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Value-Based Cancer Care: Creating Partnerships between the Oncology Patient Navigator and Oncology/Hematology Physician Practices

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PROPRIETARY & CONFIDENTIAL

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Objectives

- Definition and Brief History of Navigation
- Value-Based Care, Oncology Care Model, and Medical Neighborhoods
- Academy of Oncology Nurse & Patient Navigator (AONN+) National Evidence-Based Navigation Metrics
- Navigation and Integration with Oncology/Hematology Physician Practices
- Case Study: Enhancing the Services of Head & Neck Cancer Patients with the Multidisciplinary Team

Quotes from Administrators

"What is the return on our investment with our navigation program?"

"How are we going to measure success with our navigation program?"

"How can we better coordinate the care of our patients and families?"

"How can our navigators support value-based care initiatives with our physicians?"

Quotes from Providers

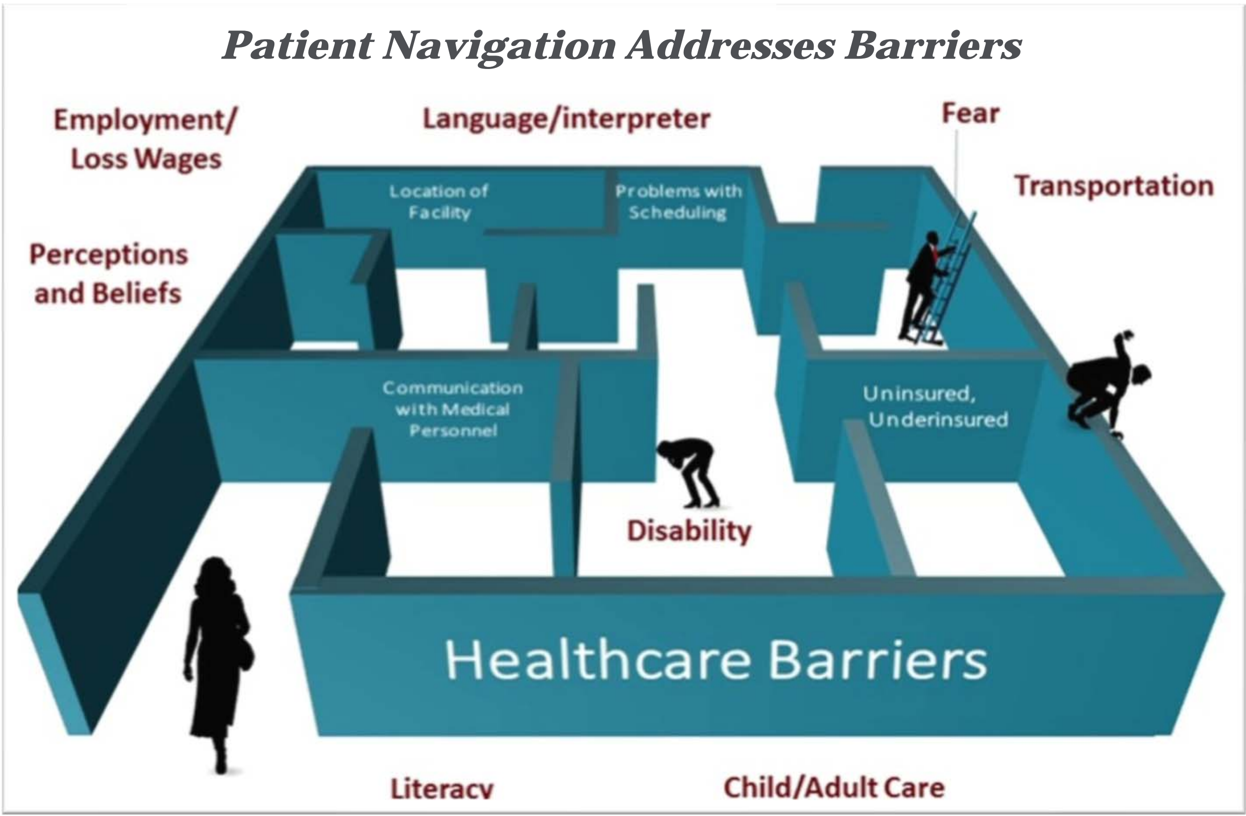
"I just wanted to hit the GO button to start the navigation process as soon as possible; I want everything to be automatic."

"Our navigator is essential to our program and our goal of delivering patient- and family-centered care. She provides a comprehensive assessment of the patient and families needs and keeps us all up to date."

"The care of our head & neck patients has never been so coordinated."

Definition and Brief History of Navigation

Definition of Navigation



ASCO University. http://meetinglibrary.asco.org/content/149216-156

C-Change Definition:

"Individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality medical and psychosocial care from pre-diagnosis through all phases of the cancer experience."

Brief History of Patient Navigation

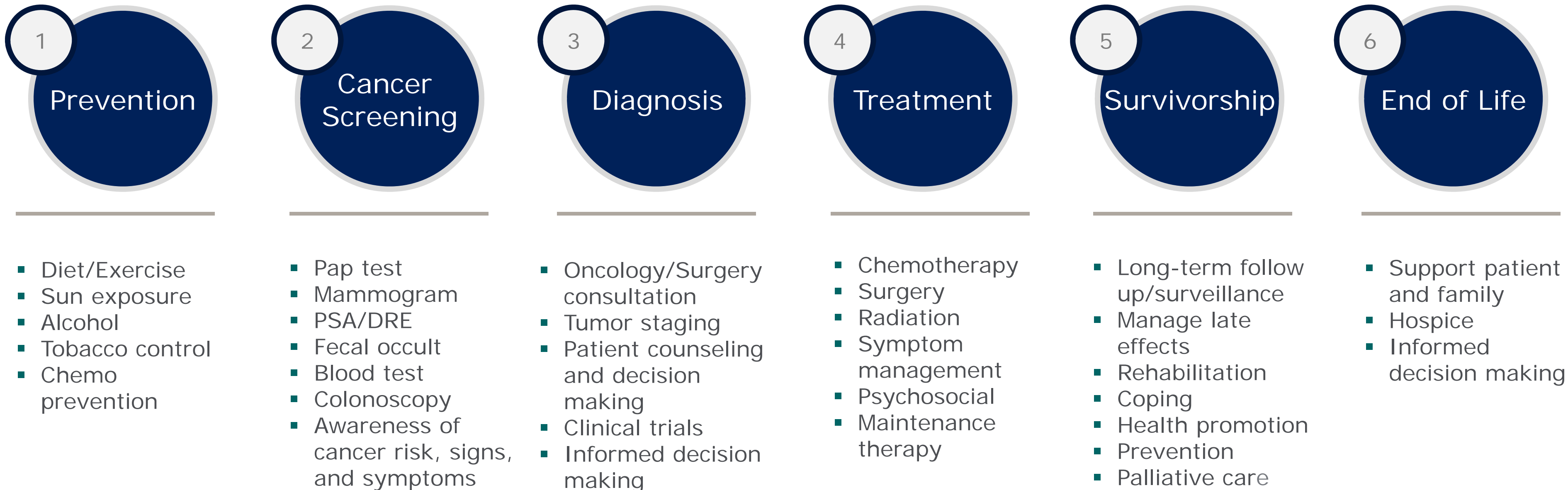
1970: Utilization Review	Monitor use & delivery of service	Adversarial	Inpatient	Retrospective chart review
1980: Utilization Management	Evaluate appropriateness, medical need & efficiency	Adversarial	Inpatient	Concurrent chart review
1990: Case Management	Assess, plan, implement, coordinate, monitor & evaluate	Collaborative	Involved in patient care	Hands-on care
1990: Patient Navigation	Identify, reduce barriers to access to care, diagnose, prescribe	Collaborative	Underserved patients	Community outreach
2000: Patient Navigation	Identify, reduce barriers to access to care, diagnose, prescribe	Clinical collaborative	Across the continuum of care, hands-on	Hands-on care and coordination of care

Source: Shockney, L. "Becoming a Breast Cancer Nurse Navigator," 2011

Navigator Roles and Responsibilities

- Coordinate the care of the patient and family from prediagnosis through survivorship or end-of-life services
- Improve patient outcomes through education, support, and performance-improvement monitoring
- Collaborate and facilitate communication between patients, family/caregivers, and healthcare team
- Coordinate care among healthcare providers
- Ensure education and access to clinical trials
- Provide cancer program and community resources
- Participate in multidisciplinary centers, tumor conferences, and cancer committee

Navigation Continuum of Care



Phases of Cancer Care

Adapted from: http://cancercontrol.cancer.gov/od/continuum.html

Navigation Continuum of Care

1 Prevention
- Diet/Exercise
- Sun exposure
- Alcohol
- Tobacco control
- Chemo prevention

2 Cancer Screening
- Pap test
- Mammogram
- PSA/DRE
- Fecal occult
- Blood test
- Colonoscopy
- Awareness of cancer risk, signs, and symptoms

3 Diagnosis
- Oncology/Surgery consultation
- Tumor staging
- Patient counseling and decision making
- Clinical trials
- Informed decision making
- **Palliative care**
- **Pre-habilitation**
- **Introduction of SCP components**
- **Goals of care**
- **Advance directives**

4 Treatment
- Chemotherapy
- Surgery
- Radiation
- Symptom management
- Psychosocial
- Maintenance therapy

5 Survivorship
- Long-term follow up/surveillance
- Manage late effects
- Rehabilitation
- Coping
- Health promotion
- Prevention
- Palliative care

6 End of Life
- Support patient and family
- Hospice
- Informed decision making

We must initiate critical conversations earlier in the continuum. Your navigator can help.

Adapted from:
http://cancercontrol.cancer.gov/od/continuum.html

Value-Based Care, Oncology Care Models,
and Medical Neighborhoods

Pilot Projects Driving OCM

- Began in 1997
- 9 physician oncology practices in PA
- 29% increase in patient volume since 2009—with the same number of physicians and a decrease in office staff
- 51% drop in emergency room visits
- 68% drop in inpatient admissions
- 95% adherence to NCCN Guidelines for first line therapy

COME HOME

- *$20M CMS Innovation grant award 2012*
- *Community oncology medical home*
- *7 community oncology practices*

What is the Oncology Care Model (OCM)?

The Center for Medicare & Medicaid Innovation (CMS Innovation Center) is developing new payment and delivery models designed to improve the effectiveness and efficiency of specialty care. Among those specialty models is the OCM launched in July 2016, which aims to provide higher-quality, more highly coordinated oncology care at the same or lower cost to Medicare.

Goals of the Oncology Care Model

Cancer diagnoses comprise some of the most common and devastating diseases in the United States; more than 1.6 million people are diagnosed with cancer each year in this country. Through OCM, the CMS Innovation Center has the opportunity to achieve three goals in the care of this medically complex population: ***better care, smarter spending, and healthier people.***

Oncology Care Model Practice Redesign

OCM practices committed to providing enhanced services to Medicare beneficiaries such as care coordination, navigation, and national treatment guidelines for care.

Participating practices are implementing the six practice redesign activities:

- 24/7 clinician availability with real-time access to patients' medical records
- Certified EHR Technology
- Use of data for continuous quality improvement
- Patient navigation
- Individualized care plans with the 13 components in the Institute of Medicine Care Management Plan
- Therapies compliant with nationally recognized clinical guidelines

What are Medical Neighborhoods?

Partnerships with physicians, specialists, skilled nursing facilities, home health care, hospice, and other local organizations to improve success rates in value-based care.

What they did:

- Targeted opportunities for savings on acute and post acute care
- Integrated local elder resources, ASAPs: Aging Services Access Points
- Collaborated with VNA home health care and social work services
- Provided support for families and caregivers
- Created champions in the community on advance care planning/discussions on care wishes
- Conversations turned from which Skilled Nursing Facility (SNF) to why SNF

Source: https://aishealth.com/archive/nvbc0916-07

Academy of Oncology Nurse & Patient Navigators (AONN+)
National Evidence-Based Navigation Metrics

Navigation Metrics Background

There is a gap in the literature to measure the success of navigation programs:

- Patient experience
- Clinical outcomes
- Business performance or return on investment (ROI)

Standard metrics were developed in the area of patient experience, clinical outcomes, and ROI using the AONN+ DOMAINS for certification:

- ✓ Professional Roles and Responsibilities
- ✓ Patient Advocacy
- ✓ Psychosocial Support Assessment
- ✓ Care Coordination
- ✓ Community Outreach
- ✓ Operations Management
- ✓ Survivorship/End of Life
- ✓ Research and Quality Performance Improvement

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Standardized Navigation Metrics Project Results

The taskforce developed standardized metrics, which focused on the AONN+ Certification Domains for navigation, concentrating on ROI, PE, and CO. After the completion of extensive literature review and putting each metric through rigorous criteria to ensure the accuracy and soundness of each metric, **35 metrics were developed.**

These metrics are baseline metrics that all institutions can use regardless of the model of navigation.

Care Coordination/Care Transitions Metrics

CARE COORDINATION/ CARE TRANSITIONS

01.	**Treatment Compliance** Percentage of navigated patients who adhere to institutional treatment pathways per quarter.
02.	**Barriers to Care** Number and list of specific barriers to care identified by navigator per month. Barriers to care definition: Obstacles that prevent a cancer patient from accessing care, services, resources and/or support.
03.	**Interventions** Number of specific referrals/interventions offered to navigated patients per month. Intervention definition: The act of intervening, interfering, or interceding with the intent of modifying the outcome.
04.	**Clinical Trial Education** Number of patients educated on clinical trials by the navigator per month.

Care Coordination/Care Transitions Metrics

CARE COORDINATION/ CARE TRANSITIONS

05.	**Clinical Trial Referrals** Number of navigated patients per month referred to clinical trial department.
06.	**Patient Education** Number of patient education encounters by navigator per month.
07.	**Diagnosis to Initial Treatment** Number of business days from diagnosis (date pathology resulted) to initial treatment modality (date of first treatment).
08.	**Diagnosis to First Oncology Consult** Number of business days from diagnosis (date pathology resulted) to initial oncology consult (date of first appointment).

Research, Quality, Performance Improvement Metrics

RESEARCH, QUALITY & PERFORMANCE IMPROVEMENT

09.	**Patient Experience/ Patient Satisfaction with Care** Patient experience or patient satisfaction survey results per month (utilize institutional specific navigation tool with internal benchmark).
10.	**Navigation Program Validation based on CNA** Monitor one major goal of current navigation program annually as defined by cancer committee Example: Population served.

Research, Quality, Performance Improvement Metrics

11.	**Patient Transitions from Point of Entry** Percentage of navigated analytic cases per month transitioned from institutional point of entry to initial treatment modality. Care transitions definition: "The movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness" (Coleman, n.d., para 1). Modality definition: Chemotherapy, surgery, radiation therapy, endocrine therapy, and biotherapy.
12.	**Diagnostic Workup to Diagnosis** Number of business days from date of abnormal finding to pathology report for navigated patients Abnormal finding definition: Number of business days from abnormal finding diagnostic workup (date of workup) to diagnosis (date pathology resulted).

RESEARCH, QUALITY & PERFORMANCE IMPROVEMENT

Operations Management Metrics

13.	**30-, 60-, 90-Day Readmission Rates** Number of navigated patients readmitted to the hospital at 30, 60, 90 days. Report quarterly.
14.	**Navigation Operational Budget** Monthly operating expenses by line item. Definition: Operational budget is a combination of known expenses, expected future costs, and forecasted income over the course of a year.
15.	**Navigation Caseload** Number of new cases, open cases, and closed cases navigated per month. New cases definition: New patient case referred to the navigation program per month. Open cases definition: Patient case that remains open/month. Number of patient cases closed per month. Closed cases definition: Formal closing of a patient case from the navigation program.

Operations Management Metrics

OPS MGMT, ORG DEVELOPMENT & HEALTH ECONOMICS

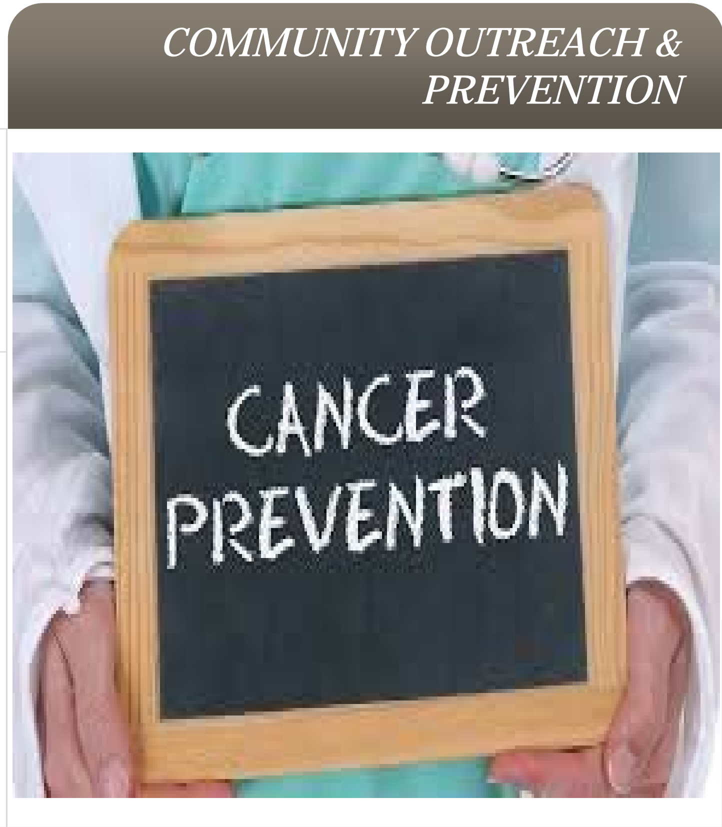
16.	**Referrals to Revenue Generating Services** Number of referrals to revenue generating services per month by navigator.
17.	**No Show Rate** Number of navigated patients who do not complete a scheduled appointment per month.
18.	**Patient Retention through Navigation** Number of analytic cases per month or quarter that remained in your institution due to navigation.
19.	**Emergency Room Utilization** Number of navigated patient visits to the emergency room per month.
20.	**Emergency Admits Per # of Chemo Patients** Number of navigated patient visits per 1,000 chemotherapy patients who had an emergency room visit per month.

Community Outreach and Prevention Metrics

COMMUNITY OUTREACH & PREVENTION

21.	**Cancer Screening Follow Up to Diagnostic Workup** Number of navigated patients per quarter with abnormal screening referred for follow up diagnostic workup. Cancer screening definition: Screening tests can help find cancer at an early stage, before symptoms will appear. When abnormal tissue or cancer is found early, it may be easier to treat or cure. By the time symptoms appear, the cancer may have grown and spread. This can make cancer harder to treat or cure.
22.	**Cancer Screening** Number of participants at cancer screening event and/or percentage increase of cancer screening.

Community Outreach and Prevention Metrics

		COMMUNITY OUTREACH & PREVENTION
23.	**Completion of Diagnostic Work Up** Number of navigated individuals with abnormal screening who completed diagnostic workup per month/quarter.	
24.	**Disparate Population at Screening Event** Number of individuals per quarter at community screening events by OMB Standards. Disparate population definition: The National Institute on Minority Health and Health disparities definition is differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific populations in the United States (racial and ethnic minorities, low socioeconomic status). OMB definition: Office of Management and Budget.	

Professional Roles and Responsibilities Metrics

		PROFESSIONAL ROLES & RESPONSIBILITIES
25.	**Navigation Knowledge at Time of Orientation** Percentage of new hires who have completed institutionally developed navigator core competencies.	
26.	**Navigator Annual Core Competencies Review** Percentage of staff who have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation.	

Psychosocial Support Services and Assessment Metrics

PSYCHOSOCIAL ASSESSMENT & SUPPORT SERVICES

27.	**Psychosocial Distress Screening** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool. Pivotal medical visit definition: Period of high distress for the patient when psychosocial assessment should be completed. Define various validated tools as examples: FACT, NCCN Psychosocial Distress Screening Thermometer.
28.	**Social Support Referrals** Number of navigated patients referred to support network per month.

Patient Advocacy/Patient Empowerment Metrics

PATIENT EMPOWERMENT & ADVOCACY

#	Metric
29.	**Patient Goals** Percentage of analytic cases per month that patient goals identified and discussed with the navigator.
30.	**Caregiver Support** Number of caregiver needs/preferences discussed with navigator per month.
31.	**Identify Learning Style Preference** Number of navigated patients per month whose preferred learning style was discussed during the intake process. Learning styles: ▪ Visual/spatial: using pictures, images & spatial understanding ▪ Aural (auditory-musical): using sound & music ▪ Verbal (linguistic): using words, in speech & writing ▪ Physical (kinesthetic): using body, hands & touch ▪ Logical (mathematical): using logic, reasoning & systems ▪ Social (interpersonal): learning in groups or with people ▪ Solitary (intrapersonal): work alone & use self study

Survivorship/End-of-Life Metrics

SURVIVORSHIP & END OF LIFE

32.	**Survivorship Care Plan** Number of navigated patients (patient with curative intent) per month who received a survivorship care plan and treatment summary.
33.	**Transition from Treatment to Survivorship** Percentage of navigated analytic cases per month transitioned from completed cancer treatment to survivorship. Care transitions definition: "[T]he movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness."
34.	**Referrals to Support Svcs at Survivorship Visit** Number of navigated patients per month referred to appropriate support service at the survivorship visit.
35.	**Palliative Care Referral** Number of navigated patients per month referred for palliative care services.

Navigation and Integration with
Oncology/Hematology Physician Practices

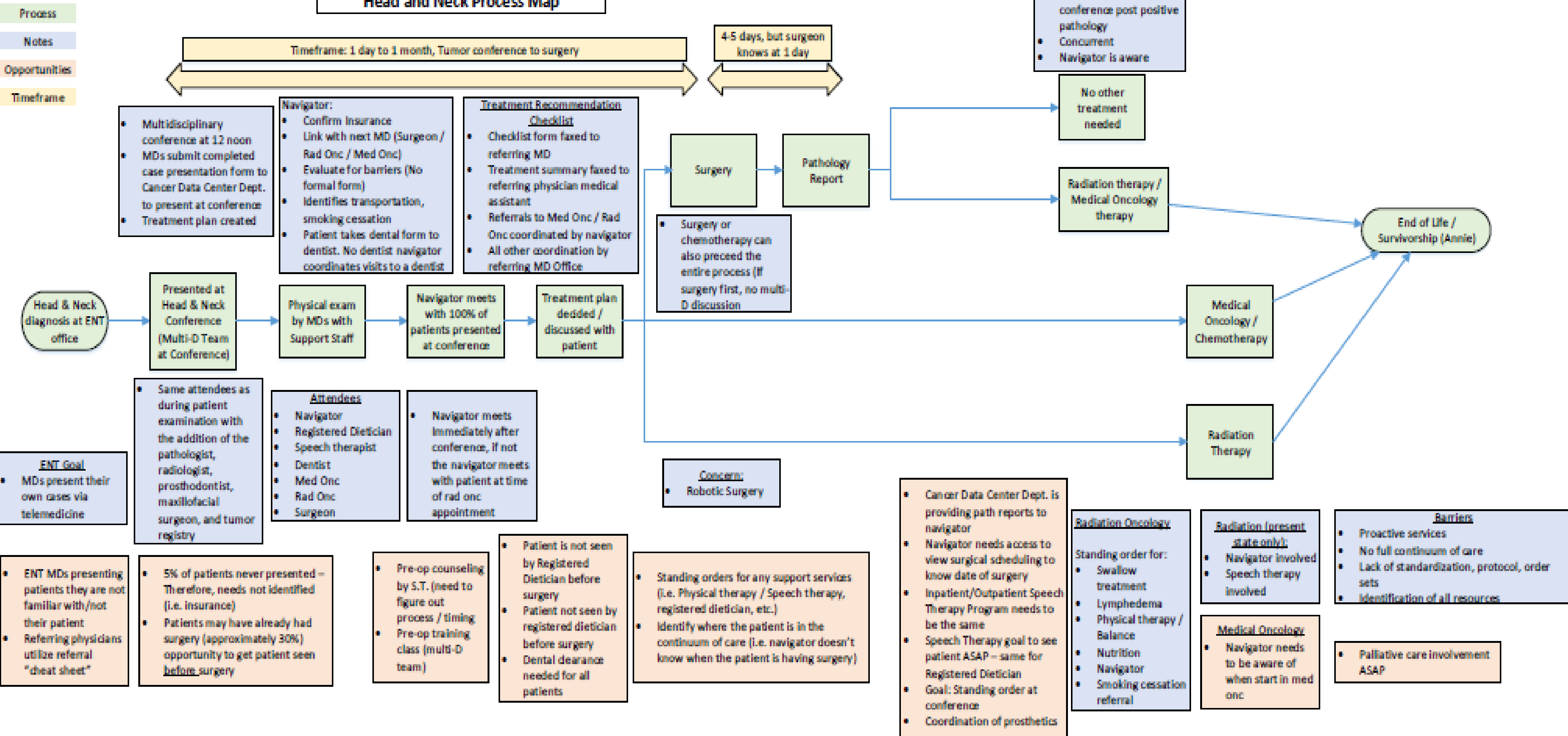
Navigation Integration with Oncology/Hematology Practices

- Coordination of care for your patients and families across the continuum from pre-diagnosis through survivorship or end-of-life services
- Create partnerships, incorporate performance improvement based on navigation and value-based cancer care metrics
- Increase efficiency and timely access to services by providing comprehensive assessments and referrals to appropriate disciplines
- Reinforce patient education and empowerment through decision aids and patient appointment checklist
- Create standing order sets, physician profiles, pathways, and guidelines
- Increase support for providers, i.e., early discussions regarding palliative care, goals of care, advance care planning, and pre-habilitation
- Increase contacts with “frequently flyers” to decrease ER visits and avoidable admissions
- Automatic financial counseling referrals at time of diagnosis (generate self-referral reports)

Head & Neck Cancer Case Study

A cancer center in Louisiana was having a very difficult time coordinating the care of its head & neck cancer patients. Services were not being scheduled in the correct order and dental clearance was taking two to three weeks, which held up the initial treatment for the patient. The multidisciplinary team, which included surgeons, medical oncologists, radiation oncologists, navigators, SW, RD, dentists, speech/swallowing, prosthodontists, and health psychologists, reviewed the NCCN Guidelines, created a process map, and brainstormed best practices for its patients to ensure success, a smooth transition, and enhanced patient experience. The navigator drafted the following tools and presented to the team:

- Head & neck standing order sets
- Head & neck patient appointment checklist
- Policy to introduce palliative care earlier in the continuum
- Palliative Care Discussions: Tip Sheet for Navigators and Social Workers
- Head & neck dashboard
- Dental clearance forms and process
- Welcome letter and FAQ



Head and Neck Process Map
Process
Notes
Opportunities
Timeframe
Timeframe: 1 day to 1 month, Tumor conference to surgery
4-5 days, but surgeon knows at 1 day
Multidisciplinary conference at 12 noon
MDs submit completed case presentation form to Cancer Data Center Dept. to present at conference
Treatment plan created
Navigator:
Confirm Insurance
Link with next MD (Surgeon / Rad Onc / Med Onc)
Evaluate for barriers (No formal form)
Identifies transportation, smoking cessation
Patient takes dental form to dentist. No dentist navigator coordinates visits to a dentist
Treatment Recommendation Checklist
Checklist form faxed to referring MD
Treatment summary faxed to referring physician medical assistant
Referrals to Med Onc / Rad Onc coordinated by navigator
All other coordination by referring MD Office
Surgery
Pathology Report
Surgery or chemotherapy can also preceed the entire process (If surgery first, no multi-D discussion
Treatment rediscussed at conference post positive pathology
Concurrent
Navigator is aware
No other treatment needed
Radiation therapy / Medical Oncology therapy
End of Life / Survivorship (Annie)
Head & Neck diagnosis at ENT office
Presented at Head & Neck Conference (Multi-D Team at Conference)
Physical exam by MDs with Support Staff
Navigator meets with 100% of patients presented at conference
Treatment plan decided / discussed with patient
Medical Oncology / Chemotherapy
Radiation Therapy
ENT Goal
MDs present their own cases via telemedicine
Same attendees as during patient examination with the addition of the pathologist, radiologist, prosthodontist, maxillofacial surgeon, and tumor registry
Attendees
Navigator
Registered Dietician
Speech therapist
Dentist
Med Onc
Rad Onc
Surgeon
Navigator meets immediately after conference, if not the navigator meets with patient at time of rad onc appointment
Concern:
Robotic Surgery
ENT MDs presenting patients they are not familiar with/not their patient
Referring physicians utilize referral "cheat sheet"
5% of patients never presented – Therefore, needs not identified (i.e. insurance)
Patients may have already had surgery (approximately 30%) opportunity to get patient seen before surgery
Pre-op counseling by S.T. (need to figure out process / timing
Pre-op training class (multi-D team)
Patient is not seen by Registered Dietician before surgery
Patient not seen by registered dietician before surgery
Dental clearance needed for all patients
Standing orders for any support services (i.e. Physical therapy / Speech therapy, registered dietician, etc.)
Identify where the patient is in the continuum of care (i.e. navigator doesn't know when the patient is having surgery)
Cancer Data Center Dept. is providing path reports to navigator
Navigator needs access to view surgical scheduling to know date of surgery
Inpatient/Outpatient Speech Therapy Program needs to be the same
Speech Therapy goal to see patient ASAP – same for Registered Dietician
Goal: Standing order at conference
Coordination of prosthetics
Radiation Oncology
Standing order for:
Swallow treatment
Lymphedema
Physical therapy / Balance
Nutrition
Navigator
Smoking cessation referral
Radiation (present state only):
Navigator involved
Speech therapy involved
Medical Oncology
Navigator needs to be aware of when start in med onc
Barriers
Proactive services
No full continuum of care
Lack of standardization, protocol, order sets
Identification of all resources
Palliative care involvement ASAP

Goals for Head & Neck

- Proactive identification of support service needs (i.e. protocols, standing order sets, etc.)
  - ❑ Registered Dietician
  - ❑ Speech therapy – Functional Oral Intake Scale
  - ❑ All support services
- Same standard of care for inpatient/outpatient
- "Meet Your Head & Neck Team"
- Multidisciplinary support service team meeting (Includes all support staff)
- Create multi-D educational materials (R.D, S.W, S.T, etc.)
- Patient appointment checklist for medical oncology, radiation oncology, "Meet your team" to include date/time
- Other ideas include virtual tours and YouTube videos
- Prospective patient conference prior to any treatment
- Patient team (entire team) follows patient across the continuum of care (pre-diagnosis through survivorship or End of Life

Standing Order Set for Head & Neck Cancer Patients

Name: _________________ MRN#: ________________ICD-10: _________

☐ Referral to Surgeon, Dr ____
☐ Referral to Medical Oncologist, Dr ___________________________________
☐ Referral to Radiation Oncologist, Dr _________________________________
☐ Referral to Dentist, Dr ____
☐ Cardiac Clearance, Dr ____
☐ Referral to Rehabilitation, reason ____________________________________
  ☐ pre-op, ☐ post-op
☐ Referral to Cancer Research
☐ Referral to Registered Dietitian
☐ Speech and Swallowing evaluation with Speech Pathologist
  ☐ pre-op, ☐ post-op, ☐ pre-radiation
☐ Referral to Social Worker, reason _________________________________
☐ Referral to Health Psychologist
☐ Positron Emission Tomography (PET)
☐ CT scan Type: ____
  ☐ with IV contrast, ☐ without IV contrast
  Is patient diabetic? ☐ yes, ☐ no
☐ Magnetic Resonance Imaging (MRI), Type: ________________________
☐ Feeding Tube consult, Dr _______________________________________
☐ Test tissue biopsy for HPV, P-16 and EGFR
☐ Referral to Smoking Cessation Program
☐ Referral to Alcohol Cessation Program
☐ Other, specify ____

Head & Neck Cancer Patient Appointments

Your physician has ordered the following for you. Each referral is important to the success of your cancer treatment. We are here to help you understand the importance of each referral.

Referral	Definition
Otolaryngologist / ENT Surgeon	A surgeon who specializes in operating on tumors found in the head and neck
Dentist	A doctor qualified to treat conditions that affect the teeth and gums You may need to have dental work done prior to starting treatment
Medical Oncologist	A doctor to provide chemotherapy or other specific medications to treat your cancer
Radiation Oncologist	A doctor that provides the type of radiation that will treat your cancer Radiation treatment utilizes high energy rays that destroy cancer cells
Feeding Tube insertion	A tube that is placed into your stomach for feeding when it is hard to swallow
Rehabilitation	A program to assist with fatigue (feeling tired), peripheral neuropathy (tingling in hand and toes), lymphedema (swelling in the arm/s or leg/s after lymph nodes removed) or other cancer specific rehabilitation needs
Cancer Research	A person to educate and determine eligibility for a clinical trial Clinical trial researches new cancer treatments to find better ways to treat cancer
Registered Dietitian	A person to provide nutrition counseling
Speech/Swallowing for evaluation with speech pathologist	A person that specializes in speech and swallowing, they will review exercises to maintain your speech and swallowing throughout your treatment

Discussions: Tip Sheet for Navigators and Social Workers

Table of Contents

- When and why is it important to discuss the role of palliative care with the patient and their family?
- What is the Ask-Tell-Ask Approach; discussions with your patients and families
- Communication pearls for palliative care discussions
- Triggers for palliative care for healthcare professionals
- Palliative care fact sheet for patients and their families
- Definition of terms
- References/Additional resources

Palliative Care Initial Discussion Script

Hello, my name is ______________________, I am your ______________________ (role), and I work with Dr. ____________________ (MD name).
(Depending on the person having the discussion they will review their role. I will use the role of the navigator).

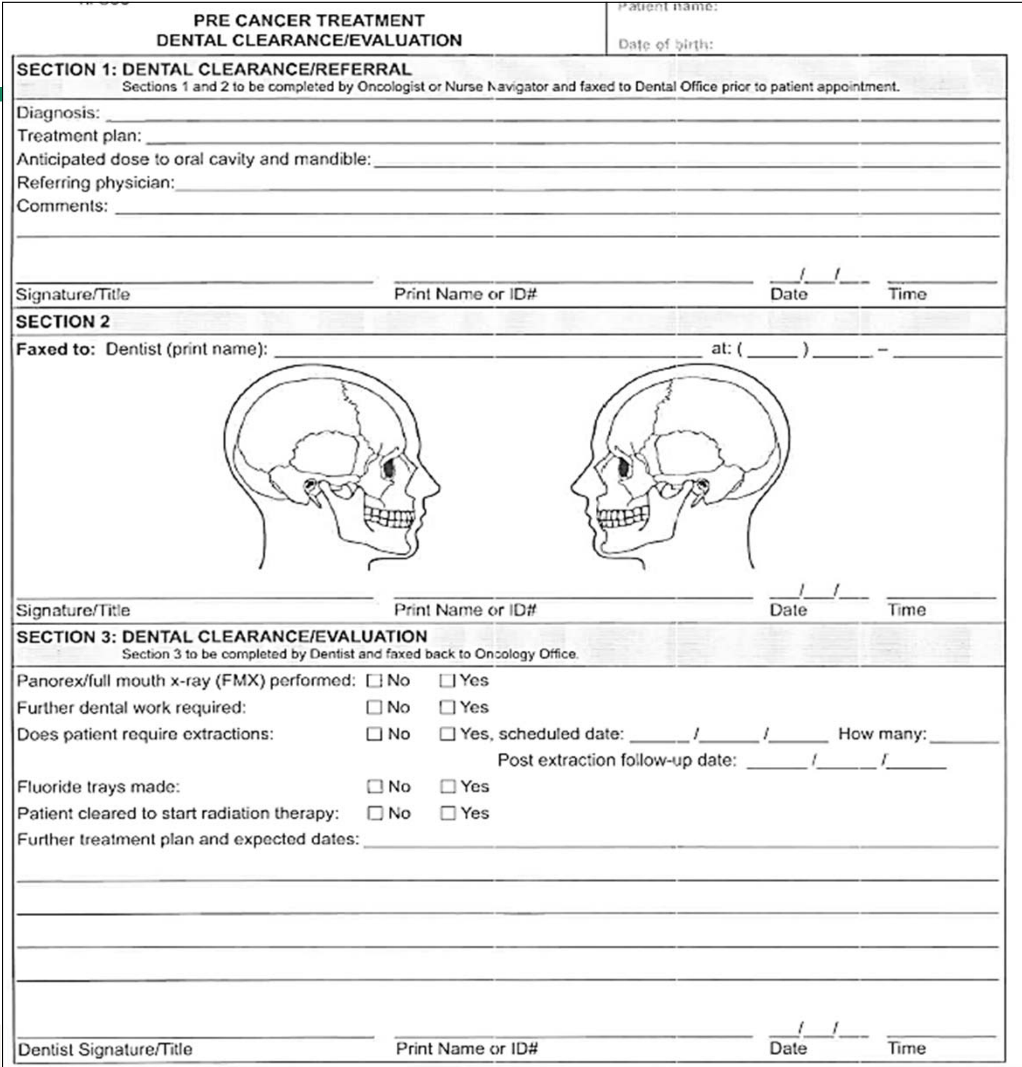
My role as the navigator is to guide you and your family through our system. We will discuss your educational needs as well as any physical, emotional, spiritual, or financial concerns. I work very closely with your physicians and their office. Our team is here to help you and your family.

It is also very important that we discuss our palliative care program with you. Palliative care is an important part of every cancer patient's treatment plan; we review palliative care with all our patients and their families. The goal of palliative care is to reduce symptoms, improve quality of life, and support our patients and their families during their entire cancer journey. (Last sentence source: ASCO Advance Planning Booklet)

It is important that we listen to your specific request and needs for your treatment. We also want to make sure you understand advance care planning, which includes advance directives and goals of care.

Dashboard Example

Process Measures	2015	2016	Internal Goal	Action
Average time from diagnosis to treatment start. SURGERY (chart audit: 10 random charts)	28	22	N/A	
Average time from diagnosis to treatment start. RADIATION (chart audit: 20 random charts)	32	23	N/A	
Average time from diagnosis to definitive treatment plan to radiation start (tumor registry: 5 random charts)	N/A	27	4-6 weeks	
Average Hospital Length of Stay (Finance)	6.27	8.96	N/A	



Patient name:
Date of birth:

PRE CANCER TREATMENT
DENTAL CLEARANCE/EVALUATION

SECTION 1: DENTAL CLEARANCE/REFERRAL
Sections 1 and 2 to be completed by Oncologist or Nurse Navigator and faxed to Dental Office prior to patient appointment.

Diagnosis: ______
Treatment plan: ______
Anticipated dose to oral cavity and mandible: ______
Referring physician: ______
Comments: ______

Signature/Title | Print Name or ID# | Date ___/___/___ | Time

SECTION 2

Faxed to: Dentist (print name): ______ at: (____) ____ – ______

Signature/Title | Print Name or ID# | Date ___/___/___ | Time

SECTION 3: DENTAL CLEARANCE/EVALUATION
Section 3 to be completed by Dentist and faxed back to Oncology Office.

Panorex/full mouth x-ray (FMX) performed: ☐ No ☐ Yes
Further dental work required: ☐ No ☐ Yes
Does patient require extractions: ☐ No ☐ Yes, scheduled date: ____/____/____ How many: ____
Post extraction follow-up date: ____/____/____
Fluoride trays made: ☐ No ☐ Yes
Patient cleared to start radiation therapy: ☐ No ☐ Yes
Further treatment plan and expected dates: ______

Dentist Signature/Title | Print Name or ID# | Date ___/___/___ | Time

Welcome Letter

Thank you for choosing ____________________ for your healthcare needs. Our navigation team is available to you, your family, and/or caregivers at any time during your diagnosis, treatment, and recovery. We will help you coordinate and access the support services you need. Our team can help with the following:

- Help you, your family, and/or caregiver cope with the emotional issues of your illness through individual or group support
- Work with your doctors and their staff to plan and coordinate your care
- Provide education about your illness and treatments you may receive
- Determine if you might qualify for new treatments being tested
- Help you identify other community-based programs that may offer additional support
- Provide individual nutritional counseling and group classes to answer your questions about nutrition
- Provide rehabilitation programs for managing fatigue, lymphedema, pain, and other complications associated with cancer
- Link you to resources that help answer questions about transportation needs and financial concerns

Frequently Asked Questions for Newly Diagnosed Cancer Patients

1. What is my cancer? Where is it located?
2. What is the stage of my cancer and what does that mean?
3. What are my treatment options for my cancer?
4. What side effects will occur due to my treatment?
5. Will my insurance pay for my cancer treatment?
6. Are there clinical trials available at this cancer center for my cancer?
7. What support groups and education programs are available for me, my family, and/or caregiver?
8. What support services are available for me, my family, and/or caregiver?
   - Social work, registered dietitian, health psychology, genetics, etc.
9. What resources are available to me, my family, and/or caregiver in the community?

Discussion

Patients First

Thank you