Improving Psychosocial Care in Outpatient Oncology Settings

Psychosocial Care of Cancer Patients

A recent Institute of Medicine (IOM) report, “Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs,” summarized the current status of efforts to provide psychosocial care for people with cancer. Among the report’s main conclusions was that, despite evidence of the effectiveness of psychosocial services, many patients who could benefit from this type of care do not receive the help they need. According to the report, failure to address these problems causes needless patient and family suffering, obstructs quality health care, and can potentially affect the course of disease. The reasons for this failure are many, and include the tendency of oncology care providers to underestimate distress in patients and not link patients to appropriate services when needs are identified. To address these problems, the report recommended that provision of appropriate psychosocial services should be adopted as a standard of quality cancer care.

The report also identified a model for the effective delivery of psychosocial services that specifies implementation of processes for 1) facilitating effective communication between patients and care providers; 2) identifying patients’ psychosocial needs; 3) designing and implementing plans that link patients with needed psychosocial services, coordinate their biomedical and psychosocial care, and engage and support them; and 4) systematically following up on, reevaluating, and adjusting the plan.

These recommendations are similar to those described in the Clinical Practice Guidelines in Oncology: Distress Management first issued by the NCCN in 1999 and updated annually. These guidelines were developed based on the recognized need for better management of distress and with the intent of promoting best practices for the psychosocial care of patients with cancer. Similar to the IOM report, the NCCN guidelines recommend that all patients be screened routinely to identify the level and source of their distress. The specific services and resources subsequently recommended are designed to be appropriate to the nature and severity of the problems identified through screening and further evaluation.

Relatively little is known about the extent to which the NCCN Distress Management Guidelines are being followed. One of the few pieces of evidence is a 2005 survey completed by institutional representatives from 15 NCCN member institutions. Findings suggested that, even among NCCN member institutions, there has been limited implementation of the recommendation that all patients be screened routinely for distress. However, processes did appear to be in place, if screening was performed, to link distressed patients at major cancer centers with needed services. It should be noted that these findings were based on responses from institutional representatives. The extent to which these responses would be confirmed by information contained in individual patient medical records was not examined.

Development and Evaluation of the Quality Indicator of Psychosocial Care

Together, the IOM report and the survey of NCCN member institutions suggest the need to foster greater implementation of recommendations and guidelines for the psychosocial care of cancer patients. One way to foster greater implementation would be to measure the quality of the psychosocial care that individual cancer patients receive and use this information to guide quality improvement efforts. Evaluating this possibility first requires measurable indicators of the quality of psychosocial care. In the absence

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of accepted indicators, in 2007 the American Psychosocial Oncology Society (APOS) formed a workgroup to develop quality indicators. Members of the workgroup included 5 mental health professionals (psychologists, psychiatrists, and social workers) with extensive experience in delivering psychosocial care to cancer patients. The committee’s initial focus was on developing process measures of the quality of psychosocial care that can be evaluated through medical record abstraction. After a review of relevant literature, including the IOM report and the NCCN Guidelines, committee members identified several potential indicators that were then reduced using a modified Delphi method. This process resulted in the selection of measures assessing 2 components considered necessary (although not sufficient) for providing quality psychosocial care.

The first quality indicator stipulates that the medical record should show that the patient’s emotional well-being was assessed within 1 month of the first visit with a medical oncologist. The second quality indicator stipulates that, if a problem with emotional well-being was identified, the medical record should show that action was taken to address the problem or an explanation for inaction. Measurement of these indicators is operationalized by formulating questions that can be answered yes or no based on the review of an individual patient’s medical record.

These indicators have now undergone preliminary evaluation in 2 quality of care projects. In the first project, conducted as part of the Florida Initiative for Quality Cancer Care (FIQCC), the indicators were pilot tested using the medical records of 388 colorectal cancer patients first seen by a medical oncologist in 2006 at 7 practice sites in the state of Florida. Rates of assessment of emotional well-being ranged from 6% to 84% across sites (mean, 60%). Among the 12% of patients identified as having a problem with emotional well-being, rates of action taken (or explanation for no action) ranged from 0% to 100% (mean, 51%). Scores on a combined “defect-free” psychosocial indicator ranged from 3% to 78% (mean, 54%). Direct comparison of mean performance rates indicated that pain was more likely to be assessed than emotional well-being (87% vs. 60%; P < .001).

Improving the Quality of Psychosocial Care for Cancer Patients

The findings from these evaluations consistently indicate that, to date, efforts to promote routine symptom assessment have been more successful for pain than for emotional well-being. In addition, findings show considerable variability in quality of psychosocial care across practices. Most importantly, findings provide information that can be used by individual practices to make decisions about the need to improve the quality of psychosocial care they provide.

In the FIQCC, a report was provided to every participating oncology practice that summarized the practice’s performance on each quality indicator relative to all other practices combined and to each practice individually (with identities of individual practices masked to preserve anonymity). Thus, each practice was able to determine how its performance compared with the average of all practices and to every practice individually. Evidence suggests that providing feedback in this manner can yield improvements in the quality of psychosocial care provided to patients. For example, among practices that participated in QOPI across 2 rounds of chart abstraction, overall performance on measures of the quality of cancer care was found to have improved significantly over time.

Although provision of feedback alone may yield improvements in the quality of psychosocial care, a more deliberate approach seems more likely to achieve the desired results. One strategy would be to encourage practices scoring poorly on the psychosocial indicators but higher on pain indicators to examine their processes for assessing emotional well-being and compare and contrast them with their processes for assessing pain. An in-depth review might reveal procedures in place at the practice for assessing pain that could be adapted or extended to ensure that emotional well-being was also assessed. Beyond this, it may be possible to encourage collaboration among practices to improve care. Specifically, practices scoring well on the psychosocial indicators could share information about their processes for assessing and addressing emotional well-being that would be helpful to other sites seeking to improve performance.

The approaches outlined earlier focus on promoting the “best processes” that exist among the practices surveyed. However, whether the processes used by practices achieving high performance rates qualify as “best” is unknown. For example, qualifying methods used to assess emotional well-being could range from informal questioning conducted as part of a clinical examination, to administration of a standardized screening measure validated in oncology.
settings, such as the Distress Thermometer. The specific screening method used is important because research has shown that informal methods often result in underrecognition of psychological distress when compared with standardized screening measures. Although having some process in place to screen for emotional well-being may be better than having none, plans to improve quality should focus on implementing proven and effective methods. These considerations suggest the need to move beyond use of existing indicators to improve psychosocial care based on involving a practice’s self-evaluation and information exchange with other oncology practices. Two developments can be identified that would facilitate greater progress.

First, the existing quality indicators may need to be revised or supplemented to permit more direct comparisons of processes currently in place with those recommended by clinical practice guidelines. For the psychosocial care for cancer patients, comparisons could be made directly with the NCCN Distress Management Guidelines. These guidelines represent the consensus of experts in psychosocial oncology informed by a review of available research evidence. The guidelines are presented primarily in the form of clinical pathways that describe recommended procedures for screening and evaluating patients, and recommended uses of psychological, psychiatric, social work, and pastoral care services to treat a wide range of problems. To be more consistent with these guidelines, for example, the quality indicator regarding assessment of emotional well-being might be revised to specify that screening was performed using a validated screening measure. Similarly, the guideline on action taken to address an emotional problem might be revised to specify that patients received certain forms of care known to be effective for their problems.

Second, practices seeking to improve the psychosocial care they provide to their patients need models of psychosocial care consistent with clinical practice guidelines to guide them. Given the vast differences in size and organizational structure that exist among outpatient oncology practices in the United States, no single model of care will suffice. The local availability of psychosocial professionals, which can also vary considerably across practices, must be considered. Thus, for example, some models of care are more appropriate for large practices where psychosocial resources may be readily available on-site, and other models more appropriate for smaller practices where psychosocial resources may be largely available off-site. Beyond providing models of care, practices need guidance on how to implement these models and sustain the changes they make in the organization and delivery of psychosocial care to their patients. Many of these goals could be achieved by conducting quality improvement demonstration projects. These projects would involve the development and evaluation of models for improving psychosocial care in “real world” oncology settings. As part of the projects, successful methods for implementing change would be carefully documented and the impact of introducing changes carefully evaluated. To be considered successful, these projects should yield disseminable models of psychosocial care that have been shown to result in meaningful improvements in the emotional well-being of patients being treated in that setting.

In summary, there is growing momentum to expand and improve psychosocial care for cancer patients. The recent development of quality indicators for psychosocial care in oncology settings holds the promise of providing practitioners with information useful for evaluating the psychosocial care their patients receive and in identifying the need for quality improvement efforts. The next step will be to develop and evaluate methods for improving the quality of psychosocial care that are practical and effective and can serve as useful models for practices seeking to deliver care in a manner consistent with clinical practice guidelines for distress management.

References

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