
GUEST EDITORIAL

Interdisciplinary programmatic approaches to comprehensive distress screening for implementing the quality care standard of whole-patient care

Recognition of psychosocial distress as part of the cancer journey is one of the most significant developments in cancer control in the twenty-first century. For example, it has been >30 years since Weisman and Worden (Worden & Weisman, 1980; 1984) described the emotional distress of patients diagnosed with cancer, distress that they described as heightened during the days of diagnosis and early treatment. And it has been >15 years since the National Comprehensive Cancer Network's (NCCN) Distress Management Clinical Practice Guidelines have called for comprehensive distress screening of all patients with cancer (National Comprehensive Cancer Network, 2003). Adoption of these guidelines into everyday clinical practice, however, has been slow.

To speed adoption, the Institute of Medicine (IOM) empanelled the Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting. The IOM Committee recommended in its 2008 report that oncology practices implement comprehensive distress screening programs to meet its new standard of care that "All cancer care should ensure the provision of appropriate psychosocial health services" (Adler & Page, 2008). As a result of these and other efforts, the importance of distress screening has been globally recognized. The International Psycho-Oncology Society (IPOS) endorsed a statement supporting distress as the sixth vital sign, which has also been endorsed by the Union for International Cancer Control (International Psycho-Oncology Society, 2013) and by Canada (Accreditation Canada, n.d.). In 2012, the American College of Surgeons Commission on Cancer (ACoS) endorsed ensuring patient-centered care as the core value of all standards for cancer programs it accredits (American College of Surgeons, 2012). One of these patient-centered standards is psychosocial distress screening.

As cancer centers begin to implement distress screening initiatives, the focus cannot be just on

identifying distressed patients. Screening alone is insufficient to improve patients' experience. The ACoS mandates a comprehensive psychosocial distress screening process (American College of Surgeons, 2012). A comprehensive distress screening process first uses a rapid screen of all patients at pivotal points along the cancer care continuum. Using the results of this rapid screening, the process then assesses those patients at risk for distress, identifies distressed patients, refers them to appropriate psychosocial care, and follows up as a way of integrating psychosocial care into biomedical cancer care. The goal is to intervene before distress escalates and immobilizes patients. As a way of ensuring the new standard of care of integrating psychosocial care with biomedical cancer care, a comprehensive distress screening process also includes documenting the results of screening, referral, and follow-up. Such a programmatic approach is essential if we are to see adoption of the new quality care standard of providing appropriate psychosocial cancer care to all patients who need it.

It is important to note that distress screening is not an end in itself. It is, rather, a means of achieving the new quality care standard of integrating psychosocial and biomedical cancer care. That is, it is a means of achieving whole-patient care.

This vision of screening for distress as driving the practice change necessary to achieve whole-patient care was the impetus for collaboration between the IPOS and the International Society of Nurses in Cancer Care (ISNCC). The collaboration led to offering a symposium on the topic of oncology nursing and screening for distress at the 2010 IPOS Congress held in Quebec City, Canada. Screening for distress was beginning to gain momentum at the time, and implementation of distress screening programs was in its infancy. Early lessons from efforts to implement distress screening programs emphasized the need for

initiatives to include more than simply introducing routine application of a standardized instrument to measure distress, anxiety, or depression. The symposium was organized to showcase some of the early efforts and share the emerging lessons.

The experiences shared during the symposium were drawn from nursing and psychosocial leaders in Canada, the United States, and Australia. As recommended by the NCCN guidelines, oncology nurses are an important point of contact for patients regarding psychosocial concerns. The nurse's initial interaction and assessment has a significant impact on whether patients feel supported and are connected with the appropriate resources. Hence, the symposium was designed to explore the role of oncology nurses in meeting the psychosocial needs of patients with cancer. The symposium highlighted the developments at the time to support and engage oncology nurses in how to use distress screening not as the be-all and end-all, but rather as a means of providing psychosocial care; of providing, that is, whole-patient care (Aranda, 2010; Howell, 2010; McCorkle, 2010; McLeod & Morck, 2010).

The presentations provided clear illustration regarding the need for, and value of, collaboration between oncology nurses and other psychosocial disciplines if whole-patient care was to be achieved. Whereas oncology nurses play a key role in early response to screening for distress scores, clear pathways for patient referral to, and engagement with, psychosocial colleagues was critically important. Successful implementation also required access to tools and educational support for staff members. Evidence-based guidelines, referral algorithms, articulated care pathways, and easily accessible education were integral to early successes.

In the 2 years since this IPOS-ISONCC symposium, the momentum surrounding screening for distress in cancer care and the lessons garnered through program implementation have mushroomed. In many parts of the world, successful introduction of comprehensive distress screening programs have seen improvements in communication among members of the inter-professional team and patients and families, as well as increased patient satisfaction with care. There is a growing recognition that comprehensive distress screening programs can drive culture change in a practice arena, even serving as the catalyst for broadening our understanding of that which is included in the psychosocial care of patients. Comprehensive distress screening programs are not just about ensuring referrals to psychology or psychiatry services. Distress can arise from many sources, and early identification of that distress can result in patients being connected with various services that may assist with the management of physical symp-

toms, practical and financial concerns, and spiritual and existential concerns. Patients' experiences with cancer care and the overall standard of care can be influenced with a careful implementation of a programmatic approach to comprehensive distress screening.

Another important development has been that accreditation standards for cancer care facilities in both Canada and the United States have incorporated the expectation that comprehensive distress screening programs will be implemented in cancer care facilities (Accreditation Canada; American College of Surgeons, 2012). The evidence base to guide implementation of such programs continues to grow, and lessons continue to emerge.

Our ongoing collaboration since 2010 has led to the production of this special issue. The issue reflects our experiences over the past 2 years and outlines some of the current thinking around distress screening. The collection of articles from cancer nurses and psychosocial oncology leaders provides insight into the realities of implementing comprehensive distress screening in the real world of busy clinical settings and key notions that guide current efforts.

In this special issue, we present examples of research, clinical practice initiatives, and an educational program for providers from three international communities: Australia, Canada, and the United States.

In the first article, which is from Australia, "Profile and predictors of global distress: can the Distress Thermometer guide nursing practice in prostate cancer?" by Lofti-Jam, Gough, Schofield, and Aranda, the authors found that the majority of their sample—ambulatory men in radiotherapy treatment for prostate cancer successfully—reported low distress. However, Lofti-Jam and associates demonstrated that a subsample of high-risk men can be identified for distress through screening.

The second article is from Canada: "What to do with screening for distress scores? Integrating descriptive data obtained from nurse navigators into clinical practice," by Blais, St-Hilaire, Fillion, de Serres, and Tremblay. The authors demonstrated that nurse navigators were successful in screening 911 patients representing multiple primary sites of cancer. Using the NCCN's Distress Thermometer (DT) and the Edmonton Symptom Assessment Scale, they were successful in identifying patients with high distress.

From the United States, "Comparing the Distress Thermometer (DT) with the Patient Health Questionnaire (PHQ)-2 for screening for possible cases of depression among patients newly diagnosed with advanced cancer," Lazenby, Dixon, Bai, Ercolano, and McCorkle demonstrated that all 123 patients newly diagnosed with late-stage cancers were at risk for

ongoing high emotional distress. Their results indicated that a cutoff score of ≥ 4 may be too high for this vulnerable subgroup of patients. Patients newly diagnosed with life-limiting cancers warrant close monitoring for depression, Lazenby and colleagues' findings suggest.

In the fourth article, from the United States, "Monitoring patient distress and related problems before and after hematopoietic stem cell transplantation," Crooks, Seropian, Bai, and McCorkle used the DT and problem list to monitor patients' distress during hospitalization and after discharge. The authors demonstrated that the DT and problem list helped their interdisciplinary team to prioritize problems and make assignments to individual team members so that patients' needs could be met effectively and efficiently.

In the fifth article, "Promoting Quality Breast Cancer Care: Psychosocial Distress Screening," United States authors, Knobf, Major-Campos, Chagpar, Seigerman, and McCorkle, found that distress screening better fit into their breast cancer clinic in the medical oncology setting rather than the surgical oncology setting. In the surgical setting, patients were screened who, after pathology results, were found not to have cancer. They also show how the NCCN Distress Thermometer's Problem List can be adapted to meet the needs of a specific population.

From the United States, in the sixth article, "Use of an electronic patient-reported outcome measurement system to improve distress management in oncology," Smith, Rowe, and Abernethy demonstrated the success of a population-based distress screening program throughout the ambulatory service of one comprehensive cancer center. Their computer-based system screened 17,338 patient encounters and referred 1952 patients for supportive care services. Outcomes are reported for a subsample of breast patients.

From Canada, the seventh article, "Cancer distress screening data: Translating knowledge into clinical action for a quality response" by Howell, Hack, Green, and Fitch, presents an overarching framework for implementing distress screening that incorporates a systematic approach to management and follow-up, thus completing the full cycle in integrating psychosocial care into routine cancer care.

In the final article, again from Canada, "Pan-Canadian Web-based education program to support screening for distress: Evaluation of outcomes," McLoed, Morck, and Curran present a Web-based learning program to meet the demands of educating nurses and other professionals about comprehensive distress screening and the skills needed to be successful. The program was cost-effective, accessible, and time saving.

The IOM's 2008 (Adler & Page, 2008) report put forth a vision in which the full range of psychosocial

care is integrated with biomedical care. It was a vision of shifting the focus from anticancer treatments to care of the whole patient. And although accrediting bodies have now mandated comprehensive distress screening programs as a means of realizing this vision, our special issue puts bricks and mortar onto the scaffolding of the vision and mandate: Who is at risk, and among those at risk, how best to identify them and who is best equipped to help them? Articles in this special issue address these questions. It is clear that, in the past two years, clinics that have implemented comprehensive distress screening programs have not been overwhelmed with patients who need psychosocial interventions. Rather, the studies reported in this special issue show that we can know those patient populations who are at high risk for distress and target them. Because of comprehensive distress screening programs, the right care gets to the right people. Authors of articles in this special issue also show that the work of providing whole-patient care through comprehensive distress screening programs can be accomplished across the complex expanse of comprehensive cancer centers. Moreover, the very people who are central to implementing distress screening programs need to be trained, and authors in this special issue demonstrate that such training can be accomplished efficiently and cost effectively online. This special issue, then, puts walls on the edifice of whole-patient care envisioned by the 2008 IOM report.

The mortar of these walls is the interdisciplinary approach seen in the authorship of these articles. Authors of these articles are nurses, physicians, psychologists, and social workers, and they describe programs that employ the skills and expertise of these disciplines. This special issue, which began as a joint effort, proves that such interdisciplinary collaboration among providers is possible. But it is also *necessary*, if comprehensive distress screening programs are to be the walls on the scaffolding of the new quality care standard of whole-patient cancer care.

The future of integrated whole-person cancer care is bright; however, much work needs to be done. In our research we need to continue to ask questions about the effect of comprehensive distress screening programs on quality of life, but we also need to include hard endpoints: we need to ask whether integrated whole-person cancer care improves survival, just as some have shown with advanced practice cancer nursing interventions (McCorkle et al., 2000) and with palliative care among patients with advanced cancer (Temel et al., 2010); and in this era of leaner healthcare economics, our research needs to include questions of the cost-effectiveness of comprehensive distress screening programs. If interdisciplinary work is the mortar that holds the walls of the vision of integrated whole-person

cancer care together, then this type of forward-thinking but end-point driven research will enlarge the vision and ensure that the new quality care standard of whole-patient cancer care becomes the norm.

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