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Examining the Sustainability of Screening for Distress, the Sixth Vital Sign, in Two Outpatient Oncology Clinics

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Examining the Sustainability of Screening for Distress, the Sixth Vital Sign
In Two Outpatient Oncology Clinics

by

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A THESIS

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Abstract

Background: This study explored the sustainability of Screening for Distress, a program that facilitates distress management, in two cancer clinics six months post-implementation. **Methods:** A mixed-method cross-sectional design was utilized. To assess program sustainability and explore the barriers and facilitators of sustainability 184 charts were reviewed and sixteen semi-structured interviews were conducted. **Results:** 163 (88.6%) charts had completed tools and a conversation about the tool took place in 130 (79.8%) of those. 89 (54.6%) tools warranted an intervention and 68 (76.4%) of those had an intervention documented. Five themes influencing sustainability emerged: attitudes, knowledge and beliefs, outcome expectancy, implementation approach, integration with existing practices, and external factors. **Conclusions:** This study suggests that screening was largely sustained, possibly due to positive attitudes and outcome expectancy. However, sustainability may be enhanced by formally integrating screening with existing practices, addressing potential knowledge gaps, and ensuring engagement with all stakeholder groups.

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Dedication

This thesis is dedicated to my family, without your love and support this would not have been possible. To my parents, you have always been there for me and showed me the value of education. To my sister, and my best-friend, thank you for always being there to listen to me about life, work, and school. Although I have been separated from all of you by distance, I feel that you have been with me, supporting me every step of the way. Finally, to my husband, you were with me when I started this journey and have stayed beside me the whole way through. Thank you for always keeping me grounded and for ensuring I lived life even through the craziness. I love you all.

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List of Abbreviations

Symbol	Definition
TBCC	Tom Baker Cancer Centre
NCCN	National Comprehensive Cancer Network
ESAS	Edmonton Symptom Assessment System
CPC	Canadian Problem Checklist
CHREB	Conjoint Health Research Ethics Board
NHS	National Health Service
KTA Cycle	Knowledge-to-Action Cycle

Chapter One: Introduction

1.0 Chapter Introduction

This introductory chapter summarizes the study purpose and rationale. Additionally, background information is provided on several key areas pertaining to the current study. Firstly, Screening for Distress programs and distress as the sixth vital sign are discussed. Secondly, the implementation of Screening for Distress and its relation to the field of knowledge translation is highlighted. Thirdly, the area of sustainability is explored. Lastly, a Screening for Distress program implemented at the Tom Baker Cancer Centre (TBCC) is described and a chapter summary is provided.

1.1 Study Purpose and Rationale

A diagnosis of cancer is often a distressing experience for cancer patients and their families. To address the distress experienced by cancer patients, Screening for Distress programs are increasingly being developed and implemented. Screening for Distress involves utilizing a standardized approach to identify and manage the psychosocial, practical, and physical concerns of patients in order to alleviate distress and improve the quality of life of those affected by cancer and its treatments. Since the inclusion of Screening for Distress in Accreditation Canada Standards, numerous screening programs have emerged.¹ Despite the increasing number of programs, a review of the literature revealed no studies have explored the sustainability of Screening for Distress beyond the initial implementation. Given that significant resources are required to implement screening, such as a dedicated coordinator and hours of training for front line staff, it is important to ensure that the program is sustainable.

The purpose of this study was to evaluate the sustainability of a Screening for Distress program implemented in the Head and Neck and Neuro-Oncology clinics at the TBCC in

Calgary, Alberta, Canada, six months post the conclusion of the implementation. Developing an understanding of the sustainability of this implementation will inform current implementations taking place across Alberta as well as implementations at other centres. This study also sought to shed light on the barriers and facilitators to the sustainability of Screening for Distress. Two research questions were addressed through this study: 1) determine if screening rates, screening conversations, and appropriate interventions were maintained post implementation, and 2) determine the barriers and facilitators to the sustainability of screening.

1.2 Distress, the Sixth Vital Sign

Distress can be defined as an unpleasant emotional experience caused by psychological, social, practical, informational, or physical concerns.² The term distress was chosen as it was deemed more acceptable and less stigmatizing than “psychiatric” “psychosocial” or “emotional.” Research indicates that approximately 35-45% of cancer patients will experience significant and persistent distress,^{3,4} which can lead to negative health outcomes including reduced quality of life⁵ and poor satisfaction with medical care.⁶ A recent review article concluded that Screening for Distress is likely to benefit communication, enhance referrals for psychosocial support, and improve patient well-being when effectively implemented into practice.⁷ Given the prevalence of distress in cancer patients, distress as the Sixth Vital Sign has been endorsed by over seventy national and international organizations including the International Union for Cancer Control thus calling for its routine monitoring.⁸

1.3 Screening for Distress Programs

1.3.1 The Emergence of Screening for Distress Programs

Screening for Distress programs have become the primary strategy for identifying and managing the distress experienced by cancer patients, and research has supported the ability of

screening programs to improve quality of care for patients.⁷ In 2002, the National Comprehensive Cancer Network (NCCN) released recommendations for screening programs. It was recommended that screening programs screen all cancer patients on a routine basis, measure the level and nature of distress, and include an educational training program for healthcare providers.⁹ Following these recommendations a survey was conducted of NCCN member institutions and it was determined that only 53% of the centres were conducting any routine screening as recommended.¹⁰

In 2009, recommendations emerged from the Cancer Journey Portfolio of the Canadian Partnership Against Cancer which supported the NCCN recommendations and went one step further to suggest the domains that should be included in screening programs (psychosocial, practical, and physical) and a minimum data set that should be collected for monitoring outcomes.¹¹ Recommendations included that all patients are screened for distress on a routine basis, and that psychosocial (e.g. coping, worry), practical (e.g. financial, transportation), and physical domains (e.g. pain, fatigue) are included. Furthermore, the Edmonton Symptom Assessment System (ESAS) and Canadian Problem Checklist (CPC) were endorsed as the minimum tools that should be utilized as part of a comprehensive screening program. Additionally, a model of Screening for Distress was put forward which consisted of three basic steps: 1) completion of the screening tool 2) conversation with the patient about concerns indicated (usually between a nurse and the patient) and 3) assessment and intervention of concerns by the primary healthcare team or through referral.

As recommendations emerged and more organizations endorsed distress as the Sixth Vital Sign, an increasing number of programs began to materialize. In 2008 a study of Screening for Distress in Canada found that 36.5% of cancer centres were Screening for Distress¹²;

however, this number has likely increased with the inclusion of screening in Accreditation Canada standards¹ and the endorsement of screening as a driver towards person-centred care by the Cancer Journey Portfolio of the Canadian Partnership Against Cancer.¹³ In 2013, another study of NCCN member institutions was conducted and found that there had been modest progress in the implementation of screening with a 7% increase in any routine screening and a 10% increase in institutions screening all patients. Based on the review above, it is clear that the number of Screening for Distress programs is growing and will likely continue to rise over the coming years.

1.3.2 Implementing Screening for Distress Programs

With the rising number of Screening for Distress programs attention is shifting to the implementation of these programs in clinical practice settings. The largest coordinated implementation of Screening for Distress to date took place in Canada from 2009-2012 through the support of the Canadian Partnership Against Cancer.¹⁴ Through this implementation nine jurisdictions representing eight provinces partnered with Canadian Partnership Against Cancer to implement screening of all patients in a variety of clinics regardless of disease type. The implementation involved 26 rural and 13 urban locations and over 1500 healthcare providers. A theoretical framework was not utilized during the implementations; however, based on the experience of several jurisdictions five key steps to implementation were put forward: 1) engaging high-level stakeholders, 2) providing general staff education on key concepts, 3) establishing interprofessional teams, 4) providing targeted training to staff (i.e. role specific), and 5) rolling out screening in a phased approach.¹¹ Additionally, at the conclusion of funding an evaluation of the implementations led the group to put forward 9 key principles of knowledge implementation: 1) gap assessment and understanding, 2) assessment of individual perceptions

and motivations, 3) barrier identification and management, 4) identification of social influences, 5) training and coaching, 6) patient engagement and outcomes, and implementation, 7) tailoring to local context, 8) organizational capacity building and infrastructure development, and 9) monitoring, evaluating, reporting, and disseminating.¹⁴ Through this work clinical staff raised four key barriers to the implementation of screening: time constraints, inconsistent usage, lack of buy-in, and lack of resources for follow-up.

Another implementation of Screening for Distress involved the implementation of an electronic version of screening with lung and palliative care patients in 14 regional cancer centres across Ontario.¹⁵ Components of the implementation also included examining and reorganizing work flow and responsibilities of healthcare professionals, educational activities for staff and volunteers, and the development of guidelines. A target of 90% of patients screened was established at the beginning of the program. After one year of implementation the average percentage of lung patients screened at all centres had only reached 47% and palliative clinics consistently reported between 70-90% of patients were screened. The authors noted that the challenges in achieving the 90% target were generally related to three categories: process issues, resource issues, and people/culture issues. By March 2010 the program had expanded to include the screening of all patients and the percentage of lung cancer patients screened had improved to 60% with approximately 40% of all other patients screened as well.

The emergence of Screening for Distress programs is not limited to Canada. A group in the United States has implemented a Screening for Distress program in four settings including three comprehensive cancer centres and one community hospital.¹⁶ In discussing their implementation, Loscalzo et al¹⁶ suggest that it is essential to understand the culture of the clinic, engage clinic staff, and understand the clinic processes before attempting to implement. They

note that their strategies for implementation are based on experience and supported by international leaders who are experts on engagement, but they do not discuss utilizing a theoretical framework.

A group from Japan has also developed a Screening for Distress program to facilitate the treatment of major depression and adjustment disorders in cancer patients.¹⁷ They found that after the implementation of their screening program a significantly higher proportion of patients were treated for major depression or adjustment disorders than prior to the implementation. However, although screening was useful there were two main challenges: 1) the time required for nurses to administer the tool; 2) only one quarter of patients who qualified accepted a referral for further care. Given its usefulness in clinical settings this group has begun planning to disseminate this Screening for Distress program nation-wide. Although there are no current publications on this suggested nation-wide implementation it will be interesting to follow as it will provide further insight into translating Screening for Distress research into practice.

Overall, Canada and the United States have been leading the research and policy on Screening for Distress. Much of the work on screening beyond North America has focused on research around feasibility,¹⁸ acceptability,¹⁹ and the prevalence of distress,²⁰ which are areas that have been previously explored in North America.^{3,4} There is the possibility that additional Screening for Distress programs have been implemented but have not been described in the literature. As we are interested in real world applications of screening this is a possibility and calls for the importance of publishing program models and descriptions whenever possible.

1.3.3 Screening for Distress Programs: Who does what?

Another area of debate in the implementation of Screening for Distress programs is what roles various professionals play. Who should provide patients with the tool, who should review

the tool, and who should be responsible for assessment and intervention are all questions currently being faced by centres planning to implement screening. An article by Fitch et al²¹ calls for oncology nurses to play a pivotal role in reviewing the tool and assessing and intervening with distressing concerns. This is supported by a study by Mitchell¹⁹ which found that once distress was detected approximately 90% of nurses were prepared to give distressed patients the time needed to address their concerns, whereas this was only the case with 40% of physicians.

Another common consideration is who is best situated to coordinate the implementation. Researchers and clinicians from multiple jurisdictions reported at recent international and national psycho-oncology conferences that coordinators were extremely valuable in the implementation of Screening for Distress.²²⁻²⁶ Coordinators facilitate the implementation of screening in busy clinical environments by coordinating activities such as the establishment of steering teams, development of processes such as how the tool gets on the patients' chart, and education of staff.²⁷ All of the large scale implementations discussed above were supported by coordinators who oversaw program development and implementation.¹⁴⁻¹⁶ The requirement of a coordinator to support the implementation has important funding implications and raises questions about whether funding for such initiatives needs to account for a permanent coordinator.

1.4 Implementing Screening for Distress: A Knowledge Translation Activity

As highlighted in the discussion above, to date there have been a few large programmatic implementations to Screening for Distress. A common quality improvement conceptual model used in several of these implementations employs rapid cycles of plan, do, study, and act.^{11,15} This model is focused on addressing challenges as they emerge throughout an implementation but does not guide the implementation process as a whole. Potentially this is a gap in current

implementation strategies. Graham et al²⁸ have argued that all implementations should be guided by conceptual models that provide a systematic structure and a rationale for activities.

In identifying potential conceptual models to guide the implementation of Screening for Distress, the field of knowledge translation provides some important insights. The Canadian Institute of Health Research has defined knowledge translation as “a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians.”²⁹ Based on this definition, the implementation of Screening for Distress is an example of knowledge translation as programs seek to disseminate and apply knowledge with the intention of changing practice and improving patient outcomes.

Given the implementation of Screening for Distress represents a knowledge translation activity, knowledge translation conceptual models would likely be applicable. Understanding the reasons why knowledge translation conceptual models have not been utilized, or at least are not mentioned in publications, requires further investigation. A possible reason for this disconnect is that the field of knowledge translation is relatively new and still evolving. From 1990 to 2013 the number of articles found in MEDLINE in the area of knowledge translation has increased dramatically.³⁰ It is suggested that this rapid increase in interest has also led to confusion about what knowledge translation is and is not. However, in recent years, important steps have been taken to provide clarity around the concept of knowledge translation, and research funders, such as the Canadian Institute of Health Research, have worked to ensure knowledge translation is a fundamental part of their mandate.²⁹

One widely utilized model of knowledge translation is the knowledge-to-action cycle (KTA cycle). The KTA cycle was developed through a review of planned action theories.³¹ In

this model, research knowledge is distilled into a knowledge tool/product that is then implemented into clinical practice through a series of nonlinear steps including: adapting to local context, assessing barriers to knowledge use, selecting, tailoring, and implementing intervention, monitoring knowledge use, evaluating outcomes, and sustaining knowledge use. Recently the Canadian Partnership Against Cancer adopted the KTA cycle as a model to aid in the implementation of Screening for Distress.¹⁴ Only time will tell if this endorsement will lead to the more frequent utilization of conceptual models such as the KTA cycle moving forward.

1.5 Examining Sustainability

Research in relation to the implementation and sustainability of Screening for Distress is still in its infancy. Just as conceptual frameworks for implementation are seldom mentioned, the same is true for the topic of sustainability. Sustainability has occurred when new ways of working are implemented and the corresponding outcomes become the norm.³² In respect to Screening for Distress, sustainability is achieved when it becomes part of routine care and part of the culture within the clinic setting. That is, when the three key steps: 1) completion of the screening tool 2) conversation with the patient about concerns indicated and 3) management of concerns, are taking place regularly. To quantify this, the Cancer Journey Portfolio of the Canadian Partnership Against Cancer has established key aims of 90% for patients screened, conversations charted, and of assessments and interventions occurring when required.¹⁴

Literature on the implementation of Screening for Distress continues to grow; however, a review of the literature revealed no studies that have explored the sustainability of Screening for Distress beyond the initial implementation. Despite a lack of research on sustainability, jurisdictions implementing Screening for Distress have noted that it is extremely important. To create a sustainable program, jurisdictions focused on embedding Screening for Distress into

institutional processes but it is still unknown whether, and if so what kind, of permanent support will be required for sustainability to be achieved.²²⁻²⁶ Overall, there is a lack of knowledge around how to create a sustainable program and whether or not a permanent coordinator is essential to achieve sustainability.

The knowledge translation literature provides some insights into the area of sustainability. A recent systematic review examining the sustainability of new programs and innovations, and the factors that influence sustainability, found that there were very few studies in this area that were comprehensive or methodologically rigorous.³³ They were unable to quantify or generalize the extent to which new programs or practices were sustained because there was such a range of results reported; however, they did identify a few key findings. Firstly, they found that partial sustainability was more common than the continuation of the entire program. Secondly, they found that over the past five years there has been an increase in the number of studies reporting sustainability. Lastly, they found that less than half of providers sampled about their practice reported practicing in accordance to the intervention at high levels of fidelity. They noted that sustainability appeared to be influenced by three main areas: 1) the context (internal and external), 2) the innovation itself, and 3) the capacity to sustain. In hopes to shed more light on the area of sustainability, Tricco et al³⁴ are currently completing a scoping review examining the sustainability of knowledge translation interventions in healthcare. In their protocol they outline that the objectives of their review are to 1) identify the impact on healthcare outcomes beyond implementation, 2) identify factors that influence sustainability, 3) identify how sustained change should be measure, and 4) develop a framework for assessing sustainability of knowledge translation interventions.

Despite the paucity of research in the area, the National Health Service (NHS) has developed a sustainability model and guide to assist improvement teams in enhancing the sustainability of various initiatives.³² The model was developed by involving practical and theoretical experts in change to identify and rate relevant factors in sustainability and to develop a theoretical model which was then tested for theoretical robustness and practicality. Intervention strategies were then developed and the model was evaluated. The model is based on three domains: 1) process, 2) staff, and 3) organization. The model has been adapted to an easy to use tool where the likelihood of the sustainability of a specific improvement initiative can be assessed by answering a series of questions. It is designed to be used at multiple points throughout a project so work can be done to enhance areas where scores are low before the completion of a project. Although more work is needed to evaluate this model in practice it does provide some much needed guidance to those looking to enhance the sustainability of a program.

Attention to the importance of sustainability is increasing, as the recognition of the costs associated with programs/initiatives that are not sustained becomes apparent. Although reviews of the existing literature provide important insight into the topic, the reviews are only as useful as the evidence that is included in them. Clearly more primary studies are required and this study serves to add to this literature.

1.6 Screening for Distress at the Tom Baker Cancer Centre

A comprehensive Screening for Distress program was implemented in the Head and Neck and Neuro-Oncology clinics at the TBCC in May 2010. The implementation and evaluation was funded as part of an Integrated Symptom Relief Program through a grant from the Alberta Cancer Foundation Advisory Committee on Research.³⁵ The screening program was based on national recommendations from the Cancer Journey Portfolio of the Canadian Partnership

Against Cancer.¹⁴ All patients in these tumour groups were screened at initial and at follow-up visits.

The model of the program included the following components: 1) patients completed a screening tool (see Appendix A for tool) consisting of the ESAS and CPC in the waiting room prior to their appointment; 2) the primary healthcare team (generally the nurse) discussed the concerns with the patients; and 3) the appropriate assessment and interventions were undertaken. To assist with program development, an implementation group consisting of program and clinic staff was formed and key champions were identified. Prior to the implementation, staff presentations and education sessions were held and referral pathways were developed. Significant attention was paid to ensuring that staff had the training to open conversations with patients and the knowledge to respond to concerns. Given that all concerns could not necessarily be addressed in one visit, staff were trained to work with patients to prioritize concerns and further assess and intervene with those concerns that were most meaningful to patients.

The implementation of Screening for Distress occurred from May 2010 to April 2011. At the beginning of the implementation, the program coordinator and assistant were available in clinic to support clinic staff with questions or concerns. As the implementation progressed, champions took on this role and mentored fellow clinic team members. Throughout the implementation, quality improvement methodology was utilized to address challenges and monitor progress. The program coordinator and assistant maintained their involvement from April 2011 to December 2011 to support the program primarily through monthly meetings and troubleshooting.

The initial implementation was evaluated using a comparative two-cohort pre-post sequential design. Patient data indicated that patients who were exposed to Screening for Distress

had fewer outstanding psychosocial, practical, and physical concerns than historical controls.³⁶ Evaluation data also indicated that the program was well received by health care providers.³⁷ Providers identified numerous benefits including a streamlined approach to symptom identification, improved communication with patients, and better documentation of patient symptoms and subsequent discussions. Additionally, data from the fall of 2011 indicated that approximately 90% of patients were being routinely screened and over 90% of follow-up conversations were occurring and being charted. In January 2012, the program coordinator and assistant roles ceased. However, clinic leaders decided they would continue utilizing Screening for Distress as part of standard of care in their clinics. This provided a unique opportunity to explore the sustainability of the program and led to the creation of the current study (see Appendix B for timeline of implementation and study).

1.7 Chapter Summary

This chapter highlighted the purpose and research objectives of this study. Additionally, literature on key areas including Screening for Distress programs and their implementation, knowledge translation, and sustainability was discussed. Finally, the implementation of Screening for Distress that took place in the Head and Neck and Neuro-Oncology clinics at the TBCC was described. The subsequent chapter will outline the design of the study and discuss the methods utilized.

Chapter Two: Methods

2.0 Chapter Introduction

The introductory chapter summarized the literature around Screening for Distress and sustainability and described the screening program that was implemented at the TBCC. Chapter two highlights the two research questions and design of the study. Additionally, the methods utilized for each research question are presented.

2.1 Study Purpose and Research Questions

The purpose of this study was to evaluate sustainability of the Screening for Distress six months post the completion of the implementation in the Head and Neck and Neuro-Oncology clinics at the TBCC. There were two research questions:

1. Determine if screening rates, screening conversations, and appropriate interventions were maintained post the completion of implementation.
2. Determine the barriers and facilitators to the sustainability of Screening for Distress in these clinics.

2.2 Study Design

A cross-sectional design with mixed-method data collection was utilized to assess the sustainability of Screening for Distress. Chart reviews were conducted to obtain quantitative data surrounding screening rates, screening conversations, and interventions. Semi-structured interviews with staff were conducted to determine the barriers and facilitators to the sustainability of Screening for Distress.

2.3 Methods for Research Question 1

The first research question explored if screening rates, screening conversations, and appropriate interventions were maintained post the completion of the implementation.

2.3.1 Sample

Charts of consecutive patients attending the Head and Neck or Neuro-Oncology outpatient clinics at the TBCC for a new patient consultation or follow-up visit during the three week study period were reviewed.

2.3.2 Procedure

Eligible charts were identified through the electronic medical record system used at the TBCC, ARIA®, and all visits during the three week period were included in the review. Chart reviews were conducted at least three weeks after the patient's visit to allow sufficient time for documents to be scanned and included in the electronic record and for transcription and approval of notes to occur. Chart reviews were conducted by a graduate student (S.G.) and the reviews focused on the visit that occurred during the study period.

A waiver of consent from the Conjoint Health Research Ethics Board (CHREB) of the University of Calgary was received for this study. The request was granted based on the grounds that it was impractical to obtain consent for this retrospective review of charts. Additionally, as the research questions was focused on the extent to which Screening for Distress was being utilized in the clinic it would have been infeasible to obtain consent prospectively without alerting staff. This in turn could have led staff to modify their behavior (i.e. be more likely to screen for distress/discuss psychosocial concerns) and thereby impact the integrity of the findings.

2.3.3 Data Collection & Management

The following data points were collected from each chart reviewed:

- Tumour group where the patient was seen (Head and Neck or Neuro-Oncology)
- Whether there was a completed screening tool for the date of interest (yes or no)

- Did a healthcare team member sign the screening tool (yes or no)
- Were there notes from a member of the healthcare team from the visit of interest indicating that a conversation about the screening tool took place (yes or no) and if yes, which team member had this discussion with the patient
- Was there indication of an intervention either directly from the healthcare team (i.e. prescription for pain control) or through a referral to another healthcare provider (i.e. psychosocial resources for counselling) (yes or no). If there was an intervention provided details about the intervention were recorded

Data was entered in a password protected database and all records were assigned a unique ID number.

2.3.4 Outcome Measures

The sustainability of Screening for Distress was assessed by determining 1) the percentage of patients screened, 2) the percentage of patients screened who had a conversation with a healthcare provider about the screening tool, and 3) the percentage of patients who scored above a clinical cut-off on the tool and were offered interventions. These measures have been previously utilized by the Cancer Journey Portfolio of the Canadian Partnership Against Cancer as key outcome measures in the implementation of Screening for Distress.¹⁴

The first outcome, percentage of patients screened, indicates whether the first step of screening, the completion of the screening tool, was taking place. This outcome was calculated with the following formula:

$$= \frac{\text{\# of patients who have a completed screening tool on their chart}}{\text{Total \# of patient charts reviewed}} \times 100$$

Commonly, the bench mark of 90% is utilized to indicate successful implementation.¹⁴ Although challenging, both research and clinical programs, including screening at the TBCC, have been able to achieve 90% of patients screened upon implementation of the program.^{17,24}

The second outcome examined the percentage of patients who were screened and had a conversation with a healthcare provider about the screening tool. This outcome was calculated with the following formula:

$$= \frac{\text{\# of patients who complete tool \& discuss it with member of healthcare team}}{\text{\# of patients who completed the screening tool}} \times 100$$

This outcome is linked to the second component of Screening for Distress programs, discussing the screening tool with the patient and his or her family. Acknowledging the screening tool, whether or not high scores are indicated, is considered pivotal to the success of Screening for Distress as patients are likely to disengage in the process if they feel no one is using the tool.¹¹ In order to assess whether a conversation occurred, the tool itself was examined to see if there were notes written on the paper-based tool. Additionally, the progress notes section of the chart and any other assessment forms were reviewed for the visit of interest. Consistent with the previous outcome, a benchmark of 90% was utilized.

The final outcome examined whether the appropriate assessment and intervention occurred for all concerns indicated above a clinical cut-off. For the ESAS items, a score of 4 or above was considered clinically significant and any items indicated on the CPC were considered significant. “Appropriate intervention” in this situation was indicated if the high score was explicitly acknowledged, assessed, and a plan for either further monitoring, intervention by the healthcare team, or referral was indicated. This outcome was calculated with the following formula:

$$= \frac{\text{\# of patient who score above a clinical cut-off and are provided intervention} \times 100}{\text{\# of patients who scored above a clinical cut-off}}$$

2.3.5 Sample Size

Given that the purpose of this study was to determine the sustainability of Screening for Distress, a sample size was desired which was sufficiently large enough to capture the routine practice in clinics. As oncologists often hold only one clinic per week a period of time spanning at least two weeks was desired to capture multiple clinics for each oncologist. In order to meet these requirements, a three week period was deemed appropriate to capture at least 150 individual patient visits and multiple clinics for each provider.

2.4 Methods for Research Question 2

The second research question explored the barriers and facilitators to the sustainability of Screening for Distress. To address this research question, following the chart reviews semi-structured interviews were conducted with clinic staff.

2.4.1 Participants

Nurses, oncologists, surgeons, clerks, and administrators working in the Head and Neck or Neuro-Oncology clinics at the time of data collection were invited to participate in interviews examining their experiences with Screening for Distress.

2.4.2 Interview Procedure

Potential participants were introduced to the study and the graduate student researcher via email by a member of the local Screening for Distress Steering group. The graduate student researcher (S.G.) then contacted each potential participant individually via email to assess their interest in participating. If the researcher did not hear back from a potential participant, a second email was sent approximately two weeks later. If there was still no response no further contact was made. If the potential participant expressed interest in participating a date and time was

arranged at the participant's convenience and a quiet and confidential location was utilized. At the beginning of the interview, the study was further explained and consent was obtained (see Appendix C for consent form). Interviews were conducted using a semi-structured format and were recorded using a digital recorder. Once complete all interviews were transcribed verbatim.

2.4.3 Measures

A semi-structured interview guide was developed by the study team and was used to facilitate the interviews (see Appendix D). Question categories include: awareness/beliefs about Screening for Distress, role in Screening for Distress, integration into practice, and barriers and facilitators. The purpose of these questions was to gauge the participants' current understanding and practices, as well as the barriers and facilitators to Screening for Distress. Basic demographics were collected including role (i.e. nurse, oncologist, etc.), years in profession, any advanced training and education, and months working in Head and Neck or Neuro-Oncology clinics.

2.4.4 Sample Size

Given that this study is focused on examining Screening for Distress in the Head and Neck and Neuro-Oncology clinics, available participants for interviews consisted of staff working in these clinics. At the time of study recruitment, there were sixteen oncologists/surgeons, nine nurses, and four administrators working within these clinics eligible for participation. In order to facilitate the participation of all of those who were interested, flexible dates, times, and locations were provided.

2.4.5 Data Management, and Analysis

As mentioned above, the interviews were transcribed verbatim into Microsoft Word. The transcribed data was then imported into QSR NVivo 10® software which supports the sorting

and coding of qualitative data. The qualitative data was then analyzed within the framework of thematic analysis. Thematic analysis serves as a tool for identifying, analyzing, and reporting themes within data.³⁸ Thematic analysis can be broken down into six phases: familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Below are the phases of thematic analysis as described by Braun and Clarke³⁸:

- 1) Familiarizing yourself with the data: This phase involves reading and re-reading the data and jotting down notes and initial ideas.
- 2) Generating initial codes: This phase involves going through the data in a systematic fashion, coding interesting features, and collating data relevant to each code.
- 3) Searching for themes: During this phase, codes are collated into potential themes and all data is gathered around the potential themes.
- 4) Reviewing themes: In phase four, the themes are reviewed in terms of how they fit with the coded extracts and the dataset as a whole.
- 5) Defining and naming themes: This phase involves ongoing analysis and the refinement of the themes. Additionally, clear definitions and names are developed for each theme.
- 6) Producing the report: The writing of the report represents a final opportunity for analysis and involves the selection of extracts to assist in communicating the findings.

In the current study, the graduate student researcher (S.G.) completed all of the phases as described above. The data was printed and reviewed multiple times to gain a sense of the data. Initial codes were generated through the support of QSR NVivo 10® software. Additionally, to enhance dependability, the phases of searching for themes, reviewing themes, and defining and

naming themes were peer reviewed by two experienced researchers. Finally, the results were written up and will be described in the next chapter.

2.5 Chapter Summary

This chapter highlighted the study purpose and the research methods utilized. The purpose of the current study was to explore the sustainability of Screening for Distress in the Head and Neck and Neuro-Oncology clinics at the TBCC post implementation. The first research question, to determine if screening rates, screening conversations, and appropriate interventions were sustained, was explored through the collection of quantitative data. Specifically, chart reviews were conducted for all visits over a three week period. The second research question, focused on identifying the barriers and facilitators to the sustainability of Screening for Distress, was explored using qualitative research methods. Semi-structured interviews were conducted with healthcare providers who worked in the Head and Neck or Neuro-Oncology clinics. The following chapter will discuss the results of the chart reviews and interviews.

Chapter Three: Results

3.0 Chapter Introduction

The results obtained through the data analysis are discussed in this chapter. First, the quantitative results from the chart reviews are presented including descriptive and outcome related data. Specifically, results related to the research question: “Are screening rates, screening conversations, and appropriate interventions maintained six months post the implementation of Screening for Distress?” are presented. Second, qualitative data from interviews conducted with participants are presented. This data is focused on the research question, “What are the barriers and facilitators to the sustainability of Screening for Distress?” Lastly, a chapter summary is provided.

3.1 Chart Reviews

The charts of 184 consecutive patients who attended either the Head and Neck or Neuro-Oncology clinic over a three week period from May 1, 2012 to May 17, 2012 were reviewed. Of the charts reviewed, 84 (45.7%) were from the Head and Neck clinic and 100 (54.3%) were from the Neuro-Oncology clinic. Screening tools were present in 163 (88.6%) of 184 charts.

Among the 163 charts with a completed screening tool, the signature of a healthcare provider was present on 137 (84.0%). One-hundred and thirty (79.8%) of the 163 charts had notes indicating a conversation about the tool had occurred between the patient and a provider; 129 (99.2%) of these conversations were between the nurse and the patient. Among the 89 charts where an intervention was warranted, an intervention was indicated in 68 (76.4%). Interventions ranged from teaching the patient fatigue management strategies to providing self-referral information to the Department of Psychosocial Resources. Approximately 65% of the time the intervention was managed solely by the primary care team, followed by team and referral (13%),

referral (9%), providing self-referral information (7%), and in 6% of the cases it was unclear what intervention was provided due to illegible writing.

3.2 Interviews

Interviews were conducted with 16 of the 29 eligible nurses, physicians, and administrative staff within the Head and Neck and Neuro-Oncology clinics. Seven of 9 nurses, 6 of 16 physicians and 3 of 4 administrative staff participated in the interviews, which ranged in length from 9:36 to 43:00 minutes (mean = 23:17 minutes). Participants had an average of 17 years (range = 3 to 41 years) of healthcare experience and had been working in the Head and Neck or Neuro-Oncology clinics for an average of 6 years (2 months to 20 years).

3.3 Sustainability

To explore if Screening for Distress was sustained in these clinics participants were asked if screening was well integrated into their clinics, if they felt screening had been sustained since the departure of the designated Screening for Distress program staff, and what they felt could impact its sustainability moving forward. When asked about the integration of Screening for Distress in their clinics, the majority of participants described screening as “routine (N1)” and noted it was “being used regularly by nurses (N3).” Several participants also described screening as “fully integrated (N4)” and indicated that “screening is sustained (N1).” One nurse noted, Screening for Distress is “essential to our clinic process (N4)” and an administrator noted “it has been embraced in a way that it is sustained (A2).”

When asked about the impact of the removal of the designated program staff on the sustainability of the program, several participants noted that “it [screening] was pretty entrenched before they left (O1)” and that the impact of their departure was minimal as screening had already become part of the norm. This was described by one participant who stated “once it

becomes part of the norm then you're good (N2)." Another participant noted, "it was great having them around for a resource... but I don't think we are under-serving patients anymore because they're not there because I think it's a sustainable part of our assessment process (N4)."

When asked about threats to sustainability, one participant indicated "I think it's just so routine now that I don't think anything is going to fall apart (N1)." None of the participants indicated that screening was not being utilized or that it had fallen off since the departure of program staff. Taken together with the quantitative findings these comments indicate that screening is routinely being conducted as part of clinic practices.

3.4 Themes Related to the Sustainability of Screening for Distress

An additional objective of this research was to determine the barriers and facilitators to Screening for Distress. To gain insight into this question, participants were asked, what, if any, was the impact of screening on clinical care, if they felt the processes related to screening were efficient, what were the barriers and facilitators to the utilization of the tool, and how they felt screening fit into the larger objectives of the cancer centre. Five themes that influenced the sustainability of the program emerged from the data (Figure 1): 1) Attitudes, Knowledge and Beliefs, 2) Outcome Expectancy of Providers, 3) Implementation Approach, 4) Integration with Existing Practices, and 5) Factors External to the Program. Additionally, within the themes, nine subthemes emerged.

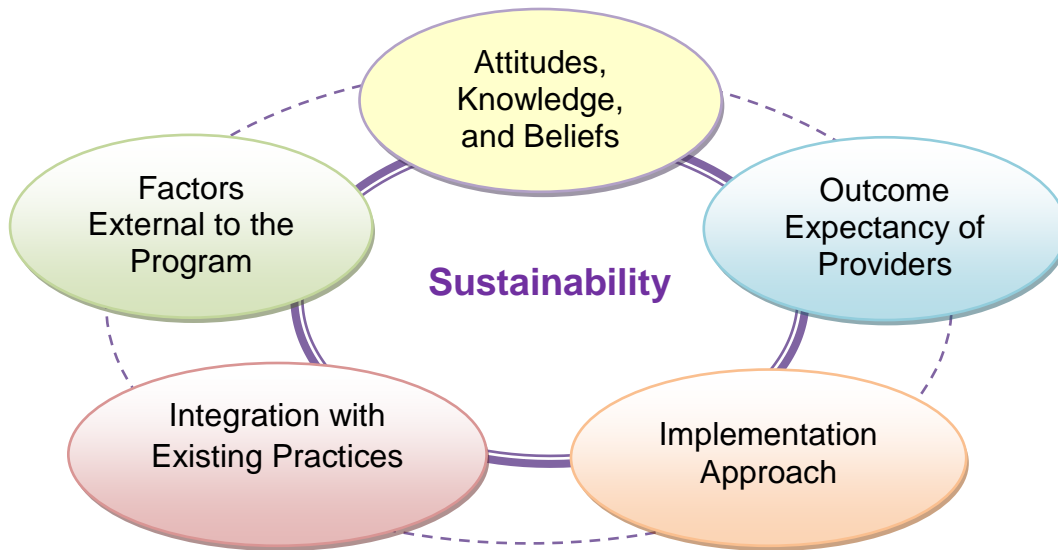


Figure 1: Themes related to the sustainability of Screening for Distress

3.5 Theme 1: Attitudes, Knowledge, and Beliefs about Screening for Distress

Theme 1 relates to the attitudes, knowledge, and beliefs of the healthcare providers towards Screening for Distress. The majority of participants held positive attitudes and beliefs about screening and they described it as helping to “give the best quality, all inclusive, well-rounded care that we can to patients and their families (A2).” As one administrator described,

I may have started a long time ago in terms of the actual process and what it would mean in the clinics as being a bit of a skeptic and I’m a total believer. I think it’s one of the best things we’ve done, you know, for patient care it really rounds out the quality (A2).

Screening was also described as “shifting the culture of care from strictly biomedical to a more holistic way of being and a way of looking after people (A1).” Some participants noted that “it’s better for us and our patients (N7).” Within this theme, two subthemes emerged: 1) current gaps in knowledge and 2) beliefs about responsibility for Screening for Distress.

3.5.1 Theme 1 Subtheme 1: Current Gaps in Knowledge

The first subtheme captures knowledge gaps that existed post implementation. Firstly, some participants noted challenges managing diverse patients particularly those who spoke a different language. As one nurse described, “language barriers is a big thing... we have to find areas where they can have help in their own language... it’s harder to navigate through talking to them (N7).” A physician also expressed concerns noting that “patients have had distress and it slipped through the screening because of a language barrier, you know, it just never got communicated (O1).” Secondly, several participants noted challenges in knowing how to respond to certain concerns. For example, one nurse stated “I honestly don’t feel like I’m equipped to handle a lot of [concerns] like anxiety and depression (N3).” Another nurse, when talking about not knowing how to help a patient, stated “I don’t have all of the answers and I feel horrible about it (N5)” and a third nurse noted “It’s always a challenge for me in terms of knowing about what’s available out in the community and just keeping current with that (N4).”

The final gap in knowledge relates to understanding the program. There is a long history of screening for distress at the TBCC and several participants indicated confusion between the current and past version of the program. In their interviews, three of the six physicians made comments that indicated confusion between the current and past programs. For example, one physician referred to “new patients” as the “ones that get screened for distress (O4)” when in actuality all patients are screened (only new patients were screened prior to the current program). There was also confusion about who was leading the work as originally screening was led by the Department of Psychosocial Resources but the current program is a joint venture between the Department of Psychosocial Resources and nursing. This was demonstrated through comments such as “the psychosocial group does a very good job of letting us know what they are up to

(O3)” and “the psychosocial department does the information gathering and synthesis and research much better (O4).” As a whole, this subtheme revealed gaps in knowledge that existed post implementation. The areas of the gaps varied by participant and professional group with nurses indicating more apprehension about responding to certain concerns and physicians indicating more gaps in understanding the current version of the program.

3.5.2 Theme 1 Subtheme 2: Beliefs about Responsibility for Screening for Distress

As noted in the program description, screening consists of three main steps: 1) completion of the tool 2) assessment through a conversation with the patients and 3) intervention to address priority concerns. When participants were asked who did what in the screening process, the majority of participants described discussing the tool with patients and conducting further assessment as a responsibility of nurses. As one administrator stated “I know it’s a nursing tool, and it’s handled as a nursing tool (A2).” The nurses who participated agreed with this perception and described it as part of their role to go through the screening scores with patients and talked about screening “as part of my nursing assessment (N1, N4, N6).”

The responsibility of the physicians was less clear. Some physicians saw nurses as managing the assessment and intervention as seen in the statements “...usually it’s just they [the nurse] that deals with it (O1)” and “the nurses often protect us from that (O6).” However, others viewed nurses as the first line of response who would raise concerns to the physician if required. This is seen through statements such as “the nurse will talk a little bit about whatever the patient marked in the scale with the patient and then the nurse will review it with me (O2)” “If they identify an area that is quite obvious from the screening tool they will bring it to my attention and I’ll try and address that (O3)” and “I’m not directly involved with the screening I’m more overseeing what has happened or is happening (O1).” The latter approach suggests the

intervention is a joint responsibility of nurses and physicians. This subtheme highlights that there is some confusion about who is responsible for the various components of screening particularly when it comes to providing intervention.

3.6 Theme 2: Outcome Expectancy of Providers

The second theme relates to the expectations of providers as a result of the implementation of Screening for Distress. Three sub-categories emerged from the data 1) patient-related outcomes 2) patient-provider outcomes, and 3) provider-provider outcomes.

3.6.1 Theme 2 Subtheme 1: Patient-Related Outcomes

Patient-related outcomes refer to the outcomes providers noticed or expected in relation to the patients' experience. The majority of participants reported that they generally felt Screening for Distress positively impacted the experiences of patients as indicated in the statement "I genuinely believe that this has been a significant improvement for them [patients] (O6)." Several participants also noted that screening provides patients the "chance to have a voice (N1, N2, N5)" and that they "encourage patients to use it as a tool (N2)." Participants also described liking that screening is "so patient driven (N2)". This is seen through comments such as "I think that patients feel like at least the question is being asked because it wasn't being asked before (O6)" and "it's perfect because it's all about patient experience (N2)." This subtheme highlights that participants saw numerous benefits for patients as a result of the Screening for Distress program. Furthermore, no participants indicated concerns or potential negative outcomes for patients as a result of the program.

3.6.2 Theme 2 Subtheme 2: Patient-Provider Outcomes

Patient-provider outcomes refer to outcomes that participants noticed or expected in terms of how screening effected their conversations and relationships with patients. In terms of patient-

provider outcomes, there was a general expectation that Screening for Distress helped participants connect with patients by facilitating and enhancing conversations. As one nurse commented “when it’s not there you’re kind of lost right, because that’s how we start our conversations (N1)” and another noted “I think it’s super helpful just to start conversations and they’re obviously willing to disclose kind of what they are going through (N3).” Several participants also indicated that patients opened up about concerns that might not have been discussed previously. As one nurse said “it’s opened the conversation for other things that may have been going on in their lives that we weren’t seeing (N7)” and another noted “last week we had someone who I would not have expected at all to check off intimacy and sexuality and I definitely would not have asked about that (N3).” Collectively, these comments indicate that participants felt screening facilitated connections with patients and the opening of difficult conversations.

3.6.3 Theme 2 Subtheme 3: Provider-Provider Outcomes

Provider-provider outcomes refer to outcomes participants noticed or expected in terms of how they relate to one-another. Some participants discussed that screening provided a common language as highlighted in the comment “it gives everyone the common terminology, common language, and perhaps a repertoire of solutions or assistance that they can provide to the patients (A1).” Other participants indicated that screening helped them to refer to resources:

It’s enhanced the way that we work... if I refer somebody to social work because of the conversations that I’ve had with the patient that were triggered because of the screening tool I can give them a little bit better of an assessment of why I am referring them (N4).

Some participants discussed how they felt Screening for Distress had improved their charting. As one nurse said “I think it’s helped charting because you can just tick and sign and it shows that you’ve done something (N2)” and another said “I’m actually finding the charting is probably better (N5)”. These comments indicate that screening enhanced the way providers worked together by providing a common language, assisting referrals, and improving charting.

3.7 Theme 3: Implementation Approach

The implementation approach also emerged as a key theme influencing sustainability. Participants indicated both positive and negative elements of the implementation approach. Several participants discussed how they felt that it was good that there were dedicated program staff helping to implement the program. Some participants indicated that the program staff were vital to establishing the processes required for screening and identifying resources. As one participant noted, “there has to be someone on the ground who has the time, not only to help you work out the process... but also ways of responding to issues identified (A1).” Without designated program staff one participant noted that “the processes wouldn’t be as smooth as they are now (O1).”

The implementation approach appeared to be successful in achieving buy-in from clinic staff, particularly from nursing staff. This was highlighted in the following quotes: “We bought in. We had a nursing champion that bought in, our unit clerk bought in and I think those are key players (N1)” and “buy-in is the biggest one and we definitely have that (N4).” However, there was no mention of buy-in or champions regarding the physician groups.

One negative element of the implementation was that several participants felt that there was insufficient educational support at the beginning of the implementation. As one nurse said “I don’t think we had the education, the time to do the modules... so that was not supportive if you

ask me (N1)” and another said “It wasn’t really well explained at the beginning so most of us really didn’t know what was going on (N2).”

An advantage and disadvantage of the implementation approach that was raised by participants was the phased approach. Some of the benefits of the phased implementation include the ability to select groups where success was likely, as one administrator noted “we targeted those groups for a reason right (A1).” Another advantage of working with just a few groups at a time that was noted by participants is that it allowed for flexibility. As one participant said,

If you want to think of this as a culture change, culture change takes time so you have to do your implementation in a methodical responsive manner that takes into account and adapts to the challenges as they’re identified by the care teams and the patients if that’s what comes up (A1).

The phased approach was also seen as a disadvantage. One participant explained why it was challenging:

We sometimes get a nurse who’s covering who has never used it so it doesn’t get used and again that problem is going to be fixed when everybody uses it, when it’s a standard for everybody I think it will be addressed (N2).

This theme highlights several positive elements of the implementation including having dedicated program staff securing buy-in from key team members. It also reveals some gaps in the implementation particularly around education, including education of staff upfront and educating casual staff as required.

3.8 Theme 4: Integration with Existing Practices

The fourth theme that emerged was the integration of Screening for Distress with existing practices. This theme can be broken down into two sub-themes: 1) integration with other forms/assessments and 2) integration with existing practices.

3.8.1 Theme 4 Subtheme 1: Integration with other Forms/Assessments

Several participants expressed that they felt screening could be better integrated with existing forms and assessments. In particular, participants indicated that the screening tool could be better integrated with other assessment forms used in clinic. As one nurse noted,

I think one big thing is we need to coordinate the pink sheet and the screening so that we don't have so much. People do sometimes say, "okay I've filled out the same thing in more than one place..." I think we could streamline things quite a bit (N2)."

Another nurse reiterated this point when stating "I think it would be good if it could be put into one form so that we don't have two sheets for the patients to fill out (N5)."

Several participants also noted that it was "difficult to know what was the distress screening done previously... it's hard to look at the old one (O1)." To address this, some participants suggested that screening could be better integrated with the existing electronic medical record. As one participant said, "It's not efficient when we have to go back and look at them and bring them up on ARIA [electronic medical record] (N5)."

Another challenge that was raised by participants, particularly physicians, was that screening does not fit well with the documentation required for clinical trial patients. Clinical trials require documentation from physicians on any concerns indicated even if in the mild range and is based on the National Cancer Institution toxicity grading which is different from the

ESAS that is used as part of the screening tool. As one physician noted, “It increased the [work] load because even if the patient marks one sometimes we have to report it as a side effect... (O2)” and another noted “...this has increase my workload exponentially and truthfully has dampened my enthusiasm for the program because of this unforeseen problem (O6).” Taken together this subtheme highlights that there are several areas where Screening for Distress could be better integrated into other assessments and forms.

3.8.2 Theme 4 Subtheme 2: Integration with Existing Practices

In terms of integration with existing practices, participants highlighted several areas where screening could be better integrated. Firstly, several participants indicated the need to incorporate screening into staff education. As one new nurse in clinic noted “when I was doing my orientation there was so much to cover that this [screening] kind of got a five second blurb (N3).” To address this concern, some participants suggested integrating screening into staff orientations. As one administrator said “education is an on-going commitment... it [needs to] get built into physician orientation, nursing orientation, clerical orientation, patient orientation so that it becomes part of the fabric of who we are and how we conduct our business (A1).”

Secondly, some participants indicated the need to have community resource lists maintained to aid in the initiation of appropriate interventions. As one participant stated “it would be great if we had somebody that could kind of investigate and find out those community resources and could maintain that more currently (N4).” Finally, a few participants indicated that screening had not been integrated into rounds. As one nurse noted “we talked about integrating it into our rounds and we haven’t done that yet (N2).” As a whole, this subtheme highlights that there are areas where screening could be better integrated in existing practices. Participants

discussed these areas as potential areas of improvement but they generally did not discuss them as discouraging their enthusiasm for the program.

3.9 Theme 5: Factors External to the Program

The final theme refers to the potential influence of external factors on the sustainability of Screening for Distress. The majority of participants indicated that they felt Screening for Distress fit with the objectives of the centre and TBCC as a whole. Within this theme two sub-themes emerged: the impact of competing priorities and the commitment of senior management.

3.9.1 Theme 5 Subtheme 1: Impact of Competing Priorities

Some participants discussed that there are “at least a hundred other priorities (A1)” that compete with Screening for Distress and that these priorities have the potential to threaten the sustainability of the program. As one administrator highlighted,

You need to be able to focus on this [Screening for Distress] and give it the time it deserves to do it well and in a way that will be sustainable. You could push something in quickly but it won't be sustainable (A1).

To this affect, competing priorities limit the time that can be spent focusing on screening for distress.

Some participants also noted that priorities change over time and that new priorities could impact the sustainability of the program. As one physician said,

“I guess we just have to see what's coming down the pipeline because we are going to be implementing a sort of quality of life exercise nutrition program as well so there's going to be some quality of life questionnaires associated with that so we just don't want to overload the patients in terms of the amount of things they are filling out. So we will have to see. We will carry on with the screening

tool for now but there is going to be some additional things that we might ask the patients to do (O1).”

This challenge was also highlighted by a nurse who said, “the day somebody complains about putting them on the chart and they come off will be the problem (N1).” This subtheme highlights the potential negative impact of competing priorities on the implementation process and the long term sustainability of the program.

3.9.2 Theme 5 Subtheme 2: Commitment of Senior Management

In terms of the commitment of senior management, some participants indicated that they felt senior management was committed to the implementation of Screening for Distress and that screening “fits in with the larger objectives of healthcare and AHS (A1).” As one participant said, “senior administration has now said for cancer care, Screening for Distress is a priority and will be implemented across the province (A1).” However, participants did question if senior management appreciated the work required to implement screening. As one participant noted,

I think there is very senior level commitment. I’m not always convinced that they fully appreciate what that will take but I think it’s there... I think there is a lack of appreciation for the amount of work that goes into doing it well. (A1)

This was reiterated by another participant, who, when asked whether there was support from senior management stated “In broad-brush strokes I’d say yes, but in operational day-to-day stuff I’m not sure (A2).” Overall, the majority of participants felt screening was endorsed by senior management and fit with the larger objectives of the centre; however, there was still some apprehension around whether the senior leaders appreciate the work it takes to effectively implement Screening for Distress.

3.10 Chapter Summary

In this chapter, screening rates, screening conversations, and appropriate interventions six months post the completion of the Screening for Distress implementation gleaned from chart reviews were presented. Additionally, qualitative data collected through interviews with sixteen physicians, nurses, and administrators was presented. Specifically, the sustainability of Screening for Distress as well as the barriers and facilitators to its sustainability were explored. Five themes related to the sustainability of Screening for Distress were presented along with nine subthemes. The discussion chapter will further explore these results within a broader context.

Chapter Four: Discussion

4.0 Chapter Introduction

The results section highlighted the findings from the quantitative and qualitative data collected. This chapter seeks to triangulate the data and further explore what it tells us about the sustainability of Screening for Distress in the Head and Neck and Neuro-Oncology clinics at the TBCC. Firstly, the model developed in this study is utilized to facilitate a discussion and interpretation of the findings. Secondly, the strengths and limitations of the study are discussed. Lastly, directions for future research and conclusions are presented.

4.1 Discussion and Interpretation

4.1.1 Attitudes, Knowledge, and Beliefs

Participants held positive attitudes about Screening for Distress, often noting benefits such as improved quality of care. One study which utilized a similar tool and screening philosophy found that cancer patient navigators in Quebec and Nova Scotia, who were Screening for Distress, also reported positive perceptions of screening.³⁹ As there are few studies which examine attitudes, knowledge and beliefs in relation to Screening for Distress, the field of knowledge translation provides some insight into the potential impact of these variables on programs.

Michie et al⁴⁰ explored domains of behaviour change and found attitudes and knowledge were in the top five domains. This is consistent with a guide produced by the National Institute of Clinical Studies⁴¹ which described knowledge and attitudes as potential barriers to best practices. Building upon this work, Flottorp et al⁴² conducted a review of domains influencing behaviour change and found that 10 of 12 articles reviewed included attitudes and knowledge as factors that influence behaviour change. In their new model, Flottorp et al⁴² identified seven

domains which influence implementation, with one of those domains being individual health professional factors. This domain includes factors such as knowledge about the intervention and attitudes towards the intervention.

One area where the model proposed in the current study differs slightly from the models in the literature is the concept of beliefs, which is likely contributable to the ambiguousness of the term beliefs. The literature of behaviour change does capture the concept of beliefs but there is variation within this body of literature when it comes to how the term is used. For example, Michie et al⁴⁰ indicate beliefs about capabilities and beliefs about consequences as two domains that explain behaviour change; whereas, Damschroder et al⁴³ discusses beliefs about the intervention. In the current study, beliefs not only captures beliefs about the intervention, Screening for Distress, but also beliefs about who is responsible for the various components of screening and this is something that is unique to this intervention. Despite this variation, the literature supports the idea that knowledge and attitudes are key components of behaviour change, and as such are likely to contribute to the sustainability of the program.⁴⁴ Given that the overwhelming majority of participants held a positive attitude towards screening and had a good working knowledge of its purpose, these elements are likely significant contributors to the sustainability of the program.

Although study participants held positive attitudes towards Screening for Distress, there were a few gaps in knowledge which existed post implementation, specifically managing diverse patients and responding to certain concerns such as anxiety and depression. These knowledge gaps tie into two other themes, the implementation approach and integration of Screening for Distress with existing practices. In terms of the implementation approach, some participants felt that there was a lack of upfront education. Possibly if more upfront education was provided

participants would have felt they had the knowledge to manage these situations. This gap also ties into the integration with existing practices theme as these gaps in knowledge could be addressed through integration with ongoing staff education. Given that the primary care team managed the majority of the concerns raised by patients it is important that they have the knowledge and skills required to do so.

These gaps in knowledge may also provide some insight into why there were several charts with no notes indicating that a conversation took place about the concerns highlighted on the screening tool. Possibly, the lack of confidence managing anxiety and depression that was described by participants limited the providers' willingness to engage in certain conversations. Additionally, for those situations where English was not the patient's first language the tool may be scanned and included on the chart but a conversation about the tool may fail to take place. Unfortunately, exploring the literature on the conversational aspect of Screening for Distress yields little insight, as this is a fairly new component of screening. Although gaps in knowledge may represent a plausible explanation for the lack of conversations occurring in some cases, additional work is required to explore this further.

One area of confusion for staff was who was responsible for the three components of Screening for Distress (screening, assessment, and intervention). Although, there was agreement that discussing the tool with patients and conducting the initial assessment of the screening was the responsibility of nurses there was less clarity around the management of interventions. This confusion is likely why only three quarters of patients who required an intervention had one documented. This is an important area to address as research has found that the ability of screening programs to improve patient outcomes is tied to the ability to provide patients with appropriate interventions.⁴⁵

The topic of who is, or who should be, responsible for the various components of screening is still up for debate. Nurses clearly play a large role in this process but what is less clear is what is and isn't their responsibility. An article by Fitch et al²¹ provides some important insight into this discussion. The article highlights that oncology nurses through their scope of practice are equipped to respond to distress and that their response can range from providing education and supports, facilitating symptom management, to supportive counseling; however, they note that the responsibility for responding to the various aspects of distress needs to be customized locally based on the skills of the providers and the resources available. This variation in the providers available is seen in Quebec and Nova Scotia where cancer patient navigators play a pivotal role in the screening process.³⁹ Although resource pathways were developed for the current implementation, these pathways did not delineate the responsibilities of nurses and physicians. Further work is required to explore this gap and how it can be addressed moving forward.

4.1.2 Outcome Expectancy of Providers

The most robust and positive theme in this study was the outcome expectancy of providers. Participants held positive views about the ability of the Screening for Distress program to provide a voice for patients, to facilitate conversations between patients and providers, and to enhance communication between providers. These benefits of screening have been documented in other studies. Fillion et al³⁹ reported that nurse navigators utilizing screening felt that it facilitated clinical assessment, opened dialogue with patients, and supported timely interventions and referrals. The NHS model of sustainability highlights the importance of the positive outcome expectancy demonstrated by participants as credibility of the benefits and it is

one of ten factors influencing the sustainability of programs.⁴⁴ Given the strength of this area, it likely contributed to the sustainability of Screening for Distress in these clinics.

4.1.3 Implementation Approach

There were positive and negative elements of the implementation approach highlighted by participants. The implementation approach was not based on a particular model of knowledge translation. However, one commonly utilized model for the implementation of programs that the current implementation can be compared to is the KTA cycle which was developed through a review of planned-action theories.³¹ The KTA cycle involves a series of steps to facilitate the integration of new knowledge/practices including selecting knowledge, adapting the knowledge to the local context, assessing the barriers to knowledge use, selecting, tailoring, and implementing interventions, monitoring knowledge use, evaluating outcomes, and sustaining knowledge use. As described in the introduction, the implementation of Screening for Distress encompassed all of these elements to some extent. One of the likely reasons the implementation was able to capture these important elements was that there were dedicated program staff available to help develop and actualize the required processes. Although the implementation did not intentionally include elements of the KTA cycle, the fact that these elements were present demonstrates that the implementation was well thought out and that these findings may be applicable to other implementations using an approach similar to the KTA cycle.

One area of the KTA cycle where the implementation at the TBCC did not focus a lot of attention was sustaining knowledge use. Despite being an important consideration, sustainability is often not addressed in implementations or at best is left until the end.³³ Some of the reasons for a lack of attention to program sustainability include the limited availability of long-term funding and disengagement of project leaders towards the end of projects.⁴⁶ In the current

implementation, concrete sustainability strategies accounting for challenges such as staff turnover were not in place prior to the departure of program staff and this may have contributed to the slight decrease in the screening rates, conversations, and interventions that occurred.

In terms of the implementation, the results suggest that more directed attention to educating and engaging physicians may have been beneficial. As highlighted in the results, nurses reported good buy-in and champions but there was virtually no mention of physician buy-in or champions. Although physician representatives were involved in planning of the implementation, their role as champions and the overall role of physicians in screening and responding to distress was ambiguous. This lack of clarity and communication with the physician group may have contributed to the low rates of interventions as this is an area where physicians are likely to play the largest role. Additionally, this lack of clarity may also explain the confusion between the current and previous versions of the program, as this confusion was limited to a few physicians. It also may explain why the concerns raised on the Screening for Distress tool were not integrated into tumour group rounds, as these rounds are lead by and primarily attended by the physician group. This lack of engagement with the physician group is a potential threat to sustainability, as staff involvement, training and clinical leadership are important areas of sustaining change.⁴⁴

The literature on physician engagement sheds some light on how this group could be better engaged. The Institute for Healthcare Improvement, as part of their innovation series, published a framework for engaging physicians in quality improvement activities.⁴⁷ The framework outlines six elements important to engaging physicians: 1) discovering common purpose (e.g. improving patient outcomes), 2) reframe values and beliefs (e.g. physicians as partners), 3) segment the engagement plan (e.g. identify and activate champions), 4) use

“engaging” improvement methods (e.g. make the right thing easy to do and try), 5) show courage (e.g. backup and support), and 6) adopt an engaging style (e.g. involve from the beginning, build trust). The implementation of Screening for Distress at the TBCC captured many of these elements; however, based on the feedback of participants, the areas of “segment the engagement plan” and “adopt an engaging style” may have warranted further attention. Specifically more attention could have been paid to activating champions, making physician involvement visible, and communicating candidly and often.

4.1.4 Integration with Existing Practices

Integration with existing practices is a theme that provides insight into the challenges of the current screening program and how sustainability could be enhanced. Both the need to integrate the screening tool with other assessment forms and the need to integrate with existing practices were raised. One example that was highlighted by physicians was that screening does not fit with the requirements for clinical trial patients. Physicians are required to assess and document all symptoms indicated by clinical trial patients, whereas, during the training for screening clinicians are told to address the concerns that are priorities for the patient and that they do not need to assess every concern. Therefore, when clinical trial patients are screened physicians are likely torn on which approach to follow.

Another area that this study highlighted was the need to have a close link between programs, such as Screening for Distress, and new staff orientation practices. If screening does not become part of the orientation process then staff turnover is likely to impact sustainability and lead to decreased effectiveness of the program, as the required training and skill development would not occur in a standardized way. Similarly, this study identified the importance of ensuring that essential materials developed and maintained by the Screening for

Distress program staff are transferred to permanent staff in order to ensure the program is properly sustained post-implementation. For example, one document requiring ongoing updating is the resource pathways put together to help guide staff around the resources available when an intervention is required. In the NHS model of sustainability, the authors go one step further and suggest that program requirements should be built into job descriptions to ensure accountability for program tasks.⁴⁴

It is important to note that these areas do not necessarily represent areas of neglect by program staff but rather may be a result of how the implementation was designed for these two clinics. Focusing the implementation on two groups likely posed a challenge to integrating the current program into existing structures and practices as it would have limited the ability to change or modify documents or practices that were centre wide, such as documentation. By the time the pilot was deemed successful and it was decided that screening would continue, funding for program staff had ceased and there was not support to do some of the tasks which may have enhanced sustainability. This highlights how funding models often do not support program sustainability.

4.1.5 Factors External to the Program

This study found that there was a fit between Screening for Distress, the objectives of the centre, and the organization as a whole. Although senior managers were not interviewed, front line staff and mid-level administrators indicated that they felt there was commitment from senior management. The importance of the senior management is highlighted in the NHS model of sustainability.⁴⁴ In the NHS model, it is suggested that senior leaders need to be trustworthy, influential, respected and possess a good working knowledge of the initiative and take personal responsibility for ensuring its sustainability.

Although interview participants indicated that they felt senior management was committed to Screening for Distress, some felt senior management had a lack of appreciation for the work and resources required to successfully implement a thriving and sustainable screening program. This highlights the importance of not only providing verbal support around the initiative but also providing the infrastructure required. The NHS model includes the domain “Infrastructure for Sustainability” which represents aspects of the concerns raised by participants.⁴⁴ This includes areas such as having the facilities and equipment to support initiative, building initiative tasks into job descriptions, and having policies and procedures in place to support the new way of working. It would appear that in the current implementation these were areas not well supported. For example, screening related tasks ranging from printing the tool to educating new staff were not included in the job descriptions of staff members.

One challenge that was highlighted in this study, but not discussed in the NHS model of sustainability, is the area of competing priorities. These priorities exist at the administrator level (i.e. other programs/initiatives) and on the front line (i.e. time management with multiple areas to address). Program staff can serve to ensure that a particular program receives the required attention and resources but once program staff are removed competing priorities become a threat to sustainability, especially if they are in conflict of the existing program. This is an area that has received little attention in the literature.

4.2 Implications

This study has implications for policy makers and program implementers. For those who are implementing programs such as Screening for Distress, it emphasizes the importance of considering sustainability from the beginning and throughout the implementation process. It also highlights five domains which influenced the sustainability of Screening for Distress in this

setting. Although the purpose of this study was to describe the current situation of Screening for Distress in this particular setting, the findings are likely applicable to other tumour groups and settings. This is because even if the implementation and sustainability strategy varied in another setting, the themes identified in this study would still likely be applicable and influence sustainability. For example, in a larger tumour group, such as breast, issues around external barriers, integrating into existing practices and addressing staff attitudes and knowledge are likely to still apply. More work is required to explore how this model holds up across implementation but as the first study to explore this area it does provide an important starting point.

For policy and decision makers it speaks to the importance of supporting initiatives that are being implemented and ensuring that there are the facilities, staffing, and policies and procedures to support program sustainability. It also requires engagement of all relevant stakeholder groups.

4.3 Strengths and Limitations

This study provides insight into the sustainability of Screening for Distress; however, it does have some limitations which should be noted. First, the data collected provides a snapshot at one point in time. It is possible that this time point was not representative of the clinic as a whole; however, this risk was mitigated by randomly selecting a three week period and by conducting the chart reviews prior to inviting staff to participate in interviews so that they did not intentionally or unintentionally change their behaviour.

Another limitation is that the number of interview participants was limited to those staff members working in the Head and Neck and Neuro-Oncology clinics, which could have affected the ability to achieve saturation. To mitigate this risk, all team members were contacted to

participate and flexible times and locations for the interviews were provided. In total 16 of 29 team members were interviewed and saturation was achieved given that common messages and themes occurred throughout the interviews. Another possible limitation is that there may have been some selection bias as over three quarters of eligible nurses and administrators participated in the study, but just over one third of eligible physicians participated. The lack of participation from the physician group may be attributed to their demanding schedules or potentially their lack of engagement with Screening for Distress as discussed earlier. If in fact those who chose not to participate were less engaged in screening then possibly the physician group's perspectives were positively inflated in this study. This should be kept in mind when interpreting the results.

A final limitation is that the quantitative data is based on what is recorded on the chart. It is possible that a staff member discusses the tool, assesses concerns, and intervenes appropriately but does not chart it. This represents a threat to the internal validity of the study. Although this is a limitation, staff have been trained over the past two years to chart on the Screening for Distress tool and by the end of 2011 chart reviews indicated that over 90% of the screening tools had documentation on them indicating follow-up. However, if elements related to screening were not documented the quantitative data would be under representing the actual percentages.

There are also several strengths of this study. First, the mixed-method approach to data collection provides depth by allowing the triangulation of qualitative and quantitative data. As highlighted in the results and in the discussion above, both sources of data provide important insights into the sustainability of the program. Utilizing either approach individually would not have yielded as informative data. For example, utilizing the quantitative data alone would have revealed that screening rates were high but below the target of 90% and utilizing just the qualitative data would reveal some areas where screening could be further embedded but would

have provided no objective insight into how screening was actually being utilized in clinic. A final strength of this study is that it explores various perceptions of Screening for Distress, including those of nurses, physicians, and administrators. As screening is an interdisciplinary program it is important that research on screening also take into account these multiple perceptions.

4.4 Directions for Future Research

As Screening for Distress and research on sustainability are both relatively new areas, further research is required in both of these areas. Firstly, this study provides a model of how the various aspects of Screening for Distress and its implementation can influence the sustainability of the program. Future research is required to determine if this model is applicable to other settings where screening has been implemented. Future research is also required to further explore the knowledge gaps expressed by staff, specifically those around managing diverse patients and concerns such as anxiety and depression. For example, the feasibility of including more upfront education or ongoing interprofessional education sessions in the areas of supportive care could be explored.

As discussed earlier, the area of sustainability often receives little attention due to funding models and disengagement of program leads over time; therefore, it is an area which requires much attention. A review of the literature on sustainability in 2012 found that there were few comprehensive studies on sustainability and that even fewer conducted some sort of independent evaluation.³³ Currently there is a scoping review underway to identify factors that influence sustainability and to create a framework for assessing sustainability.³⁴ This review will help to establish the current status of the field and assist us in moving forward.

4.5 Conclusions

This descriptive study which utilized mixed-method data collection sought to explore the sustainability of Screening for Distress in two clinics at the TBCC. Through mixed-method data collection, this study found that Screening for Distress was largely sustained six months post the departure of program staff. Quantitative data indicated that the screening tool continued to be used on a regular basis but the percentage of conversations and assessments/interventions occurring post screening were slightly lower than the targets. Qualitative data provided insight into why these percentages may be lower than the targets. Key reasons include knowledge gaps, lack of integration with existing practices and possible issues with physician engagement. Qualitative data also provided insights into the aspects of the program and its implementation which contributed positively to its sustainability. Key aspects include positive attitudes towards screening, positive outcome expectancy on various levels, and the implementation approach. Overall, this study provides important insight into two areas where little research has occurred, Screening for Distress and sustainability. Further research is required to explore the model of sustainability developed and determine if it is applicable to other similar implementations.

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Appendix A: Screening for Distress Tool



Tom Baker Cancer Centre



Completed by:

Patient

Family

Health Professional

Assisted by family or health professional

Patient Label

Do you or anyone with you today, have any of the following: rash, cough, cold, fever, diarrhea or flu?
 If yes, please report to the reception desk now.

1. Edmonton Symptom Assessment System (ESAS):

				STAFF TO COMPLETE SHADED SECTION			
Date: _____							
Please circle the number that best describes:				Action Taken			
				Directly managed	Managed by other care team member	Referral required	
No Pain	0	1	2 3 4 5 6 7 8 9 10	Worst possible pain			<input type="checkbox"/> Pain
Not Tired	0	1	2 3 4 5 6 7 8 9 10	Worst possible tiredness			<input type="checkbox"/> Fatigue Class
Not nauseated	0	1	2 3 4 5 6 7 8 9 10	Worst possible nausea			<input type="checkbox"/> Fatigue Coordinator
Not depressed	0	1	2 3 4 5 6 7 8 9 10	Worst possible depression			<input type="checkbox"/> Physical Activity Programs
Not anxious	0	1	2 3 4 5 6 7 8 9 10	Worst possible anxiety			<input type="checkbox"/> Counselling Referral
Not drowsy	0	1	2 3 4 5 6 7 8 9 10	Worst possible drowsiness			<input type="checkbox"/> Spiritual/Pastoral Care
Best appetite	0	1	2 3 4 5 6 7 8 9 10	Worst possible appetite			<input type="checkbox"/> Resource Class
Best feeling of wellbeing	0	1	2 3 4 5 6 7 8 9 10	Worst possible feeling of wellbeing			<input type="checkbox"/> Resource Counselling
No shortness of breath	0	1	2 3 4 5 6 7 8 9 10	Worst possible shortness of breath			<input type="checkbox"/> Rehabilitation
Other problem	0	1	2 3 4 5 6 7 8 9 10				<input type="checkbox"/> Living Well With Cancer Class
				Staff use only			<input type="checkbox"/> Optimal Nutrition Class
							<input type="checkbox"/> Nutrition
							<input type="checkbox"/> Speech and Language
							<input type="checkbox"/> Patient Advocate
							<input type="checkbox"/> Home Care
							<input type="checkbox"/> Other:

2. Canadian Problem Checklist:

Please check all of the following items that have been a concern or problem for you in the past week including today:

Emotional:	Practical:	Informational:	Spiritual:	Physical:
<input type="checkbox"/> Fears/Worries	<input type="checkbox"/> Work/School	<input type="checkbox"/> Understanding my illness and/or treatment	<input type="checkbox"/> Meaning/Purpose of life	<input type="checkbox"/> Concentration/Memory
<input type="checkbox"/> Sadness	<input type="checkbox"/> Finances	<input type="checkbox"/> Talking with the health care team	<input type="checkbox"/> Faith	<input type="checkbox"/> Sleep
<input type="checkbox"/> Frustration/Anger	<input type="checkbox"/> Getting to and from appointments	<input type="checkbox"/> Making treatment decisions	Social/Family:	<input type="checkbox"/> Weight
<input type="checkbox"/> Changes in appearance	<input type="checkbox"/> Accommodation	<input type="checkbox"/> Knowing about available resources	<input type="checkbox"/> Feeling a burden to others	<input type="checkbox"/> Mobility
<input type="checkbox"/> Intimacy/Sexuality	<input type="checkbox"/> Quitting Smoking	<input type="checkbox"/> Taking medications as prescribed	<input type="checkbox"/> Worry about family/friends	<input type="checkbox"/> Physical Activity
<input type="checkbox"/> Change in who I am			<input type="checkbox"/> Feeling alone	

Date: _____ RN Signature: _____

Integrated Symptom Relief Service-Screening for Distress - Version 3.2 *Questionnaire adapted from the Cancer Journey Action Group, Canadian Partnership Against Cancer's minimum data set

Appendix B: Implementation and Study Timeline

	2010												2011												2012														
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug										
Pre Data Collection																																							
Implement Program																																							
Post Data Collection																																							
Ongoing Quality Improvement																																							
Sustainability Phase																																							
Quantitative Data Collection																																							
Qualitative Data Collection																																							

Appendix C: Interview Consent Form



Jayna M. Holroyd-Leduc, MD, FRCPC
Assistant Professor, Division of Geriatrics
Depts. of Medicine and Community Health Science

FOR INTERVIEW PARTICIPANTS

TITLE: Examining the Sustainability of Screening for distress in 2 Outpatient Oncology Clinics

INVESTIGATORS: Dr. Jayna Holroyd-Leduc, Ms. Shannon Groff, Dr. Barry Bultz

If you have questions or concerns please don't hesitate to contact Dr. Jayna Holroyd-Leduc at 403-944-1771

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

The Tom Baker Cancer Centre is committed to supporting patients and families cope with cancer and its treatment. Screening for Distress involves screening all patients for psychosocial, practical, and physical concerns. The objective of screening is to provide an opportunity for patients to share their concerns and is used to guide the conversation with the patient. Screening for Distress has been conducted at the TBCC over the last several years and this research seeks to examine the effectiveness of the current program.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to evaluate the sustainability of a screening for distress program in the head and neck and neuro-oncology clinics at the Tom Baker Cancer Centre (TBCC) 6 months post implementation.

WHAT WOULD I HAVE TO DO?

You will be asked to participate in an interview. This interview will take approximately 45 to 60 minutes and it will be digitally-recorded and then transcribed.

WHAT ARE THE RISKS?

There are no specific risks to you from participating. Some people may become tired or upset about the questions. If this happens, you should tell the interviewer

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. We hope that this research will allow us learn more about what has worked well and what may help us to provide better knowledge and training in symptom management.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary. You may refuse to participate. If you decide to participate you may withdraw at any time.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

There are no direct costs to you for participating in this study. You will not be paid to complete the interview and the only cost to you is your time.

WILL MY RECORDS BE KEPT PRIVATE?

You will not be referred to by name in the transcripts from the interview and the digital files will be destroyed once transcribed. No names or identifying information will be used in any publication or presentation. Quotes may be used in publications and presentations; however, the researchers will ensure confidentiality and anonymity.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Jayna Holroyd-Leduc (403) 944-1771

Or

Dr. Barry Bultz (403) 355-3205

If you have any questions concerning your rights as a possible participant in this research, please contact The Chair of the Conjoint Health Research Ethics Board at the Office of Medical Bioethics at 403-220-7990.

Participant's Name

Signature and Date

Investigator/Delegate's Name

Signature and Date

Witness' Name

Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix D: Semi-Structured Interview Guide

Interview ID: _____

Date: _____

Purpose: To examine the sustainability of Screening for Distress in the head and neck and neuro-oncology groups at the TBCC 6 months post implementation

Research Question: Determine the barriers and facilitators to the sustainability of Screening for Distress in these clinics

Topic	Question
Background Questions	<ol style="list-style-type: none"> 1) What is your role in the clinic (administrator, unit clerk, nurse, oncologist, etc.)? 2) How many years have you been working in this profession? 3) Do you have any advanced training and/or education? 4) How many months have you been working in the head and neck or neuro-oncology clinic?
Awareness/ beliefs about Screening for Distress	<ol style="list-style-type: none"> 5) Can you tell me about your understanding of the purpose of Screening for Distress/ISRS? 6) Can you tell me how you are involved in Screening for Distress? 7) Could you walk me through a typical patient appointment where the tool would be used? <ul style="list-style-type: none"> • Prompt: Can you tell me a bit about how the tool is used in clinical practice? • Prompt: Do you generally discuss the tool explicitly with patients? • Prompt: Do you sign the tool? • Prompt: Do you chart on the tool? How is this done? 8) What, if any, do you think is the impact of Screening for Distress on clinical care?
Integration in practice	<ol style="list-style-type: none"> 9) How do you feel that Screening for Distress impacts your work?

	<p>10) Do you feel the processes (i.e. how screening tool is handed out, getting it to the chart, etc.) related to Screening for Distress are efficient?</p> <ul style="list-style-type: none"> • Prompt: Are there any areas for improvement? Is anything working particularly well?
Barriers/ Facilitators	<p>11) Do you feel screening for distress is well integrated in your clinics?</p> <ul style="list-style-type: none"> • Prompt: What is working really well? <p>12) What are the barriers to the utilization of this tool?</p> <ul style="list-style-type: none"> • Prompt: Can you tell me about any times where you felt it was difficult to screen for distress? • Prompt: Are there any ways the integration of screening could be enhanced? <p>13) What are the facilitators to the utilization of this tool?</p> <ul style="list-style-type: none"> • Prompt: What enables you to use the tool?
Sustainability	<p>14) How well do you think Screening for Distress has been sustained in your clinic?</p> <ul style="list-style-type: none"> • Prompt: Is there anything in particular that has enabled the clinic to continue to Screen for Distress? • Prompt: Do you feel there are any significant barriers to the sustainability of Screening for Distress? <p>15) What do you feel is vital to its sustainability in the future?</p> <ul style="list-style-type: none"> • Prompt: e.g. integration in orientation, regular meetings, further evaluation <p>16) Could you tell me a bit about any changes in screening since program staff (the project assistant or coordinator) has been less involved in the day to day operations?</p> <ul style="list-style-type: none"> • Prompt: Do you feel there have been any changes in screening practices or has it remained stable over the last 6 months?
Other	<p>17) How does Screening for Distress fit into the larger objectives of the centre?</p> <p>18) Do you have any other comments you would like to add?</p>

Note: Probes (e.g. “can you tell me more about...” and “if I understand correctly, you’re saying...”) to be used as needed