

Piloting an Automated Distress Management Program in an Oncology Practice

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Background: New administrative requirements to provide assessment and treatment for distress in patients with cancer, as well as concern for positive patient outcomes, highlight oncology practitioners' need for a high-quality distress management program.

Objectives: Researchers designed, developed, implemented, and evaluated a nurse-led quality-improvement project that pilot tested a distress management program in an outpatient medical oncology practice.

Methods: The program used a tablet computer for data collection, immediate analysis, and recommendation display to provide individually tailored psychosocial coping recommendations, referrals, or both to nurses and patients.

Findings: Pre- and postprogram evaluations suggest that the program is feasible, safe, and effective for detecting and reducing distress in patients with cancer. In addition, tailoring psychosocial coping strategies to the patient's emotional situation may have been key to the program's effectiveness.

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Key words: distress management; cancer; automated tailoring; tablet computer

Digital Object Identifier: 10.1188/16.CJON.E9-E15

Healthcare systems in the United States, including private oncology practices, have mandates and guidelines to ensure that all patients with cancer are assessed, and, if necessary, treated for psychosocial distress. There are three primary administrative drivers for these practice changes. In 2012, the American College of Surgeons (ACS), 2015 Commission on Cancer (COC) created a standard about screening for distress that became a requirement for facility accreditation in 2015. About 1,500 accredited ACS COC sites throughout the United States are at risk of losing accreditation if they do not adhere to this new requirement. These 1,500 accredited sites treat 70% of newly diagnosed patients. The American Society of Clinical Oncology (ASCO, 2015) developed the practice-centered Quality Oncology Practice Initiative (QOPI®). This initiative requires about the same distress management program as the ACS COC standard to achieve accreditation (ASCO, 2015). In addition, the Patient Protection and

Affordable Care Act (ACA) has a potential direct financial impact on oncology offices through the use of a reimbursement value-based payment modifier, established on quality indicators from the Centers for Medicare and Medicaid Services (CMS, 2014). CMS uses the Physician Quality Reporting System (PQRS), which specifically includes assessment and treatment of distress (Zhang & Polite, 2014). Several studies, however, indicate that oncology practices are still inconsistently assessing and offering treatment for distress, if at all (Donovan & Jacobsen, 2013; Hammelef, Friese, Breslin, Riba, & Schneider, 2014; Jacobsen & Wagner, 2012).

To provide the type of care mandated and guided by these requirements, new processes embedded in medical oncology offices need to be created. Every patient should be routinely assessed for distress and, if significant distress is reported, a plan of care needs to be determined, provided, and documented. Considering the economic constraints and likely increase in the number of patients treated for cancer because of the ACA,