Using the Science of Psychosocial Care to Implement the New American College of Surgeons Commission on Cancer Distress Screening Standard

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Abstract
The American College of Surgeons (ACoS) Commission on Cancer (CoC) has advanced a new patient-centered accreditation standard requiring programs to implement psychosocial distress screening and referral for psychosocial care. The field of psychosocial oncology has advocated for routine distress screening as an integral component of quality cancer care since the NCCN Distress Management Panel first recommended this practice in 1999. Accreditation standards have a significant impact on practice patterns and quality of care. The new ACoS CoC Psychosocial Distress Screening Standard provides a unique opportunity to integrate the science of psychosocial care into clinical practice. National organizations, including the American Psychosocial Oncology Society, the Association of Oncology Social Work, the Cancer Support Community, and LIVESTRONG, can offer valuable guidance and resources. This article reviews ACoS CoC requirements, highlighting key research findings and providing practical considerations to guide programs with implementation. Although screening for distress encompasses many domains, this article reviews the evidence linking depression—one aspect of distress—and cancer outcomes to highlight the profound influence psychosocial care delivery can have on promoting medical outcomes and quality cancer survivorship. The authors describe distress screening program accomplishments at Northwestern University, including the electronic administration of NIH Patient Reported Outcomes Measurement Information System computerized adaptive testing item banks. Electronic medical record integration facilitates real-time scoring, interpretation, provider notification, and triage for psychosocial care. Roughly one-third of patients have requested assistance with psychosocial needs. As ACoS CoC programs implement psychosocial distress screening and management, the emerging field of implementation science can guide future clinical program developments and research priorities. (JNCCN 2013;11:214–221)
culture. Therefore, a “one size fits all” model of distress screening is impossible to provide. The CoC standard outlines key parameters for screening, while allowing sites flexibility in designing the optimal implementation strategy for their setting. This article provides guidance for standard implementation.

**ACoS CoC Standard 3.2: Psychosocial Distress Screening**

The CoC standard states “The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.” The accreditation standard, definition, and requirements for compliance are available through ACoS and summarized in Table 1. The CoC maintains an online best practices repository of publications relevant to standard implementation and webinars to guide implementation (http://www.facs.org/cancer/). This standard will be phased in for 2015 to provide institutions time to develop and implement screening. This phase-in provides psychosocial providers the opportunity to establish local collaborations to implement a best practices model that will function effectively in their setting.

The field of psychosocial oncology has advocated for implementing distress screening for the past few decades, given the prevalence of distress among adults with cancer, the consequences of unmet psychosocial health needs on cancer outcomes, the availability of effective interventions, and improved outcomes from distress screening and referral. The Institute of Medicine’s report “Cancer Care for the Whole Patient” provides a comprehensive review of this research, concluding that distress screening is a key element of quality cancer care. However, efforts to promote distress screening have yielded limited success. Concordance with NCCN Distress Management Guidelines was 20% among NCCN Member Institutions and may be lower in non-NCCN practices. The new ACoS CoC standard affords an unparalleled opportunity for distress screening implementation, given that noncompliance has consequences for accreditation status.

**ACoS CoC Psychosocial Distress Screening: Process Requirements**

CoC standard process requirements encompass 1) timing of administration, 2) method of administration, 3) tools to be administered, 4) assessment and referral, and 5) documentation (see Table 1). Key research findings and practical considerations are reviewed to guide programs with implementation.

**Timing of Administration**

The standard states that patients are to be screened a minimum of one time at a “pivotal medical visit.” Pivotal medical visits include at diagnosis, pre-/postsurgical visits, first visit with a medical oncologist, radiation oncologist visit, or posttreatment follow-up. Screening should occur during visits associated with the greatest risk for distress, including at diagnosis, treatment transitions (one modality to another), and treatment completion. The standard requires a minimum of one screening, although ongoing monitoring for distress is recommended by NCCN. Information on the longitudinal trajectory of distress may be prognostic. Women with metastatic breast cancer reporting reduced depressive symptoms over 12 months had longer survival than those reporting increased symptoms. A considerable proportion of cancer survivors show elevated distress even years after treatment. These findings underscore the value in ongoing, routine distress screening throughout the trajectory of cancer care and posttreatment.

**Method of Screening Administration**

The CoC standard allows some flexibility regarding screening method. This important decision point for cancer programs has implications for clinic flow and staff responsibilities. Broadly categorized, distress screening can be implemented through clinician-administered or patient self-report screening items or questionnaires. Clinician-administered screening could include a verbal distress rating, similar to a pain assessment, and can assess the source of distress (eg, symptom burden, financial concerns) when present. Clinicians could administer a semistructured screening questionnaire, such as the Primary Care Evaluation of Mental Disorders, to screen for the presence of mood and anxiety disorders. One benefit of clinician-administered screening is that it can be easily integrated with a review of systems and other clinical domains that are routinely assessed at every
visit. Through doing so, distress is given the same priority as other patient concerns and will be routinely monitored. Clinicians can immediately score and interpret screening results. Clinical intervention and triage can then occur in real-time and with direct patient input, which is particularly important when assessing potential risk (eg, suicidal ideation).

However, clinician-administered screening is time-intensive for staff directly involved in administering the screening and for cancer center program staff. This approach requires the availability of clinical staff to administer and score screening measures and, when needed, implement a clinical action plan. Clinician-administered screening is likely to be most effective if staff are provided with specialized training and clear algorithms to manage distress, particularly for acute distress and suicidal ideation. Training would bolster staff comfort in discussing personal and sensitive topics and competence in managing acute distress. Programs planning to use clinician-administered assessment should factor in the time required of the staff directly involved in assessment administration, and the resources required for staff training.

Clinician-administered assessment offers many advantages, including real-time clarification of patient responses and immediate clinical action for acute distress (eg, suicidal ideation) as needed. The disadvantage of this approach is that patients may be reluctant to disclose sensitive information directly to their medical providers and may be more open using self-administered forms.

Patient-administered screening includes paper-and-pencil questionnaires or electronically administered screening through telephone-based questionnaires using interactive voice response technology, or through computer-administered assessment. Numerous options exist for computer-administered assessment, such as Web-based assessment available to patients using a home computer, or providing computer access, kiosks, or e-tablets in the clinic. Paper-and-pencil questionnaires can be completed in the

### Table 1 American College of Surgeons Commission on Cancer Psychosocial Distress Screening Standard 3.2

<table>
<thead>
<tr>
<th>Psychosocial Distress Screening Standard 3.2</th>
<th>The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing</td>
<td>Patients with cancer are offered screening for distress a minimum of 1 time per patient at a pivotal medical visit to be determined by the program. Some examples of a “pivotal medical visit” include time of diagnosis, presurgical and postsurgical visits, first visit with a medical oncologist to discuss chemotherapy, routine visit with a radiation oncologist, or a postchemotherapy follow-up visit. Preference is given to pivotal medical visits at times of greatest risk for distress, such as at time of diagnosis, transitions during treatment (eg, from chemotherapy to radiation therapy), and transitions off treatment.</td>
</tr>
<tr>
<td>Method</td>
<td>The mode of administration (eg, patient questionnaire, clinician-administered questionnaire) is to be determined by the program.</td>
</tr>
<tr>
<td>Tool</td>
<td>Facilities select the tool to be administered to screen for current distress. Preference is given to standardized, validated instruments with established clinical cutoffs; however, facilities may use a measure of their choice. Facilities are encouraged to use established clinical cutoffs when possible; however, facilities may determine the cutoff score used to identify distressed patients.</td>
</tr>
<tr>
<td>Assessment and referral</td>
<td>As recommended in the 2007 Institute of Medicine report, if clinical evidence exists of moderate or severe distress, the patient’s oncology team (oncologist, nurse, social worker, and/or psychologist) is to “identify and examine the psychological, behavioral, and social problems of patients that interfere with their ability to participate fully in their health care and manage their illness and its consequences.” This evaluation will confirm the presence of physical, psychological, social, spiritual, and financial support needs and indicate the need to link patients with psychosocial services offered on-site or through referral.</td>
</tr>
<tr>
<td>Documentation</td>
<td>Screening, referral or provision of care, and follow-up are documented in the patient medical record to facilitate integrated, high-quality care.</td>
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quality of care, so would assessing patient distress without responding to elevated distress.

**Tools to be Administered**

The CoC standard allows sites to select the screening tools and clinical cutoff that will work best in their setting, with preference for standardized, validated instruments with established clinical cutoffs. To select the best screening tools, sites must decide how narrow or expansive to be in defining distress. The term distress has been adopted in cancer care because it is more acceptable to clinicians and patients than psychiatric or psychological terms, and because it is broad enough to encompass the far-reaching impact of cancer in disrupting social, occupational, financial, and spiritual functioning. The NCCN Clinical Practice Guidelines for Oncology (NCCN Guidelines) for Distress Management (available in this issue; to view the most recent version of these guidelines, visit NCCN.org) recommend the Distress Thermometer (NCCN-DT; 0–10 distress rating) and problem checklist, with further assessment and referral for patients scoring a 4 or higher. Although the NCCN-DT has face validity and is similar to well-established clinical practices (eg, pain rating), its psychometric properties are not as robust as lengthier measures. The NCCN-DT can detect clinically significant anxiety; however, it does not accurately detect depression. The following section describes the use of NIH Patient Reported Outcomes Measurement Information System (PRO-MIS) measures to assess outpatients at Northwestern University. A comprehensive review of 14 of the most commonly used screening tools was recently published. Distress screening tools have high negative predictive value and low positive predictive value; therefore, a clinical interview or a needs assessment tool is needed for patients who screen positive to identify the specific nature of distress. An extensive review of the content and psychometric properties of 29 needs assessment tools is also included in this comprehensive review. At a minimum, the NCCN-DT should be administered with a depression screening tool, given the profound effects of depression on quality of life and cancer outcomes.

**Significance of Depression in Cancer**

Depression extends beyond distress, which is a normal reaction of discomfort to stressors, many of which naturally accompany the diagnosis and treatment of cancer. Depression involves a negative turning in-
ward, with feelings of hopelessness, helplessness, and worthlessness, which amplify the impact of stressors and impair response to them. The lethal potential of depression is underscored by a recent study indicating an elevated rate of suicide among patients with recently diagnosed cancer.23 The 1-year prevalence rates of depression among patients with cancer are between 15% and 29%,24–28 which are significantly higher than the 8.6% prevalence rate of major depression in the general US population.29

Depression and cancer interact, with cancer increasing the likelihood of depression, and depression increasing the risk of cancer progression. Recent evidence shows that the inflammatory response to cancer and its treatment, including tumor cell lysis, elevates the levels of circulating cytokines that can induce depressive symptoms, similar to the lethargy associated with acute infectious disease.30 The identification of depressive symptoms is crucial to directing treatment choice. Strong evidence shows that the psychotherapeutic treatment of depression, even among patients with advanced cancer, is highly effective.31 In addition, because comorbid depression predicts shorter survival time with cancer,12,32 there is good reason to think that treatment of depression may improve quantity and quality of life. Studies assessing depression over longer periods show that chronic depression is related to increased cancer risk34 and shorter subsequent survival.35 A recent thorough meta-analysis of 25 independent studies32 found that a full diagnosis of depression was associated with a 39% increase in mortality (relative risk [RR], unadjusted, 1.39; 95% CI, 1.10–1.89; P=.03), whereas depressive symptoms were associated with a 25% elevation in mortality risk (RR unadjusted, 1.25; 95% CI, 1.12–1.40; P<.001).32 The authors noted that because adjustment for known prognostic variables did not alter these associations, depression may play a causal role in cancer mortality, and therefore its treatment could extend survival.36 Patients with cancer who are depressed are often less adherent to oncologic treatment17 and experience sleep and other circadian rhythm disruptions that can affect disease outcome.36,39 Depression among patients with cancer is a serious complicating comorbid illness and risk factor. Detection and treatment of depression is an important opportunity to improve the effectiveness of treatment.

**ACoS CoC Psychosocial Distress Screening Standard: Implementation**

The CoC standard states that when clinical evidence of moderate or severe distress exists, the oncology team (defined as the oncologist, nurse, social worker, and/or psychologist) is to identify physical, psychological, social, spiritual, and financial support needs and provide a link to services on-site or through referral (see Table 1). Oncology team members are advised to maintain a resource list to locate internal hospital psychiatrists, psychologists, and pastoral care providers. The network of psychosocial resources can be greatly expanded through integrating resources in the local community, such as Cancer Support Community sites, and nationally (eg, American Cancer Society, CancerCare, LIVESTRONG).

Academic and high-volume cancer centers may have greater access to on-site psychosocial care providers through integrating psychosocial providers as members of the oncology care team. The challenge for these settings is to manage volume, specifically with regard to distress screening administration and triage. Advances in health informatics and technology provide unparalleled opportunities to conduct distress screening within high-volume practices and deliver tailored resources to patients immediately after the reporting of concerns. Examples of electronic screening programs have begun to populate the literature over the past few years.

Electronic screening programs exist in various stages of development, from pilot testing to full implementation, at multiple cancer centers in the United States. These programs may be disease-specific40–42 or relevant to all disease sites.15,17,43 In addition, at least one program is using electronic symptom management assessment outside of the United States.44 A comprehensive review of electronic patient-reported symptom assessment systems in oncology was recently published.45

**Using Advances in Measurement Science and Health Informatics to Implement Distress Screening**

Northwestern University has applied advances in measurement science and health informatics to implement patient-reported outcomes (PROs) assessment with EMR integration to facilitate provider notification and psychosocial triage. NIH-funded
advances in measurement science provide accurate and precise assessment through the PROMIS network (www.nihpromis.org). PROMIS computer adaptive testing (CAT) item banks use a computer algorithm to administer PRO items tailored to the patient’s symptom severity. Precise, reliable, and valid symptom scores are generated, with 4 to 6 items per symptom, computer-scored, and benchmarked based on normative data from thousands of patients. Assessment consists of PROMIS CAT item banks to measure anxiety, depression, fatigue, pain, and physical function, administered through Assessment Center. Assessment also includes a checklist of emotional, practical, and informational concerns that can be addressed by social workers or a medical librarian.

The authors have implemented this assessment in their Gynecologic Oncology outpatient clinics. Patients receive an email 72 hours before a scheduled physician visit, with instructions to complete an assessment through the patient electronic communication portal (MyChart, Epic Systems Corporation, Verona, Wisconsin). Patients can complete the assessment from home through MyChart or in the clinic using an iPad, administered to the patient by the clinic check-in staff. Assessment results immediately populate the EMR. Severe symptoms trigger electronic notification to the physician and nursing pool. A message notification is sent to the social work team for patients reporting severe anxiety or depression, or who express a concern on the problem checklist. If the checklist identifies an educational request, a message is sent to the medical librarian. Medical and psychosocial providers follow-up with patients through a MyChart message to the patient, by telephone, or during clinic visits.

The intent of the EMR-integrated screening was 2-fold. First, communication barriers are bypassed through collecting PROs before clinic visits. Second, this system can enhance provider efficiency because medical staff know which symptoms to target before any direct interactions with the patient. This affords providers more time to focus on symptom treatment, rather than assessment. Last, through using the EMR to facilitate the assessment of depression and anxiety and provide triage and referral when clinically indicated, the program’s efficiency is enhanced through connecting patients most in need of psychosocial care with the on-site team. This system meets ACoS CoC requirements by assessing patients immediately before (within 72 hours) a “pivotal medical visit,” identifying patients with distress, conducting in-depth assessment of the severity and nature of distress, and facilitating triage to available resources.

From November 2011 to September 2012, a total of 562 assessments have been administered. The assessment takes approximately 10 minutes for patients to complete. A total of 210 message notifications (19 per month) were sent to the social worker, indicating 37% of patients endorsed social work needs. The most common psychosocial needs identified include help with managing stress (13%), obtaining information on support groups (8%), and coping with a diagnosis of cancer (8%). The medical librarian received 127 (23%) message notifications, averaging 12 per month. The psychosocial team reported that the message notifications have effectively identified patients with unmet psychosocial needs. Medical providers have reported that having advance knowledge of patient symptom concerns helps them prepare for clinic visits. The authors initiated implementation in their Gynecologic Oncology clinic based on physician leadership. Over the next several months, the authors will pursue the ultimate goal of implementation throughout the entire cancer center.

Conclusions

The new ACoS CoC patient-centered standards will have a profound impact on cancer care. Changes in accreditation standards have an undeniable impact on practice patterns. ACoS CoC–accredited sites can use the robust evidence base in psychosocial oncology to guide distress screening implementation. Psychosocial oncology clinicians and researchers have had a long-standing interest in the implementation of distress screening and are eager to partner with cancer care settings on these efforts. ACoS CoC and other emerging accreditation standards offer an unparalleled opportunity to apply the science of psychosocial care in clinical practice. The mandate is to use implementation science to maximize outcomes for patients. Through doing so, the quality of cancer survivorship can be improved dramatically.

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ACoS CoC Distress Screening Standard


