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Psychosocial Distress Screening:

An educational program's impact on participants' goals for screening implementation in routine cancer care

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Abstract

BACKGROUND—Psychosocial distress screening is a quality care standard in cancer care. Screening implementation may be facilitated by an educational program that uses goals to evaluate progress over time.

OBJECTIVES—This article describes the content and design of the Screening for Psychosocial Distress Program (SPDP), reports on its delivery to 36 paired participants, and evaluates its effects on distress screening activities and goals.

METHODS—The SPDP used a one-group pre-/post-test design. It was delivered at 2 workshops and 10 conference calls during a two-year period. Data on screening and goal achievement were collected at 6, 12, and 24 months. Data on the quality of dyads' relationships were collected at 24 months.

FINDINGS—At 24 months, all 18 dyads had begun screening. Dyads reported working effectively together and being supportive of the other member of the dyad while achieving their goals for implementing psychosocial distress screening.

Keywords

implementation; distress; screening; psychosocial; SMART goals

A diagnosis of cancer, whatever its prognosis, is distressing. The diagnosis itself, plus physical symptoms and treatment, can challenge patients' emotional coping strategies. Mood disturbances and other forms of distress, such as financial, existential, and spiritual, may result. Mehnert et al. (2018) report that the rate of distress among patients with cancer may be as high as 50%. This distress may persist throughout the cancer care continuum, not only affecting patients' quality of life but also their ability to adhere to treatment (Yee et al., 2017).

For this reason, the Institute of Medicine convened an expert panel on delivering psychosocial services to patients with cancer. Based on the strength of the evidence, the resulting report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, set the quality care standard that psychosocial care must be routinely integrated with biomedical cancer care for all patients (Adler & Page, 2008). The best way to integrate care, the panel found, is to screen patients early for psychosocial distress to connect them with psychosocial healthcare services. Routine psychosocial distress screening is a comprehensive five-step process that (a) identifies patients with clinically significant psychosocial distress, (b) evaluates the sources of their distress, (c) triages them to psychosocial healthcare resources if needed, (d) follows up with patients and the primary care team to ensure that psychosocial needs are being addressed, and (e) documents the process in the medical record and uses that documentation to conduct quality improvement (Lazenby, Tan, Pasacrete, Ercolano, & McCorkle, 2015). In a randomized, controlled trial of patients with lung and breast cancer, routine distress screening decreased depression and anxiety (Carlson, Groff, Maciejewski, & Bultz, 2010).

International organizations have endorsed the quality care standard of whole-patient care that is achieved through routine comprehensive psychosocial distress screening (Lazenby, 2014). In the United States, the American College of Surgeons' (2016) Commission on Cancer has mandated that every patient receiving treatment for cancer be screened for psychosocial distress "at a pivotal medical visit" (p. 56). Cancer care organizations accredited by the Commission on Cancer have to prove compliance with this mandate through periodic on-site surveys (American College of Surgeons, 2016).

Education and support related to implementation of routine comprehensive psychosocial distress screening have not accompanied these endorsements and mandates. Consequently, the authors of the current article developed the Screening for Psychosocial Distress Program (SPDP) to provide education and support to cancer care professionals across the United States coinciding with the implementation of routine comprehensive psychosocial distress screening at their institutions. This article describes the SPDP, reports on its delivery to a cohort during a two-year period, and evaluates its effects on this cohort's screening activities and goals for implementing comprehensive psychosocial distress screening programs.

Methods

Design and Participants

The SPDP used a one-group pre-/post-test design to measure participants' outcomes at 6, 12, and 24 months. The program is an education and implementation support program delivered to cancer care professionals from 18 U.S.-based cancer care organizations (two professionals from each organization); it was conducted during a two-year period with the aim of preparing participants to meet the mandate of routinely screening patients with cancer for psychosocial distress. To be included in the SPDP, participants needed to demonstrate that they would be responsible for implementing psychosocial distress screening in their organizations by providing two letters from key administrators. Seventy-four organizations representing 148 participants applied to the training program, and 36 cancer care professionals, or 18 dyads, from 18 cancer centers representing 16 states were selected. Participant and institutional characteristics are fully described elsewhere (Lazenby, Ercolano, et al., 2015).

Screening for Psychosocial Distress Program

The program consisted of two in-person eight-hour education workshops, each 12 months apart, as well as six support-oriented one-hour conference calls during the first year and four conference calls during the second year. The content for the introductory (year 1) and advanced (year 2) workshops was developed based on a comprehensive review of the literature regarding cancer-related psychosocial distress screening and was independently reviewed by the program's directors. The workshops were delivered as preconference seminars at the 2014, 2015, 2016, 2017, and 2018 annual conferences of the American Psychosocial Oncology Society (APOS). The SPDP covered participants' registration fees for the two-day APOS conferences that followed.

Two of the program faculty members previously directed cancer research education programs and incorporated strategies for facilitating engagement and retention of participants into the SPDP (e.g., reception on the night prior to the workshops, a poster to introduce the dyads and their institutions, scheduled conference calls between workshops). Figure 1 describes the SPDP in terms of its components, content areas, and content delivered.

On entry into the SPDP, each dyad set three goals related to implementation of comprehensive psychosocial distress screening; these goals were to be accomplished during the two years of their participation in the program. Participants established these goals based on the progress they needed to make to meet the Institute of Medicine's quality care standard and the Commission on Cancer's mandate. An SPDP faculty member had previously used SMART (specific, measurable, achievable, realistic, and time-bound) goals in a cancer research education project (Grant, Economou, Ferrell, & Uman, 2012); these have been a mainstay of management theory since the early 1980s (Doran, 1981). During the first workshop, this faculty member presented on SMART goals and dyads revised their original goals to be SMART goals, with one-on-one guidance from the faculty. In the second

year, participants presented a poster on their 12-month progress in achieving their SMART goals during the APOS conference poster session.

Framework

Donabedian's (1988) quality-of-care framework, which has evolved from a health service delivery model to a quality-of-care evaluation model, provided a template for SPDP organization, operationalization, and evaluation. According to the model, quality of care can stem from three essential components: structure, process, and outcomes. Structure refers to the institution that supports the care and the settings in which health services are delivered. It includes material resources, such as facilities and the number and characteristics of personnel. Process refers to the means or strategies of providing health care (in the case of the SPDP, this would be psychosocial distress screening); it also includes the transactions between and among participants throughout the delivery of health care. Outcomes represent the consequences or impacts of the process on participants' ability to bring about a change in the healthcare delivery system; they may also involve improvements in participants' knowledge, behaviors, and satisfaction. See Figure 2 for a description of these components and how they have been operationalized and measured for their effect. Pilot testing of the SPDP is described elsewhere (Lazenby, Ercolano, et al., 2015).

Data Collection

Data were collected from individual participants at baseline (after the first preconference workshop) and at 12 months (after the second preconference workshop) and concerned satisfaction with the educational activities. Possible scores ranged from 1 (not satisfied at all) to 5 (extremely satisfied). Participants consisted of nurses, social workers, psychologists, and one psychiatrist. Recruited professionals represented disciplines that provide psychosocial services. Using investigator-developed, Internet-based data collection forms, data were collected at 6, 12, and 24 months after baseline regarding screening activities and level of accomplishment of SMART goals (i.e., completed, in process, stalled, stopped or canceled, and never started). Screening activities were assessed by adoption (standardized screening tool selected, psychosocial committee in place, policy formulated), implementation (started screening and internal and external referral networks established), and maintenance (auditing health records for documentation of screening and referral to psychosocial health services if needed). Data were also collected at 24 months on the quality of dyads' working relationship and their perceived support from management. The 24-month data collection timepoint marked the end of dyads' participation in the SPDP. The data were imported and stored in a secure Microsoft Access® database and exported to Microsoft Excel® for analysis of frequencies and percentages. The Yale University Institutional Review Board exempted the study from review.

Analysis

Data analysis included frequencies and percentages to describe nominal data and measures of central tendency and dispersion to describe scaled data by timepoint.

Results

All 18 dyads completed the two-year SPDP; there was no attrition. Participants reported that they were highly satisfied with the content of the preconference workshops. The range of scores on all preconference evaluation surveys was 4.35–5, with 5 representing extremely satisfied.

Table 1 describes the dyads' report of their screening activities, whereas Table 2 shows dyads' levels of SMART goal accomplishment. At baseline, 11 dyads had started screening in at least one clinic or patient population. However, by the 24-month data collection period, all 18 dyads had adopted a psychosocial distress screening process (which included a standardized tool and a method for evaluating patients who reported clinically significant distress) and implemented this process in their organizations. Fifteen of the dyads had developed (and their organizations had adopted) a psychosocial policy on comprehensive psychosocial distress screening, and 10 dyads had formed psychosocial committees to guide ongoing implementation of their comprehensive psychosocial distress screening programs. Each of the 18 dyads had established a network within their respective organizations of providers to whom they could refer patients who needed psychosocial healthcare services. Almost all the dyads ($n = 17$) had audited patient health records to include documentation of patients being screened for distress and referred to services when needed.

Over time, the dyads reported high levels of goal accomplishment. Of the 54 SMART goals that dyads identified at baseline, 45 goals were completed, 7 were in process, and 2 were canceled at 24 months after baseline. The stalled or canceled goals were attributed to staffing changes and institutional cutbacks in resources.

Dyads also reported that they worked effectively together, were supportive of each other, and had a good relationship (see Table 3). Dyads that consisted of a nurse and an individual from a different professional discipline reported quickly learning how to work together to maximize their resources. They said that they received support from management and that the institution's goals and their goals as a dyad were aligned.

Discussion

Quality care standards and the accompanying accreditation mandates do not typically come with implementation support. This was the case with the IOM's quality care standard and the Commission on Cancer's accreditation mandate concerning the use of psychosocial distress screening to integrate psychosocial and routine biomedical cancer care (Adler & Page, 2008; American College of Surgeons, 2016). As a result, the multicomponent education program described in this article was developed to support cancer care professionals' implementation efforts.

This National Cancer Institute–funded SPDP included an evidence-based didactic component, delivered to participants in two workshops held before the annual APOS conference. The SPDP also provided access to the latest scientific evidence on psychosocial oncology (via the annual APOS conference) and ongoing support from expert faculty (via

conference calls). Overall, according to participant survey responses, participants were extremely satisfied with the SPDP's structure.

The SPDP also included process components. Dyads interacted with one another during receptions before workshops, during the workshops, and during subsequent conference calls. These process components provided a forum for participants to share progress on achieving their implementation SMART goals.

The setting of SMART goals was another process component of the program. During the two years of their participation in the program, the dyads worked steadily to secure buy-in from administrators, healthcare professionals, and patients. Psychosocial cancer committees were formed, and policies were developed. Using these strategies, dyads were able to accomplish 83% of their goals by the end of the program. The remaining 17% of goals were in process or canceled.

The time-bound nature of SMART goals was important because it allowed dyads to measure their progress at each evaluation timepoint. Faculty encouraged dyads to set one goal that could be accomplished by the first evaluation timepoint. In addition, faculty suggested that dyads focus their short-term goals on adopting a standardized screening instrument, creating a psychosocial committee, developing a screening policy, implementing screening, and referring patients who needed psychosocial services. Six months after the first workshop, more than half of the participants had achieved their short-term goals that focused on getting a comprehensive psychosocial distress screening program in place. Faculty also encouraged dyads to center their long-term goals on quality improvement, such as auditing the medical record for documentation of psychosocial distress screening and offering referral to psychosocial services when needed. The intention was to build dyads' capacity for tackling the increasing challenges of institution-wide diffusion of comprehensive psychosocial distress screening. By the 24-month data collection period, nearly all participants reported that the use of SMART goals enabled them to measure their progress in implementing distress screening.

Like the SPDP, the Consolidated Framework for Implementation Research (CFIR), a metatheoretical framework, suggests the use of SMART goals as a way of reflecting on and evaluating implementation (Damschroder et al., 2009). However, unlike their use in the CFIR, SMART goals in the SPDP were not meant to serve as a way to measure implementation, as though that process could be completed at a set point. Instead, participants were encouraged to continuously reflect on and evaluate their SMART goals to ensure ongoing quality improvement, particularly after full-scale implementation of comprehensive psychosocial distress screening programs in their respective cancer care institutions.

Another finding from the SPDP was the quality of the dyadic relationship. During the course of their participation in the SPDP, dyads reported that they formed an effective, supportive, and goal-oriented working relationship. This relationship is important so that these dyads can continue the process of implementing and maintaining comprehensive psychosocial distress screening in their organizations, particularly through ongoing quality improvement.

The elements of structure, process, and outcome were woven into the evaluation of the SPDP. In other words, evaluation did not just involve the evidence-based content presented at the workshops but also included participants' focus on the process of achieving their goals over time. In addition, the multiple timepoint pre-/postevaluation design allowed participants to remain centered on the ultimate outcome of their participation in the SPDP (i.e., meeting the quality care standard and the accreditation mandate of using psychosocial distress screening to deliver whole-patient care at their cancer care organization).

Limitations

This project presents self-reported data, and data about screening activities were collected as binary (yes/no). Objective data (such as data gleaned from electronic health records at participants' organizations regarding the number of patients screened for psychosocial distress and the number of patients referred to psychosocial health services after reporting clinically significant distress) would be helpful. With advances in electronic health records, these types of big data capture hold promise in assessing the effectiveness of educational programs, such as the SPDP.

In addition, participants' screening activities were not assessed in depth at baseline. A one-group design was used, which resulted in limitations because of the lack of a comparison group. Adaptive designs, in which nonresponding participants are randomized to receive additional evidence-based interventions, are being used in implementation science (Kilbourne et al., 2014; Nigenda, González-Robledo, Juárez-Ramírez, & Adam, 2016). Future cancer education research that is focused on supporting the implementation of quality care standards can employ such adaptive designs. In terms of the current study, the authors could randomize participants who have not achieved at least one SMART goal by the 12-month data collection timepoint to one of two groups that receive different implementation support strategies (e.g., one-on-one telephone calls with faculty members to discuss barriers and facilitators versus online discussion forums with other participants). Then, the authors could analyze whether dyadic or institutional characteristics predict the effectiveness of the different support strategies.

Conclusion

Despite study limitations, the current authors found that the SPDP's unique blend of Donabedian's (1988) quality-of-care framework and SMART goal evaluation during a two-year period supported participants in implementing comprehensive psychosocial distress screening programs in their respective organizations. Nurses who participated with a dyadic member from a different professional discipline reported that working together facilitated the process of implementing comprehensive psychosocial distress screening in their institutions.

The strategies used to implement and evaluate the SPDP were operationalized. Others may be able to model their educational interventions after this program. The mandate of the Commission on Cancer that all patients with cancer be screened for psychosocial distress has been endorsed, and site visits to monitor progress are ongoing (American College of Surgeons, 2016). In the current study, the SPDP provided essential structure, process, and

outcomes for participants to be successful in achieving their goals for meeting the mandate at their respective institutions. This study also supports participant use of SMART goals to evaluate progress over time. Working in dyads facilitated participants' efforts to obtain managerial buy-in, which was needed to accomplish their goals. This article describes one approach to educating and supporting providers regarding how to implement comprehensive psychosocial distress screening in routine cancer care. Nurses reported that working with professionals from multiple disciplines is important to be successful in achieving implementation goals. Additional efforts that use objective data and adaptive designs are needed to evaluate whether completing the five steps of comprehensive psychosocial distress screening result in improved patient outcomes and are cost effective.

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IMPLICATIONS FOR PRACTICE

- Realize the impact that nurses have in screening patients with cancer for distress, which can have positive implications for patients' quality of life and adherence to treatment.
- As a stakeholder, take part in ongoing educational efforts about distress screening.
- Follow up with patients after routine screening and referral to psychosocial health services, when needed, to ensure effectiveness of the screening program.

<p>YEAR 1</p> <p>Homework</p> <ul style="list-style-type: none"> Assigned readings <p>Poster displayed for program participants</p> <ul style="list-style-type: none"> "Where I Work and Who I Am" <p>Reception</p> <ul style="list-style-type: none"> The night before the workshop <p>Preconference workshop (Introductory)</p> <ul style="list-style-type: none"> Program overview and introduction History of psychosocial distress screening (historical problems confronting psychosocial oncology, solutions to the problems, why the word "distress," the "distress continuum," National Comprehensive Cancer Network Psychosocial Care Panel, Institute of Medicine panel) Overview of comprehensive distress screening (screening, evaluating, referring, following up, auditing/quality improvement) How to write achievable SMART (specific, measurable, achievable, realistic, and time-bound) goals Just do it: revising SMART goals (vision, inspiration, infrastructure, education, evidence) Review of psychosocial screening tools (single-item tools, tools that assess anxiety and depression, tools that assess symptoms) Communication skills to elicit buy-in (common barriers to implementing distress screening, communicating with key stakeholders, how to consider context when developing communication strategies, key communication skills) Group practice: communication with key stakeholders (patients, providers, and administrators) How to provide psychosocial healthcare services (providers of psychosocial care, types of psychosocial care services, possible sources of funding) Psychosocial distress standard: development of policy and psychosocial care committee (critical components of a policy, key stakeholders as members of the psychosocial care committee) <p>American Psychosocial Oncology Society conference</p> <ul style="list-style-type: none"> 2014 theme was "Implementing Quality Care Standards for Psychosocial Oncology and Supportive Care" <p>Bimonthly 1-hour conference calls</p> <ul style="list-style-type: none"> Content areas were talking points to key stakeholders, getting started 	<p>(selecting a screening tool), developing a distress screening policy, developing a psychosocial cancer committee, strategies to overcome barriers to screening, and operationalizing a distress screening policy.</p> <p>YEAR 2</p> <p>Homework</p> <ul style="list-style-type: none"> Assigned readings <p>Poster for display at American Psychosocial Oncology Society conference</p> <ul style="list-style-type: none"> Detailed level of goal achievement <p>Reception</p> <ul style="list-style-type: none"> The night before the workshop <p>Preconference workshop (advanced)</p> <ul style="list-style-type: none"> Using the psychosocial matrix to evaluate distress screening activities (institutional self-assessment tool, used to evaluate ongoing programs, criteria drawn from Institute of Medicine panel) Building effective dyadic relationships (definition of dyadic team, benefits and limitations of dyads, definition of a team, five dysfunctions of a team, how SMART goals overcome these dysfunctions) Examples of successful distress screening programs (presentations from two institutions with fully running psychosocial distress screening programs) Integration of distress screening process into electronic health record (how to work with information technology at your institution to integrate screening, proprietary considerations) Establishing an internal and external referral network (operational networking to improve capacity, personal networking to provide information and developmental support, strategic networking for support to achieve goals) Group practice: strategies to develop referral networks Preparing for accreditation site visit (presentation by a Commission on Cancer site visitor/auditor) <p>American Psychosocial Oncology Society conference</p> <ul style="list-style-type: none"> 2015 theme was "From National to Global: Implementing the Standard of Psychosocial Care in Oncology" <p>Quarterly 1-hour conference calls</p> <ul style="list-style-type: none"> Content areas were education of new staff to adopt distress screening, review of American Society of Clinical Oncology's Quality Oncology Practice Initiative, transfer of distress screening tool to electronic health record, and strategies to overcome barriers to distress screening.
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FIGURE 1.
SCREENING FOR PSYCHOSOCIAL DISTRESS PROGRAM CURRICULUM

FIGURE 2.
APPLICATION OF DONABEDIAN’S QUALITY OF CARE FRAMEWORK TO THE
SCREENING FOR PSYCHOSOCIAL DISTRESS PROGRAM

Note. Based on information from Donabedian, 1988.

TABLE 1

SCREENING ACTIVITIES ACCOMPLISHED BY DYADS (N = 18)

ACTIVITY	6 MONTHS	12 MONTHS	24 MONTHS
	n	n	n
Standardized screening tool selected	12	17	18
Psychosocial committee in place	10	12	10
Psychosocial distress policy formulated	11	12	15
Psychosocial distress screening started	12	17	18
Internal referral network of psychosocial providers established	16	18	18
External referral network of psychosocial providers established	11	14	17
Health records audited for screening documentation	9	11	17
Health records audited for referral to psychosocial health services documentation	9	12	17

TABLE 2

SMART GOAL ACCOMPLISHMENT BY DYADS (N = 54)

	<u>6 MONTHS</u>	<u>12 MONTHS</u>	<u>24 MONTHS</u>
LEVEL OF ACCOMPLISHMENT	n	n	n
Completed	16	36	45
In process	28	16	7
Stalled	6	1	–
Stopped/canceled	–	1	2
Never started	4	–	–

SMART—specific, measurable, achievable, realistic, and time-bound

TABLE 3

QUALITY OF DYADS' WORKING RELATIONSHIP AND SUPPORT AT 24 MONTHS (N = 18)

COMPONENT OF QUALITY	$\bar{X}$	MEDIAN	RANGE
The dyad worked together effectively to implement distress screening.	1	1.4	1–3
The dyad members were very supportive of each other.	1	1.1	1–2
There was a good relationship between the dyad members.	1	1.1	1–2
There was management support for the dyad members.	1	1.4	1–3
The dyad's goals were aligned with the organization's goals.	1	1.4	1–3

Note. Possible scores ranged from 1 (very true) to 5 (not true at all).