Published in final edited form as:

Curr Oncol Rep. 2015 ; 17(5): 447. doi:10.1007/s11912-015-0447-z.

The five steps of comprehensive psychosocial distress screening

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Abstract

Despite the growing recognition of the impact psychosocial distress has on the quality of life of patients with cancer, the implementation of the NCCN Distress Management Guidelines and the mandate of evidence-based policy for routine distress screening continue to lag. To speed adoption of the guideline, The American Psychosocial Oncology Society (APOS) and Yale School of Nursing (YSN) launched the Screening for Psychosocial Distress Program in 2014. The program resulted in the development of five steps necessary to carry out routine psychosocial distress screening. The steps are consistent with the NCCN Distress Management Guidelines and the new criterion for accreditation by the American College of Surgeons (ACS) Commission on Cancer as of 2015. These five steps are: (1) screen, (2) evaluation, (3) referral, (4) follow-up and (5) documentation & quality improvement. The purpose of this article is to summarize the detailed procedure of the five steps for cancer care professionals-including oncologists, nurses, psychiatrists, psychologists, and social workers-so they can manage psychosocial distress efficiently in their own clinical environments.

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Conflict of Interest Statement

The authors have no conflicts of interest associated with this work.

Keywords

Five-step; Psychosocial; Distress; Management; Whole-patient; Cancer; Care

Introduction

It is well known that a cancer diagnosis and subsequent treatment can lead to significant psychosocial distress [1]. In recent years, there is growing advocacy for routine distress screening of cancer patients as a result of its high incidence (up to 40% in some populations) [2] and the availability of effective interventions [3]. In 2009 the International Psycho-Oncology Society (IPOS) endorsed distress as the “sixth vital sign,” in addition to temperature, blood pressure, pulse, respiration and pain, and recommended regular screening for distress be implemented [4]. In 1997 the National Comprehensive Cancer Network (NCCN) developed consensus-based guidelines on the identification and treatment of psychosocial distress in patients with cancer, which have been updated as recently as 2014 [5]. The American College of Surgeons (ACS) Commission on Cancer requires that cancer centers implement screening programs for psychosocial distress as a criterion for accreditation as of 2015 [6]. However, clinicians in the field of oncology are faced with unique and complex challenges in terms of distress screening implementation as there are few models available that adequately describe distress screening programs and practices for managing psychosocial distress among cancer survivors [7]. To address the challenges, The American Psychosocial Oncology Society and Yale School of Nursing launched the Screening for Psychosocial Distress Program in 2014. Experts on psychosocial distress management, as part of the project, established a 5-step screening process to assist cancer centers in the implementation of distress management.

The five steps in the APOS screening for psychosocial distress program

The five steps of psychosocial distress management are as follows: 1) screening, 2) evaluating, 3) referring, 4) following-up and 5) documenting & quality improvement (See Figure 1).

Step 1: Screening

Distress screening is a comprehensive process that achieves the quality care standard of whole-patient care, which is the integration of both psychosocial and biomedical cancer care [8]. The NCCN recommends using the validated Distress Thermometer (NCCN-DT), a visual analogue scale that allows patients to rate their perceived level of distress in the last 7 days on a scale of 0 (“no distress”) to 10 (“extreme distress”). Patients clarify the source of distress using a 39-item problem list with 5 categories: practical, family, emotional, spiritual/religious, and physical. A score of 4 or greater has been established as the cutoff point for providers to further assess identified patients and their need for treatment [9].

The NCCN recommends that all patients be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status (i.e., remission, recurrence, progression) [10]. However, the progress in implementation of

the NCCN guidelines has been modest at best. In 2005, Jacobsen and Ransom conducted a study of 15 NCCN Member institutions to evaluate the implementation of the NCCN Guidelines for Distress Management. Of those 15, 8 (53%) conducted routine distress screening for at least some patient groups, with 4 additional institutions (27%) pilot-testing screening strategies. However, only 20% of surveyed member institutions screened all patients as the guidelines recommend [11]. Seven years later, the NCCN Distress Management Panel was asked to complete a similar survey and the results were compared with those from 2005. The survey showed a 7% increase in institutions conducting any routine screening and a 10% increase in institutions screening all outpatients routinely, as well as a 23% increase in the use of screening alone or in combination with an interview [12]. While this is a modest improvement, work still needs to be done to ensure that all patients with cancer are properly screened for distress at their initial visit, at intervals throughout the cancer care continuum, and when clinically indicated.

Step 2: Evaluating

A process of evaluation, followed by appropriate referral, is the central component of a screening program, as the goal of screening for psychosocial distress is to identify patients who need further assessment, support, and interventions [13]. Thus, evaluating screened patients is the next step in distress management. The evaluation should include thorough exploration of psychological and behavioral symptoms including past behavioral health issues, suicidal ideation, use of medications, substance dependence, and concerns about body image and sexuality [14]. Wagner, Spiegel and Pearman recommend the NCCN-DT should be administered with a depression-screening tool, given the profound effects of depression on quality of life and cancer outcomes [15]. Lazenby, Dixon, Bai, Ercolano, and McCorkle suggest a cutoff score of 4 might be too high for newly diagnosed patients with late-stage cancers who need close monitoring for depression and that Emotional Problem List (EPL) items may be used with the DT score to triage patients for evaluation [16]. Because clinical depression and anxiety are the most common causes of distress in cancer patients, The American Society of Clinical Oncology (ASCO) Survivorship Committee adopted the Pan-Canadian guideline on Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer [17]. The guideline recommends that all patients with cancer and cancer survivors be evaluated for symptoms of depression and anxiety at periodic times across the trajectory of care [18]. The Personal Health Questionnaire-9 (PHQ-9) can be used to evaluate the depressive symptoms [19]. The recommended cutoff for the PHQ-9 is 8 and a two-item depression screen (Patient Health Questionnaire-2 [PHQ-2]) has been shown to be effective in identifying patients with severe distress or psychiatric morbidity in cancer settings [20]. Additionally, the Generalized Anxiety Disorder (GAD-7) scale is recommended to evaluate anxiety. A total score of 0–4 indicates no symptoms, 5–9 indicates mild symptomatology, 10–14 indicates moderate anxiety, and 15–21 is considered severe [21]. Based upon screening results, the primary oncology team of oncologists, nurses, and social workers should perform real-time and rapid evaluation for high-risk patients (with moderate to severe distress). A nurse's initial response to a patient's report of distress and anxiety will help to guide a more detailed assessment of his or her concerns and initiate appropriate management to address his or her needs [22].

Step 3: Referring

Screening alone is not enough to improve patients' experience [23]. Evidence suggests that screening in the absence of an established triage algorithm, does not improve outcomes [24]. For patients with cancer who have been identified as having a moderate to severe level of distress, cancer care professionals should provide triage to appropriate referrals within the institutions (mental health services, social work and counseling services, chaplaincy services) [25]. For example, patients with practical and psychosocial problems should be referred to social workers; those with emotional or psychological problems should be referred to mental health professionals; patients with spiritual concerns should be referred to certified chaplains. The NCCN encourages conducting multicenter trials that explore treatment guidelines; specifically, a randomized controlled trial conducted with a detailed triage algorithm that is followed by a discussion of referral options with the patient. The screening for distress triage algorithm includes all referrals that were offered to a patient by a member of the screening team, via phone, within 3 business days. For instance, when suicide assessments were completed, if required, within 1 business day all referrals were documented and indicated on patients' charts [26]. A study on the referral wishes of patients according to relationship status found that single and living-apart-together (LAT) those who have a partner but do not share a home) patients were 2.5 and 3.4 times as likely, respectively, to desire a referral for professional care than married patients. Seventy percent of single and LAT patients did want help when they were distressed. The study also showed that younger patients (<65) were most likely to report elevated distress and want help, up to 2.1 times more likely than older (≥65) patients [26]. If patients are unable to access institutional services, professionals can locate psychosocial services using online resources provided by professional organizations, such as APOS, the American Psychological Association (APA), the American Cancer Society, and the Cancer Support Community.

Step 4: Following-up

A successful program of comprehensive psychosocial distress screening should include providing follow-up information to the patient, as well as communication with the primary oncology team and family caregivers. A clinician or team of clinicians (nurse, social worker, psychologist, psychiatrist, or physician) is responsible for reviewing the screening data, determining which patients require a follow-up assessment based on the established criteria of the screening instruments, and ensuring those patients receive follow-up evaluation. Reevaluation of distress screening instruments can provide an indication of what further action should be taken. Based on this reevaluation, healthcare professionals can simply continue to monitor and support patients with stable or diminished distress, or refer patients with increased or persistent distress to the appropriate cancer care professional, as well as modify or replace the current intervention [14]. Examples of these modifications may be adding a psychological or pharmacologic intervention, changing medication, or referring a patient to individual psychotherapy if group therapy has not proved helpful. In addition, a study recommends that the clinician inquire about suicidal ideation as suicide rates are higher in the population with cancer [27]. A randomized control trial has shown that 50% of patients complete the follow-up two and six-month assessments on-line [28].

Step 5: Documenting & Quality Improvement

The first four steps—screening, evaluation, referral or provision of care, and follow-up—are all documented in the patient’s medical record to facilitate integrated, high-quality care. When the level of distress is identified, a clinician should document the following at the appropriate time points: type, source, and severity of the distress; relevant history; any suicidal ideation; and types of recommended interventions, including a plan for further evaluation and by whom, or that no further evaluation or treatment is needed [13]. If a patient declines any of the aforementioned steps, then the clinician should document the patient refusal with the stated reasons. The institution’s electronic health record system, pen-and-paper instruments, or clinical notes are acceptable forms of documentation.

Documenting the status of patient distress is necessary to demonstrate to managers, department directors, hospital administrators and executives the value of psychosocial screening and to help improve the quality of whole-patient care.

In addition, documenting allows the institution to conduct quality improvement, and for this reason we combined these two steps as one. Quality improvement projects can be conducted along the lines of the American Society of Clinical Oncology’s Quality Oncology Practice Initiative ([QOPI] <http://www.instituteforquality.org/>). Following QOPI’s practices, cancer care institutions can audit patients’ medical records for documentation of screening, evaluating, referring when indicated, and following-up, and then develop systematic efforts to improve the quality of comprehensive distress screening. Jacobsen and colleagues have shown that participation in QOPI has improved cancer care practices [29]. These five steps ensure the evaluation of the distress screening process and help to fulfill our responsibilities to patients to provide whole patient care. Once these five steps become standard and routine, the data will enhance our ability to demonstrate relationship of psychosocial distress to patients’ quality of life, treatment tolerance and completion, and ultimately, survival.

Summary

Recognition of psychosocial distress as part of the cancer journey is one of the most significant developments in cancer care in almost forty years, since Worden and Weisman’s identification of existential plight in cancer in 1976 [30]. From the development of the Symptom Distress Scale in 1976 [31], to the launch of the Screening for Psychosocial Distress Program with APOS in 2014, McCorkle and her research team have been working diligently to implement the quality care standard in order to relieve the psychosocial distress of patients with cancer. Following these steps, starting by rapidly screening all patients at pivotal points and ending with the documentation of the results of evaluation, referral and follow-up, is essential in order for cancer care professionals to be able to adopt the NCCN Distress Management Guideline and COC criterion of accreditation. With the implementation of these steps and the adherence to the distress screening program, the quality of whole-patient cancer care can be greatly improved.

Acknowledgments

This work was partially supported by NIH Grant # R25CA177553-02, Ruth McCorkle, PI.

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Figure 1.
The 5 steps of Comprehensive Distress Screening