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Oncology Nurse Communication Training Needs Across the Cancer Continuum

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Abstract

Background: Oncology nurses are increasingly responsible for communication aimed prognosis, patient education about cancer care and treatment, survivorship, and care coordination. Communication difficulties and uncomfortable communication topics put nurses at risk for compassion fatigue.

Objectives: Supporting nurse communication skills requires institutional policies and structures to foster patient-centered communication. The purpose of this study is to report on communication training needs for oncology nurses to inform future development of communication curricula and institutional training.

Methods: A national survey of oncology nurse teams attending one of four communication training courses ($n=355$ nurses). Survey method was used to evaluate institutions' current patient-centered communication practices and to ascertain institutional communication training needs across the continuum of cancer care.

Findings: Nurses' role in communicating prognosis remains unclear and training is needed for discussing survivorship. Curriculum development should be congruent with institutionally-defined roles for nurse communication.

Keywords

communication education/training; nursing; oncology; patient-centered care; Staff development/education; Communication (patient-provider)

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Introduction

As the cancer treatment landscape has expanded to include new immunotherapy agents, oncology nurses need to be skilled communicators who are able to educate patients and families and advocate for management of short and long-term side effects (Sheldon, 2017). Nurses are increasingly responsible for communication aimed at promoting healthy living, patient education about cancer care and treatment, and care coordination among a variety of cancer providers. Communication skills have been identified as a component of the scope and standards of practice for oncology nurses and as a standard for professional performance (Brant & Wickham, 2013). Given that interprofessional oncology clinical practice is essential for coordinating cancer care, the Oncology Nurse Generalist Competencies highlight the importance of nurse communication skills in the area of teamwork, requiring “effective therapeutic communication skills during interactions with people with cancer, caregivers, and fellow members of the interprofessional care team” (Gaguski et al., 2017). Knowledge gaps in nursing education about oncology remain, however, making it essential for institutions to foster an infrastructure that supports patient-centered communication practices as well as provide ongoing staff education and training for communication skill building. In oncology nursing, staff training and education and appropriate staffing levels are among the most pressing practice challenges (Nevidjon, 2018), and high patient workload is a strong predictor of unfavorable ratings of nurse communication (McFarland, Johnson Shen, & Holcombe, 2017).

The COMFORT™ SM Communication Course for Oncology Nurses training program is a National Cancer Institute (NCI) supported project (R25CA174627) that educates oncology nurses about palliative care communication to improve patient-centered communication and cancer care. The communication course provides essential communication skills and tools oncology nurses need to provide quality care across the cancer continuum. The purpose of this article is to present institutional practices and communication training needs as reported by a national sample of oncology nurses who attended one of four communication training courses. Capturing a national perspective of communication training needs for oncology nurses will inform the development of communication curricula and institutional training and policy priorities which are imperative to ensuring quality cancer care.

Background

Research shows that oncology nurses experience communication difficulties with patients, families, and other cancer care providers (Kalowes, 2015; Pfeil, Laryionava, Reiter-Theil, Hiddemann, & Winkler, 2015). Nurses experience the tension between wanting to be hopeful for the patient and family, and wanting to provide truthful prognostic information (Leung et al., 2017). Nurses find it difficult to preserve family trust (Leung et al., 2017) and report that they do not know what to say, do not know the ‘right’ words to use, fear they may upset the patient/family, and are unsure how to assess the individual needs of the patient (Banerjee et al. 2016) They are uncomfortable discussing prognosis with families (Aslakson et al., 2012), mostly due to personal feelings of sadness or distress for the patient/family (McLennon et al., 2013), and have uncertainty about what to say.

A lack of communication training and experience decreases nurse communication confidence in discussing certain topics with patient/family (Bumb, Keefe, Miller, & Overcash, 2017). Difficulties communicating empathy and discussing end-of-life goals of care exist for oncology nurses who report a lack of skills, not enough time, and cultural differences between nurse and patient (Banerjee et al., 2016). Discussions about clinical trials can also be challenging; communication barriers to these discussions include nurses' lack of strategies for addressing patient uncertainty and misconceptions and determining when the appropriate time is for these discussions (Flocke et al., 2017). Some nurses are uncomfortable discussing complementary health approaches (Wanchai, Armer, Smith, & Rodrick, 2017), feel inadequate in initiating conversations about spiritual concerns (Wittenberg, Ferrell, Goldsmith, & Buller, 2016), avoid discussions about sexuality during cancer treatment (Reese et al., 2017), and do not discuss religious considerations or spiritual concerns with patients (Wittenberg, Ragan, & Ferrell, 2017).

Nurses often feel constraints on communication as a result of interprofessional team dynamics or limited communication with the team (Leung et al., 2017). In pediatric palliative care settings, nurses have described that a busy team process can leave them feeling on the outside looking in, unaware of changes in patient status, and omitted from care planning (Montgomery, Sawin, & Hendricks-Ferguson, 2017). Interprofessional communication conflicts are commonly the product of oncologists' focus on the biomedical model, exclusive of quality of life, and often result in the delivery of treatment that is counter to patients' needs (Finley & Sheppard, 2017). When oncology nurses are not included in team discussions, and nurse assessment is not included in care planning, there can be unintentional and unnecessary emotional distress incurred by the nurse, patient, and family as a result of failed communication (Montgomery et al., 2017).

Demanding workloads limit time for communication and conversations with patient and family about disease and prognosis (Nevidjon, 2018), and nurses report that it is difficult to protect time to have these conversations (Ehsani, Taleghani, Hematti, & Abazari, 2016). The absence of a shared common language with patients is especially problematic (Weber, Sulstarova, & Singy, 2016). Uncertainty and discomfort communicating with patients from minority backgrounds have been reported by nurses (Watts et al., 2017), and providing care to patient and family who are culturally and linguistically diverse (Weber et al., 2016) or who speak English as a second language (Wittenberg, Ferrell, Kanter, & Buller, 2018) are among patient factors that create communication challenges. Overall, nurses have difficulty navigating the emotional responses of family caregivers (Irwin, Dudley, Northouse, Berry, & Mallory, 2018).

Nurses' lack of communication skills and theoretical tools for assessing patient/family's emotional responses contributes to compassion fatigue (Wentzel & Brysiewicz, 2017) and burnout (De la Fuente-Solana et al., 2017). Oncology nurses who feel distressed and experience compassion fatigue feel cut off from others and are unable to share feelings of empathy with others' suffering (Duarte & Pinto-Gouveia, 2017). Symptoms of compassion fatigue include internalizing patients' pains and fears, feeling emotionally depleted or emotionally numb, and manifesting a hypervigilant protection for loved ones (Finley & Sheppard, 2017). High levels of burnout are often caused by over-relating to patient/family,

long patient stays, long-term connections with patients/family, witnessing protracted suffering, and high patient mortality rates, which result in repetitive feelings of grief and loss (De la Fuente-Solana et al., 2017; Finley & Sheppard, 2017). A recent meta-analysis of burnout in oncology nursing found that 30% of nurses suffered from emotional exhaustion and depersonalization, and 35% described low personal performance (Canadas-De la Fuente et al., 2018). Communication challenges can leave oncology nurses feeling little sense of personal accomplishment (Gomez-Urquiza et al., 2016).

While research has documented that communication difficulties and uncomfortable communication topics put nurses at risk for compassion fatigue (Gomez-Urquiza et al., 2016), there remains a lack of information on: institutional practices that may foster patient-centered communication; communication training available to nurses, and institution-wide communication training. Additionally, extant literature has focused solely on one aspect of nurse communication in cancer care (e.g., breaking bad news); little is known about communication training needs across the cancer continuum.

Methods

Prior to attending a national communication training course, oncology nurses working in teams of two completed personal demographics, provided institutional demographics, and completed a survey. The survey was based on a prior educational assessment tool used in several cancer education program grant projects funded by the National Cancer Institute and modified to assess communication training needs. The purpose of the survey was to evaluate institutions' current patient-centered communication practices and to ascertain institutional communication training needs across the continuum of cancer care. The survey was determined to be exempt under the institutional review board at the supporting institution.

Instrument

The survey consisted of three parts: 1) Institutional Assessment; 2) Educational Program Offerings; and 3) Institutional Communication Assessment. The institutional assessment surveyed patient-centered communication practices, available support services and resources to patients, family members, and caregivers, and institutional standards present. The assessment is a pre-training, self-rating tool used to assess communication studies conducted at City of Hope. Educational program offerings accounted for communication-specific instruction offered to healthcare professionals at the institution over the past two years. The institutional communication assessment assessed teams' perceptions of communication effectiveness with patients across the continuum of cancer care (0=Not Effective; 10=Very Effective), the degree of difficulty teams have with certain communication topics (0=Not Difficult; 10=Very Difficult), and teams' involvement with breaking bad news and providing prognosis information (present; not present).

Data Analysis

Descriptive statistics (frequencies and means) were used to examine the distribution of participants, institutional characteristics, and survey results. Quantitative data were entered,

audited for accuracy, and analyzed using the Statistical Package for the Social Sciences (SPSS).

Results

Three hundred fifty-five nurses from 42 states and Washington, D.C. completed the survey. The majority (92.7%) were female and Caucasian (70.4%), with the remaining representing: Asian (10.7%); African-American (5.9%); more than one race (3.4%); and 1% from American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and unknown cultural groups. Twenty-four individuals (6.8%) did not indicate race.

Oncology nurses represented community cancer centers (37%), NCI-designated cancer centers (32%), ambulatory cancer clinics (22%), university medical centers (3%), and Veterans Health Systems (6%). The institutional patient populations were predominantly Caucasian (62.8%), with the remaining 37.2% representing African-American (15.3%), Asian (9.5%), American Indians or Alaska Native (3.4%), Native Hawaiian or other Pacific Islander (3.2%), and unknown cultural groups (6.4%).

Table 1 summarizes findings regarding available, institutional, support services and resources for patients, family members, and caregivers and the standards within participants' home institutions. The assessment included seven areas of patient-centered communication support: vision and management; practice; visiting; spiritual, religious and cultural; psychosocial and emotional; quality improvement; and community network and partnerships. Institutional settings were consistent in administrative executive staff support for implementation of initiatives to improve communication (95%), providing interpreters and a having a clear referral process (92%), provider availability for family meetings in person (92%) and by phone (91%), and availability of a palliative care team (81%). However, only 64% of institutions included a public display or distributed feedback on excellent communication received from patients/families, and only 61% had current contact information and staff knowledge of community resources. Use of video technology to support patient-centered communication was lowest, with 43% of institutional settings offering video to explain treatment options and 18% providing video conferencing to patient and family.

The most frequent communication educational programs offered by institutions addressed Culture (96%) and Team Communication (69%). Educational programs were less frequently offered on how to have conversations about recurrence (15%), transitions in care (26%), and discussing bad news (25%). These data are summarized in Table 2.

Results from the institutional communication assessment, Table 3, reveal that across all points on the cancer continuum and across all institution types, participants' perception of communication with patients were least effective (0=not effective, 10=effective) at their institutions during bereavement (M=4.4), when facing end of life (M=5.2), and through survivorship (M=5.3). On a scale of 0-not difficult and 10-very difficult, nurses across all institution types reported having most difficulty handling conflict among patients and their families (M=5.51) and among team members (M=5.35). Initiating talks with patients about

hospice/palliative care (M=5.1) was also reported as difficult. Across institutions, nurses reported being present for bad news delivery (62%) and prognosis sharing (55%), yet this role was less likely to include delivering the bad news (16%) or sharing prognosis (10%) with patients (see Table 4).

Discussion

The current study is the first national survey investigating current institutional patient-centered communication practices, educational offerings for communication skill building for nurses, and communication training needs across the cancer continuum. This study offers important information that assesses institutional practices supporting communication training and quality communication among nurses, patients, and families in oncology.

Across all institution types, findings demonstrate an institutional prioritization of patient-centered communication standards; however, there is a substantial need to develop policies and practices that support nurse communication with patient/family to achieve this priority. While palliative care was predominantly available and providers accessible, many institutions are not yet able to provide technological resources aimed at supporting communication, such as video conferencing and email among providers, patient and family. Findings also revealed a need for improvements in video educational materials and online library access for patient/family.

Educational program offerings were similar between NCI-designated cancer centers and ambulatory clinics, with most education in these settings focused on culture, while academic medical centers and VA Health systems focused on end-of-life communication. However, findings regarding institutional practices did not support cultural communication practices, despite the common report of cultural training. As the absence of written materials in other languages inhibits patient-centered communication, there remains a need for cross cultural training for oncology providers (Weber et al., 2016). Moreover, although research has shown that experienced nurses self-report higher confidence and comfort with communication (Moir, Roberts, Martz, Perry, & Tivis, 2015), more experienced nurses report more difficulty with low-literacy populations than less experienced nurses (Wittenberg et al., 2018). With an increasing call to integrate oncology and palliative care, oncology nurses must be trained to communicate with patients to determine patient goals and patient/family preferences and to assist with healthcare decision-making (National Consensus Project for Quality Palliative Care, 2013). Such training will require learning to practice cultural humility when communicating with patients and families (Neubauer, Dixon, Corona, & Bodurtha, 2015), especially when institutional resources for navigating cultural or language differences are not available.

Despite educational programming for team communication, nurses reported difficulty managing conflict with other team members. Potential conflicts may arise over the nurse's role in discussing prognosis with the patient (Aslakson et al., 2012). A nurse's unwillingness to communicate with the patient and family about prognosis is often the result of negative experiences or anticipation of conflict with physicians, resulting primarily from role ambiguity (McLennon et al., 2013). Nurses report feeling 'stuck in the middle' between

physician and patient/family, because they do not know the patient's prognosis, are unclear about their own role in prognosis discussions, and do not know if the physician has had a prognosis discussion with the patient/family (McLennon et al., 2013). In cancer care, nurses' understanding of their role in end of life discussions, including prognosis, remains unclear (Pfeil et al., 2015), and nurses feel uncomfortable discussing prognosis, because they are not sure if it is acceptable to have these discussions (Aslakson et al., 2012), which is antithetical to patient-centered oncology care. Still, it should be noted that survey findings may not accurately reflect clinical practice, as the term 'colleague' in the survey item was vague and may have been interpreted as another nurse rather than another interdisciplinary team member. Survey findings are also limited by a predominantly white sample of nurses.

Although logistical barriers can keep all parties (ICU physicians, surgeons, nurses) from being present when prognostic conversations occur (Aslakson et al., 2012), this study shows that an increasing number of nurses are present for bad news and prognosis delivery. Prior research has revealed that experienced oncology nurses or those who work in inpatient settings are more likely to deliver bad news (Helft, Chamness, Terry, & Uhrich, 2011) and findings from this study identify academic medical centers and VA Health systems as clinical sites for this nurse role. In order to ensure timely transitions and integration of palliative care for cancer patients (Leung et al., 2017), formal institutional structures are needed to facilitate nurse participation in decisionmaking and in sharing prognostic information in institutional settings where the nurse's role is only defined by their presence.

Across the cancer continuum, oncology nurses perceived that their institution is least effective with communication during bereavement, at time of death, and through survivorship. Comprehensive training, such as the End of Life Nursing Education Consortium, has been successful at supporting these educational needs by offering a train-the-trainer course, yet it provides only one hour of education on communication. Nurses at community cancer centers, academic medical centers, and VA Health systems reported difficulty initiating talks with patients about hospice and palliative care topics.

The majority of institutions offered nurse education on survivorship care planning; however, few institutions offered instruction on communicating recurrence. While these findings demonstrate that institutions are implementing National Institutes of Health requirements for survivorship care plans, it also identifies existing gaps in nurse communication training needs. Survivors may have difficulty expressing their emotions, and providers frequently do not recognize emotional cues and may respond inappropriately (Dean & Street, 2014). The ability to speak to nurses between follow-up visits can provide reassurance regarding the meaning of symptoms and decrease survivors' anxiety (Clayton, Dingley, & Donaldson, 2017). Providing tailored information based on the survivor's information preference and coping style may be beneficial in addressing concerns and fears (O'Malley et al., 2016). Nurses need preparation for facilitating these conversations.

Implications for Nursing Practice

The communication difficulties oncology nurses consider problematic highlights areas where training is needed, as well as institutional changes, such as policies that structure teams and their processes. Nurse communication training increases nurses' awareness of

their communication with the patient/family and can improve communication skill and confidence (Coyle et al., 2015; Milic et al., 2015). Institutions need to develop and offer interventions aimed at reducing emotional exhaustion in order to support nurse communication skill building (Gomez-Urquiza, 2016). Although a review of institutional interventions aimed at reducing compassion fatigue in oncology care revealed a lack of evidence for evaluating the effectiveness of interventions (Wentzel & Brysiewicz, 2017), nurse knowledge of compassion fatigue, self-awareness and self-care can be improved by an educational workshop that could improve nurse confidence in communication (Adimando, 2017). Strategies to reduce burnout among oncology nurses can include nursing support groups, mentorship programs for new nurses, and continuing education about compassion fatigue (Finley & Sheppard, 2017).

Institutional strategic plans should establish opportunities to develop nurse leaders who can champion patient-centered communication. In order for nurses to practice to the full extent of their education and training, institutional support is needed to ensure life-long learning beyond acute care settings and to include the continuum of cancer care. Nurse leadership competencies should include communication, and institutions should promote leadership development and opportunities for communication training. Building internal resources and addressing nurse communication needs may increase the level of occupational work support and positive outcomes; this includes establishing orientation programs and yearly education programming in communication skills, conflict resolution, ethical issues, and self-care (Aycock & Boyle, 2009).

Delivering patient-centered cancer care involves quality communication skills, interdisciplinary collaboration, and use of constantly evolving information technology, warranting communication curriculum development and delivery in these areas. This study reiterates the need to provide nurses with education about end-of-life communication and further identifies survivorship as an underdeveloped area of communication training and institutional support. Consonant with national policy requirements for survivorship care planning, there is a need to improve the nurse's ability to advocate for the patient and family by providing educational program offerings in the area of survivorship.

Finally, it is essential for institutions to clearly define oncology team format and structure so that nurses can better understand their role as patient advocate. Variation in nursing practice across institutional settings shows inconsistency in nurses' communication during delivering of bad news and prognosis. While nurses are frequently present for these conversations regardless of institutional setting, the role of nurses at academic medical centers was most likely to include delivering bad news and sharing prognosis. As institutions face increasing demands from licensing and certification organizations, it is essential that nurse education prepares nurses for a defined scope of practice. If institutional workplace roles define that nurse-physician collaboration about patient prognosis includes the nurse's role in clarifying, explaining, and sharing information between patient and physician, then nurses should be prepared for this role. Otherwise, it is essential that nurses receive comprehensive communication training for sharing difficult news and prognosis disclosure/clarification as these competencies are likely to influence workplace burnout and compassion fatigue.

Institutional educational offerings should consistently parallel the defined scope of practice at that institution, rather than a general educational module.

Conclusion

Awareness of the need for communication training among cancer providers is increasing (Knoop, Wujcik, & Wujcik, 2017). While communication training programs and curricula are becoming more prevalent (Bumb et al., 2017), there remains an exigent need to address the specific training demands of oncology nurses. Clinical nurse specialists in cancer care who have had advanced communication skills training report feeling prepared and confident when communicating significant news to patients and families (Mishelmovich, Arber, & Odelius, 2016). The current study demonstrates communication training needs across the cancer continuum and highlights needed changes to institutional practices and their efforts to achieve and deliver patient-centered communication.

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Implications for Practice

- The vast majority of oncology nurses report that few educational programs at their institutions are aimed at improving discussions about recurrence, transitions in care, and breaking bad news.
- Although most institutions provide educational programs about team communication, oncology nurses report that handling conflict among team members is considered most difficult.
- Oncology nurses consider communication with patients and family at their institution least effective during bereavement and at end of life.

Response to Reviewers

We appreciate this careful feedback and hope you will find the manuscript much improved. As requested, responses are listed below and the changes are highlighted in the manuscript.

Comments from Reviewers	Revisions made to manuscript
Need to clearly identify a research gap that this study addresses	This manuscript addresses two research gaps: <ol style="list-style-type: none"> 1- It addresses the knowledge gap in nursing education by exploring institutional course offerings related to communication 2- It addresses the research gap on nurse communication by exploring communication training needs 'across the continuum of cancer care' rather than nurse communication in one aspect of cancer care <p>The last paragraph of the introduction prior to the methods shows this revision.</p>
Abstract – the objective needs to be revised to match the introduction of the manuscript <ul style="list-style-type: none"> - Background explores nurse discomfort with communication, but objective of study is to report on communication training needs 	We added a sentence in the background section of the abstract to acknowledge the introduction summary of nurse communication difficulties.
There is a lack of data analysis and a need to move beyond descriptive data and contextualize survey findings (e.g., NCI-designated cancer centers are different from ambulatory clinics)	Based on the recommendations of reviewers we have re-analyzed the data and revised tables 1–4 to illustrate study findings by institutional type. Given that nurse teams (2 nurses from an institution) completed the survey we did not correlate findings for Table 3 by nurse age or years of clinical experience.
Survey is not a standard measure and there is concern over validity of the measure.	The survey has been used in four prior National Cancer Institute (NCI) supported projects (R25CA132664, R25CA107109, R25CA101706, R25CA110454) conducted by City of Hope to ascertain oncology provider training needs. We have added a sentence in the first paragraph of the methods section.
Need to condense results section so that it is not redundant with Tables	The results section has now been re-written to summarize findings by institution type. The results section now includes range of scores by institutional type rather than mean scores for the entire data set.
Discussion: Would like to hear more about success/unsuccess of other nurse training programs – ELNEC, what makes this program work well for nurses?	We have added a sentence explaining that the End of Life Nursing Education Consortium is a successful train-the-trainer course yet only provides one hour of communication content.
Need better suggestions for implications for practice and conclusions drawn from data	Based on the recommendations of reviewers, this section now summarizes areas for institutional change so nurses can support patient-centered communication and identifies topics needed for nurse communication training. We also added three additional references.
Study is limited by: <ul style="list-style-type: none"> - definition of colleague is vague in survey item regarding bad news and prognosis delivery - predominantly white sample 	We added these study limitations in the discussion section.
APA editing needed; grammar problems; need to spell out all abbreviations; correction of “immuno-oncology” or “immunotherapy”	We have edited the manuscript for APA style and grammar and highlighted portions of the introduction

Comments from Reviewers	Revisions made to manuscript
	where this was done. We also edited as “immunotherapy agents”

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Table 1.

Institutional Assessment of Available Support Services and Resources (n=179)

Criteria	Institutions responding Yes (n, %)				
	NCI-Designated Cancer Center (n=59)	Community Cancer Center (n=65)	Ambulatory Clinic (n=40)	Academic Medical Center (n=6)	VA Health (n=9)
Vision and Management Standards					
Administrative executive staff support implementation of initiatives to improve communication	53 (89%)	63 (96%)	40 (100%)	5 (83%)	9 (100%)
Education resources designed to support development of competencies and practices in communication	38 (64%)	47 (72%)	32 (80%)	4 (66%)	7 (77%)
Display/distribution of patient feedback of excellent communication (such as bulletin board with patient comments)	39 (66%)	42 (64%)	25 (62%)	4 (66%)	4 (44%)
Practice Standards					
Advance care planning support available and plan communicated	43 (72%)	51 (78%)	28 (70%)	4 (66%)	6 (66%)
Visiting Standards					
Policies for treatment and care settings clearly explained (safety procedures, visiting hours)	52 (88%)	57 (87%)	35 (87%)	6 (100%)	5 (55%)
Inpatient visitor policies clearly explained	44 (74%)	54 (83%)	33 (82%)	4 (66%)	6 (66%)
Spiritual, Religious, and Cultural Standards					
Interpreter available and process for referral is clear	56 (94%)	58 (89%)	39 (97%)	6 (100%)	7 (77%)
Chaplain/spiritual care provider available and process for referral is clear	53 (89%)	54 (84%)	34 (85%)	6 (100%)	6 (66%)
Written materials available for treatment options	51 (86%)	56 (86%)	36 (90%)	6 (100%)	8 (88%)
Written materials available in different languages	46 (77%)	48 (73%)	35 (87%)	4 (66%)	7 (77%)
Video available to explain treatment options and procedures	29 (49%)	20 (30%)	16 (40%)	2 (33%)	6 (66%)
Computer access with Internet available for patient/families	47 (79%)	44 (67%)	25 (62%)	3 (50%)	5 (55%)
Complementary or integrative therapies are discussed with patients	42 (71%)	37 (56%)	29 (72%)	5 (83%)	5 (55%)
Families have access to library for additional resources	43 (72%)	34 (52%)	23 (57%)	6 (100%)	4 (44%)
Psychosocial and Emotional Standards					
Palliative care team is available and referral process is clear	51 (86%)	50 (76%)	34 (85%)	3 (50%)	6 (66%)
Providers are accessible via email for patients & families	43 (72%)	30 (46%)	25 (62%)	6 (100%)	5 (55%)

Criteria	Institutions responding Yes (n, %)					VA Health (n=9)
	NCI-Designated Cancer Center (n=59)	Community Cancer Center (n=65)	Ambulatory Clinic (n=40)	Academic Medical Center (n=6)		
Providers are available for family meetings with patients & families	55 (93%)	60 (92%)	38 (95%)	6 (100%)	7 (77%)	
Providers are available for phone conversations with patients & families	53 (89%)	61 (93%)	36 (90%)	6 (100%)	6 (66%)	
Video conferencing with providers is available for patients & families	10 (16%)	9 (13%)	7 (17%)	0 (0%)	4 (44%)	
Quality Improvement Standards						
Routine feedback from patients, family caregivers, and community partners is obtained	50 (84%)	51 (78%)	33 (82%)	4 (66%)	8 (88%)	
Community Network and Partnerships						
Referral process for community resources in place	51 (86%)	56 (86%)	35 (87%)	6 (100%)	8 (88%)	
Staff knowledge of community resources & contact information is current	33 (55%)	43 (66%)	22 (55%)	3 (50%)	5 (55%)	

Table 2. Educational Program Offerings in Oncology Communication Content Areas (n=174)

Oncology Communication Content Areas	Institutions indicating educational program in past two years (n, %)				
	NCI-Designated Cancer Center (n=58)	Community Cancer Center (n=65)	Ambulatory Clinics (n=38)	Academic Medical Center (n=5)	VA Health (n=8)
Breaking Bad News	14 (24%)	14 (64%)	12 (31%)	0	3 (38%)
Health Literacy	26 (44%)	22 (33%)	13 (34%)	3 (60%)	3 (38%)
Culture	44 (75%)	42 (64%)	28 (73%)	4 (80%)	5 (63%)
Being Present/Mindfulness	32 (55%)	29 (44%)	19 (50%)	3 (60%)	4 (50%)
Support for Family Caregivers	32 (55%)	22 (33%)	17 (44%)	5 (100%)	4 (50%)
Goals of Care Conversations/Patient-Centeredness	25 (43%)	18 (27%)	16 (42%)	3 (60%)	6 (75%)
Transition in Care Conversations	14 (24%)	14 (21%)	9 (23%)	3 (60%)	5 (63%)
Team Communication (e.g. shift handoff & safety)	34 (58%)	46 (70%)	29 (76%)	5 (100%)	6 (75%)
Diagnosis (e.g. assessment & evaluation of patient understanding)	25 (43%)	29 (44%)	18 (47%)	3 (60%)	5 (63%)
Treatment Conversations (e.g. shared decisionmaking)	20 (34%)	17 (26%)	14 (36%)	3 (60%)	6 (75%)
Survivorship Care Planning	19 (32%)	26 (40%)	16 (45%)	2 (40%)	1 (12%)
Recurrence Conversations	7 (12%)	8 (12%)	6 (15%)	2 (40%)	3 (38%)
End of Life Communication	33 (56%)	33 (50%)	21 (55%)	5 (100%)	6 (75%)
Grief/Bereavement	32 (55%)	21 (32%)	20 (52%)	4 (80%)	5 (63%)

Table 3.

Institutional Communication Assessment Mean Scores (n=178)

Perception of Communication with Patients at Institution Across Continuum of Care	NCI-Designated Cancer Center (n=58)	Community Cancer Center (n=66)	Ambulatory Clinics (n=40)	Academic Medical Center (n=6)	VA Health (n=9)
At time of diagnosis	6.79	5.93	6.22	7.33	5.66
During treatment	6.98	6.65	6.62	7.16	5.44
Through survivorship	5.82	4.95	5.60	4.33	4.88
At recurrence	6.56	5.87	6.35	6.66	5.11
Facing end of life	5.27	5.06	5.35	6.66	4.44
At time of death	5.32	5.15	5.52	7.16	4.66
During bereavement	4.53	4.06	4.35	5.83	4.00
The Degree of Difficulty the Team has with the Following:					
Scale: 0=Not difficult to 10 =Very Difficult					
Determining how the patient and family like information shared with them	3.00	3.33	3.80	2.0	3.33
Evaluating your own communication with patients and families	3.91	3.77	4.02	4.0	3.77
Evaluating your own communication with colleagues	4.29	3.74	3.97	4.0	4.22
Telling others when you observe or have concerns about errors in care	4.86	4.13	4.90	5.66	5.33
Keeping regular communication with other providers about patient transition in care	4.24	3.86	3.17	4.16	3.44
Sharing information during interdisciplinary team meetings	3.10	2.96	3.20	2.83	2.77
Initiating talks with patients about hospice and palliative care topics	5.55	4.81	5.35	5.66	4.44
Handling conflict among patients and family	5.86	5.21	5.45	5.50	5.55
Handling conflict among team members	5.75	4.81	5.07	5.83	5.33
Discussions with patient/family about spirituality (e.g. existential distress)	4.44	4.25	4.60	2.50	4.22
Discussion with patient/family about cultural concerns (e.g. beliefs, traditions, rituals)	4.13	4.04	4.10	2.16	4.11
Discussions with patient/family about financial concerns	4.27	4.43	4.62	2.66	5.22

Table 4.

Nurse Role in Bad News and Prognosis Sharing (n=170)

	Nurse teams responding yes (n, %)				
	NCI-Designated Cancer Center (n=58)	Community Cancer Center (n=62)	Ambulatory Clinics (n=36)	Academic Medical Center (n=6)	VA Health (n=8)
When bad news is given to a patient:					
Are you present?	37 (63%)	37 (59%)	22 (61%)	6 (100%)	4 (50%)
Do you deliver the news?	10 (17%)	10 (16%)	4 (11%)	3 (50%)	1 (12%)
Is a colleague with you?	20 (34%)	26 (41%)	20 (55%)	3 (50%)	4 (50%)
When prognosis information is given to a patient:					
Are you present?	32 (55%)	29 (46%)	25 (69%)	3 (50%)	4 (50%)
Do you deliver the news?	8 (13%)	5 (8%)	1 (2%)	2 (33%)	1 (12%)
Is a colleague with you?	23 (39%)	24 (38%)	21 (58%)	2 (33%)	3 (37%)