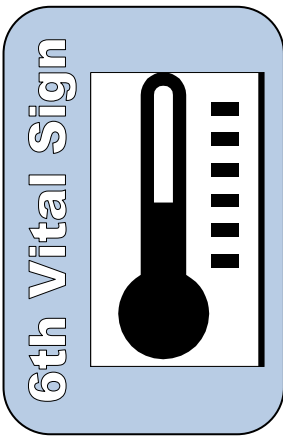
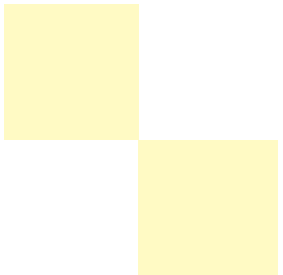


Cancer Journey Portfolio



# Screening for Distress, the 6<sup>th</sup> Vital Sign: A Guide to Implementing Best Practices in Person-Centred Care



September 2012

## Acknowledgements

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### Reference:

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## Purpose of this Guide

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This guide is a series of modules that provide the steps and considerations necessary to implement Screening for Distress, the 6<sup>th</sup> Vital Sign. It includes links to helpful tools and resources. This guide advocates a programmatic approach to implementation, with recommended strategies and techniques that are based on key learnings from nine jurisdictions. These jurisdictions were monitored and evaluated while implementing Screening for Distress in partnership with the Cancer Journey Portfolio (Cancer Journey) of the Canadian Partnership Against Cancer (the Partnership).

## Background and Context

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- Distress, the 6<sup>th</sup> Vital Sign
- Screening for Distress Model
- Implementing Screening for Distress across Canada
- Recommendations for Screening for Distress

## Distress, the 6<sup>th</sup> Vital Sign<sup>1</sup>

Cancer presents not only physical but also emotional, social, informational, spiritual and practical challenges for patients and their families.<sup>2</sup> The cancer journey often begins when a person first learns something might be wrong, and it can continue long after treatment. Throughout the journey, the person and their family will face myriad challenges, and no two individuals will respond in exactly the same manner. All, however, will feel some degree of distress that may interfere with their ability to cope effectively with a cancer diagnosis. Distress can be defined as:

“a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioural, emotional), social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis.”<sup>3</sup>

Incidence rates of significant distress at all phases of cancer have been reported at 35% to 45% in North America.<sup>4,5</sup> The prevalence of significant distress has led to the recognition of distress as the 6<sup>th</sup> vital sign (the others being temperature, pulse, blood pressure, respiratory rate and pain), thus calling for its routine monitoring. Over the past several years, various national and international organizations have endorsed distress as the 6<sup>th</sup> vital sign, including the Canadian Association of Psychosocial Oncology, the Canadian Association of Nurses in Oncology, the International Psycho-Oncology Society and the Union for International Cancer Control. Building on these endorsements, Screening for Distress is now included in cancer program accreditation standards in Canada.<sup>6</sup>

To manage distress some people mobilize their own resources and handle the situation on their own; others benefit from additional assistance. Such assistance can be provided by various professionals, and connecting the person to the right service in a timely fashion is a challenge in the Canadian cancer system. What is required is a person-centred cancer system; one that intentionally focuses specifically on what is of importance to the person and attends to the range of their needs, not just the tumour. Patients and survivors want quality care that is comprehensive, coordinated and continuous. They want future patients to have a better experience during their cancer journey than is possible in the current system.

#### Picker Principles of Person-Centred Care

- Respect for patient's values, preferences and expressed needs
- Coordination and integration of care
- Information, communication and education
- Physical comfort
- Emotional support and alleviation of fear and anxiety
- Continuity and transition
- Access to care

To achieve a vision of person-centred care, a change in health care culture is required and this change can only be achieved by changing practice. Health care professionals must broaden their perspectives to see the whole person and work collaboratively to meet the full range of each patient's needs. The interprofessional team needs to work in partnership with the cancer patient and their family to ensure that care is responsive and tailored to the specific needs of each patient and family. Screening for Distress helps achieve a vision of person-centred care by allowing patients to indicate their concerns and worries and using those to drive assessment and intervention. Additionally, Screening for Distress goes beyond the typical physical symptoms and includes common emotional and practical concerns. Screening routinely ensures that the health care team is in a position to address needs in a timely manner and respond to changing needs. By increasing timely and appropriate access to the full range of services throughout the cancer journey, the burden of suffering for patients, survivors and family members will be reduced. In turn, people affected by cancer will feel better able to cope and thus experience heightened quality of life.

To reach this vision of person-centred care, a programmatic approach to Screening for Distress should be used. A programmatic approach is the planned and systematic process of implementing an evidence-based intervention that engages all relevant stakeholders within and outside of the institution. Stakeholders share a common vision and objective and have a clear perspective on the results of the initiative. A programmatic approach is a process that aims to embed the intervention in a comprehensive and sustained manner, where the final result is systemic change in health care capacity, practices and performance.<sup>7,8</sup>

Despite the considerable resources devoted to health sciences research, incorporating research evidence into practice is often slow and haphazard.<sup>9</sup> This means patients are not receiving the best possible care and limited health care resources are being used



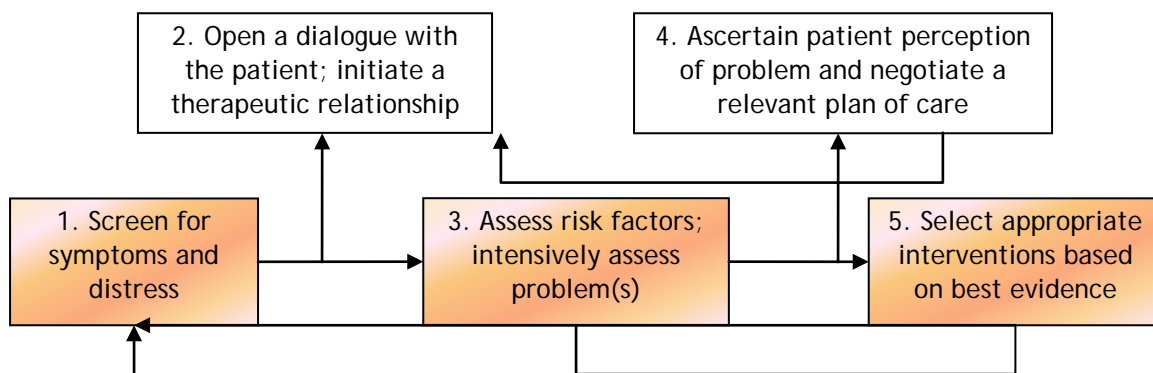
inefficiently. A programmatic approach is recommended for implementing Screening for Distress because changing practices is a complex process. Screening for Distress is a means of improving health-related quality of life and patient outcomes, while also enhancing professional practice based on research evidence.

## Screening for Distress Model

To achieve a vision of person-centred care and ensure that each patient's concerns are being addressed by the right professional in a timely manner, Screening for Distress includes five components:

1. completing a standardized screening tool,
2. opening a dialogue and initiating a therapeutic relationship,
3. assessing risk factors and intensively assessing concern(s),
4. ascertaining patient perceptions and negotiating a plan of care, and
5. providing interventions either directly or by referral when required.

### Screening for Distress Model<sup>10</sup>



In this model, completing the screening tool is the first step that occurs routinely with all patients. This is followed by a conversation with the patient to acknowledge the scores. Edmonton Symptom Assessment System (ESAS) scores of 1 to 3 suggest low distress, scores of 4 to 6 suggest moderate distress, and scores of 7 and above suggest severe distress.<sup>10</sup> The ranges of ESAS scores have been assigned a stoplight colour. Low scores (green zone) need to be acknowledged by the clinician, but the patient may not need intervention beyond standard care. If there are multiple problems identified, the patient will need to be asked about their perception of the effects of the problems and which problem is causing the most distress. Moderate scores (yellow zone) require more assessment to determine the related factors, current management and the patient's expectations for further management. If necessary, this should be followed by intervention. High scores (red zone) require immediate comprehensive and focused assessment followed by intervention to alleviate the symptom.<sup>10</sup> The stoplight colour



system corresponds to actions for assessment and intervention as laid out in the Pan-Canadian Symptom Management Guidelines, which are available at [www.cancercare.on.ca/toolbox/symptools/](http://www.cancercare.on.ca/toolbox/symptools/).

This model highlights the fact that completing a screening tool is not sufficient to achieve person-centred care. A coordinated, evidence-based response to distress needs to be implemented in a planned and systematic way to change practice.

Recommendations and guidelines continue to emerge to ensure jurisdictions that are implementing Screening for Distress have a comprehensive program. Below are some examples that are covered throughout this guide:

- **Completing the Screening Tool:** Recommendations from a pan-Canadian group on who, when, how and what to screen.
- **Opening a Dialogue with the Patient and Initiating a Therapeutic Relationship:** An Interprofessional Psychosocial Oncology Distance Education (IPODE) course has been developed to help train staff in initiating and managing these conversations.
- **Assessing and Intervening:** Several pan-Canadian clinical practice guidelines and algorithms have been developed to facilitate evidence-based assessment and intervention in clinical settings.

#### The Imperatives of Screening for Distress

- Cancer presents psychosocial, practical and physical challenges for patients and their families.
- Incidence of distress ranges from 35-45%.<sup>3,4</sup>
- Like other vital signs, Distress, the 6<sup>th</sup> vital sign, should be monitored routinely.
- Screening for Distress includes screening for psychosocial, practical and physical concerns.
- Screening for Distress gives for health care providers the opportunity to better understand the concerns of their patients.

By using these tools and focusing on knowledge translation and change management techniques, jurisdictions can implement Screening for Distress in a way that promotes adept management of practice change and program sustainability.

The following are characteristics of Screening for Distress:

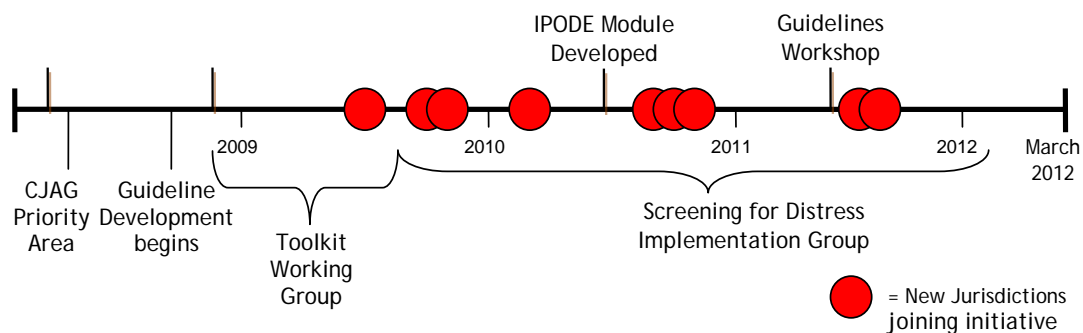
- Sensitivity for and recognition of the individual patient's unique and changing emotional, practical and physical needs.
- A person-centred approach that responds to a person's emerging needs.
- Consistent compassion and support from all caregivers.
- Coordinated services.
- Accessibility of information (including patient's medical information) and support.
- Empowerment of patients by providing information, respect and options.
- Understanding and accommodating special needs and challenges of patients from rural and remote areas and from diverse backgrounds.
- Identification and outreach to patients who lack an adequate support network.

## Implementing Screening for Distress across Canada

Given the substantial burden of distress and the desire to move toward a more person-centred cancer system, in 2008, the Cancer Journey Action Group portfolio of the Partnership endorsed Screening for Distress as one of its drivers to move toward person-centred care. From 2008 to 2012, Cancer Journey engaged in several activities to move Screening for Distress forward, including (see also the figure following):

- Supporting the first national Screening for Distress Workshop in March 2008.
- Establishing national recommendations through the Screening for Distress Toolkit Working Group.<sup>11</sup>
- Establishing the Screening for Distress Implementation Group, which is composed of members from nine jurisdictions involved in implementing Screening for Distress.
- Developing an IPODE course on Screening for Distress in collaboration with the Canadian Association of Psychosocial Oncology (CAPO).
- Facilitating leadership and collaborative partnerships in developing guidelines and algorithms focused on how to respond and manage the physical symptoms and psychological aspects of distress and supporting a knowledge translation workshop.
- Partnering with nine jurisdictions (Centre Hospitalier Universitaire de Québec, Cancer Care Nova Scotia, Regional Cancer Program of the Hôpital régional de Sudbury Regional Hospital and the Community Oncology Clinic Network in Northeastern Ontario, British Columbia Cancer Agency, Princess Margaret Hospital, Cancer Care Manitoba, Alberta Health Services – Cancer Care, Saskatchewan Cancer Agency, and the Prince Edward Island Cancer Treatment Centre) in implementing Screening for Distress.

### Timeline of National Screening for Distress Activities



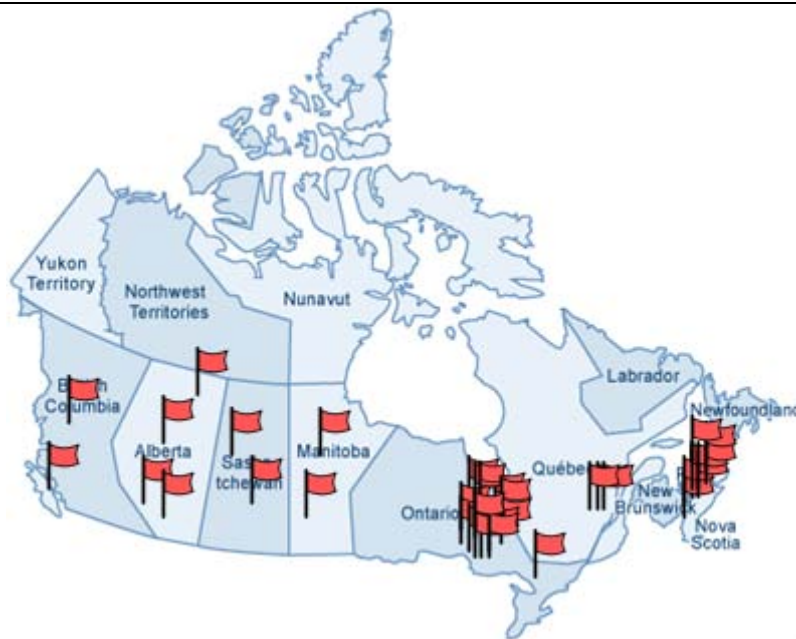
CJAG = Cancer Journey Action Group

IPODE = Interprofessional Psychosocial Oncology Distance Education

This guide is based on the wealth of knowledge obtained while establishing and implementing a national approach to Screening for Distress. Additionally, this guide pulls from the literature on Screening for Distress (see Appendix A for recommended readings). Implementing Screening for Distress across Canada involved nine jurisdictions with:

- Over 25,000 screens completed
- Over 1,500 health care providers trained in Screening for Distress
- Both rural and urban implementations
  - 26 rural locations
  - 13 urban locations

### Map of Canada with Red Flags Indicating Screening Locations



## Recommendations for Screening for Distress

The table below highlights several recommendations that emerged from multiple meetings of the Screening for Distress Toolkit Working Group.

### Summary of Recommendations and Conclusions

Area	Recommendations and Conclusions
Screening definition	Pro-active identification of indicators that allow for further assessment and appropriate referral.
Who to screen	All cancer patients should be screened for distress.
When to screen	Standardized routine screening, including at point of entry and at critical time points.*
How to screen	<i>No formal recommendation was put forward.</i> It was noted that, when possible, electronic screening offers advantages over paper and pencil screening (e.g., less paper work and automatic data entry).
Screening domains	Screening for Distress should screen for three domains: emotional, practical and physical.
Minimum data set	The recommended minimum data set includes the following tools: <ul style="list-style-type: none"> <li>Edmonton Symptom Assessment System</li> <li>Canadian Problem Checklist</li> </ul>

\*Critical time points in the cancer journey include initial diagnosis, start of treatment, during treatment, end of treatment, post-treatment or transition to survivorship, at recurrence or progression, during advanced disease, and during times of personal transition or re-appraisal (e.g., in a family crisis or when approaching death).<sup>12</sup>

### Minimum Data Set

A minimum data set – the practical, physical and emotional parameters collected using valid and reliable tools to screen for distress – was recommended. The Screening for Distress Toolkit Working Group unanimously endorsed the ESAS and the Canadian Problem Checklist to collect the minimum data set required for screening. These recommended tools were selected as the briefest tools that met the basic agreed-upon requirements. It was noted that these tools allow centres to collect a minimum amount of data, but centres may wish to add questions based on their specific needs.

#### *Edmonton Symptom Assessment System*

Across Canada, the ESAS is the most commonly used screening tool.<sup>13</sup> It is a valid and reliable tool that screens for nine common symptoms experienced by cancer patients. The severity of each symptom at the time of screening is rated on a numerical scale from 0 to 10 – 0 means that the symptom is absent and 10 that it is the most severe – and results are trended over time. This tool screens for pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing and shortness of breath. A systematic review of cancer symptom assessment instruments found that the ESAS is a psychometrically sound instrument.<sup>14</sup> The ESAS has been validated in a variety of populations, including both advanced cancer populations and patients earlier in the

cancer trajectory.<sup>15,16</sup> The ESAS adequately screens for emotional and physical concerns but does not capture practical concerns. The ESAS was revised (ESAS-r) to make it easier for patients to understand and complete. Changes include specifying a “now” time frame, adding definitions for potentially confusing symptoms, modifying the order of symptoms, adding an example for “other symptom” and altering the format to improve readability. The interprofessional team should use the ESAS-r (without the body diagram) to collect the minimum data set.

There are several advantages to the ESAS-r:

- Free: go to [www.palliative.org](http://www.palliative.org) and choose "Assessment Tools" under "Health Professionals"
- Available in a number of languages (<https://www.cancercare.on.ca/cms/one.aspx?objectId=58189&contextId=1377>)
- Clear guidelines and instructions and additional information (e.g., care plans)

### *Canadian Problem Checklist*

The Screening for Distress Toolkit Working Group developed the Canadian Problem Checklist to screen for the most common problems experienced by patients. The Checklist asks a series of questions to screen for emotional, practical and physical concerns. Item selection was based on the following criteria:

“The Canadian Problem Checklist enhances the story of ESAS.”  
— Jurisdiction Representative

- Prevalent and falls into one of the screening domains (emotional, practical and physical)
- Potentially negative outcome if not addressed
- Not already covered in the ESAS-r

With these criteria in mind, the group endorsed 21 items for the minimum data set.

### *Adapting the Tools*

The order of the items in these tools should be maintained, especially for the ESAS-r, since changing the order could affect the validity of the measure. The Toolkit Working Group endorsed using headings with the problem checklist. If additional items are added to the checklist, they should be added to the bottom of the appropriate categories. To view the ESAS-r combined with the Canadian Problem Checklist, see Appendix B, which includes both the original ESAS and the ESAS-r.

### *Demographics*

At a minimum, information about age, gender and tumour site should be collected. When possible, additional demographic variables, such as ethnicity, income, education and marital status, should be reported. Capturing this type of demographic data can help clinicians better understand supportive care needs in different jurisdictions and at a national level.

### *Using a Minimum Data Set*

One benefit of using a common minimum data set across the country is that it will enhance clinicians' ability to better understand the concerns of patients and how they vary from one type of cancer to another, from one location to another and for an individual throughout the cancer journey. Jurisdictions implementing Screening for Distress have reported that the minimum data set is acceptable and that the Canadian Problem Checklist is extremely useful in capturing concerns not indicated on the ESAS-r.

### **Guidelines and Algorithms**

As highlighted by the Screening for Distress Model, assessment and intervention are key components of responding to concerns indicated by the Screening for Distress tool, which is the combination of the ESAS-r and the Canadian Problem Checklist. Practice guidelines for specific distress symptoms have been created to increase consistency in the quality and level of service cancer patients receive across the country. For patients, the benefits of the practice guidelines include best practices to improve distress management, more consistent care, a more integrated approach to patient care and better quality of life. However, passive dissemination of practice guidelines fails to result in practice change and non-compliance to practice guidelines is commonplace.<sup>17</sup> The knowledge synthesized in guidelines is not part of common practice and their uptake is inconsistent. The uptake of clinical guidelines requires a planned action approach and evidence-based implementation strategies.

This guide aims to improve patient outcomes and experiences by giving practical advice to health care professionals to encourage changes in their practices. The goal is for the practices of health care professionals to be in line with the current best evidence, which has been synthesized in pan-Canadian distress management practice guidelines. Effective care (action) based on current evidence (knowledge) is a critical step to ensuring that Screening for Distress leads to improved patient outcomes. To facilitate the use of evidence in practice, clinical practice guidelines have been developed in partnership with Cancer Journey, the Canadian Association of Psychosocial Oncology and Cancer Care Ontario (available through [www.capo.ca/](http://www.capo.ca/) and at [www.cancercare.on.ca/toolbox/symptools/](http://www.cancercare.on.ca/toolbox/symptools/)).

## Module 1: Planning and Assessment

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- Implementation and Practice Change
- Guiding Principles of Knowledge Implementation
- Key Learnings about Change
- The Foundations of Implementation Planning
- The Process and Plan

### Implementation and Practice Change

Implementation is defined as “a specific set of activities designed to put into practice an activity or program of known dimensions.”<sup>17</sup> The challenge is to craft an implementation plan that takes into account, as much as possible, the known dimensions of the new program and activity, as well as the known dimensions of the potential adopters and their practice environment. Once the innovation and the local context are well understood, an implementation plan can be put into place. Enacting the implementation plan requires knowledge, skills and strategies regarding change management.

The purpose of this module is to explore the dimensions of the task at hand (implementing Screening for Distress) within the unique context of the local setting. A Screening for Distress program logic model has been developed to outline the general components, inputs, activities, outputs and various outcomes associated with implementation (Appendix C). The logic model can be adapted to suit the local context and is a key component of implementation planning and execution. The planning and assessment phase is the beginning of stakeholder engagement in the implementation process, and it is the beginning of change management.

### About Managing Change: Key Principles<sup>18</sup>

- Think big, act small. Keep the big picture or vision in mind at all times, but make sure that all stakeholders and individuals have their say and are allowed to contribute.
- Go where the energy is. Try to work with the most energetic and enthusiastic staff at the early stages to make sure that things happen. The 30:40:30 rule is often invoked to encourage a realistic focus on change. The leading 30% of staff (proportions may vary) are usually prepared to support and participate in change. If they get convincing early results, the next 40% can probably be persuaded to embrace change and this is where the main effort needs to be applied. For the remainder, it is reasonable to insist on compliance but they are unlikely to accept the arguments for change.
- Help and support is required after initiation as well as before.

See the [Change Management Toolkit](#)<sup>18</sup> for more tools and tips to manage change.



- Do not think you can build ownership at the beginning of a change. Involve people throughout the development process.
- Beware of “brute sanity.” One of the things that many managers do when trying to promote change is to give lots of clear, loud messages to staff about how wonderful the innovation is, how it will revolutionize the service, etc. This is brute sanity. If the messages are said often enough and loud enough, staff will tend to back off and build barriers.

### More Principles of Change

- The innovation will get adapted.
- Implementation is a process of professional development and growth.
- Implementation is a process of clarification.
- Interaction and technical assistance are essential.
- Planning at the service delivery and structure levels are essential.
- Developing and using a plan is itself an implementation problem.
- It is difficult to achieve 100% implementation.

### Guiding Principles of Knowledge Implementation

From 2009 to 2012, nine jurisdictions partnered with Cancer Journey to implement Screening for Distress. These jurisdictions participated in a national external evaluation of the initiative that focussed on the conditions that support adoption of Screening for Distress, the barriers to implementation and the strategies employed by the jurisdictions across Canada. To assist with this analysis, the evaluators established nine guiding principles of knowledge implementation based on change management literature. Change management knowledge, skills and strategies are recognized as integral to successful implementation of Screening for Distress.<sup>19</sup> These principles are designed to be used as a package, and thus *all* principles should be applied to achieve full knowledge implementation and to ensure that the management of change is as effective as possible. The principles are embedded in a Program Logic Model, which is described in more detail in Module 6: Monitoring, Evaluating, Reporting, Disseminating.

The first three principles, which are the focus of this module, are integral to the planning and assessment phase. A thorough assessment and understanding of local factors are central to developing a systematic and well-informed implementation strategy and plan. At the same time, the process of implementation requires constant change management, and the tools and resources in this module can assist with assessing the local capacity for change, and the skills and knowledge required to manage it.

### Guiding Principles of Knowledge Implementation

1. Problem 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
9. Monitoring, Evaluating, Reporting, Disseminating

## Key Learnings about Change

Below are the key learnings pertaining to the management of change from the national evaluation of Screening for Distress.<sup>19,20</sup>

- Develop and adopt a clear vision for change. Extensive work is required to conduct presentations and outreach to key stakeholders to introduce the concept of Screening for Distress and to articulate a vision and plan for how practice change will be achieved.
- Undertake stakeholder analyses (e.g., surveys, interviews and Delphi group techniques) to determine who will most likely influence or be affected by implementation. Assess stakeholder interpretations of the need for change, and how they can facilitate change. Map the results of the stakeholder analysis and establish strategies to facilitate stakeholder transition.
- Assess change readiness, identify cultural barriers and facilitators, measure and facilitate commitment, and identify knowledge brokers and key leaders. Implementation champions and senior-level decision-makers were understood to be critical for uptake of Screening for Distress. Champions, such as a clinic nurse or nurse educator, were instrumental in setting up local implementation teams, providing support and guidance to staff, and sharing positive experiences to engage others. Administrative champions (e.g., disease site group chairs, chief nursing officers and supportive care coordinators) assisted in communicating with sites and provided support through formal and informal discussions with colleagues. A few sites noted the importance of also engaging physician champions to engage physicians who were resistant to the changes brought about by Screening for Distress.

“The better the organization is at learning and course correcting — as individuals, teams and a whole system — the smaller the adjustments need to be. Establishing learning and course correcting require building the skills and practices that support each.”<sup>17</sup>

- Design and implement a communications plan that focuses on different strategies and tactics to disseminate information based on stakeholder needs to ensure appropriate customization. Local implementation teams must be given the freedom and flexibility to determine how best to structure screening at their site.
- Develop and implement a training plan that integrates with the overall communications, change management and implementation plans. The training plan should include orientation to the innovation, opportunities to practice and booster sessions to ensure comprehensive understanding. The training plan should occur as close in time to implementation as possible to allow for application.

## The Foundations of Implementation Planning

### Principle 1. Problem Assessment and Understanding

Early identification, supported by evidence, and the subsequent introduction of knowledge can help alleviate a problem or issue.

As a first step, the management team needs to gather evidence to support the need for Screening for Distress. How is the clinic or team currently managing distress? How satisfied are the patients with the experience of care? What are the gaps or bottlenecks in care processes? The answers to these kinds of questions can be used to create key messages about how Screening for Distress can solve problems for the patients, staff, organization and health care system. Some of this data may already be available from existing surveys, patient data or other sources, but it may need to be collected. Data may be useful to provide a pre-implementation baseline. For more information about generating key messages and strategies to communicate and transfer new knowledge, see the Knowledge Translation Planning Template in Module 4: Teamwork and Collaboration. See also [Quality Improvement and Evaluation](#) by Melanie Barwick for more information on data collection.

#### Gather Evidence

- Picker surveys or other patient surveys
- Needs assessment and gap analysis
- Baseline data from clinics and disease site groups

Next, the management team should assess organizational readiness for change, beginning with a self-assessment. Does the management team have the knowledge, skills and expertise to effectively manage change (see Appendix D)? If these skills are lacking, the team might consider how to build capacity in these areas. For more information about selecting members of the management team see Module 2: Staff Selection, Training and Support.

## Leadership, Change Agents and Facilitation

Implementing and adapting Screening for Distress is a change process that must be active, managed and participatory. Key components of the process are leadership, change agents and facilitation.<sup>21</sup>

**Leadership:** Senior management must lead the change and their commitment is vital:<sup>22</sup>

- To enable the change process
- To ultimately be accountable and responsible for initiating and guiding the change process

**Change Agents:** Change agents are central to the process of managing change effectively. A change agent is an “an individual who influences clients’ innovation decisions in a direction deemed desirable by a change agency.”<sup>23</sup> Change agents:

- Take the change forward
- Provide the right blend of support and pressure to motivate staff
- Maintain momentum

A great deal has been written about the skills and qualities needed to be a good change agent, and learning to be an effective change agent is important.<sup>24</sup> The checklist in Appendix D has been designed to reflect this work.

**Facilitation:** A key role of a change agent is facilitation.<sup>23</sup> Facilitation is defined as “the process of enabling (making easier) the implementation of evidence into practice.”<sup>25</sup> It is “a deliberate and valued process of *interactive problem solving and support* that occurs in the context of a recognized need for improvement and a supportive interpersonal relationship.”<sup>23</sup>

The facilitator role is about supporting people to change their practice:<sup>25</sup>

- It is an appointed role
- It is about helping and enabling versus telling and persuading
- It ranges from providing help to achieve a specific task to using methods that enable individuals and teams to review their attitudes, habits, skills, and ways of thinking and working

In their 2010 article in *Worldviews on Evidence-Based Nursing*, Doherty et al. outlined the activities involved in facilitation in a table titled Taxonomy of Facilitation Interventions/Strategies and Facilitator Role Synopsis.<sup>26</sup> The key activities and skills of facilitation are:

- Planning for change
  - Increasing awareness
  - Developing a plan

- Leading and managing change
  - Managing knowledge and data
  - Managing the project
  - Recognizing the importance of context
  - Fostering team building and group dynamics
  - Supporting project administration
- Monitoring progress and ongoing implementation
  - Problem solving
  - Supporting
  - Effectively communicating
- Evaluating change
  - Assessing

The following are assumptions that a facilitator must or must not make:<sup>18</sup>

- Do not assume that your version of what the change should be is the one that could or should be implemented.
- Assume that, to result in change, any significant innovation requires individual adopters to work out their own meanings.
- Assume that conflict and disagreement are not only inevitable but fundamental.
- Assume that people need pressure to change but that it will only be effective under conditions that allow them to react and form their own positions.
- Assume that real change takes time – a minimum of three years.
- Do not assume that lack of implementation is outright rejection of the values embodied in the change.
- Do not expect everyone to change.
- Assume you will need a plan and that it is essential to have knowledge about the change process.
- Assume that no amount of knowledge will ever make it totally clear what action should be taken.
- Assume that change is a frustrating, discouraging business.

Once the management team has assessed its own skills and knowledge in change management, it is time to assess the readiness of the organization and the staff within it.

**Principle 2. Assessment of Individual Perceptions and Motivations**

It is important to assess the individual perceptions and motivations of the intended users of the knowledge.

**Principle 3. Barrier Identification and Management**

Barriers to using knowledge may include lack of understanding of the knowledge, poor attitudes toward using the knowledge, lack of skills for implementation and established habits. Those who want to bring about change must assess the local situation for potential barriers that may impede or limit uptake of the knowledge. These barriers must then be managed by targeting interventions to help minimize or remove them.

The need to assess individual perceptions about and motivation for the uptake of new knowledge and practices cannot be under-estimated. The results of such an assessment provide the foundation for identifying receptivity for and barriers to change at both the level of the individual and the organization. Identifying barriers is an essential step in implementation because it allows change agents to discover and anticipate, as much as possible, the hurdles that may occur in moving forward with practice change. Knowledge of some of the barriers that are present means that implementation can be tailored with strategies that address those barriers. Experts in organizational change contend that readiness to change is critical to successful implementation of new practices.<sup>27</sup>

**Individual and Staff Assessment**

The Readiness for Change Checklist (see Appendix E) is an excellent place to start to assess staff preparedness for, and attitudes toward, the implementation of Screening for Distress. Assessment can include, for example, an examination of individual values, belief in the credibility of the new knowledge that staff are being asked to adopt, behaviour toward sustaining the knowledge, beliefs about staff capabilities and confidence, the emotional response to the knowledge, and the place of the initiative among competing priorities. Various methods for collecting this information are discussed below.

## Assessing the Practice Environment

What does a practice environment that is really ready for change look or feel like? Ten features of an adaptive practice environment are shown below. The quotes beside each are typical of the sorts of things that people will say if they are working in an adaptive work setting:<sup>28</sup>

- Shared goals ..... “We know where we’re going”
- Responsibility for success..... “We will make this work”
- Collegiality ..... “We’re in this together”
- Continuous improvement ..... “We can still do better”
- Lifelong learning ..... “Learning is for everyone”
- Risk taking ..... “We learn by trying something new every day”
- Support ..... “There’s always someone there to help”
- Mutual respect ..... “Everyone has something to offer”
- Openness ..... “We can discuss our differences”
- Celebration and humour ..... “We are a good team”

Practice environment factors can facilitate or constrain the uptake of new practices. Factors to consider are listed below:<sup>29</sup>

- Structural factors
  - The decision-making structure
    - Rules
    - Regulations
    - Official policies
  - The physical structure
    - Workload
    - Resources
    - Supplies
  - The system of incentives
- Social factors
  - The politics and personalities involved
  - The presence of local champions or advocates of the innovation
  - The culture and belief systems operating within the setting
    - Culture is about how things are done within your practice environment and is heavily influenced by shared unwritten rules. Unwritten rules are one of the most powerful parts of culture. They are described as “unwritten” because they are:
      - Not often openly discussed in meetings and formal documents
      - Rarely questioned or challenged because they are not frequently discussed
      - Usually shared by most, if not all, the people who work within the team



- Provide a common way for people to make sense of what is going on around them, to see situations and events in similar ways, and behave accordingly
- Often influence people without them necessarily realizing it
- Have a powerful influence on how people behave at work
- Patients
  - Patient influence or pressure may stimulate practitioner adoption of guidelines while patients' inability or unwillingness to comply with guideline recommendations may discourage practitioners from applying the guideline
- Other
  - Medico-legal issues

Equipped with an understanding of the types of barriers faced by health care practices generally, the management team now needs to look at the specific barriers in the practice environment. Management can use a number of methods to identify where change is needed and potential barriers to that change. The choice of method should be guided by local context, including the number of people involved, the time and resources available, acceptability, accuracy, generalizability, reliability and cost. In some situations, more than one approach may be needed. See Appendix F for a more detailed version of the following methods of examining barriers, including advantages and disadvantages of employing these methods. This section is adapted from "How to Change Practice," a guide from the National Health Service (NHS) in the United Kingdom.<sup>30</sup>

Change initiatives need to:

- Benefit staff and patients
- Address current frustrations
- Link to professional priorities
- Link to study and research interests
- Create clinician recognition

National Health Service<sup>30</sup>

## Methods for Examining Barriers

**Talk to Key Individuals:** Key individuals have specific understanding of a given situation and have the knowledge, skills and authority to think about a topic and explore new ideas. The change management team may want to consider talking to a group of key individuals at one of their regular meetings, such as a staff meeting.<sup>30</sup>

**Observe Clinical Practice in Action:** Sometimes the best way to assess current clinical practice is by observing individual behaviours and interactions. This is especially appropriate if you are looking at events that happen quite often. A more formal way of doing this is through a chart audit.<sup>30</sup>

**Use a Questionnaire:** A questionnaire is a good way to explore the knowledge, beliefs, attitudes and behaviour of a group of geographically dispersed health care professionals. Careful thought needs to be given to the design of the questions, as the

quality of the answers relies heavily on the quality of the questions. Both electronic and paper formats can be used to encourage responses.<sup>30</sup>

**Brainstorm:** Brainstorming is a way to develop creative solutions to problems. It can be done informally in small groups or using a focus group. The session starts with an outline of the problem and then participants are encouraged to come up with as many ideas as possible to solve it. One of the great things about brainstorming is that participants can bounce ideas off each other and develop and refine them further. [www.brainstorming.co.uk](http://www.brainstorming.co.uk) provides free online training in brainstorming, including the rules of brainstorming and running a brainstorming session.<sup>30</sup>

**Run a Focus Group:** Focus groups are a powerful means of evaluating current practice and testing new ideas. They are a facilitated discussion with a group of six to 10 people. Open questions are posed by the facilitator, who then encourages the group to discuss their experiences and thoughts, and reflect on the views of others.<sup>30</sup>

**Case Studies:** Case studies are useful when very detailed information about a past event may shed light on existing barriers.<sup>31</sup>

**Interviews:** A face-to-face, one-on-one discussion with individuals who are asked specific questions by an interviewer. Interviews can be unstructured, semi-structured or structured.<sup>31</sup>

**Surveys:** A survey is a standardized set of questions to assess participants' knowledge, attitudes and/or self-reported behaviour. The questions can be open ended, allowing participants to report their responses verbatim; closed, requiring participants to select answers from a predetermined list; or a combination of both.<sup>31</sup>

**Nominal Group Technique:** The Nominal Group Technique is a highly structured discussion among a group of people whose ideas are pooled and prioritized.<sup>31</sup>

**Delphi Technique:** The Delphi Technique is an iterative process in which information is collected from the same group of participants through a series of surveys.<sup>31</sup>

**Arts-Based Techniques:**<sup>32</sup> Arts-based approaches to examining barriers offer the potential to foster critical awareness, to facilitate understanding and to nurture sympathy. Dramatic performances have successfully helped health care professionals reflect on the care they provide and increase their understanding of patient care issues.<sup>33-35</sup>

## The Process and Plan

Promising practices from the jurisdictions engaged in implementing Screening for Distress show that a phased and systematic approach is required to effectively implement Screening for Distress. The Implementation Process Map (see Appendix G) is a template that outlines a standard process for implementation in each clinic or disease site. It can be tailored to suit each site. Key approaches to a phased approach to implementation include:

- Selecting one clinic or disease site group that exhibits the greatest readiness to begin implementation, followed by the next site that is most ready. Begin with a few strategically selected clinics first (those with existing champions and/or lower patient volumes) to iron out issues and learn from their implementation.
- Creating an inclusive implementation team composed of staff representatives in the clinic or disease site. The team must have regular meetings about the process and plan for implementation and should have significant decision-making authority (within set parameters) about how the new practice will be integrated with current practice.
- Taking the time to understand how Screening for Distress can be integrated to reflect and mesh with the practice realities of each clinic. Understanding the extent of customization required with regard to resource development, clinic flow, human resource availability and skill level, and differences in tumour group needs. Timelines for implementation of the first phase of Screening for Distress (implementation of the screening tool in the first site) were often delayed by an underestimation of the time required to prepare staff (e.g., raising awareness and education) and to create the infrastructure to support Screening for Distress (e.g., IT, workflow and other process issues).
- Working together to create a timeline and process map to implement Screening for Distress. The plan needs to include assigned responsibilities for each task with regard to the steps and activities to implement, data collection, communication and reporting, and budgeting.
- Reporting successes early and often to the clinic and to the other sites that are to follow in implementation (see Module 6: Evaluating, Monitoring, Reporting and Disseminating for more information about implementing changes and monitoring and communicating progress).

This module has provided a review of the key components to the planning and assessment phase of implementing Screening for Distress. By completing activities noted in this module, the management team has:

- Established how Screening for Distress can address local needs (problem assessment and understanding)
- Assessed the organization's capacity to lead and manage practice change (self-assessment of change management skills and the facilitator role)

- Assessed barriers in the individual adopters and in the practice environment (assessment of individual perceptions and motivations and barrier identification and management)
- Tailored the Program Logic Model to suit the local context
- Created a phased approach to implementation, selecting clinics or disease sites based on readiness, and working with the clinic team to devise a phased approach to implementation

Additional information about implementation planning and execution is available in Module 4: Teamwork and Collaboration, where the topic of tailoring the intervention to the local context (knowledge translation strategies) is addressed, as well as the next steps to engage local teams in the implementation process. See Module 5: Organizational Capacity Building for additional information about sustaining and embedding the intervention within the institution. Module 6: Evaluating, Monitoring, Reporting, Disseminating features suggestions and lessons learned about evaluation and monitoring.

Practice change that relies heavily on human interaction requires clear communication, a clear theory of change that makes the case for the change, and champions who consistently advocate, cajole, recognize, reward and encourage.

E.M. Rogers <sup>60</sup>

## Module 2: Staff Selection, Training and Support

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- Considerations: Culture, Education and Perspectives
- Team Selection
- Staff Education
- Overcoming Resistance
- Volunteer Roles

### Considerations: Culture, Education and Perspectives

When approaching education, it is important to embrace multiple strategies. Additionally, it is critical to consider factors such as organizational culture, socialization of various professionals, educational experiences and perspectives on change. Health care professionals use various approaches to changing clinical practice. Most of these approaches are based on beliefs rather than scientific evidence.<sup>36</sup> Michie et al. suggest that the differences between professional groups may require different strategies.<sup>37</sup>

#### Principle 4. Identification of Social Influences

Social influences such as teamwork, champions and norms can affect people's behaviour when choosing whether or not to implement knowledge. Positive role models, opinion leaders and social supports can help to facilitate knowledge uptake. Negative social influences can hinder knowledge uptake and must therefore be recognized and addressed.

### Professional Culture

It is important to consider how the people working in your organization were socialized to the health care environment. The way nurses are socialized is very different from how physicians are socialized. Typically physicians are used to being more autonomous and they need to thus be approached in unique ways to engage them in change.<sup>38</sup> The professional culture of physicians is strongly imprinted by their training and practice experiences. Physicians are taught to feel personally responsible for each individual patient's care and thus place great value on their autonomy in care decisions. Thus any proposed change in how patients are to be cared for is viewed as a personal judgment about the care they have been providing.<sup>39</sup>

"The implementation of Screening for Distress appears to require a change in clinic processes, alteration of clinic flow, champions to maintain momentum within clinics, and ongoing support and coaching for those who are new to screening."

Piceps Consulting Inc.<sup>19</sup>

Health care organizations do not have a single culture. They contain multiple micro-cultures that correspond to departments, medical groups, sub-specialties and so forth.<sup>38,40</sup> Physicians do not view all physicians as equals and ascribe more credibility to those whose experience is closer to their own.<sup>40</sup> Physicians have a strong sense of collegiality. During training, they share their knowledge with each other. Later, consultants share expertise and opinions with colleagues. Awareness of this tradition of collegiality can be used to garner support for clinical practice guidelines. Very little happens in the health care system without a physician's order. Therefore any changes in the way care is designed and delivered requires physician acceptance, either as individuals or as a professional body.<sup>40</sup>

## Education of Professionals

Professions have evolved in varied ways and over different time frames. The educational experience of each profession, which forms the basis of their professional socialization, is radically different for each profession. For example, different professions seek knowledge from different published sources, most of which are not shared. Different professions have different hierarchies in the forms of evidence. Professions have different views about what constitutes credible evidence.<sup>38,41</sup> Evidence is differentially available to different professions. Evidence is scarcer for nurses and professions allied to medicine (e.g., speech language pathologists and physiotherapists) than physicians.

A number of medical specialties, such as surgery and physiotherapy, stress the critical importance of craft skills. These skills are individual and difficult to codify or transfer, but many clinicians claim they are essential to producing a positive outcome for the patient. Acknowledging the tacit and experiential knowledge of colleagues needs to be woven into tailoring guideline discussions. Pogorzelska et al. found that nurses and other health care professionals reported more positive attitudes to practice guidelines than physicians.<sup>42</sup>

## Perspectives on Change

Physicians see a proposed change as risky. Their thinking tends to go as follows: "what's being done now can't be bad or else we wouldn't be doing it. Any change has the potential to make things worse. So we should be absolutely certain that the change is the right thing to do before we make the change." Physicians sometimes debate the merits of a paper or article rather than implementing change, possibly resulting in "paralysis by analysis."<sup>40</sup> One way to deal with this is to present the change as an opportunity to try out the idea and that not everyone will do it this way forever. Suggest that this is a test of a change, that it is time limited and that it will be done on a small scale.

Lomas et al. describe how change finds its way into medical practice.<sup>43</sup> The closed nature of medical communities leads to physicians acting as communities rather than a collection of unrelated individuals. The importance of product champions and opinion leaders translates to medical behaviour seen as being contagious. Lomas et al. state

that the change cannot be defined too explicitly with too many restrictions on its modification. They stress that modification and adaptation to the local context are important to the process of adoption. Characteristics of the change will influence its adoption within medical practice – its compatibility with personal and local norms, its complexity, its relative advantage for patient care and the adoptee, its trialability (i.e., that it can be tried temporarily and discarded if found wanting), and its observability or how easily the expected results can be achieved.

## Responses to Change

The stages of grief model by Kubler-Ross was first developed to reflect the experience of grieving.<sup>44</sup> Since then, this model has been found to apply to many of life's transitions and major events, including the process of organizational change.<sup>45</sup> The model recognizes that not all people will experience all emotions, nor will the journey necessarily be linear. But many people will experience at least some the emotions, and they may move back and forth between different stages as well. The model is helpful in understanding where resistance to change comes from and in understanding the complexity of the process.

Resistance is commonplace, as most of us respond to change with greater and lesser degrees of trepidation. The planning and assessment stage of an implementation should help identify aspects of resistance that will be met, but resistance is also a necessary part of change.

It is important to keep culture, education and perspective in mind when developing plans for education. It is also important to use multiple strategies and to tailor educational strategies to specific individuals and groups.

## Team Selection

One of the first steps in moving Screening for Distress forward in your jurisdiction is creating a management team and establishing a steering group.

### Management Team

Given that Screening for Distress requires significant involvement from nursing and psychosocial professionals, both groups should be represented when establishing a management team. The majority of implementations that were evaluated were guided by one lead and one coordinator; however, some jurisdictions used co-leads. Some of the most successful implementations included at least one person with a nursing background and one with a psychosocial background on the management team. These partnerships are critical and establishing them at the beginning of a project can be extremely beneficial.



## Steering Committee

A steering committee is vital to gathering support and directing the implementation. All members of this committee should act as visible champions of the program. Ideally, the committee includes members from all levels of care and throughout the continuum of care, such as administration, interdisciplinary health care professionals and support staff. If possible, individuals who inspire and motivate others around them are part of this group. It may be useful to engage high level administrators in choosing individuals for the steering committee (most steering committees in the initial nine jurisdictions met on a quarterly basis).

Each jurisdiction established slightly different steering groups, but in general the following were included:

- Management team: coordinator and lead(s)
- Chief Executive Officer, Chief Operating Officer or Director of cancer centre or program
- Medical Director or Chief Nursing Officer
- Ethnicity or Diversity Representative
- Psychosocial Manager or Representative
- Nursing Manager or Representative
- Oncologist
- Palliative Care Representative
- Allied Health Representative
- Patient Representative
- Representatives from associated groups (e.g., navigation, survivorship)
- Research and Evaluation Support Representative
- IT Support Representative
- Volunteer Representative

## Implementation Team

In general the implementation team varies from the steering group in that it comprises more front line staff and individuals representing groups directly involved with implementation. The following are some the groups or representatives that could be included:

- Management team: coordinator and lead(s)
- Representatives from the area where implementation is beginning (e.g., representative from the tumour group or clinic)
- Front line staff member

- Oncologist
- Nurse educator
- Manager for relevant areas of implementation
- Administrative representative (e.g., unit clerk)
- IT representative

It is likely that a large implementation would have more than one implementation team. For example, if the implementation is based on tumour groups, there may be one implementation team focused on the implementation with lung cancer patients while another focuses on breast cancer patients. Furthermore, if the implementation is based in a province, then there may be an implementation team in each centre where screening is being implemented. The establishment of more than one implementation team helps ensure that the needs of each group or centre are addressed and involves many key front line staff. If there are multiple implementation teams, it is important to have some consistency across all groups (e.g., all should follow the same key principles). Regardless of how many teams there are, it is advisable to have the implementation team meet once a week or once every two weeks in the development and early implementation stages. This can be adjusted to once a month once screening is established.

## Staff Education

### Principle 5. Training and Coaching

Individuals need to understand new knowledge and must learn when, where, how and with whom to use it. New skills will likely be required. Training and coaching helps individuals take up knowledge by enhancing their understanding and by helping them develop the necessary skills for implementation within their practice environment. Training and coaching also serve to reinforce uptake by providing advice, encouragement, practice opportunities and feedback.

Education is a key component of implementing Screening for Distress and occurs not only in the beginning of the implementation but throughout and beyond. Jurisdictions generally provided both general and targeted education. The following chart highlights the difference between these two strategies.

**General Education vs. Targeted Education**

	<p><b>General Education</b></p> <ul style="list-style-type: none"> <li>• Distress, 6<sup>th</sup> Vital Sign</li> <li>• Endorsement and accreditation</li> <li>• Why screen</li> <li>• Recommendations</li> </ul>	<p><b>Targeted Education</b></p> <ul style="list-style-type: none"> <li>• Specific role responsibilities</li> <li>• Providing patients the tools</li> <li>• Discussing concerns</li> <li>• Further assessment and management based on symptom management guidelines</li> </ul>
Who	All staff members, including nurses, oncologists, managers, administrators	All groups, including admin staff, nursing, oncologists, psychosocial, allied health professionals; training occurs within specific groups
Timing	At beginning of planning implementation and ongoing	At beginning of implementation and revisit throughout implementation
Purpose	Get people thinking and talking about screening; build interest	Train people on specific skills they will need to carry out day-to-day tasks; ensure clarity on roles and responsibilities; improve assessment and management of symptoms
Strategies	Grand rounds; tumour group presentations; staff meetings	In-person training sessions/ workshops; IPODE course; mentorship; role playing; clinical audit and feedback

When providing general or targeted education, various strategies can be used. The following table summarizes educational strategies and their overall effectiveness at changing practice.<sup>46</sup>

Consistently Effective	Variably Effective	Little or No Effect	Unknown Effectiveness
<ul style="list-style-type: none"> <li>• Educational outreach visits</li> <li>• Decision support systems and other reminders</li> <li>• Interactive educational meetings</li> <li>• Multifaceted interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Audit and feedback</li> <li>• Local opinion leaders</li> <li>• Local consensus processes</li> <li>• Patient-mediated interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Educational materials alone</li> <li>• Didactic educational meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Financial incentives</li> <li>• Administrative interventions</li> <li>• Arts-based interventions</li> </ul>

A description of each of the strategies follows<sup>18</sup> along with examples of how the strategy can be used to provide general or targeted education.

Strategy	What Evidence Tells us	General Examples	Targeted Examples
<b>Educational material</b> <ul style="list-style-type: none"> <li>• Booklets, leaflets, journal supplements, CD-ROMs, videos and DVDs, online tools and computer programs</li> </ul>	<ul style="list-style-type: none"> <li>• Educational materials raise awareness of the desired change.</li> <li>• Formats and layout can affect the influence of materials in changing behaviour.</li> <li>• The impetus is on health care professionals to read and recognize what change is needed.</li> <li>• Even if the change produced is modest, this could be important if replicated in everyday practice.</li> <li>• Printed materials are low cost.</li> <li>• Educational materials are most effective in changing behaviour when they are combined with other methods.</li> </ul>	Patient posters and/or pamphlets (see Appendix H for national examples)	Specific resource sheets developed for nurses that indicate referral options (Appendix I)
<b>Educational meetings</b> <ul style="list-style-type: none"> <li>• Conferences, workshops, training courses and lectures</li> </ul>	<ul style="list-style-type: none"> <li>• The more interactive a meeting is, the more effective it is in changing behaviour. Adults cannot learn merely by listening to instructions; they must also absorb the new information, use it experimentally and integrate it with their existing knowledge. This also means that you cannot teach everything there is to know about a subject in one session. It is much better to break down the formal teaching into modules, with time in between for the learners to reflect, experiment and apply the new principles.</li> </ul>	Grand rounds presentations, tumour-group presentations	Training course with small group where there is interaction and exercises designed to have participants play an active role

Strategy	What Evidence Tells us	General Examples	Targeted Examples
	<ul style="list-style-type: none"> <li>• Conferences and lectures raise awareness about the desired change but are less effective in making changes happen.</li> </ul>		
<p><b>Educational outreach visits</b> (aka academic detailing)</p> <ul style="list-style-type: none"> <li>• Trained individuals visit health care professionals in their own practice and offer information, support and instruction in line with current best practice</li> </ul>	<ul style="list-style-type: none"> <li>• Outreach visits are effective in tackling certain types of change, such as changes in prescribing, the delivery of preventative services and management of common clinical problems in general practice.</li> <li>• Visiting more than once increases its effectiveness.</li> <li>• The identity of the outreach visitor may have an impact on its effectiveness.</li> <li>• Visits are more effective when combined with reminders and/or interventions aimed at patients.</li> <li>• Visits are also more effective when tailored to individual barriers and situations.</li> <li>• It is not clear if visits are effective in tackling more complicated changes in practice, such as the use of diagnostic tests and referral practices.</li> <li>• Visits can be expensive and time consuming.</li> </ul>	<p>Going to a site to present information rather than having site reps attend a larger centre</p>	<p>Going to a site and holding interactive training sessions</p>
<p><b>Opinion leaders</b></p> <ul style="list-style-type: none"> <li>• Use influence to motivate and inspire health care professionals to achieve the best possible care for patients</li> <li>• Well respected among their peers and act as role models for junior colleagues</li> </ul>	<ul style="list-style-type: none"> <li>• Can make a positive difference in a variety of ways, from providing a signature for a letter accompanying the guidelines, to delivering speeches, writing articles in influential journals or undertaking outreach visits.</li> <li>• Using the influence of opinion leaders is generally an effective way of disseminating information.</li> <li>• It can be difficult to identify appropriate opinion leaders; the most influential individuals are not necessarily evident from their job titles.</li> <li>• There are two types of positive opinion leaders. Expert opinion leaders can explain the evidence and respond to academic debate. Peer opinion leaders are individuals who have used the guideline in their own practice and can give colleagues support and confidence.<sup>47</sup></li> <li>• Hostile opinion leaders may undermine the views of positive change champions or may dilute the influence by creating conflict.<sup>47</sup></li> </ul>	<p>Letter signed by opinion leader sent to all physicians indicating support for screening</p>	<p>Opinion leader helps facilitate training session and acts as a mentor in clinical settings</p>

Strategy	What Evidence Tells us	General Examples	Targeted Examples
<p><b>Clinical audit and feedback</b></p> <ul style="list-style-type: none"> <li>Data are collected from practice to provide insight into particular aspects of care</li> <li>Feedback may be on outcomes of care, costs or other elements of clinical performance, and may also include a comparison against peers</li> </ul>	<ul style="list-style-type: none"> <li>Audit can be a positive way to generate change.</li> <li>The quality and type of data gathered are important. Clinically rich data are more interesting to health care professionals.</li> <li>Audit is more effective if staff buy in to the process and if they have an active role in it.</li> <li>Audit is also more effective if the person delivering feedback is respected by those receiving it.</li> <li>Feedback on audit is more effective in changing practice when it is timely.</li> <li>Feedback is particularly effective when combined with educational materials and meetings.</li> <li>Feedback data and schedules need to be adjusted based on the local conditions. Frequency of feedback, meaningful and locally acceptable benchmarks and outcomes need to be seriously considered.</li> </ul>	<p>Centre-wide numbers and progress distributed through newsletter</p>	<p>Individual or clinic-based feedback provided with time for discussion and troubleshooting</p>
<p><b>Reminder systems and computer-aided decision-support systems</b></p> <ul style="list-style-type: none"> <li>Aim to provide health care professionals with specific information when they need it</li> <li>Designed to reflect best practices and remind health care professionals to take or avoid a certain action</li> </ul>	<ul style="list-style-type: none"> <li>Reminder stickers on medical notes and computer-aided decision-support systems all enable quick access to patient-specific best practices during a consultation.</li> <li>Reminders are effective in changing behaviour.</li> <li>They are more effective if given at the point of decision-making.</li> <li>Increasing the frequency of the reminder increases its effectiveness.</li> <li>Health care professionals who are still training are likely to benefit more than established staff.</li> <li>Computer-aided decision-support systems can be effective in changing prescribing and in the delivery of preventative services.</li> <li>Such systems are not set up to handle complex decision-making.</li> </ul>	<p>Reminder stickers around the clinic</p>	<p>IPhone app with symptom management guideline cheat sheets</p>

## Educational Tools

Throughout the implementations, jurisdictions developed various educational strategies and

“For both early and later adopters, Screening for Distress was seen as a way to standardize, strengthen and add depth to the work that jurisdictions were already doing to address psychosocial issues.”

resources. The following are a few examples of the strategies and resources that were used:

- Presentations that focused on addressing the myths of Screening for Distress
- Succinct and efficient summaries of information (“Coles notes”)
- Integrated screening tool and charting (see Appendix J for example from Alberta)
- Screening for Distress training manuals specific to each provider role
- Specific resource sheets for nurses that indicate referral options (Appendix J)
- Consistent messaging by working closely with educational roles in the institutions
- Role playing and/or modeling in clinical settings
- IPODE course (described below)
- Algorithms to assist with the implementation of guidelines

### **Interprofessional Psychosocial Oncology Distance Education (IPODE)**

The Screening for Distress Education Program is an online IPODE course that was designed to educate staff (primarily nurses) about Screening for Distress. The program was created to develop knowledge to screen for distress, develop skills to respond to distress and develop an understanding of supportive counselling. The program is free and is available to any psychosocial oncology or medical professional who wishes to access it. The Screening for Distress, the 6<sup>th</sup> Vital Sign, Education Program can be accessed at [www.ipode.ca/screening](http://www.ipode.ca/screening).

### **Overcoming Resistance**

The topic of resistance was often discussed by the National Screening for Distress Implementation Team. The following table provides some of the most common points of resistance, and the strategies to respond to that resistance. In some instances, successful responses to resistance were less about the use of a particular strategy than about a particular approach to resistance. Facilitator skills are useful here. Concerns need to be heard and validated, and staff members need to be engaged in problem-solving.



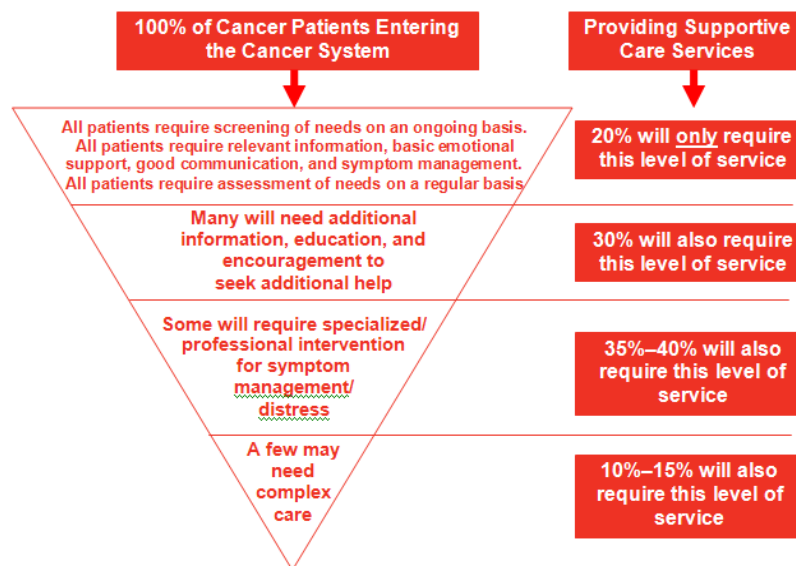
## Overcoming Common Points of Resistance

Common Points of Resistance	What Have We Learned	Strategies or Responses
"No time to screen or to have the conversation"	<ul style="list-style-type: none"> <li>Once staff are familiar with Screening for Distress, the process can save time by focussing the conversation.</li> <li>Often "time" is the first point of resistance from staff. It can be legitimate, but it can also be masking other concerns. Try to uncover other worries that may be at the root of resistance.</li> </ul>	<ul style="list-style-type: none"> <li>Work with the clinic implementation team to find mutually agreeable solutions. Concerns about new tasks and scope of practice are legitimate. Be prepared to listen and discuss with the implementation team. The most important response to concerns about clinic time is that the patient should be asked to identify the topmost concern (or two).</li> </ul>
"Screening for Distress will overwhelm us with referrals"	<ul style="list-style-type: none"> <li>A very common fear about Screening for Distress that does not come true.</li> <li>Jurisdictions found that referrals were more timely and appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>Encourage monitoring of referrals to assess timeliness, appropriateness, etc.</li> <li>Monitoring referrals through Screening for Distress is also an opportunity to assess which services are needed and available, or not, for patients.</li> <li>Develop referral pathways to streamline actions.</li> </ul>
"One powerful person is against this"	<ul style="list-style-type: none"> <li>You can't win 'em all. There will be detractors.</li> </ul>	<ul style="list-style-type: none"> <li>Keep moving ahead, in spite of the obstacle.</li> <li>Use good evidence to continue to make the case for screening. Craft a few compelling practice stories.</li> <li>Use your champions and find more champions.</li> <li>Go to meetings in pairs (do not be a solitary leader).</li> </ul>
"No time for the team to meet, discuss, plan, train or educate"	<ul style="list-style-type: none"> <li>A legitimate and ongoing concern.</li> <li>Support from the organization, management, and some key champions needs to be established at the beginning of the implementation.</li> </ul>	<ul style="list-style-type: none"> <li>Establish an implementation team that agrees to meeting on a regular basis and has the support of management to do so.</li> <li>Some jurisdictions would acquire certification for nursing education time.</li> <li>Use "team huddles." Gather in the hallway at a designated time for a 10-minute check on how implementation is going.</li> </ul>
"No way to educate staff in external sites"	<ul style="list-style-type: none"> <li>A legitimate and ongoing concern where the management team is geographically distant from the implementation team.</li> <li>Creativity and multi-pronged approaches are key.</li> </ul>	<ul style="list-style-type: none"> <li>One jurisdiction created a video for training in external sites; videoconferencing was used for team meetings.</li> <li>Site visits were infrequent but necessary for guidance and support.</li> </ul>

Common Points of Resistance	What Have We Learned	Strategies or Responses
"Screening opens up a Pandora's box of patient concerns"	<ul style="list-style-type: none"> <li>Dealing with distress can make people uncomfortable if they do not have the knowledge and skills to address it.</li> </ul>	<ul style="list-style-type: none"> <li>This concern reveals our own fears and discomfort with emotional distress. Screening helps to normalize patient distress and the health care provider's comfort with responding to it.</li> <li>Targeted education and training interventions are required to increase awareness, knowledge and skills to treat emotional distress.</li> <li>Strategies can focus on the vision and goals of person-centred care, where the breadth of patient concerns include psychosocial and supportive care needs.</li> </ul>

When discussing barriers related to resources and referrals, it is important to remember that not all patients require assistance beyond the front line team. The following figure is a pictorial representation of service requirements and the proportion of patients that require each level of assistance. This diagram highlights the reality that all patients need information and support but that only some patients need specialized intervention.

### Proportion of Patients Requiring Services



*Adapted from the Supportive Care Framework.<sup>2</sup>*

Several jurisdictions noted arriving at a point of critical mass, where the initiative was no longer meeting resistance. This point was reached after Screening for Distress had been implemented in several sites and after a certain amount of time had passed. Instead of resistance, the program was widely accepted and expected – perhaps on its way to normalization.

## Volunteer Roles

Volunteers can play a pivotal role in supporting and facilitating Screening for Distress. For example, in two jurisdictions where computer kiosks are used to collect Screening for Distress data, a volunteer assisted patients in completing the screening tool. In another jurisdiction, where screening uses pen and paper, volunteers call new patients to remind them of their first visit, and when patients arrive at the clinic, volunteers introduce the tool to the patients and provide assistance if needed. Volunteers therefore support Screening for Distress by ensuring that fewer patients miss being screened and assisting them with completion of the tool.

Selection, training and support of volunteers to implement Screening for Distress is crucial. In addition to the standard volunteer training in each institution, volunteers who assist with Screening for Distress should be trained in the role and responsibilities specific to Screening for Distress. [Providing](#)

For more information about volunteer initiatives to support Screening for Distress, contact BCCA, PMH and PEI. Contact information is provided at the beginning of this document.

[Care through a Psychosocial Lens: Volunteer Learning Kit](#) provides a full day of education about person-centred care, psychosocial and supportive care needs, local resources, and listening and communication skills. The Learning Kit provides a solid foundation, but each institution needs to develop training specific to the Screening for Distress volunteer role and to the particular organization. Some jurisdictions adapted this learning kit to include training regarding Screening for Distress. Jurisdictions also found it necessary to carefully screen for dedicated and long-term volunteers to work with the Screening for Distress program. Additionally, a volunteer coordinator or manager needs to provide direct and ongoing supervision of and support to Screening for Distress volunteers.

Using volunteers to support Screening for Distress can build capacity within the organization by enhancing the role of the volunteer and including volunteers in teamwork and collaboration. Using volunteers can also help embed Screening for Distress into the institutional culture by spreading the initiative into the volunteer realm, and by using volunteers to inform and communicate with patients so that all

“We set up a new role for volunteers who now meet with each new consult, contact patients to remind them of their appointment, introduce them to Screening for Distress, help them to fill out the tool, and pass it to nursing.”

Participant in national evaluation<sup>19</sup>

are involved in Screening for Distress as a standard of care. Using volunteers can also be cost-effective, but the cost-savings need to be balanced against the need for a volunteer coordinator or manager to supervise and support the volunteers.

## Module 3: Patient-Mediated Education Strategies

### Principle 6: Patient Engagement and Outcomes, and Implementation

If an innovation is to improve the experience of patients and families, the implementation process must include them. The process must ensure that patients and families are informed about the innovation; are aware of the scope, role and expectations of themselves and their health care providers; and are given the opportunity to participate meaningfully in implementation and in evaluation and subsequent decision-making.

Patient-mediated strategies focus on giving information to patients and the wider public. These strategies can help change the behaviour of health care professionals in a number of ways. Equipped with knowledge about the latest developments in Screening for Distress, patients are more able to influence decisions made during consultations about their care. Patients are also more accepting of any changes to their care if they know that it is in line with the evidence. There is evidence that mass media campaigns work by educating both professionals and patients about changes in practice. Patients are also more likely to adhere to the treatment offered if they are well informed, which in turn helps to keep professionals motivated. The evidence tells us that:

- Providing educational materials to patients is effective in changing the behaviour of health care professionals.
- Providing educational materials to patients helps ensure they will adhere to practices, which leads to better outcomes and thus motivates health care professionals.

“Patients tell us how impressed they are that we care about them as real people.”

“The tool forces them to really identify what their issues are, rather than just checking off yes to everything.”

Participants from national evaluation, Piceps Consulting Inc.<sup>19</sup>

To educate patients about Screening for Distress, Cancer Journey, in collaboration with the jurisdictions, developed patient posters and pamphlets (see Appendix H).

Mass media campaigns use varied methods of communication to reach large numbers of people via television, radio, newspapers, posters, leaflets and brochures. It is a way to reach many target groups at one time and includes local, professional and trade media. It can be expensive or inexpensive. The evidence tells us that:

- Information disseminated through mass media is effective in changing behaviour
- Both planned and unplanned media campaigns are effective

## Module 4: Teamwork and Collaboration

- Phases of Implementation

- Social Influences: Culture, Education and Perspectives
- Knowledge Translation
- Barrier Identification and Management
- Tailoring a Guideline to the Local Practice Context
- Systematic Approaches to Change: Theories and Models

The entire interprofessional team is responsible for helping patients and their families manage emotional, practical and physical concerns, and the Screening for Distress tool is team oriented. Implementing the tool is an opportunity to clarify the roles of the team members, streamline care processes, and improve team collaboration and communication so that patient care is more efficient, effective and patient-centred.

## Phases of Implementation

The adopters of Screening for Distress across Canada followed remarkably similar journeys. In systematic and phased approaches to implementing the screening tool, a single site or clinic was selected to begin the implementation process because it was deemed most ready – the most eager and well-positioned to take up screening. Often, the first site began the roll out of the Screening for Distress tool on a small scale (e.g., with a handful of staff or only with new patients) and then expanded implementation with additional patients and staff. Eventually, the tool was administered routinely as part of the site's standard of care. From there, the next clinic or site roll out would begin. The jurisdictions found it necessary to get the tool firmly and fully integrated with current practice before considering the next key phase of implementation – the uptake of symptom management guidelines.

"We found that the process (of Screening for Distress) helped to promote teamwork and collaboration among the health care team members."

Participant in national evaluation<sup>19</sup>

This module is designed to support practice environments as they grapple with the challenge of incorporating Screening for Distress, including guidelines and algorithms, into their clinical practice. Much of this work is about how to manage change, how to assess the readiness of the practice environment to adopt a change in practice, how to identify possible barriers to adoption and how to design strategies to mitigate, as best as possible, those barriers. Change management is about how people can be encouraged and empowered to work with a new resource, in this case distress management practice guidelines.

The purpose of this module is to familiarize the management team with the knowledge translation strategies necessary to ensure an effective response (assessment and intervention) to the screening tool. The aim is to enhance and develop confidence, leadership and skills to advance the implementation and adaptation of clinical practice guidelines to a particular practice environment. The emphasis is on utility, applicability, relevance and use.

## Social Influences: Culture, Education and Perspectives

Different health care professionals use different approaches to changing clinical practice. Most of these approaches are based on beliefs rather than scientific evidence.<sup>36</sup> Michie et al. suggest that the differences between professional groups may require different strategies to encourage uptake of new practices.<sup>37</sup> Some considerations pertinent to the range of possible professional cultures, education and perspectives on change are outlined in Module 2: Staff Selection, Training and Support. The key point is that the management team should do as much as possible to understand the receptivity of its staff and its teams to the uptake of new knowledge.

## Knowledge Translation

No tool, no matter how great, nor clinical practice guidelines themselves, will automatically change a practice.<sup>32</sup> Knowledge translation is a process that emphasizes “moving knowledge off the shelf into practice” and making it relevant and accessible to patients and practitioners.<sup>48</sup> This section briefly describes a knowledge translation framework and the basic tenets of planned action – foundational information in the move toward changing practice.

Knowledge translation is the “dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective services and strengthen the health care system.”<sup>49</sup> In other words, knowledge translation is about:

- Making users aware of knowledge and facilitating their use of it
- Closing the gap between what we know and what we do
- Moving knowledge into action

“One of the greatest pains to human nature is the pain of a new idea. It makes you think that after all your favourite notions may be wrong, your firmest beliefs ill-founded... Naturally, therefore, common men hate a new idea and are disposed more or less to ill-treat the original man who brings it.”

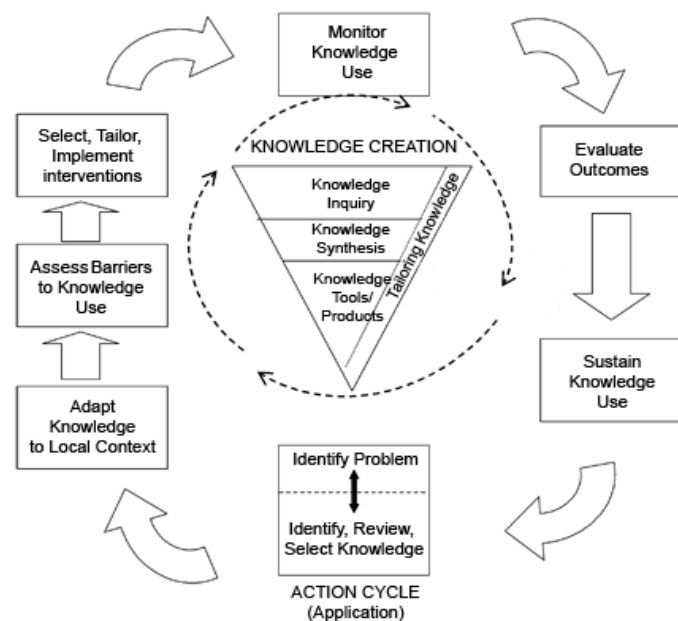
— Bagehot, 1873, cited in Rogers<sup>64</sup>

The Knowledge-to-Action cycle is a framework to practice knowledge translation.<sup>50</sup> It involves creating and applying (action cycle) knowledge.



Knowledge-to-Action Cycle<sup>51</sup>

(reprinted with permission)



Knowledge creation is a process by which research is distilled and refined, resulting in a product that is useful to users. Knowledge inquiry, knowledge synthesis, and knowledge tools and products are the processes within knowledge creation.<sup>9</sup> One end product of knowledge creation is a clinical practice guideline. Clinical practice guidelines are systematically developed statements of recommended practice in a specific clinical area. They are designed to provide direction to practitioners.<sup>52</sup>

The action cycle is the process by which knowledge, in this case, distress management practice guidelines, is implemented or applied. The cycle is based on theories of planned action. The process of planned action is deliberate, logical and systematic. The objective of planned action is to alter ways of doing things.<sup>9</sup>

Planned action tenets include the following:<sup>22</sup>

- Individuals in the practice setting are the experts about their setting and its ways.
- The process embraces the concepts of action and reflection to surface understanding and enable change.
- Each individual's personal knowledge, gained from practical or theoretical knowledge, is acknowledged and respected.
- There is interplay between practical wisdom and theoretical concepts.
- The end product is uncertain and the road may lead to unexpected discovery.
- The process is dynamic, solves real issues and enables meaningful change.
- Most importantly, the process is concerned with knowledge that is created in and for action at the local level.



### The Hero-Innovator<sup>18</sup>

This then is the myth of the hero-innovator: The idea that you produce, by training, a knight in shining armour who, loins girded with new techniques and beliefs, will assault the organizational fortress and institute changes in himself and others at a stroke... The fact of the matter is that organizations ... will, like dragons, eat the hero-innovator for breakfast!!



— Giorgiades and Phillmore, 1975

The movement of clinical practice guidelines into practice does not happen on its own. Implementing and adapting clinical practice guidelines is a change process that must be active, managed and participatory. Key components of the process are leadership, change agents and facilitation.<sup>21</sup> These are the same skillsets described in Module 1: Planning and Assessment.

## Barrier Identification and Management

As described in Module 1: Planning and Assessment, the practice environment and the individuals within it must be assessed to understand the state of readiness to adopt clinical practice guidelines, and to identify the primary barriers to implementation. Several tools are available to assist with this task:

- The Readiness for Change Checklist (see Appendix E) can be adapted to assess individual perceptions about clinical practice guidelines and the prospect of change. This checklist thoroughly assesses components of individual knowledge about, attitudes toward and motivation to adopt clinical practice guidelines (including structural factors) using a scoring mechanism.
- The Survey to Assess Barriers is a quantitative tool that is useful in gathering information from a large number of staff.<sup>53</sup>
- The Guidelines Survey (see Appendix K) provides a series of qualitative questions designed to explore the knowledge, beliefs and current practices of staff.

## Tailoring an Innovation to the Local Practice Context

### Principle 7. Tailoring to Local Context

Innovations need to be tailored to suit the local situation, organizational characteristics, patient needs, etc. The goal is to have a planned and focused innovation that is suitable for the character and needs of the local context.

Because of the uniqueness of each practice environment, the screening tool and the guidelines need to be tailored to the local context for them to be accepted and implemented. As Screening for Distress is relatively new, most of our knowledge on tailoring and implementing comes from literature on the implementation of clinical practice

guidelines; however, most of the learnings from practice guidelines are also relevant in implementing Screening for Distress. This section explores this process of tailoring and the key issues to consider.

The process of tailoring begins with:<sup>54</sup>

- Promoting awareness
- Stimulating interest and involvement
- Creating an overall understanding of the innovation and the nature of specific changes recommended
- Developing insights into practice routines

### Tailoring Guidelines and Algorithms

Despite the high quality and rigor of practice guidelines, they are not effectively used in daily practice. Practice guidelines lack details on applicability or descriptions of the changes to the practice environment required to apply the recommendations contained within them.<sup>55</sup> Clinical practice guidelines focus on *doing the right things*, but there also needs to be a focus on *doing things right*<sup>56</sup> within each unique practice environment.

Ferlie et al. describe another way to look at practice guidelines: clinical practice guidelines have a hard-core and a soft periphery.<sup>41</sup> The hard core is the element that is irreducible and that carries the key potential benefit – doing the right things. This is surrounded by a gamut of complementary arrangements involved in delivering the benefit that may take a variety of forms. It is this soft periphery that offers considerable scope for adapting an innovation (clinical practice guidelines) in a way that will ensure support from members within the practice environment.

Tailoring or customizing a clinical practice guideline to a particular practice environment may improve acceptance and adherence. The active involvement of the end-users of the guideline in this tailoring process has been shown to lead to significant changes in practice.<sup>21</sup> An innovation that is adapted to the local context is more likely to be implemented.<sup>57</sup>

The use of a participatory action approach assists with the process, and all staff in the practice setting need to be involved. Within the participatory action approach:

- Individuals in the practice setting are the experts about their culture and its ways.
- Values and beliefs are unraveled. For example, the evidence within a clinical practice guideline is represented by randomized control trials believed to be the gold standard in determining appropriate care. Issues such as equity and patient choice may legitimately underlie the positions of other members of the practice setting. Dealing

A round man cannot be expected to fit into a square hole right away.

He must have time to modify his shape.

— Mark Twain

with disagreements about values necessitates a richer information exchange, involving face-to-face discussions, to find room for mutual understanding.<sup>58</sup>

- Social interaction between members of the practice allows everyone to express their concerns about practice guidelines. These discussions result in an appreciation of and insight into each member's issues and concerns. Barriers can be confronted mutually, and facilitating ideas can be optimized.
- Each member of the group has a voice in co-constructing both the knowledge to be tailored and the approaches for tailoring it.
- These discussions provide an understanding of the proposed implementation from the adopters' perspective.
- The process is dynamic and ongoing, which is appropriate to resolve local issues.
- Reflection, action, and questioning or evaluation are interrelated strands in the construction of new (adapted) knowledge.
- Knowledge is created in and for action.
- The end product is uncertain at the start of the process, and the road to that end may lead to unexpected discovery and learning.
- An emotional connection among health care professionals about the practice guidelines will occur, along with the beginnings of a sense of ownership of the change and the implementation process. People change only when they can internalize the change and make it theirs. The end effect will be that all participants will sculpt a final product that is more compatible with their local practice context.<sup>59</sup>

All staff within the practice environment need to have an opportunity to consider what clinical practice guidelines can achieve, how they might use clinical practice guidelines, what will be involved, what the changes might look like and how clinical practice guidelines will affect them.

The following questions can help set the stage for tailoring guidelines:<sup>18</sup>

- Do staff know what practice guidelines are and are not?
- Do staff know about the distress management practice guidelines?
- Is this change a response to real needs? If so, what needs?
- What do staff believe is driving the change?
- What is the purpose of implementing symptom management practice guidelines?
- In addition to helping patients, are there other benefits? What's in it for me?
- How fundamental a change is the implementation of symptom management practice guidelines for your organization, unit or self? Will this affect only a few working practices or does it represent a shift in how people think about and deliver care?
- How far reaching is this change? Does it affect most staff?

- How important is this change? Is it crucial in helping your organization achieve its goals of improved patient care or is it an extra?
- What are the boundaries of the implementation of symptom management practice guidelines? The whole organization? Certain clinics?
- How do we currently address identified distress? What evidence are these interventions based on?
- What do we want to create together?

Document the responses to the above questions to refer to as you move through the process of moving the clinical practice guidelines for distress into clinical practice.

## Overcoming Barriers

There are a number of consequences of poor employee engagement during change programs. Some of the more common consequences are reduced magnitude of the benefits achieved, drawn-out timescales for their achievement and the failure to sustain change beyond the immediate implementation phase. Such consequences should be compelling enough to encourage involving staff from the beginning, urging them to express their ideas and valuing their input.

### Where to Start? Selecting a Guideline

The Screening for Distress tool provides an easy measure of the frequency of patient symptoms, and this data can help the implementation team decide where to begin with symptom management guidelines. In one site, a local team noticed high scores in pain and fatigue, and discussed the need to improve responses to these scores. Multiple strategies were undertaken. To begin, staff were educated about the pain and fatigue symptom management guidelines using a variety of approaches. Care pathways were reviewed and streamlined so that the team could work at improving responses to pain and fatigue.

Tailoring and implementing guidelines is anything but a straight line because:

- The future state is being discovered
- The route to the future state will have twists and turns
- The pace and the amount of work required is unknown

## Helpful Hints

Deviations need to be viewed as learning opportunities for mid-course corrections. People will react differently to the uncertainty of the process of change. Reminding staff of the core purpose of improving patient outcomes and experiences will help focus their efforts.<sup>20</sup> People need to remember that no one can predict the future.

There is no one method or strategy to overcome all the different barriers that arise. Different approaches will be effective for different people and different situations.<sup>60</sup> The methods described below can be used on their own or together, and combining methods may have a bigger impact on implementing Screening for Distress. Strategies tailored to prospectively identified barriers are more likely to improve professional practice than no intervention or only the dissemination of guidelines.<sup>61</sup>

The following summary of strategies and their overall effectiveness is provided in Module 2: Staff Selection, Training and Support, where a description of each is also provided.<sup>32,46</sup>

Consistently Effective	Variably Effective	Little or No Effect	Unknown Effectiveness
<ul style="list-style-type: none"> <li>• Educational outreach visits</li> <li>• Decision support systems and other reminders</li> <li>• Interactive educational meetings</li> <li>• Multifaceted interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Audit and feedback</li> <li>• Local opinion leaders</li> <li>• Local consensus processes</li> <li>• Patient-mediated interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Educational materials alone</li> <li>• Didactic educational meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Financial incentives</li> <li>• Administrative interventions</li> <li>• Arts-based interventions</li> </ul>

## Linking Barriers and Strategies

Now that the barriers to implementation have been identified, and you understand the different types of strategies available, the table in Appendix L summarizes which strategies could be used for the barriers you have identified. The members of the practice setting may have other ideas that should also be considered.

## Systematic Approaches to Change: Theories and Models

Using a theory, model or framework to plan a program of change is helpful to the process. In different ways, each offers signposts along the journey of change – of moving guidelines into action. A theory describes and explains what is observed and why it happens.<sup>62</sup> Theories can explain professionals' behaviour and provide inspiration for the design of interventions to move knowledge to action or to change behaviour.<sup>63</sup> A planned change model or theory is a set of logically interrelated concepts that explain, in a systematic way, the means by which planned change occurs. Planned change refers to deliberate (not haphazard) efforts to engineer change in groups with the objective being to alter the ways of doing things. The following examples of theories, models and frameworks are outlined in some detail in Appendix M.

- Rogers Diffusion of Innovation Theory<sup>64</sup>
- Precede-Proceed Model<sup>65</sup>

- The Ottawa Model of Research Use<sup>66</sup>
- Berwick's Rules for Dissemination<sup>67</sup>
- Multi-method Assessment Process/Reflective Adaptive Process (MAP/RAP)<sup>68</sup>
- PARiHS (Promoting Action on Research Implementation in Health Services) Framework<sup>69</sup>

The purpose of this module is to illuminate the conditions that shape the practice environment, to introduce the concept of effective knowledge translation, and to provide the tools to assess institutional barriers to implementation. With skillful leadership and facilitation, the barriers can be mitigated by multi-faceted and targeted intervention strategies – a planned action approach. A tool was developed that captures these key aspects of knowledge translation in the context of guideline implementation. The Clinical Guideline Implementation Practice Change Framework (see Appendix N) was developed for the jurisdictions implementing Screening for Distress from 2009 to 2012. It synthesizes the knowledge presented in this module in a series of steps to engage the health care team in the uptake of symptom management guidelines.

Best practices in knowledge translation strategies are captured in a handy “at-a-glance” resource, the Knowledge Translation Planning Template (see Appendix O).<sup>70</sup> The template covers the key components of knowledge transfer planning for any project, with emphasis on communication. The components include the main messages, audience(s), and methods, as well as considerations such as budget and costs.

The Knowledge Translation Planning Template is also available as an online fillable form at:

[www.melaniebarwick.com/training.php](http://www.melaniebarwick.com/training.php)

## Module 5: Organizational Capacity Building

- Embedding Screening for Distress
- Sustainability
- Building Capacity for Supportive and Psychosocial Care

### Principle 8. Organizational Capacity Building and Infrastructure Development

For an innovation to be implemented, the organization must be ready for change and be able to support implementation of the innovation. Innovations must fit with an organization's strategic aims and culture, must be well supported by an infrastructure that includes dedicated human resources and financial supports, and must be visibly supported by leaders in the organization.

This module considers ways to build organizational capacity to support Screening for Distress. A key concept is the notion of embeddedness. The activities of implementation all serve to embed Screening for Distress into the everyday workings of the organization. For the management team, it is important to be aware that targeted strategies and activities are necessary to ensure that Screening for Distress is incorporated into the institution's knowledge reservoirs. The embeddedness of Screening for Distress will result in the sustainability of the initiative as it moves from being an innovative practice to a "norm" or routine practice. This module provides further elaboration of these key concepts and some useful tools to assess and plan for sustainability.

## Embedding Screening for Distress

In the implementation of pain management guidelines in neonatal care across Canada, Stevens established the following four levels where barriers to implementation and knowledge translation exist.<sup>71</sup> The categorization of barriers is helpful because management teams must consider how strategies to implement and embed Screening for Distress must be targeted to all levels in the organization:

Embed Screening for Distress in:

- Staff and volunteer position descriptions
- Staff and volunteer orientation, training and professional development
- Institutional policies, procedures, quality metrics
- Institutional website, newsletters
- Staff performance metrics and reviews
- Research activities
- Institutional performance indicators
- Patient education initiatives
- Patients' expectations as a standard of care

1. **Individual:** behaviour, attitudes and beliefs, previous knowledge and experiences
2. **System:** organizational priorities, institution-wide policies, guidelines and procedures
3. **Unit:** culture and context, unit leadership, evaluation methods, staffing issues



#### 4. All levels: time and workload, resources, buy-in

In another classification of the practice environment, Virani et al. discuss “organizational memory,” which refers to the storage or embodiment of knowledge in various “reservoirs” within the institution.<sup>72</sup> It can be thought of as the ability of an organization to sustain new initiatives, institutionalize the initiatives in standard operating procedures and to make them a permanent component of the practice environment (make them routine).

Knowledge reservoirs are mechanisms that serve to retain knowledge within the practice environment’s memory. Examples of knowledge reservoirs include individuals with expertise (people), standard screening processes (routines), policies and procedure documents (artifacts), one person prompting another (relationships), bulletin boards (information space), water cooler conversations (culture) and formal role expectations (structure). There are advantages and disadvantage to each type of reservoir and these are outlined in Appendix O.

## Sustainability

Sustainability occurs when new ways of working and improved outcomes become the norm. It suggests a process of mutual adjustment where the change loses its separate identity and becomes part of the practice environment’s regular activities.<sup>73</sup>

### External Drivers of Screening for Distress

- Accreditation Canada
- Provincial-level strategies
- Progress in other provinces and regions

## Challenges in Sustaining and Embedding Change

**Interaction of Knowledge Reservoirs:** Sustainability is at risk if the knowledge becomes lost, decays or is not stored appropriately. For example, investing all guideline implementation resources in staff training and development results in an over-reliance on people for organizational memory. This is risky, particularly in environments where there is a high turnover of staff. On the other hand, there is also risk in embedding knowledge in information systems, such as electronic documentation, without the appropriate engagement of people. It is people who need to negotiate what informational elements to include in the system and provide the necessary orientation to end users. If the necessary people are not engaged, the system may be used inadequately, which could result in knowledge that is not accessible to end users. Careful consideration of the interaction between knowledge reservoirs (e.g., people and information systems) can help address such problems and create greater maintenance of clinical practices in the organization.

**Maintenance of Knowledge Base:** The departure of key staff, such as nurse educators, managers or other resource staff, may lead to a knowledge base that is not updated, linked with experiential knowledge or refreshed through booster sessions, leading to knowledge loss.

**Staff:** Staff turnover, movement of staff to new areas where they do not use their specialized knowledge and the introduction of new employees who may not have received adequate orientation and training can also lead to knowledge loss.<sup>74</sup> Additionally, employees hired who do not have the prerequisite knowledge with which to assimilate new knowledge may have difficulty maintaining the new practices in the organization.

**Policies and Procedures:** Knowledge concentrated in a policy or procedure that is not reviewed with staff on a regular basis may lead to a lack of use and eventual knowledge loss.

**Ongoing Improvement:** It is not enough to maintain practice knowledge in knowledge reservoirs. Knowledge must be continuously improved, for example, as a result of the availability of new research evidence. The active process of continuous quality improvement therefore becomes an additional strategy for sustaining practice change.

The appropriate balance in the choice of location and design of organizational memory accompanied by salient cues to motivate its retrieval and use will determine its long-term sustainability. Sustainability of practice changes therefore requires systematic, thoughtful planning and action to ensure that the changes are embedded into the various knowledge reservoirs in the organization. A more rigorous implementation plan leads to retention of practice knowledge in a number of diverse knowledge reservoirs beyond just the people.

## Sustainability Tool and Guide

The U.K. NHS (National Health Service) Institute for Innovation and Improvement developed a diagnostic tool that is used to predict the likelihood of the sustainability of your change project.<sup>75</sup> This sustainability guide provides practical advice on how you might increase the likelihood of sustainability for your improvement initiative. This tool was found useful by the jurisdictions implementing Screening for Distress.

The NHS Sustainability Guide is available at:  
[http://www.qihub.scot.nhs.uk/media/162236/sustainability\\_model.pdf](http://www.qihub.scot.nhs.uk/media/162236/sustainability_model.pdf)

## Building Capacity for Supportive and Psychosocial Care

Implementing Screening for Distress is about improving the delivery of supportive care for all patients and increasing access to psychosocial expertise for those who require the care. Members of the national implementation group observed that Screening for Distress uncovers institutional barriers and challenges. As the existing processes for assessing and responding to distress are closely examined, gaps and bottlenecks are revealed. For example, limited knowledge of locally available supportive care resources and services presented a potential serious barrier to the implementation of Screening for Distress – both for adequate patient follow-up and referral, and as a detriment to enhancing multidisciplinary collaboration.

### Top Organizational Challenges in Implementing Screening for Distress

- Time and workload concerns
- Referral concerns
- Information technology delays and challenges
- Staff absences and turnover
- Documentation of actions taken to address screening scores

Piceps Consulting Inc.<sup>19</sup>

All organizations prepared to implement Screening for Distress by conducting an inventory of on-site and off-site psychosocial and supportive care resources, so that nurses and social workers would be able to respond to the need for referrals as required. This undertaking varied enormously depending on each institution's existing infrastructure and availability of resources. Often, the inventory also helped create care pathways for Screening for Distress (see Appendix I).

For rural and remote sites, the scarcity of much-needed psychosocial and supportive care services was laid bare in this exercise. Some creative thinking was therefore required to forge new links with external partners to improve access to existing services. In all cases, implementing Screening for Distress provided an opportunity to improve staff knowledge and skills about services available within and outside of the institution.

In implementing Screening for Distress in community-based rural clinics in Ontario, the management team worked to strengthen the links between the clinics and community care access centres. Rural sites and their regional cancer centre also needed enhance links to each other to improve access to specialists and to patient education classes using telemedicine networks.

In larger sites, where psychosocial and supportive care services exist alongside ambulatory care, Screening for Distress encourages staff to improve communication, assessment and referral processes.

The jurisdictions found that Screening for Distress helps to identify patients' needs and priorities for supportive and psychosocial care. The data collected about these needs was very useful to the jurisdictions. Some of the data helped local teams find creative ways to streamline access to existing services and make the case for service enhancement.

## Module 6: Monitoring, Evaluating, Reporting, Disseminating

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- The Program Logic Model
- Quality Improvement and Evaluation Framework
- Quality Improvement
- National Evaluation of Screening for Distress Implementation: Knowledge Dissemination

### Principle 9: Monitoring, Evaluating, Reporting, Disseminating

Any innovation must have specific and measurable aims. Implementation and subsequent improvement must be tracked over time and the results and lessons learned shared with appropriate stakeholders. A process of continuous quality improvement should be adopted whereby measurements of quality are frequently conducted and quickly fed back to a team. This feedback must then lead to modifications that can be tried, tested and improved upon. Results and lessons learned from the implementation of an innovation must be shared with appropriate stakeholders within the organization in order to make informed policy and practice decisions. Results and lessons learned should also be shared with a wider audience interested in implementation research. This information can be shared via conferences, publications, presentations, formal networking initiatives and collaboration.

Cancer Journey's Quality Improvement (QI) and Evaluation Team developed a framework for implementing and evaluating Screening for Distress for the jurisdictions involved in the national initiative. The framework outlines the key areas for collecting evaluation data – including mechanisms to monitor progress and make course corrections as necessary to ensure that program goals and targets are being reached (continuous quality improvement). The purpose of this module is to describe the framework, provide some tools for evaluation and quality improvement, and share some examples and lessons learned from the jurisdictions. Key documents for monitoring and evaluating are:

- Screening for Distress Program Logic Model (see Appendix C)
- Screening for Distress Quality Improvement Framework (see figure on page 7)
- Implementation Process Map (see Appendix H)

## Quality Improvement and Evaluation Framework

Cancer Journey's framework (see Appendix P) recommends beginning by collecting baseline data prior to implementation using standardized measurement tools. These tools are used again after Screening for Distress has been fully implemented to evaluate the implementation. Some jurisdictions conducted mid-point evaluations. Baseline data collection can also be built into the assessment phase. The key areas for data collection are:

- The Screening for Distress tool
- Staff knowledge and skills
- Staff satisfaction
- Patient satisfaction and experience
- Organizational culture (team collaboration)

The framework depicts the four key components for implementing Screening for Distress. The elements of the program logic model that correspond to the framework components are shown in the following table.

### Program Components

QI and Evaluation Components	Program Logic Model Components
1. Screening and Early Identification of Distress	<ul style="list-style-type: none"> <li>• Planning and Assessment</li> <li>• Organizational Capacity Building</li> <li>• Monitoring, Evaluation and Reporting</li> <li>• Dissemination</li> </ul>
2. Education and Training	<ul style="list-style-type: none"> <li>• Staff Selection, Training and Support</li> </ul>
3. Teamwork and Collaboration	<ul style="list-style-type: none"> <li>• Teamwork and Collaboration</li> </ul>
4. Patient Engagement and Outcomes	<ul style="list-style-type: none"> <li>• Patient Engagement and Outcomes</li> </ul>

The Quality Improvement and Evaluation Framework assigns aims (targets) in four areas. The aims are intentionally high and exist as a goal or target for the management and implementation teams to reach for.

### Components and Aims

QI and Evaluation Components	Program Logic Model Components	Aim(s)
1. Screening and Early Identification of Distress	<ul style="list-style-type: none"> <li>• Planning and Assessment</li> <li>• Organizational Capacity Building</li> <li>• Monitoring, Evaluation and Reporting</li> <li>• Dissemination</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of target group screened for distress</li> </ul>
2. Education and Training	<ul style="list-style-type: none"> <li>• Staff Selection, Training and Support</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of targeted staff have knowledge and skills required to screen</li> <li>• 90% of targeted staff have competencies and skills to take action</li> </ul>
3. Teamwork and Collaboration	<ul style="list-style-type: none"> <li>• Teamwork and Collaboration</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of target group have scores acknowledged by health care provider</li> <li>• 90% of target group with scores <math>\geq 4</math> are further assessed and referred, as needed</li> <li>• 90% of team members engaged in collaboration and integrated care team planning using evidence-based approaches</li> </ul>
4. Patient Engagement and Outcomes	<ul style="list-style-type: none"> <li>• Patient Engagement and Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of patients and families satisfied with the process of care</li> <li>• 90% of patient population experience a reduction in distress over time</li> </ul>

The next table indicates the key variables collected by the jurisdictions. It demonstrates that process data from the screening tool and from staff educational sessions were most commonly collected. Staff and patient satisfaction were often collected at baseline and post-implementation.

See Appendix Q for a more detailed table that outlines the individual jurisdiction's approaches to quality improvement and evaluation.

### Key Variables Collected by the Jurisdictions

Category	Variables	Collected by		
		All	Most	Some
Screening and Early Identification of Distress	# and type of disease sites	•		
	# of patients screened	•		
	% of patients screened			•
	# of screens completed	•		
	# of patients missed and/or declined			•
	Distress levels (mild, moderate, severe)	•		
Staff Education and Training	# and type of educational sessions	•		
	# and category of staff attending sessions	•		
	# of staff who have competencies and skills to respond to distress scores			•
Teamwork and Collaboration	# of patients with scores $\geq 4$	•		
	Of patients with scores $\geq 4$ , % assessed further and/or referred		•	
	Type of referral and referral accepted			•
	Uptake of clinical practice guidelines			•
	Staff satisfaction		•	
Patient Engagement/ Outcomes	% of patients with decreased scores			•
	Patient and family satisfaction		•	

### Key Learnings about Evaluation

#### *Data Collection Systems*

In preparing for implementation, it is essential to establish methods to log and extract data from the Screening for Distress tool. The methods to log and extract data vary depending on whether the tool is administered with pen and paper or electronically. The jurisdictions found that electronic integration of the Screening for Distress tool often caused unexpected delays in the timeline for implementation. In the case of paper and pen screening, program sustainability depended on integrating responsibility for manual data entry and extraction into a job description. It is beneficial to have experts in data management and evaluation on the management team to mitigate such challenges and hurdles.



### *Baseline Data*

It is critical to collect relevant baseline data. Many institutions have access to some measures of patient satisfaction and experience with care, such as Picker surveys, but sometimes these measures are not specific enough to know if any changes in patient outcomes can be attributable to Screening for Distress. In one jurisdiction, the management team opted to add several questions to the Picker survey to address management of distress. In another, the management team established a Screening for Distress indicator for the institution. The team conducted a chart audit as a baseline, and will follow up post-implementation to track the number and percent of patients screened for distress, the symptoms, and the actions taken to respond to distress scores.

### *Documentation*

Screening for Distress relies on good documentation of the acknowledgement of screening scores by staff, of the patients' prioritizing of their concerns, of in-depth assessment of moderate and high scores by nursing staff, and of the follow-up and referral processes. The management team may need targeted strategies focused on improving and enhancing documentation of Screening for Distress, since the quality and consistency of data relies on this documentation.

### *Expectations for Change*

It is important to have realistic expectations with regard to when changes in practice or in clinical outcomes are perceptible. Another key learning from the jurisdictions is that change in practice and in patient outcomes takes a lot of time, and thus its effects will take some time to detect as well. The previous table reflects the key variables for the first 12 to 24 months of implementation. Few jurisdictions began to assess organizational culture or team collaboration because the management team recognized that these effects may not yet be measureable.

## Quality Improvement

Quality improvement offers a proven methodology for improving care for patients and for improving staff practices. It is a continuous process of identifying areas where process changes are needed and monitoring progress in the implementation of those changes. The implementation of Screening for Distress is an opportunity to streamline and improve the delivery of person-centred cancer care. Con-

### Benefits of Quality Improvement<sup>73</sup>

- Identifies quality issues
- Clarifies perceived and actual service delivery
- Tags and tracks indicators to know if change is an improvement
- Provides data on early gains
- Allows change with little risk to patients or of service disruption
- Allows shared learning and motivation
- Promotes quality activities to all stakeholders

tinuous quality improvement ensures that the changes that are being made are in fact improvements, and that the changes being made lead to the desired goals or aims of the program.

Quality improvement is a method that formalizes the way teams work. When a bottleneck or gap is apparent in clinic operations, a solution is applied to fix it. Using quality improvement activities, the team collects small amounts of data to measure change and ensure that modifications implemented by the team are having the intended effect.

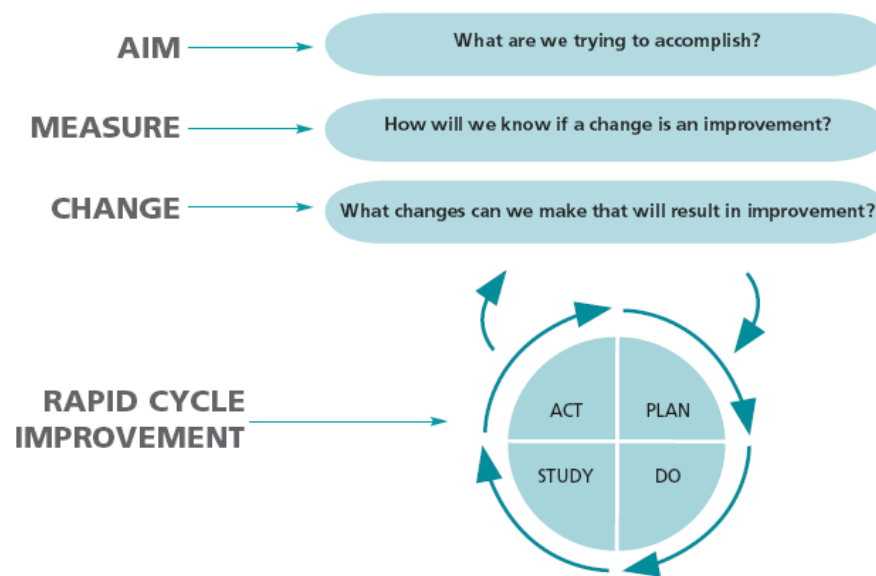
Importantly, quality improvement is a method that implementation teams can use to engage stakeholders to participate in the process. The teams are empowered to identify problems or flaws in system design that lead to poor quality. Teams can try out different ideas to improve how care is delivered in multiple, brief, small experiments of change. The teams conduct frequent, targeted quality measurement in a way that gives them instant feedback on whether the changes help move the team toward their goal or not.

In this section we outline the Model for Improvement. There are, however, many different models for quality improvement and “no one strategy is superior than another based on effectiveness, ease of implementation or cost.”<sup>76</sup>

## Model for Improvement

The Model for Improvement has two basic components: the first addresses three fundamental questions and the second is the rapid cycle improvement process.<sup>77</sup> In the first component of the model, the implementation team asks about the aim, how to measure the improvement and what changes are required. The second component is a method of rapid cycle improvement. The overall model is designed to develop, test and implement changes.

## The Model for Improvement<sup>77</sup>



### Three Fundamental Questions

The first component of the Model for Improvement is the three fundamental questions that need to be asked and answered.

#### 1. What are we trying to accomplish?

**Setting the Aims:** Improvements require clearly defined aims. Aims will help you stay on track throughout your improvement efforts. To facilitate the work of those implementing Screening for Distress, the Cancer Journey Quality Improvement and Evaluation Framework articulates the aims for each component of the Screening for Distress initiative.

#### 2. How will we know if a change is an improvement?

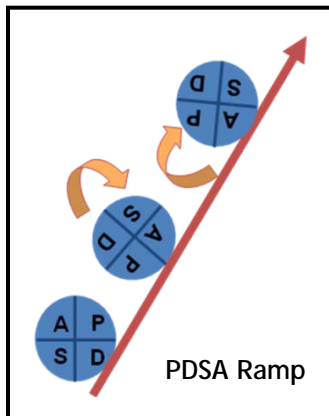
**Establishing Measures:** Measures assess whether the changes made are leading to tangible improvements. They provide concrete evidence to support the case for change.

#### 3. What changes can we make that will result in improvement?

**Testing Changes:** All improvements require changes, but not all changes result in improvements. The implementation team will have ideas about the changes that need to be made and the changes that are most likely to result in improvement. Ideas for change can come from a variety of sources, such as team problem-solving, critical thinking and reflection, creative thinking, a hunch or an idea from the scientific literature. Once the change is identified, the next step is to test the change by using Rapid Cycle Improvement, or the PDSA (Plan-Do-Study-Act) cycle. The implementation team plans for the change, tries the change, observes the results and acts on what is learned. This is the method used for action-oriented learning.

### Rapid Cycle Improvement

The second component of the quality improvement model is implementing a rapid cycle improvement process – the PDSA cycle. PDSA is a way to implement and assess change, and to keep the team and the project on track. PDSA cycles can be used to develop change ideas, test small-scale changes and implement changes to achieve aims.



Rapid cycle improvement works because processes have to change so that practices can change.

The time frame for testing small-scale changes is brief. Cycles should be conducted over a short time period, preferably no more than one to two weeks. Each change idea may require a series of PDSA cycles to test it. Any changes must be small and step-wise. The process of using a series of PDSA cycles to test an idea is called a PDSA ramp. The team can implement PDSA ramps one after the other or simultaneously.

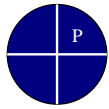
Below are the steps to follow to conduct a PDSA cycle:

- 1) *Gather your implementation team.* Discuss your progress to date and some of the current barriers or hurdles in your work. Select one of the most relevant problems or hurdles and identify the purpose of the action that is needed to address it. Does the team need to...
  - *Develop a change idea* (brainstorm to solve a problem or conduct rapid cycles to gather information and address a problem)? The team knows there is a problem but is not sure how to address it. Try a Defect Check Sheet or a Small Survey to isolate and identify the problem. (See Appendix R: Examples of Rapid Improvement Cycle Tools.)
  - *Implement and test a change* (take the steps to make a change and make sure that it worked). The team knows what needs to happen next, so it designs a small-scale modification to implement systematically and measure to track the outcome. If the change appears to be successful, the change can be implemented on a larger and/or more complex scale.
- 2) *Use the PDSA Cycle worksheet* to plan the rapid cycle (Appendix S).
- 3) *Communicate results* early and often to all stakeholders.

Teams identify the change ideas and use a series of PDSA cycles to develop and test small changes on a small scale in different contexts.

## PDSA Cycle Steps<sup>78</sup>

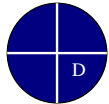
### Step 1: Plan



State the purpose of the PDSA:

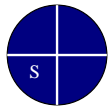
- Are you developing a change idea, testing a change or implementing change?
- What is your change idea?
- What indicator(s) of success will you measure?
- How will data on these indicators be collected?
- Who or what is the subject of the test?
- How many subjects will be included and over what time period?
- What do you hypothesize will happen and why?

### Step 2: Do



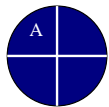
- Conduct the test
- Document results, including problems and unintended consequences.
- Collect and begin analysis of the data

### Step 3: Study



- Complete analysis of the data and study the results
- Compare the data to your predictions
- Summarize and reflect on what was learned

### Step 4: Act



- Refine the change idea based on lessons learned from the test
- Prepare a plan for the next test

## Tips for Testing Change

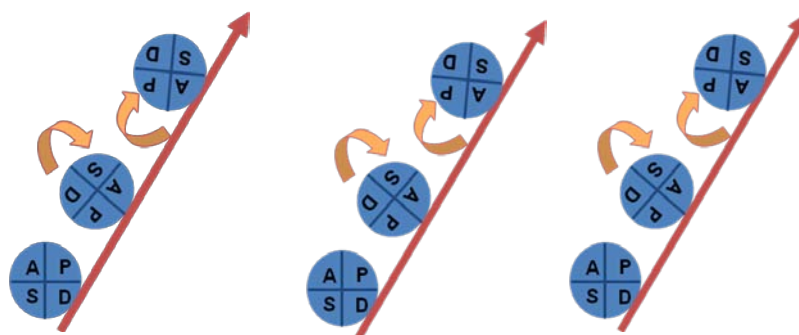
- *Stay a cycle ahead.* When designing a test, imagine at the start what the subsequent test or two might be given the possible findings of the study phase of the PDSA cycle.
- *Scale down the scope of tests and keep measurements small and feasible.* Rather than testing the change on 100 patients, use a sample of 10 patients. The same idea applies to the location or duration of the test. Keep the time frame for the test small, to occur over one or two weeks rather than several months.
- *Pick willing volunteers.* Work with those who want to work with you.
- *Avoid the need for consensus, buy-in or political solutions.* Save these for later stages. When possible, choose changes that do not require long processes of approval, especially during the early testing phase.
- *Don't reinvent the wheel.* Instead, replicate changes made elsewhere.
- *Pick easy changes to try.* Look for the ideas that seem most feasible and will have the greatest impact.
- *Avoid technical slowdowns.* Don't wait for the new computer to arrive, try paper and pencil instead.
- *Reflect on the results of every change.* Most work systems leave too little time for reflection on work. The study phase of the cycle is crucial and is too often overlooked. After making a change, a team should ask:

- What did we expect to happen?
  - What did happen?
  - Were there unintended consequences?
  - What was the best thing about this change? The worst?
  - What might we do next?
- Too often, people avoid reflecting on failure. Remember that teams often learn very important lessons from failed tests of change.
- *Be prepared to end the test of a change.* If the test shows that a change is not leading to improvement, the test should be stopped. Note: Failed tests of change are a natural part of the improvement process. If a team experiences very few failed tests of change, it is probably not pushing the boundaries of innovation.
  - *Collaboration among different departments and across professions* is essential to achieving systemic change.

### Linking Tests of Changes

Testing changes is an iterative process: the completion of each test rolls directly into the start of the next test. A team learns from the test (What worked and what didn't work? What should be kept, changed or abandoned?) and uses the new knowledge to plan the next test. As the cycles continue, the tests increase in complexity, scope and application. The team continues linking tests in this way, refining the change until it is ready for broader implementation and ultimately achievement of the aim. Remember that a team can implement PDSA ramps one after the other or simultaneously (see the figure following).

### Simultaneous PDSA Ramps



### Rapid Cycle Improvement: Examples from the Jurisdictions

The following table illustrates some of the areas identified for improvement by the jurisdictions. Following this table, two specific examples of rapid cycle improvement are illustrated.

### Areas for Improvement

Component	Aim(s)	Areas for Improvement
Screening and Early Identification of Distress	<ul style="list-style-type: none"> <li>80% of target group screened for distress</li> </ul>	<ul style="list-style-type: none"> <li>✓ Increase screening rates to 80% as per CCO guideline</li> <li>✓ Reduce number of missed screens from 15% to 5%</li> <li>✓ Increase % of patients screened on a routine basis (e.g., once per visit)</li> <li>✓ Increase % of patients screened by kiosk (from pen and paper)</li> </ul>
Teamwork and Collaboration	<ul style="list-style-type: none"> <li>90% of target group have scores acknowledged by health care provider</li> <li>90% of target group with score <math>\geq 4</math> will be further assessed and referred, as needed</li> <li>90% of team members engaged in collaboration and integrated care team planning using evidence-based approaches</li> </ul>	<ul style="list-style-type: none"> <li>✓ Increase # of referrals to health professional for patients with a score of <math>\geq 7</math> on depression or anxiety</li> <li>✓ Increase adherence to clinical pathways from 75% to 90%</li> <li>✓ Decrease % of patients assessed with pain guideline for scores of <math>\geq 7</math></li> <li>✓ Decrease % of patients with scores <math>\geq 7</math> for tiredness after first screen</li> </ul>

### Example 1: Screening and Early Identification of Distress

*Aim:* 90% of patients screened at third week of radiation therapy treatment

*Objective for this series of cycles:* Increase the number of patients screened by radiation therapists (currently at 50% due to staff concerns about availability of time and space to screen for distress)

*Measures:* Increase percent of patients screened from 50% to 90%; increase number of screening tools returned

- Cycle 1: For two weeks, 10 technicians give patients screening tool to complete at home; technicians have conversation with the patient the following day in the treatment room
- Cycle 2: Determined best practice and implemented across all radiation therapists (screening occurs at mid-treatment and is part of routine care)

### Example 2: Teamwork and Collaboration

*Aim:* Reduce number of patients with a pain score above 6

*Objective for this series of cycles:* Improve the management of pain

*Measure:* % of patients with score above 6 within 72 hours of team intervention

- Cycle 1: Test use of pain guideline with 1 provider and 1 patient
- Cycle 2: Revise and test with 2 providers and 6 patients



- Cycle 3: Revise and test with 3 providers and 9 patients
- Cycle 4: Monitor implementation and continued use by providers

#### Online QI Resources and Tools

- [The Institute for Healthcare Improvement](#)  
Resources and tools can be accessed free of charge once a login and password are acquired.
- [The Health Quality Ontario QI Guide](#)

## National Evaluation of Screening for Distress Implementation:<sup>19</sup> Knowledge Dissemination

The findings from rapid cycle improvements can be used to promote the gains and successes of the new program to all stakeholders and can contribute to the key messaging of the project. Use as many existing channels of communication as possible to communicate these successes and advances in implementation (e.g., newsletters and websites). Tailor the format and content of communications to intended audiences (e.g., brief emails to management and updates in volunteer newsletters). Finally, ensure that the program leads, champions and facilitators are informed of quality improvement and evaluation activities so that this information is conveyed through all channels of communication.

The following presents findings from the national evaluation of jurisdictions implementing Screening for Distress with regard to effective knowledge dissemination.

The jurisdictions recognized the importance of sharing results and lessons learned with appropriate stakeholders within the organization and with a wider audience interested in implementation research. The knowledge dissemination practices used by the jurisdictions adhere to traditional activities and audiences and have been demonstrated to work locally:

- *Targeted face-to-face meetings* were used to share the results of Screening for Distress and highlight opportunities to facilitate Screening for Distress. Screening for Distress program leaders delivered presentations to disease site groups, attended staff meetings and held dedicated, local, discipline-specific meetings to share results and discuss strategies of mutual interest to promote screening.
- *Inter-jurisdictional meetings and teleconferences* were sponsored by Cancer Journey. Many jurisdictions have posted materials on the CancerView and jurisdiction websites.
- *Screening for Distress program indicators* (e.g., program performance and outcomes) were provided to community and referral partners to facilitate engagement in and understanding of the program and its activities and results.
- *Testimonials* were gathered from patients describing their experiences with screening. The testimonials were communicated in regular, standing reports and through existing communications vehicles (e.g., intranet, internet, newsletters and email blasts to program leaders, managers and supervisors).
- *Front-line nurses shared their experiences* through meetings with and presentations to nurses new to screening. These communications helped alleviate concerns about additional time and workload.
- *All sites developed a list of resources*, often in the form of a formalized resource binder or directory of services. This resource was crucial in disseminating informa-

tion about locally available supportive care services and helped alleviate fears about inadequate resources for patient follow-up and referral.

- *Journal submissions* enhanced dissemination to the research community.

Additional suggestions for enhancing knowledge dissemination using creative and targeted methods include:

- *Ensuring that Screening for Distress reports become part of the cancer program's standing management reporting process.* These Screening for Distress reports should include a section on the status of Screening for Distress (including results from peripheral sites) as a standing component of the report. The status can include data on the number of screens, proportion and number of patients identified to be in distress, and the proportion and number of these patients who were referred to services. The section can also include any other highlights that bring to life the progress of the initiative, including new people trained/educated on Screening for Distress, participation in any professional or academic events regarding Screening for Distress, testimonials from patients and other notes of interest.
- *Identifying knowledge brokers.* These individuals are seen to have substantial knowledge about Screening for Distress, have credibility with co-workers, can facilitate the delivery of key messages and presentations, identify opportunities for collaboration, and isolate issues and risk mitigation strategies to help achieve the longer-term sustainability of the initiative. The knowledge brokers should be supported by speaking notes and scheduled into targeted meetings (such as those with specific disciplines) to share knowledge on Screening for Distress activities and outcomes.
- *Identify patients who can present at "rounds" and other practice-level meetings.* These patients can share experiences with Screening for Distress and the effect on their participation in cancer care, quality of life, relationships with care providers and use of health care resources. These patients could also act as knowledge brokers to present to community partners and patient groups to help validate the importance of Screening for Distress.
- *Provide physician-specific reports.* Reports can include the number of patients screened for that physician, and the percentage of patients who were identified as in distress and referred to supportive services. These reports would be created separately for each physician to help provide context and a metric for each physician regarding Screening for Distress at the site and in their practice.
- *Explore the potential to use social media* to share program results, which would help "normalize" Screening for Distress for patients and providers.

## Appendix A: Recommended Readings

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## Appendix B: Screening for Distress Minimum Data Set

Date of Completion: \_\_\_\_\_ Time: \_\_\_\_\_

Completed by:  
 Patient  
 Family  
 Health Professional  
 Assisted by family or health professional

**1. Edmonton Symptom Assessment System (ESAS):**

Please circle the number that best describes:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other problem	0	1	2	3	4	5	6	7	8	9	10	

**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:

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

*\*Questionnaire from the Cancer Journey Advisory Group, Canadian Partnership Against Cancer's Minimum Data Set*



**Edmonton Symptom Assessment System:  
(revised version) (ESAS-R)**

**Please circle the number that best describes how you feel NOW:**

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness <i>(Tiredness = lack of energy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness <i>(Drowsiness = feeling sleepy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression <i>(Depression = feeling sad)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety <i>(Anxiety = feeling nervous)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing <i>(Wellbeing = how you feel overall)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem <i>(for example constipation)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by (check one):

- Patient
- Family caregiver
- Health care professional caregiver
- Caregiver-assisted

**BODY DIAGRAM ON REVERSE SIDE**

**ESAS-r**

Revised: November 2010



## Appendix C: Screening for Distress Program Logic Model<sup>79</sup>

Components	Planning & Assessment	Staff Selection, Training & Support	Teamwork & Collaboration
Inputs	<ul style="list-style-type: none"> <li>Staffing</li> </ul>	<ul style="list-style-type: none"> <li>IS/IT</li> </ul>	<ul style="list-style-type: none"> <li>Facilities</li> <li>Materials/Documents</li> </ul>
Activities	<p>Assessment of:</p> <ul style="list-style-type: none"> <li>Problem or local situation</li> <li>Individual staff perceptions, motivation</li> <li>Existing social supports</li> <li>Organizational capacity for Screening for Distress program</li> <li>Barriers to implementation</li> <li>Tailoring Screening for Distress program to local context</li> <li>Creation of implementation plan</li> </ul>	<ul style="list-style-type: none"> <li>Select and recruit staff</li> <li>Conduct education and training in:                             <ul style="list-style-type: none"> <li>Person-centered approach</li> <li>Screening for distress, comprehensive assessment and appropriate referrals</li> <li>Guidelines, standards, algorithms</li> <li>Integration of Screening for Distress into workflow</li> <li>QI and PDSA cycles</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Develop capacities to work as an interprofessional team by expanding scope and communication</li> <li>Use guidelines, standards and algorithms to inform care planning process</li> <li>Assess patients' key concerns and make referrals as appropriate</li> </ul>
Outputs	<ul style="list-style-type: none"> <li>Documentation of rationale for need for Screening for Distress programs</li> <li>Best practice guidelines for Screening for Distress</li> <li>Implementation plan</li> <li>Barrier management strategy</li> <li>Tailored components of screening plan, including tools, methods, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Person-centered educational modules for Screening for Distress</li> </ul>	<ul style="list-style-type: none"> <li>Interprofessional model of care for Screening for Distress</li> </ul>
Process Outcomes	<ul style="list-style-type: none"> <li>Increased preparation and readiness for implementation of Screening for Distress programs</li> <li>Overcoming the barriers for Screening for Distress programs</li> </ul>	<ul style="list-style-type: none"> <li>Increased knowledge skills and capacity for screening, assessment and making referrals as part of cancer care process</li> <li>Increased awareness and integration of key attributes of person-centered care</li> <li>Increased knowledge about the core competencies required</li> </ul>	<ul style="list-style-type: none"> <li>Increased adherence to evidence-based guidelines for screening and referral</li> <li>Improved team collaboration and service coordination</li> <li>Provision of safe and accessible care</li> <li>Staff satisfaction with teamwork and collaboration</li> </ul>
Short-Term Outcomes	<ul style="list-style-type: none"> <li>Screening for Distress program implemented as designed</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced staff competencies and capacity for person-centered approach to Screening for Distress and referral</li> </ul>	<ul style="list-style-type: none"> <li>Improved coordination, continuity and integration of screening and referral within cancer care delivery</li> <li>Working toward person-centered care</li> </ul>
Intermediate Outcomes	<ul style="list-style-type: none"> <li>Increased patient and family satisfaction with the experience of care</li> </ul>	<ul style="list-style-type: none"> <li>Increased patient and family awareness of supportive care services and resources</li> </ul>	<ul style="list-style-type: none"> <li>Increased patient and family knowledge about self-management and self-care</li> </ul>
Long-Term Outcomes	<ul style="list-style-type: none"> <li>Sustainability of Screening for Distress program</li> </ul>	<ul style="list-style-type: none"> <li>Reduced patient and family stress and increased quality of life</li> </ul>	<ul style="list-style-type: none"> <li>Reduced costs to cancer care system</li> </ul>

Components	Organizational Capacity Building	Patient Engagement	Monitoring, Evaluation & Reporting	Dissemination
Inputs	<ul style="list-style-type: none"> <li>Staffing</li> </ul>	<ul style="list-style-type: none"> <li>IS/IT</li> </ul>	<ul style="list-style-type: none"> <li>Facilities</li> </ul>	<ul style="list-style-type: none"> <li>Materials/Documents</li> </ul>
Activities	<ul style="list-style-type: none"> <li>Identify and promote champions and other positive social influences</li> <li>Develop policies and boundaries for screening</li> <li>Secure skilled human and financial resources</li> <li>Develop intra-organizational communication mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>Create and implement processes to ensure that patients are screened for distress:                             <ul style="list-style-type: none"> <li>Are involved in conversations as part of the health care team</li> <li>Participate meaningfully in decision-making and priority setting</li> <li>Receive timely, complete and accurate information</li> <li>Identify and discuss concern</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Measurement development</li> <li>Tracking and progress reporting of patients screened, % with decreased distress scores, etc.</li> <li>Barrier management</li> <li>Sharing results</li> </ul>	<ul style="list-style-type: none"> <li>Creation of mechanisms to share results and lessons learned about the practice of screening for distress with internal stakeholders</li> <li>Development of products to share lessons learned with external stakeholders</li> <li>Participation in conferences, collaborations, etc.</li> </ul>
Outputs	<ul style="list-style-type: none"> <li>Champions</li> <li>Policy documents</li> <li>Resource allocation documents</li> </ul>	<ul style="list-style-type: none"> <li>Patient information sessions and consultations</li> <li>Patient is screened for distress</li> <li>Patient concerns are addressed</li> </ul>	<ul style="list-style-type: none"> <li>Data collection and reporting system</li> <li>Progress reports</li> </ul>	<ul style="list-style-type: none"> <li>Knowledge products</li> <li>Collaborations</li> <li>Conferences</li> <li>Publications and presentations</li> </ul>
Process Outcomes	<ul style="list-style-type: none"> <li>Improved infrastructure to support screening program</li> </ul>	<ul style="list-style-type: none"> <li>Patients and families increasingly involved in all aspects of the screening and referral process</li> </ul>	<ul style="list-style-type: none"> <li>Continued implementation of QI and PDSA cycle</li> </ul>	<ul style="list-style-type: none"> <li>Internal and external stakeholders increasingly aware of existence of Screening for Distress programs</li> </ul>
Short-Term Outcomes	<ul style="list-style-type: none"> <li>Enhanced infrastructure that supports an integrated approach to screening and referral</li> </ul>	<ul style="list-style-type: none"> <li>Increased knowledge, awareness, involvement in, and understanding of the screening and referral process</li> </ul>	<ul style="list-style-type: none"> <li>Increased understanding of screening program effectiveness and necessary modifications at individual, team and organizational levels</li> </ul>	<ul style="list-style-type: none"> <li>Increased understanding of Screening for Distress program by internal and external stakeholders, including challenges and opportunities</li> </ul>
Intermediate Outcomes	<ul style="list-style-type: none"> <li>Increased patient and family satisfaction with the experience of care</li> </ul>	<ul style="list-style-type: none"> <li>Increased patient and family awareness of supportive care services and resources</li> </ul>	<ul style="list-style-type: none"> <li>Increased patient and family knowledge about self-management and self-care</li> </ul>	
Long-Term Outcomes	<ul style="list-style-type: none"> <li>Sustainability of Screening for Distress program</li> </ul>	<ul style="list-style-type: none"> <li>Reduced patient and family stress and increased quality of life</li> </ul>	<ul style="list-style-type: none"> <li>Reduced costs to cancer care system</li> </ul>	

## Appendix D: Self-Assessment of Change Management Skills<sup>18</sup>

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This tool will help individuals think about whether they have the range of skills needed to make good change agents. It will help them identify their areas of strength and those that need to be developed. It can help senior management think about who would make a good change agent. How to use the tool:

- As a checklist for individuals to consider what aspects of their skills they need to develop.
- As a basis for management discussion about who would make a good change agent.
- As a discussion tool: Allow approximately 20 minutes for people to complete the checklist and to identify their areas for attention. Focus discussion on areas where there is consensus that work is needed, not on individual responses to particular questions.

### Interpersonal Skills Needed to Manage Change Effectively

	Good	Ok	Needs work
1. I speak persuasively when addressing an audience (a good advocate)			
2. I intervene and project myself successfully in meetings			
3. I listen attentively to others			
4. I respond positively to colleagues' points			
5. I am able to be open and share my thoughts and feelings with colleagues			
6. I am articulate when talking to colleagues			
7. I can sustain an argument when talking in meetings			
8. I am sensitive to and aware of my colleagues' personal needs			
9. I can help colleagues find solutions to problems			
10. I inspire confidence through enthusiasm			
11. I am able to control my emotions when dealing with colleagues			
12. I am capable of accepting advice			
13. I am able to admit my weaknesses			
14. I can accept group decisions with good grace			
15. I am not patronizing or condescending			
16. I am not afraid to confront my colleagues when necessary			
17. I am assertive			
18. I encourage colleagues to use their initiative			
19. I avoid being over directive or bossy			
20. I am capable of cheerful compromise			
21. I am aware of the effect of body language on social interaction			
22. I am able to raise my colleagues' self-esteem through praise			

	Good	Ok	Needs work
23. I am able to reflect critically on my own performance			
24. I am able to gather data and evidence to evaluate my own performance			
25. I am good at passing responsibility on to colleagues			
26. I give colleagues room to try things out, even if it means mistakes are made			
27. I look for and share examples of good practice and success			
28. I am genuinely interested in colleagues' ideas and views			
29. I continue to learn from my colleagues			
30. I am able to stand back and not over-organize others			
31. I am able to communicate optimism to colleagues in the face of difficulties			
32. I am able to find out how colleagues feel			
33. I provide constructive and well-focused feedback			

When you have completed the above table, use the following table to assess what skill areas are particularly strong or weak for you. All change agents tend to have stronger and weaker skill areas. The weaker areas will lead to particular types of problem in managing change. You need to try to develop your skills in all the key areas below:

Skill Areas	Strategies	Question #
Help Individuals	<ul style="list-style-type: none"> <li>• Support</li> <li>• Reward</li> <li>• Feedback</li> <li>• Not blaming but helping without taking over (show trust)</li> </ul>	4, 9, 15, 26, 31, 33
Communicate as you never have before	<ul style="list-style-type: none"> <li>• Vision, goals and actions</li> <li>• Coalition building, advocacy and bargaining</li> <li>• Checking things out</li> </ul>	1, 2, 6, 7, 10, 17, 21
Do not over-organize	<ul style="list-style-type: none"> <li>• Reduce focus on details</li> <li>• Allow flexible implementation</li> <li>• Integrate colleague's ideas into the process of change</li> </ul>	12, 14, 18, 19, 25, 26, 30
Dealing with conflict and differences	<ul style="list-style-type: none"> <li>• Without getting over-emotional or personally involved (staying in adult behaviour). <ul style="list-style-type: none"> <li>– Handling opposition well helps achieve active implementation</li> </ul> </li> </ul>	11, 14, 16, 17, 20
Building trust, confidence and self-esteem	<ul style="list-style-type: none"> <li>• Provide genuine feedback</li> <li>• Listen to others' ideas</li> <li>• Focus on progress and examples of development rather than statistics, performance, indicators, etc.</li> <li>• Feedback on success</li> </ul>	4, 10, 14, 22, 27, 33
Real interest in others	<ul style="list-style-type: none"> <li>• Contrived collegiality does not work</li> </ul>	3, 8, 15, 29, 32
Emotion is important	<ul style="list-style-type: none"> <li>• Do not minimize expressions of feelings</li> <li>• Recognize that it is alright to not always be rational</li> </ul>	5, 8, 13, 32
Self-awareness	<ul style="list-style-type: none"> <li>• Be aware of your own challenges and performance</li> </ul>	12, 13, 23, 24

## Appendix E: Readiness for Change Checklist<sup>18</sup>

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This tool can be used as an individual self-reflection tool, but it will be more useful if used with groups of staff. If used with groups of staff:

- Have each participant complete the tool individually (allow 10 minutes for completion).
- If you, as manager, think that the team/section/service has a long way to go for more change, pool the results anonymously by collecting them beforehand (in blank envelopes) or invite the group to record their responses on a master copy using a flipchart, so that people do not feel obliged to defend their own perception.
  - Put the emphasis on moving forward not on ascribing blame.
- If you, as manager, feel that the group will be comfortable sharing their perceptions openly, work through each row in turn, checking out different perceptions.
  - If you all opt for a particular column, how can you get to the next column to the left?
  - If you differ in your views, why is this?
  - What ideas do any group members have for moving toward the left (as represented on this tool!)?

Please Circle the appropriate statement – one of the four columns in each row below.

1. In the past, new policies or systems introduced by management have been:	Seen as meeting employee needs	Not well understood	Greeted with some resistance	Vigorously resisted
2. Employees may be best described as:	Innovative	Independent	Uncommitted so far	Conservative or resistant to change
3. The implementation of Screening for Distress and related changes in the organization is viewed as:	A success	Moderately successful	Having only peripheral impact	Not successful
4. Expectations of what this change will lead to are:	Consistent throughout the organization	Consistent among senior management but less so otherwise	Not consistent	Unclear
5. What can people directly affected by the changes tell you about the Screening for Distress implementation plan:	A full description	A description of where it affects their own department or activity	A general idea	Nothing

6. Intended outcomes of the change have been:	Specified in detail	Outlined in general terms	Poorly defined	Not defined
7. Work procedures following the introduction of Screening for Distress are seen as needing:	Major change	Significant alteration	Minor improvement	No change
8. The problems addressed through Screening for Distress were first raised by:	The staff directly involved	Managers	Outside bodies: CPAC, provincial cancer organizations	The change is not seen as addressing important and relevant service problems
9. The next stage of change is viewed by staff as:	Crucial to the organization's future	Generally beneficial to the organization	Beneficial only to part of the organization	Unimportant
10. Top management support for Screening for Distress is:	Enthusiastic	Limited	Minimal	Unclear
11. The management team has:	Committed significant resources to the changes	Assigned token additional resources to the changes	Expects the change to be implemented from existing resources	Not planned the resources that are needed
12. The management performance appraisal and review process is:	An important part of management development	A helpful problem-solving process	Routine	An obstacle to improvement
13. The change deals with issues of relevance to the practice environment:	Directly	Partly	Only indirectly	Not at all
14. Screening for Distress and related changes:	Make jobs more rewarding	Make jobs easier and more satisfying	Have little impact on people's work	Make jobs harder
15. Screening for Distress and related change is technically:	Similar to others already underway	Similar to others undertaken in the recent past	Novel	Technically unclear

## Readiness for Change Checklist: Some Problems and Solutions

### Track Record of Changes (Questions 1-3)

The potential problems are:

- Past changes have met with resistance
- Past changes were poorly understood
- Employees are thought to be too cautious
- Recently introduced changes have had limited or little success

The solutions are:

- Keep everyone informed by making information available, explaining plans clearly and allowing access to management for questions and clarification.
- Ensure that change is solid realistically by making a practical case for it. Explain change in terms which the employee will see as relevant and acceptable. Show how change fits service needs and plans. Spend time and effort on presentations.
- Prepare carefully by making a full organizational diagnosis by spending time with people and groups, and building trust, understanding and support.
- Start small and build up a successful track record. Implement changes in clear phases.
- Plan for success by starting with things that can give a quick and positive pay-off. Publicise early successes. Provide positive feedback to those involved in successes.

### Expectations of Change (Questions 4-6)

The potential problems are:

- Different people hold different ideas about the change
- People do not know what to expect
- Objectives are not clearly defined

The solutions are:

- Clarify benefits of changes by emphasising benefits to those involved, that is, to the service.
- Choose messages and messengers carefully and communicate often.
- Reinforce that the guidelines are evidence-based and that much of the value of the guideline pertains to improving patient and family experience with cancer (i.e., every patient will be screened and assessed for distress and all interventions will lead to the best possible outcome).



- Confirm that the initiative is being adopted as a standard around the country and is not a “cookbook” standardization project.
- Minimize surprises by specifying all assumptions about the change. Focus on outcomes. Identify potential problems.
- Communicate plans by being specific in terms that are familiar to the different groups of employees. Communicate periodically and through various media. Ask for feedback. Do not suppress negative views; listen to them carefully and deal with them openly.

### **Who ‘Owns’ the Problem or the Idea for Change? (Questions 7-9)**

The potential problems are:

- The procedures, systems, sections and services involved are seen to be a problem.
- The change was planned or introduced by top management or staff sections.
- The change is viewed as purely a matter of procedure.

The solutions are:

- Specify plans in terms that people understand. Ensure that employees’ problems are addressed explicitly as part of the change. Arrange for visible outcomes
- Clarify employees’ views by exploring their concerns about the changes and examining the impact on the day-to-day routines.
- Present a clear case by specifying who wants change and why. Explain longer-term advantages. Identify common benefits. Present potential problems clearly. Listen to problems.

### **Top Management Support (Questions 10-12)**

The potential problems are:

- Concerns or doubts about top management support for the change.
- Whether top management will provide resources.
- The current management performance appraisal process is seen to be an obstacle to change.

The solutions are:

- Build a power base by becoming the expert in the problems involved. Understand top management concerns. Develop informational and formal support. Develop a strong and polished presentation in top management language.
- Develop clear objectives and plans by establishing a clear timetable. Set up review processes to be supportive. Bring top and middle management into the review process. Focus meetings on specific outcomes and specific problems.

## Acceptability of Change (Questions 13-15)

The potential problems are:

- The planned change conflicts with or does not with fit other plans.
- There a little or no clear sense of direction.
- The proposed changes are perceived to place greater demands on people.
- The change is perceived to involve new technology products/services and expertise.

The solutions are:

- Identify relevance of change to plans by reviewing plans and specifying how change fits. Incorporate changes into on-going developments. If possible, frame changes in terms of the organization's style.
- Clarify plans for changes by communicating simply and openly.
- Implement with flexible or adaptable people, and people familiar with some or all of the change, in a part of the service where there are strong supporters for change. Recognize why people support change (career, rewards, organizational politics).
- Do not oversell the change by being adamant about conflicts with present practices. Encourage discussion of these conflicts.

## Appendix F: Identifying Barriers

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### Talk to Key Individuals<sup>30</sup>

Key individuals have specific understanding of a given situation and have the knowledge, skills and authority to enable them to think around a topic and explore new ideas. You may want to consider talking to a group of key individuals through one of their regular meetings, for example, a staff meeting.

Advantages:

- It enables ideas to be explored in an iterative fashion
- Detailed information can be obtained
- It is quick and inexpensive.

Disadvantages:

- It relies heavily on the key individual(s)
- The responses may be subject to bias
- It may be difficult to find the right person (or people) to talk to
- Additional corroboration may be needed.

### Observe Clinical Practice in Action<sup>30</sup>

Sometimes the best way of assessing current clinical practice is by observing individual behaviours and interactions. This is especially appropriate if you are looking at events that happen quite often.

Advantages:

- It enables detailed analysis of current behaviours in a specific context
- It eliminates reporting bias
- It can provide a useful method for monitoring progress, if repeated on a regular basis

Disadvantages:

- It can be difficult to gain consent from the people you want to observe
- Peoples' behaviour can alter when they know they are being watched
- A skilled observer is needed to minimise influence on the person being observed
- Methods of data collection need careful consideration

A more formal way of doing this is through an audit.

## Use a Questionnaire<sup>30</sup>

A questionnaire is a good way of exploring the knowledge, beliefs, attitudes and behaviour of a group of geographically dispersed healthcare professionals. Careful thought needs to be given to the design of the questions, as the quality of the answers relies heavily on the quality of the questions. Both electronic and paper formats can be used to encourage responses.

Advantages:

- It allows rapid collection of relatively large amounts of data from a large number of people
- It enables statistical analysis of standardized data
- It provides the opportunity to highlight the need for change through communication of the results
- It is relatively inexpensive.

Disadvantages:

- Significant time is needed to develop good questions
- It is not possible to ask follow-up questions
- The response rate may be poor and may be biased towards high performers
- The nature of self-reporting means it can be inaccurate.

## Brainstorm<sup>30</sup>

Brainstorming is a way of developing creative solutions to problems. It can be done informally in small groups or as part of a focus group. The session starts with an outline of the problem and then participants are encouraged to come up with as many ideas as possible to solve it. One of the great things about brainstorming is that participants can bounce ideas off each other and develop and refine them further.

Advantages:

- It is fast and easy to do
- It generates lots of ideas
- It helps engage people in the process of change

Disadvantages:

- It needs a skilled facilitator
- More vocal members of the group may dominate the discussion
- Organising a session among a group of healthcare professionals can be difficult because of their clinical commitments

Provides free online training in brainstorming including the rules of brainstorming and running a brainstorming session.

## Run a Focus Group<sup>30</sup>

Focus groups are a powerful means of evaluating current practice and testing new ideas. They comprise a facilitated discussion or interview involving a group of 6-10 people. Open questions are posed by the facilitator, who then encourages the group to discuss their experiences and thoughts, and reflect on the views of others.

Advantages:

- It enables a representative group of people to share ideas
- It allows a wide range of in-depth information to be obtained
- It encourages new ideas and perspectives
- It helps get people engaged in the change process
- It is relatively quick and easy to perform

Disadvantages:

- A skilled facilitator is needed to ensure everyone is able to express their views
- It can be difficult to find a suitable time for everyone to attend
- Incentives may need to be offered to encourage attendance
- Analysis can be time consuming
- Careful planning and analysis are needed

## Case Studies<sup>31</sup>

Case studies are useful when very detailed information about a past event may shed light on existing barriers.

Advantages:

- Can provide very detailed information about an issue or event
- Can gain insights when combined with other techniques

Disadvantages:

- Multiple forms of data collection and analysis are required
- Input from a variety of experts may be needed
- Can be time consuming and expensive
- Findings are open to subjective interpretation
- Findings from one case study may not be readily generalizable to other groups

## Interviews<sup>31</sup>

A face-to-face discussion with individual participants who are asked specific questions by an interviewer. The Interviews can be unstructured, semi- structured or structured.

Advantages:

- Detailed, in-depth information can be obtained
- Participants can express their own views
- Complex or unanticipated issues can be explored

Disadvantages:

- Time consuming and expensive
- The interviewer may introduce bias in terms of how the questions are asked or recorded
- Some participants responses may be inhibited
- Summarizing and comparing responses to open ended questions can be difficult

## Surveys<sup>31</sup>

A survey is a standardized set of questions assessing participants' knowledge, attitudes and/or self-reported behaviour. The questions can be open ended allowing participants to report their responses verbatim, closed, where participants have to select answers from a predetermined list, or a combination of both.

Advantages:

- They can be sent to healthcare professionals or patients anywhere in the country.
- Data can be collected from a large number of people in a relatively short period of time
- Respondents can complete the survey at their convenience
- Respondents can remain anonymous
- Relative inexpensive

Disadvantages:

- Considerable time may be needed for development and pilot testing
- It is not possible to ask follow-up questions
- Individuals may not accurately report their behaviour or the factors influencing their practice
- Response rate may be low

## Nominal Group Technique<sup>31</sup>

Nominal Group Technique is a highly structured discussion among a group of people whose ideas are pooled and prioritized.

Advantages:

- Many ideas can be generated in a short period of time
- All participants have input
- Fast and easy to execute
- Can be used to seek group consensus regarding prioritization of ideas

Disadvantages:

- Requires a highly skilled moderator
- Incentives are needed for people to attend
- Only a single issue or topic can be explored

## Delphi Technique<sup>31</sup>

The Delphi Technique is an iterative process in which information is collected from the same group of participants through a series of surveys.

Advantages:

- Participants remain anonymous
- Surveys can be sent out

Disadvantages:

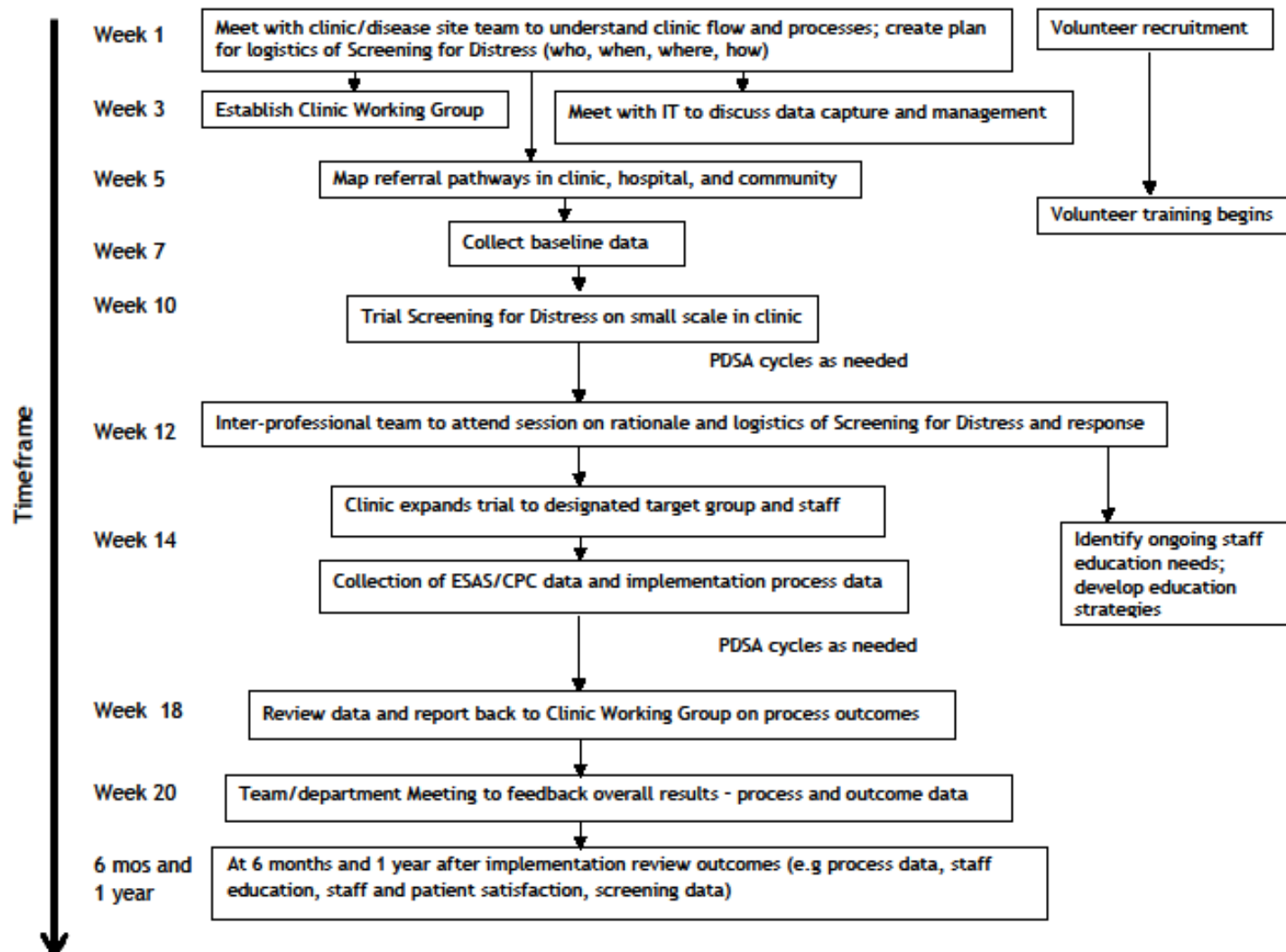
- Considerable time is needed for question development, analysis and revision
- Participants may not be willing to fill out multiple surveys
- Response rate may be low

## Arts Based Techniques<sup>32</sup>

Arts based approaches offer the potential to foster critical awareness, to facilitate understanding and nurture sympathy. Dramatic performances have been successful in helping health care professionals reflect on the care they provide and increase their understanding of patient care issues.<sup>33-35</sup> Another technique is Improvisational theatre, where a short play is performed, followed by an identical presentation in which audience members are encouraged to physically replace the main character when they feel inspired to enact an alternative approach that might result in a more favourable outcome. This can foster critical thinking about the lived reality of the participants, the root causes and solutions to social problems, and change.



## Appendix G: Implementation Process Map



Adapted from "PMH Clinic Roll Out" document, Princess Margaret Hospital DART Implementation Team

## Appendix H: Patient Poster and Pamphlet

### Poster



**Screening for Distress,  
the 6<sup>th</sup> Vital Sign**

**You don't have to face cancer  
alone. We're here to help.**

- Distress is common during a cancer experience.
- Screening for Distress helps your health care team identify and address your concerns.
- Ask to participate in Screening for Distress at your next visit.



CANADIAN PARTNERSHIP AGAINST CANCER  PARTENARIAT CANADIEN CONTRE LE CANCER

## Pamphlet

### Patient Feedback:

"I am extremely pleased with being a part of an innovative program that is changing the face of patient care."



"I am amazed at what you people are offering me."

"I felt alone at first but I feel like the people at the cancer centre really care."

"I never knew these resources were out there, and I really appreciate having someone help me with my specific concerns."



Cancer Journey Portfolio  
Canadian Partnership Against Cancer  
<http://www.partnershipagaincancer.ca/>

Le Partenariat canadien contre le cancer  
<http://www.partnershipagaincancer.ca/fr/>

Telephone: 1-877-360-1665

E-mail: [info@partnershipagaincancer.ca](mailto:info@partnershipagaincancer.ca)  
[info@partenariatcontrecancer.ca](mailto:info@partenariatcontrecancer.ca)

Production of this pamphlet has been made possible through a financial contribution from Health Canada through the Canadian Partnership Against Cancer

Moving towards Person-Centred Care

## Screening for Distress, the 6<sup>th</sup> Vital Sign



## Screening for Distress, the 6th Vital Sign

### What is Distress?

Distress can be described as a general feeling of discomfort or upset. Distress is commonly experienced by patients and may be due to emotional, social, informational, spiritual, practical, and/or physical concerns.

### What is Screening for Distress?

Screening for Distress helps your health care team identify if you are experiencing distress, and what concerns are causing this distress, at the earliest point in time. Once your concerns are identified your health care team will work with you to address these issues.



### Why is Distress called “The 6th Vital Sign”?

It may seem odd to consider distress as a vital sign, along with pulse and blood pressure, but attitudes have changed. We understand that your well-being is a vital factor in your treatment—as important as physical signs. You have the right to ask for and receive resources that will help you cope not only with your physical concerns but also the emotional, social, and practical sides of cancer.

### What can I expect if I go to a centre where Screening for Distress is taking place?

You will complete a short questionnaire designed to capture your concerns. This questionnaire is then used to guide the discussion between you and your health care team.

### How will Screening for Distress impact my care?

The screening questionnaire enables the health care team to quickly identify concerns you are experiencing. The health care team is then able to use this information as a starting point for further assessment. You, your family, and the health care team will then work together to find ways to deal with any concerns that you may have.



### Who has access to my Screening?

The information you provide becomes part of your health record and will be shared as needed with other health care providers. It will be protected in the same way as all health care information. Additionally, screening results may be used to evaluate the success of programs aimed at decreasing distress. If your information is used for this purpose it would be reported in such a way as to protect your identity.



### What are some benefits of Screening for Distress?

- Screening for Distress enables concerns to be quickly identified and addressed
- Taking part in screening encourages you to be an active participant in your care
- Screening for Distress encourages collaboration between you and your health care team
- Screening for Distress encourages learning about programs and resources



# Appendix I: Example Resource Sheet for Referrals from CancerCare Manitoba

COMPASS		CCMB COMPASS RESOURCES			CancerCareManitoba
For All Patients	A-S-K	Green Zone Score of 0-3	Yellow Zone Score of 4-6	Red Zone Score of 7-10	
	1. Scores Acknowledged 2. Scores & Conversation charted on Questionnaire "COMPASS (ESAS & CPC Distress Screen)"	Patient appears to be managing concern well • Assess information needs • Build on strengths	Further Assessment • Information / Education • Support Group, Class or Program • Possible Referral	• Further Assessment • Provider Referral Recommended	
• The Navigator Newsletter has a complete listing of support groups, programs and resources available to patient and their families • Patient & Family Support Services (787-2109) can assist in determining patient need for referrals, programs, support and resources (Programs listed are free, unless otherwise noted) • Patient & Family Resource Centre "PFRC" (787-4357) has patient books, handouts and resources for every item and a Nurse Coordinator for consultation. Resources can be mailed to patients o <a href="http://www.cancercare.mb.ca">www.cancercare.mb.ca</a> —Patient and Family—full searchable online library listing / Cancer Treatment Info Sheets available online • All handouts are available on the CCMB shared drive (J:) Screening for Distress folder—Patient Handouts folder					
ADDITIONAL RESOURCES AVAILABLE (as required) to support your patient care in addition to your current practice / basic interventions and accepted clinical practice guidelines & protocols.					
ESAS Item	CPC Item	Possible REFERRAL / CONSULT / PROGRAM / SUPPORT as required		Examples of PATIENT RESOURCES / HANDOUTS	
1. PAIN		CCMB Pain & Symptom Clinic: 787-2476 Pain in Adults with Cancer: Guide to Practice Algorithm		CCMB Patient & Family Resource Centre (PFRC) Virtual Hospice Website ( <a href="http://www.virtualhospice.ca">www.virtualhospice.ca</a> ) CCS Booklet "Pain Relief"	
2. TIRED / FATIGUE "EXERCISE"		Fatigue in Adults with Cancer: Guide to Practice Algorithm OT in community / Community Therapy Services CCMB Psychosocial Oncology: 787-2109 • Fatigue Education Session • CCMB Pilates & Cancer Fee Programs: Stay Strong, Cancer Management Exercise Program • Cancer Transitions (post-tx) • CCMB Yoga & Cancer		Cancer Treatment Info Sheet: "Fatigue" Sleep Disturbances / fatigue handout (J: Drive Patient & Family Education) CCMB Patient & Family Resource Centre (PFRC) CCS Booklet "Eat well, be active"	
CONCENTRATION / MEMORY (Physical)		CCMB Psychosocial Oncology: 787-2109 Brain Fog Program (Telehealth): 787-2109		Brain Fog information sheet (J: Drive Patient & Family Education) CCMB Patient & Family Resource Centre (PFRC)	
6. DROWSY		CCMB Psychosocial Oncology: 787-2109 *can be symptom of depression		CCMB Patient & Family Resource Centre (PFRC) Sleep Disturbances / fatigue handout (J: Drive Patient & Family Education) Sleep Protocol Handout	
SLEEP (Physical)		Patient & Family Resource Centre: 787-4357			
9. DYSPNEA		Evidence Based Toolkit for Breathless Management Dyspnea in Adults with Cancer: Guide to Practice Algorithm		CCMB Patient & Family Resource Centre (PFRC) CCS Booklet "Living with Advanced Cancer" <a href="http://www.youtube.com/user/ManagingSOB">http://www.youtube.com/user/ManagingSOB</a>	
3. NAUSEA		CCMB Pharmacist: 787-1902 CCMB Dietitian: 787-2109		CCMB Patient & Family Resource Centre (PFRC) Cancer Treatment Info Sheet: "Nausea and Vomiting" CCS Booklet "Chemotherapy & other drug therapies" / "Radiation therapy"	
7. APPETITE		CCMB Nutrition Services / Dietitian: 787-2109 Home Nutrition Program		Cancer Treatment Info Sheet: "Nutrition" CCMB Patient & Family Resource Centre (PFRC)	
WEIGHT (Physical)				CCS Booklets "Eating well when you have cancer," / "Eat well, be active." / "When your child has cancer, a guide to good nutrition"	
PHYSICAL: • Constipation/Diarrhea • Swallowing • Falling / Loss of balance		CCMB Pain & Symptom Clinic: 787-2476 CCMB Pharmacist: 787-1902 CCMB Dietitian or Speech Language Pathologist(Swallowing): 787-2109		Cancer Treatment Info Sheets: "Constipation" / "Diarrhea" / "Sore Throat and Mouth" PFRC: Soft Foods resources / texts Falling Brochure	
INFORMATIONAL: • Understanding my illness and/or treatment • Infection Control • Talking with the health care team • Making treatment decisions • Knowing about available resources		Patient & Family Resource Center: Resource Coordinator for consult: 787-4357 Breast Cancer Centre of Hope (Nurse Educator): 788-8080 Patient Representative: 787-2065 Canadian Cancer Society: 1-888-857-6658 Health Links: 1-888-315-9257		CCMB Patient & Family Resource Centre (PFRC) Cancer Treatment Info Sheets: "Cancer Treatment Tips" / "Radiation" / "Chemotherapy" CCS Booklets "Chemotherapy and other drug therapies" / "Radiation Therapy" / "Clinical Trials" / "Understanding your diagnosis" series <a href="http://www.labtestsonline.org">www.labtestsonline.org</a>	
MEDICATIONS (Informational)		CCMB Pharmacist: 787-1902		Cancer Treatment Info Sheets: "Sore Throat and Mouth"	
QUITTING SMOKING (Informational) SMOKED IN THE LAST SIX WEEKS		CCMB Smoking Cessation Clinic: 787-1202 Smokers Conversation Guide – Resource / Shared Drive CCS Smoker's Help Line: 1-877-513-5333 CCS Smoker's Help Line Referral Form		CCMB Handout: Helping You to Stop Smoking CCS Booklets "One step at a time" series: "For smokers who want to quit," "For smokers who don't want to quit," "If you want to help a smoker quit"	



## CCMB COMPASS RESOURCES



For All Patients	A-S-K	Green Zone Score of 0-3	Yellow Zone Score of 4-6	Red Zone Score of 7-10
→	1. Scores Acknowledged 2. Scores & Conversation charted on Questionnaire "COMPASS (ESAS & CPC Distress Screen)"	Patient appears to be managing concern well <ul style="list-style-type: none"> <li>Assess information needs</li> <li>Build on strengths</li> </ul>	Further Assessment <ul style="list-style-type: none"> <li>Information / Education</li> <li>Support Group, Class or Program</li> <li>Possible Referral</li> </ul>	<ul style="list-style-type: none"> <li>Further Assessment</li> <li>Provider Referral Recommended</li> </ul>
• The Navigator Newsletter has a complete listing of support groups, programs and resources available to patient and their families • Patient & Family Support Services (787-2109) can assist in determining patient need for referrals, programs, support and resources (Programs listed are free, unless otherwise noted) • Patient & Family Resource Centre "PFRC" (787-4357) has patient books, handouts and resources for every item and a Nurse Coordinator for consultation. Resources can be mailed to patients <ul style="list-style-type: none"> <li>www.cancerca.mb.ca—Patient and Family—full searchable online library listing / Cancer Treatment Info Sheets available online</li> <li>All handouts are available on the CCMB shared drive (J:) Screening for Distress folder—Patient Handouts folder</li> </ul>				
<b>ADDITIONAL RESOURCES AVAILABLE (as required)</b> to support your patient care in addition to your current practice / basic interventions and accepted clinical practice guidelines & protocols.				
ESAS Item	CPC Item	Possible REFERRAL / CONSULT / PROGRAM / SUPPORT as required		Examples of PATIENT RESOURCES / HANDOUTS
4. DEPRESSION		<input type="checkbox"/> CCMB Psychosocial Oncology / Social Worker: 787-2109 Depression in Adults with Cancer: Guide to Practice Algorithm		"The Emotional Facts of Life with Cancer" Booklet  <input type="checkbox"/> The Navigator newsletter  <input type="checkbox"/> Cancer Treatment Info Sheets: "The Emotional Impact of Cancer" <input type="checkbox"/> PFRC- ALL TOPICS further resources / copies Coping Texts Children: "When a Parent is Sick" by Joan Hamilton  Virtual Hospice Website ( <a href="http://www.virtualhospice.ca">www.virtualhospice.ca</a> )  <input type="checkbox"/> CCS Booklets "Living with cancer, a guide for people with cancer and their caregivers" "Living with Advanced Cancer"
5. ANXIETY		Anxiety in Adults with Cancer: Guide to Practice Algorithm		
8. WELLBEING		<input type="checkbox"/> CCMB Patient & Family Support Services: 787-2109 <ul style="list-style-type: none"> <li>Support Groups (Telehealth)</li> <li>Online Support Groups</li> <li>Art Therapy</li> <li>Helping Kids When Someone They Love Has Cancer</li> <li>Mindfulness Based Stress Reduction</li> <li>Cancer Transitions (following treatment)</li> <li>CCMB Pilates &amp; Cancer, Yoga &amp; Cancer</li> <li>Fee Programs: Stay Strong, Cancer Management Exercise</li> </ul> <input type="checkbox"/> CCMB Patient & Family Resource Centre: 787-4357 <input type="checkbox"/> Canadian Cancer Society Peer Support: 787-7483/1-888-939-3333 <input type="checkbox"/> Breast Cancer Centre of Hope: 788-8080 / 1-888-660-4866		
SOCIAL / FAMILY: Feeling a burden to others Worry about family/friends Feeling alone Relationship difficulties				
EMOTIONAL: Fears/Worries Sadness Frustration/Anger Coping Change in sense of self Loss of interest in everyday things				
INTIMACY AND SEXUALITY (Emotional)		<input type="checkbox"/> Sexuality Counselor (Telehealth): 787-4495 <input type="checkbox"/> CCMB Psychosocial Oncology: 787-2109		"Man Cancer Sex" by Anne Katz "Woman Cancer Sex" by Anne Katz <input type="checkbox"/> CCS Booklet "Sexuality and Cancer"
CHANGES IN APPEARANCE (Emotional)		<input type="checkbox"/> CCMB Psychosocial Oncology: 787-2109 <input type="checkbox"/> Guardian Angel Caring Room: 787-4180 Look Good Feel Better: 848-2163		Look Good Feel Better handout Guardian Angel Caring Room Pamphlet
SPIRITUAL: Meaning/Purpose of life Faith		<input type="checkbox"/> CCMB Spiritual Care Specialist: 787-2109 <input type="checkbox"/> CCMB Psychosocial Oncology: 787-2109		"The Emotional Facts of Life with Cancer" Booklet Spiritual Health Specialist Handout
PRACTICAL: Work/School Finances Child/ Family/ Elder care		<input type="checkbox"/> CCMB Psychosocial Oncology: 787-2109		<input type="checkbox"/> PFRC- ALL TOPICS "A Legal Information Guide for Seniors" Booklet
GETTING TO & FROM APPOINTMENT (Practical)		<input type="checkbox"/> CCS Transportation Office: 787-4121 / 888-857-6658		<input type="checkbox"/> CCS Transportation Brochure
ACCOMMODATION (Practical)		<input type="checkbox"/> PFRC for Winnipeg: 787-4357		<input type="checkbox"/> PFRC Winnipeg Accommodation Handout

Updated: Dec.19, 2011. For Review: Dec. 2012-PFSS and PFRC

## Appendix J: Example Integration of Screening Tool and Charting from Alberta



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

2. Canadian Problem Checklist:				
Please check all of the following items that have been a concern or problem for you in the <u>past week</u> including today:				
<b>Emotional:</b>	<b>Practical:</b>	<b>Informational:</b>	<b>Spiritual:</b>	<b>Physical:</b>
<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	<b>Social/Family:</b>	<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"/> Intimacy/Sexuality	<input type="checkbox"/> Quitting Smoking	<input type="checkbox"/> Taking medications as prescribed	<input type="checkbox"/> Worry about family/friends	
<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 K: Guidelines Survey<sup>37</sup>

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This questionnaire assesses knowledge, skills and beliefs about consequences, professional role and identity, motivation, goals, memory, attention, decision processes, environmental context and resources, social influences and planning.

### Interview Questions

1. Have you heard about the new Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer Clinical Practice Guideline produced by the Partnership?

If **yes**, are you aware of the recommendations for Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)?

If **yes**, what is your understanding of the recommendations for Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)?

If **no**, the recommendations are... [KNOWLEDGE]

2. **Pre-amble:** To what extent do you think the recommendations are being implemented? Can you give me a recent example of it happening? Do you know how to Screen, Assess and Care for Adults with Psychosocial Distress (Depression, Anxiety)? Do you think that other members of your team know how to Screen, Assess and Care for Adults with Psychosocial Distress (Depression, Anxiety)? [SKILLS]
3. What are your views about guidelines in general? Does that opinion apply to this guideline? Do you think it is an appropriate part of your job to be following this recommendation? Would following this recommendation create a problem for your professional autonomy? [SOCIAL/PROFESSIONAL ROLE AND IDENTITY]
4. Is it easy or difficult to do? What problems have you encountered? What would help you to overcome these problems? [BELIEFS ABOUT CAPABILITIES]
5. What are the consequences of offering Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) (prompt for advantages and disadvantages, e.g., time, people, etc.)? Would you say that the benefits outweigh the costs? What would happen if you didn't offer it? [BELIEFS ABOUT CONSEQUENCES]
6. Do you feel motivated to offer Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)? Do you feel that you should be offering Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)? Does offering Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) conflict with any of your other goals as a health professional? [MOTIVATION AND GOALS]

7. How often do you offer Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)? What are your reasons for not offering Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) (prompt for attention, forgetting, time constraints, etc.) [MEMORY, ATTENTION AND DECISION PROCESSES]
8. To what extent do resources influence whether you offer Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) (prompt for existence of trained staff, time constraints, etc.)? [ENVIRONMENTAL CONTEXT AND RESOURCES]
9. What do you think the views of the other team members are? Do these views influence whether you offer Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)? [SOCIAL INFLUENCES]
10. Do you think that any emotional factors influence whether Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) is offered? And what about for you? [EMOTION]
11. Are there procedures or ways of working that encourage offering Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety)? If you see a patient and decide they should be offered Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety), what are your next steps? [ACTION PLANNING]

## Appendix L: Linking Barriers and Strategies

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Barrier	Strategy											
	Educational Materials	Educational Meetings	Educational Outreach	Opinion Leaders	Audit and Feedback	Reminder Systems	Patient-Mediated Strategies	Mass Media	Local Consensus	Financial Incentives	Administrative Interventions	Arts-Based Interventions
<b>Knowledge</b> <i>Lack of awareness</i>	x	x	x	x			x	x				x
<i>Lack of familiarity</i>	x	x	x	x			x	x				
<i>Forgetting</i>					x	x				x	x	
<b>Attitude/Motivation</b> <i>General Attitude</i>		x		x								
<i>Lack of agreement with clinical practice guidelines due to:</i> • The scientific value of evidence		x	x	x					x			
• The rigidity of the guideline	x	x	x	x					x			
• The threat to professional autonomy	x	x	x	x					x			
• The perceived bias of the author	x	x	x	x					x			
• The lack of clarification and impracticality of the guideline	x	x	x	x					x			
• Incompatibility or conflict with professional standards	x	x	x	x					x			
<i>Lack of applicability due to:</i> • The characteristics of the patient	x	x	x	x			x		x			
• The clinical situation	x	x	x	x					x			
• The perception that knowledge implementation is not cost effective	X	X	x	x								

Barrier	Strategy											
	Educational Materials	Educational Meetings	Educational Outreach	Opinion Leaders	Audit and Feedback	Reminder Systems	Patient-Mediated Strategies	Mass Media	Local Consensus	Financial Incentives	Administrative Interventions	Arts-Based Interventions
<ul style="list-style-type: none"> <li>The lack of confidence in the individuals who are responsible for developing or presenting knowledge implementation</li> </ul>	X	x	x	x								
<i>Lack of expectancy due to:</i> <ul style="list-style-type: none"> <li>The perception that implementation will not lead to improved outcomes for either the patient or the health care process</li> </ul>	x	x	x	x			x	x	x			
<ul style="list-style-type: none"> <li>The negative feelings that may be provoked by the new behaviour resulting from knowledge implementation and/or not having taken into account existing feelings around the process of implementation</li> </ul>	x	x	x	x					x			x
<ul style="list-style-type: none"> <li>The lack of self-efficacy or skills</li> </ul>	x	x	x	x	x		x					
<ul style="list-style-type: none"> <li>The lack of motivation to use knowledge or to change one's habits</li> </ul>		x	x	x			x	x		x	x	
<b>Behaviour</b> <i>Lack of insight into own routines:</i> <ul style="list-style-type: none"> <li>Open-minded or defensive attitude</li> </ul>		x	x	x	x		x					x
<ul style="list-style-type: none"> <li>Unwillingness to acknowledge gaps in performance</li> </ul>		x	x	x	x		x	x			x	x
<i>Enculturement of health care professionals</i> <ul style="list-style-type: none"> <li>Any proposed change in how patients are to be cared for is viewed as a personal judgement about the care they have been providing</li> </ul>		x	x				x	x				x

Barrier	Strategy											
	Educational Materials	Educational Meetings	Educational Outreach	Opinion Leaders	Audit and Feedback	Reminder Systems	Patient-Mediated Strategies	Mass Media	Local Consensus	Financial Incentives	Administrative Interventions	Arts-Based Interventions
<p><b>External Barriers</b>  <i>Factors associated with patient:</i></p> <ul style="list-style-type: none"> <li>The inability to reconcile patient preferences with the use of knowledge</li> </ul>	x	x	x	x			x					x
<p><i>Factors associated with knowledge use as an innovation:</i></p> <ul style="list-style-type: none"> <li>The perception that the innovation cannot be experimented with on a limited basis</li> </ul>	x	x	x									
<ul style="list-style-type: none"> <li>The perception that the innovation is not consistent with one's own approach</li> </ul>	x	x	x	x					x			
<ul style="list-style-type: none"> <li>The perception that the innovation is difficult to understand and to put into use</li> </ul>	x	x	x	x			x					
<ul style="list-style-type: none"> <li>The lack of visible results in using the innovation</li> </ul>	x	x	x	x	x		x	x				
<ul style="list-style-type: none"> <li>The perception that the innovation cannot be created and shared with one another to reach a mutual understanding</li> </ul>	x	x	x	x					x			
<ul style="list-style-type: none"> <li>The perception that the use of the innovation will increase uncertainty (e.g., the lack of predictability, of structure, of information)</li> </ul>	x	x	x	x	x		x	x	x			
<ul style="list-style-type: none"> <li>The perception that the innovation lacks flexibility to the extent that it is not changeable or modifiable by a user in the process of its adoption and implementation</li> </ul>	x	x	x	x	x				x			

Barrier	Strategy											
	Educational Materials	Educational Meetings	Educational Outreach	Opinion Leaders	Audit and Feedback	Reminder Systems	Patient-Mediated Strategies	Mass Media	Local Consensus	Financial Incentives	Administrative Interventions	Arts-Based Interventions
<p><i>Factors associated with environmental factors:</i></p> <ul style="list-style-type: none"> <li>• Insufficient time to put knowledge into practice</li> </ul>	x	x	x				x				x	
<ul style="list-style-type: none"> <li>• Insufficient materials or staff to put knowledge into practice</li> </ul>	x	x					x				x	
<ul style="list-style-type: none"> <li>• Insufficient support from the organization</li> </ul>	x	x	x				x	x			x	x
<ul style="list-style-type: none"> <li>• Inadequate access to actual or alternative health care services to put knowledge into practice</li> </ul>	x	x	x				x	x			x	
<ul style="list-style-type: none"> <li>• Insufficient reimbursement for putting knowledge into practice</li> </ul>		x									x	
<ul style="list-style-type: none"> <li>• Perceived increase in malpractice liability if new knowledge is put into practice</li> </ul>	x	x	x								x	

## Appendix M: Systematic Approaches to Change — Theories and Models

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### Rogers Diffusion of Innovation Theory<sup>64</sup>

The classical theory of change is Everett Rogers' Diffusion of Innovation Theory. Rogers proposes four main elements that influence the spread of a new idea: the innovation, communication channels, time and the social system. The innovation-decision process consists of five stages that potential adopters pass through as they decide to adopt an innovation. These stages are:

1. *Knowledge*: becoming aware of the innovation
2. *Persuasion*: developing positive attitudes toward the innovation
3. *Decision*: making a cognitive decision to adopt the innovation (i.e., developing an intention to adopt)
4. *Implementation*: using the innovation
5. *Confirmation*: continuing to use the innovation, adapting the innovation or abandoning the innovation

Rogers<sup>64</sup> asserted that innovations are more quickly adopted when they are:

- Compatible with current values, beliefs and ways of doing things
- Seen to be more advantageous than the current practice (relative advantage)
- Easy to do or use (low complexity)
- Observed by others to be in use (observability)
- Easily tested before being formally adopted (trialability)

### Precede-Proceed Model<sup>65</sup>

The Precede-Proceed Model can be used to identify barriers to implementation and help develop action plans. The model specifies the steps that precede an intervention and suggests ways to proceed with implementation, including subsequent evaluation.

In the *precede* stage, the problem and the factors that contribute to it are identified. The factors are categorized as predisposing, enabling or reinforcing, and then rated in terms of importance and amenability to change. Predisposing factors include attitudes, beliefs, values, knowledge, existing skills and perceptions, all of which provide the stimulus for change and may facilitate or hinder behaviour change. Enabling factors are often environmental or system factors that allow a particular behaviour to occur in a given context. These may include having appropriate skills, adequate staff, systems to support new practices, and time or access to health facilities. Reinforcing factors relate to the consequences of behaviour and may affect the likelihood that be-



haviour will be repeated. They include peer influence, and rewards or incentives, such as positive feedback, that encourage change.

The key *proceed* stages are implementation and evaluation of the intervention. The evaluation stage examines the degree to which the protocol was implemented. It also assesses the effect the intervention had on behaviour, and on predisposing, enabling and reinforcing factors.<sup>54</sup> This model was used to frame a survey questionnaire and analysis to explore barriers and facilitators to cervical screening among Chinese Canadian women<sup>80</sup> and to guide the training of health care students in oral cancer screening and detection.<sup>81</sup>

## The Ottawa Model of Research Use<sup>66</sup>

The Ottawa Model of Research Use follows a six-step approach to guide the implementation of an innovation:

1. Set the stage.
  - Identify individuals with the authority needed to make changes within organizations.
  - Determine available resources that can be used to implement the innovation.
  - Identify agents of change responsible for implementing the innovation.
2. Specify the innovation.
  - Clearly articulate what the innovation is and what implementation will involve.
3. Assess the innovation, potential adopters and the environment for barriers and facilitators.
  - Conduct a situational assessment. Determine current practice. Identify any barriers to and facilitators of the innovation. Identify potential adopters. Identify the practice environment that could influence adoption of the innovation.
  - Identify ways to overcome any barriers to implementation.
  - Identify perceptions and attitudes of potential adopters.
  - Identify gaps between current practice and recommended changes.
4. Select and monitor the knowledge translation strategies.
  - Based on the situational assessment, select appropriate strategies and interventions to increase awareness and understanding of the innovation, and provide skills or training so that adopters can carry out the innovation.
  - Supplement with follow-up interventions to the initial knowledge translation strategies. This may be particularly useful for innovations that involve a long learning curve or diverse groups of adopters.
  - Evaluate the knowledge translation strategies for effectiveness.

5. Monitor innovation adoption.
  - Evaluate adoption of the innovation. Determine the extent to which the innovation has spread throughout the organization and how practice has changed.
  - Assess if the knowledge translation strategies applied have been sufficient for effective innovation adoption. If not, decide if the knowledge translation strategies need to be changed or if additional strategies are required.
6. Evaluate outcomes of the innovation.
  - Evaluate the impact of the innovation on clients, patients, practitioners and systems to determine the effectiveness of the innovation.

## Berwick's Rules for Dissemination<sup>67</sup>

Berwick's rules for dissemination are based on the work of Rogers. Dissemination is the active and planned efforts to persuade a target group to adopt an innovation.<sup>82</sup> Berwick states that the rate of spread of a change is determined by:

- Perceptions of the innovation.
- Characteristics of the people who adopt or fail to adopt the innovation.
- Contextual factors, especially involving communication, incentives, leadership and management.

Perception of the innovation is a key predictor of the spread of an innovation. Factors to consider include:

- The perceived benefit of the change. The more knowledge individuals can gain about the expected consequences of an innovation, the more likely they are to adopt it.
- An innovation must be compatible with the values, beliefs, past history and current needs of individuals.
- Simple innovations spread faster than complicated ones. In a successful diffusion process, the original innovation mutates into many different but related innovations.
- Trialability is whether or not a proposed adopter believes he or she can find a way to test the change on a small scale without implementing it everywhere initially.
- Observability is the ease with which potential adopters can watch others try the change first.

A second cluster of factors that helps explain the rate of spread of an innovation is that associated with the personalities of the individuals among whom spread might occur. Berwick describes five types of adopters:

1. *Innovators* (2.5% of a group) are venturesome, tolerant of risk and fascinated with novelty.
2. *Early adopters* (13.5% of a group) are opinion leaders. They are well connected socially at the local level, but they do not tend to search quite so widely as the innovators. They do, however, speak with innovators and with each other. They cross-pollinate, and they select ideas that they would like to try out. They have the resources and the risk tolerance to try new things.
3. *Early majority* (34% of a group) are quite local in their perspectives. They learn mainly from people they know well, and they rely on personal familiarity more than on science or theory before they decide to test a change. They are more risk-averse than early adopters.
4. The *late majority* (34% of a group) will adopt an innovation when it appears to be the new status quo, not before. They watch for local proof. They do not find remote sources of knowledge to be either trustworthy or particularly interesting.
5. *Traditionalists* or *resistors* to change (16% of a group) use the past as their point of reference. They often make choices that are wise and useful to the community or organization. They swear by the tried and true.

Berwick contends that once innovators and early adopters have embraced a change, the early majority will follow their lead if they can interact with them. Once those in the early majority have adopted a change, the late majority will discover that the majority has shifted and will thus feel comfortable making the change.

A third cluster of influences on the rate of diffusion of innovations has to do with contextual and managerial factors within an organization or social system that encourage and support, or discourage and impede, the process of spread. Berwick identifies key strategies, including:

- Leadership change from compliance to support.
- Face-to-face communication.
- New concepts usually have to come from outside the current system, but new processes — the things that make the concepts live — must come from inside or they will not work. To work, changes must be not only adopted locally, but also adapted locally. An initial idea tends to proliferate into several divergent and parallel ideas during the innovation process.”<sup>83</sup> Many leaders seem to regard reinvention as a form of waste, narcissism or resistance. It is often none of these. Reinvention is a form of learning and, in its own way, it is an act of both creativity and courage. Leaders should celebrate individuals who take ideas from elsewhere and adapt them to make them their own.
- Adoption and adaption take time and energy.

## Multi-method Assessment Process/ Reflective Adaptive Process (MAP/RAP)<sup>68</sup>

Multi-method Assessment Process (MAP)/Reflective Adaptive Process (RAP) is a change process that uses a path built on explicit opportunities for learning, reflection and adaptation. MAP also emphasizes looking at practices as integrated systems rather than focusing on one part of the system at a time. This approach is guided by a set of strategies rather than prescribed steps. Five principles inform the MAP process:

1. Shared vision, shared mission and shared values are fundamental in guiding ongoing change processes.
2. Creating time and space to learn and reflect is necessary if medical practices are to adapt to and plan change.
3. Tension and discomfort are essential and normal during practice change.
4. Improvement teams should include a variety of practice stakeholders with different perspectives of the practice and its environment, including representatives from multiple levels of the practice and patients.
5. Practice change requires supportive leadership that is actively involved in the change process, ensuring full participation from all members and protecting time for reflection.

RAP creates a practice setting that pilots changes, reflects on and uses mistakes, encourages listening to diverse perspectives and adapts to its environment. These strategies seek to optimize the practice setting's capacity to learn, adapt and co-evolve with its internal systems as well as external institutions, regulations and its local community.

Guiding principles of the RAP process:

- Having a shared vision, shared mission and shared values will guide a practice setting in making ongoing improvements. A practice vision and mission focuses the improvement team on defining what the practice wants to become and how to get there.
- Improvement teams need to meet regularly at a defined time and place to reflect on and learn from their activities. Effective meetings allow teams to define how the practice currently works and the types of changes they want to undertake.
- Tension and conflict are normal during practice change. Improvement teams must set ground rules to encourage all opinions to be heard and to handle resulting conflicts.
- Including diverse members on the improvement team broadens the skills and opinions that contribute to practice change. Improvement teams should include representatives from the practice's different functional areas and should invite patients to participate as well.

- Practice leaders need to actively support and be involved in a change process, endorsing the improvement team's goals and protecting the time and resources the team needs for the process to flourish.
- Core improvement team goals include:
  - Relationships within the practice that are built on trust, honesty and self-respect, with all perspectives valued.
  - Practices that are open to self-reflection and new ideas.
  - Practices that acknowledge how all parts of the practice depend on each other to produce a well-functioning practice.
  - Practices that appreciate the value of diversity in practice roles and staff backgrounds. Differences of perspectives strengthen the practice's internal and external connections.
  - Practices that employ both formal and informal means of communication, determining when each is most appropriate.
  - Practices that have a balance between strong and weak connections both internally and externally to allow for innovation and the adoption of new ideas while maintaining interconnections among staff.

## **PARiHS (Promoting Action on Research Implementation in Health Services) Framework<sup>69</sup>**

The PARiHS Framework is another knowledge translation framework that can be used to implement research into practice. This framework asserts that successful implementation of evidence into practice is a function of the interaction between three key elements: evidence (E), context (C) and facilitation (F). According to this framework, successful implementation of evidence into practice is a function of the quality of the evidence, the context or setting in which the evidence is being introduced and how effective the facilitation of the evidence into practice was.

The key principles underpinning this framework are as follows:

- Implementing research into practice is an organizational rather than an individual issue.
- Research evidence must be of the highest quality (systematic review of methodologically sound studies).
- Strategies for implementation must be carefully planned and comprise a range of interventions (i.e., education, audit and the management of change).
- Criteria for evaluating the impact of the intervention must be identified and agreed upon prior to implementing the change.

Similar to other frameworks, the PARIHS Framework emphasizes the need to develop a shared understanding of the benefits of the new practice with those implementing the evidence, an organizational context that embodies transformational leadership, elements of a learning organization and appropriate facilitation by a skilled and designated facilitator. The use of this framework will still require the integration of theoretical perspectives into the framework and the interrelationships between the different elements in the framework and how they impact on knowledge translation outcomes still requires testing.

Successful implementation is a function of the evidence, the organizational context and the quality of facilitation. Each of these three factors consists of sub-elements that can be rated on a scale of low to high, with high ratings more likely to produce successful implementation results.

1. **Evidence:** There are four bases on which to assess the nature and strength of the evidence and its potential for implementation:
  - a. **Research:** Evidence needs to be translated and adapted so it makes sense in the local context. Research evidence is less certain and less objective than is often acknowledged.
  - b. **Practitioner Expertise and Experience:** The tacit knowledge of practitioners, or their practical know-how, needs to be made explicit for practitioner expertise to be shared, critiqued and developed.
  - c. **Community or Intended Population:** Groups and communities need to be included in decision-making.
  - d. **Local Context and Environment:** Data regarding the local context, such as evaluation data, local community stories and knowledge of the organizational culture, needs to be considered.
2. **Context:** The context is the environment or setting in which the proposed change is to be implemented. Context is subdivided into three core elements: an understanding of the prevailing culture, leadership roles and the organization's approach to measurement (evaluation). Other key aspects of context include:
  - a. Relevance of the innovation to the organization.
  - b. Organizational fit of the innovation to organizational structures and procedures such that the innovation is more likely to be adopted.
  - c. Adequate resources for implementation, where resources are appropriately allocated, targeted and managed.
  - d. Use of implementation strategies with a multi-disciplinary focus.

3. **Facilitation:** Facilitation describes the type of support needed to help people change their attitudes, habits, skills and ways of thinking and working. Facilitators help people understand what they have to change and how to change it to achieve the desired outcome. The facilitation role includes personal characteristics (e.g., open, credible, authentic), role characteristics (e.g., clarity of role, authority) and facilitation style (e.g., range and flexibility of style, consistent and appropriate presence). The key features of facilitation within this framework include the following:
  - a. Facilitation is a process that depends on the person (the facilitator) carrying out the role with the appropriate skills, personal attributes and knowledge.
  - b. The purpose of facilitation varies from providing help and support to achieve a goal, to enabling individuals and teams to analyze, reflect on and change their own attitudes, behaviours and ways of working.
  - c. A facilitation continuum distinguishes between a doing-for-others role that is more discrete, practical, technical and task-driven, to an enabling-and-empowering role that is developmental and seeks to mentor and support others in their learning and change processes.
  - d. Facilitation skills are developed through experiential learning and by acquiring key facilitation competencies.
  - e. Facilitation is a discrete intervention (knowledge translation strategy).



## Appendix N: Clinical Guideline Implementation Practice Change Framework

Prepared by Doris Howell for the Screening for Distress Implementation Team, Oct. 2011; reproduced with permission.

A. Prepare for Implementation	Steps to Take	Tips	Rationale
<p>1. Increase awareness of the guideline.</p> <p><b>INCITE PASSION FOR THE CHANGE</b></p> <ul style="list-style-type: none"> <li>✓ Do they know about the guideline?</li> <li>✓ Do they trust the evidence?</li> <li>✓ Do they have leadership support for change?</li> <li>✓ Does the guideline need to be tailored?</li> <li>✓ Do you have support from the top?</li> </ul>	<ul style="list-style-type: none"> <li>a. Familiarize yourself with the evidence embedded in the guideline algorithm.</li> <li>b. Prepare a brief regarding the urgency of the problem and the need to address it to improve the quality of care and patient/family experience (use prevalence data from your ESAS-r for the population and impact from current literature).</li> <li>c. Engage your target population – the disease site team and clinicians – in dialogue to create awareness of the guideline.</li> <li>d. Provide an opportunity for clinicians to speak about the current practice and the changes needed, along with the barriers and enablers to a different practice.</li> <li>e. Promote discussion of how the guideline might need to be tailored to the local context.</li> <li>f. Engage key stakeholders across the organization and get commitment from senior leaders.</li> </ul>	<ul style="list-style-type: none"> <li>a. Acknowledge the hard work done in getting red flag ESAS-r screening into place.</li> <li>b. Emphasize that the hard work of improving outcomes and patient experience will be challenging, but that the initial steps have already been made (i.e., team working; new processes for screening uptake).</li> <li>c. Provide various educational opportunities to diverse target audiences to orient to the symptom or problem and the role of the guidelines in improving care quality.</li> <li>d. Bring in an expert or respected authority to discuss the symptom or problem and the evidence in the guideline.</li> <li>e. Identify a team that is passionate about the issue to work with you to move this forward from within the practices.</li> <li>f. Do not get stuck on one discipline or person who is resistant; engage early responders.</li> </ul>	<p>Large-scale passive education with written materials are not effective in practice change but can increase initial awareness as part of a marketing plan.<sup>30</sup></p> <p>Using the Guideline will have only small effects unless it is successfully integrated into clinical settings using a systematic and managed change plan.<sup>84</sup></p> <p><i>Identifying barriers is critical because your implementation strategies must be tailored to address these barriers.</i></p>

A. Prepare for Implementation	Steps to Take	Tips	Rationale
<p>2. Create a sense of urgency about the problem as a quality of care problem.</p> <p><b>ENGAGE HEARTS AND MINDS</b></p> <ul style="list-style-type: none"> <li>✓ Do staff believe the guideline will achieve better patient outcomes?</li> <li>✓ Are they excited about the role they can play to improve patient experience and quality of care?</li> <li>✓ Do they have the resources needed and do they feel valued?</li> </ul>	<ul style="list-style-type: none"> <li>a. You will experience resistance to “yet another guideline” .</li> <li>b. Prepare a fact sheet on the urgency of the problem from prevalence statistics combined with data regarding patient experience and the difference the interventions embedded in the guideline will make.</li> <li>c. Use ESAS-r data already collected to show the extent of the problem scores over time.</li> <li>d. Tell stories about the impact of other programs using the evidence in the guideline. Use a patient or family member and data from other case examples.</li> </ul>	<ul style="list-style-type: none"> <li>a. Remember that change also incites fear and strong emotional reactions in people.</li> <li>b. Communicate your vision relentlessly using marketing strategies and multiple methods.</li> <li>c. Show how other agencies have been able to make changes and achieve success (what processes and how: what would work here).</li> <li>d. Use examples that are local and that practitioners can identify with within their organization.</li> </ul>	<p><i>Stories from patients and families are a powerful motivator for change because practitioners want to do their best.</i></p>

A. Prepare for Implementation	Steps to Take	Tips	Rationale
<p>3. Understand the situation before you start in order to design a targeted action plan.</p> <p><b>START WHERE THE PRACTICE IS NOW; ENGAGE IN DIAGNOSIS</b></p> <ul style="list-style-type: none"> <li>✓ Are they currently using valid assessment tools?</li> <li>✓ Do they teach patient-specific self-management skills to manage the problem?</li> <li>✓ Are there patient education resources for this problem?</li> <li>✓ Do they understand the problem and know how to act to change it?</li> <li>✓ Are there adopters that can already model behaviour?</li> <li>✓ Are the relevant stakeholders who will need to change their practice already involved?</li> </ul>	<ul style="list-style-type: none"> <li>a. Understand the current practice by completing a gap analysis. You can create a quick audit checklist based on the expected care in the guideline or use an existing tool.</li> <li>b. Assess knowledge, attitudes and skills of potential adopters focused on the problem using surveys or focus groups and observing practice in action.</li> <li>c. Ask for specific examples of the actions already being taken.</li> <li>d. Use multi-methods to identify barriers to adopting guideline recommendations that must be addressed to design new ways of working.</li> <li>e. Identify resources that already exist (i.e., skilled Advanced Practice Nurse).</li> <li>f. Are there educational packages or training videos already available internally or externally that avoids re-invention?</li> </ul>	<ul style="list-style-type: none"> <li>a. Do not make assumptions about practice (attitudes or barriers can interfere with doing the right thing).</li> <li>b. Consider running a baseline assessment against the recommendations to identify where change is required. Ensure that everyone can see the results or, even better, helps with the audit to foster buy-in.</li> <li>c. Engage clinicians in generating solutions to barriers and to decide if tailoring of guideline is needed to fit care processes.</li> <li>d. Generate a specific plan to address identified barriers in your implementation strategy.</li> <li>e. Create a detailed road map to navigate through change and its complexity.</li> </ul>	<p>Significant variation and use of the best evidence in practice.<sup>85</sup></p> <p>Implementation strategies are more effective when targeted to existing barriers.<sup>29</sup></p> <p>Barriers exist at multiple levels (organization, disease site teams, individuals).<sup>86</sup></p> <p>Identifying the gaps is the starting point of implementing knowledge. Analysis should involve use of rigorous methods and engage relevant stakeholders.<sup>87</sup></p>

B. Implementation Strategies	Steps to Take	Tips	Rationale
<p>1. Customize or tailor the guideline for your organization.</p> <p><b>SIMPLIFY THE EXPECTED ACTIONS TO BE TAKEN</b></p> <ul style="list-style-type: none"> <li>✓ Do the resources exist to implement the guideline?</li> <li>✓ Have you engaged all relevant stakeholders in tailoring the guideline?</li> <li>✓ What processes need to be changed to achieve outcomes?</li> </ul>	<ul style="list-style-type: none"> <li>a. Determine who will need to take action based on evidence in the guideline (organize the care team).</li> <li>b. Identify if there are some recommendations that need to be tailored to local context as to how the action can be taken (match intensity of clinical resources to problem).</li> <li>c. Establish a specific action plan to address the areas needing improvement (e.g., team communication, lack of knowledge and skills, patient-mediated approaches).</li> <li>d. Integrate with other change initiatives whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>a. Turn the recommendations in the guideline into a documentation tool.</li> <li>b. Simplify by creating an algorithm of expected care processes (who, what, when, where).</li> <li>c. Link recommendation to explicit care processes already existing (i.e., drop down menu of focused assessment tools for red flag scores).</li> <li>d. Implementing changes in new care processes take time and systematic planning linked to desired outcome.</li> </ul>	<p>A number of factors influence uptake, including perception of benefit of change to the practice (cost, risk, quality, culture), extent to which the changes required are compatible with existing care processes, and to what extent local practices are allowed to adapt centrally designed recommendations.<sup>67</sup></p> <p><i>Must ensure that evidence is not changed in tailoring to local practice.</i></p>
<p>2. Engage opinion leaders and champions at every level to spread enthusiasm.</p> <ul style="list-style-type: none"> <li>✓ Have you engaged a respected opinion leader?</li> <li>✓ Is the champion an excellent facilitator?</li> <li>✓ Are the right practitioners targeted for practice change?</li> <li>✓ Have you empowered direct care teams?</li> </ul>	<ul style="list-style-type: none"> <li>a. Project leadership: change must be strategically supported and managed effectively.</li> <li>b. Identify a local opinion leader to highlight the importance and benefits of the changes for patients, and encourage health care professionals to want to make changes.</li> <li>c. Opinion leaders and champions are often different individuals.</li> <li>d. Identify a local disease site champion (i.e., advance practice nurses) to facilitate change. Consider leadership training for selected champions.</li> </ul>	<ul style="list-style-type: none"> <li>a. Empower direct care teams to take action, maximizing their full scope of capabilities and respective roles.</li> <li>b. Opinion leaders and champions motivate and inspire clinicians to achieve best possible care, often acting as role models.</li> <li>c. Champions are best chosen within local teams and, depending on the practice change target, within the discipline needing to change (i.e., advance practice nurses working with nurses to change approach to dyspnea).</li> <li>d. Identify implementation team.</li> </ul>	<p>Opinion leaders shown to have mixed effects or positive effects.<sup>88</sup> The mixed effects may be due to the choice of opinion leader, if the practice is responsive to this type of approach and how they engage practitioners.</p> <p><i>Local champions must be skilled in effective facilitation and have strong interpersonal skills. Choose wisely.</i></p>

B. Implementation Strategies	Steps to Take	Tips	Rationale
<p>3. Use a multifaceted approach to foster practice change.</p> <p><b>COMBINE ARTISTRY WITH KNOWN EFFECTIVE APPROACHES TO IMPLEMENTATION</b></p> <ul style="list-style-type: none"> <li>✓ Do they know how to implement changes and when?</li> <li>✓ Do they have time to develop new skills?</li> <li>✓ Are the right infrastructure and tools in place to enable practice change?</li> <li>✓ Have you used innovation in your approach?</li> <li>✓ Have you engaged community partners?</li> </ul>	<ul style="list-style-type: none"> <li>a. Prepare and educate all clinicians, building on initial awareness with specific education targeted to those who will deliver the intervention. Use interactive educational approaches and multi-media.</li> <li>b. Patient-mediated interventions should be part of implementation as they are responsible for day-to-day management of problems.</li> <li>c. Reminders: Tailored reminders can help to continually foster and reinforce change.</li> <li>d. Audit and Feedback: reporting of retrospective information to teams about practice is likely more effective when data is trusted and the format is based on pragmatic factors and local circumstances.<sup>90</sup></li> <li>e. Educational outreach visits (also called academic detailing) and small-scale meetings are more effective than didactic methods.</li> <li>f. Identify good examples of local practices to share across your organization and consider other ways that health care professionals could learn from one another (e.g., peer-to-peer coaching or individual academic detailing).</li> </ul>	<ul style="list-style-type: none"> <li>a. Must clearly designate who will take responsibility for specific recommendations in the guideline.</li> <li>b. Identify and brainstorm specific solutions to barriers identified and multifaceted implementation approaches to address these barriers (must address different barriers to change).</li> <li>c. Choice of implementation strategies must be based on barriers and practice setting. For instance, audit and feedback may be too labour intensive unless data and tailoring is needed (i.e., ESAS-r scores declining over time).</li> <li>d. Theories of change can guide change processes (i.e., social cognition theories focus on perceptions).</li> <li>e. Implementation theories can help to ensure a systematic approach to change.</li> </ul> <p><i>Rapid cycle change uses an audit and feedback process within the PDSA cycles and can be used for small tests of process change to reach a final practice change goal.</i></p>	<p>Thirteen systematic reviews found passive information dissemination ineffective.<sup>59,88,89-100</sup></p> <p>Multifaceted implementation strategies are best.<sup>90,98</sup></p> <p>Reminders and decision-support tools are likely to be effective.<sup>101</sup></p> <p>Materials disseminated to patients are effective in changing behaviours of health professionals.<sup>102</sup></p> <p><i>Mind mapping (brainstorming) using computer-based process can help to map barriers to change.</i></p>

B. Implementation Strategies	Steps to Take	Tips	Rationale
<p>4. Building ownership of the practice change in the clinical team at every opportunity.</p>	<p>a. Start small and show success (i.e., two nurses do a trial run using new learned intervention techniques).</p> <p>b. Conduct monthly reviews to determine progress, to elicit learnings and provide positive reinforcement.</p>	<p>a. Use specific strategies to work with target discipline's specific need but not a sole focus, as the whole team must act.</p> <p>b. Work with those who are willing and interested to work with you, rather than trying to change the most resistant.</p> <p>c. Targeted approaches may be needed to reach specific disciplines.</p>	<p>Practice change improvement collaboratives and communities of practice comprising different disciplines can effectively move change forward.<sup>103</sup></p>
C. Maintain Success and Celebrate	Steps to Take	Tips	Rationale
<p>1. Determine what success looks like and monitor over time.</p> <p><b>GETTING BEYOND GO-LIVE</b></p> <ul style="list-style-type: none"> <li>✓ Have you identify the desired future?</li> <li>✓ Is there someone skilled in evaluation and measurement on your team?</li> <li>✓ Have you embedded changes in policies and standard of care?</li> <li>✓ Have you established benchmarks of performance?</li> </ul>	<p>a. Identify the expected outcomes you will achieve.</p> <p>b. Engage someone skilled in evaluation and measurement as a member of your implementation team.</p> <p>c. Consider how you will measure improvement or success outcomes for patient.</p> <p>d. Use established indicators if available and engage the team in what indicators will be key to monitoring over time and routinely.</p>	<p>a. Rapid cycle change can be used to quickly measure if required care processes are being implemented and need for mid-course corrections.</p> <p>b. Buy-in is vital for your personnel to take ownership of the success or failure of the project.</p> <p>c. Sustaining change requires a reward or accountability system to be in place.</p>	<p>Studies show that a return to baseline can occur within a few months if changes are not maintained.<sup>104</sup></p>
<p>2. Track changes using specific data collection strategies.</p>	<p>a. Outcome-based assessment tools as part of assessment processes can ease data collection and continuous quality improvement.</p> <p>b. Engage local computer specialists to integrate outcome-based tools into medical records.</p>	<p>1. Establish benchmarks for keeping people on track in the short and long term.</p>	

C. Maintain Success and Celebrate	Steps to Take	Tips	Rationale
<p>3. Sustain the change by embedding in routine practice.</p> <p><b>MAKE IT DIFFICULT TO DO IT WRONG</b></p>	<ul style="list-style-type: none"> <li>a. Ensure the changes are incorporated into local protocols, investigations and procedures.</li> <li>b. Consider adopting a computerized reminder system.</li> <li>c. Sharing your results with other organizations can help sustain interest.</li> <li>d. Encourage work to be submitted for publication in journals and for presentation at conferences.</li> <li>e. Encourage everyone to own the data and dissemination.</li> </ul>	<ul style="list-style-type: none"> <li>a. Creating sustained change involves awareness of the need for change, acceptance of the responsibility to change, action to change (supported) and adopting practices.</li> <li>b. Adoption of new practices takes time and a number of weeks to be adopted as a habit.</li> <li>c. Teams must move through phases of change to achieve long-term sustainability: awareness, understanding, acceptance and commitment.</li> </ul>	



# Appendix O: Knowledge Translation Planning Template

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## Knowledge Translation Planning Template-R™

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 Fillable form available online at [www.melaniebarwick.com/training.php](http://www.melaniebarwick.com/training.php)

**INSTRUCTIONS:** This template was designed to assist with the development of KT plans for research but can be used to plan for non-research projects. It is universally applicable to areas beyond health. Begin with Box #1 at right and work through to box #14 to address the essential components of the KT planning process. It is recommended that you use this worksheet as a reflective and planning tool from which to write your KT plan.

Project Title: \_\_\_\_\_

(v) Research Partners	(2) Degree of Partner Engagement	(3) KT Expertise on Team
<input type="checkbox"/> researchers <input type="checkbox"/> consumers - patients & their families <input type="checkbox"/> the public <input type="checkbox"/> decision-makers <input type="checkbox"/> policy makers (government or other) <input type="checkbox"/> private sector / industry <input type="checkbox"/> research funding body <input type="checkbox"/> volunteer health sector / NGO <input type="checkbox"/> practitioner	<input type="checkbox"/> from idea formulation straight through <input type="checkbox"/> after idea formulation & straight through <input type="checkbox"/> at point of dissemination & project end <input type="checkbox"/> beyond the project	<input type="checkbox"/> scientist(s) with KT expertise <input type="checkbox"/> consultant with KT expertise <input type="checkbox"/> Knowledge Broker / Specialist <input type="checkbox"/> KT supports within the organization <input type="checkbox"/> KT supports within partner organization

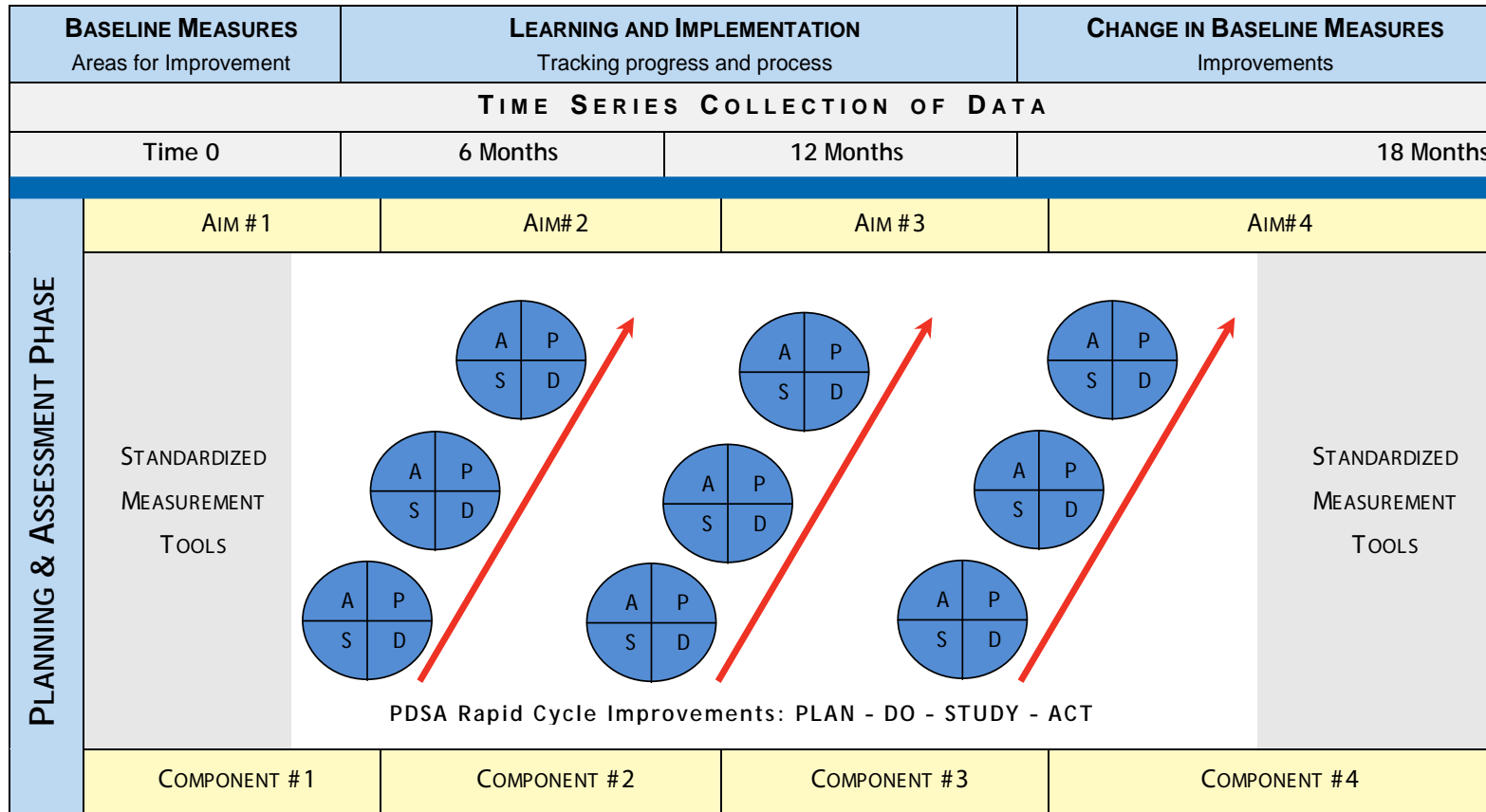
(4) Main Messages	(5) KT Audience(s) <sup>1</sup>	(6) KT Goals <sup>1</sup>	(7) KT Method(s) <sup>2</sup>	(8) KT Process	(9) KT Impact & Evaluation	(10) Partner(s) Role	(11) Resources	(12) Budget Items	(13) Estimated Cost
Briefly, your research seeks to: > What messages do you anticipate sharing (up to 3 audiences can be included on this form)? Audience @ > Audience @ > Audience @ > OR <input type="checkbox"/> No idea yet; messages will emerge during research through collaboration with partners. NOTE: Consider what you can feasibly do within this project, given time and resources.	What audiences will you target? <input type="checkbox"/> researchers <input type="checkbox"/> health practitioners or service providers <input type="checkbox"/> public <input type="checkbox"/> media <input type="checkbox"/> patients / consumers <input type="checkbox"/> decision-makers <input type="checkbox"/> in organization <input type="checkbox"/> in community <input type="checkbox"/> policy makers <input type="checkbox"/> private sector/ industry <input type="checkbox"/> research funders <input type="checkbox"/> venture capital <input type="checkbox"/> volunteer health sector / NGO <input type="checkbox"/> Other: (specify below) >	What are your KT Goals for each audience? Audiences (0) @ @ @ Generate-- <input type="checkbox"/> awareness <input type="checkbox"/> interest <input type="checkbox"/> practice change <input type="checkbox"/> behaviour change <input type="checkbox"/> policy action Impact-- <input type="checkbox"/> knowledge <input type="checkbox"/> tools Inform-- <input type="checkbox"/> research <input type="checkbox"/> product <input type="checkbox"/> patent Other: (specify) > NOTE: KT is applicable to all research; even single studies are shared via journal articles. However, intent to change practice, behaviour or policy must be supported by a body of research evidence. Always consider legal and ethical principles in your KT efforts.	What KT methods you will use? For example: Audiences (0) @ @ @ @ @ @ Mostly Effective <sup>3</sup> <input type="checkbox"/> interactive small group <input type="checkbox"/> educational outreach <input type="checkbox"/> reminders <input type="checkbox"/> IT decision support <input type="checkbox"/> multi-prof collaboration <input type="checkbox"/> mass media campaign <input type="checkbox"/> financial incentive <input type="checkbox"/> combined interventions <sup>3</sup> > Mixed Effects <sup>3</sup> <input type="checkbox"/> conferences (didactic) <input type="checkbox"/> opinion leaders <input type="checkbox"/> champions <input type="checkbox"/> educational materials <input type="checkbox"/> patient mediated interv. <input type="checkbox"/> performance feedback <input type="checkbox"/> substitution of tasks <input type="checkbox"/> peer reviewed publication Limited Effects <sup>4</sup> <input type="checkbox"/> CQ) Unknown Effects <sup>4</sup> <input type="checkbox"/> press release <input type="checkbox"/> patent license <input type="checkbox"/> social media networks <input type="checkbox"/> communities of practice <input type="checkbox"/> Café Scientifique	When will KT occur? <input type="checkbox"/> Integrated KT <sup>5</sup> - researchers and research users will collaborate to shape the research process, e.g., setting the research questions, deciding the methodology, involvement in data collection and tools development, interpretation of findings and dissemination of research results. <input type="checkbox"/> End of grant KT <sup>5</sup> - KT undertaken at the completion of the research process. <input type="checkbox"/> Both Comment on the specifics of your KT procedures: >	(a) Where do you want to have an impact? <input type="checkbox"/> health / well being outcomes <input type="checkbox"/> [clinical] practice <input type="checkbox"/> [health] policy/service <input type="checkbox"/> research (b) How will you evaluate if you achieved your KT goals? The following are examples - <input type="checkbox"/> Reach indicators (# distributed, # requested, # downloads/hits, media exposure) <input type="checkbox"/> Usefulness indicators (read/browsed, satisfied with, usefulness of, gained knowledge, changed views) <input type="checkbox"/> Use indicators (# intend to use, # adapting the information, # using to inform policy/advocacy/ enhance programs, training, education, or research, # using to improve practice or performance) <input type="checkbox"/> Partnership/collaboration indicators (# products/services developed or disseminated with partners, # or type capacity building efforts, social network growth, influences, collaborativeness) <input type="checkbox"/> Practice change indicators (commitment to change, observed change, reported change) <input type="checkbox"/> Program or service indicators (documentation, feedback, process measures) <input type="checkbox"/> Policy indicators (documentation, feedback, process measures) >	How will your partner(s) assist with developing, implementing or evaluating the KT plan? NOTE: Capture their specific roles in letters of support to funders. >	What resources are required? <input type="checkbox"/> Human <input type="checkbox"/> Financial <input type="checkbox"/> IT <input type="checkbox"/> Web <input type="checkbox"/> Leadership <input type="checkbox"/> Management <input type="checkbox"/> Worker <input type="checkbox"/> Board <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: (list) >	What budget items are related to the KT plan? <input type="checkbox"/> Accommodation <input type="checkbox"/> Art Installation <input type="checkbox"/> Evaluation specialist <input type="checkbox"/> Graphics/Imagery <input type="checkbox"/> Knowledge Broker <input type="checkbox"/> KT Specialist <input type="checkbox"/> Mailing <input type="checkbox"/> Media Release <input type="checkbox"/> Media product (video) <input type="checkbox"/> Networking functions <input type="checkbox"/> Open access journal <input type="checkbox"/> Plain text writer <input type="checkbox"/> Production/printing <input type="checkbox"/> Programming <input type="checkbox"/> Public relations <input type="checkbox"/> Reimbursements for partners (e.g., time, parking, travel) <input type="checkbox"/> Tech Transfer/ <input type="checkbox"/> Commercialization <input type="checkbox"/> Teleconferencing <input type="checkbox"/> Travel: conferences <input type="checkbox"/> Travel: meetings/ educational purposes <input type="checkbox"/> Web 2.0 (blogs, podcasts, wikis) <input type="checkbox"/> Webinar services <input type="checkbox"/> Website development <input type="checkbox"/> Venue <input type="checkbox"/> Other: (list) >	(a) Do you intend to seek additional support for KT? > From whom? > (b) List estimated costs for items listed in box #12: > NOTE: Be sure to include all KT costs in your budget for funders.

(14) Describe how you will optimize your KT strategy. Implementation refers to the process involved with applying your KT strategies, and ensures that the knowledge you are transferring is done with fidelity and maintains quality.  
 >

<sup>1</sup>Goering, P, Ross, S., Jacobson, N, Butterill, D. 2006. A Tool and Accompanying Guide for Assessing Health Research Knowledge Translation (KT) Plans, in Towards More Effective Peer Review of Knowledge Translation (KT) Plans in Research Grant Proposals. <http://www.camh.net/hrcu>  
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## Appendix P: Cancer Journey Quality Improvement and Evaluation Framework

Developed by the Cancer Journey Portfolio Evaluation Team



BASELINE MEASURES Areas for Improvement		LEARNING AND IMPLEMENTATION Tracking progress and process		CHANGE IN BASELINE MEASURES Improvements		
TIME SERIES COLLECTION OF DATA						
Time 0		6 Months	12 Months		18 Months	
PLANNING & ASSESSMENT PHASE	<p><b>AIM #1 :</b></p> <ul style="list-style-type: none"> <li>● 90% of target group screened for distress</li> </ul>	<p><b>AIM#2 :</b></p> <ul style="list-style-type: none"> <li>● 90% of targeted staff will have the knowledge required to screen for distress</li> <li>● 90% of targeted staff will have the competencies and skills required to take action</li> </ul>	<p><b>AIM #3:</b></p> <ul style="list-style-type: none"> <li>▪ 90% of target group have scores acknowledged by health care provider</li> <li>▪ 90% of target group with scores 4 and above will have further assessment and/or appropriate referral</li> <li>▪ 90% of team members engaged in collaboration and integrated care team planning using evidence-based approaches</li> </ul>		<p><b>AIM#4:</b></p> <ul style="list-style-type: none"> <li>▪ 90% of patients/families are satisfied with the process of care</li> <li>▪ 90% of patient population will have a reduction in distress over time (e.g. reduced levels of distress over one year by tumour group or by institution)</li> </ul>	
	<p><b>Tools to measure:</b></p> <ol style="list-style-type: none"> <li>1. Staff knowledge and skills</li> <li>2. Staff satisfaction</li> <li>3. Patient satisfaction/ Experience</li> <li>4. Organizational Culture</li> </ol>				<p><b>Tools to measure:</b></p> <ol style="list-style-type: none"> <li>1. Staff knowledge and skills</li> <li>2. Staff satisfaction</li> <li>3. Patient satisfaction/ Experience</li> <li>4. Organizational Culture</li> </ol>	
	<p><b>PDSA Rapid Cycle Improvements: PLAN - DO - STUDY - ACT</b></p>					
	<p><b>COMPONENT #1:</b> Screening and Early Identification of Distress</p>		<p><b>COMPONENT #2:</b> Staff Education and Training</p>	<p><b>COMPONENT #3:</b> Teamwork and Collaboration</p>		<p><b>COMPONENT #4:</b> Patient Engagement</p>

## Template for Implementing Screening for Distress, The 6<sup>th</sup> Vital Sign

**Goal: To screen all cancer patients for distress, pro-actively identify key concerns**

<p><b>Screening and Early Identification of Distress</b>  <i>Objective:</i> To organize and plan implementation of screening for distress.  <i>Activities*:</i></p> <ul style="list-style-type: none"> <li>• Develop detailed implementation plan (to include readiness assessment, plans for field preparation, stakeholder assessment, marketing, etc.)</li> <li>• Incorporate core concepts of person-centered care in implementation plan</li> <li>• Implement quality improvement and evaluation data collection processes (systematic measurement and feedback cycle)</li> </ul>	<p><b>Staff Education and Training</b>  <i>Objectives:</i> To develop the skills, knowledge, and core competencies to screen for distress.  <i>Activities:</i> Conduct education and training in the following:</p> <ul style="list-style-type: none"> <li>• Person-centered approach</li> <li>• Screening for distress, comprehensive assessment and appropriate referrals</li> <li>• Guidelines, standards and algorithms</li> <li>• Integration of screening for distress into workflow</li> <li>• Quality improvement and PDSA cycles</li> </ul>	<p><b>Teamwork and Collaboration</b>  <i>Objective:</i> To establish interprofessional collaboration in care planning.  <i>Activities:</i></p> <ul style="list-style-type: none"> <li>• Develop capacities to work in an interprofessional team (expand team scope and communication)</li> <li>• Use guidelines, standards, and algorithms to inform care planning process</li> <li>• Assess patients' key concerns and make referrals, as appropriate</li> </ul>	<p><b>Patient Engagement</b>  <i>Objective:</i> To improve the experience of the patient and family.  <i>Activities:</i> Implement processes to ensure that patients screened for distress are:</p> <ul style="list-style-type: none"> <li>• Part of the health care team (involved in the conversations)</li> <li>• Participating meaningfully in the clinical decision-making and priority setting</li> <li>• Provided with timely, complete, and accurate information</li> <li>• Having their key concerns discussed and addressed as possible</li> </ul>
<p><b>Process Outputs:</b></p> <ul style="list-style-type: none"> <li>• Detailed implementation plan</li> <li>• Data collection and reporting system</li> <li>• # of patients screened for distress</li> </ul>	<p><b>Process Outputs:</b></p> <ul style="list-style-type: none"> <li>• Education and training materials</li> <li>• # and type of educational sessions</li> <li>• # and category of staff attending sessions</li> <li>• # of staff who have competencies and skills</li> </ul>	<p><b>Process Outputs:</b></p> <ul style="list-style-type: none"> <li>• Interprofessional model of care for screening for distress</li> <li>• # of patients with scores &gt;4</li> <li>• % of patients with scores &gt;4, % assessed further and/or referred</li> <li>• Uptake of evidence-based guidelines</li> <li>• Staff satisfaction with teamwork</li> </ul>	<p><b>Process Outputs:</b></p> <ul style="list-style-type: none"> <li>• % of patients with decreased distress scores</li> <li>• Patient and family satisfaction</li> </ul>
<p><b>Process Outcome:</b></p> <ul style="list-style-type: none"> <li>• Implementation and evaluation of a Screening for Distress program within a model of continuous quality improvement</li> </ul> <p><b>End Outcome:</b></p> <ul style="list-style-type: none"> <li>• Infrastructure that supports a person-centered approach to screening for distress</li> </ul>	<p><b>Process Outcomes:</b></p> <ul style="list-style-type: none"> <li>• Increased knowledge about and skills to address distress (screening, assessment &amp; making referrals)</li> <li>• Increased awareness and integration of key attributes of person-centered care</li> <li>• Increased knowledge about the core competencies required to screen for distress</li> </ul>	<p><b>Process Outcomes:</b></p> <ul style="list-style-type: none"> <li>• Increased adherence to evidence-based guidelines to inform practice</li> <li>• Improved team collaboration</li> <li>• Provision of safe and accessible care</li> </ul> <p><b>End outcomes:</b></p> <ul style="list-style-type: none"> <li>• Improved coordination, continuity, and integration of care</li> <li>• Practice change</li> </ul>	<p><b>Process Outcomes:</b></p> <ul style="list-style-type: none"> <li>• Increased satisfaction with health-care</li> <li>• Improved patient experience of care</li> <li>• Increased knowledge of disease and the cancer care trajectory</li> <li>• Increased awareness of available services and resources</li> </ul>

\*Activities not limited to those listed here.

## Appendix Q: Jurisdictions' Approaches to Quality Improvement and Evaluation

### Jurisdiction 1

Screening and Early Detection of Distress	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• number of patients screened</li> <li>• distress levels (mild, moderate, high)</li> <li>• problems experienced</li> <li>• referrals made and accepted</li> </ul>	<ul style="list-style-type: none"> <li>• pre-implementation survey: patient satisfaction (n=52)</li> <li>• patient survey: awareness of screening, rationale and satisfaction (n=53)</li> </ul>	<ul style="list-style-type: none"> <li>• increase in % of patients screened by nurses in radiation therapy clinics (assigned a champion, modified training to suit local team)</li> <li>• increase in % of patients screened by radiation therapy technicians (changed when and where screening and conversation occurred in clinic)</li> <li>• increase in % of patients screened by chemotherapy nurses (screened in small numbers based on tumour group and frequency to increase perceptions of feasibility)</li> </ul>

### Jurisdiction 2

Screening and Early Detection of Distress	Teamwork and Collaboration	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• number of patients screened</li> <li>• number of patients with mild, moderate, and high distress</li> <li>• number of patients referred for specialist care. Referral pathways followed? If not, why not?</li> </ul>	<ul style="list-style-type: none"> <li>• survey: health care professionals</li> <li>• focus groups: health care professionals</li> <li>• survey specialists?</li> </ul>	<ul style="list-style-type: none"> <li>• baseline: oncology patient experience</li> <li>• survey: NRC Picker, Jan 2010</li> <li>• survey: patient satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• improve team communication and charting (conducted chart audit of patient documentation + flow chart of present + ideal communication pathways; screening results placed on oncology patient chart, copies sent to referral disciplines)</li> <li>• increase number of patients screened by navigators in busy clinics (if patient missed, timing of conversation changed to phone call next day)</li> <li>• increase number of patients screened in one region (placed tool on first page of patient chart)</li> <li>• increase number of patients screened in one site (engaged support of leaders and had them attend meetings and communicate directly to staff, further education sessions)</li> </ul>

### Jurisdiction 3

Screening and Early Detection of Distress	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• number of sites screening for distress</li> <li>• number of patients screened for distress at chemotherapy visits once per cycle</li> <li>• number of patients with index score <math>\geq 4</math> reduced during cycle of chemotherapy</li> <li>• number of patients with index score <math>\geq 7</math> reduced to <math>\leq 4</math> by next cycle of chemotherapy</li> <li>• number of patients who score <math>\geq 4</math> referred to another professional</li> <li>• number of patients who accept referral</li> <li>• number of patients who received services (broken down by discipline)</li> <li>• number of patients who received services in their community</li> <li>• number of patients who received services via telemedicine</li> <li>• number of patients who had a decreased score on subsequent visits</li> <li>• demographic/medical:                             <ul style="list-style-type: none"> <li>- gender</li> <li>- age</li> <li>- cancer diagnosis</li> <li>- staging</li> </ul> </li> <li>• Francophone and first nations demographic information</li> <li>• nursing outcome data (actions taken)</li> </ul>	<ul style="list-style-type: none"> <li>• patient satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• improve clarity and completeness of screening documentation by nurses and patients (chart audit of screening tool; improved nursing instruction and education)</li> <li>• increase number of completed screening tools at one site (on-site visit to re-engage local team; champion assigned to support appropriate responses to high scores)</li> </ul>



## Jurisdiction 4

Screening and Early Detection of Distress	Staff Education and Training	Teamwork and Collaboration	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• number of patients screened</li> <li>• how many patients receive a Symptom Self-Assessment form, how many complete it and how many decline</li> <li>• how many patients rate themselves as having medium to high (4-6) and high (<math>\geq 7</math>) rating of symptom distress</li> <li>• assess how many nursing appointments were generated</li> <li>• determine symptom severity by tumour group</li> <li>• compare symptom severity of new patients and follow-up patients</li> <li>• compare patient's symptoms for radiation and systemic therapy</li> <li>• assess referrals generated</li> <li>• determine the % of symptom clusters</li> </ul>	<ul style="list-style-type: none"> <li>• demonstrated use of guidelines (chart audits)</li> <li>• understanding of the process</li> </ul>	<ul style="list-style-type: none"> <li>• staff satisfaction, knowledge and competency: screening implementation (survey, focus groups and observation)</li> <li>• staff satisfaction, knowledge and competency: guideline implementation (survey, focus groups and observation)</li> </ul>	<ul style="list-style-type: none"> <li>• patient survey: experience and satisfaction with care</li> </ul>	<ul style="list-style-type: none"> <li>• increase uptake of algorithms (observation; applied mentoring, rewards, + extra clinic time to increase uptake)</li> <li>• improve management of symptom clusters and for scores <math>\geq 7</math> (mentoring)</li> <li>• reduce number of patients with scores <math>\geq 4</math> missing nursing assessment (streamlined delivery of ESAS-r scores to nurses, verbal reminders to patients)</li> <li>• improve volunteer education and knowledge of screening tool (improved training materials; assigned dedicated Screening, Assessment and Management of Symptoms volunteers)</li> <li>• improve clinic flow (clarified screening and assessment roles and duties for nurses and oncologists)</li> </ul>



## Jurisdiction 5

Screening and Early Detection of Distress	Staff Education and Training	Teamwork and Collaboration	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• number of patients screened</li> <li>• number of patients missed</li> <li>• number and type of patient referrals</li> <li>• number of patients who declined all screening</li> <li>• intelligent programming study (2-step approach to screening)</li> </ul>	<ul style="list-style-type: none"> <li>• staff attendance</li> <li>• staff satisfaction with education provided</li> </ul>	<ul style="list-style-type: none"> <li>• staff survey: satisfaction with Distress Assessment and Response Tool (DART)</li> <li>• Review of DART responses from report and chart audits</li> </ul>	<ul style="list-style-type: none"> <li>• patient satisfaction with DART + quality</li> <li>• patient satisfaction with care and quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• increase tracking of referrals (nursing documentation, added checkbox to SW form and using DART as referral)</li> <li>• increase automated screening in one clinic by 5% per month (implementing smart programming, May 2011)</li> <li>• increase screening rates to 90% in clinics with yellow card system (communication of findings from pilots and extra volunteer support)</li> <li>• increase education of float staff from 0% to 10% with drop in DART sessions</li> <li>• decrease DART suicide false positives from 7% to &lt;5% with intelligent programming</li> <li>• increase integration of Symptom Management guidelines with chart audits and case study education – measure satisfaction</li> </ul>

## Jurisdiction 6

Screening and Early Detection of Distress	Staff Education and Training	Teamwork and Collaboration	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• baseline survey of current practice</li> <li>• number and % of patients screened</li> <li>• number of times patients screened</li> </ul>	<ul style="list-style-type: none"> <li>• pre- and post-education session survey</li> </ul>	<ul style="list-style-type: none"> <li>• monthly chart audit (n=10) of interventions that did or did not occur</li> </ul>	<ul style="list-style-type: none"> <li>• patient survey: satisfaction and experience with tool and staff interaction</li> </ul>	<ul style="list-style-type: none"> <li>• PDSA cycles, based on chart audits</li> <li>• cycles also determined based on problem-solving at clinical implementation team meetings</li> </ul>

## Jurisdiction 7

Screening and Early Detection of Distress	Staff Education and Training	Teamwork and Collaboration	Patient Engagement and Outcomes	Rapid Cycles
<ul style="list-style-type: none"> <li>• baseline chart audit (10-20 per site)</li> <li>• clinic visit number's compared to number of screening tools completed</li> <li>• number of patients with distress to whom assessment, intervention or referral were offered</li> <li>• number of patients who accepted the referral</li> <li>• number of interventions supported by nursing (scope of practice)</li> </ul>	<ul style="list-style-type: none"> <li>• pre- and post-IPODE course survey: knowledge + awareness of distress, assessment + intervention</li> <li>• staff education survey at 6 months</li> </ul>	<ul style="list-style-type: none"> <li>• pre- and post-staff questionnaire on team collaboration, symptom management and patient-centeredness</li> <li>• midpoint and final staff survey: working with the screening tool</li> </ul>	<ul style="list-style-type: none"> <li>• pre- and post-implementation patient survey: satisfaction and experience, and quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• PDSA cycles planned on ongoing basis to meet aim of 90% of target group screened (chart audit, midpoint surveys)</li> </ul>

## Appendix R: Examples of Rapid Cycle Improvement Tools

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### Chart Audit Tool (Example)

Developed by D. Howell and E. Pathak; reproduced with permission.

#### Audit of Cancer-Related Fatigue

Practice environment: \_\_\_\_\_

	N	%
Number of charts reviewed		
Number of new patients		
Number of new patients screened for fatigue		
Number of new patients with positive fatigue scores		
Number of new patients with positive fatigue scores with documented interventions		
Number of patients receiving treatment		
Number of patients screened for fatigue during treatment		
Number of patients with positive fatigue scores during treatment		
Number of patients with positive fatigue scores during treatment with documented interventions.		
Number of patients post treatment		
Number of patients screened for fatigue post treatment		
Number of patients screened for fatigue post treatment with positive fatigue scores		
Number of patients post treatment with positive fatigue scores with documented interventions		

## Defect Check Sheet<sup>78</sup>

Quality Improvement Project: \_\_\_\_\_

Defect / Defect Cause of Interest: \_\_\_\_\_

Instructions to Recorders on When to Record a Defect: \_\_\_\_\_

\_\_\_\_\_

Type of patients or services being observed for defects: \_\_\_\_\_

\_\_\_\_\_

Setting: \_\_\_\_\_

Time Frame for Data Collection: \_\_\_\_\_

Data Recorders: \_\_\_\_\_

Defect or Defect Cause	Count
(list known/suspected defects here)	
Other: (important to have an "other" category)	

(Optional)

# of Defects:	# of People Served / Items Processed

## Short Survey<sup>78</sup>

Short surveys are intended to provide just enough simple and prompt feedback to tell you whether your attempts to improve are going in the right direction. Teams can also use them to pinpoint certain areas of interest (i.e., did the patients find the new form easy to understand?). These surveys are useful for answering question 2 in the Model for Improvement (How will we know that a change is an improvement?) and in running Plan-Do-Study-Act (PDSA) cycles.

Using short surveys has a variety of benefits:

- They are less expensive than large-scale surveys.
- They provide immediate feedback, permitting rapid completion of PDSA cycles and rapid learning.
- They are easy to use.
- They allow segmenting of a population (e.g., only diabetic patients) or a process (e.g., only those using the services of a new outpatient lab).
- They yield a higher return rate if administered in real time (e.g., given to the patient or family member and having them complete it at the time, rather than mailing surveys or calling at a later time).

### Short Survey: Directions

1. Identify the purpose of the survey.
2. Design 1 to 5 simple questions that will provide the needed information.
3. Test the questions on 5 to 10 patients or family members to see if the questions are easily understood and if, when completed, the questions actually yield the information that is being sought.
4. Rewrite the questions based on what was learned from testing them.
5. Design a method for distribution (e.g., a nurse may give patients the survey and ask them to place it in a sealed box when finished).
6. Collect the surveys on a daily or weekly basis.
7. Display the data on a run chart whenever possible and analyze for trends, data points out of control limits, etc.
8. Be prepared to respond quickly to complaints or other feedback warranting immediate follow-up.

## Example

### *XYZ Health System: Short Survey*

XYZ Health System is committed to serving our patients and families in the best way possible. Please take a few moments to answer the questions below:

How well did we do with:

Explaining test results to you in a way that you could understand?	Excellent				Poor
	1	2	3	4	5
Getting your test results back to you quickly?	Excellent				Poor
	1	2	3	4	5
Listening to your questions or concerns about your test results?	Excellent				Poor
	1	2	3	4	5

Thank you very much for helping us to improve our services. Please write any comments that you would like us to hear on the back of this card.

## Appendix S: PDSA Worksheets — Conducting Rapid Cycles (Small Group Work)

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### 1. Brainstorm Areas for Improvement

As a team, list several area for improvement (e.g., need to increase screening rates, need to improve management of a particular symptom, need to improve response to screening scores, need to improve follow-up or need to improve documentation).

### 2. Brainstorm to Set Some Aims

- a. Select two of the areas for improvement that the team agreed on. How do you know this area for improvement is a problem or challenge? What evidence do you have?

Evidence of need for improvement 1: \_\_\_\_\_

Evidence of need for improvement 2: \_\_\_\_\_

**Note:** *If the team does not know enough about the problem or challenge (why is x happening? what is not working?), what does the team need to do to better understand it (e.g., process map, chart audit, check sheet)? Once the team understands the nature of the problem or challenge in full, then they are ready to design the aim and a PDSA cycle.*

- b. Write an aim statement for each area of improvement so that it is specific.

**Examples:** *Reduce the number of patients with a pain score above 6 by 50%. Increase the number of patients screened once per clinic visit by 20%.*

Aim 1: \_\_\_\_\_

Aim 2: \_\_\_\_\_

### 3. Brainstorm and Select Change Ideas

- a. Select one of the aims that is listed in section 2b. Brainstorm to come up with some ideas for change (e.g., a change in process or a change in practice) that would help to reach the aim.
- b. How could you measure the change?



**Examples:**

**Change idea #1:** *Reduce the number of patients with a pain score above 6 by 50%.*

**Measure:** *% of patients with score above 6 within 72 hours of team intervention.*

**Change idea #2:** *Increase the number of patients screened once per clinic visit by 20%.*

**Measure:** *% of patients screened once per clinic visit or number of screens over 14 days.*

Change Idea #1:	Possible Measures:
Change Idea #2:	Possible Measures:
Change Idea #3:	Possible Measures:

- c. Select the best idea and the best measure and fill out the Rapid Cycle Worksheet (see following page) for the first change idea. If there is time, fill out the worksheet for the second change idea as well.

## 4. Plan the PDSA Cycle

*PDSA Cycle Worksheet: Cycle #1*

*(use same sheet for additional cycles as required)*

Aim: \_\_\_\_\_

Objective for this cycle: \_\_\_\_\_

Measure: \_\_\_\_\_

Describe your first test of change	Person responsible	When to be done	Where to be done
Cycle #1:			

### Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1.			
2.			
3.			
4.			
5.			

Predict what will happen when the test is carried out	Measure(s) to determine if prediction succeeds
1.	1.
2.	2.
3.	3.

**Do:** Describe what actually happened when you ran the test.

**Study:** Describe the measured results and how they compared to the predictions.

**Act:** If successful, apply the change on a wider scale and continue to measure success until fully implemented.

If not successful, can the test be changed or modified? Conduct the new change on a small scale again. Or maybe the change idea was not a good one. Go back to the brainstorming stage to come up with another change idea.

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