Institutional capacity to provide psychosocial oncology support services: A report from the association of oncology social work. *Cancer*, 122(12), 1937-1945. doi:10.1002/cncr.30016 [doi]

Keywords: Interdisciplinary Care, Distress/CoC

Course Designation: Clinical

Presentation Level: Intermediate

PO9

Title: Efficacy of Community-Based Palliative Care in Improving Quality of Life for Cancer Patients: Current Literature Review

Author(s): *Maren Fulbright*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Current research indicates that cancer patients do not receive necessary supportive care from hospice in the community in the months preceding their death – half of all hospice clients are referred in the last month of life, and a quarter of all patients receive less than one week of care. To address this problem, hospitals have developed palliative care programs, but Medicare does not officially cover palliative care services outside of the hospital for chronically ill patients. Clinical research studies have illustrated the value of outpatient palliative care for certain types of cancers, but their applicability across all cancer diagnoses is still being assessed. The purpose of this literature review is to assess the existing research on the accessibility, effectiveness and structural challenges to provision of community-based palliative care services for cancer patients. This review will summarize current research to identify the evidence base for community-based (home and outpatient) palliative care services. Databases such as PubMed, PsychInfo and information from the Center to Advance Palliative Care and the National Hospice and Palliative Care Organization will be searched for studies and commentary on community-based palliative care. Information to be presented will include: current distribution of outpatient and home-based palliative care; financing options for coverage of palliative care; effectiveness of community-based palliative care with specific cancers and facilitators and challenges to ensuring access to supportive care outside of the hospital environment. The review will end with a discussion of steps oncology social workers can take to advocate for palliative care for cancer patients, including potential changes to health policy that might be enacted at some point to more fully cover palliative care services for the chronically ill.

Abstract Summary:

Current research indicates that cancer patients do not receive necessary supportive care from hospice in the community in the months preceding their death – half of all hospice clients are referred in the last month of life, and a quarter of all patients receive less than one week of care. To address this problem, hospitals have developed palliative care programs, but Medicare does not officially cover palliative care services outside of the hospital for chronically ill patients. The

purpose of this literature review is to assess the existing research on the accessibility, effectiveness and structural challenges to provision of community-based palliative care services for cancer patients.

Learning Objectives:

1. Summarize research on the accessibility, effectiveness and structural challenges to provision of community-based palliative care services for cancer patients.
2. Evaluate gaps in existing research relating to the benefits of palliative care for cancer patients.
3. Provide insight into ways social workers can continue to advocate for the provision of palliative care to people with cancer and their families.

References:

- Cunningham, C., Ollendorf, D., and Travers, K. (2017). The effectiveness and value of palliative care in the outpatient setting. *JAMA Internal Medicine*, 177(2), 264-265.
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Keywords: Pain, Palliative Care and End of Life

Course Designation: Clinical

Presentation Level: Introductory

PO10

Title: Survey Results of Patients' and Health Care Professionals' Experiences With Managing Cancer Symptoms

Author(s): *Carole Mayer, Ph.D., RSW; Mark Collins, M.A.; Silvana Spadafora, MD, FRCPC*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Background Patients in Northeast Ontario receiving cancer treatment are screened for distress to improve symptom management as part of a person-centred cancer care approach. Screening for distress is a rapid method to prospectively identify patients who may experience difficulty coping and adapting to their diagnosis and treatments of cancer due to high symptom burden (Smith et al., 2018). Patients complete the Edmonton Symptom Assessment System Revised (ESAS-r) scale, the Patient Reported Functional Status and Canadian Problem Checklist. Patient completion of distress screening measures, combined with a Health Care Professional (HCP) addressing screening scores, has been shown to provide several benefits including improved communication between HCPs and patients (Chen et al., 2013), better symptom control (Kotronoulas et al, 2014), improved clinical outcomes (Howell et al., 2017), decreases in Emergency Department visits (Barbera et al., 2013), and lessened financial burden on the health care system (Howell et al., 2017). The purpose of this scientific mixed-methods research project (interviews and surveys) was to understand cancer patients' experiences completing patient reported outcomes measures (PROMs) and understand how they manage symptoms of distress. We also sought to understand HCPs' experiences in addressing cancer patients' symptoms of distress. This presentation will focus on survey results. Methods Nine out of thirteen eligible hospitals participated in the study, with some sites located in rural and remote communities. The study received ethical approval from all participating sites. A total of 56 surveys were distributed to HCPs between June 19 and August 27th, 2017. They had the option of completing the survey electronically or via paper copy. The survey included questions regarding:

demographics; using symptom management tools in clinical practice; and the use of symptom management guides. Participating hospitals received 495 surveys to give to patients undergoing cancer treatment between August 28, 2017 and February 4, 2018. The survey asked patients a range of questions including: demographics; cancer diagnosis and type of treatment; experiences completing symptom reports; clinician response to reported symptoms; and experiences accessing support and services. Chi-square analysis, Kruskal-Wallis, regressions, and correlations were used to analyse responses using SPSS software. Results A total of 47 surveys (return rate 84%) were completed by HCPs. Median years of experience was 6-10 years, ranging from 0 - 5 years to more than 20 years. 81% (n=38) of HCPs indicated that the ESAS-r is a useful aid to documenting symptoms, while 72% (n=34) indicated that ESAS-r enables them to better manage patient symptoms. Patients completed a total of 208 surveys (return rate 42%). Patient respondents had an average age of 65, ranging from 31 - 88. 71% (n=140) of patients reported that their HCP team always responded to physical symptoms, while 60% (n=118) of patients reported that their HCP team always responded to emotional concerns. Discussion Results of this study will be used to improve the service delivery of symptom management in Northeast Ontario. Understanding cancer patients' perspectives' with symptom reporting in community hospitals will help plan the provision of cancer service delivery with the ultimate goal to improve quality of life.

Abstract Summary:

Patients in Northeast Ontario receiving cancer treatment are screened for distress to improve symptom management as part of a person-centred cancer care approach. Screening for distress is a rapid method to prospectively identify patients who may experience difficulty coping and adapting to their diagnosis and treatments of cancer due to high symptom burden. The purpose of this scientific mixed-methods research project (interviews and surveys) was to understand cancer patients' experiences completing patient reported outcomes measures (PROMs) and understand how they manage symptoms of distress. We also sought to understand HCPs' experiences in addressing cancer patients' symptoms of distress. This presentation will present findings from the survey portion of the study. Results of this study will be used to improve the service delivery of symptom management in Northeast Ontario.

Learning Objectives:

1. Describe how cancer patients manage symptoms of distress when living in rural and remote communities.
2. Describe how Health Care Professionals manage symptoms of distress in community hospitals.
3. Illustrate how survey results can be applied through a change management strategy to improve how clinicians respond to patients' distress scores.

References:

1. Smith, S., Loscalzo, M., Mayer, C., Rosenstein, D., (2018). Best Practices in Oncology Distress Management: Beyond the Screen, American Society of Clinical Oncology Education Book.
2. Chen J, Ou L, Hollis S. A systematic review of the impact of routine collection of patient reported outcome measures on patients, providers and health organizations in an oncologic setting. BMC Health Services Research 2013;13:211.
3. Kotronoulas G, Kearney N, Maguire R, et al. What is the value of the routine use of patient-reported outcome measures toward improvement of patient outcomes, processes of care, and health service outcomes in cancer care? A systematic review of controlled trials. J Clin Oncol 2014;32(14):1480-501.
4. Howell, D., Li, Madeline, Rosberger, Z., Montgomery, N., Mayer, C., Snider, A, Bryant-Lukosius, Hamel, M., Faria, R., Martelli, L., Macedo, A (2017). A person-centred e-proms multi-faceted intervention to improve patient experience and health outcomes: A multi-site implementation study in diverse ambulatory oncology practices. Journal of Clinical Oncology, 35:8, supplement, 182-182
5. Barbera, L., Atzema, C., Sutradhar, R., Seow, H., Howell, D., Husain, A., . . . Dudgeon, D. (2013). Do patient-reported symptoms predict emergency department visits in cancer patients? A population-based analysis. Annals of Emergency Medicine, 61(4), 427-437.

Keywords: Distress/CoC, Research

Course Designation: Ethics

Presentation Level: Intermediate

PO11

Title: Leading End-of-Life Conversations: Empowering Glioblastoma Patients to Incorporate Quality of Life Into Their Treatment

Author(s): Amy Bragman, MSW, LCSW; Melanie Cavazos, MSSW, LCSW; Megan Whetstone, MSW, LMSW

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Glioblastoma multiforme is the most common type of malignant brain tumor and carries a median survival of 12 to 15 months (Hemminger et al., 2017). With the recent diagnoses and deaths of well-known public figures, including John McCain, Beau Biden, and Ted Kennedy, glioblastoma has been gaining increasingly more national and worldwide attention. As oncology social workers, glioblastoma is a diagnosis we encounter daily. Glioblastoma patients typically undergo surgical resection of the tumor, radiation treatment, and chemotherapy. Throughout their treatment course, these patients often experience a wide array of symptoms affecting their quality of life, including fatigue, weakness, aphasia, cognitive decline, and seizures (Sizoo et al., 2010). Based on our clinical experience and literature review, initiating end-of-life conversations earlier in a glioblastoma patient's treatment course would be most beneficial to the patient, family, and medical team. Miranda et al. (2017) found that end-of-life conversations most commonly occur late in the patient's treatment course and do not accurately reflect the patient's values and goals. Due to the cognitive decline, fatigue, and aphasia that patients with glioblastoma often experience, it can be extremely challenging for them to engage in meaningful end-of-life conversations later in their disease process. Based on the research done by Miranda et al. (2017), glioblastoma patients typically rank life prolongation, mental awareness, support for their families, independence, and peace as their priorities when it comes to their care. Earlier conversations would provide patients with the opportunity to discuss their specific and individualized goals of care, particularly in relation to these quality of life issues. At present, neuro-oncology assessments of glioblastoma patients consist of a neurological exam, review of recent imaging, and Karnofsky Performance Scale (KPS) score. In order to accurately evaluate and address quality of life issues in these patients, it may be beneficial to incorporate a quality of life measure, such as the European Organisation for the Research and Treatment of Cancer Quality of Life Questionnaire Core 30 (EORTC QLQ-C30) or the Functional Assessment of Cancer Therapy – General (FACT-G), which have both been validated and widely used (Lockett et al., 2011). Additionally, social workers collaborate with their medical teams to increase frequency and comfort level of discussions about hospice and other palliative options with patients and their families. Based on the patient's individual performance status and quality of life preferences, hospice is likely an appropriate care plan for any patient with recurrent glioblastoma and should be a shared decision between the patient and their medical team (Patel, Neil, & Maiser, 2018). This poster will review current literature about quality of life measures and current trends in end-of-life care in glioblastoma patients. Next, we will utilize case studies to highlight social work interventions related to quality of life and end-of-life discussions. Finally, identify areas for further research to prioritize quality of life through multidisciplinary involvement in end-of-life decision-making.

Abstract Summary:

Glioblastoma multiforme is the most common type of malignant brain tumor and carries a median survival of 12 to 15 months (Hemminger et al., 2017). Due to the aggressive nature of this disease and the poor prognosis, it is important to engage patients and families in quality of life and end-of-life conversations early in their treatment course. Earlier conversations would provide patients with the opportunity to discuss their specific and individualized goals of care, particularly in relation to these quality of life issues. As oncology social work counselors, we can empower our patients in taking an active role in their care and lead our medical teams in having these difficult conversations with increased comfort level and frequency. Using current literature, case studies, and proposed areas for future research, we aim to assist patients and multidisciplinary teams to prioritize quality of life in end-of-life decision-making.

Learning Objectives:

1. Review current literature about quality of life measures and current trends in end-of-life care in glioblastoma patients.

2. Utilize case studies of glioblastoma patients to highlight social work interventions related to quality of life and end-of-life discussions.
3. Identify areas for further research to prioritize quality of life through multidisciplinary involvement in end-of-life decision-making.

References:

- Hemminger, L. E., Pittman, C. A., Korones, D.N., Serventi, J. N., Ladwig, S., Holloway, R. G., & Mohile, N. A. (2017). Palliative and end-of-life care in glioblastoma: Defining and measuring opportunities to improve care. *Neuro-Oncology Practice*, 4(3), 182-188. <https://doi.org/10.1093/nop/npw022>
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Keywords: Pain, Palliative Care and End of Life, Disease Type (ovarian, lung, GYN, etc.)

Course Designation: Clinical

Presentation Level: Intermediate

PO12

Title: The Social Work Role: Where Do Oncology Social Workers fit Into the Clinical Trial Process?

Author(s): *Thomas Verm, MSW, LMSW; Teresa van Oort, MHA, MSSW, LCSW*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Clinical trials are an integral part of the ongoing cancer research, as they aid in the creation of new treatments, improve existing treatments, and contribute to the scientific knowledge of oncology (Brandbery, Johnsson, & Bergenmar, 2015). Cancer patients and their caregivers can encounter a multitude of psychosocial barriers and challenges throughout the clinical trial process. The Oncology Social Worker's role when working with clinical trial patients is to address barriers including addressing feelings of anxiety and uncertainty, as well as, socio-economic logistical barriers. Previous research by the National Cancer Institute (Nass, Moses, & Mendelsohn, 2010) estimates that about 20-40% of patient's seen at community or academic medical centers are eligible to act as a participant in a clinical trial. This patient population can face a variety of challenges. This includes participation in the initial screening process, the comprehension of informed consent of information provided, and meeting bio-psycho-social needs experienced during participation as the patient's success in the program often depends on addressing such needs as financial, housing, and transportation needs with additional regard to emotional distress and the coping needs of the caregiver. At MD Anderson Cancer Center, Social Workers in the Lymphoma/Myeloma department have become a part of the treatment team for patients undergoing the Chimeric Antigen Receptor (CAR) T-cell therapy, which is an immunotherapy treatment taking the patient's own T-cells and genetically altering them to be able to recognize and attack cancer (MD Anderson.org, 2018). This poster will examine the social work role in the addressing the psychosocial challenges and barriers presented to clinical trial patients using case studies from CAR-T patients. This process usually includes pre-trail assessment, active participation in the trial, and addressing post-trail needs. As part of the interdisciplinary team, our role is to provide interventions necessary to meet the patient where they are involving the completion of psychosocial assessments, assistance in the

clarification of clinical trial logistical requirements based on conversation about consents, providing the provision of supportive counseling to address coping needs of patient and caregiver, and offering guidance regarding financial, housing, transportation and advance care planning resources.

Abstract Summary:

This poster will examine the social work role in the addressing the psychosocial challenges and barriers presented to clinical trial patients using case studies from CAR-T patients. This process usually includes pre-trial assessment, active participation in the trial, and addressing post-trial needs. As part of the interdisciplinary team, our role is to provide interventions necessary to meet the patient where they are involving the completion of psychosocial assessments, assistance in the clarification of clinical trial logistical requirements based on conversation about consents, providing the provision of supportive counseling to address coping needs of patient and caregiver, and offering guidance regarding financial, housing, transportation and advance care planning resources.

Learning Objectives:

1. Participants will open dialogue about the psychosocial, socio-economic, and logistical stressors of a patient in a clinical trial.
2. Participants will learn about the unique needs of patients enrolled in a clinical trial program.
3. Participants will learn about best practice methods to meet the aforementioned needs, with aid of case examples.

References:

Brandberg, Y., Johansson, H., & Bergenmar, M. (2016). Patients knowledge and perceived understanding – Associations with consenting to participate in cancer clinical trials. *Contemporary Clinical Trials Communications*, 2, 6-11. doi:10.1016/j.conctc.2015.12.001 MD Anderson (2018). CAR-T Cell Therapy. Retrieved from <https://www.mdanderson.org/treatment-options/car-t-cell-therapy.html> Nass, Moses, & Mendelsohn. (2010). A national cancer clinical trials system for the 21st century: Reinvigorating the NCI Cooperative Group Program. Washington, D.C.: National Academies Press.

Keywords: Clinical Practice/Skill Building, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Introductory

PO13

Title: Measuring What You Treasure: Outcome Evaluation of the Impact of Structured Peer Support Services for Young Women Facing Breast Cancer

Author(s): Adina Fleischmann, LSW; Elana Silber, MBA; Kathryn Rehberg, MA; Suzanne O'Neill, PhD; Kenneth Tercyak, PhD

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Background: Outcome measures assessing breast cancer support organizations' program impact on the constituents and communities they serve are essential to advancing national cancer control priorities. Yet few evidence-based tools exist for doing so, especially for key constructs such as satisfaction with program engagement among special populations. We sought to address this gap by developing and implementing new outcome evaluation measures, and examining their psychometric properties (factor structure, reliability, validity). Methods: We evaluated select information and support programs of Sharsheret -- a national nonprofit dedicated to helping all Jewish women and their families at-risk for and surviving with breast cancer. Outcome data were ascertained from 126 analytic cases ~30 days following engagement with Sharsheret's 1:1 peer support program: impact was indexed by both organizational and program-specific satisfaction. Measure development included both exploratory factor analysis (EFA) and scale **statistics. Results: The EFA**

revealed a 2-factor solution to the 9-item organizational satisfaction measure ($\alpha=.87$, $M=9.38$, $SD=1.34$): Scale 1) quality of specific support (6 items, $\alpha=.95$, $M=6.26$, $SD=1.05$), and Scale 2) quality of general support (3 items, $\alpha=.95$, $M=3.12$, $SD=0.56$). These factors/scales accounted for >85% of the variance in organizational satisfaction. For the 8-item peer support program satisfaction scale, >79% of its variance was accounted for by a single factor, resulting in an internally-consistent scale ($\alpha=.95$, $M=9.04$, $SD=2.00$). Together, these scales were highly correlated ($r's=.46-.61$, $p=.00$) and satisfaction was significantly higher for those who participated in the peer support program on quality of specific report ($p=.006$), and quality of general support ($p=.05$). Conclusions: The results suggest these scales have sound psychometric properties and are sensitive enough to be utilized in high-risk populations. Information gleaned from organizational satisfaction may however be moderated by participation in an organizations' key programs (e.g., peer support programs), suggesting higher engagement across domains is linked to overall organizational satisfaction.

Abstract Summary:

Outcome measures assessing breast cancer support organizations' program impact on the constituents and communities they serve are essential to advancing national cancer control priorities. Yet few evidence-based tools exist for doing so, especially for key constructs such as satisfaction with program engagement among special populations. We sought to address this gap by developing and implementing new outcome evaluation measures, and examining their psychometric properties (factor structure, reliability, validity). The results suggest these scales have sound psychometric properties and are sensitive enough to be utilized in high-risk populations. Information gleaned from organizational satisfaction may however be moderated by participation in an organizations' key programs (e.g., peer support programs), suggesting higher engagement across domains is linked to overall organizational satisfaction.

Learning Objectives:

1. Understand the impact of oncology support programs on national cancer control priorities.
2. Review the developed outcome evaluation measures and examine their psychometric properties (factor structure, reliability, validity).
3. Explore the impact of higher engagement across domains linking to overall organizational satisfaction.

References:

Tercyak, Kenneth P., Silber, Elana, Johnson, Andrea C., Fleischmann, Adina, Murphy, Sarah E., Mays, Darren, O'Neill, Suzanne C., Sharkey, Christina M. & Shoretz, Rochelle. (2015). Survey on Addressing the Information and Support Needs of Jewish Women at Increased Risk for or Diagnosed with Breast Cancer: The Sharsheret Experience Healthcare, 3(2), 324-337. doi:10.3390/healthcare3020324

Coreil J, Wilke J, Pintado I (2004) Cultural models of illness and recovery in breast cancer support groups. Qual Health Res 14(7):905–923. <https://doi.org/10.1177/1049732304266656>

Keywords: Special Populations, Research

Course Designation: Cultural Competency

Presentation Level: Introductory

PO14

Title: Breaking the Transportation Barrier: Enhancing Access to Cancer Treatment Through Navigation, Technology and Philanthropy

Author(s): *Rebecca Cammy, MSW, LCSW; Stephanie Chapman, BA*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Objective: The utilization of navigation support, technology-based platforms, and philanthropic funds to completely eliminate the transportation disparity for patients receiving cancer treatments. **Background:** Transportation has been identified as a significant barrier for patients needing cancer treatment such as chemotherapy or radiation. Access to

transportation resources is especially challenging for individuals traveling far distances for treatments that require repeat visits (Guidry, Aday, Zhang & Winn, 1997). Furthermore, elderly, racial and ethnic minorities, as well as patients with lower socioeconomic status and less social support have increased transportation needs (Zullig et al., 2012). As a result, patients with limited resources are often forced to pursue treatment centers based on geographic proximity and accessibility, regardless of the quality and effectiveness of care (Finlayson, Birkmeyer, Tosteson & Nease, 1999).

Method: The American Cancer Society (ACS) and the NCI-designated Sidney Kimmel Cancer Center (SKCC) at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania have focused efforts on increasing patient access to care. A full-time ACS patient navigator connects patients with appropriate resources including ACS volunteer driver and transportation resources, medical assistance transportation programs, community-based shared rides services for seniors and persons with disabilities, and private car services. SKCC has also collaborated with technology-based companies including Uber Health, RoundTrip, and Ride Health to ensure that all patients have access to transportation in order to be fully compliant with treatment regimens. In 2017, SKCC was awarded a \$50,000 philanthropic donation to completely eliminate the transportation disparity and promote access for all oncology patients. Results: SKCC at Jefferson, a large urban health system, provides care to a diverse patient population including a large number of underserved and underinsured individuals. Philadelphia represents a diverse population: 42% African American, 13% Hispanic or Latino, and almost 7% non-Hispanic Asian (US Census Bureau, 2010). Many patients experience financial toxicity stemming from treatment-related costs where the annual patient household income is \$16,500. In 2017, SKCC provided 2,877 rides to approximately 1,976 patients, which is equivalent to \$51,170 in support. These rides accommodated patients for medical oncology, radiation oncology, surgical oncology, and other cancer-related appointments. Conclusion: Through the utilization of patient-focused transportation platforms, oncology patients are more compliant with treatment regimens. Patients with a variety of physical limitations can also connect with wheelchair vans and stretcher support vehicles to get to and from appointments. Patients are empowered to act autonomously with instant pick-ups and reduced wait times, texting updates on ride arrival, and options for will-call returns. The ACS patient navigator is able to track rides in real-time and receive regular reports on ride usage. With support from philanthropy, the institution no longer has to bear the cost of the transportation burden. Practice implications: With an increasingly competitive market for technology-based platforms, institutions are looking for more cost-effective options to decrease missed appointments and ultimately increase patient compliance. Having one less stressor in the cancer journey is a powerful reliever of anxiety and worry for patients and families who are already overwhelmed and stretched so thinly.

Abstract Summary:

Cancer patients face many obstacles and challenges after being diagnosed with cancer. Thomas Jefferson University Hospitals' Sidney Kimmel Cancer Center (SKCC) has effectively eliminated transportation as a barrier to care for patients receiving cancer treatments such as chemotherapy and radiation. SKCC dedicates a full-time patient navigator to assess and connect patients with appropriate transportation resources based on location, insurance coverage, and mobility. The utilization of patient-focused transportation platforms, such as Uber Health, RoundTrip, and Ride Health have streamlined the process, while SKCC philanthropic funds have assisted with associated financial costs. As a result of these resources, oncology patients who would have ordinarily missed appointments due to lack of transportation are now more independent and compliant with cancer treatment.

Learning Objectives:

1. Evaluate predominant barriers to care including patient access to transportation for cancer treatments.
2. Institute the triple threat -- full time navigation, modern technology, and philanthropy -- to completely eliminate the transportation disparity in a large, urban medical setting.
3. Highlight an innovative model that empowers patients to be autonomous in care planning by taking responsibility in arranging transportation for treatment appointments with navigation support.

References:

Demographic Profile Data, American Fact Finder, US Census Bureau. (2010). Retrieved from <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF> Finlayson, S. R., Birkmeyer, J. D., Tosteson, A. N. & Nease, R. F. (1999). Patient preferences for location of care. *Medical Care*,37(2), 204-209.

doi:10.1097/00005650-199902000-00010 Guidry, J. J., Aday, L., Zhang, D. & Winn, R. J. (1997). Transportation as a barrier to Cancer treatment. *Cancer Practice*,5(6), 361-366. Zullig, L. L., Jackson, G. L., Provenzale, D., Griffin, J. M., Phelan, S. & Ryn, M. V. (2012). Transportation – A vehicle or roadblock to cancer care for VA patients with colorectal cancer? *Clinical Colorectal Cancer*, 11(1), 60-65. doi:10.1016/j.clcc.2011.05.001

Keywords: Patient Navigation, Financial Toxicity

Course Designation: Clinical

Presentation Level: Introductory

PO15

Title: Building an Innovative Supportive Care Program in Collaboration With a Cancer Institute's Patient and Family Advisory Council

Author(s): *Susan Garland, LICSW, OSW-C; Lynn Shaw, RN, BSN; Diane Passantino, LICSW; Carol Massey; Dana Del Bonis*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Background: Over the past 2 years the Lifespan Cancer Institute (LCI) Patient and Family Advisory Council (PFAC) worked in collaboration with the Institute's Clinical Social Workers and RN Patient Navigator to launch a new supportive care program, Peer to Peer Support Program. Since the initiation of the PFAC at Rhode Island Hospital, its members advocated for an avenue for outreaching patients and caregivers directly to offer support and a model of one who has walked in their path. The PFAC participated directly in the development of all phases of the program. The goal of the program is to offer patients or caregivers experiencing a cancer diagnosis face to face emotional, informational and social support from a trained volunteer guide. **Methods:** The LCI team, including 2 PFAC members, developed the program in 4 phases: program development, volunteer recruitment and training, patient and caregiver support visits and investigational opportunities. These opportunities include exploring the impact being a volunteer guide has on one's own survivorship as well as potential improvement in patient/caregiver satisfaction with medical care. Program development included a literature review, written proposal, bench marking with relevant oncology peer support programs and development of volunteer specialized training. The proposal was reviewed and approved by LCI and Social Work Leadership, as well as Corporate Compliance and Risk Management. Fourteen volunteers applied to the program completing application, reference check and personal interview. All attended the 5 hour training session held in April 2018. The session included structure and requirements of face to face visit, HIPPA, effective communication and listening skills, adjustment to cancer diagnosis, crisis intervention, types of cancer treatment and side effects as well as tips for caregivers and patients (presented by 2 PFAC members). **Results:** Following completion of the training and hospital based volunteer enrollment, support visits were initiated. Extensive outreach from the program staff to LCI health care professionals was provided throughout the process to recruit volunteers and patients and caregivers desiring support visits. A second volunteer training session is planned for the fall 2018, with an additional 10-15 volunteers anticipated. Feedback from the training evaluation tool completed following the first session will guide refinement of future training sessions. Support visits began summer 2018 for both patients and caregivers. Volunteers completed a self-assessment tool prior to their first support visit with a patient or caregiver. Support visit contact forms are completed after each visit and provided to program staff to address any unmet patient needs. **Conclusion:** Peer to Peer Support offers the Lifespan Cancer Institute a new avenue of patient and caregiver engagement across its 4 cancer centers. The program is inspired by the passion and belief of the PFAC members that their first-hand perspectives and experiences offer patients and caregivers supports through the expression of empathy, information and an example of one who has successfully navigated the cancer experience.

Abstract Summary:

This poster presents an innovative patient-centered supportive care program, Peer to Peer Support Program, inspired by the Lifespan Cancer Institute's Patient and Family Advisory Council (PFAC). The program connects trained volunteer guides with patients or caregivers to offer face to face emotional, informational and social support. PFAC members

participated in all phases of the development of the program. The program is offered to patients and caregivers of all four Lifespan Cancer Institute's centers. Fourteen volunteers participated in the initial specialized training session held in April 2018 with patient/caregiver support visits initiated summer 2018. A second volunteer specialized training session is planned for November 2018. The program aims to explore not only the impact of peer support on patients and caregivers, but also investigate the significance of the volunteer experience on cancer survivorship.

Learning Objectives:

1. Identify the necessary steps for creating an innovative cancer center's peer to peer support program.
2. Describe the collaborative process in working with a patient-centered advisory council to develop a peer to peer program.
3. Identify relevant research opportunities to expand the current knowledge base regarding the benefits of oncology peer to peer support for both volunteers and patients/caregivers.

References:

Bergin, R., Grogan, S., Bernshaw, D., Ilona, J., Penberthy, S., Mileskin, L., Krishnasamy, M. Hocking, A.Aranda, S.,& Schofield, P. (2016). Developing an Evidence-Based, Nurse-Led Psycho-educational Intervention With Peer Support In Gynecologic Oncology. *Cancer Nursing*, 39(2), 19-30.

Johnson, K., Mroz, T., Abraham, M., Gray, M.F., Minniti, M., Nickel, W., Reid, R., Sweeney, J., Frosch, D., Ness, D. & Hsu, C. (2016). Promoting Patient and Family Partnerships in Ambulatory Care Improvement: A Narrative Review and Focus Group Findings. *Adv Ther*, 33:1417-1439.

Lee, R., Lee, K.S., Oh, E. & Kim, S.H. (2013). A Randomized Trial of Dyadic Peer Support Intervention for Newly Diagnosed Breast Cancer Patients in Korea. *Cancer Nursing*, 36(3), 15-22.

Meyer, A. Coroiu, A. & Korner, A. (2015). One-to-one peer support in cancer care: a review of scholarship published between 2007 and 2014. *European Journal of Cancer Care*, 24. 299-312.

Keywords: Specialized Needs, Survivorship

Course Designation: Clinical

Presentation Level: Introductory

PO17

Title: Destressing the Staff: Initiation of Debriefing Sessions After Difficult ICU Cases—A Quality Initiative

Author(s): *Laura Walther-Broussard, LCSW, OSW-C; Annabelle Bitter, LCSW*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

Introduction: Multi-disciplinary debriefing sessions have been used at other institutions as a manner of dealing with staff members' unresolved feelings after difficult cases. During these sessions, facilitators encourage staff to discuss both rewarding and challenging aspects of management of these patients. Methods: In July 2016, the MD Anderson Cancer Center ICU Psychosocial Committee anonymously surveyed the staff members of the ICU regarding their feelings after difficult cases, as well as the perceived level of stress in the ICU due to the tasks inherent in job performance and methods of managing stress. Specific questions regarding the use of debriefing sessions were included with the survey. Responses on a Likert scale indicated that the staff was open to the use of debriefing sessions to assist with emotional dissonance and challenges experienced during care of certain patients. Difficult cases were identified by attending physicians and social workers. ICU staff members were also encouraged to contact the committee leadership to request a debriefing when needed. The sessions are led by ICU social workers in a structured manner and are attended by any interested healthcare provider. The session starts with a brief case review, followed by discussion of stressful aspects of care and wraps up with structured discussions of the staff's positive contributions to the patient regardless of outcome. Frustrating issues that occurred during care are discussed, but the facilitators also emphasize self-awareness of the positive impact of the caregiver in spite of obstacles. Evaluation forms are distributed at the conclusion of each

debriefing session and responses are yes/no, Likert scale and open-ended questions. Results: Since initiation of the program, nine debriefing sessions have occurred. Sessions are held in the afternoon after most services have completed formal daily rounds and are in an area immediately adjacent to the ICU. Six patients were deceased, two patients were discharged to the floor and one patient was transferred to an outside facility. Reasons for sessions included prolonged length of stay, perceived futility by care team, and cultural or social issues affecting interactions between family and the care staff. Sessions ranged from 30 to 60 minutes in duration. Participants include physicians, nurses, respiratory therapists, physical therapists and nursing assistants. All participants have agreed that the sessions are helpful with resolution of outstanding feelings and are personally meaningful. In addition, participants have indicated that they will continue to participate in sessions. Written and verbal feedback has revealed educational opportunities in cultural and religious diversity to better understand frame of reference in which difficult situations arise. Conclusions: Structured debriefing sessions assist healthcare providers in resolution of emotional challenges regarding a particular patient case and increase abilities of staff in management of future difficult cases. Intervention strategies are provided which can be carried forth in care of future patients. Staff are encouraged to recognize their meaningful contributions in spite of adverse circumstances. Interaction and feedback from participants can identify need for specific education regarding issues including cultural expectations, verbal de-escalation and self-care during times of stress.

Abstract Summary:

All levels of ICU staff deal with stressful patient situations. In addition, about 20% are more stressful due to cultural disparity, conflicting expectations of outcomes and need for continuous high level of care. This can lead to fatigue, burnout and lack of collegiality among various medical teams. Multi-disciplinary debriefing sessions led by social workers were used to encourage staff to discuss rewarding and challenging aspects of these patients. These were evaluated by participating staff with questions as well as Likert scale responses.

Learning Objectives:

1. Describe the structure/components of a debriefing session.
2. Consider the emotional impact of working with critically ill cancer patients has on staff caring for them.
3. Demonstrate the role of oncology social work in staff wellness.

References:

1. Salas E, Klein C, King H, et al. Debriefing medical teams: 12 evidence-based best practices and tips. *Jt Comm J Qual Patient Saf.* 2008 Sep; 34(9): 518-27. 2. Gaba D, Fish K, Howard S, et al. *Crisis Management in Anesthesiology*, 2nd ed. Elsevier, 2015.

Keywords: Self Care, Interdisciplinary Care

Course Designation: Cultural Competency

Presentation Level: Intermediate

PO18

Title: Oncology Caregiver Support: Build It and They Will Come

Author(s): Nancy Tharler, LICSW; Suzanne O'Regan, MSW, LICSW; Nancy Borstelmann, PhD, MPH, LICSW; Ruth Cope, PhD, LICSW

Date Scheduled:

6/5/19, 7:00 p.m. - 8:30 p.m.

Abstract Content:

At our comprehensive cancer center, a pilot program is being developed to deliver formal caregiver support embedded within our oncology clinics. Our goal is to establish a model for one-on-one caregiver assistance and provide barrier-free caregiver support. In oncology care, there is a wealth of evidence-based research highlighting the need for caregiver support (Kent, Rowland, Northhouse, Litzelman, Wen-Ying, Shen, Turner, Franks, Hoss, 2016). In psychosocial oncology, a range of caregiver resources is provided, generally aiming to support family members and

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friends including: websites, apps, support groups, psycho-educational programs and reference-room materials. However, we know—through research findings and anecdotal feedback—that caregivers are often overwhelmed trying to sort through all the options to promote effective coping. Subsequently, getting support becomes an additional task for the already burdened caregiver. The research indicates a need for readily available and individualized information and resources (Lund, Ross, Petersen, Groenvold, 2014). We identify cancer as a “family” illness. In 2015, the National Alliance for Caregiving and AARP, approximated “43.5 million caregivers have provided unpaid care to an adult or child in the last 12 months” (Family Caregiver Alliance, 2016). Patient and caregiver experiences are inextricably linked; the physical and mental health of both can be positively or negatively affected by access or lack thereof to pertinent resources. If the caregiver feels well supported, their enhanced coping skills will ultimately benefit the patient’s well-being. There has been insufficient attention and awareness to the pivotal role of caregivers with risk for resource underutilization. In our pilot support project, we propose to provide caregivers with the assistance they need in a more formalized manner. If our resource information centers become part of the natural landscape of our oncology clinics, we hope to promote recognition of the role of the caregiver; reduction of caregiver guilt around tending to their own needs; acknowledgment of caregiver fatigue; increased use of internal and external resources; peer-to-peer caregiver connection; introduction of services such as: hand massage, Reiki, chair massage, meditation and orientation to cancer center supportive services (Porter, Dionne-Odom, 2017). With the discovery of gene mutations and targeted therapies, our patients with cancer are living longer, correlating increase in need for caregiver support. A caregiver roadmap will provide direction for improved patient and caregiver outcomes. This pilot project is in keeping with the recent Congressional passage of the RAISE Family Caregiver Act (Recognize, Assist, Include, Support and Engage) signed into law on January 23, 2018 (Howrey, M.M. 2018). In our role as oncology nurses, we are charged with embracing the national roll out of caring for our caregivers. Our pilot project is a step toward addressing the unmet emotional and practical care needs of caregivers.

Abstract Summary:

At our comprehensive cancer center, a pilot project is being developed to deliver formal caregiver support embedded within our oncology clinics. Our goal is to establish defined locations for one-on-one caregiver assistance and provide barrier-free caregiver support. Patient and caregiver experiences are inextricably linked; the physical and mental health of both can be positively or negatively affected by access or lack thereof to pertinent resources. If the caregiver feels well supported, their enhanced coping skills will ultimately benefit the patient’s well-being.

Learning Objectives:

1. Apply, recognize, create and implement opportunities to formalize caregiver support within your organization.
2. Provide barrier-free caregiver support with embedded resource provision and psycho-education, thereby reducing the risk for resource underutilization by underserved and diverse populations.
3. Discuss a model for providing an embedded caregiver resource center that is in alignment with the the RAISE Family Caregiver’s Act of January 23, 2018.

References:

Howrey, M. M. (2018). Health sciences library outreach to family caregivers: A call to service. *Journal of the Medical Library Association*, 106(2), 251-258. doi:10.5195/jmla.2018.390

Porter, L.S., Dionne-Odom, N.J. (2017) Supporting cancer family caregivers: How can frontline oncology clinicians help? *Cancer*, 2017 Sep 1: 123 (17); 3212-3215, doi 10.1002/cncr.30759

Lund, L., Ross, L., Petersen, M.A., Groenvold, M (2014) Cancer caregiving tasks and consequences and their associations with caregiver status and the caregiver’s relationship to the patient: a survey. *BMC Cancer*, 2014;14:541, doi: 10.1186/1471-2407-14-541

Kent, E. E., Rowland, J. H., Northouse, L., Litzelman, K., Chou, W. S., Shelburne, N., Timura, K., O’Mara, A., Huss, K. (2016). Caring for caregivers and patients: Research and clinical priorities for informal cancer caregiving. *Cancer*, 122(13), 1987-1995. doi:10.1002/cncr.29939

Litzelman K, Kent EE, Mollica M, Rowland JH. (2016) How Does Caregiver Well-Being Relate to Perceived Quality of Care in Patients With Cancer? Exploring Associations and Pathways. *J Clin Oncol*. 2016 Washington, K. T., Pike, K. C., Demir, G., & Oliver, D. P. (2014). Unique characteristics of informal hospice cancer caregiving. *Supportive Care in Cancer*, 23(7), 2121-2128. doi:10.1007/s00520-014-2570-z

Alliance, Family Caregiver. “Caregiver Statistics: Demographics.” Selected Long-Term Care Statistics | Family Caregiver Alliance, Family Caregiver Alliance, 2016, www.caregiver.org/print/23216

Keywords: Special Populations, Education

Course Designation: Clinical Presentation

Level: Advanced

PO19

Title: Creating Emotional Safety: The Critical Role of Assessment in Building Online Communities

Author(s): *Caroline Edlund, LCSW-R*

Date Scheduled:

6/5/19, 7:00 p.m. – 8:30 p.m.

Abstract Content:

As oncology social workers, we understand that professionally-led support groups can offer important psychosocial and concrete benefits to the cancer patients and cancer caregivers who participate. Core psychosocial benefits of participation can range from reductions in depression and anxiety symptoms to reduced isolation, enhanced coping and communication skills, and better access to information and supportive resources (Docherty, 2004). The presence of a professional moderator is perhaps one important predictor of these positive group outcomes. Another important factor is the perception of emotional safety – or an “oasis” – experienced within the group space itself. This is especially true and necessary for online support communities where explicit and implicit communications cues are not readily apparent. To build and maintain a sense of safety in online communities, group moderators can expand on standard clinical interventions employed in the group space like engagement and validation. Importantly, moderators can also take key steps before the group even begins – in the form of a careful pre-screening assessment of the group’s prospective members. While traditionally the concept of pre-screening has been applied within therapeutic process groups rather than peer support groups, it has an essential role in building and sustaining online cancer communities. When online group members experience their groups as safe, they will be more likely to share about themselves and their circumstances in open and honest ways, more likely to create rich and meaningful connections based on shared personal disclosure, and more likely to reap the core psychosocial benefits cited above. This poster presentation will examine the screening methods and rationale employed by oncology social workers as they determine the membership of 15-week online support groups designed to separately serve adult cancer patients, cancer caregivers, and the bereaved. The screening model consists of a thorough psychosocial assessment of each prospective member’s current stressors, degree of emotional coping, available social support networks, previous group experiences if applicable, and hopes and expectations for their upcoming online group experience. Armed with this information, this model can enable oncology social workers to make a more educated determination of whether someone’s emotional and concrete needs may be met within an online group space. The author will address reasons why this assessment can be critical in both creating and maintaining an essential sense of safety within an online community because of unique aspects of the online medium. The author will provide feedback from approved group members about their group experience and how they understand the concept of “safety.” The author will also provide examples of when and why prospective group members are screened out as well as limitations of the screening model. Presentation will include literature review and testimonials.

Abstract Summary:

As oncology support groups increasingly occur online, group protocols should expand to better meet and function alongside unique aspects of the medium. In building online cancer communities, online group moderators can maximize outcomes by taking steps to ensure an essential sense of safety through pre-screening assessment.

Learning Objectives:

1. Define new practice in online community development
2. Recognize the impact of pre-screening assessment on online community dynamics and outcomes
3. Assess how pre-screening has particular utility within online communities due to unique aspects of the online medium

References:

Barak, A., Boniel-Nissim, M., Suler, J. Fostering Empowerment in online support groups. *Computers in Human Behavior*. 2008; 24(1), 1867-1883. Batenburg, A., Das, Enny. Emotional Coping Differences Among Breast Cancer Patients From an Online Support Group: A Cross-Sectional Study. *Journal of Medical Internet Research*. 2014; 16(2): e28. Docherty, A. Experience, functions, and benefits of a cancer support group. *Patient Counseling and Education*. 2004; 55(1), 87-93. Grande, G.E., Myers, L.B., Sutton, S.R. How Do Patients Who Participate in Cancer Support Groups Differ From Those Who Do Not? *Psycho-Oncology*. 2006; 15(1), 321-334. Ren, Y. et al. Building Member Attachment in Online Communities: Applying Theories of Group Identity and Interpersonal Bonds. *MIS Quarterly*. 2012 36(3), 841-864. Uden-Kraan, C., Drossaert, C., Tall, E., Shaw, B. R., Seydel, E.R., van de Laar, M. Empowering Processes and Outcomes of Participation in Online Support Groups for Patients with Breast Cancer, Arthritis, or Fibromyalgia. *Qualitative Health Research*. 2008; 18(3), 405-417. Yalom, I.D. (2005). The Selection of Clients. In *The Theory and Practice of Group Psychotherapy*. (pp. 233-256). New York, NY: Basic Books. Young, C. Community Management That Works: How to Build and Sustain a Thriving Online Health Community. *Journal of Medical Internet Research*. 2013. 15(6). Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3713910/>.

Keywords: Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Introductory

AOSW 35TH ANNUAL CONFERENCE ABSTRACT BOOK
THURSDAY, JUNE 6, 2019

CLINICAL PRACTICE INTENSIVE SESSIONS

Title: Learning to Lead: The Social Worker's Role in Developing and Demonstrating Leadership Skills and Organizational Competence in Today's Health Care System

Author(s): Julie Ackerman, MSW, LCSW; Darah Curran, MSW, LCSW

Date Scheduled:

6/6/2019, 8:30am - 10:00am

Abstract Content:

Historically, social work began with a twofold micro-macro mission. There were pioneers like Mary Richmond who focused on serving individuals and families, while Jane Adams focused on social reform through environmental and organizational change (Rothman & Mizrahi, 2014). Today, however, there appears to be a shortage of social workers focusing on macro practice. Data from the 2014 survey by the Council on Social Work Education (CSWE) indicated that only 6% of 37,699 MSW students were in macro-oriented placements that emphasized community development or planning, administration, advocacy, or social policy (CSWE, 2014). The NASW Code of Ethics mandates administrative competence. Unfortunately, there is a leadership crisis in the field of social work administration, with experienced leaders leaving the field altogether (Watson & Hoefler, 2016). As healthcare shifts to an integrated model of care, it is no longer sufficient for social workers to be exclusively clinically competent; social workers must also be aware of organizational factors that influence and drive clinical practice in order to provide optimal care to patients (Spitzer, Silverman & Allen, 2015). Oncology social workers may be excellent clinicians, but if they are not able to navigate their organization and work within the organizational confines, they will be unable to produce maximum results for patients. It is therefore imperative that social workers learn to lead with organizational competence rather than solely social work ideology, which is often in direct contrast to other stakeholder perspectives and priorities (Spitzer, Silverman & Allen, 2015). Many times clinicians are promoted into management because they are skilled clinicians, trained as therapists and not as managers, with no metrics or standards for measuring productivity or effectiveness (Bennett, 2017). By learning evidence based leadership styles, oncology social workers can implement strategies proven to be effective in motivating others, increasing morale, affecting results, and creating cultural change in organizations; whether they are a manager or working independently in their organization. Transformational leadership is one effective model for social workers in the healthcare setting. This style of leadership strives to develop followers into leaders, bring about cultural change in an organization, and attempts to advance the needs of followers to higher levels (Gellis, 2001). Transactional leadership, on the other hand, focuses more on managerial tasks and the exchange of rewards for tasks completed by workers (Shearer, 2012). Servant leadership is another style practiced in the healthcare setting that aligns nicely with the ideals of social work, such as creating an encouraging environment, and seeking the ideas and unique contributions of others (Cable, 2018). This style of leadership "inverts the pyramid" of the organization so that leaders are on the bottom of the pyramid serving all other members of the organization (Heyler & Martin, 2018). All three of these leadership styles have characteristics that oncology social workers can easily adopt to sharpen their leadership skills in any setting. Oncology social workers are reminded that they can be leaders at all levels, irrelevant of the unit, department, medical specialty or setting in which they practice (Case Management Monthly, 2017).

Abstract Summary:

Historically, social work began with a twofold micro-macro mission. Today, however, there appears to be a shortage of social workers focusing on macro practice, which includes leadership and organizational competence (CSWE, 2014). As healthcare shifts to an integrated model of care, it is no longer sufficient for social workers to be exclusively clinically competent; social workers must be aware of organizational factors that influence and drive clinical practice in order to provide optimal care to patients (Spitzer, Silverman & Allen, 2015). By learning evidenced based leadership styles,

oncology social workers can implement strategies proven to be effective in motivating others, increasing morale, getting results, and creating cultural change in organizations; whether they are a manager or working independently in their organization. Oncology social workers are reminded they can be leaders at all levels; irrelevant of the unit, department, medical specialty or setting in which they practice (Case Management Monthly, 2017).

Learning Objectives:

1. Describe barriers to social work leadership in the healthcare setting and opportunities to overcome these obstacles.
2. Identify three leadership models and significance for oncology social work leaders in the healthcare environment.
3. Define formal and informal leadership and ways in which leader attributes have the ability to increase oncology social work influence within the healthcare organization.

Outline:

- 8:30 a.m. – 9:00 a.m. Describe barriers to social work leadership in the health care setting and opportunities to overcome these obstacles.
- 9:00 a.m. – 9:30 a.m. Identify three leadership models and significance for oncology social work leaders in the health care environment.
- 9:30 a.m. – 10:00 a.m. Define formal and informal leadership and ways in which leader attributes have the ability to increase oncology social work influence within the healthcare organization.

References:

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Keywords: Leadership/Administration

Course Designation: Clinical

Presentation Level: Intermediate

Title: Advancing Oncology Social Work Leadership: Articulating Our Value

Author(s): *Iris Fineberg, PhD, MSW, ACSW, OSW-C, FAOSW; Shirley Otis-Green, MSW, MA, ACSW, LCSW, OSW-C*

Date Scheduled:

6/6/2019, 10:30am - Noon

Abstract Content:

Oncology social work leadership takes various forms, and central to this leadership is communication about what oncology social workers do and why it matters. Current and evolving models of health care delivery, such as value-based care and integrated health care, bring great potential for social workers to have significant roles in shaping and delivering oncology care. These health care models contain central elements that have long been core to social work, making social workers particularly well suited and prepared to have prominent presence in these models. Concepts such as providing well-coordinated interdisciplinary care, focusing on the person, and considering environmental factors (including social determinants of health) are important elements in the health care models and highly familiar areas of practice for social workers. In order for patients, families, colleagues, program managers, administrators and potential funders to realize the strengths that social workers bring, social workers need to be adept at articulating what they do and why it is relevant and important to the goals of the audience. This learning institute will focus on developing and refining language about what oncology social workers do, tailored to several different audiences with whom social workers interact. The session will introduce and review the theoretical connections between emerging health care models and social work to illuminate the potential roles and opportunities for oncology social workers. Session participants will have the opportunity to work together to develop and refine messaging and phrasing to use with varied audiences in order to articulate oncology social work contributions and value. Participants will leave the session equipped with conceptual and concrete tools to help them build and demonstrate their leadership in oncology care.

Abstract Summary:

Oncology social work leadership takes various forms, and central to this leadership is communication about what oncology social workers do and why it matters. Current and evolving models of health care delivery, such as value-based care and integrated health care, bring great potential for social workers to have significant roles in shaping and delivering oncology care. In order for patients, families, colleagues, program managers, administrators and potential funders to realize the strengths that social workers bring, social workers need to be adept at articulating what they do and why it is relevant and important to the goals of the audience. This learning institute will focus on developing and

refining language about what oncology social workers do, tailored to these varied audiences. Participants will leave the session equipped with conceptual and concrete tools to help them build and demonstrate their leadership in oncology care.

Learning Objectives:

1. Describe currently emerging models of health care that influence the context and practice of oncology social work.
2. Identify the intersection of theoretical tenets underlying emerging models of health care and existing theoretical tenets of oncology social work.
3. Articulate what they do and why it is valuable to a number of audiences such as patients and families, health care colleagues, and administrators.

Outline:

- 10:30 a.m. – 11:00 a.m. Identify currently emerging models of health care that influence the context and practice of oncology social work.
- 11:00 a.m. – 11:30 a.m. Identify the intersection of theoretical tenets underlying emerging models of health care and existing theoretical tenets of oncology social work.
- 11:30 a.m. – Noon Session participants will be able to articulate what they do and why it is valuable to a number of audiences such as patients and families, health care colleagues, and administrators.

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(*Contributed equally as first authors)
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Keywords: Professional Issues, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Introductory

Title: “We Treat Everyone The Same”: Fostering Health Equity for Sexual and Gender Minorities

Author(s): *Mandi Pratt-Chapman, MA*

Date Scheduled:

Abstract Content:

One of the most common mistakes clinicians make is treating everyone the same. Health equity requires that patients be treated in a culturally-responsive way based on need, rather than being treated “the same.” Oncology social workers can play a leadership role in the provision of affirming care to sexual and gender minorities (SGM), also referred to as LGBTQI patients, by modeling culturally responsive communication and championing systems changes. SGM have been largely invisible in health care delivery and health services research until recently. Emerging work has demonstrated poorer health promotion behaviors, health care avoidance, and health disparities among SGM due to chronic social stigma and past or anticipated discrimination, including outright denial of care (Dowshen, et al., 2013). SGM have statistically higher tobacco, alcohol and substance abuse rates compared to heterosexual and cisgender peers, increasing SGM risks for cancer and chronic disease (Cochran, Bandiera & Mays, 2013; Coulter et al., 2018; Gonzales, Przedworksi and Henning-Smith, 2016). SGM also experience access to care barriers, including health care avoidance, discrimination, and denial of care (National Women’s Law Center, 2014; Obedin-Maliver, et al., 2011). In 2018, thirty-seven discrimination complaints to the U.S. Health and Human Services (HHS) from transgender patients denied routine health care were discovered (Diamond, 2018). This half-day workshop is grounded in the fundamental cause theory and knowledge translation theory. Fundamental cause theory suggests that multiple mechanisms work together and evolve to perpetuate health inequities (Hazenbuehler, Phelan and Link, 2015). Stigma is viewed as the fundamental cause. Intrapersonal, interpersonal and system-level factors that reinforce stigma of SGM people will be explored. This theory draws from minority stress theory and identity threat models (Meyer, 2003; Major and O’Brien, 2005). Drawing from knowledge translation theory (Kolb and Kolb, 2013), the workshop will use interactive learning activities to reinforce knowledge and apply knowledge through role play. At the conclusion of the workshop, participants will be able to: 1. Recognize that individuals identify with multiple, overlapping social categories 2. Describe interpersonal and system-level factors that reinforce health inequity 3. Apply ethical principles to gay, bisexual, transgender, and intersex care scenarios Oncology social workers are well positioned to identify opportunities for change to improve health equity for SGM. This workshop will equip participants with foundational knowledge, encourage self-reflection, and provide opportunities to practice application of new knowledge in a safe environment.

Abstract Summary:

Oncology social workers are well positioned to identify opportunities to improve health equity for sexual and gender minority patients. This workshop will equip participants with foundational terminology and knowledge about lesbian, gay, bisexual, transgender, and intersex people; encourage self-reflection; and provide opportunities to practice application of new knowledge in a safe environment.

Learning Objectives:

1. Recognize that individuals identify with multiple, overlapping social categories.
2. Describe interpersonal and system-level factors that reinforce health inequity.
3. Apply ethical principles to gay, bisexual, transgender, and intersex care scenarios.

Outline:

- 8:30 a.m. – 9:00 a.m. The session will start with a pre-session assessment followed by an introduction to LGBTQI statistics and health inequities. The first portion of the session will include lecture, video and individual reflection on sex, sexual orientation, gender identity and gender expression.
- 9:00 a.m. – 9:30 a.m. Ethical considerations of caring for sexual and gender minorities and why discrimination happens will be explored through video and self-reflection.
- 9:30 a.m. – 10:00 a.m. Small groups will discuss case vignettes of challenging LGBTQI clinical scenarios.
- 10:30 a.m. – 11:00 a.m. Each group will select a reporter to report to the large group what the highlights of the small group discussion included.
- 11:00 a.m. – 11:30 a.m. We will explore ways to respond in a situation where a colleague is insensitive to a patient’s identity. Three volunteers needed for a role play!

- 11:30 a.m. – Noon A discussion of personal and system-level strategies for more affirming care of sexual and gender minorities will lead to individual action planning to bring your new knowledge back to your workplace. We will wrap up with a post-session evaluation.

References:

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Coulter, R.W.S., Bersamin, M., Russell, S.T., & Mair, C. (2018). The effects of gender- and sexuality-based harassment on lesbian, gay, bisexual, and transgender substance use disparities. *Journal of Adolescent Health, 62*(6), 688-700.

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Keywords: Special Populations, Clinical Practice/Skill Building

Course Designation: Cultural Competency

Presentation Level: Introductory

Title: Practice-Informed Research for Oncology Social Workers 101: From Practice Experience to Scientific Inquiry

Author(s): Heather Goltz, PhD, LMSW, MEd; Chiara Acquati, PhD, MSW

Date Scheduled:

6/6/2019, 8:30am - Noon

Abstract Content:

Over the past decade, social work professional societies have revised recommendations and standards for education, practice, and research in response to a volatile sociocultural and political environment. In 2012, the American Academy of Social Work and Social Welfare (AASWSW) launched its Grand Challenges for Social Work initiative, resulting in 12 highly-ambitious goals with far-reaching societal implications, including “clos(ing) the health gap” and “advanc(ing) long and productive lives” (AASWSW, 2018). During this same year, the Association of Oncology Social Work (AOSW) released its Standards of Practice in Oncology Social Work in 2012. The first AOSW Standard of Practice specifies that oncology social workers (OSWs) must hold master’s degrees from Council on Social Work Education (CSWE)-accredited programs, while the remaining standards outline services to patients and families, institutions/centers, the community, and the

profession (AOSW, 2012). Standards II-V specifically include research as a component of clinical and programmatic service provision or addressing the needs of stakeholders at various levels (e.g., Standard II. Services to Patient and Families, “L. Development and utilization of research to improve clinical practice and implement evidence-based psychosocial support programs, services and interventions”; and Standard V. Services to the Profession, “I. Development of research based knowledge that relates to clinical issues, interventions and outcomes”). As of 2015, the CSWE Educational Policy and Accreditation Standards (EPAS) set a “threshold for professional competence” via nine competencies, including Competency 4 that requires the knowledge, values, skills, and cognitive and affective processes to “engage in practice-informed research and research-informed practice” (CSWE, 2015). Thus, all OSW should have some degree of competence in research to meet the AOSW Standards of Practice and to contribute to the Grand Challenges. It is unclear how experienced OSW, whose academic experiences may pre-date these initiatives, will develop the competencies necessary to serve as practitioner-researchers in their clinical settings. The existing literature primarily focuses on social work students and supports training in applied, collaborative research (Gehlert et al., 2017; Lein et al., 2017) that is community-based (Gehlert et al., 2017; Kwong, 2017; Lein et al., 2017) and utilizes experiential learning (Kwong, 2017). Few professional development trainings focus on developing research ethics and competency among current practitioners. The proposed 4-hour workshop provides an overview of practice-informed research from ethics to development of research questions and building multidisciplinary teams to selection of appropriate and feasible context-specific study designs and methodologies. Presenters will utilize case examples, small group discussions, brief one-on-one consultations, and other learning strategies. Participants should bring a laptop or other electronic device and will receive a workbook containing templates and other materials. OSWs who complete this workshop will be able to use the knowledge and skills gained in this workshop to 1) effectively design and implement basic quality improvement or outcomes projects in their oncology settings; and 2) develop and submit abstracts for presenting at future AOSW meetings.

Abstract Summary:

In 2012, the American Academy of Social Work and Social Welfare launched its Grand Challenges for Social Work, which include “clos(ing) the health gap” and “advanc(ing) long and productive lives” (AASWSW, 2018). During this same year, the Association of Oncology Social Work released its Standards of Practice in Oncology Social Work in 2012. Given the recent adoption of competency-based social work education, all oncology social workers (OSW) will need some degree research competence to meet the Standards of Practice and to contribute to the Grand Challenges. The proposed 4-hour workshop provides an overview of practice-informed research from ethics to developing research questions and building multidisciplinary teams to selecting appropriate and feasible context-specific study designs and methodologies. Presenters will utilize case examples, small group discussions, brief one-on-one consultations, and other learning strategies. Participants should bring a laptop or other electronic device and will receive a workbook containing templates and other materials.

Learning Objectives:

1. Employ ethical decision-making by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research and additional codes of ethics as appropriate to context. (CSWE 2015 EPAS Competency 1: Behavior 1)
2. Utilize practice experience and theory to inform scientific inquiry and research. (CSWE 2015 EPAS Competency 4: Behavior 11)
3. Select and use appropriate methods for evaluation of outcomes. (CSWE 2015 EPAS Competency 9: Behavior 28)

Outline:

- 8:30 a.m. – 8:35 a.m. Introductions and Expectations
- 8:35 a.m. – 9:10 a.m. Didactic Training on Research Ethics; Literature Reviews; Research Topic vs. Research Questions & Hypotheses
- 9:10 a.m. – 9:40 a.m. How trauma history can the impact health and functioning
- 9:40 a.m. – 10:00 a.m. Skills Training: Identifying Gaps in Practice and the Existing Literature; Developing a Research Question

- 10:30 a.m. – 11:15 a.m. Didactic Training Part II – Research Designs (Non-Experimental, Quasi-Experimental); Qualitative, Quantitative, and Mixed Approaches
- 11:15 a.m. – 11:45 a.m. Skills Training Part II -- Putting It All Together & Next Steps
- 11:45 a.m. – Noon Conclusion and References to AOSW member benefits (Research SIG)

References:

1. American Academy of Social Work and Social Welfare (AASWSW) Grand Challenges for Social Work. (2018). Retrieved on September 6, 2018, from AASWSW website: <http://aaswsw.org/grand-challenges-initiative/>
2. Association of Oncology Social Work (AOSW) standards of practice in oncology social work. (2012). Retrieved on September 6, 2018, from AOSW website: <http://www.aosw.org/professional-development/standards-of-practice/>
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Keywords: Research, Education

Course Designation: Clinical

Presentation Level: Introductory

Title: Saying Goodbye: Ourselves, Our Patients, Our Caregivers

Author(s): *Patrice Al-Shatti, LMSW; Ellen Levine, MSW, LCSW, OSW-CE*

Date Scheduled:

6/6/2019, 8:30am - Noon

Abstract Content:

There are many paths to saying goodbye to your career, but someday we all must do it. And the psychological struggles embedded in this process can parallel the challenges our patients and caregivers face when confronted with changes forced upon them by illness. When you feel dissatisfied, disengaged, disoriented, disenchanting and de-identified with your career, an ending may be knocking on the door or you may instead be feeling the whispers of compassion fatigue. These situations require different responses. The first is calling you to construct a new life and the second to fine tune your response to stress. How can we tell the difference? And are there seasons in our lives for each of these circumstances?

If you face a true transition, you must first struggle through a neutral zone where you aren't what you were, but also aren't what you will become. The pressure to recreate one's self can be enormous but the process can't be rushed. You must also consider the implications of staying where you are when you should be heading elsewhere. We may not be able to give our patients our best at those times, and the ethical struggle is recognizing when the best way to care for your patients is stepping back and allowing someone else to do it.

Our patients and caregivers have their own roles to juggle when they come to us and, over time, it may be clear to them that the old way of living can't continue. Transition must begin. Patients seeking reasonable accommodation at their jobs may find that they can't really do the work any longer. Caregivers may find that a career that they loved, or that paid the bills nicely, can't coexist with compelling needs at home. They can, at times, have many things to say goodbye to, and the struggle through transition and identity stress involves the same universal fears of change and loss of self as those we feel when compelled to leave roles we once loved.

This clinical practice intensive will bring you two presenters who have navigated this challenge and come out the other side. Their transitions represent both sudden change resulting from external pressures and incremental change resulting from growing awareness. We will explore these paths to career change and the theories that underlay all adult life transition. We will explore strategies for identifying a true developmental transition versus compassion fatigue and ramifications for ethical practice during these times. We will also explore the parallels with the patient and caregiver experience. Lastly, we will engage in small group discussion and support to make these ideas personal and practical. Are you feeling the pull? Someday you will. Saying goodbye is both opportunity and challenge. Learn what you will need to know so that you flourish, throughout the transitions that your life brings.

Abstract Summary:

There are many paths to saying goodbye to your career, but someday we all must do it. And the struggles embedded in this process can parallel those our patients and caregivers face. When you feel dissatisfied, disengaged, disoriented, disenchanted and deidentified with your career, an ending may be arriving or you may be hearing the whispers of compassion fatigue. These situations require different responses. The first is calling you to construct a new life and the second to fine tune your response to stress. Our patients and caregivers have their own career transitions to face. Patients seeking reasonable accommodation may find that they can't really do their work well any longer and caregivers may find that a career can't coexist with compelling needs at home. They have many things to say goodbye to, and the struggle involves the same fears as those we feel when compelled to leave roles we once loved. This clinical practice intensive will bring you two presenters who navigated this challenge and came out the other side. We will explore strategies for identifying a true developmental transition versus compassion fatigue and ramifications for ethical practice during these times. We will also explore the parallels with the patient and caregiver experience. We will also engage in small group discussion to make these ideas personal and practical. Are you feeling the pull? Someday you will. Learn what you will need to know so that you flourish, throughout the transitions that your life brings.

Learning Objectives:

1. Describe at least one theory of adult transition and articulate several reasons why patients and family member might face career transition.
2. Examine their own life experiences, particularly as related to career, and assess for the signs of transition.
3. Identify several differences between career burnout and career transition.

Outline:

- 8:30 a.m. – 8:45 a.m. Introductions & Transition Stories
- 8:45 a.m. – 9:30 a.m. Overview of transitions perspective on adult development, how to identify approaching transitions/endings, life in cocooning/neutral zone, overview of patient/family member parallels
- 9:30 a.m. – 9:50 a.m. Small group activity on transition
- 9:50 a.m. – 10:00 a.m. Questions/report back from groups
- 10:30 a.m. – 11:15 a.m. Overview of compassion fatigue, signs and symptoms, risk factors, differential diagnosis, strategies for coping
- 11:15 a.m. – 11:30 a.m. Ethical caregiving when facing transition/compassion fatigue
- 11:30 a.m. – 11:45 a.m. Small group activity on compassion fatigue and differential diagnosis.
- 11:45 a.m. – Noon. Report back from groups and wrap up

References:

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Keywords: Leadership/Administration, Professional Issues

Course Designation: Clinical

Presentation Level: Intermediate

Title: In the Eye of the Beholder: Recognizing Our Unconscious Bias in Oncology Social Work Practice

Author(s): Jennifer Dunn, MSW, LCSW, OSW-C; Eucharika Borden, MSW, LCSW, OSW-C; Susan Hedlund, MSW, LCSW, OSW-C, FAOSW

Date Scheduled:

6/6/2019, 8:30am - Noon

Abstract Content:

The 2016 AOSW Membership survey revealed a lack of diversity among Oncology Social Workers with approximately 90 percent identifying as Caucasian. As a result, the AOSW Board of Directors overwhelmingly approved a Diversity and Inclusion statement aimed at recruiting and retaining professionals to build a community that reflects all people affected by cancer. The Diversity and Inclusion goals of the AOSW align with those of other leading health care organizations who recognize the importance of racial and ethnic diversity among health care providers as essential to assuring high-quality cancer care to minority populations. Although the causes are multifactorial, The Institute of Medicine attributes lack of diversity and the propensity of unconscious bias as contributing factors to health care disparities and inequalities that are well documented in cancer care. Through a combination of videos, self-reflection exercises and group interaction, this presentation aims to explore how lack of diversity and unconscious bias impacts our healthcare settings and practices. Participants will demonstrate an understanding of unconscious bias, as well as develop an awareness for exploring blind spots within themselves and how unconscious bias impacts communication and interactions with diverse patients, clients and colleagues. Participants will consider how to use this information to mitigate unconscious bias in clinical practice, as well as in their health care settings. The AOSW Diversity and Inclusion Toolkit will be introduced to participants who will explore ways to incorporate tools and strategies into their practice and health care setting.

Abstract Summary:

The 2016 AOSW Membership survey revealed a lack of diversity among Oncology Social Workers with approximately 90 percent identifying as Caucasian. As a result, the AOSW Board of Directors overwhelmingly approved a Diversity and Inclusion statement aimed at recruiting and retaining professionals to build a community that reflects all people affected by cancer. The Diversity and Inclusion goals of the AOSW align with those of other leading health care organizations who recognize the importance of racial and ethnic diversity among health care providers as essential to assuring high-quality cancer care to minority populations. Although the causes are multifactorial, The Institute of Medicine attributes lack of diversity and the propensity of unconscious bias as contributing factors to health care disparities and inequalities that are well documented in cancer care. Through a combination of videos, self-reflection exercises and group interaction, this presentation aims to explore how lack of diversity and unconscious bias impacts our healthcare settings and practices. Participants will demonstrate an understanding of unconscious bias, as well as develop an awareness for exploring blind spots within themselves and how unconscious bias impacts communication and interactions with diverse patients, clients and colleagues. Participants will consider how to use this information to mitigate unconscious bias in clinical practice, as well as in their health care settings. The AOSW Diversity and Inclusion Toolkit will be introduced to participants who will explore ways to incorporate tools and strategies into their practice and health care setting.

Learning Objectives:

1. Discuss the impact of Unconscious Bias on the healthcare system and its contribution to health disparities and inequities and identify “blind spots” and ways to mitigate them.
2. Demonstrate an understanding of the concept of Unconscious Bias and examine their impact on communication and interactions with diverse patients and/or clients.
3. Explore the AOSW Diversity and Inclusion Statement and Toolkit as tools to mitigate unconscious bias in their practice and their healthcare settings.

Outline:

- 8:30 a.m. – 8:35 a.m. Why Diversity & Inclusion? Why is this important to AOSW?
- 8:45 a.m. – 9:30 a.m. Unconscious Bias: What it is; its implications in clinical practice and employment; institutional racism in health care
- 9:30 a.m. – 9:40 a.m.: Exploring Unconscious Bias
- 9:40 a.m. – 9:55 a.m.: Self-Reflective Activity and Process
- 9:55 a.m. – 10:00 a.m.: Wrap-Up
- 10:30 a.m. – 10:35 a.m. Review from break; experiential share; discussion
- 10:35 a.m. – 11:35 a.m. Interactive self-reflection of personal unconscious bias and discussion
- 11:35 a.m. – 11:55 a.m.: Discussion- How can we use this information to mitigate Unconscious Bias in our clinical work and build a more diverse profession?
- 11:55 a.m. – Noon: Wrap-Up and Review of Diversity & Inclusion subcommittee goals

References:

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- Teal, C.R., Gill, A.C., Green, A.R., & Crandall, S. (2012). Helping Medical Learners Recognise and Manage Unconscious Bias Toward Certain Patient Groups. *Medical Education*, 46: 80-88.
- van Ryn, M. & Fu, S.S. (2003). Paved With Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health? *American Journal of Public Health*, 93(2): 248-255.
- Winkfield, K.M., Flowers, C.R., Patel, J.D., Rodriguez, G., Robinson, P., Agarwal, A., Pierce, L., Brawley, O.W., Mitchell, E.P., Head-Smith, K.T., Wollins, D.S., & Hayes, D.F. (2017). American Society of Clinical Oncology Strategic Plan for Increasing Racial and Ethnic Diversity in the Oncology Workforce. *Journal of Clinical Oncology*, 35(22): 2576-2579.

Keywords: Special Populations

Course Designation: Cultural Competency

Presentation Level: Intermediate

LEARNING INSTITUTE/PANEL SYMPOSIA SESSION I

COLLABORTIVE CARE PANEL SYMPOSIUM

Title: The Collaborative Care Model: A New Opportunity for the Oncology Social Worker

Author(s): *Tiffany Courtnage, MSW, LICSW, OSW-C*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

The Collaborative Care Model (CCM) is a team-based approach to providing integrated psychosocial care that is effective in oncology settings. Social workers working as care managers (SWCM), who are integrated into the various disease groups, identify psychosocial needs, initiate and coordinate evidence-based care, and track clinical outcomes through an electronic registry. This presentation will describe the development, implementation and experiences of the clinical oncology social worker's role as care manager within the Integrated Psychosocial Oncology Program (IPOP) at the Seattle Cancer Care Alliance (SCCA). It will also discuss the unique benefits to the clinical social worker serving as care manager within the CCM. The SCCA's IPOP, staffed by 13 SWCM and 2 psychiatrists, was launched in 2010. Prior to initiating this program, social workers at the SCCA were primarily working to assist patients and families with tangible needs. With the completion of a robust training provided by SCCA Psychiatry, social workers significantly expanded their role and were able to begin practicing clinically. Each of the IPOP SWCM's are integrated into their respective oncology teams/disease groups and is central to the coordination and delivery of psychosocial patient care. In our outpatient oncology setting, the SWCM is responsible for initial and follow-up psychosocial assessment, treatment coordination (including assisting with psychopharmacologic monitoring), patient/family psychoeducation, patient and family counseling using evidence-based treatment modalities such as motivational interviewing and behavioral activation, coordination of care with the primary oncology team and other supportive care providers, and referral to specialty care. Anonymous surveys were administered to determine social workers' perceptions of advantages and disadvantages of practicing within the CCM. The implementation of the IPOP model has relied greatly on the role of the SWCM. This model has not only improved clinical outcomes, broken down barriers between social work and other supportive care services and Psychiatry, it has also brought about significant benefits for the SWCM specifically. The CCM allows social workers to: work at the top of their clinical licensure, experience greater recognition as a critical member of the multidisciplinary oncology team, further legitimize their clinical role with both patients and medical team counterparts and increase overall job satisfaction dramatically. From the survey results, social workers rated on a 1-5 scale that the CCM: helps patients achieve better clinical outcomes (4.5, SD 0.7), improves timely access to care (4.6, SD 0.5), and improves patient satisfaction (4.4, SD 0.8). They also noted that working within the CCM allows them to: integrate better with oncology teams (4.9, SD 0.3), work at the top of their licensure (4.8, SD 0.4) and improve overall job satisfaction (4.8, SD 0.4). Social Workers are uniquely poised to serve as care managers within the Collaborative Care Model given the profession's holistic focus on person in his/her environment. Overall, clinical social workers at the SCCA felt that transitioning their roles to the CCM was feasible, led to improved patient care, and led to improved job satisfaction.

Abstract Summary:

The Collaborative Care Model (CCM) is a team-based approach to providing integrated psychosocial care that is effective in oncology settings. Social workers working as care managers (SWCM), who are integrated into the various disease groups, identify psychosocial needs, initiate and coordinate evidence-based care, and track clinical outcomes through an electronic registry. This presentation will describe the development, implementation and experiences of the clinical oncology social worker's role as care manager within the Integrated Psychosocial Oncology Program (IPOP) at the Seattle Cancer Care Alliance (SCCA). It will also discuss the unique benefits to the clinical social worker serving as care manager within the CCM.

Learning Objectives:

1. Discuss the role of social worker as care manager within the CCM and well as identify the many benefits it provides to the profession.
2. Explain the core components of collaborative care model and identify strategies and tools to implement them into one's practice.
3. Describe the benefits to patients and families of working within the Collaborative Care Model.

References:

1. Fann JR, Ell K, Sharpe M. Integrating psychosocial care into cancer services. *J Clin Oncology*, 30:1178-1186, 2012
2. Fann JR, Fan MY, Unutzer J. Improving primary care for older adults with cancer and depression. *J Gen Intern Med* 24(Suppl 2):417–424, 2009
3. Ratzliff, Unutzer, et al (2016) Integrated Care: Creating Effective Mental and Primary Health Care Teams

Keywords: Interdisciplinary Care, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

Title: Shifting the Culture at Stanford Cancer Center: The Implementation of a Collaborative Psychosocial Care Model

Author(s): *Karen Nelson, MSW, MBA; Sheila Lahijani, MD*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Many disciplines may work within the same setting but function independently and sometimes at cross purposes to each other. This creates a less than optimal experience for patients and wasted time and frustration for care providers. The presentation will describe the journey to develop a collaborative model of care delivery for oncology patients needing psycho-oncology care at the Stanford Cancer Center. Led by psychiatry, and using lessons from other Cancer Centers, the social workers and FMT at the Stanford Cancer Center have begun the transition to a model which provides a continuum of care for patients which is integrated and supported by a team based approach. Although the clinicians have shared goals and a shared vision regarding the delivery of optimal psychosocial oncology care, changing culture and obtaining organizational support can be a challenge. Many of the duties assigned to social workers at the Cancer Center historically have been resource based, including requests for housing, insurance questions, transportation help and tasks which do not require the training and skills of a clinical social worker. Moving from a model where the clinic teams consult social work for resources to one where the social worker provides more clinical intervention around individual, marital and family distress is a seismic shift. Lessons learned and challenges yet to overcome will be identified.

Abstract Summary:

A collaborative care model was identified as a more effective way to deliver Psycho-Oncology care to patients and families at the Stanford Cancer Center. With leadership from Psychiatry and support from Social Work leaders, the disciplines have undertaken the task of developing a program where the disciplines work together clinically to manage distressed patients on a continuum from moderate to high risk. The challenges of changing culture, roles, team expectations and service delivery models will be explored together with the enhanced patient and provider experience.

Learning Objectives:

1. Discuss some of the challenges related to changing a practice model from an individual one to a collaborative one.
2. Describe some of the barriers both culturally and organizationally to making changes which will improve service delivery.
3. Recognize how social workers can be effective in expanding the range of patients seen through Psychosocial Oncology when there is an effective collaborative care model in place.

References:

- Fann JR, Ell K, Sharpe M. Integrating psychosocial care into cancer services. *Journal of Clinical Oncology* 30:1178-1186, 2012. Li M, Kennedy EB, Byrne N, Gérin-Lajoie C, Katz MR, Keshavarz H, Sellick S, Green E. Systematic review and meta-analysis of collaborative care interventions for depression in patients with cancer. *Psycho-Oncology*. 2016 Sep 19. Fann

JR, Sexton J. Collaborative Psychosocial Oncology Care Models. In: Psycho-OncologyTextbook, Third Edition. Holland JC, Breitbart W, Butow P, Jacobsen PB, Loscalzo M, McCorkle R (eds), Oxford University Press, NY, 2015

Keywords: Interdisciplinary Care, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

Title: Implementing the Collaborative Care Model to Deliver Population-Based Psychosocial Oncology Care

Author(s): *Jesse Fann, MD; Tiffany Courtnage, MSW*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Background: Despite existing practice guidelines and quality measures that call for universal distress screening during cancer treatment, ensuring that all patients identified as distressed receive evidence-based treatment and follow-up remains a significant challenge. The Collaborative Care Model (CCM) is a team-based, patient-centered approach to providing psychosocial care that is integrated into routine medical care. The clinical oncology social worker, who plays a central role as care manager in this model, assesses the patient, provides measurement-based treatment to target facilitated by an electronic registry, and delivers and coordinates evidence-based stepped care in collaboration with the team psychiatrist. A recent meta-analysis demonstrated that the CCM is a highly effective and flexible approach to delivering psychosocial care to cancer patients within diverse healthcare systems. The advent of new payment structures, such as through the Centers for Medicare and Medicaid Services (CMS), further bolsters the sustainability of this model. This talk will provide information to assist cancer programs of all types interested in implementing collaborative care by describing the core principles of the model and key tools for implementation. The experience of developing and implementing the CCM at the Seattle Cancer Care Alliance (SCCA), an NCI-designated comprehensive cancer center, will be presented as an example. Opportunities for dissemination of the CCM will be discussed. Methods: The SCCA's Integrated Psychosocial Oncology Program (IPOP) was launched in 2010 following a structured training program. Following a successful pilot in the breast, lung-head & neck and stem cell transplant clinics, the program was rolled out throughout the SCCA, which treats more than 7,500 new patients annually from throughout the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) region. The program is responsible for managing the psychosocial needs of the clinic population and uses multimodal treatment approaches in accordance with evidence-based treatment guidelines. Technology enhancements are used to improve outcomes tracking, quality improvement, and clinical reach. Results: The CCM was successfully implemented with minimal increase in resources. While there were initial challenges primarily stemming from cultural and role changes, strategies were identified to overcome barriers to implementation. Following implementation of the CCM, psychosocial process (e.g., screening, follow-up) and clinical (e.g., depression, anxiety) outcomes as well as job satisfaction among team members improved. A training program has been developed to assist other cancer centers in implementing the CCM. Conclusions: Collaborative Care is a flexible and efficient model that can be implemented to provide population-based integration of psychosocial oncology care into cancer care.

Abstract Summary:

The Collaborative Care Model (CCM) is a team-based, patient-centered approach to providing psychosocial care that is integrated into routine medical care. The clinical oncology social worker, who plays a central role as care manager in this model, assesses the patient, provides measurement-based treatment to target facilitated by an electronic registry, and delivers and coordinates evidence-based stepped care in collaboration with the team psychiatrist. A recent meta-analysis demonstrated that the CCM is a highly effective and flexible approach to delivering psychosocial care to cancer patients within diverse healthcare systems. This talk will provide information to assist cancer programs of all types interested in implementing collaborative care by describing the core principles of the model and key tools for implementation. The experience of developing and implementing the CCM at the Seattle Cancer Care Alliance (SCCA) will be presented as an example.

Learning Objectives:

1. Describe the core components of the Collaborative Care Model for psychosocial oncology care.
2. Apply the core components of the Collaborative Care Model at their own institution.
3. Identify strategies and tools to overcome potential challenges to implementing the Collaborative Care Model.

References:

1. Fann, J.R., Ell, K., & Sharpe, M. (2012). Integrating psychosocial care into cancer services. *Journal of Clinical Oncology*, 30, 1178-1186. 2. Li, M., Kennedy, E.B., Byrne, N., Gérin-Lajoie, C., Katz, M.R., Keshavarz, H., Sellick, S., & Green, E. (2017). Systematic review and meta-analysis of collaborative care interventions for depression in patients with cancer. *Psycho-Oncology*, 26(5), 573-587. 3. Fann, J.R. & Sexton, J.. (2015). Collaborative Psychosocial Oncology Care Models. In: *Psycho-Oncology Textbook, Third Edition*. Holland JC, Breitbart W, Butow P, Jacobsen PB, Loscalzo M, McCorkle R (eds), Oxford University Press, NY. 4. Fann, J.R., Fan, M.Y., & Unutzer, J. (2009). Improving primary care for older adults with cancer and depression. *Journal of General Internal Medicine*, 24 Suppl 2, S417-424. 5. Sharpe, M., Walker, J., Holm Hansen, C., Martin, P., Symeonides, S., & Gourley, C., et al. (2014). Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. *Lancet*, 384(9948), 1099-1108

Keywords: Interdisciplinary Care, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

Title: The CaLM Model: Building a New Patient-Centered Cancer Institute With Social Work Leadership and Engagement in Interprofessional Whole-Person Collaborative Care

Author(s): *Barbara Jones, PhD, MSW; Rebekkah Shear, MIA*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Background: Scheduled to open in December 2018, the mission of the LCI is to radically improve people's cancer experience and quality of life; revolutionize how we treat cancer; and reinvent the way cancer patients are cared for. We are developing an innovative cancer care delivery model that is value-based and patient-centered. Central to our approach is the creation and operationalization of what we are calling the "CaLM Clinic," which is a comprehensive, patient-centered clinical and supportive service with care for patients and caregivers in all phases of the cancer journey. CaLM, which stands for "CAncer Life reiMaged" is an oncology home approach that will integrate high acuity, sub-specialty clinical cancer care with comprehensive, ongoing supportive care. We are creating a "flipped clinic" where psychosocial whole person care is the center of the practice. At the core of CaLM clinic will be the Patient Support Team (PST), a multidisciplinary team of supportive care experts who collaboratively manage patient care in a team-based approach. Social workers have been at the forefront of developing this model engaging in leadership, collaborative planning, community organizing, and patient advisory groups and will continue to have leadership in the collaborative care model. Methods: The CaLM clinic will work to optimize every patient's Capability: the frequency or degree to which they can do the things that matter them; their Comfort: freedom from physical and emotional pain; and Calm: their ability to live life free from chaos as they undergo a healthcare experience. Into this model, we are integrating a living, learning lab where all patients will be able to participate in translational research opportunities through offering their experience and outcomes as learning grounds. Since 2017, oncology social workers have been engaged in developing this model beginning with a robust community engagement strategy that identified key goals for the development of the LCI. The CaLM leadership team, a collaborative group with strong oncology social work leadership and presence has engaged in a series of steps to build out the CaLM Model. These steps included a baseline PRO study, landscape analyses, literature reviews, community engagement, patient experience groups, and intense collaborative interprofessional planning. We have created a model of care where each patient and caregiver who enters the CaLM clinic will first be met by our CaLM team -a Lead Oncology Social Worker, a Palliative Care Advanced Practice Provider

and an Oncology Advanced Practice Provider. This team will engage and assess the whole-person needs of the patient and their family and work collaboratively with oncologists, psychiatrists, and integrative care practitioners to deliver care. Conclusions: True patient-centered care requires a collaborative approach from the leadership to the care providers. At LCI, we have built a truly collaborative care model focused on whole person care. Social workers have been an integral part of the design of intensive psychosocial oncology collaborative care. Learning Objective: The participant will be able to describe the CaLM model and the principles of whole person patient-centered collaborative care and identify strategies to develop similar models in their settings.

Abstract Summary:

The CaLM (Cancer Life Reimagined) clinic at the Dell Medical School LIVESTRONG Cancer Institutes (LCI) is designed to revolutionize how patients and caregivers receive care by creating a “flipped clinic” with psychosocial support as the core of the care delivery model. Specialty oncology medical care is woven into the whole-person care instead of the reverse. Working collaboratively, a team of oncologists, palliative care specialists, oncology social workers, oncopsychiatrists and patients have built the infrastructure for this new CaLM clinic model. Every patient begins by meeting a highly trained Patient Support Team consisting of an Oncology Social Worker, Palliative Care Advanced Practice Provider and an Oncology Advanced Practice Provider who will assess and address their needs. Instead of integrating mental and behavioral health into oncology care, this model leads with it. This workshop will describe the community-based, patient-center collaborative care approach to building a new cancer center from the ground up.

Learning Objectives:

1. Describe the CaLM model and the principles of whole person patient-centered collaborative care.
2. Identify opportunities for social work leadership in oncology care.
3. Discuss strategies to build collaborative care models in a variety of settings.

References:

Institute of Medicine. 2008. Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs. Washington, DC: The National Academies Press. <https://doi.org/10.17226/11993>.

Jones, B., Phillips, F. (2016) Social Work Leadership in Interprofessional Education in Health Care. *Journal of Social Work Education*.52 (1) 18-29.

Blacker, S., Head, B. Jones, B., Remke, S., Supiano, K. (2016) Advancing Hospice and Palliative Care Social Work Leadership in Interprofessional Education and Practice. *Journal of Social Work in Palliative and End-of-Life Care*.

Keywords: Interdisciplinary Care, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

Title: An Implementation Study to Inform Dissemination of the Collaborative Care Model to Underserved Patients In Oncology Clinical Settings

Author(s): Sarah Price, MA; Mairead McConnell McConnell, MA

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Background: There is a crucial need to improve screening and provide evidence-based interventions for cancer patients. Our team developed and tested interventions that address the specific psychosocial needs of the large number of underserved patients at University of Arizona Cancer Center (UACC). In a pilot study, the Collaborative Oncology Program to Enhance Depression Care (COPE-D), a multidisciplinary depression collaborative care management intervention based on the IMPACT model was developed and tested. Compared to 25% of patients receiving usual care, 72% of COPE-D patients showed 50% or greater reduction in depressive symptoms from baseline, demonstrating that COPE-D may be a more effective alternative to usual care. Our team also studied Telephone Interpersonal Counseling

(TIP-C) as a relatively brief, culturally appropriate and highly accessible psychosocial intervention, and found that TIP-C improved quality of life among both Latina breast cancer patients and their informal caregivers and rural women with breast cancer and their caregivers. Methods: Based on the promise of these interventions to improve psychosocial outcomes among patients with cancer, we developed a multidisciplinary program to expand their delivery at UACC. Our program, titled Expanding Patient-Centered Cancer Care for Underserved Patients in Southern Arizona, was chosen as part of the Merck Foundation's national Alliance to Advance Patient Centered Cancer Care. One of the three projects in this program is an implementation study of COPE-D, which incorporates the culturally-appropriate counseling interventions of TIP-C (including well-developed interventionist training protocols) into this new project for dissemination of psychosocial care at UACC. It expands measure-based care with outcomes assessments beyond the pilot study to the entire UACC patient population with significant depressive symptoms, with a focus on underserved cancer patients in our catchment area. Results: Through this grant, COPE-D has become integrated into the fabric of the Supportive Care for Healing (SCH) program, the existing UACC psychosocial care structure. The ability of COPE-D to supplement an already-strong psychosocial care program was due to a thoughtful implementation process involving ongoing consultation with key stakeholders and experts in collaborative care from the Seattle Cancer Care Alliance (SCCA). UACC clinical administration and oncology care professionals were engaged to determine the structure of the program to fit with existing staffing and COPE-D became a quality improvement project within the UACC Commission on Cancer (CoC) Committee. Two bilingual Spanish/English speaking depression care coordinator/counselors were hired, trained and integrated with existing Supportive Care for Healing services at UACC. To date, the project has enrolled 17 patients who screened positive for depression (PHQ-9 $\geq 8/27$). TIP-C, medication supervision, and behavioral activation are being delivered according to an IRB-approved protocol, and interventionists review registries of patient care outcomes weekly with the psychiatrist. This presentation will provide updated results from the project with discussion of challenges and barriers to implementation and how they have been addressed, as well as recommendations for future development. Conclusions: Collaboration between social workers, psychiatrists, oncology professionals and cancer care organizations can advance psychosocial cancer care. Implementation of tested approaches requires extensive adaptations to be made to local circumstances in order to succeed.

Abstract Summary:

Expanding Patient-Centered Cancer Care for Underserved Patients in Southern Arizona, was chosen as part of the Merck Foundation's national Alliance to Advance Patient Centered Cancer Care. It supports an implementation study of Collaborative Oncology Program to Enhance Depression care(COPE-D), which incorporates the culturally-appropriate counseling interventions of Telephone Interpersonal Counseling (TIP-C) (including well-developed interventionist training protocols) for advancing dissemination of psychosocial care at University of Arizona Cancer Center(UACC). Clinical administration and oncology care professionals were engaged to determine the structure of the program to fit with existing staffing. COPE-D became a quality improvement project within the UACC. Two bilingual Spanish/English speaking depression care coordinator/counselors were hired, trained and integrated with existing Supportive Care for Healing services. To date, the project has enrolled 17 patients who screened positive for depression (PHQ-9 $\geq 8/27$). TIP-C, medication supervision, and behavioral activation are being delivered. Interventionists review registries of patient care outcomes weekly with the psychiatrist.

Learning Objectives:

1. Discuss the use of research funds to leverage implementation of Collaborative Care.
2. Implement strategies for engagement of organizational stakeholders when introducing a new clinical service of social workers acting in multidisciplinary teams.
3. Describe methods for adapting the Collaborative Oncology Program to Enhance Depression care for underserved patients by means of tailored outreach activities and for those populations of cancer patients.

References:

Badger, T., et al. (2005). "Telephone interpersonal counseling with women with breast cancer: symptom management and quality of life." *Oncology Nursing Forum Online* 32(2): 273-279
Badger, T. A., et al. (2000). "Depression, service need, and use in vulnerable populations." *Archives of Psychiatric Nursing* 14(4): 173-182.
Weihs, K. L., et al. (2018).

"Predicting Future Major Depression and Persistent Depressive Symptoms: Development of a Prognostic Screener and PHQ4 cutoffs in Breast Cancer Patients." *Psycho-Oncology* 27: 420-426.

Keywords: Interdisciplinary Care, Clinical Practice/Skill Building

Course Designation: Cultural Competency

Presentation Level: Intermediate

SPECIALIZED POPULATIONS PANEL SYMPOSIUM

Title: No Solo se Trata de Mi, Esto es Entre Tu y Yo (It's not Just About Me, This is Between You and Me)

Author(s): *Jenny Rodriguez, MSW; Courtney Bitz, LCSWMD*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Cancer is a disease that affects the entire family, especially cancer survivors and their intimate partners (1) (2) (3). After a cancer diagnosis, couples must adjust to new family roles, find new ways to offer mutual support to each other, communicate, be intimate, and deal with stress and conflict (4). Couples-based psychosocial interventions improve quality of life, emotional and functional adjustment, and treatment outcomes for breast cancer survivors and their partners (5) (6) (7). However, advances in psychosocial interventions are not reaching all cancer survivors and their partners equally. Regan et al. (2012) stated that although they found positive outcomes of couples-based interventions, findings had limited cultural generalizability due to the majority of couples participating in interventions being from middle-aged Caucasian backgrounds. Latinas have higher rates of advanced stage cancer, undergo more rigorous treatments, and report heightened psychological burdens when compared to other cancer survivors (8). There is an absence of empirical research investigating the relational needs of Latina breast cancer survivors and their partners, lessening the possibility of ensuring that psychosocial interventions are culturally competent (9). The Latino culture is a collectivistic culture with an emphasis on family (10); therefore, ensuring the strength of the family and social bond is critical to health outcomes. Superando Cancer Juntos Como Pareja Pilot Program is a linguistically and culturally appropriate comprehensive, psychoeducational, couples based intervention that is part of the standard of medical care for Latina monolingual breast cancer patients and their partners. Overall, the goal of the program is to improve Latino couple satisfaction and coping and to reduce barriers to accessing psychosocial services. During the thirty minute psychoeducational intervention, the couple is provided with the wisdom from past patients, partners, research and clinical experience in a safe space to speak openly about their emotional reactions to cancer including each other's fears and concerns. The pilot program provides multiple culturally competent intervention modalities including education on gender strengths and differences in stress and coping styles, identifying and reducing gender-role conflict, teaching problem solving skills for effective medical management, and psychosocial coping, empowering the patient and partner to be active members of the medical team, and developing and practicing bonding and positive role modeling behaviors for their family. Currently the Couples Coping with Cancer Together Program for English speaking breast cancer patients and partners has been operating for approximately 5 years at a women's center. This program has prospectively screened over 1000 English speaking breast cancer patients/partners. Due to the success of the English speaking program, the opportunity to expand the program into the Latino community arose. This pilot program was launched January, 2018 at a women's center for Latina monolingual breast cancer patients/partners. Since the pilot program's inception, approximately 30 Latino couples have participated in the couples based intervention. Participants range from ages 34 to 65. The pilot program is in the process of providing distress screening for the patient and partner in an effort to collect data and address distress and the needs of this unrepresented and underserved patient population.

Abstract Summary:

Creating a safe space for Latina monolingual breast cancer patients and their partners to discuss cancer Superando Cancer Juntos Como Pareja Pilot Program was launched January, 2018 at a women's center for Latina monolingual breast cancer patients and their partners. The pilot program provides multiple culturally competent intervention modalities including education on gender strengths and differences in stress and coping styles, identifying and reducing

gender-role conflict, teaching problem solving skills for more effective medical management, and psychosocial coping, empowering the patient and partner to be active members of the medical team, and developing and practicing bonding and positive role modeling behaviors for their family.

Learning Objectives:

1. Discuss an innovative program development model for integrating culturally competent psychosocial programs into standard medical care.
2. Explain the most common areas of distress Latino couples report and learn culturally competent couples psyeducational intervention in conjunction with utilizing clinical skills to provide a safe space.
3. Examine culturally competent skills and interventions that can be employed in the oncology setting for Latino couples coping with cancer.

References:

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Keywords: Special Populations, Specialized Needs

Course Designation: Cultural Competency

Presentation Level: Introductory

Title: The Myth of the Well-Adjusted Asian Patient: The Hope Formula

Author(s): *Jenny Lu, LCSW, OSW-C, ACHP-SW, CSW-G*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

The National Comprehensive Cancer Network (NCCN) Distress Management Guidelines Panel defines distress as “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer.” (NCCN 2013). Distress is prevalent among cancer patients at all stages of illness (NCBI, 2018). Asian cancer patients are no exception (Loscalzo, et al. 2013). Asian cancer patients report high levels of symptom burden, psychological distress, and disruption of family function yet underutilize cancer services across the cancer care continuum (Tang, et al. 2000). The Asian culture rooted in Confucius philosophy, and Buddhist and Tao religions endorse suffering is inevitable and promotes self-reflection and self-sacrifice for the greater social system (Ho 1995; Sias J 2015). This fundamental belief and cultural shame and stigma of a cancer

diagnosis are often barriers to accessing psychosocial care for Asian cancer patients and their families (Daher, et al. 2012; Bedford, et al. 2003). At City of Hope, SupportScreen, an automated biopsychosocial distress screening tool is administered to cancer patients in attempt to identify cancer distress across race groups (Loscalzo, et al. 2010). The SupportScreen tool is an effective method to identify patients experiencing distress because it has been shown that people are more candid when assessed by computer rather than when assessed in person or by paper-and-pencil measures (Feigelson et al. 2000). One thousand six hundred eighty seven Asian cancer patients completed the SupportScreen at City of Hope from 2009 to 2016. The findings showed that Asian and Non-Asian cancer patients endorsed similar level of distress. The data on the top three distress concerns of Asian cancer patients in comparison to Non Asian patients are as follows: 1) side effects of treatment - Asian 35.4%, Non Asian 32%; 2) worry about the future - Asian 31.1%, Non Asian 31.4%; 3) finance – Asian 30.9%, Non Asian 33.1%. The data dispels the myth of the well adjusted Asian patient. When a patient on Support Screen indicates a moderate to very severe level of cancer distress, a referral to appropriate team member is automatically triggered. Oncology social workers are often the primary professional discipline that provides psychosocial services to cancer patients and families. However, oncology social workers may lack the knowledge of culturally sensitive strategies to serve Asian cancer patients. In this presentation, the Hope Formula will be introduced to assist clinicians in developing a clinical connection with Asian cancer patients, assessing their coping, and encouraging the utilization of resources/treatment through the continuum of care. The benefit of offering a combination of integrated East West supportive care services will also be discussed. The Hope Formula designed to capture cancer distress, cultivate a therapeutic relationship, and integrate East West support care services may bridge the gap between Asian Cancer patient's distress and psychosocial care.

Abstract Summary:

Distress is prevalent among cancer patients at all stages of illness and Asian cancer patients are no exception. The data from Support Screen administered at City of Hope from 2009-2016 showed that Asian and Non-Asian cancer patients endorse similar level of distress. However, the Asian culture rooted in Confucius philosophy, and Buddhist and Tao religions endorse suffering is inevitable and promotes self reflection and self sacrifice for the greater social system. This fundamental belief and cultural shame and stigma of a cancer diagnosis are often barriers to accessing psychosocial care for Asian cancer patients and their families. In this presentation, the Hope Formula will be introduced to assist clinicians in developing a clinical connection with Asian cancer patients, assessing their coping, and encouraging the utilization of resources/treatment through the continuum of care. The benefit of offering a combination of integrated East West supportive care services will also be discussed.

Learning Objectives:

1. Demonstrate knowledge of traditional Asian culture and social system as it relates to cancer care.
2. Identify three Asian cultural nuances for effective clinical connection.
3. Discuss three strategies to address distress in Asian cancer patients.

References:

1. National Comprehensive Cancer Network (NCCN) Distress Management Clinical Practice Guidelines in Oncology. Journal of the National Comprehensive Cancer Network 2013;11(2):186-209. 2. National Center for Biotechnology Information (NCBI) Adjustment to Cancer: Anxiety and Distress. PDQ Cancer Information Summaries 2018;1-40. Bethesda (MD): National Cancer Institute (US). 3. Loscalzo M, Clark K, Pal S, Pirl, W. Role of Biopsychosocial Screening in Cancer Care. The Cancer Journal 2013;19(5)414-420. 4. Tang T, Solomon L, McCracken L. Cultural Barriers to Mammography, Clinical Breast Exam, and Breast Self-Exam among Chinese-American Women 60 and Older. Preventive Medicine 2000;31, 575-583. 5. Ho D. Selfhood and Identity in Confucianism, Taoism, Buddhism, and Hinduism: Contrasts With the West. Journal for the Theory of Social Behavior 1995;25(2)115-139. 6. Sias J. Buddhism, Confucianism, and Western Conceptions of Personal Autonomy. The Downtown Review 2015;1(1)1-22. 7. Daher, M. Cultural beliefs and values in cancer patients. Annals of Oncology 2012;23(3)66-69. 8. Bedford O, Hwang, K. Guild and Shame in Chinese Culture: A Cross-cultural Framework from the Perspective of Morality and Identity. Journal for the Theory of Social Behavior 2003;33(2)127-143. 9. Loscalzo M, Clark K, Dillehunt J, Rinehart R, Strowbridge R, Smith D. SupportScreen: A model for improving patient outcomes. JNCCN Journal of the National Comprehensive Cancer Network 2010;8(4)496-

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Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Cultural Competency

Presentation Level: Intermediate

Title: Cultural Competency in Social Work Practice for African American Cancer Patients

Author(s): *Lisa Petgrave-Nelson, LMSW; Mohua Basu, MPH*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

African Americans (AA) in the United States have the highest incidence and mortality rates of any ethnic groups for most cancers (DeSantis, Siegal, Sauer, Miller, Fedewa, Alcaraz, 2016). Causes for these racial disparities are complex and include both biological and socioeconomic factors, such as comorbidities, low health literacy, poverty, and lower access to cancer prevention and treatment services (Ward, Cokkinides, Singh, Cardinez, Ghafoor, Thun, 2004). While AA cancer patients face the same emotional challenges as other ethnicities, many AA cancer patients grieve and cope with their diagnoses differently than their white counterparts. "There is an oral tradition among AA about when and when not to share information with outsiders, and this cultural norm may cause individuals and families not to disclose their symptoms of cancer" (Bullock and Allison, p.295). Understanding the cultural factors which influence health care behavior as well as patient barriers can facilitate effective evidence-based practices (Freeman & Chu, 2005). AA patients have a number of cultural beliefs and attitudes that influence their reluctance to disclose, treat, and cope with their cancer diagnoses. To better understand the psychosocial needs of the AA population, oncology social workers must first have a better knowledge of the experiences and racial disparities faced by AAs across the spectrum of healthcare." A history of discrimination and exploitation has led to AA's mistrusts of medical providers" (Jacobs, Rolle, Ferrans, Whitaker, Warnecke, 2006). This mistrust may lead to AA patients having lower rates of medical adherence and lower participation in clinical trials (Hu, Juarez, Yeboah & Castillo, 2014). "AA cancer patients are often less likely to accept mental health interventions and may also be reluctant to accept hospice or palliative referrals due to their religious beliefs that God will heal them from cancer" (Holt, Caplan, Schulz, Blake, Southward & Lawrence, 2009). Social workers can practice cultural competency by being mindful of these differences when completing a comprehensive psychosocial assessment that can allow them to better understand the patients' view of cancer. By understanding the patients' cultural history and religious beliefs, the social worker can better establish patient goals and expectations regarding treatment and identify caregivers and family members for the patient. "Social workers should also be mindful of the important role of spirituality and prayer for many AA patients coping with cancer" (Holt, Caplan, Schulz, Blake, Southward & Lawrence, 2009). Oncology social workers have the opportunity to provide culturally sensitive and evidenced based interventions and support to AA cancer patients and their families by being respectful and attentive of a patients' race, socioeconomic status, and culture. A concerted effort has to be made to learn the cultural preferences of the AA patient in order to provide ultimate support in cancer treatment and navigation. By practicing cultural competency to identify the specific health beliefs and behaviors of patients, social workers can ensure AA patients receive high quality care and improve healthcare outcomes regardless of race. Culturally competent social workers facilitate an oasis of healthcare equity and can begin to contribute to the elimination of racial health disparities for future generations.

Abstract Summary:

While AA cancer patients face the same emotional challenges as other ethnicities, many AA cancer patients grieve and cope with their diagnoses differently than their white counterparts. "There is an oral tradition among AA about when and when not to share information with outsiders, and this cultural norm may cause individuals and families not to disclose their symptoms of cancer" (Bullock and Allison, p.295). Understanding the cultural factors which influence

health care behavior as well as patient barriers can facilitate effective evidence based practices (Freeman & Chu, 2005). Social workers can practice cultural competency by being mindful of these differences when completing a comprehensive psychosocial assessment that can allow them to better understand the patient's view of cancer. This presentation will explore maladaptive behaviors that can surface with AA patients and explore labels of "non-compliance" or "difficult patient" in the oncology setting.

Learning Objectives:

1. Evaluate different methods of assessments for African American oncology patients.
2. Describe effective ways to use psychosocial assessments and distress screening tools to confirm the presence of social, psychosocial, financial and spiritual needs to link patients to appropriate psychosocial resources.
3. Discuss coping strategies to strengthen African American cancer patients adaptive methods of coping with cancer.

References:

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Keywords: Specialized Needs, Special Populations

Course Designation: Cultural Competency

Presentation Level: Introductory

LEARNING INSTITUTE

Title: Group Ethics: Dynamics, Deception, Disruption, Discipline and Death

Author(s): Sandra Blackburn, MSW, LSW; Heather Sheaffer, DSW, LCSW

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

As a social worker, where does your loyalty lie? Do you choose to not honor a commitment to the dead in order to protect the living? In your oncology patient group, how do you handle a person you suspect is lying? Is it appropriate for the facilitator to do an internet search on that person? How do you manage a group member who monopolizes the conversation? What is the impact on your group when a member tries to usurp group leadership? We've experienced these scenarios and more in our long-running patient group. In this presentation we will share specific case examples of ethical quandaries that were a challenge for our team. We will be open with our struggles, professional disagreements, resolutions and we will also welcome examples from others. Through the lens of ethical theories such as deontological vs. utilitarianism we will walk through case examples that will illuminate your work with groups. One of our case presentations will focus on a patient who submitted a work for our book publication (an anthology of patient writings). We accepted her work and she died soon thereafter. Upon closer examination, we realized the topic of her work was a personal account of an extra-marital affair. Unable to consult with her, and unsure of the impact of publication to her

family we had to make a decision about whether or not to publish posthumously. Every group is prone to some fairly predictable dynamics. Ethical dilemmas are but one. We will also focus on Yalom's foundational principles for both group and individual stages of group development. These include the individual group member's experience through the developmental stages of the group including differentiation vs. belonging, working through conflict, dominance, and rebellion. We will provide personal examples of how these clinical concepts emerge over time. The convergence of ethics and group dynamics is fraught with frequent challenges and decision-making imperatives. We will share some of our decisions and programmatic changes that we've made in response to specific situations. Our group exercise task in our 90-minute Learning Institute will be to use various ethical perspectives to resolve an ethical dilemma in an oncology group. We will then analyze and critique the results. This presentation will challenge you to consider how group dynamics, as well as your ethical perspective, influence your decision-making and problem resolution in clinical practice with groups.

Abstract Summary:

Do you choose to honor a commitment to the dead in order to protect the living? What is the impact in your group when a member tries to usurp group leadership? We've experienced these scenarios in our patient group. In this presentation we will share specific case examples of ethical quandaries. We will be open with our struggles and professional disagreements. For example, one patient submitted a work for our publication (an anthology of patient writings). We accepted her work - she died soon thereafter. We later discovered it referenced her extra-marital affair. Unable to consult with her, and unsure of the impact of publication on her family we had to make a decision about whether to publish posthumously. This presentation will challenge you to consider how group dynamics, as well as your ethical perspective, influence your decision-making and problem resolution in clinical practice with groups.

Learning Objectives:

1. Discuss and review the use of an ethical framework to manage ethical conflicts in your oncology group that is also applicable to working with an individual client.
2. Define and review elements of group dynamics and how they translate into individual and group behavior that may be disruptive, non-productive, or simply frustrating to the group and group leader.
3. Integrate ethical perspectives with group dynamics for application to a group setting.

References:

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Keywords: Ethics, Clinical Practice/Skill Building

Course Designation: Ethics

Presentation Level: Intermediate

LEARNING INSTITUTE

Title: Screening and Tools and Data, Oh My! The Value and Import of Measuring Patient Outcomes and Oncology Social Work Practice

Author(s): *Julianne Oktay, PhD, MSW; Makeeta Rayton, MSW*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Oncology social workers are increasingly being held accountable for collecting and reporting data on patient distress and related outcomes as well as on social worker performance. These requirements in social work practice are being driven by new policies and guidelines such as Commission on Cancer Patient-Centered standards, QOPI requirements, and an increased emphasis on demonstrating value and impact of psychosocial service delivery and performance. These changes represent opportunities for oncology social workers to demonstrate scientifically the value and contributions of social work to achieving the quadruple aims of increasing patient and provider satisfaction, improving population health, and achieving cost controls. To succeed in these efforts, oncology social workers will benefit from training opportunities that enhance their research skills, particularly with regard to data collection procedures, data analysis, and methods for presenting data analytic results to achieve desired changes. Many clinical social workers are actively searching, locating, and creating their own data collection forms and templates to monitor patient progress or work performance. Thus, this proposed learning institute is designed to build oncology social worker skills in developing or locating data collection templates suited to their practices, overcoming barriers to their use and implementation, and analyzing the data collected. The Learning Institute will begin with a brief overview of the shifts in national health care policy and establishment of guidelines that are driving increasing numbers of social workers to collect patient and performance level data. A panel of AOSW members/clinical social workers will then discuss their efforts to develop and implement screening and assessment tools/instruments, including the strategies they have employed to overcome barriers and achieve success. This will be followed by a presentation of the Oncology Social Work Intervention Index, an emerging data collection template that evolved from AOSW's Project to Assure Quality Cancer Care. This instrument has the potential to standardize data collection on social work interventions and response to distress screening across cancer programs, thereby increasing the power and representativeness of data, that when pooled together, reflect national trends for oncology social work. The interactive portion of the Learning Institute will involve participants working in small groups to review data collection templates currently in use at cancer centers across the US, and to discuss how they might adapt and adopt these data collection instruments and procedures for use in their own cancer centers. The session will close with a debriefing discussion around opportunities for advancing the implementation and dissemination of activities that promote collaboration, and opportunity for questions and answers from panelists.

Abstract Summary:

Oncology social workers are increasingly being held accountable for collecting and reporting data on patient distress and related outcomes as well as on social worker performance. This learning institute is designed to build oncology social worker skills in developing or locating data collection templates suited to their practices, overcoming barriers to their use and implementation, and analyzing the data collected. This Learning Institute will involve participants working in small groups to review data collection templates currently in use at cancer centers across the US, and to discuss how they might adapt and adopt these data collection instruments and procedures for use in their own cancer centers.

Learning Objectives:

1. Develop and use survey instruments in clinical practice for monitoring patient outcomes and social work practitioner interventions.
2. Identify data collection strategies that social workers can use to enhance tracking of patient care and Social Work interventions.
3. Describe elements of three data collection templates currently being used by oncology social workers.

References:

Zebrack, B., Kayser, K., Oktay, J., Sundstrom, L., & Sachs, A. (2018). The Association of Oncology Social Work's Project to Assure Quality Cancer Care (APAQCC), *Journal of Psychosocial Oncology*, 36(1): 19-30, doi: 10.1080/07347332.2017.1397832.

Zebrack, B, Kayser, K, Padgett, L, Sundstrom, L, Jobin, C, Nelson, K, Fineberg, I. (2016). Institutional capacity to provide psychosocial oncology support services: A report from the Association of Oncology Social Work, *Cancer*, 122(12): 1937-1945

Pirl, WF; Fann, JR; Greer, JA; Braun, I; Deshields, T; Fulcher, C; Harvey, E; Holland, J; Kennedy, V; Lazenby, M; Wagner, L; Underhill, M; Walker, D; Zabora, J; Zebrack, B; Bardwell, WA. (2014). Recommendations for the implementation of distress screening programs in cancer centers; Report from the American

Psychosocial Oncology Society (APOS), Association of Oncology Social Work (AOSW), and Oncology Nursing Society (ONS) joint task force. *Cancer*, 120(19): 2946-2954 Parry, P; Padgett, LS; Zebrack, BJ. (2012). Now What? Toward an integrated research and practice agenda in distress screening. *Journal of Psychosocial Oncology*, 30;715-727. Zebrack, B; Burg, M; Vaitones, V. (2012). Distress screening: An opportunity for enhancing quality cancer care and promoting the oncology social work profession. *Journal of Psychosocial Oncology*, 30; 615-624

Keywords: Research, Distress/CoC

Course Designation: Clinical

Presentation Level: Intermediate

LEARNING INSTITUTE

Title: Mitigating Financial Toxicity: Navigating Health Insurance

Author(s): *Joanna Morales, JD, Esq.; Monica Bryant, JD, Esq.*

Date Scheduled:

6/6/2019, 1:30pm - 3:00pm

Abstract Content:

Oncology social workers are often called upon to educate patients about health insurance options and how to navigate insurance coverage. Although the Patient Protection and Affordable Care Act (ACA) is more than five years old, there is still widespread confusion about the law, its protections and the health care system in general. Additionally, there are many potential changes to the US healthcare system coming at the state and federal levels and as a result of pending court cases. In order to most effectively navigate patients from diagnosis through cancer survivorship, social workers must not only be armed with up-to-date knowledge about health insurance options and consumer protections, they must also be given concrete tools and strategies for conducting clinical assessments that address a wide spectrum of psychosocial needs. When information about health insurance options and how to effectively navigate health insurance coverage is available throughout the continuum of care, the quality of patient survivorship outcomes improves. The American Cancer Society found that uninsured individuals had significantly increased likelihoods of advanced stage diagnoses compared to those individuals with private insurance. Given that adequacy of health insurance is the primary factor in the potential financial toxicity of a cancer diagnosis, it is critical for patients to have access to reliable and accurate information. Triage Cancer found that 75% of oncology healthcare professionals surveyed were asked for guidance on how healthcare reform might affect their patients. However, only 7% of those surveyed felt "very comfortable" answering questions about the ACA. Therefore, there is an obvious gap between the knowledge level of healthcare professionals and what they are being asked by their patients. Furthermore, an improved understanding of navigating the complexities of pre-authorizations, coverage, networks, billing, exception requests, and appeals has the potential to decrease confusion and anxiety, decrease out-of-pocket costs, alleviate some of the financial toxicity of cancer care, and ultimately improve quality of life. This learning institute will discuss relevant provisions of the ACA, the most common health insurance options, and explore recent and upcoming changes to the health care system that may impact the cancer community. Additionally, social workers in attendance will be provided with the information necessary to effectively navigate their patients through their health insurance coverage and provide resources for referrals.

Abstract Summary:

A majority of Americans do not understand their health insurance options or how to use a policy once they have one. Many individuals turn to their healthcare providers for guidance. This learning institute will explore ongoing changes to the health care system at the federal and state levels. Attendees will receive information and practical tools that they can utilize in their clinical practice to aid patients in understanding their health insurance options and navigating insurance coverage, bills, denials, and appeals to mitigate the potential financial toxicity of a cancer diagnosis.

Learning Objectives:

1. Identify current health care consumer protections and health insurance options available to their patients and their families.
2. Summarize the information necessary to effectively navigate their patients through utilizing their health insurance coverage.
3. Outline factors to consider whenever choosing between health insurance options, to lower out-of-pocket costs and mitigate the potential financial burden of a cancer diagnosis.

References:

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Keywords: Financial Toxicity, Patient Navigation

Course Designation: Clinical

Presentation Level: Intermediate

LEARNING INSTITUTE/PANEL SYMPOSIUM SESSION II

LEARNING INSTITUTE

Title: The Empowered Father: Expanding and Enhancing the Father’s Roles in Families Challenged by Cancer

Author(s): Michael Weiner, LCSW; Les Gallo-Silver, LCSW-R

Date Scheduled:

6/6/2019, 3:30pm - 5:00pm

Abstract Content:

The trauma of a cancer diagnosis and treatment test the entire family system, caregivers and children alike. Fathers are conscious that their caregiving responsibilities will need to expand but are typically unaware what these changes will entail beyond the practical. Complicating supportive parenting interventions is the fact that generally, fathers can be challenging to engage for reasons ranging from the individual's own life experiences to their reactions to enduring and rigid gender role bias. This population requires social work interventions that are specifically geared to the nuances of connecting with fathers in crisis. This workshop presents a theoretical framework for social workers to: 1) reach out and connect to this subset of fathers; 2) assist them in identifying a set of critical caretaking activities broadly based on the theories of Carl Jung; and 3) aid them in operationalizing these caregiving undertakings within their specific family systems. Jung's theories are the nucleus of a novel social work intervention paradigm that defines, expands and concretizes the emotional, physical and practical tasks of fathering with families challenged by cancer. These interventions center on two concepts: Jung's collective unconscious, a notion which presumes that all fathers intrinsically retain the ability to be "complete," comprehensive caregivers and the archetypes, a concept that describes containers that hold the skills and attributes necessary for each of these essential fathering activities (Jung, 1957; Jung & Segal, 1998; Jung, 1959; Jung, 1981; Jung & De Laszlo, 1959). The Jungian-oriented archetypes are based on providing five straightforward elements of fathering – the Captain archetype's leadership and rules, the Protector's safety and empathy, the Nurturer's affection and resources, the Educator's wisdom and teaching, and the Jester's playfulness and rule-breaking (Jung, 1934; Authors, 2018 In Press). They are constructed for ease of understanding and simplicity of use. Fathers can view these archetypes as achievable models for interactions with their children and implementing the fathering skills in ways that re-balance the familial changes induced by cancer's impact (O'Neill et al, 2018; Lundquist, 2017; Inhestern & Bergelt, 2018; Corney et al, 2016; Ljungmen et al, 2016; Hoven et al, 2016; Carroll, 2018; Leland, 2017; Canter et al, 2015). Case studies of four fathers in different cancer-related scenarios describe the use of the archetypes within a supportive counseling framework: 1) Samuel, a father of two children, with cancer; 2) Jose, a father of three children, whose wife has cancer; 3) David, a father of an adopted child, whose husband has cancer; and 4) Jamal, a divorced father, with a child who has cancer. The case studies will demonstrate how Jungian based archetypes can engage, involve and empower fathers in their evolving roles in their family when confronted by cancer. Participants will be encouraged to discuss their own case situations for further application and exploration of using the fatherhood archetypes with special emphasis on their most difficult situations. Overall this workshop will illustrate how this method, adaptable for program planning, can bring fathers unexpected passion to their role as parent during a time of great distress.

Abstract Summary:

This workshop presents a novel theoretical framework for social workers to connect to fathers with families challenged by cancer and assist in identifying critical caretaking activities. Based on Carl Jung's theories, these social work interventions prioritize and operationalize a father's caregiving during times of crisis. Jungian-oriented archetypes: Captain archetype's leadership and rules; Protector's safety and empathy; Nurturer's affection and resources; Educator's wisdom and teaching; and Jester's playfulness and rule-breaking – and their practical use in order to bolster parenting decision-making. Case studies of four fathers describe the use of the archetypes within counseling: 1) a father with cancer; 2) a father whose wife has cancer; 3) a father whose husband has cancer; and 4) a father, with a child who has cancer. They demonstrate how archetypes can engage, engender passion and empower fathers. Participants can discuss their own case clinical situations in depth for further clinical exploration of this theory.

Learning Objectives:

1. Apply a unique way of engaging and sustaining men's involvement in a counseling relationship that expands on traditional social work engagement skills.

2. Compare and contrast Jungian theories with their foundational knowledge base in ego psychology.
3. Describe and develop ways to use Jungian theories as the basis for psychoeducational program planning.

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Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Clinical

Presentation Level: Advanced

LEARNING INSTITUTE

Title: "Dwell In Possibility": Poetic Approaches to Oncological Social Work Care

Author(s): *Carrie Gilman, LCSW*

Date Scheduled:

6/6/2019, 3:30pm - 5:00pm

Abstract Content:

While oncology patients and caregivers alike demand clear and concise outcomes to cancer treatment, such results are not always realistic. For some patients, cure is not an option; for others, even when cure is achieved, side effects, functional limitations, and existential questions are a part of cancer survival. Introducing poetry and other written works as a means to assist oncology patients in processing their experiences is a useful approach for social workers whose charge it is to support an individual's path through cancer treatment. The poet Emily Dickinson once mused "I dwell in

possibility.” This sentiment recognizing multiple realities and outcomes is well suited to oncology social workers’ goal in attending to those facing cancer during individual and group counseling sessions. The field of bibliotherapy (sometimes referred to as “poetry therapy”) shares many principles with the field of social work. This includes the belief in a client’s capacity to change their perspective and/or behavior, a strengths-based approach to promoting improved self-understanding and coping abilities, and a desire to understand the client’s narrative (Hynes & Hynes Berry 2012), both pre and post cancer. The use of literature changes the dynamic between oncology patient and social worker from one of a dyad to a triad. Whether used with an individual patient or in a group setting, the words of a poem or of a written excerpt (prose, song, etc) function as a presence that can be referred to for inspiration, reflection, and projection. It is this presence that allows for a deep exploration of feelings, creation of shared metaphor, and discovering new perspectives (Hynes & Hynes Berry 2012). Burack-Weiss, Lawrence, and Mijangos (2017) reflect on the tradition of storytelling in the social work profession. They indicate how the narrative of the client is not isolated from the narrative social workers bring to their daily work and the importance of recognizing how these stories interact with one another. As such, the proposed Learning Institute will feature a 45 minute session in which oncology social workers will have the opportunity to be guided through a therapeutic writing group in which poems and/or prose are presented as the inspiration for discussion/reflection of their experience as oncology social workers. Further, they will engage in written exercises facilitated by the presenter. This experience will allow them to relate to the potential that the use of therapeutic writing can have both as a form of professional self care as well as a potential tool for oncology care. In addition, the presenter will provide information about the physiological and psychological benefits of writing based on current research that delves into not only writing but the connection between art, healing, and health (Stucky & Nobel 2010; Thompson & Adams 2015). Finally, resources for finding poems and literature that are thematically appropriate for cancer patients and specific writing exercises that oncology social workers can use as self care methods and for patient care, thus fulfilling the conference’s goal of sharing care approaches that create an oasis for both practitioners and patients.

Abstract Summary:

The poet Emily Dickinson once mused “I dwell in possibility.” This sentiment recognizing multiple realities and outcomes is well suited to oncology social workers’ goal in attending to those facing cancer during individual and group counseling sessions. This Learning Institute will feature a 45 minute session in which oncology social workers will have the opportunity to be guided through a therapeutic writing group in which poems and/or prose are presented as the inspiration for discussion/reflection of their experience as oncology social workers. In addition, the presenter will provide information about the physiological and psychological benefits of writing based on current research. Finally, resources for finding poems and literature that are thematically appropriate for cancer patients and specific writing exercises that oncology social workers can use as self care methods and for patient care.

Learning Objectives:

1. Describe the rationale for adding a bibliotherapeutic (use of poetry and/or other literature) component to their emotional support strategies of individuals and/or groups.
2. Empathize with how writing can enhance emotional processing of oncology patients by participating in an experiential writing group facilitated by the presenter.
3. Assess and choose specific writing techniques that they can apply to their practice of social work at their home organization.

References:

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Keywords: Clinical Practice/Skill Building, Self Care

Course Designation: Clinical

Presentation Level: Introductory

PANEL SYMPOSIUM

Title: Cancer is a Family Affair: A Collaborative and Multi-Disciplinary Approach to an Evidence-Based Family Communication Program

Author(s): *Shannon La Cava, PsyD; William Saltzman, PhD*

Date Scheduled:

6/6/2019, 3:30pm - 5:00pm

Abstract Content:

A cancer diagnosis is a family affair. Studies show that distress and co-morbid psychological difficulties reverberate throughout the family and marital system and that the family or spousal relationship can be instrumental in moderating patient and caregiver distress and enhancing quality of life across the various stages of treatment, survivorship, and end-of-life. Surprisingly, cancer treatment centers rarely provide direct access to evidence-based family/couple programs designed for cancer populations. This symposium will feature three presentations that describe collaboration between the Samuel Oschin Comprehensive Cancer Institute at Cedars-Sinai Medical Center, Cancer Support Community of Los Angeles, and a family trauma and loss specialist from California State University, Long Beach. Over the last three years they have adapted and implemented a brief, strength-based family/couple program that has previously been shown to reduce distress, improve quality of life and adaptive functioning among military and civilian families contending with a range of traumatic and/or loss-related experiences. They recently conducted a randomized controlled trial of this program in both the medical and community settings. The first presentation will provide a description of the need, development and design of the FOCUS Family Program for Cancer, with brief video excerpts demonstrating a family engaged in core elements of the program; the second presentation will describe the evolution of the collaborative team, our community-based participatory research approach to creating services and studies that are tied to the needs of patient families and underserved populations, and the collaborative efforts of multiple institutions to meet the American College of Surgeons' Standards of Care as described in the 2012 Commission on Cancer report; and the third presentation will provide a case study of a family who has completed the program. The symposium will conclude with a discussion about the importance of family and couple-based interventions for treating the whole patient and how the current pilot program and research will inform practice and lead to critical advances in psychosocial oncology treatment models and standards of care.

Abstract Summary:

A cancer diagnosis is a family affair. Studies show that distress and co-morbid psychological difficulties reverberate throughout the family and marital system and that the family relationship can be instrumental in moderating patient and caregiver distress and enhancing quality of life across the various stages of treatment, survivorship, and end-of-life. This symposium will feature three presentations that describe collaboration between the Samuel Oschin Comprehensive Cancer Institute at Cedars-Sinai Medical Center, Cancer Support Community of Los Angeles, and a family trauma and loss specialist from California State University, Long Beach. Focus will be placed on a description of the need, development and design of the FOCUS Family Program for Cancer; the evolution of the collaborative team and our community-based participatory research approach to creating services; and provision a case study of a family who has completed the program. The symposium will conclude with a discussion about the importance of family intervention.

Learning Objectives:

1. Recognize the importance of conjoint, evidence-based treatment for couples and families contending with cancer.
2. Identify methods of collaboration between medical and community cancer centers to support the couples and families they serve utilizing a Community Based Participatory Research approach.

3. Assemble--and interact within—a collaborative team, capitalizing on the synergy of multiple disciplines, to provide more effective support for GBM patients and their families than can the solo practitioner.

References:

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Keywords: Interdisciplinary Care, Pain, Palliative Care and End-of-Life

Course Designation: Clinical

Presentation Level: Introductory

LEARNING INSTITUTE

Title: Combating Moral Distress with Ethical Decision Making

Author(s): *Alicia Wilson, LCSW; Amy Jamerson, LCSW, OSW-C*

Date Scheduled:

6/6/2019, 3:30pm - 5:00pm

Abstract Content:

Moral distress occurs when an individual is unable to pursue a course of action that he or she has deemed to be morally correct, resulting in a compromise of their moral integrity. Moral integrity often has a significant overlap with ethical decision making in a professional setting. Specifically, if an individual is prevented from taking an ethically appropriate action by either personal or institutional factors (Fantus, Greenberg, Muskat, & Katz, 2017). Moral distress arises in the context of an ethical dilemma, but the two experiences are not synonymous. Similarly, it is distinct from compassion fatigue, occupational stress, or other job-related emotional experiences (Trautmann, 2015). The concept of moral distress has been well-documented in nursing literature but has only recently been explored in social work research (Houston, Casanova, & Leveille, 2013). Nevertheless, cross-disciplinary surveys found that social workers have similar moral distress scores as nurses and experience it at similar intensity and frequency as other disciplines (Houston, Casanova, & Leveille, 2013 and Allen et al., 2013). High levels of moral distress are linked to burnout, a desire to leave the profession, disassociation from patient care, and job dissatisfaction (Cohen & Erickson, 2006 and Trautmann, 2015). This presentation will define moral distress and discuss its root causes in oncology social work. Participants will have the opportunity to assess their own frequency and intensity of moral distress with a valid and reliable moral distress scale (MDS-R). A key strategy to alleviate moral distress is to increase moral efficacy and courage through ethics education (Fantus, Greenberg, Muskat, & Katz, 2017). Social workers who identify ethical dilemmas and clearly articulate the ethical decision-making process are better equipped to resolve dilemmas and to defend their moral decisions to themselves and others, which minimizes the potential for moral distress. This presentation will identify several

frameworks for ethical medical decision making that are relevant to oncology social work and use the NASW Code of Ethics. To reinforce the efficacy of the models, participants will have the opportunity to apply them to several oncology social work case studies. Participants will leave this session equipped with multiple tools to identify moral distress, provide education to interdisciplinary teams, make ethical decisions with efficacy and confidence, and advocate to improve unjust systems that create the potential for moral distress.

Abstract Summary:

Moral distress occurs when an individual is unable to pursue a course of action that they have deemed to be morally correct, resulting in a compromise of their moral integrity. This concept has been well-documented in nursing literature but has only recently been explored in social work research. Cross-disciplinary surveys found that social workers have similar moral distress scores as nurses and experience it at similar intensity and frequency. A key strategy to alleviate moral distress is to increase moral efficacy and courage through ethics education. This presentation will define moral distress and discuss its root causes in oncology social work, giving participants an opportunity to measure their moral distress. Presenters and participants will apply several frameworks for ethical medical decision making that are relevant to oncology social work and use the NASW Code of Ethics to enhance participants' abilities to articulate their moral decisions and to minimize moral distress.

Learning Objectives:

1. Describe moral distress as a concept in the context of oncology social work.
2. Identify theory-based frameworks for ethical decision making that are useful for increasing moral efficacy and moral courage.
3. Apply specific ethical decision-making models to case studies and assess their effectiveness to reduce moral distress for social workers and members of interdisciplinary teams.

References:

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Keywords: Ethics, Clinical Practice/Skill Building

Course Designation: Ethics

Presentation Level: Intermediate

LEARNING INSTITUTE

Title: Promoting Collaborative Practice through Collaborative Learning: Interprofessional Team Building in the Oncology Setting

Author(s): *Barbara Jones, PhD, MSW, FNAP; Alison Mayer Sachs, MSW, LCSW, OSW-C, FAOSW; Tara J. Schapmire, PhD, MSSW, OSW-C, FNAP, FAOSW*

Date Scheduled:

6/6/2019, 3:30pm - 5:00pm

Abstract Content:

Purpose: This workshop will provide methods and tools for increasing interprofessional collaborative education and practice in oncology care settings Rationale: Interprofessional education (IPE) in oncology is essential to prepare students to practice in today's healthcare environment where they will work on teams and collaborate with other disciplines in order to provide holistic, patient-centered care. Staff training and planning is key to the success of IPE curricula and activities. Strong preparation can contribute to successful interprofessional education and collaboration across professional roles. Methods and Content: Three presenters, two faculty members, from different universities, experienced in the development of robust IPE curriculum in oncology palliative education and one clinical administrator experienced in interprofessional collaborative practice (IPCP) will lead this interactive workshop. Participants will review the core competencies for IPE and IPCP. They will evaluate their own and their institution's readiness for participation in IPE/IPCP using standardized tools and an evaluation of their strengths, weaknesses, and opportunities in this area. The importance of staff development and examples of activities for such development will be explored. Common barriers to collaboration will be delineated and solutions offered. Methods for designing IPE activities will be presented and attendees will develop a draft plan for an IPE activity. At the end of this session, the participant will be able to: Describe the four core competencies for interprofessional collaborative practice. Name four important considerations when building an interprofessional team and describe methods for overcoming common barriers. Develop a preliminary plan for an interprofessional activity at their own institution

Abstract Summary:

This workshop will provide methods and tools for increasing interprofessional collaborative education and practice in oncology care settings Rationale: Interprofessional education (IPE) in oncology is essential to prepare students to practice in today's healthcare environment where they will work on teams and collaborate with other disciplines in order to provide holistic, patient-centered care. Staff training and planning is key to the success of IPE curricula and activities. Strong preparation can contribute to successful interprofessional education and collaboration across professional roles. Participants will explore resources for improving IPE and interprofessional collaborative practice in their own settings.

Learning Objectives:

1. Describe the four core competencies for interprofessional collaborative practice.
2. Name four important considerations when building an interprofessional team and describe methods for overcoming common barriers.
3. Develop a preliminary plan for an interprofessional activity at their own institution.

References:

Head, B. A., Schapmire, T., Hermann, C., Earnshaw, L., Faul, A., Jones, C., . . . Pfeiffer, M. (2014). The Interdisciplinary Curriculum for Oncology Palliative Care Education (iCOPE): Meeting the challenge of interprofessional education. *Journal of Palliative Medicine*, 17(10), 1107-1114. doi:10.1089/jpm.2014.0070

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Keywords: Interdisciplinary Care, Education

Course Designation: Clinical

Presentation Level: Advanced

LEARNING INSTITUTE

Title: Humble & Fierce: Paradox, or the Soul of Social Work?

Author(s): *Peter Flores, LMSW; Richard Dickens, LCSW-R*

Date Scheduled:

6/6/2019, 3:30pm - 5:00pm

Abstract Content:

What is social work? There's an ongoing debate to define our discipline especially in the hierarchy of health care, apparent in cutbacks in departments, lack of social workers in rural practices or impossibly large catchment areas. In an age of technology, where every expenditure is gauged by data, how do we quantify our significance? The most obvious is to join those disciplines that research and publish quantifiable outcomes. There is relevance to this train of thought. There is also risk in abdicating the value of the humanistic part of our work, the qualifiable aspect inculcated in graduate school, "start where the client is". This is our uniqueness in a field of exacting science. It requires active listening, empathizing, validating and sometimes even suffering with our clients and the injustices they face in a broken health care system. It requires us to be humble so as to build relationships of trust, regardless of differences, so that we can navigate the pitfalls of cancer along side our clients. This is the passion of social work; the issue that brings most of us into a profession of helping even when we know the odds are stacked against us. The National Association of Social Workers (NASW) outlines our field's fundamental core values as: service, social justice, dignity and worth of the person. It is the foundation of our profession going back to Hull House in Chicago and the Settlement Movement in New York City. While this is our foundation our founders recognized humility alone will not effect change; in fact, over time, it marginalizes our work by never moving it out of the suffering and stigmatizes social work to the role of friendly visitor. Early leaders like Jane Addams, "mother" of social work and one of the first women to win the Nobel Peace Prize (awarded in 1931), knew we also had to be fierce, by advocating, educating and fighting for change. That's the empowerment aspect of social work: be agents of change and empower clients to mobilize. This is the paradox of social work, the polarity causing lack of equal status among healthcare professions. Validating and qualifying the uniqueness of these qualities, now more than ever with cancer becoming a chronic illness, defines our profession and moves cancer out of the realm of impersonal science to human centered medicine. This was the goal of the Institute of Medicine 2008 report "Cancer Care for the Whole Patient": Cancer care today often provides state-of-the-science biomedical treatments, but fails to address the psychological and social problems associated with the illness. This failure can compromise the effectiveness of health care and thereby adversely affect the health of cancer patients. This workshop will ground social workers in our past history while expanding their understanding of the breath of the profession today. Through lecture, Q&A, small groups and interactive exercises attendees will hear the work of colleagues, explore collaborations, and discover ways to strengthen their voice in oncology.

Abstract Summary:

There's an ongoing debate to define our discipline in the hierarchy of health care where expenditures are gauged by data. Most obvious is following disciplines that research and publish quantifiable outcomes. There's relevance to this but also risk in abdicating the humanistic part of our work, the qualifiable aspect inculcated in graduate school, "start where the client is". The National Association of Social Workers outlines our fundamental core values as: service, social justice, dignity and worth of the person. Our founders recognized humility alone will not effect change we also had to be fierce, by advocating, educating, bargaining and fighting for change. This workshop will ground social workers in our past

history while expanding their understanding of the breath of the profession today. Through lecture, Q&A, small group discussion, and interactive exercises attendees will hear the work of colleagues, explore collaborations, and discover ways to strengthen their voice in oncology.

Learning Objectives:

1. Assess the historical significance of social worker leadership and advocacy.
2. Identify areas within contemporary social work practice where education, leadership and advocacy might aid in not only promoting the health and wellbeing of the clients we serve but to also strengthen and elevate the profession of social work itself.
3. Integrate the history of social work from the alms and settlement houses with the problems (AIDS, aging, health care, etc) and tools (social media, technology, etc.) of today. Integrate their scope of possibilities with the passion that drove them to social work and social justice.

References:

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Keywords: Advocacy, Leadership/Administration

Course Designation: Clinical

Presentation Level: Intermediate

PAPER SESSION III

Title: The Psychology of Hope: Implications for Social Work Practice at the End-of-Life

Author(s): *Katherine Easton, MSW, LCSW, OSW-C*

Date Scheduled:

6/6/2019, 5:15pm - 6:15pm

Abstract Content:

Hope has been considered an integral component of the psychological construct of individuals facing a terminal illness. The very definition of hope can be described as an expectation of a positive outcome or future. For those at the end of life, hope seems to be an elusive element that has the potential to improve psychological well-being and strengthen coping. Research has studied the impact of hope on survival, as a coping mechanism and a source of denial. Hope is a multi-dimensional and dynamic force that is impacted by the changing landscape of the cancer experience. Oncology social workers should see hope as an opportunity to provide a framework for helping individuals cope with illness and death. Studies show that feelings of hope can exist regardless of prognostic factors and is reflective of a coping style. "Patients with good personal functioning experienced a significantly lower level of hopelessness than did others...and no significant relationship was found between patient's prognoses and their reported feelings of hopelessness". (Ringdal 1995). This study also found that "psychological factors such as hope are still important for the patient's well-being and quality of life." Hope serves the patient at the end of life in a variety of favorable ways. Hope serves to protect from the psychological suffering as a result of terminal illness and may assist the patient and family to re-assess hope through communication around future goals. Hope may also provide an avenue for an individual to find meaning at the end of

life. "It is clear that hope functions as a protective mechanism, while hopelessness threatens...physical, psychological and spiritual health and quality of life." (Clark 2008) Psychological distress and hopelessness have been associated with a number of social and demographic influences. Determinants of hope are thought to include perceived social support, a locus of control, socioeconomic status, age, advanced disease and low physical function. Hopelessness has been shown to have significant associations between depression, suicidal ideation and desire for hastened death. "Correlation of depression with suicidal ideation is based largely on the variance that is shared with hopelessness." (Breitbart 2000). Another study concluded "It has emerged that the risk of suicide is especially high in terminal patients with hopelessness". (Chochinov 2000). Alternatively, another study showed a higher risk of suicidal ideation among individuals with site-specific cancers and demonstrated that overall physical health and mental health influenced a patient's desire for hastened death. (Schneider 2008). Implications for oncology social work practice are multi-faceted. The identification and assessment of depression, hopelessness and suicidal ideation is an important clinical skill in oncology social work. "Through accurate assessment, treatment planning and implementation, the psychological distress...can be ameliorated in patients and families requiring palliative care". (Walsh, Hedlund 2011). Recognition of the individual's personal strengths, the presence of social determinants of hope, such as social support and locus of control, enables the oncology social worker to develop appropriate interventions to nurture hopefulness, address desire for hastened death and improve the psychological well-being of individuals at the end of life.

Abstract Summary:

Hope has been considered an integral component of the psychological construct of individuals facing life-threatening illness. Hope may exist for individuals regardless of prognosis or severity of illness. The absence of hope has been associated with higher risks of depression and suicidal ideation in individuals with cancer at the end of life. The presence of hope may provide a framework for individuals to cope with illness and death and serve as a buffer to despair. The identification and assessment of depression, hopelessness and suicidal ideation will guide the oncology social worker to address the support and resources needed to nurture hope, reduce psychological suffering and improve quality of life. The recognition of individual personal strengths and social determinants of hope will enable the social worker to develop appropriate interventions to identify avenues for renewed hope, address desire for hastened death and improve psychological well-being.

Learning Objectives:

1. Review available research demonstrating the relationship between depression, suicidal ideation and hopelessness and the role hope plays in the psychological well-being of individuals facing terminal illness.
2. Discuss the social determinants of hope and identify individuals at greatest risk of hopelessness, suicidal ideation and desire for hastened death and the application of available screening tools to assist.
3. Recontextualize early social work movements and advocacy to current trends in (health care) social work.

References:

Gokler-Danisman, PhD. (2017) Experience of grief by patients with cancer in relation to perceptions of illness: The mediating roles of identity centrality, stigma-induced discrimination, and hopefulness, *Journal of Psychosocial Oncology*, Nov-Dec; 35(6) 776-796. Costantini, Anna, et. al, (2014) Psychiatric Pathology and Suicide Risk in Patients with Cancer, *Journal of Psychosocial Oncology*, 32:4, 383-395. Walsh, Katherine, & Hedlund, Susan (2011) *Mental Health Risk in Palliative Care: The Social Work Role*, Oxford Textbook of Palliative Social Work (Altillo and Otis-Green, ed.) Clark, Elizabeth J., Ph.D., MSW, *You Have the Right to Be Hopeful*, National Coalition of Cancer Survivorship, 4th Edition. Groopman, Jerome, MD (2004) *The Anatomy of Hope: How People Prevail in the Face of Illness*, Random House Publisher. Breitbart, William, MD, et. al (2000) Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer, *JAMA*, Vol. 284, No. 22. Bunston, Terry, Ph.D., et. al (1996) Facilitating Hopefulness, *Journal of Psychosocial Oncology*, 13:4, 79-103. Ringdal, Gerd, Ph.D. (1995) Correlates of Hopelessness in Cancer Patients, *Journal of Psychosocial Oncology*, 13:3, 47-66.

Keywords: Pain, Palliative Care and End of Life, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Introductory

Title: All of Our Work is HeartWork: Improving Patient Care and Making "Self-Care" Part of the Everyday

Author(s): Lorelei Bonet, MSW, LCSW

Date Scheduled:

6/6/2019, 5:15pm - 6:15pm

Abstract Content:

The concepts of compassion fatigue and moral distress in the healthcare professions have become an increasingly popular topic of research. For Social Work broadly, the notion of “burnout” has been a source of concern for many years before it was given a name with parameters that are increasingly better understood. Compassion fatigue (CF) is a term first coined by Joinson (1992) in observation of oncology nurses, and since then has been studied in various populations. CF can manifest physically as exhaustion, headaches and body aches (Orlovsky, 2006). Additionally, there can be a tendency to withdraw, high levels of stress, a general sense of impatience, irritability, and depression (Gough, 2007; Huggard, 2003) that can affect the emotional, spiritual, and psychological well-being of those in caring fields such as oncology social work. Over time, and left unabated, the progression of compassion fatigue impairs our ability to serve, to care, to advocate, to support our team, and to do this work that we chose to do (Decker, Brown, Ong, et al. 2015). Unfortunately, and despite our awareness of the phenomenon, it is unclear that graduate programs or professional settings have successfully been able to prepare oncology social workers beyond highlighting the general need for “self-care”, which often refers to activities that would occur outside of the work environment, and occupy only a small percentage of one’s waking hours. Additionally, long-time professionals continually work to care for themselves, to feel whole and productive, in the absence of institutional support or acknowledgment. In this talk, I would like to propose a model of work that I have been developing, that I call “HeartWork”. To do “HeartWork”, one does not view “self-care” as outside of, but rather very much as part of how we craft and perform our jobs on a daily basis. It seeks to position the work of the oncology social worker as reciprocal—with the ability to replenish and restore, not merely or exclusively to drain. Using literature from the fields of Social Work, Nursing, Chaplaincy, and Industrial Psychology, I would like to explore how and to what extent the unique challenges of our work inform the nature of our potential compassion fatigue, and to creatively contemplate alternatives to our current model of self-care as an “add on”, rather highlighting it as an essential and central element of our practice.

Abstract Summary:

For Social Work broadly, the notion of “burnout” has been a source of concern for many years before it was given a name with parameters that are increasingly better understood. Compassion fatigue can manifest as physical exhaustion, a tendency to withdraw, and high levels of stress (Gough, 2007). In this talk, I would like to propose a model of work that I call “HeartWork” that does not view “self-care” as outside of, but rather very much as part of how we craft and perform our jobs on a daily basis. I would like to explore how and to what extent the unique challenges of our work inform the nature of our potential compassion fatigue, and to creatively contemplate alternatives to our current model of self-care as an “add on”, rather highlighting it as an essential and central element of our practice.

Learning Objectives:

1. Explore how and to what extent the unique challenges of our work inform the nature of our potential compassion fatigue, and to creatively contemplate alternatives to our current model of self-care as an “add on”, rather highlighting it as an essential and central element of our practice to improve patient care.
2. Propose that “self-care” as currently defined is both limiting and inadequate to fully address the experience of being an oncology social worker. That to be the best social worker we can be for our patients, we must expand our notion of what is possible within our daily work.
3. Create a model of self-care that creatively integrates job satisfaction as a central component in an effort to reduce, if not eliminate compassion fatigue to improve our relationships with patients and caregivers.

References:

Decker, J. T., Brown, J. C., Ong, J., & Stiney Ziskind, C. A. (2015). Mindfulness, compassion fatigue, and compassion satisfaction among social work interns. *Social Work & Christianity*, 42, 28-42. Gough, D. L. (2007). Empathizing or falling in the river? Avoiding and addressing compassion fatigue among service providers. *Journal of the American Deafness and Rehabilitation Association*, 40(3), 13-25. Graham, J. , & Ramirez, A. (2002). Improving the working lives of cancer clinicians. *European Journal of Cancer Care (Engl)*, 11(3), 188-192. Huggard, P. (2003). Compassion fatigue: How much can I give? *Medical Education*, 37(2), 163–164. Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Trauma Stress*, 15(5), 423-432. Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22 (4), 116-120 Najjar, N., Davis, L.W., Beck-Coon, K., & Doebbeling, C.C. (2009). Compassion fatigue: A review of the research to date and relevance to cancer-care providers. *Journal of Health Psychology*, 14, 267–277. Orlovsky, C. (2006). Compassion fatigue. *Prarie Rose*, 75(3), 13. Pearlman, L. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp.51064). Lutherville, MD: Sidran Press.

Keywords: Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Introductory

Title: Know Yourself to Know Your Practice: A Self-Reflective Experience

Author(s): *Lauren Broschak, MSW, LGSW; Alicia Gray, MSW, LGSW*

Date Scheduled:

6/6/2019, 5:15pm - 6:15pm

Abstract Content:

Social Workers come into the field with personal experiences that shape who they are and why they decided to become a Social Worker. Within the field of social work textbook knowledge is often respected and revered more than personal lived experiences (Carlson & Erikson, 1999). However, Edwards and Bess (1998) argue that the application of the learned knowledge a Social Worker has is only helpful or effective when they are aware of who they are as a person in the room with their client. Furthermore, to be effective, Social Workers must be willing to be vulnerable and open to remembering past experiences, even when painful, as well as “experiencing previously unknown or unconscious aspects” of themselves (Edwards & Bess, 1998, p.99). The willingness to remain connected with these wounds allows for further empathetic engagement with patients (Cvetovac & Adame, 2017; Kirmayer 2003). Ultimately, intimately knowing oneself and one’s experiences can bring a certain freedom and creativity back into the work, and remind Social Workers why they originally pursued the career (Carlson & Erikson, 1999). In this session, we will explore the desires that originally sparked your aspiration to become a Social Worker, the personal experiences you had that nurtured these desires, and what these desires say about you, who you are, and what you value in life (Carlson & Erikson, 1999). We will examine how your past experiences have shaped you, and how these experiences can be a part of the clinical work that you do each day, through your personality, morals, values, and self-reflections within your work. This session is intended to be experiential, helping you tap into your original and current motives to be in this profession, and the experiences that led you here. Through expressive writing and small group discussion we hope to help you reignite passion for the work that you do each day.

Abstract Summary:

Social Workers come into the field with personal experiences that shape who they are and why they decided to become Social Workers. Getting to know yourself and your experiences can bring a certain freedom and creativity back into the work, and remind you why you originally pursued this career (Carlson & Erikson, 1999). In this session, we will explore the desires that originally sparked your aspiration to become a Social Worker, the personal experiences you had that nurtured these desires, and what these desires say about you, who you are, and what you value in life (Carlson & Erikson, 1999). This session is intended to be experiential, helping you tap into your original and current motives to be in

this profession, and the experiences that led you here. Through expressive writing and small group discussion we hope to help you reignite passion for the work that you do each day.

Learning Objectives:

1. Reflect upon and better understand how their past experiences and personal values, morals and identity impact their professional self and social work practice.
2. Develop tools to continue evaluation of personal self, professional self, and their social work practice through writing exercises and small group discussion.
3. Apply the learned knowledge to their own own supervision as well as supervision of other social workers. They will be able to use these reflections and evaluations to continue to advance their social work practice and self-care routines.

References:

Carlson, T. D., & Erickson, M. J. (1999, March). Recapturing the Person in the Therapist: An Exploration of Personal Values, Commitments, and Beliefs [Electronic version]. *Contemporary Family Therapy*, 21, 57-76. Cvetovac M.E., & Adame, A.L. (2017). The Wounded Therapist: Understanding the Relationship Between Personal Suffering and Clinical Practice [Electronic version]. *The Humanistic Psychologist*, 45, 348-366. Edwards, J. K., & Bess, J. M. (Spring 1998). Developing Effectiveness in the Therapeutic Use of Self [Electronic version]. *Clinical Social Work Journal*, 26, 89-105. Kirmayer, L.J (2003). Asklepien Dreams: The Ethos of the Wounded-Healer in the Clinical Encounter [Electronic version]. *Transcultural Psychiatry*, 40, 248-277.

Keywords: Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

Title: Forgiveness Therapy: Providing Patients an Oasis in a Desert of Emotional Pain

Author(s): Neal Niznan, MSW, LCSW

Date Scheduled:

6/6/2019, 5:15pm - 6:15pm

Abstract Content:

Cancer patients not only experience physical symptoms from their illness and its treatment but emotional upheaval from a life disrupted. Unresolved bitterness, hurt and resentments, sometimes over many years, can exacerbate feelings of anger possibly leading to depression, anxiety and other mental illness. Patients caught in this desert of bitterness and hurt can often discharge their anger inappropriately on others, sometime towards doctors, nurses and social workers providing their care. Since the publication of the second edition by the American Psychological Association Forgiveness Therapy has become a recognized treatment for resolving anger (Enright and Fitzgibbons 2015). The process model of forgiveness provides individuals a safe path to recognize patterns of hurt underlying their anger. It challenges them to reflect on the lives of those who have unjustly hurt them and consider forgiveness as a means of letting go of their own resentments and pain. A study on the correlation of forgiveness, stress and health indicates that an increase in one's ability to forgive helps reduce stress (Toussaint et.al 2016). This transformative process may even enable them over time to act benevolently towards those who hurt them. The need to express and receive forgiveness is integral in the process of one facing end of life (Byock 2014). Nurses working with terminally ill patients have often witnessed the desire to seek forgiveness as a way to resolve "unfinished business" (Ferrell et.al 2014), (Masterson et.al 2018). Social workers, especially those in hospice care, are in a pivotal position to address the psychosocial needs of the patients they work with to help provide a peaceful closure (Baker 2006). In her doctoral dissertation, Mary Hansen describes the use of forgiveness therapy with terminally-ill cancer patients. Her four week intervention study showed not only positive psychological benefits for the participants (Hansen 2002), but lead her to develop a model for a four week interactive group program implementing forgiveness techniques. In this paper the following areas will be addressed: impact of unresolved anger on emotional wellbeing, deeper understanding of forgiveness highlighting current misconceptions of

what it means to forgive and identification of specific phases of the forgiveness process. Implementation of the process model of forgiveness with individual patients as well as a small group workshop format will be presented with consideration to the role of Forgiveness Therapy for those facing end of life.

Abstract Summary:

Unresolved bitterness and hurt, sometimes over many years, can exacerbate feelings of anger possibly leading to depression, anxiety and other mental illness. Forgiveness Therapy has become a recognized treatment for resolving anger. The process model of forgiveness provides individuals a safe path to recognize patterns of hurt underlying their anger. It challenges them to reflect on the lives of those who have unjustly hurt them and consider forgiveness as a means of letting go of their own resentments and pain. The following areas will be addressed: impact of unresolved anger on emotional wellbeing, deeper understanding of forgiveness highlighting current misconceptions of what it means to forgive and identification of specific phases of the forgiveness process. Implementation of the process model of forgiveness with individual patients as well as a small group workshop format will be presented with consideration to the role of Forgiveness Therapy for those facing end of life.

Learning Objectives:

1. Differentiate among the various concepts of forgiveness. Recognize the definition of forgiveness described in Forgiveness Therapy upholds the dignity of the hurt individual and enables them release unresolved anger.
2. Describe and demonstrate the phases of the process model of forgiveness.
3. Create a four session group process workshop on forgiveness for patients facing end of life utilizing Forgiveness Therapy techniques.

References:

References Baker, M. (2006). Facilitating Forgiveness and Peaceful Closure. *Journal of Social Work in End-Of-Life & Palliative Care*, 1(4), 83-96. doi:10.1300/j457v01n04_06 Byock, Ira. *The Four Things That Matter Most: a Book about Living*. Atria Books, 2014 Enright, Robert D., and Richard P. Fitzgibbons. *Forgiveness Therapy: an Empirical Guide for Resolving Anger and Restoring Hope*. American Psychological Association, 2015. Ferrell, B., Otis-Green, S., Baird, R. P., & Garcia, A. (2014). Nurses Responses to Requests for Forgiveness at the End of Life. *Journal of Pain and Symptom Management*, 47(3), 631-641. doi:10.1016/j.jpainsymman.2013.05.009 Hansen, M.J. (2002). *Forgiveness as an educational intervention goal for persons at the end of life* (Doctoral Dissertation, University of Wisconsin-Madison, 2002). *Dissertation Abstracts International-A*, 63(04), p.1224 Masterson, M. P., Slivjak, E., Jankauskaite, G., Breitbart, W., Pessin, H., Schofield, E., . . . Lichtenthal, W. G. (2018). Beyond the bucket list: Unfinished business among advanced cancer patients. *Psycho- Oncology*. doi:10.1002/pon.4821 Toussaint, L., Shields, G. and Slavich, G. (2016). Forgiveness, Stress, and Health: a 5-Week Dynamic Parallel Process Study. *Annals of Behavioral Medicine*, 50(5), pp.727-735.

Keywords: Clinical Practice/Skill Building, Pain, Palliative Care and End of Life

Course Designation: Clinical

Presentation Level: Intermediate

Title: Boundary Violations: Sorting out the Black, the White and the Shades of Gray

Author(s): *Debra Mattison, MSW, OSW-C; Anna Millard, MSW*

Date Scheduled:

6/6/2019, 5:15pm - 6:15pm

Abstract Content:

Social Workers practice within a framework of a Code of Ethics which guides interactions with clients, colleagues and the organizations in which we are employed. While we may frequently feel grounded in an ethical practice of determining and maintaining therapeutic professional boundaries, there are ongoing challenges to the perception that "I've got this-- I know what is ethical." Boundary violations are among the most frequent ethical issues arising in the intimate practice of oncology social work. On a regular basis we hear narratives and national news reports of boundary violations which

brought significant damage and pain to clients as well as to social workers and the Social Work profession itself. We are often left wondering, “How did this happen?” While pondering this question, we may be apt to attempt to assure ourselves that “I would never do that! This would never happen to me or my colleagues!” Many factors contribute to the need to be ever-vigilant in exploring and challenging our notions of ethical practice which include changing technology, practice settings, political environments, cultural diversity and collaboration with interdisciplinary team members who may have differing core values and world views than Social Work. Indeed, it can be very difficult to get clarity and reach consensus regarding boundary dilemmas. As clinicians, we struggle to find the right balance between not wanting to be a “cold, blank slate” who is perceived as detached and unengaged; while at the same time, desiring to maintain professional boundaries that avoid dual relationships, inappropriate intimacy and other violations cautioned against in our Code of Ethics. Clarity regarding ethical boundaries is often easy to find regarding clearly visible boundary violations such as sexual relationships with clients. Clarity may be far more elusive with subtle, less visible issues such as appropriate sharing about self, the use of social media and actions taken when we feel compelled to make “this one time exception in this case.” This presentation will take a fresh look at foundational principles of ethically maintaining appropriate boundaries with patients and colleagues with attention to our Code of Ethics, practice standards and cultural humility. We will explore an array of challenges of these more subtle potential “micro boundary violations” such as use-of-self, what we wear, discussions of politics, culturally embedded behaviors and expression of religious beliefs. Relevant case examples will be interactively explored to raise our awareness of clinical boundary issues we may knowingly and unknowingly experience on a daily basis. Participants will leave with concepts to utilize as a “north star” in navigating the boundary complexities of helping relationships. Participants will be encouraged to explore opportunities to be more visible advocates and leaders in engaging other oncology professionals in these critical ethical discussions. Developing action plans to demonstrate our clinical expertise regarding transference and counter transference, cultural awareness and relational power dynamics will be encouraged with the goal of raising team members’ awareness of the clinical complexity of provider-patient relationships and the resulting impact on quality of care.

Abstract Summary:

Social Workers practice within a Code of Ethics to ethically ground us in determining and maintaining therapeutic professional boundaries. Yet, boundary violations are among the most frequent ethical issues arising in the intimate practice of oncology social work. Regularly we hear of boundary violations which resulted in significant damage to clients. Clarity regarding ethical boundaries is easier found in clearly visible boundary violations such as sexual relationships while far more elusive with subtle, less visible issues such as appropriate sharing about self, the use of social media and “this one time exception in this case.” Relevant case examples will be interactively explored to raise awareness of clinical boundary issues knowingly and unknowingly experienced in daily practice. Participants will leave with concepts to utilize as a “north star” in navigating boundary complexities and challenged to be more visible advocates and leaders in engaging interdisciplinary team members in these critical discussions.

Learning Objectives:

1. Cite examples of at least two ethical boundary challenges in one’s current practice environment.
2. Articulate at least three ethical principles to guide practice regarding maintaining ethical boundaries.
3. Formulate one action idea to apply a social work leadership role in promoting discussion of boundary issues with one’s interdisciplinary team.

References:

- National Association of Social Workers (2017). Code of Ethics. Washington, D.C.: Author.
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Keywords: Clinical Practice/Skill Building, Ethics

Course Designation: Ethics

Presentation Level: Intermediate

**AOSW 35TH ANNUAL CONFERENCE
FRIDAY, JUNE 7, 2019**

AOSW Quality of Life in Cancer Care Award & Lecture (sponsored by American Cancer Society)

Title: The Artistry of Compassion: The Elephant That Lingers in the Room

Author(s): *Carolyn Messner, DSW, BCD, LCSW-R, FAOSW*



Date Scheduled:

6/7/2019, 9:00am - 10:00am

Abstract Content:

There is a growing body of knowledge about oncology social workers and the impact on them of their close proximity to illness, stress and existential suffering. In contrast to themes of burnout and compassion fatigue are observed phenomena of creativity and innovation by oncology social workers. These practitioners confront complex human problems and life crises which require creative problem solving, innovative interventions, compassion and empathic connections with those they help.

The increasing career emphasis on data collection, technical skills and scholarly learning often circumvent and pay little attention to the significance of the human bond of compassion in our profession. Our humanity, exemplified in our compassion, facilitates the journey of cancer patients, cancer survivors, their families, partners, and children in their steadfast coping with the grim realities of serious illness.

This year's quality of life presentation will highlight the exceptional role of compassion and its value in the armamentarium of indispensable skill sets for oncology social workers. This approach will nurture and cultivate our endeavors to help people living with cancer, and our student interns and colleagues.

Abstract Summary:

There is a growing body of knowledge about oncology social workers and the impact on them of their close proximity to illness, stress and existential suffering. In contrast to themes of burnout and compassion fatigue are observed phenomena of creativity and innovation by oncology social workers. These practitioners confront complex human problems and life crises which require creative problem solving, innovative interventions, compassion and empathic connections with those they help. The increasing career emphasis on data collection, technical skills and scholarly learning often circumvent and pay little attention to the significance of the human bond of compassion in our profession. Our humanity, exemplified in our compassion, facilitates the journey of cancer patients, cancer survivors, their families, partners, and children in their steadfast coping with the grim realities of serious illness. This year's quality of life presentation will highlight the exceptional role of compassion and its value in the armamentarium of indispensable skill sets for oncology social workers. This approach will nurture and cultivate our endeavors to help people living with cancer, and our student interns and colleagues.

Learning Objectives:

1. Define compassion in oncology social work.
2. Recognize the exceptional role of compassion in the indispensable skill sets of oncology social workers.
3. Identify specific tips to nurture and cultivate compassion in our work, and that of our student interns and colleagues.

References:

- Berry, L., Danaher, T., Chapman, R. & Awdish, R. (2017). Role of Kindness in Cancer Care. In *Journal of Oncology Practice*. Practice 13, No. 11, pp. 744-750
- Bowling, J. & Damaskos, J. (2015). Building Resilience: A Multifaceted Support Program for Professional & Support Staff in a Cancer Center. In *Handbook of Oncology Social Work*: Edited by Christ, G, Messner, C., & Behar, L.; Oxford University Press: NY. pp. 771-776

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Keywords: Clinical Practice/Skill Building, Education

Course Designation: Clinical

Presentation Level: Introductory

PAPER SESSION IV

Title: When Staff Head for the Hills: Clinical Recommendations for Working with the Oncology Patient With Borderline Personality Disorder

Author(s): *Sara Toth, MSW, LCSW; Dianne Mead, MSW, LCSW-R*

Date Scheduled:

6/7/2019, 10:15am - 11:15am

Abstract Content:

Borderline personality disorder (BPD) is a complex, psychiatric disorder characterized by pervasive instability in regulation of emotion, interpersonal relationships and impulse control (American Psychiatric Association, 2013). Clinical studies have shown BPD to be highly comorbid with substance use, mood and anxiety disorders (Grant, et al, 2008). It is the most prevalent personality disorder in clinical settings. Persons with BPD represent approximately 6% of the general population (Coram, 2010), and it is assumed that the prevalence rate in cancer patients is about the same (Meyer, et al., 2011). These numbers suggest a growing need for oncology social worker (OSW) involvement in helping medical teams understand and effectively care for patients challenged by BPD. For an individual with BPD, a diagnosis of cancer is an additional, significant stressor for someone who is already in a state of emotional dysregulation (Coram, 2010). A patient's behavior may become increasingly disordered at a time when challenges of a serious illness require the most fully adaptive response (Doolittle and Holland, 2011). Based on clinical observation, patients with BPD often present to the medical team with behaviors that can present as unpredictable, demanding, manipulative, having unrealistic expectations of care, and are often labelled "noncompliant." Such behaviors often evoke anxiety, anger and aversion within the medical team. They also elicit a lower level of empathy and distancing from staff, which may result in a qualitatively lower level of care (Sansone, 2013). Clinical research indicates that the etiology of BPD is largely environmental, and there is a strong correlation between BPD and a history of abuse and/or neglect in childhood; oftentimes, the abuser was a parent, or another individual in a position of respect/trust (Yudofsky, 2005). As a result, many individuals with BPD have difficulty trusting and forming relationships, especially with those in a position of authority. For these individuals, there is a tendency to reenact relational and behavioral patterns experienced during childhood. When viewed through this lens, it is understandable that the cancer patient with BPD could experience a perceived lack of safety, along with fears of neglect and abandonment by medical staff, whom they view as figures of authority (Hay and Passik, 2000). For the OSW working with these patients, it is vital to maintain an awareness of the disorder as a psychiatric illness; further, it is important to distinguish the behaviors from the individual. This presentation will discuss case examples of patients with BPD who presented to an outpatient oncology setting with challenges of adherence to treatment, distrust of the medical team and behaviors that were persistently disruptive to their care. Drawing upon BPD and psycho-oncology literature, this presentation will discuss how the OSW can promote understanding, compassion and resilience when assessing and intervening with these patients. Strategies on how to help medical teams best communicate and remain empathetic to patients with BPD will also be discussed. Participants will gain knowledge/skills that will enhance their clinical work with patients with BPD throughout their illness and treatment.

Abstract Summary:

The cancer patient with Borderline Personality Disorder (BPD) can present as a significant challenge in the oncology setting. Based on clinical observation, staff can perceive such patients to be noncompliant and unpredictable. Such behaviors tend to evoke negative emotions in clinicians, such as guilt, irritation and aversion (Meyer and Block, 2011). When left unattended to, these emotions can negatively affect the care provided. The oncology social worker (OSW) has a critical role in caring for the cancer patient with BPD, and in assisting the medical team in utilizing best practices when working with these patients. Drawing upon BPD and psycho-oncology literature, this presentation will discuss how the OSW can promote understanding, compassion and resilience when assessing and intervening with these patients. Strategies on how to help medical teams best communicate with and remain empathetic to patients with BPD will also be discussed.

Learning Objectives:

1. Illustrate an understanding of working with cancer patients with Borderline Personality Disorder.
2. Develop clinical skills when working with patients with Borderline Personality Disorder in an oncology setting.
3. Apply skills in leading medical teams through the psychosocial complexities of working with patients with Borderline Personality Disorder.

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Keywords: Clinical Practice/Skill Building, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Intermediate

Title: Exploring The Association Between a Cancer Diagnosis and Food Insecurity: The Need for Future Research

Author(s): *Torie Gettinger, MSW, LCSW, OSW-C*

Date Scheduled:

6/7/2019, 10:15am - 11:15am

Abstract Content:

Background: Cancer not only impacts an individual's physical and psychological well-being, but also one's financial well-being.(1-3) Individuals diagnosed with cancer may face higher financial burden, are at increased risk for bankruptcy, and regularly experience decreased income.(4-8) As a result, these individuals may be forced to choose between competing demands such as food and medical treatment. This suggests individuals diagnosed with cancer may be at risk for experiencing food insecurity, meaning that in the past year they were uncertain of having or being able to acquire enough food to meet the needs of all household members. (9) Yet, few studies have empirically explored food insecurity in this population. This study aims to explore the prevalence of food insecurity of household heads diagnosed with cancer and the associated characteristics of these individuals. Methods: A sample (N=8,817) from the 2015 Panel Study of Income Dynamics is used. Food insecurity is measured using the Household Food Security Scale which represents the level of food insecurity in the previous year as determined by an 18-item scale developed by the US Department of Agriculture (USDA). In this study, using the USDA's categorical system for food security, the continuous variable representing food insecurity is converted to a dichotomous categorical variable, indicating food secure for individuals with a household food security score of 2 or less and food insecure for a score of 3 or above. Household heads were asked if they have ever been told by a healthcare professional that they have cancer. Descriptive statistics are used to examine the prevalence of food insecurity and the characteristics of household heads diagnosed with cancer who experienced food insecurity. Results: Nearly 6% (N=501) of household heads reported being diagnosed with cancer during their lifetime and of this group, approximately 14% experienced food insecurity in the previous year. Of those 69 household heads who were diagnosed with cancer and experienced food insecurity, they had an average age of 52, average household income of \$33,658, average education of 12.68 years, and 47.83% identified themselves as Non-White, 59.42% were female, 76.81% were not married, 69.5% were not working, 50.72% participated in a Food Stamp program, 29% had one or more children ages 18 or younger, 92.75% indicated at least one member in the household had medical insurance, and 21.74% had medical bills. Conclusion and Implications: The percentage (14%) of household heads diagnosed with cancer who reported that they experienced food insecurity is slightly higher than the percentage of the general population that experienced food insecurity in 2015 (12.7%), indicating that household heads with cancer experience food insecurity. (9) With the nutritional needs of this population, the lack of ability to acquire adequate food may contribute to decreased adherence, adverse health outcomes, and lead to increased costs of care. (10-13) Future research is necessary to explore the prevalence of food insecurity in this population and identify characteristics that may heighten risk. Results may have implications at the micro and macro levels, leading to new screening processes, interventions, policies, and resource allocation.

Abstract Summary:

Cancer impacts an individual's physical and psychological well-being, as well as one's financial well-being. These individuals may be forced to choose between competing demands such as food and treatment. Individuals with cancer may be at risk for experiencing food insecurity, meaning that in the past year they were uncertain of having or being able to acquire enough food to meet the needs of all household members. Few studies have empirically explored food insecurity in this population. Using data from the 2015 Panel Survey of Income Dynamics, this study explored the prevalence of food insecurity of household heads diagnosed with cancer and the associated characteristics of these individuals. Nearly 6% (N=501) of household heads reported being diagnosed with cancer during their lifetime and of this group, approximately 14% experienced food insecurity in the previous year. Future research is warranted to identify factors that increase risk of food insecurity in this population.

Learning Objectives:

1. Describe the prevalence of household food insecurity in individuals diagnosed with cancer.
2. Examine characteristics commonly associated with household food insecurity in individuals diagnosed with cancer in an effort to identify populations at highest risk for experiencing food insecurity.
3. Identify the need to conduct future research to evaluate the prevalence of food insecurity in individuals impacted by cancer, identify predictors of food insecurity, and evaluate impact on health outcomes.

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Keywords: Clinical Practice/Skill Building, Financial Toxicity

Course Designation: Clinical

Presentation Level: Introductory

Title: Life, Death and Experience of Suffering: Implementation of Meaning Centered Psychotherapy with Advanced Cancer Patients in Oncology Social Work Practice

Author(s): *Lisa Picciuti, LCSW, OSW-C, CTTS, NCTTP; Asha Bernard, LPC, NCC, GRS*

Date Scheduled:

6/7/2019, 10:15am - 11:15am

Abstract Content:

“But if there is meaning, it is unconditional meaning, and neither suffering nor dying can detract from it.” Viktor Frankl, *The Will to Meaning*, 2006. Advanced cancer creates physical, emotional and existential suffering. As providers of emotional support, oncology social workers have the opportunity to help patients find meaning in their experience, creating an oasis in which life's deepest questions can be pondered, shared and witnessed. This creates a safe haven for patients and it deepens the satisfaction clinicians feel when facilitating the opportunity for patients to make meaning out of suffering and life as a whole. Studies show (Frankl, 2006; Breitbart & Poppito, 2014; Sjoberg, Beck, Rasmussen & Edberg, 2017) that finding meaning in life's challenges has the power to alleviate suffering, enrich experience and enhance connectedness. Addressing existential concerns has been an unmet need among advanced stage cancer patients (van der Spek, Vos, van Uden-Kraan, Breitbart, Tollenaar, Cuijpers & Verdonck de Leeuw, 2013; Moadel, Morgan, Fatone, Grennan, Carter, Laruffa, Skummy & Dutcher, 1999). Our goal in implementing Meaning Centered

Psychotherapy (MCPT) is to empower patients to make meaning of their experience with cancer and suffering by facilitating reconnection to existing sources of meaning, and introducing new tools for finding and creating meaning in their lives. MCPT is a powerful intervention in time limited groups, as well as with individuals and single sessions. The purpose of this poster presentation is to demonstrate implementation of a meaning centered group with patients who have advanced stage cancer. We will demonstrate how we implemented MCPT in our outpatient community based cancer center from program development through end of group evaluation and processing. Additionally, we will show how MCPT groups are enriched by collaboration with other cancer care professionals across disciplines such as art and music therapists, oncology nurses and palliative care clinicians. Seasoned clinicians will recognize the opportunity to deepen and broaden their practice skills while providing patients support that is hard to find in more traditional offerings. MCPT potentially provides support on multiple levels – existential, spiritual, emotional, social – thus allowing patients the freedom, inspiration and support to explore all avenues of meaning making in their lives.

Abstract Summary:

This presentation will demonstrate implementation of a meaning centered psychotherapy group in an outpatient community based cancer center. Training, program development, identification of participants, enrichment activities and interventions, and end-of- group evaluation and processing will also be illustrated.

Learning Objectives:

1. Demonstrate rationale and benefits of providing support for advanced cancer patients in making meaning of their lives and cancer experience through participation in a meaning centered psychotherapy group.
2. Discuss how training for and implementing a meaning centered psychotherapy group enhances the clinical skills and visibility of oncology social work in a multidisciplinary setting.
3. Illustrate implementation of a meaning centered psychotherapy group through the stages of planning, identification of participants, through evaluation and end of group processing.

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Keywords: Clinical Practice/Skill Building, Pain, Palliative Care and End of Life

Course Designation: Clinical

Presentation Level: Advanced

Title: The Weight is Over: Comprehensive Strategies to Assist with Weight Management Following Breast Cancer Diagnosis and Treatment

Author(s): Lauren Fay, RD, CSO, CNSC; Drucilla Brethwaite, MSW, LCSW

Date Scheduled:

6/7/2019, 10:15am - 11:15am

Abstract Content:

Research for the prevention on cancer occurrence and outcomes has long focused on lifestyle interventions given their inherent ability to be altered by individuals. As this body of research has grown, it has become evident that there is increased risk of multiple cancer types due to elevation in adipose tissue, often measured by Body Mass Index (BMI) in the literature due to ability to perform this measurement easily, in addition to its correlation to increased adipose tissue.

The connection between overweight/obese BMI measurement in women before, during, and after breast cancer diagnosis contributing to increased risk for mortality and second primary breast cancer has been well documented (Azard, 2014; Chan, 2014; World Cancer Research Find, 2018). According to the Center for Disease Control, as of 2014, 66.9% of adult women in the United States had overweight or obese BMI, and weight gain following breast cancer diagnosis has been observed as early as 1978 (Makari-Judson, 2014) with increased rates of weight gain in comparison to disease free women (Gross, 2015). The mechanisms contributing to overweight/obese status and weight gain in women with a breast cancer diagnosis are multifactorial, including alterations in diet and physical activity habits, potential medication related side effects, and psycho-social stressors. In practice, the knowledge of overweight/obese BMI status on risk of worsening outcomes appears to be well known among women diagnosed with breast cancer, which unfortunately contributes to stress. The complexity of factors contributing to the existence or development of becoming overweight/obese in the breast cancer population indicates the need for a multi-faceted approach to successful intervention. Small scale studies have shown significant weight loss with interventions combining diet and physical activity counseling in comparison to general health information (Goodwin, 2014). Data showing the successful, significant weight loss combining diet and nutrition counseling with cognitive behavioral therapy in women with a breast cancer diagnosis (Mefferd, 2006; Playdon, 2013) supports the effort to combine all of these evidenced based treatment modalities in practice. Although research is currently insufficient to prove weight loss and achieving a healthy body weight after breast cancer diagnosis improves outcomes such as mortality and second primary occurrence, the improvement in proposed mechanisms that likely contribute to increased risk of poor outcomes (improvements in estrogen, growth factors, and inflammatory marker levels) with weight loss in addition to prevention of other unfavorable health conditions (diabetes, heart disease), justify the focus on identifying and implementing successful interventions to assist women diagnosed with breast cancer with achieving weight loss.

During this presentation, an oncology Registered Dietitian clinical specialist and licensed clinical Social Worker will review comprehensive approach using evidence-based research to assist women diagnosed with breast cancer diagnosis achieve weight loss. There will be a review of current research supported recommendations for diet, physical activity, and cognitive behavioral therapy techniques that result in successful interventions. Additionally, the presenters will share resources clinicians in attendance can use to apply these techniques into their own practice to help overweight/obese patients with a breast cancer successfully lose weight.

Abstract Summary:

The evidence supporting increased risk for poor outcomes (increased incidence of second primary breast cancer and overall mortality) in breast cancer patients with overweight, obese body mass indexes has been well documented (Azard, 2014; Chan, 2014; World Cancer Research Find, 2018). The existing high rates of overweight/obesity amongst American women, and the common occurrence of weight gain following a breast cancer diagnosis justify the effort to help provide interventions to help support successful weight loss to a healthy body weight range. During this presentation, an oncology Registered Dietitian clinical specialist and licensed clinical Social Worker will review comprehensive approach using evidence-based research to assist women diagnosed with breast cancer diagnosis achieve weight loss. Additionally, the presenters will share resources clinicians in attendance can use to apply these techniques into their own practice to help overweight/obese patients with a breast cancer successfully lose weight.

Learning Objectives:

1. Identify the scope of health and psychological consequences of obesity and weight gain in women with a breast cancer diagnosis.
2. Demonstrate nutritional, physical and cognitive behavioral interventions to successfully achieve positive outcomes in weight loss management in women with a breast cancer diagnosis.
3. Recognize best-practice resources clinicians can integrate into practice.

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Keywords: Clinical Practice/Skill Building, Interdisciplinary Care

Course Designation: Clinical

Presentation Level: Intermediate

Title: Ethnic Transference in the Oncology Setting: The Clinician/Patient Relationship

Author(s): Linda Mathew, LCSW-R, OSW-C; Annamma Abraham Kaba, LCSW-R

Date Scheduled:

6/7/2019, 10:15am - 11:15am

Abstract Content:

The need for cultural humility and ethnic sensitivity has never been greater for oncology social workers than the present, due to the increasing racial tensions in the country. The U.S. is increasingly becoming ethnically and culturally diverse. Ethnic minorities represent 26% of the U.S. population (US Census Bureau, 2017). In medicine, unconscious biases can be present among healthcare providers, leading to discriminatory attitudes in communication with patients and families of different ethno-cultural backgrounds (Annals of Oncology, 2010). Oncology social workers are guided by a set of professional ethics and values that emphasize dignity and worth of individuals, cultural humility and social diversity (NASW Code of Ethics, 2005). As oncology social workers, we witness profound experiences of suffering, resilience, loss, and grief, regardless of our patients' race, ethnicity, socioeconomic status and culture. Yet, we live in a culture where overt prejudices and micro-aggressions are on the rise in all facets of our society. Cultural factors affect patients' perception of cancer, suffering, their response to treatment and their relationship to the healthcare team. For clinicians, self-awareness and knowledge of one's own cultural background are key elements in implementing cultural humility in our clinical practice. Yet, in supervision we spend little time on the importance of unconscious biases and micro-aggressions that appear in the interaction between the clinician of color and patients (Hook et al, 2016). Cancer does not discriminate; it is a disease that can and does affect us all regardless of ethnicity, social status, gender, religion, and sexuality (Hughes, 2005). Ethnicity and cultural biases can operate unconsciously in most individuals and may become projections by both patient and clinician. The therapeutic relationship is complex because the clinician and patient bring to it their own cultural beliefs, behaviors, and biases. Culture, identity, and one's world view shapes how we think about a clinical encounter. These reactions by clinician and patient can generate issues of trust, anger, ambivalence, and over-identification which can significantly impact the therapeutic process and relationship (Bernstein, 2013). Exploration of these reactions and impact on the therapeutic alliance need to be explored in supervision. And within the context of a cancer diagnosis and treatment these reactions can be augmented and exacerbated by that crisis. Cultural issues are embedded in every clinical encounter, from assessment to intervention. The DSM-5 now includes a Cultural Formulation assessment in the clinical encounter because cultural identity has implications on treatment and its outcome (Fung, 2017). Therefore, it is imperative that the dialogue around cultural understanding and meaning be part of an ongoing examination in the cancer treatment setting. Research done by Comez-Diaz and Jacobsen (1991) coined the terms inter-ethnic transference, which is when the patient and clinician are from different ethnic backgrounds. Intra-ethnic transference is when the patient and clinician are from the same ethnic background (Comez-Diaz, Jacobsen, 1991). This paper will explore the concepts and perspectives of inter-ethnic and intra-ethnic transference/countertransference by using observations from clinicians of color. The paper will examine common unconscious biases that show up in the therapeutic relationship and explore ways to work through them within the context of a cancer diagnosis and treatment.

Abstract Summary:

The need for cultural humility and ethnic sensitivity has never been greater for oncology social workers than the present, due to the increasing racial tensions in the country. As OSWs, we witness profound experiences of suffering, resilience, loss, and grief, regardless of our patients' ethnicity, socioeconomic status, and culture. Cultural factors affect patients' perception of cancer, suffering, their response to treatment and their relationship to the healthcare team. Cancer does not discriminate; it is a disease that can and does affect us all regardless of ethnicity, social status, gender, religion, and sexuality. For clinicians, self-awareness and knowledge of one's own cultural background are key in implementing cultural humility in our practice. This paper will explore the concepts and perspectives of interethnic and intraethnic transference/countertransference by using observations from clinicians of color. The paper will examine common unconscious biases that show up in the therapeutic relationship and explore ways to work through them.

Learning Objectives:

1. Discuss the inter-ethnic and intra-ethnic transference and countertransference in a therapeutic context.
2. Explore common unconscious biases that impede the therapeutic relationship.
3. Examine ways to adapt cultural humility to respect the dignity of another's culture and how patient's narrative impacts their cancer journey.

References:

Bernstein, D. (2003). Therapist-Patient Relations and Ethnic Transference. *Journal of Nervous and Mental Disorder*. 191 (8): 103-121 Comas-Diaz, L and Jacobsen, F (2003). Ethnocultural Transference and Countertransference in the Therapeutic Dyad. *American Journal of Orthopsychiatric Association*. 61(3): 392-40 Foronda, C., Baptiste, D., Reinholdt, M., Ousman, K. (2016). Cultural Humility: A Concept Analysis. *Journal of Transcultural Nursing*. 27 (3): 210-217 Fung, K and Lo, T (2017). An Integrative Clinical Approach to Cultural Competent Psychotherapy. *Journal of Contemporary Psychotherapy* 47: 65-73 Hook, J., Farrell, J., Davis, D., Deblaere, C., Tongeren, D. and Utsey, S. (2106). Cultural Humility and Racial Microaggressions in Counseling. *Journal of Counseling Psychology*. 63 (3): 269-277 Parson, E. (1993). Ethnotherapeutic Empathy-Part I: Definition, Theory, and Process. *Journal of Contemporary Psychotherapy*. 23 (1): 5-18 Parson, E. (1993). Ethnotherapeutic Empathy-Part II: Techniques in Interpersonal Cognition and Vicarious Experiencing Across Cultures. *Journal of Contemporary Psychotherapy*. 23 (3): 171-182 Surbone, A. (2008). Cultural Aspects of Communication in Cancer Care. *Support Cancer Care*. 16: 235-240 Surbone, A. (2010) Editorial: Cultural Competence in Oncology: where do we stand? *Annals of Oncology* 21: 3-5 United States Census Bureau [cited 2017 25 November]. Available from <https://factfinder.census.gov/>

Keywords: Clinical Practice/Skill Building, Special Populations

Course Designation: Cultural Competency

Presentation Level: Advanced

Title: Medical Cannabis, Ethics and the Oncology Social Worker

Author(s): *Leora Lowenthal, LICSW, MPA, OSW-C; Kalen Fletcher, MSW, LCSW, MPH*

Date Scheduled:

6/7/2019, 10:15am - 11:15am

Abstract Content:

On November 5, 1996, California became the first state to legalize the use of medical cannabis. As of September 2018, legislation allowing the use of medical cannabis has been passed in 31 states and the District of Columbia. These developments aside, cannabis remains classified as a Schedule 1 drug under federal law, meaning it is considered to have a "high potential for abuse," "no currently accepted medical use," and "a lack of accepted safety." (21 U.S.C. § 812) This inherent conflict between federal and state law creates multiple challenges for patients and providers, including oncology social workers (OSWs). Patients who reside in states where medical cannabis is legal may be faced with a variety of challenges, including but not limited to: locating a provider who can certify their use and provide appropriate care; paying for their care and medicine; social stigma, concerns about abuse and dependency, an inability to travel out of state with cannabis, and even risk to employment (1,3,4,5,6). Further, as a consequence of the conflict between state and federal law, many major health institutions continue to prohibit or frown upon their providers actively advising on or certifying use. For OSWs this conflict may cause discomfort when working with patients who are using or seeking to use cannabis medicinally. The discomfort may be due to a lack of familiarity with the sociopolitical and legal landscapes, but may also result from the OSWs personal values and beliefs regarding the use of medical cannabis. There is no literature specific to OSWs and perspectives on medical cannabis but even in states where legislators and a majority of voters have supported legalized medical cannabis, the subject remains a matter of significant controversy and disagreement (1,5,6,7). The authors will present an overview of the current legislation pertaining to medical cannabis and examine the potential role and responsibility for OSWs. Using case examples they will consider some of the more common ethical quandaries that may arise in the context of clinical practice and frameworks which OSWs can use for guidance, including the NASW Code of Ethics and the four principles of bioethics identified by ethicists Beauchamp and Childress: respect for autonomy, non-maleficence, beneficence and justice (2,8). The authors do not seek to define

“right” or “wrong” answers for the individual OSW but rather to provide frameworks with which to consider some of the complex questions that surround this topic. The legalization and use of medical cannabis remains complicated and controversial with no easy resolutions in sight. OSWs cannot resolve that independently but with knowledge and forethought can better help patients who wish to explore this as part of their care experience.

Abstract Summary:

On November 5, 1996, California became the first state to legalize the use of medical cannabis. As of September, 2018, legislation allowing the use of medical cannabis has been passed in 31 states and the District of Columbia. These developments aside, cannabis remains classified as a Schedule 1 drug under federal law 21 U.S.C. § 812. This inherent conflict between federal and state law creates multiple challenges for patients and providers (1,3,4,5,6). The authors will present an overview of the current legislation and examine the potential role and responsibility for oncology social workers (OSWs). They will use case examples to consider some of the ethical quandaries that may arise in the context of clinical practice and frameworks including the NASW Code of Ethics and the four principles of bioethics identified by ethicists Beauchamp and Childress: respect for autonomy, non-maleficence, beneficence and justice (2,8).

Learning Objectives:

1. Identify common ethical dilemmas that may arise around the subject of medical cannabis when working with oncology patients.
2. Apply ethical frameworks including the NASW Code of Ethics and the four principles of bioethics identified by ethicists Beauchamp and Childress: respect for autonomy, non-maleficence, beneficence and justice.
3. Identify one's individual role and responsibility with regard to oncology patient care and medical cannabis.

References:

1. Adler, J.N., Colbert, J.A. Medicinal use of marijuana—polling results. *N Engl J Med.* 2013;368(22):e30. 2. Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York: Oxford University Press 3. Brady, J.G., Rush, M., *Employment Protections Under Medical Marijuana Laws: The Changing Landscape.* 2014. Bloomberg Law Reports; The Bureau of National Affairs, Inc. 4. Deitchler, D.L. The workplace and medical marijuana: Employer guidelines for navigating the legal haze. April 15, 2015, *Inside Counsel Magazine* 5. Johannigman, S, Eschiti, V. Medical use of marijuana in palliative care. *Clin J Oncol Nurs.* 2013;17(4):360-362. 6. Wilkie, G., Sakr, B., Rizack, T. Medical Marijuana Use in Oncology: A Review. *JAMA Oncol.* 2016;2(5):670-675. 7. Volkow ND, Baler RD, Compton WM, Weiss SRB. Adverse health effects of marijuana use. *N Engl J Med.* 2014;370(23):2219-2227. 8. National Association of Social Workers. (2017). *NASW Code of Ethics (Rev ed.)*. Retrieved from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

Keywords: Ethics, Pain, Palliative Care and End of Life

Course Designation: Ethics

Presentation Level: Intermediate

PAPER SESSION V

Title: Unmet Needs: How to Address the Gap for Millennial Caregivers

Author(s): *Erin Price, MSW, LGSW; Lauren Broschak, MSW, LGSW*

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

Millennials account for roughly one in four family caregivers in the United States (Flinn, 2018). The current generation of millennial caregivers (MCGs) is the most diverse group of caregivers the US has ever seen; more than half are Hispanic/Latino, African American/Black, or Asian American/Pacific Islander (Flinn, 2018). Additionally, almost 50% of MCGs are men, which is higher than in previous generations (Flinn, 2018). This is an important and growing group of caregivers facing a unique set of challenges, yet they are often overlooked in research and neglected in the community.

Young adults are in a critical stage of development – determining life plans, finishing education, starting a career, establishing relationships, and building a family (Flinn, 2018; James, 2018; Levine et al., 2005). With caregiver duties among this population only slated to grow, it is important for social workers to identify the unique needs and stressors that they face and be ready to support them. The burden of caregiving may be higher on a millennial than on an older adult. MCGs spend on average 21 hours per week in a caregiving role – which is equivalent to a part-time job; while 19% spend upwards of 40 hours per week providing care (Flinn, 2018). MCGs are highly likely to be employed full-time while caregiving, although less than half make an average annual salary above \$50,000 (Flinn, 2018). The time commitment required to provide care is likely to have a negative impact on the MCG’s career, finances, life goals, relationships, physical fitness, and stress management (Flinn, 2018; James, 2018; Levine et al., 2005). Additionally, MCGs are called upon to provide a wide range of caregiving responsibilities, including complex care tasks, such as medical/nursing tasks, ADLs, and household/logistical management, yet fewer than 30% who help with complex medical/nursing tasks have received instruction in how to do so (Flinn, 2018). MCGs are more likely to get assistance and information from online resources and less likely to get information from health care providers than other generations (Flinn, 2018). Most MCGs (83%) also report that they want more information than they currently have, most notably in the areas of stress management and tips for coping with caregiving challenges (Flinn, 2018). Studies have now shown that cancer caregiver, and even patient, outcomes can be negatively impacted by the caregiver’s stress, which puts MCGs and their loved ones at higher risk (Northouse, Williams, Given, & McCorkle, 2012). This presentation will address the unique needs and challenges experienced by MCGs in the cancer community and provide information on how to best serve this growing population. There is limited information and research available on MCGs in healthcare settings, and virtually no information on this population within oncology. We will aim to adapt current research and resources to the oncology MCG population in an effort to bridge this gap. We will also provide key tips, tools, and resources to use when working with MCGs and to share with this caregiver population.

Abstract Summary:

Millennials, which account for roughly one in four family caregivers in the United States, are in a critical stage of psychosocial development (Flinn, 2018; James, 2018; Levine et al., 2005). Additionally, cancer patient and caregiver health outcomes can be negatively impacted by caregiver stress (Northouse, Williams, Given & McCorkle, 2012). This presentation will address the unique needs and challenges experienced by Millennial Caregivers (MCGs) in the cancer community and provide information on how to best serve this growing population. There is limited information and research available on MCGs in healthcare settings, and virtually no information on this population within oncology. We will aim to adapt current research and resources to the oncology MCG population in an effort to bridge this gap. We will also provide key tips, tools, and resources to use in working with MCGs and to share with this caregiver population.

Learning Objectives:

1. Differentiate between needs found in a general cancer caregiver population and those specific to the millennial caregiver population including isolation from peer/psychosocial support, familial dynamics, navigating work or school, various financial challenges, stress reductions, and health literacy deficits.
2. Utilize this presentation to improve staff knowledge, millennial caregiver-patient-provider communication, as well as, caregiver and patient quality of life by integrating best-practices and resources available.
3. Demonstrate knowledge in regards to psychosocial needs and specific resources for millennial cancer caregivers.

References:

Flinn, B. (2018). Millennials: The Emerging Generation of Family Caregivers. AARP Public Policy Institute. Retrieved from <https://www.aarp.org/ppi/info-2018/millennial-family-caregiving.html> | James, N. (2018). Young adult development and caregiving: Disposition and involvement in care. University of Central Florida. Retrieved from <http://etd.fcla.edu/CF/CFE0007018/Final-Thesis-Manuscript-NTJ.pdf> | Levine, C. Hunt, G., Halper, D., Hart, A., Lautz, J., and Gould, D. (2005). Young Adult Caregivers: A First Look at an Unstudied Population. *American Journal of Public Health*, 95(11): 2071–2075. doi: 10.2105/AJPH.2005.067702 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449485/> | Northouse, L., Williams, A., Given, B., and McCorkle, R. (2012) Psychosocial care for family caregivers of patients with cancer. *Journal of Clinical Oncology*, 30(11), 1227-1234. doi: 10.1200/JCO.2011.39.5798

Keywords: Special Populations, Adolescent and Young Adult

Course Designation: Cultural Competency

Presentation Level: Introductory

Title: When a Parent Has Cancer: How Oncology Social Workers Can Enhance Children's Coping & Provide Family Support

Author(s): *Shelby Becka, MSSW, LCSW*

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

A cancer diagnosis affects every aspect of a person's life: physically, emotionally, financially, and relationally. For patients with children, additional stress is placed on the family as they worry about communicating their disease to their children and helping them cope appropriately. Cancer disrupts many routines and role responsibilities within a family unit due to treatment demands, frequent hospitalizations, potential decline in household income, and a decrease in the physical and emotional availability of both parents. (Phillips, 2017) The American Cancer Society estimates more than 367,000 people who have children under age 18 will be diagnosed with cancer annually (2018). Previous research has estimated there are almost 3 million children in the United States living with a parent who has cancer (Annunziata et.al., 2016 and Shallcross et.al., 2016). Additionally, young adult cancer rates are increasing, potentially exposing more children to a parent with cancer, given that young adulthood is typically a time to start developing families. Research also indicates that cancer patients with children have five times higher risk of developing a stress disorder during the course of their disease (Gotze et.al., 2017). A cancer diagnosis and ensuing treatment can be complex and confusing for adults to comprehend and process, therefore it is natural that children may be especially vulnerable to difficulty understanding and/or coping. Developmentally and emotionally, children have fewer coping skills than adults and may experience elevated anxiety, depression, aggression, and somatic complaints in response to the many stressors their family is facing as a result of cancer (Moeller et.al., 2014). All of these factors make it evident there is a growing need for interventions to address children's coping needs in the context of their parent's cancer. As oncology social workers, it is within our scope of practice to provide psychosocial support for the entire family as they adjust and progress through the cancer journey. One of the most common concerns parents have is how to communicate with their children about their diagnosis. Recognizing and understanding the different developmental stages children experience will help social workers inform parents of how to have these conversations. Existing family dynamics and cultural considerations may also shape these conversations. Social workers can explore with parents healthy ways to model their feelings for their children and influence age appropriate, open communication. Research has shown that families who communicate openly with one another concerning a cancer diagnosis have less reported psychosocial distress. Additionally, research suggests that psychological interventions can lead to increased quality of life, coping skills and stress management for families. (Phillips, 2017). At our institution, the department of social work has developed a program specifically to enhance children's understanding and foster healthy coping skills including resources for parents, children, and a support group. Our staff engage in ongoing trainings and education to provide the most comprehensive care for our patients with children. This presentation will explore how best to provide psychosocial support to children and families and discuss psychosocial program development to meet these needs.

Abstract Summary:

A cancer diagnosis can be stressful and overwhelming for anyone to comprehend and process. For patients with children, additional stress is placed on the family as they worry about communicating with their children and helping them cope appropriately. Children are especially vulnerable to difficulty understanding and coping as developmentally and emotionally they have less capacity to cope with life stressors than their parents. There is a growing need for interventions to address children's coping needs in the context of their parent's cancer. As oncology social workers, we provide psychosocial support for the entire family as they adjust and progress through the cancer journey. Social workers can explore with parents healthy ways to model their feelings for their children and influence age appropriate,

open communication. This presentation will explore how best to provide psychosocial support to children and families and discuss psychosocial program development to meet these needs.

Learning Objectives:

1. Review the developmental tasks of children and learn age appropriate communication techniques to enhance their understanding of cancer and foster healthy coping skills.
2. Explain the unique psychosocial needs faced by patients who have children and discuss best practices to provide them with psychosocial support.
3. Describe the program structure utilized by our institution to address children's coping with a parent's cancer diagnosis.

References:

American Cancer Society. (2018). Cancer Facts & Figures. Atlanta, Georgia. Annunziata, M.A., Muzzatii, B., & Surbone, A. (2016). Addressing the psychosocial wellbeing of teenage children of cancer patients and survivors. *Support Care Cancer*, 24, 509-511. DOI: 10.1007/s00520-015-2975-3 Check, D.K., Park, E.M., Reeder-Hayes, K.E., Mayer, D.K., Deal, A.M., Yopp, J.M., ...Hanson, L.C. (2017). Concerns underlying treatment preferences of advanced cancer patients with children. *Psycho-Oncology*, 26, 1491-1497. DOI: 10/1002/pon.4164 Gotze, H., Friedrich, M., Brahler, E., Romer, G., Mehnert, A., & Ernst, J. (2017) Psychological distress of cancer patients with children under 18 years and their partners- a longitudinal study of relationships using dyadic data analysis. *Support Care Cancer*, 25, 255-264. DOI: 10.1007/s00520-016-3411-z Moeller, B., Barkmann, C., Krattenmacher, T., Kuhne, F., Bergelt, C.,Beierlein, V., Ernst, J.,Brahler, E., ... Romer, G. (2014). Children of cancer patients: Prevalence and predictors of emotional and behavioral problems. *Cancer*, 120, 2361-70. DOI: 10.002/cncr.28644 Phillips, F., & Prezio E.A. (2017). Wonders & worries: evaluation of a child centered psychosocial intervention for families who have parent/primary caregiver with cancer. *Psycho-Oncology*, 26, 1006-1012. DOI: 10.1002/pon.4120 Shallcross, A.H., Visvanathan, P.D., McCauley, R., Clay, A., & van Dernoort, P.R. (2016). The effects of the CLIMB program on psychobehavioral functioning and emotional regulation in children with a parent or caregiver with cancer: A pilot study. *Journal of Psychosocial Oncology*, DOI: 10.1080/07347332.2016.1191577

Keywords: Special Populations, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Introductory

Title: Training Clinicians to Assess for Suicide Risk in Oncology Patients

Author(s): Traci Newsom, MSW, LCSW; Amy LaMarca Lyon, MSW, LCSW

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

On average, one person dies by suicide every 11.7 minutes. Studies have shown that most individuals have contact with their health care providers in the year prior to their death by suicide. The Joint Commission considers suicide as a sentinel event and its National Patient Safety Goal 15.01.01 that hospitals identify patients at risk for suicide. Cancer Institutions in particular have notoriously been deficient in evaluating suicidality. Social Workers are often first responders in assessing for suicide risk. Given these facts it is imperative that we improve training for oncology social workers so they feel equipped to effectively assess for suicide risk and provide interventions that evidence shows are most likely to keep people safe. In designing a day long training program for social work counselors at a large cancer institution, we first considered clinicians attitudes and comfort levels in assessing suicide risk and providing appropriate interventions (by conducting pre and post surveys). As expected most clinicians endorsed comfort in making initial assessments but were less comfortable in providing appropriate interventions. In canvassing various models of assessment and intervention the ASIST model provided a well-established training program that encourages clinicians to reassess how they engage with a client experiencing suicidal crisis. At the same time, the model is designed for non-professionals and components of the model were not well suited to an oncology setting. The program we developed is a

hybrid of the ASIST model and other current research and was informed by the in depth experience we have had working with oncology patients. In brief, there were two parts of the training. The first asked clinicians to engage on a personal level with their own experiences with suicide and how these experiences have informed their practice (consciously or unconsciously). The second half of the training was more strongly rooted in clinical skill building. There are risks in this approach, one being, the emphasis we placed on personal reflection. This did in some cases during training result in some personal revelations. Trainers must be prepared to address the possible emotional experiences of the participants that may not have ever been addressed in a professional setting or indeed in any setting at all.

Abstract Summary:

Death by suicide and suicide ideation in patients diagnosed with cancer is a very real concern; this has become evident as we employ the use of emotional distress screening tools and as research continues to become more specific to disease type and suicide. We, as clinicians, must be prepared to assess and intervene in clinically effective ways. Developing programming for training social workers with specific focus to the needs of the oncology population will only enhance the skills of our social workers and increase their confidence in addressing this critical area of need for our patients.

Learning Objectives:

1. Discuss suicide risk, assessment and intervention.
2. Examine how to design a program to better train professionals to assess for suicide risk.
3. Recognize our own influences and assumptions in evaluating for suicide risk.

References:

ASIST. (n.d.). Retrieved March 1, 2018, from <https://www.livingworks.net/programs/asist/> Detecting and treating suicide ideation in all settings. (2016 February 24). https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf Mirick, R., Mccauley, J., Bridger, J., & Berkowitz, L. (2015). Continuing Education on Suicide Assessment and Crisis Intervention: What Can We Learn About the Needs of Mental Health Professionals in Community Practice? *Community Mental Health Journal*,52(5), 501-510. doi:10.1007/s10597-015-9884-2 Regehr, C., Leblanc, V. R., Bogo, M., Paterson, J., & Birze, A. (2015). Suicide risk assessments: Examining influences on clinicians' professional judgment. *American Journal of Orthopsychiatry*,85(4), 295-301. doi:10.1037/ort0000075 U.S.A. SUICIDE: 2016 OFFICIAL FINAL DATA. (2018, January). Retrieved March 1, 2018, from <http://www.suicidology.org/resources/facts-statistics> Ullman, K. (2017). Reducing Risk of Suicide in Cancer Patients. *JNCI: Journal of the National Cancer Institute*,109(2), 3-7. doi:10.1093/jnci/djx025

Keywords: Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

Title: Oncology Social Work Leadership and Initiative: Launching and Sustaining an End-of-Life Grief Group for Resident Physicians

Author(s): *Camille Faunda, LCSW*

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

End of life discussions in oncology are inherently sensitive for all involved-- patients, family members and clinicians and can be challenging for even the most experienced and skilled interdisciplinary staff. The challenges do not end with the conversations vocalizing prognosis, goals of care and desires for end of life care. The significance of end of life conversations is that they are indeed about the end of a person's life. After clinicians address the needs of dying patients and surviving family and friends, they are left with their own thoughts, feelings, questions, ponderings and meaning to interpret. As Oncology Social Workers, we have a huge opportunity to take a leadership role in interprofessional collaboration and demonstrating our unique skill set in providing care to not only our patients but also to our

interprofessional team members. Within current health care systems, it is no longer adequate to solely depend on a team of experts to provide care to patients. The interprofessional education and collaboration movement emphasizes that we need an expert team whose members understand, support and access each other's skills in honoring both patient needs and the needs of the team to remain resilient in providing ongoing care to people with cancer. Initiating staff services may be viewed as subordinate to direct patient care, and therefore "less" important. However, we are not only attending to our patients by delivering direct clinical services, but by serving our team members and enabling them to provide their highest level of engaged care. We can raise the visibility of oncology social work by teaching our multidisciplinary teams how to communicate in ways that empower patients and families by modeling empathic patient-centered care. Our time working with our interprofessional team provides a unique space to illustrate our skills in listening, assessing and intervening as they witness these skills exemplified in the group. In result, our skills and abilities may be clearly understood thereby leading to appropriate accessibility to our services for patients and families. The presentation will describe an Oncology Social Worker's development of a monthly grief group for Internal Medicine residents. Through social work facilitation of a supportive safe space to discuss and reflect clinical skills, team benefits will be explored from addressing emotionally charged cases. Using clinical care examples from the group, this presentation will discuss the significant impact on patient care by identifying resident physicians' comfort discussing end of life care, the priority in teaching communication skills and building confidence, and the advantage of enabling the resident to identify and manage emotional distress when dealing with patients and families at the end of life. In addition, the value of this initiative in increasing the visibility of oncology social work across multiple areas will be addressed. Participants will be encouraged to consider opportunities within their own organizations to take leadership opportunities to both increase quality of care for patients and enhance the visibility of oncology social workers in an interprofessional setting.

Abstract Summary:

End of life discussions in oncology are difficult in any circumstance. I implemented a monthly grief processing group consisting of internal medicine resident physicians to determine their comfort in discussing end of life care and to teach communication skills. One of our roles as an oncology social worker is to provide an empathic example of patient centered care, and to teach our multidisciplinary teams how to communicate in ways that empower patients and families at the end of life. The main focus of this presentation is to provide an example of how social work is able to impact patient care by leading initiatives among colleagues to identify emotionally distressing cases and to provide opportunities to discuss and reflect. In result, physicians will have an opportunity to reflect on their own experiences around death and dying and develop resilient coping skills when working with patients at the end of life.

Learning Objectives:

1. Acknowledge the impact of oncology social work leadership with interprofessional team collaborations on improving the quality of patient care.
2. Articulate strategies for using social work's skill set to teach team members communication skills, to build confidence, and to manage emotional distress.
3. Identify possible areas of social work leadership in their own interprofessional team settings.

References:

- Rosenbaum, M., PhD, Ferguson, K., PhD, & Lobas, J., MD. (2004). Teaching Medical Students and Residents Skills for Delivering Bad News: A Review of Strategies. *Academic Medicine*, 79(2), 107-117.
- Kottewar, S., Bearely, D., Bearely, S., Johnson, D., & Fleming, D. (2014). Residents' End-of-Life Training Experience: A Literature Review of Interventions. *Journal of Palliative Medicine*, 17(6). Retrieved from <https://doi.org/10.1089/jpm.2013.0353>.
- Carton, E., & Hupcey, J. (2014). The Forgotten Mourners: Addressing Health Care Provider Grief—A Systematic Review. *Journal of Hospice and Palliative Nursing*, 6(5), 291-303. doi:10.1097/NJH.000000000000067
- Juliana Eng, Elizabeth Schulman, Sabrina M. Jhanwar, and Monika K. Shah (2015) Patient Death Debriefing Sessions to Support Residents' Emotional Reactions to Patient Deaths. *Journal of Graduate Medical Education*: September 2015, Vol. 7, No. 3, pp. 430-436.

Adamson, K., Loomis, C., Cadell, S., & Verweel, L. (2018). Interprofessional empathy: A four-stage model for a new understanding of teamwork. *Journal of Interprofessional Care*. doi:10.1080/13561820.2018.1511523

Wallace Chi Ho Chan, Agnes Fong, Karen Lok Yi Wong, Doris Man Wah Tse, Kam Shing Lau, Lai Ngor Chan; Impact of Death Work on Self: Existential and Emotional Challenges and Coping of Palliative Care Professionals, *Health & Social Work*, Volume 41, Issue 1, 1 February 2016, Pages 33–41, <https://doi.org/10.1093/hsw/hlv077>

Keywords: Interdisciplinary Care, Pain, Palliative Care and End of Life

Course Designation: Clinical

Presentation Level: Introductory

Title: Countertransference: Beyond the Basics and Into the Woods

Author(s): Vickie Leff, MSW, LCSW, BCD

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

Clinical social workers have an obligation to fully understand how their own reactions impact the work they do with patients, families and other providers. We have a rich tradition of learning about this phenomenon early in our social work education. Understanding countertransference in the clinical setting, particularly outside the normal therapy settings, is paramount to providing excellent care and our own resilience. Going beyond developing our own self awareness in clinical interactions, understanding the theory and practice of countertransference allows us to clarify unconscious clinical issues which can lead to more creative and effective interventions. Using the relational clinical theories from Winnicott, Kohut, Klein and others will help us unravel the complex thoughts and behaviors that act out in our clinical practice. The better we can understand these, the more patient success there will be. Understanding objective, subjective and diagnostic countertransference also informs our interventions and choices. In oncology and other medical settings, countertransference is more difficult to identify than in the variety of opportunities we have with patients; we are not usually in a traditional therapeutic relationship but rather an adjunct to their primary medical care. This environment challenges our understanding of countertransference because it looks different here. All the more reason to deeply understand how countertransference develops, how to identify it and how we can use it to better understand our clients and ourselves. We also have a unique opportunity to help our colleagues better understand how their reactions impact care of the patient. Acting on this insight into their behavior, we can illuminate interactions that may help or hinder care. We can also take leadership in educating medical providers the incredible value of self awareness in all their interactions with patient and families.

Abstract Summary:

Understanding and using countertransference in our clinical practice is paramount in the setting of deeply emotional and complex clinical situations. We will go beyond the basics of defining countertransference to exploring clinical examples of how to identify and use objective, subjective and diagnostic countertransference as clinical social workers in the medical environment. We will also identify opportunities to educate our medical colleagues about this phenomenon and how it impacts their work and resilience. Having a deep understanding of countertransference not only improves our clinical practice, but can serve as an excellent resilience skill.

Learning Objectives:

1. Review primary theories of countertransference in the therapeutic relationship and identify objective, subjective and diagnostic countertransference within medical setting interventions.
2. Identify opportunities for clinical social work education for oncology providers in the impact of countertransference in their practices.
3. Recognize the use of Self as a therapeutic tool working with oncology patients.

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Keywords: Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Advanced

Title: The Intersection of Oncology Social Work and Environmental Justice: Reawakening an Ecosystems Perspective of Environmental Consciousness in Practice

Author(s): Sky Niesen Smith, DSW, LICSW; Amy Fischer Williams, DSW

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

Ecosystems is a classic social work theory and practice perspective. It is also a hallmark that distinguishes social work from other medical-model based approaches (i.e. psychiatry, nursing). The origin of medical social work included the interactional ecosystems theory to incorporate the social and physical environment as determinants of health (NASW, 2015). Much of social work focuses on the social environment, yet the role of the physical environment is often overlooked in our assessments. Much evidence supports that indigenous and marginalized people are most burdened with the toxic impact of pollution, climate change, and destruction of the natural world (Beltran, 2015). The decline of the environment or natural world is connected to feelings of hopelessness, fear, anger, grief, and shame (Norgaard & Reed, 2017). Social workers, who craft clinical interventions and advocate for policies that mitigate healthcare-related distress, must integrate knowledge of responses to environmental oppression. This presentation will highlight environmental justice as an essential feature of oncology social work, in clinical and policy interventions. The authors will present qualitative research, using interviews with rural cancer patients and indigenous social workers that discuss the gap that exists in environmental oppression and our current psychosocial care models.

Abstract Summary:

The focus of psychosocial assessment and intervention in oncology is often the social environment, overlooking the role of the physical environment in the experience of cancer patients. Much evidence supports that indigenous and marginalized people are most burdened with the impact of environmental decline, industrial pollutants, and climate change. This presentation will connect the principles of environmental justice to current oncology practice knowledge. The presenters will offer findings of qualitative research, using interviews with rural cancer patients and indigenous social workers, that awakens the gap in our current psychosocial care models.

Learning Objectives:

1. Appraise the extent to which principles of environmental justice exist in oncology practice settings.
2. Discuss how to develop clinical and organizational interventions related to environmental injustice experiences of oncology patients.
3. Analyze perspectives of indigenous and rural social workers as essential knowledge in responding to environmental justice issues in oncology practice.

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Keywords: Clinical Practice/Skill Building, Advocacy

Course Designation: Cultural Competency

Presentation Level: Advanced

Title: Mind-Body Interventions for Cancer Related Cognitive Impairment—Why and How With the Help of Polyvagal Theory

Author(s): Michelle Ferretti, MSW, LCSW

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

Cancer related cognitive impairment (CRCI) is the most commonly reported negative side effect by patients with cancer (O'Farrell, MacKenzie, & Collins, 2013). Indeed, CRCI has been reported as the "most devastating and feared side effect of cancer treatment" (Henneghan, 2016, p. 481). The prevalence of CRCI for patients who have received chemotherapy varies from 33% in some studies (O'Farrell, MacKenzie, & Collins, 2013) to anywhere from 14% to 85% in others (Hodgson, Hutchinson, Wilson, & Nettelbeck, 2013). Debate continues about the multifactorial risk factors of CRCI, including age, chemotherapy dose, psychosocial distress, genetics, disease process, inflammation markers (cytokines), insomnia, anxiety, depression (Henneghan, 2016), and telomere length (Ahles & Saykin 2007). While research continues to identify causes of CRCI, this paper posits that oncology social workers and other oncology team members can confidently offer interventions that work with the bidirectional relationship between the body and the mind to treat the symptoms of CRCI. Mind-body interventions, including meditation, medical qigong, and mindfulness-based cancer recovery, have been shown to be effective treatments for CRCI (Craig, Monk, Farley & Chase, 2014). Further support of mind-body interventions for CRCI, at the cellular level, comes when exploring telomeres, the protective caps on the end of chromosomes. Shorter telomeres have been linked to higher disease risk, including cancer (Carlson et al., 2015). Shorter telomere length has also been used to predict poorer cognitive functioning following chemotherapy (Ahles & Saykin, 2007). Mind-body modalities have been shown to positively influence the length of telomeres in a matter of

months if practiced regularly (Carlson et al., 2015). In an effort to understand why mind-body interventions work for CRCI, one can look to how the nervous system “perceives” the physical and social environment with the help of polyvagal theory (PVT). PVT describes these “perceptions” as neuroception, the nervous system’s involuntary response to the social, physical, and internal environment. PVT postulates that a body’s neuroception can affect how the nervous system is regulated depending on whether there are cues of safety, danger, or life threat (Porges, 2009). Andreotti et al. (2014) offer that dysregulation of the system that regulates stress contributes to pathophysiology of the prefrontal region of the brain increasing the risk of CRCI. Mind-body interventions offer tools to help regulate the nervous system, with the goal of moving the body toward a neuroception of safety, thus promoting health, growth, and restoration. Clinically, PVT, and its discussion of the social engagement system, can be leveraged to increase a client’s neuroception of safety with an awareness of the clinician’s prosody of voice, body language, and facial expression (Porges, 2009). Mind-body interventions are not new to oncology social work, but a deeper dive into PVT gives clinicians a refreshed understanding of the nervous system and why and how mind-body interventions are effective in the treatment of CRCI. Participants will better be able to explain why mind body interventions are valid interventions for CRCI, as well deliver the intervention with an awareness of cues of safety.

Abstract Summary:

Cancer related cognitive impairment (CRCI) has been reported as the “most devastating and feared side effect of cancer treatment” (Henneghan, 2016, p. 481), with prevalence rates from 14-85% (Hodgson, Hutchinson, Wilson, & Nettelbeck, 2013). Even with no clear cause of CRCI, mind-body interventions can be confidently offered to treat the symptoms of CRCI, and polyvagal theory (PVT) helps clinicians understand why and how to deliver these interventions. Neuroception, the nervous system’s involuntary environmental assessment, can affect how the nervous system is regulated depending on whether there are cues of safety, danger, or life threat (Porges, 2009). Andreotti et al. (2014) offer that dysregulation of the system that regulates stress contributes to pathophysiology of the prefrontal region of the brain increasing the risk of CRCI. Mind-body interventions offer tools to help regulate the nervous system, moving the body toward a neuroception of safety, promoting cognitive and overall health.

Learning Objectives:

1. Review relevant research to understand current knowledge of chemotherapy related cognitive impairment (CRCI) including prevalence, causes and treatment, with a focus on mind body interventions.
2. Discuss polyvagal theory, its application in clinical practice in general, and specifically to managing the symptoms of cancer related cognitive impairment.
3. Explore how mind-body interventions are effective for cancer related cognitive impairment, and how the clinician's use of the prosody or their voice and their body language are relevant to the intervention itself.

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Keywords: Clinical Practice/Skill Building, Survivorship

Course Designation: Clinical

Presentation Level: Intermediate

Title: Financial Toxicity and Cancer: Proactive Screening, Assessment, and Treatment

Author(s): *Abra Kelson, MSW; Virginia Vaitones, MSW; Hira Chowdhary, MPH, MS; Krista Nelson, MSW, LCSW, OSW-C, BCD, FAOSW*

Date Scheduled:

6/7/2019, 11:30am - 12:30pm

Abstract Content:

Background: The financial burden of cancer treatment must be addressed in the larger context of a patient's personal circumstances and experiences. There are many sources of financial burden that accompany cancer care and treatment that must proactively be addressed to eliminate risk of cancer-related financial toxicity (CRFT). The Association of Community Cancer Centers (ACCC), a national organization leading education and advocacy efforts of the multidisciplinary cancer team, has taken notice of the absence of standardization in financial distress screening (FDS) and intervention in the oncology field, as well as the disparity of training and education available for healthcare professionals regarding financial distress, assessment and intervention. Adequate FDS can help to mitigate financial distress in cancer care. Recognizing that many cancer programs are unique, the survey was created with the intention of collecting case based examples to illustrate different methods for implementing FDS across cancer programs and practices. Methods: To further explore FDS methods across cancer practices, ACCC's Financial Advocacy Advisory Committee is conducting an exploratory study, using a seven-question survey to assess tools and methodology used to implement FDS. The survey includes both qualitative and quantitative information highlighting the process for FDS as reported by diverse oncology professionals. Results: Of the respondents, 48% were social workers, of whom, 66% replied that a financial worker does not screen for financial distress. Of the 74 respondents, 43% indicate that a designated financial worker does not screen for financial distress, even though 75% of respondents indicate that their cancer practice employees anywhere between one or more full time financial worker(s). The National Comprehensive Cancer Network (NCCN) Distress Thermometer (DT) was identified as the tool most utilized to screen for financial distress—60% of social workers and 50% of the survey respondents. The remaining respondents listed a variety of other distress screening tools, including home-grown processes created by the cancer program staff. Conclusion: The results of this research study imply that there is no standard for FDS and that social workers remain to be integral in the implementation of FDS among cancer practices across the United States. The frequent use of the NCCN DT could also be an indication of the vital role social work plays in identifying and mitigating financial distress in cancer patients, as this tool is regarded as the standard for psychosocial distress screening within the oncology social work profession. Additional research is needed to indicate the effectiveness of FDS tools that are utilized in practice. The current survey results provide valuable insights demonstrating different solutions that can be implemented to improve methods for FDS across cancer programs.

Abstract Summary:

There is growing concern about access to high quality affordable treatment in oncology. Cancer patients experience a great level of distress due to high cost burden. To address this, prompt and thorough assessment of potential financial toxicity should be part of supportive care in the provision of comprehensive cancer care. This research project assesses methods being used to assess financial distress among oncology patients. Screening for financial distress is not standardized, and multiple tools are implemented to assess need for intervention by social work or financial counselors advocating on behalf of the patient's financial well-being by navigating treatment related cost conversations and obtaining access to affordable care. Case examples will be presented to demonstrate the variety of methods used to implement effective financial distress screening in oncology social work practice.

Learning Objectives:

1. Distinguish opportunities for coordination between oncology social workers and financial advocates/counselors/and navigators to improve screening and referral processes to adequately support and promote the patient's financial well-being, in addition to other aspects of care and wellness.
2. Describe the unique needs of cancer patients experiencing the financial burden and distress, and recognize both the material consequences of treatment and the psychosocial impact of cancer treatment.
3. Compare how different screening tools and methods are used to assess for financial distress among oncology patients through case study examples from diverse cancer programs. Cases will be obtained from survey results (currently n=70+).

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Keywords: Financial Toxicity, Distress/CoC

Course Designation: Clinical

Presentation Level: Intermediate

LUNCH PANEL II

Title: Telecounseling with Blood and Marrow Transplant Patients and Caregivers: Be Where the Client Is

Author(s): *Katie Schoepner, MSW, LICSW; Hailey Hassel, MSW, LGSW*

Date Scheduled:

6/7/2019, 12:45pm - 2:15pm

Abstract Content:

Blood and Marrow Transplant (BMT) is an intense and demanding treatment for leukemia and other blood disorders that often reduces quality of life and can lead to anxiety, depression and post-traumatic stress syndrome in patients (1). BMT caregivers experience anxiety and depression at rates even higher than patients (2). It is vital that this unique group have accessible, affordable, and effective mental health services. Potential barriers faced by BMT patients and caregivers to receiving traditional in-person counseling may include: Financial distress, lack of mental health insurance, geographic location and risk of infection. To eliminate these barriers, a national patient advocacy organization provides free, BMT-specific mental health services via telephone. Increasingly, practitioners are providing mental health services using telehealth modalities (3). A systematic review of studies comparing telemental health to traditional in-person support reveals that there is not a significant difference between the two modalities with regard to client satisfaction or the development of therapeutic alliance (4). A counseling services program was developed using information obtained through an environmental scan of advocacy organizations serving a similar demographic. Results indicated an unmet need for accessible, mental health services for BMT patients and families. An informed consent document was drafted in accordance with the social work code of ethics and reviewed by the internal legal team. Intake processes, a client tracking tool, and a psychosocial assessment form were created. The program is promoted directly with transplant center staff and the organization's BMT Patient Navigators. Counseling is provided by two licensed social workers with experience delivering psychosocial support to BMT patients/families. Once informed consent is given, weekly, 50-minute telephone counseling sessions are provided for eight weeks. Goals for counseling are determined in accordance with a thorough psychosocial assessment and interventions are adapted to fit the client's needs. Common interventions include cognitive and dialectical behavioral approaches, mindfulness training, problem solving, communication skills development, and grief and loss work. The frequency of counseling sessions and duration of service is flexible and can change according to the client's individual needs. Program evaluation is conducted via surveys administered to the client upon termination. Clients must have completed at least three sessions in order to receive a survey. Survey questions are focused on the effectiveness of counseling, satisfaction with the therapeutic relationship with the social worker, and overall satisfaction with the service. Results, including the total number of patients served, survey response rates, and specific client feedback shape the program, inform social work interventions, and serve as a model for other organizations implementing similar services. Counseling provided via telephone by social workers is an effective way to support patients and caregivers going through BMT. The model of service presented herein can be adapted for use by social workers in a variety of settings and for different disease and treatment populations. Oncology social workers are uniquely poised to use telemental health interventions in order to meet the psychosocial needs of patients and caregivers.

Abstract Summary:

Increasingly, practitioners are providing mental health services using telehealth modalities (3). Given the potential barriers faced by blood and marrow transplant (BMT) patients and caregivers to receiving traditional in-person counseling, social workers may consider using telecounseling to meet the psychosocial and mental health needs of patients and caregivers. This session will describe a formal program for counseling that has been implemented at a national patient advocacy organization. Program elements, including referrals, intake processes, client tracking mechanisms, psychosocial assessment and evaluation methods will be described. This presentation will equip social workers with the tools to incorporate a telecounseling program into their practice with oncology patients and caregivers.

Learning Objectives:

1. Describe the potential barriers faced by BMT patients and caregivers to receiving traditional, in-person mental health services.
2. Utilize a variety of telecounseling assessment techniques and intervention with patients and caregivers in need of mental health support.
3. Integrate program planning and evaluation into practice using a variety of tools and processes.

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Keywords: Clinical Practice/Skill Building, Survivorship

Course Designation: Clinical

Presentation Level: Intermediate

Title: Embracing Technology: Creating Online Video Support Groups to Support Our Most Vulnerable Patients

Author(s): *Krista Nelson, MSW, LCSW, OSW-C, BCD, FAOSW*

Date Scheduled:

6/7/2019, 12:45pm - 2:15pm

Abstract Content:

Utilizing technology and innovation resources within cancer centers, oncology social workers are poised to enhance the clinical offerings they deliver by offering online video support groups to patients with cancer. This modality has the ability to support the patients whom are the most vulnerable, have limited mobility, as well as those in rural areas. Providence Cancer Institute gathered data from distress screening for the years 2016-2017, and showed that of the over 6,000 patients represented, 12% of our population was asking for group support. This large number (744), compared to the small number of patients that participate in traditional face to face support groups led the team to investigate alternative methods of group support. This data, coupled with the reality that 84% of adults use the internet (Wright, 2016) we inspired to create an online support program with our Telehealth team for our populations which appear most socially isolated within our community. After consulting with our patient advisory board, we piloted 3 groups, including, advanced cancer, Spanish speaking and blood cancer, with the goal of expansion to a caregiver group. Participants are invited to the group through "MyChart", and they participate in bi-monthly, hour long video support groups via the Zoom platform. This presentation will highlight implementation learnings as well as clinical considerations of facilitating online video support groups. Faced with realities of treatment changes in cancer (i.e. increase in oral chemotherapy), longer disease trajectories and patients health, online, real-time video support groups strengthen the oncology social work team's ability to expand the patient's access to psychosocial support and care. This intervention allows these populations of patients to connect with others in similar situations within the comfort of their home and increases the efficiency of the oncology social work role in providing group support. Attendees will be provided the tools needed to

implement an online video support program within their setting, including sample consents, a business case, and Epic integration learnings. Clinical discussion of ethical and confidentiality considerations in delivery of this modality of care, as well as clinical considerations facilitating online groups and managing situations like a participant death in the video support setting will be addressed.

Abstract Summary:

Utilizing technology and innovation resources within cancer centers, oncology social workers are poised to enhance the clinical offerings they deliver by offering online video support groups to patients with cancer. This intervention allows these populations of patients to connect with others in similar situations within the comfort of their home and increases the efficiency of the oncology social work role in providing group support. Attendees will be provided the tools needed to implement an online video support program within their setting, including sample consents, a business case, and Epic integration learnings. Clinical discussion of ethical and confidentiality considerations in delivery of this modality of care, as well as clinical considerations facilitating online groups and managing situations like a participant death in the video support setting will be addressed.

Learning Objectives:

1. Discuss the ethics and complexities of providing online group support.
2. Apply concepts learned with skills on how to develop a video online group in their setting.
3. Describe differences and similarities in video online vs in-person support groups.

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Keywords: Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Intermediate

CLOSING KEYNOTE

Title: Recreating the Oasis: Leading a Culture of “Taking Care” in Oncology Care

Author(s): Catherine Credeur, LMSW, OSW-C, FAOSW

Date Scheduled:

6/7/2019, 2:30pm - 3:30pm

Abstract Content:

Conference experience creates a temporary oasis of self-care, collegial connection, and an openness to learning. Transition back to work requires separation from the safe zone and re-engagement with the emotional intensity of supporting patients and families in the crisis of cancer. It can be difficult to sustain the optimistic momentum of conference when supporting human beings who are struggling. In this closing session, participants will be stirred to examine their personal coping skills and leadership strengths. Working as a collective, participants will draft a SMART (Specific, Measurable, Achievable, Realistic, Time-Limited) plan that extends the oasis experience of conference into the practice of oncology care.

Abstract Summary:

Conference experience creates a temporary oasis of self-care, collegial connection and an openness to learning. Transition back to work requires separation from the safe zone and re-engagement with the emotional intensity of supporting patients and families in the crisis of cancer. It can be difficult to sustain the optimistic momentum of conference when supporting human beings who are struggling. In this closing session, participants will be stirred to examine their personal coping skills and leadership strengths. Working as a collective, participants will draft a SMART (Specific, Measurable, Achievable, Realistic, Time-Limited) plan that extends the oasis experience of conference into the practice of oncology care.

Learning Objectives:

1. Recognize existential pain for both patients/family members and professional caregivers within oncology care settings.
2. Examine personal coping skills and leadership strengths for sustaining passion when empathy hurts.
3. Draft a SMART plan for shaping the “care” in cancer care at micro, mezzo, and macro levels of intervention.

Keywords: Professional Issues, Clinical Practice/Skill Building

Course Designation: Clinical

Presentation Level: Introductory