Distress screening

THE IMPROVING PATIENT EXPERIENCE AND HEALTH OUTCOMES COLLABORATIVE

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Session report: Rosana Faria, Lorraine Martelli, Carole Mayer and Julia Park. Implementation of distress screening and patient-reported outcome measures: Successes and challenges across the iPEHOC sites in Ontario and Quebec.

In a medical system where interventions and decisions are based on a combination of biology and economics, how do we implement a nationwide screening program aiming to attenuate emotional distress? Distress is a “multifactorial unpleasant emotional experience which extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fear to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis.” Through the efforts of researchers and advocates across Canada, distress has been recognized as the 6th vital sign in cancer care, and screening
is now an accreditation standard across the country.\(^2\) Unfortunately, this standard remains difficult to meet.

The iPEHOC project\(^1\) (Improving Patient Experience and Health Outcomes Collaborative) is a multisite quality improvement initiative for Screening for Distress in health centres in Ontario and Quebec. It aims to turn screening for distress into a system that allows overwhelmed patients to feel their suffering has been heard by their healthcare team; enables clinicians to better understand, recognize and respond to reported suffering; and translates this knowledge into a screening approach that can be implemented nationwide.

A number of health centres across Quebec and Ontario have integrated preappointment screening. This includes a special focus on First Nations, Metis, and Inuit populations. The basic methodology applied across centres allows patients to complete questionnaires, on either tablets or kiosks prior to their medical appointments, asking about their symptom burden, pain, fatigue, anxiety and depression. Clinicians are then able to print out a summary report of questionnaire responses and use this during appointment time to guide conversation and inform further followup or referral, as necessary. Beyond this general method of data collection, each centre has developed its own approach to suit their particular clinic demands and hospital culture. It is the unique experiences of the different centres that Rosana Faria (Rossy Cancer Network), Lorraine Martelli (Juravinski Cancer Centre), Carole Mayer (Health Sciences North), and Julia Park (Princess Margaret Cancer Centre) presented in this symposium, moderated by Doris Howell (Cancer Care Ontario), with Zeev Rosberger (McGill and Rossy Cancer Network) as discussant.

What stood out during these presentations was iPEHOC success in implementation across centres with different clinical models, variable readiness for change, and distinct patient populations. Common key ingredients and the true meaning of “integrating” distress screening began to emerge. Key factors included: aligning iPEHOC goals with those of the institution, developing commitment with a number of people at different levels of the system (patients, clinicians, stakeholders), working together to build momentum and tackle barriers, remaining flexible and working with everyone involved to create the best fit, and reporting and celebrating outcome data to help those involved see the growth and progress.

A number of challenges were discussed, such as competing staff priorities, multiple change initiatives in one centre, differing patient populations and working cultures, resistance to additional work, and differences (based on clinician expertise) in how the questionnaire was integrated into conversation with the patient. Despite these challenges, each centre reported promising preliminary outcomes. The Rossy Cancer Network (RCN — a network of hospitals affiliated with McGill University in Montreal) found that 55% of patients are reporting distress. Of these, 15%–20% report a severity high enough to trigger further assessment and followup. Clinicians are pleased with the program, patients are demonstrating engagement, and interdisciplinary work is enhanced, as is communication between hospital sites. At the Juravinski Cancer Centre, screening rates have increased from 73% to 86% in the central nervous system (CNS) clinic and from 63 to 93% in the gynecologic clinic. Anxiety and depression scores have decreased, and documentation regarding symptom management and referrals has improved. Teams are eager to maintain this program after iPEHOC comes to a close. Health Sciences North is finding high reports of depression (25%) and anxiety (36%) in patients. With screening, patient reported symptom burden is decreasing, there is a stronger interdisciplinary response, a clear pathway has been established to deal with suicidal concerns, and patients receive more direct support/debriefing from team members. The Princess Margaret Cancer Centre found that 53% of their patients with lung cancer and 50% with sarcoma reported symptom severity significant enough to warrant further assessment. Patients did not find the screening questionnaires fatiguing, and education tools using input from clinicians and iPEHOC modules were considered beneficial in encouraging their integration. Clinician debrief meetings were used to improve practice, conduct patient debriefs, and share outcomes.

There are challenges in assuring program sustainability as the iPEHOC project moves forward into its third and final year. Ideas discussed by presenters included maintaining alignment with their institution’s strategic plan and encouraging clinicians to mentor each other as they face challenges
in using the assessments. Clinicians are noticing that the questionnaire can actually reduce clinic time, a finding that may bolster sustainability; cost-effectiveness has not yet been determined.

It is debatable whether a single system can be developed for nationwide implementation. Based on the presentations, it would appear that different centres have been able to develop successful strategies to facilitate implementation of screening for distress in their particular context, even if these do not quite match a theoretical ideal system.

References