

Promoting quality breast cancer care: Psychosocial distress screening

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ABSTRACT

Objective: To evaluate the feasibility of implementing psychosocial distress screening in a breast center of a comprehensive cancer center, using a model of structure (personnel, resources), process (screening), and outcome (number of patients screened, number referred).

Methods: The first step in the project was to establish administrative support, educate and engage breast center staff, identify stakeholders and persons with expertise in the conduct of evidence based initiatives. A two-phase implementation approach was agreed upon with Phase I being screening of new patients in surgical oncology and Phase II being screening women in medical oncology.

Results: A total of 173 patients were screened. The new patients screened in surgical oncology reported higher average distress scores compared to patients in medical oncology (5.7 vs. 4.0). However, a greater number of patients in medical oncology reported scores >4 compared to the new patients screened in surgery (54% vs. 35%). Psychological distress was the most commonly reported distress for patients in surgery. In contrast, 60% of scores >4 in medical oncology were symptom related, managed by the nurse or physician.

Significance of results: Nurse led implementation of psychosocial distress screening is feasible, addressing this important quality indicator of patient-centered care.

KEYWORDS: Breast cancer, Distress screening, Nursing, Quality care

INTRODUCTION

Psychosocial care is accepted as an integral component of quality cancer care (Adler & Page, 2008; Jacobson & Wagner, 2012). Yet, lack of integration of assessment of psychological distress in routine clinical practice has led to unmet patient needs, contributing to lower satisfaction with care, poorer self-management, and a negative effect on quality of life (Carlson et al., 2012; Fann et al., 2012).

More than a decade ago, the National Comprehensive Cancer Network (NCCN) proposed screening guidelines for distress and support has emerged for distress screening to be the sixth vital sign in clinical practice (Bultz & Johansen, 2011; Carlson et al., 2012). Most recently, the Commission on Cancer has included psychosocial distress screening as one of the new patient-centered standards (Commission on Cancer, 2012; Fashoyin-Aje, 2012), which includes indicators for documentation of screening and action taken by the provider, if distress was reported.

The incidence of psychosocial distress has been reported in 20–35% of patients studied (Frost

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et al., 2011; Kendall et al., 2011; Knobf, 2011; Mitchell, 2007). Many of these studies have evaluated screening specifically for psychological distress, defined as anxiety, and depression (Hegel et al., 2008; Mehnert & Koch, 2008; Sollner et al., 2004), but distress reported by cancer patients is recognized as much more broad than emotional distress and includes distress related to physical symptoms and practical issues of managing everyday life (Beesley et al., 2008; Hewitt et al., 2004; Fashoyin-Aje, 2012; Frost et al., 2011). While there is consensus that psychosocial distress screening is important to help identify patient needs, there are challenges to integrating distress screening into practice. At the provider level, time, reluctance, limited awareness of clinical practice guidelines, and lack of training have been cited as barriers (Fann et al., 2012; Mitchell et al., 2008). At the institutional level, low priority, fragmented or poorly coordinated psychosocial services, and ineffective communication across clinical settings are cited (Fann et al., 2012). In addition, there are many unanswered questions about the best instrument to use, how to determine the presence or level of distress, and when and how often to screen. Despite these challenges, implementation of psychosocial screening has been identified as a practice standard and we need to identify strategies to integrate distress screening into routine clinical practice (Carlson et al., 2012; Fashoyin-Aje, 2012; Jacobsen & Wagner, 2012).

The purpose of this quality improvement project was to evaluate the feasibility of implementing psychosocial distress screening in the Breast Center at Smilow Cancer Hospital at Yale New Haven.

METHODS

The first step in the project was to establish administrative support, educate and engage Breast Center staff, identify stakeholders and persons with expertise in the conduct of evidence based initiatives. The Breast Center Director was in full support of the project and the Chair of the Psychosocial Advisory Committee and faculty with expertise in quality improvement and evidence based practice projects held several meetings with social work and nursing staff to determine the implementation approach. A two-phase implementation approach was agreed upon with Phase I screening new patients in Breast Surgical Oncology, and Phase II screening of patients with breast cancer in Breast Medical Oncology. This quality improvement project was based on the classic model by Donabedian (1980) of structure (personnel, resources), process (screening of patients), and outcomes (percent of women screened with distress

scores >4 on a scale of 1–10 and percent of women referred) (Table 1).

Phase I Implementation: Breast Surgical Oncology

Decisions on the structure and process for the implementation included distribution of the NCCN distress thermometer (DT) and problem checklist to all new patients in Breast Surgical Oncology over a 2 month period. The receptionist gave the patient the form to complete, the patient care assistant (PCA) placed it in the patient's chart for review by the surgeon or nurse. Resources to evaluate the implementation included two nurse researchers. Following evaluation, results were presented to the Breast Center Director and the social work and nursing staff. A plan for psychosocial screening in routine practice was discussed and consensus reached among staff.

Phase II Implementation: Breast Medical Oncology

Based on unique characteristics of the Breast Medical Oncology service and the nursing care delivery model, one practice nurse was identified to work with the Breast Center Program Manager and nurse researcher to determine the structure and process for the project and act as a "champion" and liaison to the nursing and physician staff (Rosswurm & Larrabee, 1999). For Phase II implementation, we decided that (1) we would establish feasibility by screening all patients in one clinic session and evaluate the process prior to the goal of screening patients in each of six breast medical oncologists' clinic sessions (2) the PCA would give the form to the patient, (3) the PCA or patient would give the form to the practice nurse, (4) the practice nurse would review all distress screenings, speak to any patient with a score > 4 and document in nursing notes within 48 hours, and (5) referral would be made based on the problem(s) as source of distress. Resources to evaluate the project were a nurse researcher and the clinical Program Manager. Following evaluation, results were presented to the Breast Medical Oncology staff. Decisions for full implementation in practice to meet the new Commission on Cancer standard for psychosocial distress (screening, documentation and action plan) were deferred due to an institution wide implementation of a new electronic medical record system.

Results: Phase I Implementation Breast Surgical Oncology

Over a 2 month period, 88 consecutive patients in Breast Surgical Oncology were screened. The average distress score was 5.7 with 77% of women

Table 1. *Planning and implementation of psychosocial distress screening*

Planning	Establish Administrative Support Identify key stakeholders Educate and engage staff Identify resources with expertise for project
Implementation: Phase I Breast Surgical Oncology	Structure Receptionist gives patient DT and Problem List PCA places on patient's chart Nurse or Physician to review and document Process Screen all new consecutive patients for a two month period Outcomes Describe distress and problems reported Percent of women with distress scores >4 Percent of patients referred to social work
Implementation: Phase II Breast Medical Oncology Feasibility pilot	Structure Identify a practice nurse as a project "champion" PCA gives patient DT and Problem list Patient or PCA gives completed form to practice nurse Nurse reviews form while patient in clinic Nurse speaks to any patient with a DT >4 Documentation in nursing notes within 48 hours scores >4 and action taken Process Screen all women in one medical oncology clinic session Outcomes Describe distress and problems reported Percent of women with distress scores >4 Percent of patients referred to social work
Implementation: Phase II Breast Medical Oncology All Physician Clinic Sessions	Structure Meet with staff to discuss feasibility pilot Engage practice nurses for implementation Adapt DT (DT plus 3 priority problems) PCA gives patient new DT form Patient or PCA gives completed form to practice nurse Nurse reviews form while patient in clinic Nurse speaks to any patient with a DT >4 within 24 hours Documentation in nursing notes within 48 hours scores >4 and action taken Process Screen all women in each of 6 clinic sessions over one month Outcomes Describe distress and problems reported Percent of women with distress scores >4 Describe problems managed by nurse and/or physician

indicating their distress in both physical and emotional problem areas. Thirty-five percent of women ($N = 31$) reported distress scores >4 on the distress thermometer and all of those women were referred to the social worker in the Breast Center (Table 2). The predominant psychological distress was related to uncertainty of diagnosis for those who had yet to receive a definitive diagnosis of their biopsy results. Based on the resolution of distress associated with a benign diagnosis, it was agreed that psychosocial distress screening would target patients diagnosed with breast cancer. Decisions for implementation of psychosocial distress screening in routine practice were made based on staffing resources. There are two Breast Surgical Nurse Coordinators who manage every patient and a dedicated social worker in the Breast Center. It was agreed

that the Nurse Coordinator would review distress screenings of all patients diagnosed with breast cancer and make the appropriate decisions for managing the problem or referral to an appropriate provider.

Results: Phase II Implementation Breast Medical Oncology

To establish feasibility, the DT and problem list were completed by patients in one Medical Oncology physician clinic. A total of 22 women diagnosed with breast cancer completed the screening. Average age was 52.3 years (range 39–70) and distress scores ranged from 0–8 with an average distress score of 3.9. Slightly more than half of the women (54%) scored >4 on the DT and 50% of those were referred (5 = social worker, 23% psychological (e.g., depression, fears)

Table 2. *Psychosocial distress screening outcomes*

Breast Surgical Oncology	Breast Medical Oncology
N = 88 new patients screened	N = 85 patients screened over one month
Distress score range 0–10 Average distress score = 5.7	Distress score range = 0–10 Average distress score = 4.0
35% distress score >4	52% distress score >4; 22% no distress
35% of all patients screened referred to social worker. 100% of patients score >4 referred.	21% of all patients screened offered social work referral (3 declined). 40% patients with scores >4 referred.
Predominant distress related to uncertainty of diagnosis (benign or malignant)	There was greater distress reported for physical problems than emotional or practical problems. 60% of distress related primarily to symptoms, which were managed by the nurse or physician and 40% were referred to social work for psychological and practical problems.

and 27% practical (e.g., insurance, family). The nursing note section of the record was used to document the screening and action taken. Results were shared with the Breast Center staff. As the DT with problem list does not associate the distress score with specific problems, and we learned that women often reported multiple problems, yet they were not all contributing to distress, we adapted the form to include the DT and asked the patient to write down up to 3 priority distressful problems. Screening was then carried out in each of the six physician clinics for broader implementation and included practice nurses in addition to the “champion” nurse on the project. Over one month, 63 women completed distress screening. Distress scores ranged from 0–10 with an average score of 4.3. No distress was reported by 22% of patients and 51% scored >4 on the DT. Of the 32 patients who scored >4, 60% were managed by the nurse or physician for problems primarily related to symptom management and 40% were offered a referral to the social worker for problems such as finances, stress, work, and family issues.

CONCLUSION AND DISCUSSION

In summary, 173 women in our Breast Center completed psychosocial distress screening with 35%–50% of women reporting a distress score >4 on the 0–10 DT. The distress in patients screened in Breast Surgical Oncology ($N = 88$) was related to uncer-

tainty for those who had not yet received a definitive diagnosis and for others, response to the diagnosis of breast cancer and decision making process for therapy. In a review of 30 studies, anxiety was identified as the predominant distress response in women during the diagnostic phase of breast care (Montgomery & McCrone, 2010). The reported distress was identified as symptom management problems, addressed by the physician or nurse and 40% were psychological or practical problems indicating a social work referral. We learned the need to adapt psychosocial screening to the population at risk and available staff resources. In Breast Surgical Oncology, there are two Nurse Coordinators and a dedicated social worker. The pilot had the receptionist give the DT to the patient and the PCA put it in the patient’s chart for physician review. After sharing the evaluation of the pilot implementation with staff, it was determined that the PCA would give the DT to the patients and the Nurse Coordinators would review the screening and document it in the record. In Breast Medical Oncology, the process of the DT given by the PCA, returned to the nurse during the clinic session, a discussion initiated by the nurse with patients for scores >4, documentation by the practice nurse within 48 hours of the screening and action taken was concluded as feasible.

Several decisions need to be made by staff prior to implementation into everyday clinical practice (Table 3): score for cut-off to review and refer; timing of initial versus repeat screening; definition of personnel tasks and responsibilities; documentation of screening score and action taken in new electronic medical record (EMR) system; and a quality improvement protocol to audit implementation. The NCCN recommends a cut-off score of 4 as an indicator for distress, yet others have reported scores as high as 7 as a sensitive cut-off measure, especially for psychological distress (Hegel et al., 2008). The Commission on Cancer’s new standard requires screening at least once (Fashoyin-Aje, 2012), yet the importance of distress screening across the cancer

Table 3. *Decision making and process for integration into routine practice*

Determine score for cut-off for distress
Decide on timing for initial screening and schedule for repeat screening
Clearly define personnel responsibilities
Determine documentation and action taken in EMR
Develop Breast Center standard for psychosocial screening. Share with physician, nursing and support staff.
Determine the protocol for quality improvement related to psychosocial distress screening

trajectory especially at transition times such as diagnosis, active therapy, end of therapy for survivors, recurrence and disease progression is essential (Fann et al., 2012; Fashoyin-Aje, 2012). Education and engagement of staff are critical in defining individual responsibilities yet we must foster collective accountability. We learned that PCAs need a better understanding of the rationale for screening and perhaps some coaching to improve interactions with the patient about the screening form. A new electronic medical record system has very recently undergone an institution-wide implementation. As the experience of the nursing staff grows with the new EMR system, they will be invaluable in guiding us in the decision making for documentation of screening, action taken by the nurse or physician and referral to another provider, if indicated. Finally, decisions about audit and ongoing quality improvement are needed to monitor screening over time, utilization of resources, patient outcomes, and patient satisfaction with care. Similar to the findings from our project, distress was not related solely to emotional problems but also as a response to experiencing and managing physical symptoms (Frost et al., 2011; Villhauer, 2008). Identifying distress related to physical and psychological symptoms and social problems guides interventions toward improving a patient's well-being and quality of life (Jacobson & Wagner, 2012). We were able to identify problems and appropriately manage based on the source of the problem causing distress. There is strong consensus that psychosocial screening needs to be integrated in routine clinical practice to achieve the goal of patient centered high quality cancer care (Carlson et al., 2012). Thus, it is incumbent on providers to identify strategies to implement screening and explore approaches that will facilitate this important quality indicator of care (Jacobsen et al., 2011; Jacobsen & Kadlubek, 2010).

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