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Cancer Center Regional Benchmarks for Psychosocial Care

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Loma Linda University
School of Behavioral Health
In conjunction with the
Department of Psychology

Cancer Center Regional Benchmarks for Psychosocial Care

By

Desiree R. Azizoddin

A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Psychology

June 2017

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Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree of the Doctor of Psychology.

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ABBREVIATIONS

ACS	American Cancer Society
ACoS	American College of Surgeons
CoH	City of Hope
CSMC-CC	Cedars Sinai Medical Center- Cancer Center
CoC	Commissions on Cancer
ICU	Intensive Care Unit
IT	Information Technology
LLEAP	Loma Linda Electronic Access Portal
LLU	Loma Linda University
LLUMOC	Loma Linda University Medical Oncology Center
NCI	National Cancer Institute
NIH	National Institute of Health
NCCN	National Comprehensive Cancer Network
QALY	Quality Adjusted Life Years

ABSTRACT OF THE DOCTORAL PROJECT

Cancer Center Regional Benchmarks for Psychosocial Care

by

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Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, June 2017
Dr. Jason Owen, Chairperson

The American College of Surgeons (ACoS) Commissions on Cancer (CoC) formulated and implemented standard 3.2 for Psychosocial Distress Screening. This standard requires that all accredited cancer centers evaluate psychosocial distress and provide appropriate triage and intervention for all cancer patients. Over the past decade, Loma Linda University Medical Oncology Center (LLUMOC) administration, physicians, nurses, psychosocial care staff, and chaplaincy collaborated to implement a psychosocial screening and referral program throughout cancer patient services. This current research includes qualitative analysis assessing strengths and barriers of the psychosocial program at LLUMOC from the perspective of LLUMOC providers and two directors of Supportive Care Services from City of Hope and Cedars Sinai Medical Center. Suggestions are provided for administrators and providers on options and mechanisms to improve psychosocial screening and referral at Loma Linda University Medical Oncology Center.

CHAPTER ONE

INTRODUCTION

The American College of Surgeons (ACoS) Commissions on Cancer (CoC) is an organization whose distinct goal is to improve survival and quality of life through standard-setting, prevention, research, education and the monitoring of comprehensive quality of care. In 2011, ACoS CoC formulated and implemented standard 3.2 for Psychosocial Distress Screening to require all accredited cancer centers to evaluate patients' psychosocial status and to provide appropriate triage, referral, and treatment when warranted by the patient's clinical status (CoC, 2012). Importantly, all accredited centers are required to be in compliance with this new standard by 2015, a goal that is challenging for smaller, community-based cancer centers. To successfully fulfill these criteria requires involvement and efforts from administration and all health care professionals involved in oncology care. As expected, such changes within a system require a lengthy period of solution-focused management, overcoming barriers, and identifying screening, treatment and program evaluation strategies that are feasible for the unique needs of each center. This paper will review previous research findings that guide the development of these recent standards and characterize multidisciplinary efforts to successfully meet the standards at the Loma Linda University Cancer Center. Finally, recommendations are provided for the Loma Linda University Medical Oncology Center (LLUMOC) to effectively utilize existing resources to both meet standard 3.2 and to improve the quality of psychosocial care for cancer center patients.

Distress: Definition and Epidemiology

The National Comprehensive Cancer Network (NCCN) first advanced the term “distress” in 1997 to capture the experience of a “multifactorial, unpleasant, emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment” (Holland, 2013, National Comprehensive Cancer Network). Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis. Specific to cancer patients, distress is a complicated and multifaceted term representing many personal aspects of the experience with cancer. Distress is used as a minimally stigmatized representation of a patient’s emotional, cognitive, and physical disability that reflects not just the experience of living with cancer but also one’s overall quality of life. With the use of a less stigmatized word, patients may feel comfortable communicating how they are feeling, creating an opportunity for the psychologist or treating physician to then further investigate and provide treatments for the designated symptoms the patient may be experiencing. To emphasize the importance of evaluating distress in cancer survivors, the Canadian Strategy for Cancer Control has proposed that healthcare professionals include distress as the 6th vital sign that is assessed routinely along with pulse, respiration, blood pressure, temperature, and pain (Bultz & Carlson, 2006).

Clinically-significant distress is highly prevalent in cancer survivors. In one of the largest studies of its kind, Carlson assessed the prevalence of distress among 3095 patients of a large regional tertiary cancer center in Canada and identified 37.8% who met

cutoff scores for marked distress (Carlson, 2004). Patients who experienced the highest levels of distress had the following characteristics: racial/ethnic minorities, had undergone longer duration of treatment, had previous psychological illness, were diagnosed with other severe comorbid illnesses, experienced substance abuse, were younger, had lower incomes, were in active treatment, or had lung, pancreatic, head and neck, brain, or Hodgkin's disease (Carlson, 2004, Harding, 2012). Data have indicated that patients at higher risk of experiencing distress include those with later stage of disease, poorer prognosis, younger age, living alone, have young children, previous physical or sexual abuse, and greater level of disease burden (Carlson, 2003). Previous studies have shown that about one-third to 45% of cancer patients indicate significant levels of distress, yet only about 10% of these are referred for psychosocial care (Carlson, 2003). Research has also highlighted the importance of intervening early in management of distress symptoms to avoid the onset of more difficult psychosocial problems later in the course of treatment or as the disease progresses. High levels of distress are associated with decreased quality of life, poor satisfaction with medical care, decreased compliance with treatment, worsening of health behaviors, difficulties with treatment decision-making, increased cost of overall treatment, and possibly reduced survival (Carlson, 2012). Increased distress within this patient population requires screening and referral if and when patients seek resources to assist in managing and altering distress. If patients' desire for assistance is present, then distress symptoms could be effectively addressed and managed using distress-focused screening and referral measures.

As the population of cancer survivors continues to increase, the need for comprehensive care policies also increases. The American Cancer Society (ACS) reports

that the population of 13.7 million cancer survivors is expected to increase to 18 million survivors by 2022 (ACS, 2012). Unmet treatment needs for distress in cancer patient populations must be examined further. By measuring unmet needs, healthcare providers will then strive to allocate limited health-care funding to appropriate, patient-driven areas of desired involvement and assistance. To understand distress and patient quality of life related to cancer care, researchers have attempted to quantify unmet needs through multidimensional needs-assessment measures. Such studies allow providers to understand the multifactorial nature of distress that cancer patients experience and patients' desire for involvement in specific areas of need. Distress has been initially measured through the prevalence and incidence of "unmet needs" reported by cancer patients including: physical, social, psychological, monetary, sexual, and religious/spiritual (Carlson, 2012; Chambers, Occhipinti, Hutchison, Turner, Morris, & Dunn, 2012; White, D'Abrew, Katris, O'Connor, & Emery, 2012). To create a more clear understanding of unmet needs present within cancer patient populations, Sanson-Fisher (2009) defined needs as "the requirement of some action of resource that is necessary, desirable, or useful to attain optimal well-being" (pg. 227). Distress within cancer patient populations may result in part from poorly identified and unaddressed needs within patient experiences. The presence, development, and characteristics of distress related to cancer patients' quality of life and physical-health outcomes should be specified by individual risk factors, cancer type, and treatment mode to generate effective intervention models and standards to successfully improve patient quality of life and health outcomes.

To specify presenting needs relevant to side effects, cross-sectional, qualitative and quantitative analysis of large patient populations have been conducted in various

cultural and geographic settings. Cancer treatment side effects lead to the development of 5 primary areas of need: psychological, health system and information, physical and daily living, patient care and support, and sexuality (Sanson-Fisher, 2000; White, et al, 2012). Estimates of the prevalence of unmet needs in each of these domains, derived from a cross-sectional analysis of over 1,200 cancer survivors in Australia, suggest that 37% of patients have moderate to high levels of unmet needs. This finding is consistent with a number of studies reporting that 40-70% of cancer patients experience unmet needs (Merckaert, 2010; Sanson-Fisher et al., 2012; White, et al., 2012). The type of unmet needs varies by cancer type. Lung cancer patients reported moderate to high levels of unmet physical and daily living needs. Seventy-two percent of this group reported “not being able to do the things I used to do” and 52% reported having “a lack of energy and experiencing tiredness.” Within a group of prostate cancer patients, 36% reported moderate to high levels of unmet sexuality needs (Sanson-Fisher et al., 2012; White et al., 2012). Additionally, those with lung, bronchus, and trachea cancers report having significantly greater unmet psychological needs compared to those with melanoma (Girgis, Lambert, Lecathelinis, 2011; Sanson-Fisher et al., 2012; White et al., 2012).

Psychologically and physically-driven needs are more prevalent than all other needs. Boyes et al. report 10 of the top 15 unmet needs were categorized as psychological, and the remaining four were categorized within physical and living status, sexuality related, and unspecified domains (Boyes, et al., 2012; Chambers, 2012). In recently diagnosed cancer patients, the majority of unmet needs for most types of cancer include “fear of spreading (45%) and returning (53.8%),” “concerns about the worries of those close to you (38%),” “to be informed about the things you can do to help yourself

get well (36%),” “not being able to do the things you used to do (33%),” and “uncertainty about the future (32%)” (Girgis, Boyes, et al., 2000; pg. 230; Sanson-Fisher et al., 2012). Additional analysis of patient needs, conducted in the United States, found similar results for unmet physical and psychological needs and concerns. In those with lung cancer, 70% reported fatigue and 64% unmet needs related to “being uncertain about the future,” (Sanders, 2010). These unmet needs were significantly correlated with cancer-related intrusive thoughts, distress, depressive symptoms, symptom bother, and avoidance coping. The majority of these needs are psychologically driven with differences in types of unmet needs varying across types of cancer. These levels of unmet needs vary by remission status, gender and age, with fewer unmet needs for patients in remission and males (Holland, 2013; White, et al, 2012), and more unmet needs for those in later stages of disease with poorer prognosis or greater disease burden, and younger age (Carlson 2003; Holland et al., 2013; White et al., 2012). Understanding unmet needs can inform development of services necessary to meet the needs of cancer patients (White et al., 2010). Distress screening measures that are sensitive to specific types of needs that typically vary per individual correlates of distress such as diagnosis, cancer stage, available social support, age, etc. can allow for more individualized interventions. More person-centered therapies can be administered to assuage patients’ psychological needs most directly leading to outcome-effective interventions. As a result, relative changes to cancer patients’ treatment adherence, decision-making, health behaviors, and overall quality of life can commence.

Consequences of Significant Distress

Treatment Adherence

Psychological status directly impact patients' treatment adherence, decision-making, health behaviors, and overall quality of life. Patients with higher levels of depression are less likely to adhere to treatment for various chronic illnesses including diabetes, coronary heart disease, HIV, and cancer and less likely to follow-up with surveillance screening (Dimatteo, Lepper, & Croghan, 2000; Lin, et al., 2004). A study of 1,899 women with early-stage breast cancer concluded that a substantial portion of patients were "sub-optimally adherent" to physician-recommended treatment medications (Partridge, LaFountain, Mayer, Taylor, Winer, & Asnis-Alibozek, 2008). Psychological distress is associated with having a history of psychiatric illness, and can lead to increased anger, anxiety, and depressive symptoms over time. Side effects of chemotherapy and radiation therapy are quite discouraging for patients, leading to feelings of hesitancy and possible aversion to dosage and treatment adherence. The relationship between distress and medication adherence is particularly important given that half of the new chemotherapy drugs are being taken orally (Bassan & Given, 2013). Patients with the greatest number of depressive symptoms exhibit less adherence (Lebovits et al., 1990; Lin et al., 2004). A meta-analysis of patient populations of various medical treatment recommendations found that patients who are depressed are three times more likely than non-depressed patients to be noncompliant with medications (Dimatteo, Lepper, & Croghan, 2013). Poor compliance is also associated with worse cognitive functioning from radiation and chemotherapies (Dimatteo, Lepper, & Croghan, 2013). Noncompliance can lead to worsening of a patient's illness and overall trajectory,

along with increased physician visits, higher hospitalization rates, and longer hospital stays in breast cancer patients (Partridge, LaFountain, Mayer, Taylor, Winer, & Asnis-Alibozek, 2008). Nonadherence can worsen the physician-patient relationship to decrease health care understanding, diagnosis/treatment process, and efficacy of treatment. Analysis of electronic pill cap records and self-reported levels of adherence indicate breast cancer patients are nonadherent to medications 36.4% to 100% of the time with an average of 55% - 85.4% (Partridge et al., 2008). Longitudinal analysis indicates that adherence to breast cancer medications also declines over time. With only 50% of women adhering to medication regimens in measurement taken four years into treatment, with ranges of 15% to 35% of breast cancer patients indicating discontinuation of medication regimen prematurely (Partridge et al., 2008). Long-term regimens (5-year courses) for breast cancer therapy recurrence are superior to short term (1-2 year) courses of therapy. Therefore, long-term adherence and short-term adherence are independently important for cancer recurrence rates. For the significant patient populations indicating nonadherence to both short- and long-term medication regimens, interventions to manage and improve levels of distress can be implemented to decrease nonadherence and improve outcomes and recurrence rates (Atkins & Fallowfiel, 2006; Partridge, et al., 2008; Waterhouse, Calzone, Mele, & Brenner, 1993).

Decision-making

Upon diagnosis, cancer patients are required to make many crucial and specific decisions. Decisions are usually required while seeking treatment from multiple doctors to decide which procedures and therapies are best for overall outcomes. Commonly, these

decisions are time limited, as the growth of different cancers are variable and may require immediate intervention. Cancer patients and family members experience an array of emotions, having been recently notified of the threatening nature of this illness, all while receiving a surplus of information regarding pertinent disease states and treatment options. The stress of being diagnosed with cancer interferes with the decision-making process, as higher levels of anxiety prevent optimal levels of cognitive functioning (Broadhurst, 1957; Balneaves, 1999). Affect in decision-making is often ignored by physicians. McCaul et al. (2005) outlined significant decision-making models suggesting that patient affect should be addressed, respected, and promoted, as many patients rely on feelings in the decision-making process (McCaul, Peters, Nelson, Stefanek, 2005). Patients experiencing increased emotionality do not carry out conventional decision-making. If physicians treating these individuals could address cancer related feelings, then more comprehensive and patient-centered decision making can occur.

Decision-making is an important and difficult process, as different treatment options will result in very different physical changes and cancer cell/disease development. Time-sensitive treatment decisions lead to diverse trajectories in lifestyle and quality of life. For example, more frequent and potent treatments can lead to increased physical and psychological disabilities compared to less rigorous treatments. Patients' decisions lead to changes in implemented care, cost effectiveness of treatment, and overall patient outcomes. Cancer patients experiencing elevated levels of distress do not take part in conventional decision-making models. Schwarz's (2000; p. 433) review of emotion, cognition, and decision making indicates that "moods and emotions can profoundly influence cognitive processes," specifically for most individuals affected by

this disease, the biological mechanisms, pharmaceutical relationships, and various disease states pertinent to the diagnosis and treatment of cancer are not common knowledge.

Understanding the variety and complexity of factors related to disease development and treatment require complex processing that is less common for cancer patient populations.

The onset of a life-threatening diagnosis initiates high levels of distress interfering with the ability to understand the complexity of a cancer diagnosis, treatments, and relevant information.

Consequences of various treatments are markedly unknown and variable by patient. A review on decision making models within cancer patient populations by Davies et al. (2010), indicated that the biggest factor in decision making is trust in one's physician. Patients indicated specifically relying on trust and confidence in his/her physician on the final decision of future treatment (Davies et al., 2010). Treatment decisions do not always lead to expected results, leading to decreased quality of life and regret. Concurrently, McCaul et al. (2005) emphasized that people in general are poor predictors of future feelings and frequently misinterpret the regret they will feel (McCaul et al., 2005). Cancer patients experiencing high risk disease states, high affect, and overall uncertainty in available treatment options can benefit from a healthcare provider organizing the information involved in this decision making process with an emphasis on patient presenting factors, support, and quality of life (Davies et al., 2010). Video recordings of oncology outpatient interactions with physicians indicate that physician messages focused around building alliance, providing support, and translating medical content to levels patients can understand positively affect patients' decision making process and outcome (Albrecht et al., 2008). An emphasis on patient preferences,

support, simplified clinical language, and values applied to delicate decision making processes can lead to more successful quality of life outcomes. Specifically, decreasing patient distress can alleviate a major deterrent of the decision making process. Distress interventions can therefore act as a valuable mechanism to increase quality of life levels and promote more patient-centered treatment resolutions through patient centered decision making processes.

Health Behaviors

Distress also impacts health behavior, which is particularly important given the impact of health behavior on survival. Improved life style factors are frequently part of cancer treatment plans to decrease resulting treatment side effects and cancer reoccurrence, yet negative health behaviors are more difficult to change when patients are distressed. Cancer patients who experience high psychological distress are more likely to engage in negative health behaviors (Choi, 2013). Cancer diagnosis is usually thought of as a teachable moment for patient health behaviors, yet few cancer survivors indicate actually carrying out these positive health behavior changes. Some survivors are more likely to implement health behavior changes if they believe a possible negative health behavior is directly related to the onset or reoccurrence of the disease (Mosher, Lipkus, et al., 2008). The process of changing reoccurrence-related behaviors may be successful through intrinsic behavioral control leading to improved levels of distress (e.g., self-regulation theory; Mosher, Lipkus, et al., 2008). Yet, changing these behaviors requires decision making that would be affected by a patient's emotional state. In a review on emotions and decision making, Schwartz et al. (2000) indicates that individuals

experiencing fear, like those recently diagnosed with a life threatening illness, made “pessimistic judgments about future events.” This could translate to a cancer patient’s pessimism about reducing recurrence through behavioral factors, such as decreasing smoking, overeating, and a sedentary lifestyle.

Patient psychosocial distress is also related to increased negative health behaviors (Choi, 2012; Park & Gaffey, 2007). For example, cancer patients who reported feelings of distress were more likely to engage in current smoking behaviors, less physical activity, and higher risky alcohol consumption (Harding, 2012). Increasing levels of distress lead to greater unhealthy diet and exercise behaviors (Choi, 2012). Many cancer patients report being unable to continue levels of pre-diagnosis physical activity as a result of cancer fatigue and distress disabling physical capability and motivation (Harding, 2012; Rabin, 2011). As such, the relationship between distress and health behaviors should be addressed in intervention strategies.

Specific relationships between distress and health behaviors vary within particular cancer patient populations. For head and neck cancer patients, elevated distress levels are related to decreased smoking, but increased alcohol consumption (Park, 2007). Interestingly, young adults with a cancer history are less likely to initiate smoking and more likely to quit than the general population (Rabin, 2011). Moreover, young adult cancer survivors who experience more distress are likely to smoke more (Harding, 2012). Cancer patients who received cranial radiation or were diagnosed with leukemia or central nervous system tumors had less healthy behaviors (Rabin, 2011). Male breast cancer survivors experience more lifetime physical conditions, more days of low emotional and physical health, feelings of being limited due to physical constraints, and

less life satisfaction than non-cancer controls and, had worse health behaviors: smoking, consumption of alcohol/binge drinking, leisure-time exercise, vigorous exercise, and personal health care (Andrykowski, 2010). Patients who previously engaged in negative health behaviors such as smoking, increased alcohol intake, over-eating, unhealthy diet of food with low nutritional value, and physical inactivity before cancer diagnosis, were more likely to continue such negative behaviors. These negative behaviors are then further exacerbated by increased distress throughout post-cancer diagnosis, treatment, and survival (Burris, & Andrykowski, 2011; Choi, Chung, & Park, 2013; Harding, 2012; Rabin, 2011). Negative lifestyle behaviors can be strongly related to the initial occurrence of cancer disease states and without augmentation, can lead to recurrence. Recurrence is most seen in obesity with breast cancer recurrence, and smoking with various other cancer recurrences (Rowan, Chlebowski, Aiello, & McTiernan, 2002).

Poor health behaviors lead to an increased risk for adverse cancer prognosis, and distress has been found to play a key role in this relationship. Engaging in risky behaviors, such as smoking, drinking alcohol, not exercising, and eating unhealthy foods, can exacerbate risk of cancer recurrence (Rabin, 2011). Advocating healthy behaviors can decrease negative behaviors thereby increasing positive health behaviors for better outcomes. Decreasing levels of depression and anxiety, can also lead to better health. It is essential to emphasize that risky behaviors linked to distress can be modified. Interrupting the progression and manifestation of psychological distress to decrease negative health behaviors and increase positive health behaviors, can decrease the risk of cancer recurrence, negative mental and physical health, and improve overall quality of life (Harding, 2012, Rabin, 2011).

Overall Quality of Life

Distress experienced by cancer patients leads to poorer quality of life and can negatively impact survival. In a longitudinal study in breast cancer patients, distress explained 46% of the variance in health-related quality of life measures at baseline and 44% six months after recurrence (Sarenmalm, Ohlen, Oden, & Gaston-Johansson, 2008). In concordance with the large portion of cancer patients reporting significant distress, half of a newly diagnosed cancer patient population reported being dissatisfied with their quality of life (Hulbert-Williams, Neal, Morrison, et al., 2011). Quality of life in cancer patients is related to stage of cancer diagnosis, treatment type, performance status, physical exercise ability, depression, older age, unemployment, pain, appetite, and spirituality (Kreitler, Peleg, & Ehrenfeld, 2007). However, perceived social stress is more predictive of quality of life than health related stressors, including stage and time of diagnosis, and treatment status. Kreitler, Peleg, and Ehrenfeld (2007) argue that social stressors entail more emotional salience and are more personal than health-based stressors. In this view, social stressors, including positive and negative emotions, coping, family, sexuality, cognitive functioning, sense of control, and meaning, are viable areas of intervention to improve cancer patients' overall quality of life.

Patients' baseline health related quality of life score is predictive of overall survival (Gotay, Kawamoto, Bottomley, et al., 2008). Specifically, a meta-analysis indicated that global quality of life and physical functioning predicted survival more often than other patient reported outcomes (Gotay, et al, 2008). Better patient-reported outcomes predicted survival. A ten-year longitudinal analysis of patient quality of life and survival demonstrates that patients reporting poor quality of life indicated a median

survival of 1.5 years versus 5.6 years in those with good quality of life (Sloan, Zhao, Novotny, et al., 2012). Patient-reported quality of life is a warning system for survival status and need for psychosocial intervention. Analysis of predictors of survival shed light on the possibility that interventions improving patient reported quality of life can improve patient suffering and possibly survival (Gotay, et al., 2008). Health related quality of life is important to to assess the impact of chronic disease on subjective life experience (Guyatt, Feeny, & Patrick, 1993). The impact of chronic disease states on distress and quality of life varies for individuals depending on personality, clinical criteria, and contextual factors. Personalized assessments allow care-teams to address patient status and highlight areas of intervention to improve patient subjective quality of life and possibly survival.

Early Detection and Intervention

Assessing levels of distress can determine factors relevant to patients' overall quality of life and disease trajectory (Quinten, Maringwa, Gotay, et al., 2011). Previous procedural analyses indicate that clinicians fail to recognize the existence and severity of cancer patients' distress symptoms which remain under or overestimated (Fromme, Eilers, Mori, Hsieh, & Beer, 2004; Mitchell, Hussain, Grainger, & Symonds, 2011; Sollner, DeVries, Steixner, Lukas, Sprinzi, Rumpold, & Maislinger, 2001). Distress includes physical complications and distress measures should be a part of the routinely administered clinical care package (Bidstrup, Johansen, & Mitchell, 2011). Having a multidisciplinary team address the multifactorial nature of distress symptoms can allow for improved outcomes (Whitmer, Pruemer, Nahleh, & Jazieh, 2006). Addressing these

symptoms early and providing treatment can elicit improvement in patient outcomes in both physical and psychological states along with overall quality of life, while improving medical management (Holland, Anderson, Breitbart, Buchmann, et al., 2013). By initiating early detection, communication regarding patient's unmet needs arise allowing for direct, comprehensive interventions and referrals necessary to improve distress symptoms (Bidstrup, Johansen, & Mitchell, 2011; Holland, Anderson, Breitbart, Buchmass, et al. 2013; Meijer, Roseman, Delisle, et al., 2013).

Early detection and treatment has been found to decrease distress symptoms overtime with the use of distress-sensitive measures and available treatments. Patients screened with high levels of distress can experience effective improvement in distress levels with the inclusion of targeted interventions. Such interventions have been found to be most effective for groups known to have distress, such as patients suffering from later stage cancers, lung cancer, and head and neck cancers (Bidstrup, Johansen, & Mitchell, 2011). In examining three variations of screening using the distress thermometer in an outpatient cancer population, lung and breast cancer patients experience alleviated symptoms of distress following appropriate triage 3 months after screening, compared to a minimal-screening intervention group (Carlson, Groff, Maciejewski, et al., 2010). Lung cancer patients with high levels of distress benefited most from the triage intervention as do most with the higher levels of distress. Early detection and effective intervention models leading to improved distress levels can therefore prevent worsening of negative symptoms (Carlson, Groff, Maciejewski, et al., 2010; Holland, Alici, et al., 2010). The intervention group receiving both distress assessment and treatment including psychoeducation, CBT, and supportive-expressive therapy treatments within a

radiotherapy patient population, experienced a significant decrease in anxiety and depressive symptoms, and significantly higher scores in health, physical, and emotional functioning (Guo, Tang, Tan, Feng, Huang, Bu, & Jiang, 2013). Screening measures sensitive to elevated and marked levels of distress are found to be most beneficial when paired with compatible resources present for patients presenting with distress (Carlson, Groff, Maciejewski, et al., 2010; Bidstrup, Johansen, & Mitchell, 2011).

For effective distress screening implementation, procedural factors must be considered to achieve the overall goal of decreasing cancer patient distress and improving overall disease experience. Screening can theoretically lead to the inclusion of patients who experience distress that would otherwise be missed and only detected when severity of symptoms increases (Mitchell, Hussain, Grainger, & Symonds, 2011). Alternatively, application of poorly sensitive distress screening tools can lead to the inclusion of patients who experience “short-lived,” and expected levels of distressing emotional responses to disease diagnosis and treatment (Bidstrup, Johansen, & Mitchell, 2011). With the inclusion of patients experiencing subclinical levels of distress, referral resources can be misused. Sensitive and specific screening tools must be utilized before and during implementation to ensure appropriate triage. All patients screened for presenting distress do not need further psychosocial services (Meijer, et al., 2013). Finally, distress screening is much less effective without applicable psychosocial resources for patient interventions available (Meijer, et al., 2013).

Analysis of effectiveness of implemented distress screening measures and models utilizing limited mental health care-teams are of great interest and need to be evaluated. Walker, et al.’s (2014) meta-analysis of systematic integrated management in cancer

centers that provided screening and treatment for major depression, concluded this integration to be cost-effective, robustly by several measures, and to be a more effective way of increasing patients' quality adjusted life years (QALY). More research supporting such findings is needed. In this way, screening and referral procedures can distribute limited resources to patients most in need and who desire psychosocial support. Care teams can then award the most beneficial and efficacious interventions to improve patients' quality of life and health status. Early detection using sensitive distress screening measures within a collaborative clinical care package leads to improvements in overall levels of distress. Decreasing and managing levels of distress through cancer treatment can improve treatment decision-making, decrease negative and increase positive health behaviors, improve medication and treatment adherence, and enhance overall quality of life. Changes in patients' illness behaviors and mood can translate to increased medical management, disease management, care-team and patient communication, decreases in office visits, levels of anxiety and depression, and overall quality of life for both patients and health care teams.

Challenges and Barriers to Identification and Treatment

Several centers and psychosocial care teams have reviewed prominent barriers to implementing distress screening and care within cancer centers throughout the world (Holland, 2004). The barriers present include the lack of resources, change to the traditional care model, provider challenges, communication barriers, nonspecific project management, patient factors, and a lack of cohesiveness within team members (Dolbeault, Boistard, Meuric, Coperl, & Bredart, 2004; Holland, 2004; Jacobsen,

Donovan, Trask, et al., 2005; Whitmer, Pruemer, Wilhelm, McCaig, & Hester, 2011). Primarily, psychosocial care teams suggest that there is a need for a unified tool to reliably and quickly measure presenting distress (Dudgeon, King, Howell, Green, Gilbert, Hughes, Lalonde, Angus, and Sawka, 2012). Distress scores are interpreted by care team members to assess patient functioning and then translated for appropriate clinical interventions (Jacobsen, et al., 2005). The lack of a unified tool to measure patient distress complicates this assessment and the intervention triage process for care teams (Dudgeon, et al, 2012). Utilizing distress specific measures to identify distress throughout clinical care packages leads to higher inclusion of distress factors in patient-physician conversations later on and often requires further intervention (Fann, Ell, & Sharpe, 2012). Current attempts to modify procedures to implement distress screening within psychosocial care teams has suffered from financial obstacles as resources are limited (Mehta & Hamel, 2011; Dudgeon et al., 2012). In centers where psychosocial care staff are few, implementing distress screening has led to overwhelmed psychosocial caregivers with hospital administration unable to fund additional psychosocial care (Dudgeon et al., 2012). The screening process provides awareness and representation for the cancer patients' distress experience, but screening also requires that appropriate treatments be available (Carlson & Bultz, 2003). The lack of financial and human resources is a problem in both psychosocial care teams, as well as, nursing care teams (Grassi, Rossi, Caruso, Giulia Nanni, Pedrazzi, Sofritti, & Sabato, 2011). Distress screening can be initiated by many means including paper-format, computerized-administration, or interpersonal contact yet follow-up requires personal contact with the patients, similar to current pain assessments administered by nurses (Jacobsen, Donovan, Trask, Fleishman,

Zabora, Baker, & Holland, 2005; Taenzer et al., 2000). Nurses have been overwhelmed with the addition of distress screening as another aspect of screening and care they are required to provide (Dudgeon et al., 2012). The time, flexibility, and structure of implementing distress screening per nurses or psychosocial care teams must be specified and developed prior to implementation and adjusted through piloted attempts (Fann, 2012). The lack of a unified distress tool and prevailing time and resource restraints in nurse and psychosocial care team schedules for implementing screening tools are definitive barriers to carrying out current implemented standards.

Guidance, coordination, and centralized management have been consistent barriers in implementing distress intervention standards (Dudgeon et al., 2012). Lack of a designated distress team leads to dispersal and inefficiency in the mandated triage process. Growing numbers of psychosocial practitioners within interdisciplinary teams are expanding throughout centers, leading to less standardized interventions (Taenzer et al., 2000). Dudgeon (2012) and Fann (2012) propose the need to resolve the organizational fragmentation by assigning a designated project manager who will be able to promote the coordinated implementation of distress screening and improving referral implementation and access. Dudgeon (2012), Fann (2012), and Jacobsen (2005) explain that resistance to changing the traditional biomedical models used by many cancer centers has been difficult to overcome. Resistance comes from providers who feel they are either already assessing for distress through different screening and interpersonal exchanges, or that they are ill-equipped to assess for distress and psychological correlates (Holland, 2004, Holland et al., 2013). Though physicians and nurses indicate that they are currently assessing for levels of distress, White (2012), Sanson-Fisher (2000), Boyes

(2012) conclude that patients' needs remain unmet. Significant elevated distress and unmet needs indicate a systematic inability to screen, identify, and refer for appropriate therapy during cancer treatment. Concurrently, analyses looking at nurse and physician sensitivity and specificity to distress indicate a lack of awareness and underestimation in levels of distress (Fromme, Eilers, Mori, Hsieh, & Beer 2004; Mitchell, Vahabzadeh, & Magruder, 201; Okuyama et al., 2011; Sollner et al., 2001). As physicians and nurses are not trained to assess distress, it is important to have specialists present within centers who can reliably address psychosocial issues. Simultaneously, patient and physician stigma to psychological and social difficulties is also a consistent barrier. "Distress" has been used to compensate for aspects of this stigma, but the lack of training, unspecified awareness, and overarching stigma of psychological and social distress from physicians and nurses is a prominent barrier.

Overall, several cancer centers have begun integrating psychosocial screening and referral services and have addressed the mentioned pitfalls that have been found through personal report and quality assessment measures in review articles. Most prominently, the University of Calgary, Medical Center and The Moffitt Cancer Center, Tampa, Florida have lead in this implementation process. In 2004, during the International Psycho-Oncology Society Conference, the review of barriers met within various cancer centers during attempts to improve psychosocial care concluded four distinct challenges: "Historical and cultural attitudes, research challenges, integration of psychosocial care into routine care, and the global perspective and priorities" (Holland, 2004, pg. 447).

Historical and Cultural Attitudes

Jacobsen (2007) reviewed the challenges and opportunities of psychological distress in cancer patients by classifying challenges to include instrument tools reliable and valid for screening and referral needs, and “strong evidence” indicating that “care delivered consistent with these guidelines...yields better control of distress than care delivered inconsistent with these guidelines” (pg. 4527). A review completed by Dudgeon et al. on fourteen regional cancer centers in the province of Ontario, Canada reported the main challenges to meeting goals of screening and referral include, process barriers of lack of consensus on tool and referral marks, resource/monetary constraints, and “people and culture” including physicians and nurses who were notably resistant to work-flow changes and felt they currently addressed such factors (Dudgeon et al., 2012, pg.261). Dudgeon et al. (2012) summarized the essential to success specific to these fourteen centers to the inclusion of a “centralized project management [including] a person dedicated to implementation of the project locally, regional engagement, clearly identified aims, monthly data reporting, and implementation of quality improvement methodologies with expectations for performance” (pg. 361). Other factors of success reported by Dudgeon et al. included psychosocial care teams distributing resources, information, and creative problem solving techniques between clinics, involvement of senior leaders and clinician managers, data analysis for tracking use of tool implementation, and lastly volunteer involvement (Dudgeon et al., 2012). Of the reported barriers and successes listed above, Loma Linda University Medical Oncology clinics faces many and has surpassed few.

Previous Needs Assessment at LLUMOC

To begin, a needs assessment was completed on two different time points in 2012 ($n_1 = 22$ and $n_2 = 31$) by Dr. Jason Owen and psychology interns at Loma Linda University's Medical Oncology clinic. Analyses of current patient distress indicated a mean of 5.3 and 4.2, respectively, on an 8 point distress thermometer, where higher scores indicated higher distress. In the second sample, over half of the sample (55%) indicated experiencing significant distress, distress thermometer score ≥ 4.0 . Analyses of types of needs in both samples concluded the highest percentage of needs relating to nutrition and "being prayed for" 75-85%, followed by exercise 57-65%, education about cancer and treatment 48-60%, support or internet group 35-40%, counseling 30-40%, spirituality 10-20%, and thoughts of ending life 4%. Patients reported prevalent physical problems including fatigue 35%, sleep and/or memory problems 30-35%, neuropathy 30%, constipation 22%, pain 12%, sex 12%, eating 12%, and symptom/side effects 10%. It is evident here that LLU patients acknowledge needs in various areas related to all aspects of the biopsychosocial nature of their illness, and currently require psychosocial screening and assessment.

Conclusion

As evidenced throughout this review, psychosocial services are needed throughout various cancer patient populations and can benefit both patients and providers. If a proper screening and referral system is initiated, all interested cancer patients would be able to address unmet needs through our services, to increase medication and treatment adherence, increase positive health behaviors, decrease

negative health behaviors, increase psychoeducational aspects of illness presentations, improve illness related decision making and improve overall quality of life. Physicians and hospital care teams can improve through cost saving measures to decrease extraneous office and emergency room visits, improve patient-physician , improve patient conceptualization and treatment of disease state, to treat patients in a biopsychosocial-spiritual and patient-centered model.

As Loma Linda University currently provides services to individuals through a non-designated referral system with few psychosocial care team members, there are distinct areas of growth and integration required for LLU to meet the CoC standards of care. The purpose of this project is to review barriers and successes of the current care model for psychosocial needs at LLU Medical, Radiology, and Surgery Centers, and present suggestions for change and growth to successfully meet the CoC standards with semi-structured interviews of key stakeholders at LLU and at another site that is successful in meeting the CoC standards.

CHAPTER TWO

METHOD

Participants

My experience working alongside social worker within the LLUMOC are included. Three key stakeholders in Loma Linda University's Medical Oncology Clinic and two key stakeholders at the City of Hope and Cedar Sinai Medical Center will be interviewed after consent is obtained to assess their successes and failures, and models of improvement which have led to meeting ACoS CoC standards to evaluate patients' psychosocial status and to provide appropriate triage, referral, and treatment when warranted by the patient's clinical status (CoC, 2012). In this way, improvement strategies and options from current efficient models can potentially be used at Loma Linda University's Medical Oncology Clinics. To translate and deliver the findings from these semi-structured interviews, I will present a comprehensive and cumulative review to the boards of administration and care team members involved in Loma Linda University Medical Oncology Centers. This review would include review of current progress, needs assessment findings, key stakeholder experiences, suggestions for improvement and directions of change, and availability to respond to needs and concerns posed by the audience to successfully meet ACoS CoC standards of care.

Data Collection: Interviewees

1. Talolo Lepale, LCSW LLU Medical Oncology Center, Social Worker & Psychosocial coordinator, April 27, 2015.

2. Gina Mohr, MD, *Palliative care specialist*, Primary care Physician, Loma Linda Medical Center, June 5, 2015.
3. Cheri McDougall, *Nurse Supervisor* LLU Medical Oncology Center, May 4, 2015.
4. Deane Wolcott, MD, *Director of Supportive Cancer Care* of Cedars Sinai Medical Center (2 Interviews), May 8, 2015; May 29, 2015.
5. Matthew Loscalzo, LCSW of City of Hope, *Director of Supportive Case Services*, June 5, 2015.
6. Judy Chatigny, MBA and Mark Reeves, MD, Cancer Center Director and Executive Director

Measures

Semi-structured interviews will be conducted to engage in dialect regarding personal views of the ACoS CoC standards process within each respective hospital setting. Individuals will complete a consent form indicating awareness that information will not be confidential, unless requested. Interviews will last 45-60 minutes in length and be recorded for reviewing and citation purposes. Interviews will include personal information relating to individual's title and main responsibilities, experience and familiarity with ACoS CoC standard, historical experience at specific cancer center, assessment of needs per cancer patients, subjective view of cultural changes, reports on monetary and managerial support, view of barriers and successes, improvements in patient care, and review of current progress and need for change in relation to LLUMOC and the interviewees respective clinic. Please refer to Appendix A for Loma Linda

University Interview outline form and Appendix B for External Cancer Center Interview outline.

Procedures

Semi-structured interviews were conducted in person. They were recorded through a locked iPod device as an mp3. Data were kept confidential unless interviewees request otherwise. Recorded interviews, notes, and word documents of data were kept confidential in password-protected files on a password protected personal computer. All interviews were recorded and reviewed to identify conceptual codes related to the Loma Linda University Cancer Center, City of Hope, and Cedars Sinai Cancer Center health systems. All interviewees were asked to review their respective clinic status on psychosocial screening and referral, monetary funding for the program, and strengths and weaknesses. Additionally, all interviewees were given information about the current status of the LLUMOC screening and referral process. They were then prompted to specify related strengths and weaknesses within the program at LLUMOC, along with weaknesses/barriers, and suggestions for change. See Appendix A & B for semi-structured interview outlines. Taxonomy and thematic analyses were conducted to analyze the data collected through the interview process (Bradley, Curry, & Devers, 2007). A code structure was developed through iterative process while reviewing interview recordings, preliminary codes were included as well. See Table 1 for complete code list (Aronson, 1994).

Table 1 Qualitative codes utilized for thematic interpretation of interviews with key stakeholders and providers

Qualitative Codes	
1	Time
2	Privacy
3	Access to referral/follow-up
4	How to address differences severity distress
5	Skills to address distress (need training)
6	Money
7	Cultural Factors
8	Fear
9	Need for Psychosocial coordinator
10	Knowledge (lack of provider education)
11	Concern about distress effects on patient
12	Tool (need change/or good)
13	Staff consistency/ need for follow up
14	Problems with reassessment
15	Computerized referral
16	Decisional change importance
17	Need for more Supportive care providers
18	Electronic tool helpful
19	Lack of Community resources
20	Administration supportive/lack
21	Physician involvement
22	Focus too much screening/ not on services
23	Emphasis on comprehensive benefit
24	Ethical requirement
25	Increase efficiency
26	Survivorship concerns
27	Lack of integration with physician, nurses, etc.

Semi-structured interviews were typed out verbatim and codes were identified for interviewee responses. Codes with compiled for each interview by interviewee. Strengths and weaknesses for each hospital were totaled. Strengths and weaknesses for LLUMOC were put together in a separate column and each code was identified for importance by frequency and relative percentage of all total codes combined. As utilized in other health

services research, and outlined in Bradley, Curry, and Devers' (2007) paper on "Qualitative Data Analysis for Health Services Research," a taxonomy classification system was applied to evaluate the multifaceted implementation of intervention to promote clearly communicated concepts.

CHAPTER THREE

RESULTS

Results of qualitative coding measures and analysis will be included italicized throughout text. See Table 1. To begin, a review of LLUMOC current program from the direct experience of this author is provided along with personal suggestions. Next, a review of current progress at LLUMOC compiled from experiences of LLUMOC providers is included. I then review current psychosocial programs at Cedars Sinai Medical Center and City of Hope. Results of qualitative analyses assigning codes to interviewee data and highlighting frequency of codes by importance are provided in two separate sections. See Table 2. The first section reviews suggestions from psychosocial care directors from City of Hope and Cedars Sinai Medical Center. The second section reviews suggestions from psychosocial care providers within the LLUMOC.

Table 2. Review of thematic codes of LLUMOC strengths from six total interviews

Category (code)	Code Frequencies	Percentages of LLU Strengths	
		% of total	% of category
Lack of Resources			
Money	0		0%
Need for Psychosocial coordinator	1		100%
Need for more Supportive care providers	0		0%
Lack of Community resources	0		0%
Total	1	2.0%	
Change to Traditional Care model			
Time	0		0%
Cultural Factors	1		12.5%
Fear	0		0%
Decisional change importance	2		25.0%
Administration support	5		62.5%
Total	8	16.3%	
Provider Challenges			
Skills to address distress (need training)	1		20.0%
Knowledge (lack of provider education)	2		40.0%
Staff consistency/ need for follow up	2		40.0%
Total	5	10.2%	
Nonspecific Project Management			
Privacy	0		0%
Focus too much screening/ not on services	0		0%
Ethical requirement	2		100%
Total	2	4.1%	
Patient Factors			
How to address differences severity distress	0		0%
Concern about distress effects on patient care	1		100%
Survivorship concerns	0		0%
Total	1	2.0%	
Cohesiveness			
Physician involvement	1		33.3%
Emphasis on comprehensive benefit	1		33.3%
Increase efficiency	0		0%
Lack of integration: physician & nurses	1		33.3%
Total	3	6.1%	
Unified Tool			
Tool (need change/or good)	1		10.0%
Electronic tool helpful	9		90.0%
Total	10	20.4%	
Model of Triage			
Access to referral/Follow-up	1		100%
Problems with reassessment	0		0%
Computerized referral	0		0%
Total	1	2.0%	
Complete Total	49	100%	100 %

Note: LLUMOC total strengths include compilation of all codes for all interviews combined.

Personal Review of Historical Experience

I will begin explaining from the start of my experience being involved in Loma Linda University, Medical, Surgery, and Radiation Oncology Centers history of implementation of the American College of Surgeons, Commission on Cancer (ACoS COC) psychosocial screening and referral requirements. In order to receive continued accreditation as an ACoS COC cancer center, standard 3.2 must be implemented designating psychosocial services to all cancer patients in need. Historically, the Medical Oncology department at Loma Linda University has supported psychosocial services by funding clinics for two social workers within the infusion and radiology clinics. In an attempt to meet these standards and to improve services offered at this center through a successful screening and triage program, a team of clinicians, researchers, and administrators were brought together to begin assessing feasibility and functional application. Dr. Jason Owen, a full-time health and psycho-oncology professor and researcher, became involved in the implementation of psychosocial care, with Talolo Lepale, LCSW (Medical Oncology/Infusion), Mildred Saravia-Guzman, LCSW (Radiation Medicine), and Carol Davis (PsyD, Radiation Medicine; Educator) to join forces with administration, nurses, and physicians hoping for effective implementation. These meetings were motivated by Dr. Owen and Talolo, and were managed and planned by a hospital administration liaison. This liaison planned monthly meetings which lasted about an hour and a half to review necessary information, directions of movements, feasibility of implementing the screening, and creating a well-designed triage referral process all through an interdisciplinary approach. Throughout these monthly meetings, each designated party had limitations and directional goals of their own; administration

was concerned about feasibility of costs and resources, charge nurses were resistant to increase staff workload, physicians recognized the need but were unsure of appropriate directions, and psychosocial staff were trying to be confident, direct, and firm with the need to implement essential psychosocial services patients were lacking.

Over a few meetings the administration, physicians, and nurses began to formulate a sense of excitement to implement the triage process, meeting patients' needs, and improving our patient care and flow throughout the cancer center. Each individual was vocal and involved in the meeting. Changes were beginning throughout patient care, particularly for patients' having major psychosocial symptoms that led physicians and nurses to feel ill-equipped to assist. A notable aspect of success included having an administration representative planning and managing meetings, facilitating communication between all members, summarizing and presenting changes towards the goal by each team, and promoting directional process change. Concurrently, the interactions between physicians, administration, nurses, and psychosocial members within the meeting included reviews of the logistical application of psychosocial screening and triage processes including perspectives of all team members. Parties reviewed their perspectives of the applicability and potential roadblocks in implementing screening that could lead to further difficulty and decreased functional success within patient care. Specifically, a main focal point requiring decisional review included comparing paper or electronic/verbal format of the screening. The paper format was reported as being difficult to administer on the side of nurses, and creates greater steps in inputting screening data and triage success. The electronic application of screening allows for more a successful triage process and data collection, once an IT

implementation could be applied. Yet electronic application is only possible with either nurses inputting information on their own, requiring a verbal conversation about a patient's psychosocial distress or an electronic tablet provided to patients to complete the distress screening on their own. With an electronic screening tool that is verbally administered the honesty of a patient's response may be adjusted if level of comfort with their nurse is minimal, while jeopardizing confidentiality. It was also addressed that if a patient was critically in-need emotionally while screening took place, nurses were untrained to deal with presenting symptoms and struggles, e.g. suicide ideation. Additionally, questions about whether adequate referral resources available for those with a positive screen and those with a very high screening score were even available with these two processes. Deciding on a short but effective screening measure that would allow nurses to complete the measurement quickly, and retrieve substantial psychosocial information became a continuous struggle. During these meetings it was decided that measures would happen quickly before the patient was seen by the doctor or while receiving infusions. Significantly, the lack of follow-up treatment resources led to the majority of patients with positive screening scores unable to schedule timely appointments (within one month of screening) with the social worker, or a lack of referral appointments all together. A more confidential and practical model of assessment would be through assessments, which utilized an electronic tablet. Administration indicated funds were unavailable for a separated electronic tablet format.

Commission on Cancer requires that patients' assessment be multi-faceted addressing not only specific psychosocial measures, but also financial needs, physical functioning, side effects to chemotherapy/radiation treatment, and pain requiring a

psychosocial measure which would address all necessary issues succinctly. At Loma Linda University Medical Oncology Center, spiritual assistance is provided and functions as a present strength. Psychosocial screening began through paper format and continued to be administered to about 70% of patients. Within the application of the CoC requirement, nurses began to appropriately sort patient distress responses by previously marked assessment threshold scores of which patients required triage application and referral. If the patient scored per moderate levels of distress they were directed and connected with appropriate triage services indicating which providers they could meet with for assistance. If the patient scored at a severe level of distress, a psychosocial team member was paged immediately for direct service and intervention. As a result, this triage process required follow-up by several departments including psychology, social work, chaplaincy, pain management, physician symptoms management, and nursing. Throughout this triage process, it became apparent that the necessary psychology and social work staff were scarce. Nurses reported sufficient time for current physician patient care requirements, yet difficulty regarding time to apply the additional psychosocial assessment to each patient. Additionally, there was no system for tracking screening scores and referral follow-up which is a necessary requirement for documenting adherence to the ACoS guidelines. The variety of team members relayed their concerns about application difficulties and reaching a decision point became perplexing. The administration associate responsible for designating the choice and form of implementation also reported limitations in financial resources delaying a conclusive plan. For separate reasons, the secretary of administration coordinating these meetings and the psychologist leading these meetings moved on to different jobs elsewhere. Loma

Linda University's Medical Oncology culture required the top of the hierarchy administration, to approve and enforce steps to follow. Unfortunately, this was unable to occur as a result of a lack of monetary resources to further support the application of the multi-faceted CoC standard.

After meetings came to a halt, implementation efforts continued. Though continued implementation problems arose requiring analysis and change. Most distinctly, using paper format for assessment and triage disabled the ability to analyze and compute data reviewing application and use of this process. Yet, nurses and social workers indicated this process to be most effective. Without this system of analysis, measuring the success of patients who had been assessed and triaged appropriately to find areas lacking efficiency would rely on unreliable, personal reports. Screening and referral implementation data are essential to support any future administration or grant funding for psychosocial assessment and treatment throughout the cancer center. Without evidence of measurements of the screening implementation, grant funding and further support from outside agencies is impossible. Having the technology team involved in this area could assist in creating a functionally appropriate administration tool, electronic triage system, and directly attainable system analysis of current performance. At this moment, a relationship with psychosocial staff and IT is consistently being pursued, with little success.

With the departure of the leading members for team meetings, a position for an alternate individual to replace the role of planning and coordinating these meeting became apparent. As a Psychology doctoral student who had been present at most meetings and was shadowing therapy sessions and patient care management meetings

with social worker Talolo Lepale, I was eager to take on the managerial role.

Unfortunately, I was unable to become the coordinator as there was no available psychologist to supervise me in the process of re-formulating this workflow, assessing progress through patient data, and engaging with patients. The psychosocial team began meeting on their own, while utilizing my knowledge of research and clinical application.

Psychosocial team meetings then began to include solely psychosocial team members who would meet in a small group once a month and review their current progress and areas of growth. This was a meaningful meeting as they could update each other on status of implementation programs within the radiation, surgery, and infusion centers but did not result in much change. The reviews completed within these meetings included addressing the lack of essential referral resources and the “effectiveness” of paper format tool given to patients. A major concern was that while paper format seemed to flow easily in the clinic process, it resulted in subjective reports of implementation as there was no quantitative support, progress was limited to individual improvements in each department, and lack of comprehensive team care integration. Administration, nurses, and physicians were not a part of these meetings, limiting interdisciplinary change throughout the Oncology clinics, further supporting the requirement of a designated staff member.

Opportunities legitimizing further investment through administration or grant funding are limited with a lack of clinical researchers and quantitative scores representing patients’ needs and utilization of services. Lack of a clinical researcher translates as a limiting facet of psychosocial services at LLU Cancer centers. Simultaneously, current practitioners are not familiar with research in the field of concurrent clinical applications

in other centers to utilize as models, and knowledge of applying evidence-based treatments and protocols was limited to my involvement and limited insight.

At this time, the psychology post-doc and Talolo Lepale gave a succinct presentation on the importance of psychosocial care on patient symptom prevalence and outcome to surgeons and residents throughout the Loma Linda University Medical Oncology Center Cancer committee monthly meeting. Many of the surgeons who work directly with cancer patients received the meeting well and were intrigued to continue the conversation after the presentation was done. There was clear support from a number of the physicians. Engaging in training modules to educate and lead current team members through evidence-based practices will be beneficial for overall program success.

As the goal to implement an effective referral system to meet American College of Surgeons Commissions on Cancer requirements for psychosocial services was stunted by decreased organization and involvement of administration and physicians, responsibility to carry on changes in the program relied on our limited psychosocial team members. Each member of the psychosocial staff had to create a network of referrals throughout our community to accommodate the volume of referrals. As each psychosocial team member was in charge of providing services to a separate clinic on their own, time to review application success and areas of change was quite limited. As a result, the referrals to the psychosocial program became unfocused and uncoordinated, as each therapist worked on their own model of triage in relation to the multidisciplinary team, stunting coordination of growth and utilization of team services. Notably, a designated meeting manager was in need to stimulate focused and continuous change supported by evidence-based methods, techniques, and practices.

In an effort to connect patients with further services, I created a list of therapists in the area that felt able to provide for psycho-oncology patients, along with updating a list of cancer support groups in the inland empire. Adding my own additional clinic hours to provide care to patients as part of the cancer center team was a mentioned opportunity but was unable to be carried out. The supervisor position was going to be appointed to one of the clinical social workers currently in place, yet administrative change to create my own clinic hours and patient care was unsuccessful.

Recommendations Based on Previous Experience

After over a year of successful integration with both onsite and offsite practice and research, I have provided a review of my experiences including areas of success and need throughout the Loma Linda University Medical Oncology Center's attempt to implement the ACoS CoC standard 3.2 psychosocial screening and referral care requirement. Beginning with screening, administering a formulated screening template through the use of electronic tablets is necessary to ensure confidentiality, deliver direct electronic triage to referrals, and provide the ability to track and measure quantitative progress within the screening and triage process. Having the power to quantitatively analyze the implementation process could legitimize further grant or administrative funding, while providing distinct information on valuable directions of success and limitations. Losing the administrative assistant who coordinated the team-members meetings and losing the psychology clinical researcher led to a halt on interdisciplinary application and change required to successfully implement this new standard. Investing and designating a new coordinator whose focus will include the development of this program will be beneficial

in functioning as a focal point and providing direction, as seen in many other successful centers. With a designated new coordinator, the strengths of each department could coalesce to formulate the required multi-faceted team. Resistance on behalf of administration and care teams decreased as administration and psychosocial care staff supported the need for these changes. The first few steps of this process have already been completed in that Loma Linda University Medical Oncology Center integrates many disciplines within one location including physicians, nurses, social workers, psychologists, nutritionists, and chaplains addressing patients' needs. Having this team already consisting of many disciplines and successfully meeting at a consistent monthly manner to review progress and areas of growth fosters change and places our center ahead in meeting the ACoS standard. In addition to these steps, emphasizing the evidentiary support for this required program to all personnel could bolster and motivate practitioners to translate research into practice and provide the standard of care required to meet their goal. In conclusion, I have designated areas of need for the success of implementing the ACoS CoC standard 3.2 at Loma Linda University in hopes of successively providing patient centered services to oncology patients in need.

Therefore the limited psychosocial care team at LLUMOC prevents effective and sufficient treatment options for patients' needs at LLUMOC. The lack of a psychosocial coordinator designated to this process, lack of integration promoting the service by physicians and administrations functions as a major barrier to achieving ACoS standards. Lastly, having an electronic format that can be tracked with system reports prevent assessment of our program and evidence to support grant funding for further projects.

Current Progress of Psychosocial Screening & Referral at LLUMOC

A review of current progress for the Loma Linda University Medical Oncology Center, Medical Oncology service is provided below. Information for this review was gathered by interviews with three stakeholders involved in the psychosocial screening and referral process at LLUMOC; McDougall, Nurse Supervisor (personal communication, May 4, 2015); T. Lepale, Psychosocial coordinator (personal communication, April 27, 2015); G. Mohr, Palliative care specialist (personal communication, June 5, 2015). Current psychosocial team members report that 90% of new patients are being screened before physician visits. The nurse supervisor and psychosocial coordinator noted that screening before physician visits is most feasible (McDougall, personal communication, May 4, 2015; T. Lepale personal communication, April 27, 2015). This screening measure includes a nurse asking cued questions through the LLUMOC electronic medical record Loma Linda Electronic Access Portal (LLEAP) and encoding patient responses to markers in LLEAP. The nurses or medical assistants serve as mediators in the communication between patient responses and input into the patient's electronic medical record. The form in LLEAP includes the "Distress thermometer" which incorporates a zero to 10-point Likert-scale rating for current distress (Zwahlen, Hagenbuch, Carley, Recklitis, & Buchi, 2008; McDougall, personal communication, May 4, 2015; T. Lepale, personal communication, April 27, 2015).

If the patient responds below a score of four, a script is prompted for the nurse to read which includes feedback on the patient's management of current distress, a brief explanation of psychosocial distress, and then the patient is given the ACoS booklet on distress. If the patient scores between 4-7, considered significant distress, a different

script is prompted for the nurse. This moderate level of distress prompt includes normalization that the patient is experiencing some distress, and the patient is asked to qualify what aspects of life his/her distress is related to (financial, psychological, spiritual, symptoms, pain, etc.). Depending upon patient rating and specification of distress, the patient is triaged to the appropriate care provider. The referral process is not yet an automated system, which has been reported as a significant barrier for the cancer center (McDougall, personal communication, May 4, 2015; T. Lepale, personal communication, April 27, 2015). Contact on July 15, 2015 with the nurse supervisor confirmed that the referral process which should input patients' screening score responses and lead to a direct and appropriate referral within the LLEAP electronic system has still not been applied.

For onsite referrals, when a patient is reporting significant distress related to social work services, the patients' distress scores are noted to the patients' chart within LLEAP. High distress scores of eight or higher trigger an email message to the social worker on staff and will indicate specificity for follow-up; be it time intensive, financial concerns, psychological distress, etc. The psychosocial coordinator reported that he would like this referral process to be automated for most screening and referral success. The referral process is not currently automated. This automated referral would include an encounter created immediately along with a direct link to the scheduling department to create a clinic visit with the patient and social work/chaplain/pain management/physician services. With an automated referral system, psychosocial care team providers and administration would be able to keep track of patient screening progress and follow-up as required by ethical guidelines; this process cannot be tracked currently and patients may

be lost to follow-up as a result.

Additionally, scoring eight or higher on the distress thermometer is considered a crisis event. Currently a mobile page is sent to the psychosocial provider on staff for that team. The goal being that one of the psychosocial providers would be able to speak to the patient before the end of their visit, and most importantly assess the patient's current level of safety/suicidality (T. Lepale, personal communication, April 27, 2015).

According to the psychosocial coordinator, there are not enough staff members available. For days that he is previously scheduled with a full clinic of patients, social work availability to meet with crisis patients is extremely limited. Lack of provider time leads to the patient in a crisis waiting for many hours and available nurses are ill-equipped to provide intervention for psychosocial distress (McDougall personal communication, May 4, 2015). Commonly, the nurse will then clarify the severity of the crisis, if a mandated report is necessary, and designate a time the patient can return within 48 hours though this is not the standard of care. It is unclear at this time the success of patients presenting for follow up assessment because these referrals cannot be tracked at this time.

Currently, there are only two full-time licensed clinical social workers throughout the medical oncology and radiation medicine centers. One social worker is also designated as the psychosocial coordinator for the cancer center. Additionally, this individual supervises two students, one MFT doctoral student and one psychology doctoral student. These individuals partially cover clinic at surgery oncology clinics. An unlicensed psychologist is the educator for proton therapy and does not provide therapy. All together the LLUMOC-Medical Oncology psychosocial care team includes two full-time social workers and three other part-time providers. As providers reported 90% of

patients are being screened, this translates to increased patients identified for needed interventions, yet provider resources are not consistent with this increased demand and inappropriate wait times for care.

Within the LLEAP distress tool there are areas requiring further improvement. Currently the psychosocial coordinators reported that 90% are being screened which is above exceeded expectations, and before seeing a medical provider. Screening before the visit is optimal based on previous clinical examples (Jacobsen et al., 2005; Kircheiner et al., 2013). However, re-assessment required by the ACoS guideline, is not occurring frequently (McDougall, personal communication, May 4, 2015; T. Lepale, personal communication, April 27, 2015). As seen in our previous needs analysis conducted in 2013, over 50% of cancer patients receiving care at LLUMOC indicated elevated distress and desire for further support. In addition, patients reporting elevated distress are receiving suboptimal follow up for services leaving many patients without needed care (McDougall, personal communication, May 4, 2015; T. Lepale, personal communication, April 27, 2015). If the two full-time social workers have no access, then patients must seek outside assistance. Unfortunately, receiving specific care pertinent to cancer symptoms, concerns, and needs such as cancer support groups, complementary cancer care services, and free and affordable varieties of complementary medicine is less available in the Inland Empire community, unlike those available throughout Los Angeles County. Also, outside providers will not have access to patients current disease status and treatment, and cannot integrate care with the patient's other medical providers. Lack of integration with care limits overall patient care success and hinders the success of meeting the ACoS guideline. It is clear that LLUMOC-Medical Oncology needs to

improve the current referral process both electronically and resulting access to treatment services. Patients currently in need are not receiving the ACoS required services to treat the whole person.

Current Overall Strengths at LLUMOC Defined by LLUMOC Providers

1. Administrative support in the psychosocial program
2. Funding for two LCSW's within the cancer center and openness on part of administration to support changes suggested by LCSW's.
3. Funding and approval for psychologist and psychology intern throughout the cancer center.
4. Wholistic focus of care supported and integrated in the culture of cancer care within LLUMOC
5. Chaplaincy services throughout the hospital
6. Attendance and coordination of interdisciplinary psychosocial meetings
7. Availability of services related to psychosocial care on part of the pain management, social work, and nursing teams
8. Openness on part of physicians to become more involved in how they can improve patient experience and care
9. Information Technology from LLEAP becoming involved in supporting an electronic format of screening
10. Integrated patient care team meetings (physicians, social work, nurses, medical student, chaplain, psychology, and pharmacy)

Review of Cedars Sinai Medical Center- Cancer Center Screening and Referral Program

Screening Program and Referral Services

I met with Dr. Deane Wolcott, Director of supportive care services at CSMC-CC and a psychiatrist specializing in oncology and pain patient care, twice on May 8, 2015 and May 29, 2015. He is currently the head of supportive care services at Cedars Sinai Medical Center- Cancer Center (CSMC-CC). Currently at Cedars-Sinai Medical Center- Cancer Center, the behavioral oncology team has completed implementing screening and referral programs within two cancer centers; Radiation medicine and The Breast Center. They are at partial implementation throughout other cancer centers in the entire facility. The Cedars-Sinai Medical Center- Cancer Center currently provides services to 10,000 patient a year and 20,000 cancer patient visits in total. The supportive care/pain management service staff at Cedars-Sinai Medical Center- Cancer Center includes a pain specialist/psychiatrist, one full time rehabilitation physician, one fulltime hospice/palliative care physician, seven full time social workers, four dieticians, one full time nurse manager service, and two full time physician support nurses. These services are available for any patient receiving care through any regions of the Cedars-Sinai Medical Center- Cancer Center.

The screening program at the Cedars-Sinai Medical Center- Cancer Center encompasses a biopsychosocial screening measure administered to patients before physician visits within waiting rooms. Patients are handed an electronic screening measure on an iPad. The Cedars-Sinai Medical Center- Cancer Center utilizes the SupportScreen screening program which provides a review of the patient's demographic

information (gender, marital status, age, religion, race, language, income level, and education level), physician and clinical team photographs, biopsychosocial screening, psychoeducation, referrals for specific providers, and summary reports for physicians and administrative care teams. The biopsychosocial screening instrument includes assessments of a wide array of aspects of cancer care including but not limited to:

transportation needs, finances, assistance with medical care, sleeping, patient physician communication, understanding treatment, communication with family, emotion management, problem solving, irritability/angry, managing work/school/home life, too ill to communication choices about medical care, worry about future, questions and fear of end of life, finding community resources near where I live, getting medicine, spiritual or religious concerns, fear of medical procedures, ability to have children, controlling urine/stool, feeling anxious/fearful, swelling, losing control of important life aspects, feeling down or depressed, walking stairs, thinking clearly, pain, side-effects of treatment, being unable to care for self, substance use, joint limitations, fatigue, bowel movement, sexual function, suicide, family coping, eating, chewing, swallowing, feeling isolated, recent weight change, nausea/vomiting, feeling hopeless, needing practical help at home, health insurance, speech, ability to cope, providing care for someone, tobacco use, importance of physical activity, food/herbal supplements, complementary medicine, and finding meaning in life. These questions are all answered on a five -point Likert-scale with zero indicating “not a problem” and five indicating a “very severe problem”; “prefer not to answer” and “do not know” are also response options. The second part of each question also includes a sub-question “How can we best work with you on this problem?” with possible solutions for patient needs including “provide written information,” “talk with a member of the team,” “written information & talk with team member,” and “Nothing needed at this time.”

The SupportScreen measure is comprehensive in the range and depth of information collected to specify patients’ needs and provide the most appropriate services in return.

This system collects data per patients’ responses and automatically generates educational support materials printed by check-in staff that is provided to patients when the iPad is returned to the front desk. If referrals are requested, patients are provided information for referrals and services in the community, with insurance companies addressed, and which individuals need to be contacted to begin receiving support. Additionally, if the patient is

requesting services/information/ help from providers or staff, the staff member (physician, nurse, chaplain, social worker, and dietician which coordinates per triage) is contacted with a message including the patient's responses, desired information/intervention, and means for follow up. In this way, the on-staff providers can track patients requiring help with automated and reliable information, and provide instant support. SupportScreen collects data and provides summaries for all information collected to administrators on monthly, quarterly, and yearly schedules. Administrators and providers can have a clear understanding of the needs of their patients, utilization services, areas lacking support, and effectiveness in overall patient care and wellbeing. Information from data collected through SupportScreen about patients' needs are analyzed and presented at international conferences for further support of patient services. Atop the comprehensive nature of the SupportScreen measure which assesses a wide variety of cancer patients' needs, this service provides quick and effective referral resources within-clinic or throughout the community, and establishes complete summary reports of a wide variety of patients concerns and needs.

Having an electronic measure allows for quick integration of patients' responses to patients charts leading to increased efficiency and follow-up for patient care. Quality improvement and overall patient care can be tracked and improved through more efficient processes as a result of having feedback that is specific to each aspect of care within the cancer center. Support Screen also includes an advanced directive plan to be completed by the patient and care givers. This SupportScreen tool has proved to be a strong asset to the Cedars-Sinai Medical Center- Cancer Center.

Funding

In my interviews with the Director of supportive care services at CSMC-CC, we reviewed specifics of funding for the supportive care services paid for by the cancer center. It costs the Cedars-Sinai Medical Center- Cancer Center 1.5-2.5% of the total cancer center operating revenue to fund the supportive care services/behavioral oncology department. The Director explained the rate of 1.5-2.5% of total revenue for supportive care services is consistent throughout 14 different cancer centers nationwide (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). Through assisting implementation of the psychosocial program within 14 other cancer centers around the United States, the Director and his team indicate they specified that on average supportive care services account for \$14 of the patient visit. Over the past year one of every six patients at the Cedars-Sinai Medical Center- Cancer Center (breast and radiation medicine) utilized supportive care services with a breakdown of 45% to social work, 25-30% dieticians, and the last 25-30% being a combination of chaplain, psychiatry, psychology, and pain management services (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). The SupportScreen services costs an initial \$25,000, and an annual \$10,000 for upgrades and assistance with the program. As a result of utilizing and implementing the SupportScreen tool within their center, the Cedars-Sinai Medical Center- Cancer Center is able to track utilization and cost for this program. SupportScreen allows the Cedars Sinai supportive care team to modify changes per the needs of the patients and hospital system more easily than previous implementation without this tool.

Strengths and Barriers

(Note: codes per qualitative analysis are italicized throughout text)

During our interviews on May 8, 2015 and May 29, 2015, the CSMC-CC Director reviewed the strengths and barriers of the Cedars Sinai Medical Center- Cancer Center (CSMC-CC) screening and referral program. See Table 2 for codes of CSMC-CC strengths and barriers. During our conversation he most frequently addressed the *emphasis on comprehensive benefit* for all providers, patients, and the institution that The Cedars-Sinai Medical Center- Cancer Center respected by investing in and providing supportive care services throughout their cancer center (17.5% total CSMC-CC strengths listed). See Table 2. The next prevalent strength leading to success in Cedars Sinai Medical Center screening and referral program was the ability administration has to complete and enlist *decisional change* throughout the Cedars-Sinai Medical Center- Cancer Center, in devising funding sources, increasing supportive care staff, and requiring integration for the patient care teams (8.7% total CSMC-CC strengths listed). Emphasizing the needs for *physicians to be involved* and promoting supportive care services through managerial change and patient involvement, along with providing support on how physicians and care team can address patients' *differences in severity of distress* also promoted the success in complete implementation and utilization of screening and supportive care referrals (Each code topic 7.0% of total CSMC-CC strengths listed). He indicated that sharing evidence-based information with physicians supporting the need for psychosocial services and effectiveness in patient care by providing these services led to overall support on physicians becoming involved in interdisciplinary care. Lastly, the Director of CSMC-CC addressed *funding, concern*

about distress effects on patients, computerized referrals, supportive care providers, ethical requirement, and increased efficiency as the major strengths in leading to the success and utilization of the screening/referral program (Each code topic 5.3% of total CSMC-CC strengths listed). He believes that Cedars-Sinai Medical Center- Cancer Center works to put “patients in the center of the care model” is the “best and only way to provide care” leading to a comprehensive benefit for most importantly the patients. Administrative decisions that support funding for the large group of psychosocial providers at Cedars Sinai is the cornerstone of success for their psychosocial program. By having a patient centered care model at Cedars Sinai, physicians, care team members, and the cancer center institution fulfill their ethical requirements in an effective and efficient manner (D. Wolcott, personal communication, May 8, 2015; May 29, 2015).

Barriers for the Cedars-Sinai Medical Center- Cancer Center include the need for improving *cultural factors* related to increased interdisciplinary team care (18.5% total CSMC-CC strengths listed), increased *administrative support* (14.8% total CSMC-CC strengths listed), increased *funding* (11.1% total CSMC-CC strengths listed), increased *physician involvement* (11.1% total CSMC-CC strengths listed), and *increased emphasis on comprehensive benefit* (11.1% total CSMC-CC strengths listed) (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). Having physicians become even more integrated within interdisciplinary team meetings, providing financial support for another psychologist, and therefore having access to further research can promote even further success. Though the Director mentioned many of these similar code topics as major areas of strength for Cedars-Sinai Medical Center- Cancer Center, he indicated that the program could be improved and even more successful with improved integration.

City of Hope Screening and Referral Program

Screening Program and Referral Services

The City of Hope cancer center marks one of the longest standing cancer care providers that incorporates psychosocial screening and referral throughout their care model. City of Hope has provided supportive care services since 1993 and continues to be one of the major leaders in cancer care and more specifically psycho-oncology care today (Loscalzo, Clark, & Holland, 2011). Matthew Loscalzo, a licensed clinical social worker who specializes in psychosocial screening and referral nationally and internationally, functions as the director of supportive care services at City of Hope. He has published a large number of manuscripts reviewing the importance, need, implementation of, and process management for psychosocial screening in cancer centers. Mr. Loscalzo has worked with a large number of providers and administrators throughout different cancer centers around the world to help improve psychosocial screening and referral. We completed a 50-minute in person interview at City of Hope on June 5, 2015.

Throughout the past couple of years, Mr. Loscalzo met with several other psychosocial providers, physicians, families with cancer, and information technology groups to establish and build the SupportScreen tool and program implementation. His long history of experience building psychosocial tools and implementing screening in different centers informed his practice and development of the SupportScreen tool and practice at City of Hope. He indicated his experience at different cancer centers that varied in patient load, diversity in populations, and cancer type educated his current tool and practice implementation over the years.

Through his time at City of Hope, Mr. Loscalzo focused on building models of supportive care for patients receiving cancer care within this hospital. City of Hope is a cancer center in the United States that has had psychosocial screening and referral in place long before the ACoS standard. Mr. Loscalzo strongly believes that this new standard has motivated major change for several cancer care providers like Loma Linda University Medical Oncology Center- Oncology clinics. He is committed to further expanding psychosocial integration. Currently, the City of Hope psychosocial care team is vast. They house five palliative care physicians, three nurse practitioners, three psychiatrists, five psychologists, 20 social workers, five nurse navigators, three child psychologists, three spiritual care chaplains, and seven health educators. Patients highly utilize the variety of psychosocial care services available at City of Hope.

At City of Hope, the SupportScreen tool is given to patients in the waiting room, before each physician visit. Patients complete surveys utilizing an iPad which is automatically connected to printers in the check-in office to provide patients requested information. See SupportScreen review for full explanation above (*Cedars Sinai Medical Center- Cancer Center Screening and Referral Program; Screening program and referral services*).

At City of Hope, physicians are highly involved in the psychosocial aspects of patient care. Specifically, physicians help connect patients to services and promote utilization of services through normalization of distress during the cancer experience. Physician involvement is particularly significant for patients suicidal thoughts and meeting the ethical guidelines for patient safety. The Director of supportive care services explained that nurses are most heavily involved, next to psychosocial providers at

following up and integrating psychosocial needs and services for patients. He emphasized the connected team effort carried out for cancer patient care throughout City of Hope permits success in efficiency and ethical achievement (M. Loscalzo, personal communication, June 5, 2015).

Funding

Funding for the large supportive care program at City of Hope consists of different funding agencies within a unified structure. To begin, the hospital funds 70% of the total monetary cost for the psychosocial program each year. Endowment funding through fundraising makes up a portion of funding. Lastly, the CoH Director and his team complete National Institute of Health (NIH) grants each year to fund specific social work/psychology positions within the supportive care team. Similar to Cedars Sinai Medical Center, hospital funding makes up a large portion of the funding supporting psychosocial care programs.

Strengths and Barriers

(Note: codes per qualitative analysis are italicized throughout text)

The City of Hope Director spoke about the broad concepts leading to success in psychosocial care at CoH. He emphasized patient-centered care, not fee-for-service or disease status throughout care at City of Hope leads to overall success for both patients and the institution. More specifically, the Director of support care services labeled *increased efficiency* with the integration of psychosocial care on the entire care process as the biggest strength for City of Hope (20.8% total CoH strengths listed). See Table 2.

Next he labeled the SupportScreen *electronic tool* and *physician involvement* as the second and third biggest strengths of City of Hope care (both codes 12% total CoH strengths listed). At City of Hope “patients have higher satisfaction, less emergency room visits for psychosocial issues, and overall less stressed staff with a systematic way to address all issues,” which very clearly outlines the principal benefits of the program at City of Hope. The culture throughout City of Hope emphasizes the need and importance of providing psychosocial services throughout the care model. Psychosocial integration leads to successful improvements in patient care and overall efficiency with both time and money for City of Hope.

Mr. Loscazlo did not review current barriers to care at City of Hope. He indicated that support for the program, monetary funding, and cooperative care team members over the years led to a successful psychosocial program.

Suggestions for Improving Care at LLUMOC from Cedars Sinai Medical Center and City of Hope

Suggestions for the development of the Loma Linda University Medical Oncology Center-Oncology clinics include both broad and specific areas to address. See Table 2 and 3.

Table 3. Review of thematic codes of LLUMOC weaknesses from six total interviews

Category (code)	Code Frequencies	Percentages of LLU weaknesses	
		% of total	% of category
Lack of Resources			
Money	15		26.79%
Need for Psychosocial coordinator	14		25.00%
Need for more Supportive care providers	22		39.29%
Lack of Community resources	5		8.93%
Total	56	25.00%	
Change to Traditional Care model			
Time	6		18.75%
Cultural Factors	8		25.00%
Fear	1		3.13%
Decisional change importance	7		21.88%
Administration support	10		31.25%
Total	32	14.29%	
Provider Challenges			
Skills to address distress (need training)	8		21.62%
Knowledge (lack of provider education)	20		54.05%
Staff consistency/ need for follow up	9		24.32%
Total	37	16.52%	
Nonspecific Project Management			
Privacy	1		11.11%
Focus too much screening/ not on services	1		11.11%
Ethical requirement	7		77.78%
Total	9	4.02%	
Patient Factors			
How to address differences severity distress	4		25.00%
Concern about distress effects on patient care	9		56.25%
Survivorship concerns	3		18.75%
Total	16	7.14%	
Cohesiveness			
Physician involvement	12		30.00%
Emphasis on comprehensive benefit	9		22.50%
Increase efficiency	11		27.50%
Lack of integration: physician & nurses	8		20.00%
Total	40	17.86%	
Unified Tool			
Tool (need change/or good)	4		66.67%
Electronic tool helpful	2		33.33%
Total	6	2.68%	
Model of Triage			
Access to referral/Follow-up	20		71.43%
Problems with reassessment	3		10.71%
Computerized referral	5		17.86%
Total	28	12.50%	
Complete Total	224	100%	100 %

Note: LLUMOC total strengths and weaknesses include compilation of all codes for all interviews combined.

While comparing the Loma Linda University Medical Oncology Center (LLUMOC) supportive care services to those of Cedars Sinai Medical Center and City of Hope, it is evident that LLUMOC is behind in implementation success. Most directly LLUMOC does not have an integrated, effective screening tool leading to direct referrals, and LLUMOC is scarce on the amount of supportive care providers necessary for the majority of cancer patients' needs. As seen in our previous needs analysis conducted in 2013, over 50% of cancer patients receiving care at LLUMOC indicated elevated distress and desire for further support. At this time LLUMOC are not addressing this patient need effectively or ethically. As The Director of support care services at CSMC-CC indicated in our interview regarding increasing supportive care needs, "It is not only the right thing to do from a clinical and business standpoint, but it's the right thing to do in terms of tradition and values of Loma Linda University and Adventist health" (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). It is clear that LLUMOC as a 7th day Adventist institution, striving "To Make Man Whole," has the appropriate cultural context needed to further funding and integration for psychosocial services. To continue to be competitive in the market of cancer care, it is essential for LLUMOC to compare current programs and care to leading industries in our region such as Cedars Sinai Medical Center and City of Hope, and make appropriate changes.

Ethical requirements to ensure patient safety for vulnerable cancer populations promotes legislation for including psychosocial care for patients. Patients attending hospitals for care are interested in improving health and mood status related to disease states. As the Director of support care services at CoH explained, "...people come to hospitals to find ways to continue living their life, to try and not be

sick/anxious/depressed... they don't come because they like their cancer treatment medication regimens” (M. Loscalzo, personal communication, June 5, 2015). With an overwhelming mentality emphasizing patient-centered care, it is essential for medical practice to strive to achieve this model. CSMC-CC’s director stressed, “If you want to change, you need physician and senior leadership to understand what you value physicians for actually, and how are you going to move a care system away from treating tumors to caring for people?” (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). LLUMOC is making this transition in an effective way, and providing administrative decisional support, financial backing, physician and care team education, along with the expansion of supportive care service members could complete the patient centered care model.

Both Directors emphasized the sizeable profits Cedars Sinai Medical Center and City of Hope continue to gain by encapsulating a patient-centered, supportive care environment to cancer care. The CoH Director stated that psychosocial screening and referral as a whole has improved overall workflow at City of Hope as “It has made a physician’s job more effective and efficient, allowing them to be at the top of their licenses” (M. Loscalzo, personal communication, June 5, 2015). He emphasized that patients’ safety needs, concerns, and stressors are met by support providers leaving physicians to care for medical issues related to patients’ cancer illness.

Previous analyses have confirmed that nurses and physicians are not accurate in measuring patient’s distress and suicidality (Kirchheiner et al., 2013; Jacobsen et al., 2005). Having a formulated screening tool allows the institution as a whole to identify patients in distress and possibly in danger, taking this burden out of the hands of

physicians. Essentially, addressing patient's distress and needs on a clinical schedule can also lead to increased efficiency, where stress driven emergency room visits and elongated intensive care unit (ICU) visits would be decreased leading to cost improvements. While helping several hospitals implement a biopsychosocial model of integrated patient care, the Director from CSMC-CC has seen organizations grow two to three times the projected rate. He indicated this is a result of attracting patients and care providers to outstanding care services. Patients have higher satisfaction, less emergency room visits, less hospital stays related to psychological-driven issues, leading to overall decreased stress on physicians, nurses, and other staff members as a result of psychosocial, patient-centered cancer care (M. Loscalzo, personal communication, June 5, 2015).

Specifically, implementing psychosocial programs improves patients' adherence with recommended behavioral changes. Assisting patients cope with the distress related to the cancer experience can curtail the negative behavioral manifestation of distress such as decreased medication adherence, increased negative health behaviors, avoidant coping, unfocused decision making, and decreased quality of life. The CSMC-CC Director noted the main focus of the Cedars Sinai supportive care program as "...helping patients cope with stresses and adhere to regimens" (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). As a result of providing support to address distress and psychosocial needs, supportive care directors indicated a large investment especially when addressing quality measures. The CSMC-CC Director explains, "it's a very modest investment in relation to success, and you cannot measure this by money. We are moving from monetary measures, to quality measures much more" (D. Wolcott, personal

communication, May 8, 2015; May 29, 2015). Measuring and providing sufficient support to aid in improving psychosocial distress requires proper screening and treatment referrals provided by the physician team.

Directors from both hospitals stressed the partial success of the electronic tool implemented by Loma Linda University Medical Oncology Center in the Oncology and Surgery clinics. The application of the distress tool by nurses asking the questions limits true responses by patients. Many patients are hesitant to share the severity of their distress, especially when they feel uncomfortable with their nurse. The modality of orally measuring distress through dialogue with patients is done at LLUMOC within infusions/treatment rooms. Infusion rooms are not private areas and result in unethical sharing of private patient information leading to decreased truthful responding due to a lack of confidentiality. Moreover, nurses and physicians do not accurately perceive patient distress and needs. Implementing a comprehensive, biopsychosocial tool to address all aspects of patients' cancer care, through an electronic application where personal interactions are not biasing responses is necessary. Having a wide range of questions that can be easily applied to a patient's visit allows care providers to specify the distinct need of a patient. Specifying this need affords more precise integration of services which will address patient difficulties and barriers to treatment success. LLUMOC's current tool does assess the biopsychosocial nature of the patients' distress, yet the modality of assessment, the referral system, and the communication with care physicians is limited. The unethical nature of assessment, limitation of referrals and sharing distress levels with the care team prevents comprehensive care on behalf of the physicians and team care as a whole.

Having an electronic tool that provides summary reports and directly delivers education and referrals to patients is the most effective way to meet the new ACoS standard for psychosocial care. Similar to City of Hope and Cedars Sinai Medical Center, investing in iPad or tablets to provide patients hand-held and private assessments of distress result in increased efficiency in meeting patient needs. The SupportScreen program also allows frequent tracking of patient information and necessary program evaluation. Additionally, the program allows for easy integration of sharing information with all care providers directly to the patients chart. Patients are provided immediate information on the needs addressed or immediate referrals to care providers. Direct referrals are placed within the system where care providers can provide immediate or relatively immediate services. Our providers will be able to keep track of patients' changes in distress to ascertain effectiveness of interventions and continuing care desired. Patients will also complete an advanced care plan that can help solve another problem within cancer centers addressing patients' end of life concerns. Having a tablet-based biopsychosocial distress tool serves as a solution to the current unethical modality, lack of referrals and physician integration. The SupportScreen measure would provide a solution to the LLUMOC current concerns, while including necessary advanced care plans and patient support summaries.

Having an appropriate and effective screening tool is only efficient if referral services, which are required by the ACoS standard are provided. With only two full time social workers and two part time students, LLUMOC does not provide sufficient psychosocial providers for patients' present needs. Further investment in psychosocial providers is necessary for successful implementation of the program. The Director from

CoH emphasized LLUMOC's *lack of funding* and *lack of providers* as the most significant two barriers to fulfilling our ethical requirement of psychosocial care, respectively (code 12.3% and 10.5% total LLUMOC barriers listed). See Table 2. Increased psychosocial staff is necessary to meet ethical requirements of providing patients with the services they evidently need. In comparison to the large psychosocial care teams present at City of Hope and Cedars Sinai Medical Center, LLUMOC is far behind providing the same amount of and access to support.

Distress-based education for physicians and care teams needs to be provided to address the effects of increased distress within cancer patient populations. In this way, physicians and care team providers will be able to become more involved in the psychosocial program and to efficiently integrate care. To begin, providing a comprehensive training module for physicians and care team providers is essential. Mr. Loscalzo connected the LLUMOC oncology team to an National Cancer Institute NCI/NIH-funded program "Implementing Comprehensive Biopsychosocial Screening Program," which provides training for teams of providers addressing ways to improve psychosocial screening and referral systems within cancer centers. This program is free and includes a comprehensive two- day training program. This information was disseminated as part of the present investigation at LLUMOC. At this time (July 27, 2015) two social workers and one psychology doctoral student committed to attending the program. This lack of interest indicates a lack medical provider involvement in psychosocial care integration. The Director of care at CSMC-CC explained the *need for decisional support* and change on behalf of administrators as the most significant barrier and *lack of physician involvement* as the second most significant barrier to implementing

change for LLUMOC, respectively (Code 12.5% and 10% total barriers listed) (D. Wolcott, personal communication, May 8, 2015; May 29, 2015). See Table 2. Relative to suggestions from both external cancer center directors, I have connected LLUMOC to an educational service provided through the pharmaceutical company **Novartis**. This education program funds Mr. Loscalzo and other psychosocial providers from City of Hope to speak and educate our team on the importance of distress and changes needed to be made to meet current ACoS standards. After speaking with the Novartis representative, LLUMOC needs to schedule a time for education about cancer related distress and indicate that there is administrative support for this aspect of care.

LLUMOC-Medical Oncology is a 7th day Adventist healthcare institution and as such has cultural values that are advantageous to this care integration. Representing a culture of wholeness and integration, it is important that our care represents the values this institution encompasses. To do this, LLUMOC's healthcare team needs to embrace this interdisciplinary culture and foster integration throughout all aspects of care. This is not a requirement per the NCCN ACoS standards, and LLUMOC are few steps away from completing this standard, however, the cultural values can be put into action and move the institution toward compliance. Providing funding for the appropriate psychosocial staff to deliver psychosocial services throughout the LLUMOC cancer center is of utmost importance. Integrating a more comprehensive and effective tool is necessary to tailor LLUMOC care to specific patient's needs and efficiently provide patient education and referral services. Lastly, educating our current health care providers on the importance of distress and models of integrative care are essential to promote successful implementation of psychosocial screening and treatment.

Suggestions from Loma Linda Medical Oncology Staff

Though outside perspectives and suggestions are essential and helpful in providing various perspectives for program development, collecting suggestions from providers within the LLUMOC department is equally as important. Data from interviews were collected from Talolo Lepale, LCSW; Dr. Mohr, Palliative care physician; and Cheri McDougall, Nurse Supervisor for Medical Oncology. To begin on current strengths, the LLUMOC providers emphasized the strength of administrative providers who have been open and supportive to decisions made by psychosocial providers. The nurse supervisor emphasized the large amount of support and trust placed in the psychosocial coordinator from administration for his decision-making and clinical integration (McDougall, personal communication, May 4, 2015). It is evident that administrative providers are aware and supportive of the increased levels of distress and need for services within the LLUMOC Medical Oncology department. Though administration is supportive of policy and practical changes, they do not provide financial support to translate these changes into practice. Psychosocial care required for cancer patients cannot succeed without the financial support to increase psychosocial providers .

To date, persistence on part of the current psychosocial providers enables positive changes in psychosocial oncology care. Though the psychosocial staff and nurse supervisors are consistent in emphasizing psychosocial care, physicians and nurses have a more difficult time transitioning to include the psychosocial tool and motivating changes in overall care. The lack of consistency on education materials and reminders seems to lead to this stagnant plateau in changes to care (C. McDougall, personal communication, May 4, 2015). To address staff consistency, frequent reminders electronically, within

meetings, and posted handouts should be provided to help boost change in implementation in positive directions. LLUMOC rides on a cultural strength of encompassing patient-centered care as a treatment guideline. This is a perfect stepping-stone to translating theory to practice for all of our patients and improved provider experience.

All interviewees also noted our current electronic tool as a great strength in implementing psychosocial care at LLUMOC- Medical Oncology clinics. Having a biopsychosocial tool allows the care team to further specify the nature of a patients' distress and aim to provide more accurate care. The nurse supervisor Ms. McDougall and psychosocial coordinator/social worker continue promoting and keeping track of the use of the electronic screening tool which helps continue integration. Currently 90% of patients are being assessed on their initial visit for distress, but this is not being done when patients return for treatment changes, during treatment regimens, or at termination. According to the LLUMOC social worker, the tool is effective at measuring different aspects of distress such as spirituality, financial needs, and anxiety, but is not effective at measuring depression (T. Lepale, personal communication, April 27, 2015). The lack of assessment for depression requires modification as depression has been found to be related to decreased quality of life, difficult coping with disease states, and adhering to treatment regimens (See sections "Consequences of Significant Distress" above). The oral modality utilized by nurses while administering the distress tool heightens vulnerability to sharing confidential patient information as patient distress assessments are rarely conducted in a private, separate room (C. McDougall, personal communication, May 4, 2015). Having an electronic tool that enables privacy and is automated directly

into the patient's chart at the LLUMOC Medical Oncology clinics will be a major strength in meeting the ACoS standard of psychosocial care. Increasing utilization and application of the tool, improving the depth of topics assessed by this tool, and converting the tool to a completely electronic-patient completed measure will lead to improved patient confidentiality and understanding of patient needs resulting in direct treatment in the most comprehensive fashion.

Similar to suggestions by Directors of care from CoH and CSMC-CC, it is evident that LLUMOC clinics are in dire need of a psychosocial coordinator and additional psychosocial care team providers (psychologists, psychiatrists, and licensed clinic social workers) to continue growth and success of the LLUMOC psychosocial program.

According to the LLUMOC social worker, who receives non-electronic referrals from the current LLEAP screening, "referrals across the board still need to be worked out" (T. Lepale, personal communication, April 27, 2015). The *need for more supportive care providers* and the *improved access to referral/follow-up* made up the two most significant codes mentioned by LLUMOC providers, respectively (9.82% and 8.93% of total LLUMOC barriers listed). See Table 2. The current referral process is impractical as it relies on verbal referrals resulting in only patients with severe distress receiving access to psychosocial support. This leads to a large majority of patients noting moderate levels of distress who are not able to receive the care they desire. Solutions for improving referrals and follow-up include hiring more psychosocial care providers, building relationships with outside providers, and clarifying outside providers that accept patient insurance plans.

The LLUMOC psychosocial coordinator specified the need to bring a

psychologist on the behavioral oncology team. With this particular addition, LLUMOC clinics could build leverage on the psychologist's position. Leverage from the psychologist's position would provide opportunities for supervision to psychology students and interns. With a student supervisor, access for patient services would increase significantly while instilling opportunities for research projects continuing our success within the oncology treatment realm (T. Lepale, personal communication, April 27, 2015). This psychologist, along with another member could function as a specific psychosocial coordinator. Mr. Lepale holds this position currently, but has limited time to provide services to this role, as he is the only psychosocial provider in the medical oncology clinic at this time. Hiring a full time clinical psychologist would provide leverage to supervise further student therapists, formulate the psychosocial coordinator role, and complete necessary research analysis relative to LLUMOC's current progress and growth.

Financial support is required to help fund new behavioral oncology providers. Having a designated psychosocial coordinator, a psychologist, and additional social workers could allow for a team with sufficient time to develop and complete grant applications and fund psychosocial positions atop hospital support. This financial investment could expand to include several students to provide care through our Loma Linda University psychology and social work departments. A financial investment supporting positions will provide wide investment potentials and cost offset throughout the LLUMOC oncology clinics. As seen in our previous needs analysis conducted in 2013, over 50% of cancer patients receiving care at LLUMOC indicated elevated distress and desire for further support. Interviewees together agree that two social workers are

insufficient support for the total needs of patients receiving care at LLUMOC oncology clinics.

CHAPTER FOUR

DISCUSSION

To complete the integrative care model, it is essential for care team physicians, nurses, and other team members to cooperate on the overall goal of assessing and providing care to address psychosocial problems for patients. Implementing an effective and efficient tool is the first step. Designating and providing psychosocial team members for referral and treatment comes second. Lastly, completing cooperative care models for total patient-centered care is the “glue” to bring the entire program together.

For success in integration, onsite care providers need to have the education and knowledge related to the importance of distress screening and treatment. Lack of physicians and care provider education and knowledge on distress and continued physician involvement were identified as two significant barriers to comprehensive care at LLUMOC, respectively (8.93% and 5.36% of total code barriers). See Table 2. Currently, providers have received few information sessions reviewing distress significance. Education on distress intervention requires support on part of administrators to integrate education sessions during physicians and care team monthly meetings. Engaging in educational programs is essential to continue this program. Providers with the knowledge of the importance of distress can better gear treatment models to fit patient’s needs. Investing funding in an electronic tool that includes electronic referral is necessary to enable the integrated model of patient care. Providing funding to increase psychosocial care team members will lead to possible integration of student therapists for overall efficiency, and possibly will become self-sufficient through grant funding. Having

administration staff and physician leaders to support this program to assist in decisional changes and cultural support will lead to overall interdisciplinary care for our patients. In conclusion for investing funds and administration change to improving the psychosocial program at LLUMOC, cancer patients will experience improvements in levels of distress and resulting negative consequences of elevated distress will be alleviated. For instance, cancer patients decision-making will no longer waver as sensitively to levels of distress. Patient will be more likely to engage in increase positive health behaviors, and increased adherence to medication regimens and overall treatment. Cancer providers may experience less burnout and stress as patient distress will be managed effectively and overall quality of life for patients and providers will improve. These changes that can be made by designating funding for further psychosocial providers and implementing cancer center-wide changes to models of care all together will lead to overall improvement for the LLUMOC Cancer Center both through monetary gains and patient-centered gains.

Review of Barriers at LLUMOC

1. Limited psychosocial staff to provide sufficient interventions for patients' current needs
2. Limited financial support to implement complete psychosocial screening/referral program
3. Need for complete electronic, patient-completed screening tool
4. Lack of electronic system to track screening and referral
5. Electronic screening that connects directly to patient referrals or information

6. Clinical researcher needed to assess implementation status and provide support for grant funding
7. Physician/Nurse training emphasizing importance of distress with cancer patients and how to intervene effectively
8. Designated psychosocial coordinator
9. Re-assessment of distress during changes in treatment regimens, end of treatment, and critical time points
10. Oral administration of screening tool leading to breach of patient confidentiality
11. Lack of supportive involvement from physicians
12. Limited integrated communication and management of patients' needs.

Review of Suggestions from Cedars Sinai and City of Hope

1. Submit applications for community grants and/or 1.5-2.5% of hospital operating revenue to financially support psychosocial program needs. (On average as seen in other cancer centers, psychosocial care team cost \$14 per patient visit).
2. Provide funding to hire two psychosocial care providers (one psychologist and one social worker)
3. Invest in SupportScreen program for electronic screening, referral, psychoeducation, and advanced care plan on electronic tablets
4. Promote psychologist integration of research projects and student clinic supervision to provide leverage for further patient services

5. Promote and engage physicians in distress screening trainings (NCI/NIH and Novartis meetings)
6. Provide education modules from NCI/NIH and Novartis training for nurses and care team
7. Allot hours within schedule for designated psychosocial coordinator separate from clinical hours
8. Integrate communication about patient needs and safety through meetings and electronic reminders

Potential Gains “To Make Man Whole”

1. Bringing to life the basis of whole person care at Loma Linda University
2. Systematic model to address patients’ issues
3. Decreased stress on staff
4. Decreased emergency room visits related to psychosocial issues
5. Improved safety and ethical care for all patients
6. Improved patients’ behavioral and medication adherence
7. Patient and physician higher satisfaction with care
8. Reduced burden on physicians and nurses leaving them to focus on medical issues for patients and increased efficiency
9. Patients’ needs will be met
10. Electronic psychoeducation and referrals made immediately
11. Decreased delays in care needs

12. Ability to systematically measure patient needs, care model success, and evidence for increased grant funding
13. Physicians can track all aspects of patient care (screening/referral directly to electronic chart)
14. *Advanced care plan to be completed on SupportScreen*
15. Physician and nurse training (NCI/NIH and Novartis distress training programs)
16. Increased efficiency and effectiveness with patient-centered model of care
17. Achieving quality, whole-person, patient-centered, and integrated care as a team

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APPENDIX A

INTERVIEW OUTLINE FOR CANCER CENTER STAFF AND

ADMINISTRATION

1. What is/was your role at the LLU's Medical Oncology Center?
2. With whom do you work for on a regular basis?
3. What are your requirements?
4. Who is your head authority?
5. Who decides the nature and inclusion of your job?
6. What do you know about the current ACS CoC 3.2 standard for psychosocial services?
7. How did you hear about this standard?
8. What are your goals for the psychosocial care screening and referral system here at LLU Medical Oncology Center? (List top 3-5)
9. Where do you think we are at with this process? What goals have we achieved thus far?
10. Did you attend the psychosocial team meetings in 2013?
11. What was your role in these meetings?
12. What progress do you think was made in these meetings?
13. What were the main roadblocks in your eyes for implementing these standards?
14. What do you think you could change on your part to continue this process in a positive direction?
15. Who was involved in making decisional change?

16. How was communication carried out in these meetings?
17. If you could change one thing about the meeting what would you change?
18. Do you think it would be valuable to have these meetings again?
19. Who do you think has been leading effective change for this process thus far?
20. How much of the current change is based on monetary funds?
21. How do you think administration could further promote change in this process to meet current CoC standards?
22. How could physicians work to promote change in meeting these standards?
23. Nurses?
24. What do you think would function better a paper or electronic screening format?
25. Can you provide some insight for the assessment screening tools your site used and which were most effective? And why?
26. Do you think it's important to have psych services in the hospital or to rely on outside referral services?
27. How would you say LLU managed monetary funding changes required to implement this standard of care?
28. If present, how were you able to modify and overcome historical and cultural attitudes regarding mental health and its integration?
29. What aspects of implementation were most powerful in initiating and sustaining change in LLU to date? And why?

APPENDIX B

INTERVIEW OUTLINE FOR EXTERNAL CANCER CENTERS

1. What is/was your role at the XX Oncology Center?
2. What are your requirements?
3. Who is your head authority?
4. Who decides the nature and inclusion of your job?
5. What do you know about the current ACS CoC 3.2 standard for psychosocial services?
6. How did you hear about this standard?
7. Have needs assessments for psychosocial stressors been completed at your site? If so, what did the needs assessments indicate?
8. Where do you think your site is at with this process? What goals have they achieved thus far?
9. Are multidisciplinary team meetings held at your clinic?
10. What was your role in these meetings?
11. What progress do you think was made in these meetings?
12. What were the main roadblocks in your eyes for implementing these standards?
13. Who was involved in making decisional change?
14. How was communication carried out in these meetings?
15. Can you provide some insight for the assessment screening tools your site used and which were most effective? And why?
16. What do you think would function better a paper or electronic screening format?

17. Do you think it's important to have psych services in the hospital or to rely on outside referral services?
18. What types of treatment or program evaluations did you site engage in to elicit this program in the most successful direction of change?
19. How would you say your site managed monetary funding changes required to implement this standard of care?
20. Did you have a distinct case consultant/manager leading development of this project and implementation of this standard? If so, how was it helpful. If no, why not and how were managerial barriers overcome?
21. If present, how were you able to modify and overcome historical and cultural attitudes regarding mental health and its integration?
22. How could physicians work to promote change in meeting these standards?
23. Nurses?
24. What aspects of implementation were most powerful in initiating and sustaining change in your program to date? And why?
25. How much of the current change is based on monetary funds?
26. How do you think administration could further promote change in this process to meet current CoC standards?
27. Overall, what would you say are the main improvements seen in patient care at your facility?