

# Psychosocial staffing at National Comprehensive Cancer Network member institutions: data from leading cancer centers

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## Abstract

**Objective:** The National Comprehensive Cancer Network (NCCN) is comprised of 25 National Cancer Institute-designated cancer centers and arguably could thus set the standard for optimal psychosocial staffing for cancer centers; therefore, information was sought from NCCN Member Institutions about their current staffing for psychosocial services. These findings are put into perspective given the limited existing literature and consensus reports.

**Methods:** The NCCN Best Practices Committee surveyed member institutions about their staffing for psychosocial services. The survey was administered electronically in the winter of 2012.

**Results:** The survey was completed by 20 cancer centers. Across institutions, case managers and mental health therapists, typically social workers, were utilized most frequently to provide psychosocial services (67% of full-time-equivalents (FTEs)), with other psychosocial professionals also represented but less consistently. Most psychosocial services are institutionally funded (ranging from 64 to 100%), although additional sources of support include fee for service and grant funding. Training of psychosocial providers is unevenly distributed across responding sites, ranging from 92% of institutions having training programs for psychiatrists to 36% having training programs for mental health therapists.

**Conclusions:** There was variability among the institutions in terms of patient volume, psychosocial services provided, and psychosocial staff employed. As accreditation standards are implemented that provide impetus for psychosocial services in oncology, it is hoped that greater clarity will develop concerning staffing for psychosocial services and uptake of these services by patients with cancer.

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## Background

Studies of cancer patients have demonstrated that psychosocial distress is a significant concern, with reported rates varying between 32 and 35% across outpatient oncology patients [1,2]. Distress appears to increase during inpatient stays (64%) [3] and continues through immediate treatment completion (37%) and survivorship (31% 2 months after completing cancer treatment) [4]. It has been associated with increased patient suffering and poorer medical outcomes [5,6]; yet, existing consensus reports have indicated that distress is not being adequately detected by oncology staff, and thus, the psychosocial needs of patients with cancer are not being met [7,8]. Several organizations, including the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology, and the American College of Surgeons Commission on Cancer (ACOS CoC), have advocated for screening and management of psychosocial distress as a standard of quality cancer care, and indeed, distress screening became a new American College of Surgeons Commission on Cancer accreditation standard in 2015.

As distress in patients with cancer is identified, the need for psychosocial services becomes more pressing. Comprehensive data are not available regarding current levels of psychosocial staffing in cancer centers, the optimal level of staffing, nor how positions are funded. One recent study of American Psychosocial Oncology Society (APOS) members examined existing psychosocial services for cancer survivors [9]. Survey responses were received from 233 psychosocial oncology professionals, and findings suggested that there is great variability in the psychosocial services offered to patients with cancer. From this survey, it was clear that social work is the most common profession to provide these services. However, a consensus has not developed about staffing of psychosocial positions within cancer centers.

Thus, the goal of this project was to explore how leading institutions are providing staffing for the psychosocial needs of patients with cancer. The NCCN is comprised of 25 National Cancer Institute-designated cancer centers and arguably could thus set the standard for optimal staffing; therefore, information was sought from NCCN

Member Institutions about their current staffing for psychosocial services.

**Methods**

The Best Practices Committee (BPC) of the NCCN initiated a survey to explore current practices of member institutions for providing psychosocial services for patients with cancer. Survey questions were developed by the first and third authors who were employed at one member institution (Siteman Cancer Center) and the fourth author who is employed at NCCN, with consultation from BPC members. The survey was administered electronically via Survey Monkey and emailed to the 21 institutions, which were NCCN members in the winter of 2012. The survey was completed by the BPC representative for the member institution or their site designee with expertise in psychosocial services. The results were compiled by NCCN staff

and analyzed by all authors. Survey questions are available in the Appendix.

This project was completed using resources of the NCCN BPC. Data were compiled and analyzed at NCCN. The project was reviewed administratively by the Institutional Review Board at Washington University School of Medicine, but it was determined that this project did not require Institutional Review Board review as it was a study of institutions, not individuals.

**Results**

Surveys were returned by 20 respondents representing 19 of 21 NCCN member institutions (90% response rate).<sup>1</sup>

There were some missing data, which are delineated in the comments in the succeeding texts and in the figures. The majority (70%) of institutions indicated they are matrix or consortium sites, whereas 30% (n=6) reported being an independent cancer center. As seen in Figure 1, institutions reported great variability in the number of newly diagnosed patients with cancer seen annually (range=2076–35 000) and the number of annual outpatient visits (range= 17 000–1 200 000, median= 160 000). When queried about their service model, 50% of respondents reported that psychosocial services were *both* stand-alone entities (e.g., a central service coordinating all psychosocial providers) and embedded throughout the institutions (e.g., psychosocial providers distributed across treatment areas and reporting to those areas). In contrast, other institutions indicated embedded services only (35%) or stand-alone services only (10%), and 5% reported another model.

Results were variable concerning how many patients were seen for specific psychosocial services. Five institutions did not provide a specific answer to this question, noting that they did not track this information. Others tracked number of contacts, but not the numbers of individual patients, and some did not track types of

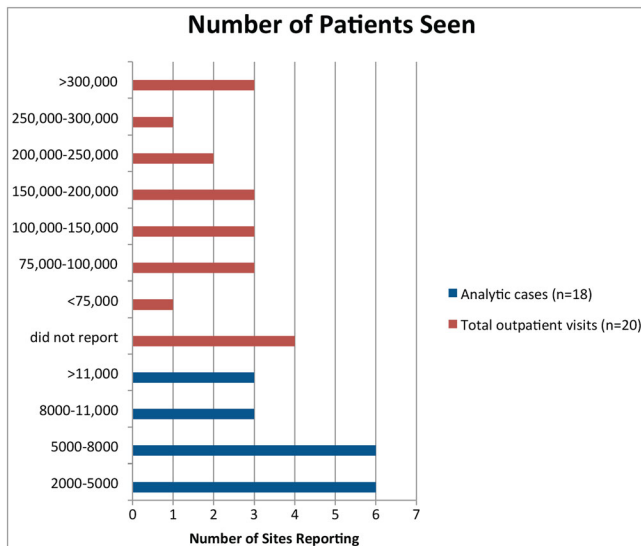


Figure 1. Number of patients seen

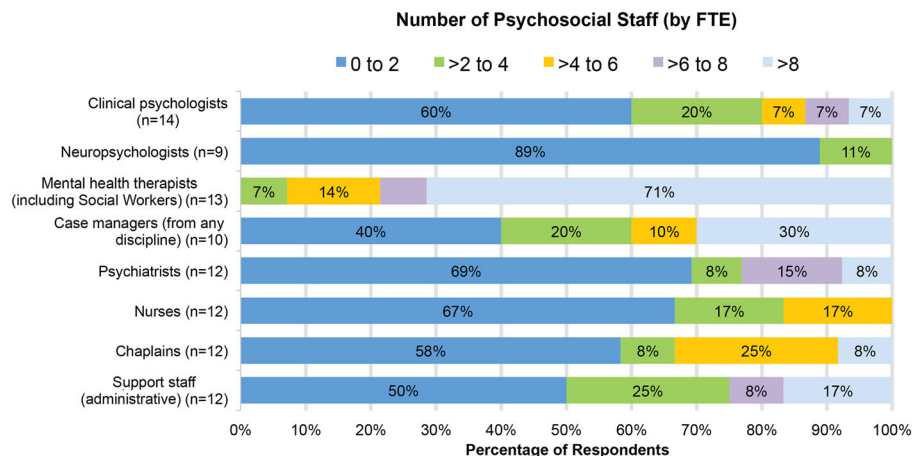


Figure 2. Number of psychosocial staff by FTE

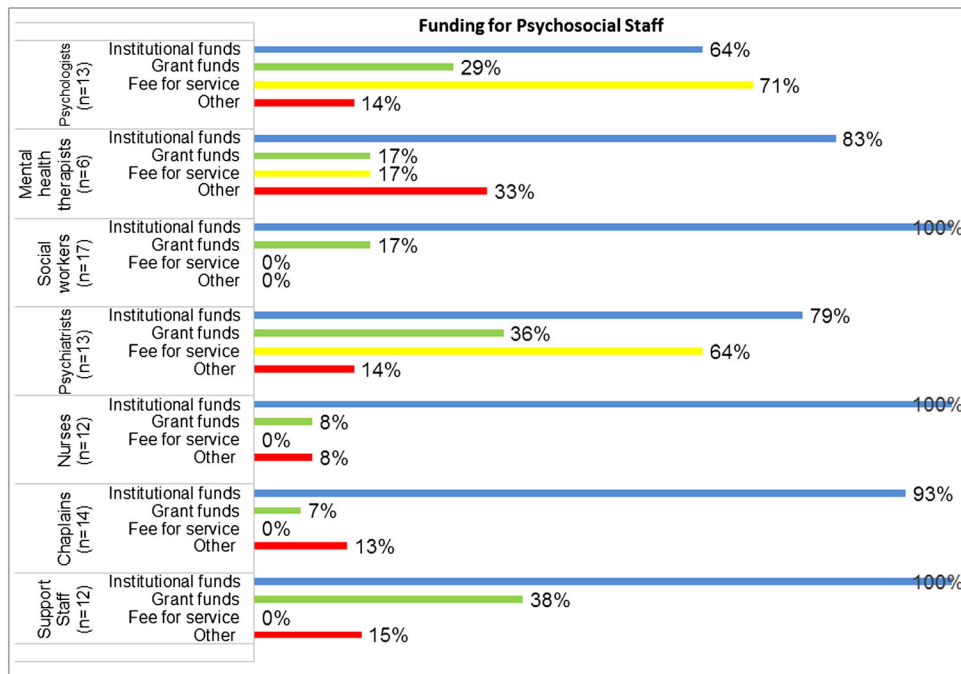


Figure 3. Funding for psychosocial staff

psychosocial services provided. For those who responded ( $n = 15$ ), the range was 550–70 751 patients. The numbers varied dramatically for specific services. For instance, one institution reported seeing 16 000 patients for psychotherapy, while another institution indicated serving 50 patients. Similarly, one institution noted providing educational/wellness programs to 18 000 patients, whereas a different institution reported serving no patients in this capacity.

Figure 2 illustrates the number of institutions that reported employing psychosocial staff members, as well as the number of individuals. Across institutions, 486.2 full-time-equivalents (FTEs) were reported as providing psychosocial services, and case managers (FTEs=94, 19%) and mental health therapists (FTEs=231.95, 48%), who are often social workers, were utilized most frequently. Psychosocial care was provided less often by nurses, chaplains, psychologists, and psychiatrists (FTEs=144.27, 30%). Of note, only six sites reported employing a neuropsychologist. In addition to the most common psychosocial services provided, some sites offered unique programs and employed staff such as artists in residence, a bereavement coordinator, and a legacy therapist.

With regard to funding of psychosocial staff positions, most were supported by institutional funds (refer to Figure 3). This was particularly true for social workers (100%), nurses (100%), chaplains (93%), mental health therapists (83%), and administrative staff (100%). Psychologists (64%) and psychiatrists (79%) were also supported by institutional funds but were the health

professionals most likely to be funded by fee for service income, 71% and 64%, respectively (many institutions reported more than one type of funding for these providers). Of the 17 institutions who answered a question about volunteers, a slight majority (59%) reported utilizing volunteers for addressing patient and family psychosocial needs. The most common volunteer activities were providing emotional support (peer support), hospitality and navigation, as well as serving on patient advisory boards and other committees. There were a variety of other unique volunteer activities noted by one respondent, such as self-image volunteers, office volunteers, and art cart volunteers.

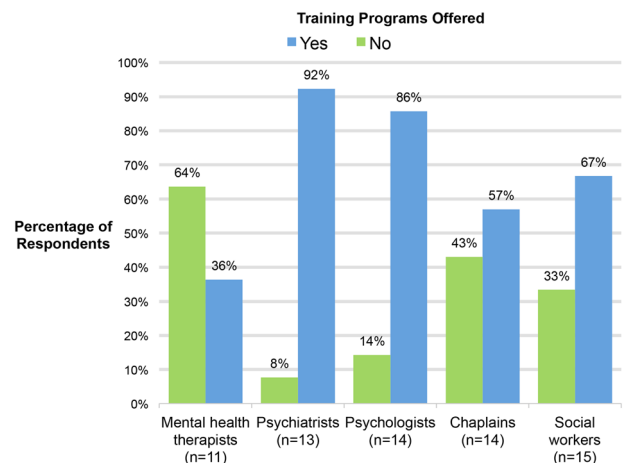


Figure 4. Training programs offered

A number of NCCN institutions offer training programs for psychosocial health professionals (refer to Figure 4). Training programs for psychiatrists, psychologists, social workers, and chaplains were provided by more than half the institutions. While training programs were prevalent, they were fairly small with most having one to two FTE psychiatrists (60% of institutions reporting results), psychologists (63%), or chaplains (60%) in training. Of note, there were several institutions that have a significant training component. Three institutions had a significant number of training slots (at least five) for social workers, while two had a significant number of slots for chaplains, one had this for psychiatrists, and one for mental health therapists.

## Conclusions

The goal of the present study is to benchmark the state of staffing for psychosocial services in a select group of National Cancer Institute-designated cancer centers. Our findings highlight that reflective of cancer care across the USA, there is great variation among NCCN institutions regarding institutional size, structure, and staffing levels for psychosocial services. These factors likely affect institutional culture and impact how care is delivered to patients and their caregivers, thus affecting patient flow, experience, and satisfaction.

This study sought to assess how many patients and caregivers are seen annually for specific psychosocial services; however, most institutions either were unable to provide data or made comments that they could not estimate the number of visits. It appears that many institutions are not tracking these data in a systematic way that allows for reporting, making it difficult to delineate the impact of psychosocial services. As there is no incentive from a regulatory or accrediting body to track this type of data, doing so may be seen as an unnecessary use of funds and staff time. Nevertheless, we recommend documentation of the type and uptake of psychosocial services in oncology in order to measure progress in addressing psychosocial needs as advocated by the 2007 Institute of Medicine report 'Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs' [8].

From the data provided, it is clear that there is significant variability among sites in the services offered and the scope of the programs. These results suggest that there is not a 'standard package' of psychosocial services nor relevant staffing across surveyed cancer centers. Psychosocial services were provided mainly by mental health therapists and social workers, and occasionally nurses, consistent with the APOS survey [9]. Psychosocial care was also provided, albeit less frequently, by other experts, including chaplains, psychologists, neuropsychologists, and psychiatrists. If the goal is holistic cancer care, as advocated by the Institute of Medicine [8], it will be important for these latter professions to be routinely represented in cancer care institutions.

Interestingly, as demonstrated here, cancer centers may have 'aspirational' programs and staff. In this survey, among others identified, some less typical programs included a guided imagery therapist, legacy therapist, bereavement program coordinator, activity therapist, artist, and disability specialist. While these specialty services are less common, it is recommended that program evaluation and dissemination research are occurring to demonstrate evidence for effective programs that may be replicated at other institutions.

Regarding funding, respondents had much more consistent responses. Interestingly, grant monies funded each discipline included in this survey, highlighting that cancer centers actively sought out 'soft' money to develop and supplement psychosocial programs. Most psychosocial services were institutionally supported as they did not generate sufficient revenue; however, 10 institutions reported some fee for service revenue for psychologists' clinical activity and 9 institutions reported the same for psychiatrists' clinical work. Therefore, most psychosocial services tend to come with a financial cost to cancer centers. In a national healthcare climate of having to do more with less, when research and expert consensus demonstrate the need for enhanced psychosocial services for patients with cancer [10,11], how can psychosocial services be provided to meet patient, survivors, and families' needs? Beyond being the right thing to do, experts argue that supportive care programs demonstrate their value to institutions and are financially sound (e.g., [12]). Moreover, the use of supportive care services is positively associated with higher patient satisfaction scores, which in turn are important to payers including the Centers for Medicare and Medicaid Services [13].

Recommendations from leaders in the field include diversifying staff to include those who can charge fees, engaging in distress screening that allows for triaging patients with the most need, developing strong business models that demonstrate how psychosocial services may directly and indirectly benefit the institution (e.g., decrease length of clinic visits with physicians and increase patients' enrollment duration in clinical trials), and adding cost data into evaluations of the efficacy of psychosocial treatments [13,14]. As cancer centers develop, enhance and refine psychosocial and supportive care programs, financial considerations are critical for ensuring adequate staffing.

The costs of employing staff may be one reason that a slight majority (56%) of institutions used volunteers to provide psychosocial services. Of course, volunteers are often utilized for other purposes including sharing personal knowledge of being a patient or caregiver, providing specialized professional or technical knowledge, and connecting with local community members. In an age when national rates of volunteering are high [15] and with 1 665 540 new cases of cancer expected in 2014 [16], the use of volunteers can be a way to supplement and enhance psychosocial services. When used with appropriate professional oversight



and good support, volunteers can contribute greatly to an institution's mission and programming. Although not surveyed in this study, many cancer centers employ a manager of volunteer services or other similar position to provide strong management and coordination of a volunteer program, thus maximizing benefits to the institution.

It seems that the burden of training new psychosocial professionals to work in oncology is borne unevenly. There are a few institutions that have large training programs, but they are in the minority. Training programs may be seen as taking professional time and resources away from clinical services, thus perhaps being a luxury that only the most 'academic' of institutions can offer. It may be that most psychosocial professionals in oncology receive their training in other areas of medical care. Of note, however, the 2007 Institute of Medicine report [8] advocated for the inclusion of properly trained psychosocial providers who have the expertise and experience to address the biopsychosocial complexities involved in the treatment of cancer, suggesting that clinicians ideally receive specialty training in oncology.

A limitation of this study is that the survey was given to the BPC member at each NCCN institution, and those individuals then either completed the survey or forwarded it to the individuals in their institutions they felt were best suited to complete it. Therefore, variability exists across institutions as to the professional role of who may have completed the survey, and it is not clear how knowledgeable the individuals who completed the study survey were about psychosocial staffing. However, it is standard practice at NCCN to use the BPC mechanism to survey member institutions about a wide variety of issues of concern. There was no attempt to independently verify data provided by the institution.

In summary, this paper presents the results of a survey about the psychosocial staffing patterns of NCCN member institutions, arguably a group of leading cancer institutions that could set the standard for staffing patterns. The survey highlighted the challenges in examining data regarding psychosocial services. It also documented the significant diversity even among this group in how psychosocial care is delivered. As distress screening programs become more universally incorporated into cancer care, more attention will be paid to psychosocial services and the clinicians who provide them. However, as noted previously, examining data about the staffing and delivery of psychosocial services has highlighted that many institutions are not tracking these data in a consistent manner that allows for assessment and comparison among institutions and patient populations. The field of psychosocial oncology, and ultimately our patients, will benefit from more detailed, standardized recordkeeping by cancer centers. Therefore, we suggest that the time may be ripe for moving towards systematic reporting of psychosocial services, staffing, and patient outcomes.

## Appendix: Survey questions

1. Please provide background information. (Name, title, NCCN Member Institution, email address, phone number)
2. Please provide information regarding the size of your cancer center: (Number of newly diagnosed cancer patients seen annually, number of outpatient visits annually.)
3. Is there a stand-alone service within the cancer center that provides psychosocial services or are psychosocial services integrated/embedded throughout the cancer center?
4. If there is a stand-alone psychosocial service, what is the official name for that service at your institution?
5. Regardless of the structure of services, please estimate how many patients your psychosocial staff see annually... (for psychotherapy of patients with cancer; for psychotherapy of caregivers and family members, for financial/ transportation/ housing needs, for medication management needs only, for support groups, for education/ wellness programs, for other needs not identified).
6. If your psychosocial staff sees patients for other needs not identified in the previous question, please specify.
7. Please list the number of psychosocial staff employed at your institution. Some individuals may have multiple roles/duties; therefore, please report activity in terms of FTEs. (Clinical psychologists, neuropsychologists, mental health therapists, case manager, psychiatrists, nurses, chaplains, support staff, psychosocial researchers, other)
8. Please provide any additional comments regarding FTEs of psychosocial staff at your institution.
9. For the staff reported in the preceding texts, please provide information on how each position is funded. Select all that apply. (Institutional funds, grant funds, fee for service, other)
10. Do you utilize volunteers to assist with psychosocial support?
11. For each of the professions listed in the succeeding texts, please indicate whether your institution offers a training program. (Social workers, chaplains, psychologists, psychiatrists, mental health therapists, other professions)
12. If applicable, please provide the total number of current psychosocial trainees per discipline. (Social workers, chaplains, psychologists, psychiatrists, mental health therapists, other professions)
13. If applicable, please provide the corresponding full-time equivalent (FTE) numbers of psychosocial trainees per discipline. (Social workers, chaplains, psychologists, psychiatrists, mental health therapists, other professions)
14. Would the director/ point person for your psychosocial program be willing to speak with other NCCN Member Institutions about the services you provide?
15. Please provide any additional information that you think may be helpful regarding psychosocial services and staffing at your institution.

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## Conflict of interest

Teresa Deshields is on the speaker's bureau for Eli Lilly and Company, Oncology Division.

## Note

1. NCCN had 21 Member Institutions when the survey was delivered to Best Practices Committee members; however, one of the Member Institutions is in fact two separate cancer centers and each of the two centers provided a response.

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