

# ADDRESSING THE PSYCHOSOCIAL NEEDS OF CANCER SURVIVORS IN 2023

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Patricia A. Ganz, MD

Jonsson Comprehensive Cancer Center

UCLA Schools of Medicine & Public Health

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## Disclosures

- Editorial leadership:
  - Up-to-Date, editor section on survivorship—Wolters-Kluwer
- Consulting:
  - Blue Note Therapeutics
  - GRAIL
  - InformedDNA
  - Roche-Genentech

# Case Presentation

- JH was a 39 year old woman referred to me for a Survivorship Consult by her primary care physician in January 2012; married, one child, works as teacher
- PMH: Hodgkin lymphoma stage IIB **diagnosed 1995 at age 23**
  - Treated with ABVD chemotherapy for 6 cycles, cumulative Adriamycin 300 mg/m<sup>2</sup>; low dose involved field radiation to mantle field of chest
  - Asymptomatic recurrence detected on PET scan **1998 at age 25**; treated with high dose chemotherapy, stem cell rescue, additional full dose radiation to the chest

## Case Presentation (continued)

- PMH: Other health conditions as of 2012
  - Hypertension, on medication
  - Premature ovarian failure on hormone therapy
  - Cholecystectomy, 2006
  - Right breast core needle biopsy, 2011
  - Migraine headaches
- Pertinent findings reviewed:
  - Lipid panel LDL 150 mg/ml; TSH normal
  - Echocardiogram: LVEF 50-55%, trace aortic and mitral regurgitation
  - **Moderately severe anxiety, white coat hypertension**

# My Consultation Recommendations

- Late effects monitoring
  - **Cardiac**-needs close follow-up secondary to chest radiation and anthracycline therapy, low ejection fraction---referred to cardio-oncologist
  - **Breast health**-high risk screening for breast cancer related to chest radiation exposure; consider d/c of hormone therapy
  - **Skin health**-follow-up for skin cancers in radiation port
  - **Bone health**-monitor with DEXA scan as baseline with past history of stem cell transplant
  - **Health promotion/prevention**-BMI 26.8, increased LDL—consider lifestyle interventions and pharmacologic intervention with a statin
- Psychosocial concerns-address anxiety, and evaluate for medication in Simms/Mann Integrative Oncology Center

## Fast Forward, 2018, now age 46

- Interval history: thyroid nodules on suppressive therapy (2012); severe anxiety related to health condition
- January 2018: new onset orthopnea and pre-syncope; echocardiogram shows aortic sclerosis and regurgitation, mitral regurgitation, low EF
- March 2018: breast MRI, suspicious nodule left breast
- April 2018: cardiac cath shows 90% stenosis LAD, 90% stenosis left circumflex; 3+ aortic insufficiency; LVEDP 35mm
- *Contacts me re: severe anxiety related to decision-making related to need for surgery*
- June 2018: cardiac surgery, AVR and 2 vessel bypass
- August 2018: breast biopsy shows DCIS; hormones discontinued

## Some reflections on this case....

- Patient is only 46 years old and has multiple chronic health conditions.
- Patient has severe post-traumatic stress symptoms from cancer treatment that are poorly controlled.
- She has had excellent co-management by an internist and cardiologist with special interest in oncology/cancer survivors.
- She has required major cardiac surgery and has non-invasive breast cancer.
- *Has anyone addressed her psychosocial needs?*

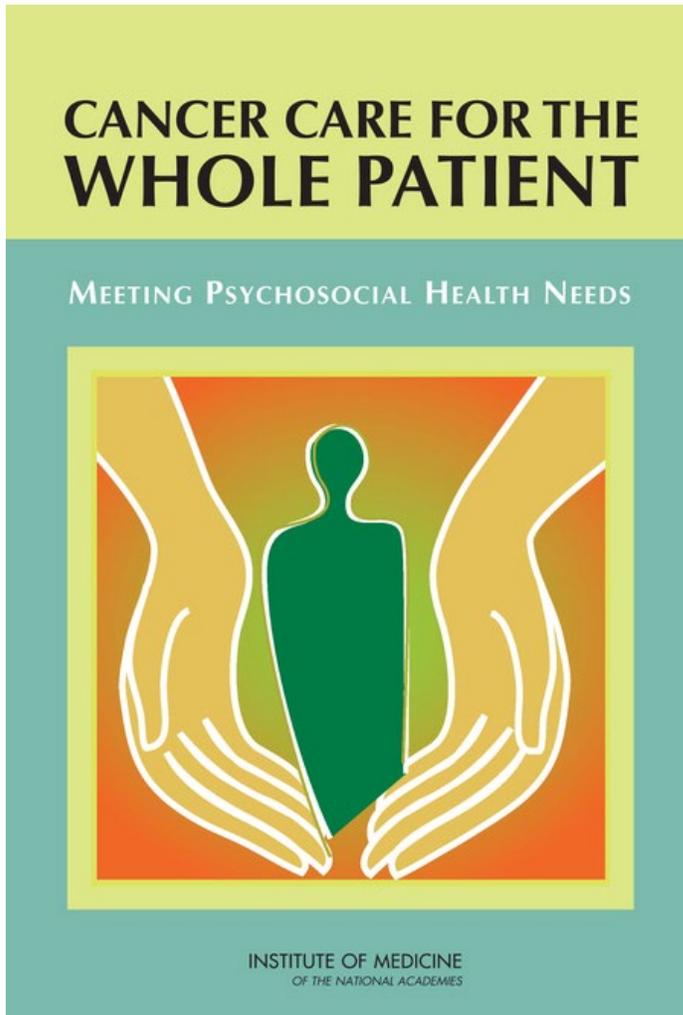
## Another follow-up with me in June 2020, now age 48

- Patient requested an update visit to review any additional late effects that should be monitored.
- Done by telemedicine visit due to COVID; very anxious about returning to the classroom to teach given her underlying health conditions.
- PHQ-9 score was 7, endorsing little interest or pleasure in doing things, feeling down and depressed some of the time, as well as trouble with sleep, feeling tired, difficulties with eating, feeling bad about herself and being restless.
- Reports that she is now finally receiving counseling for her anxiety and post-traumatic stress

# What am I going to talk about?

- What did the 2008 IOM Report on “Caring for the Whole Patient” recommend and what impact did the report have?
- What are the current psychosocial needs of cancer survivors?
- Special vulnerability of AYA survivors
- Implementation of depression screening in cancer survivors as a standard of care
- Challenge of linking cancer survivors to psychosocial resources

# 2008 IOM Report: Meeting Psychosocial Health Needs



“Cancer care today often provides state-of-the-science biomedical treatment, *but fails to address the psychological and social (psychosocial) problems associated with the illness....* Psychological and social problems created or exacerbated by cancer—including *depression and other emotional problems; lack of information or skills* needed to manage the illness; *lack of transportation or other resources*; and *disruptions in work*, school and family life—cause additional *suffering*, weaken *adherence* to prescribed treatments, and *threaten patients’ return to health.*”

## Key Report Recommendations

1. Provision of psychosocial services should be a **standard of cancer care**
2. All cancer care providers should ensure **implement this standard of care** in their practices
3. Patient and family **education** is a key component to **support active engagement in care decisions**
4. NCI, CMS, AHRQ should provide support for **dissemination and uptake of the standard of care**
5. Payers for health care should fully **support evidence-based interventions** necessary to deliver this care
6. NCI, CMS, AHRQ should fund research focused on the development of **performance measures for psychosocial cancer care**

## Key Recommendations- continued

7. Need for **workforce that is trained** with competencies and accreditation; legislation to increase workforce
8. Develop standardized nomenclature to facilitate **quality measurement of psychosocial interventions** to be led by NIH and AHRQ
9. Research priorities include **development of tools and strategies to implement the standard of care in clinical practice**, including improvements in patient-provider communication and linking patients to services, as well as creation and testing of reimbursement arrangements
10. **NCI/NIH should monitor progress toward delivery of psychosocial services** in cancer care and report its findings on at least a biannual basis to oncology providers, consumers, and health care plans/purchasers

# Proposed Model for the Delivery of Psychosocial Health Services

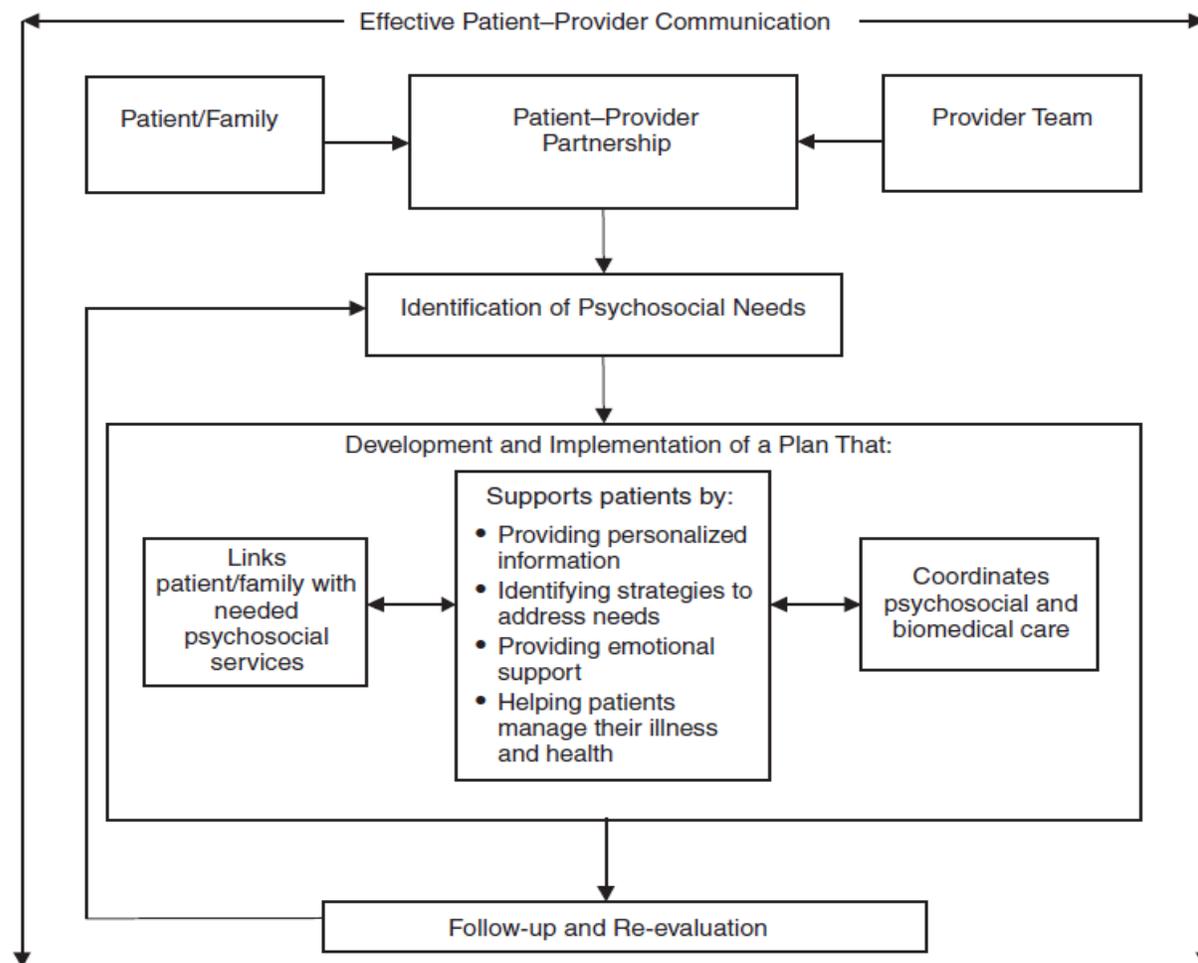
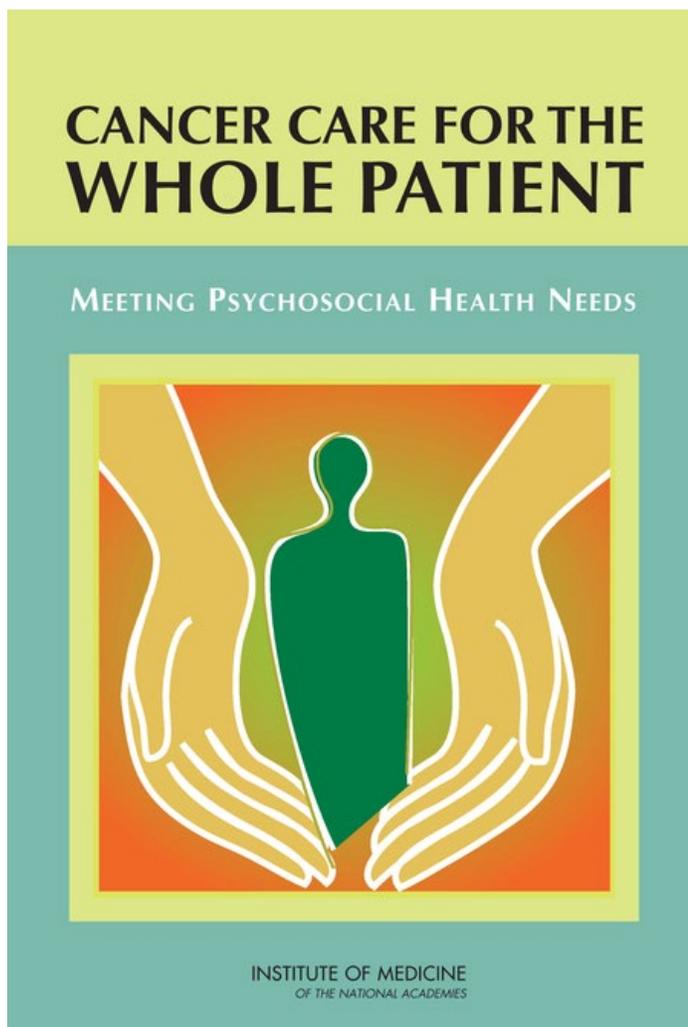


FIGURE S-1 Model for the delivery of psychosocial health services.

## Other Key Observations from the IOM Report

- Many psychosocial resources already exist, but patients are not linked to them
- Many tools exist for psychosocial screening, but are not used in clinical cancer care settings
- Reimbursement of mental health services is limited and not well-integrated into cancer care delivery

# What short term impact did the report have?

## *My personal observations....*

- The report gave champions of psychosocial “distress” assessment a platform to lobby for the report recommendations

Holland



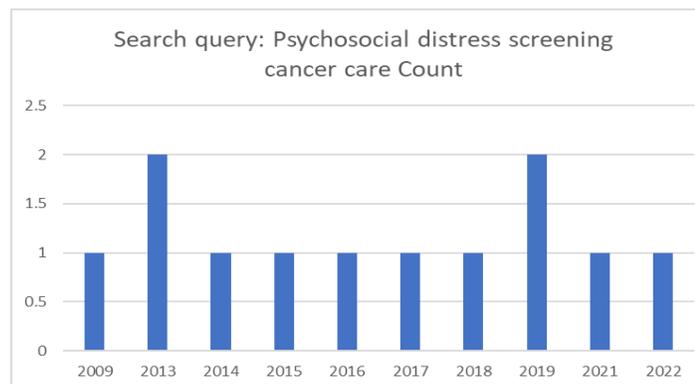
Alter



- NCCN and the American College of Surgeons endorsed distress screening in guidelines and standards of care for psychosocial distress screening
- ASCO QOPI measure: “Patient emotional well-being assessed within 1 month of first office visit.”
- ASCO Clinical Guideline on Screening for Anxiety & Depression 2014

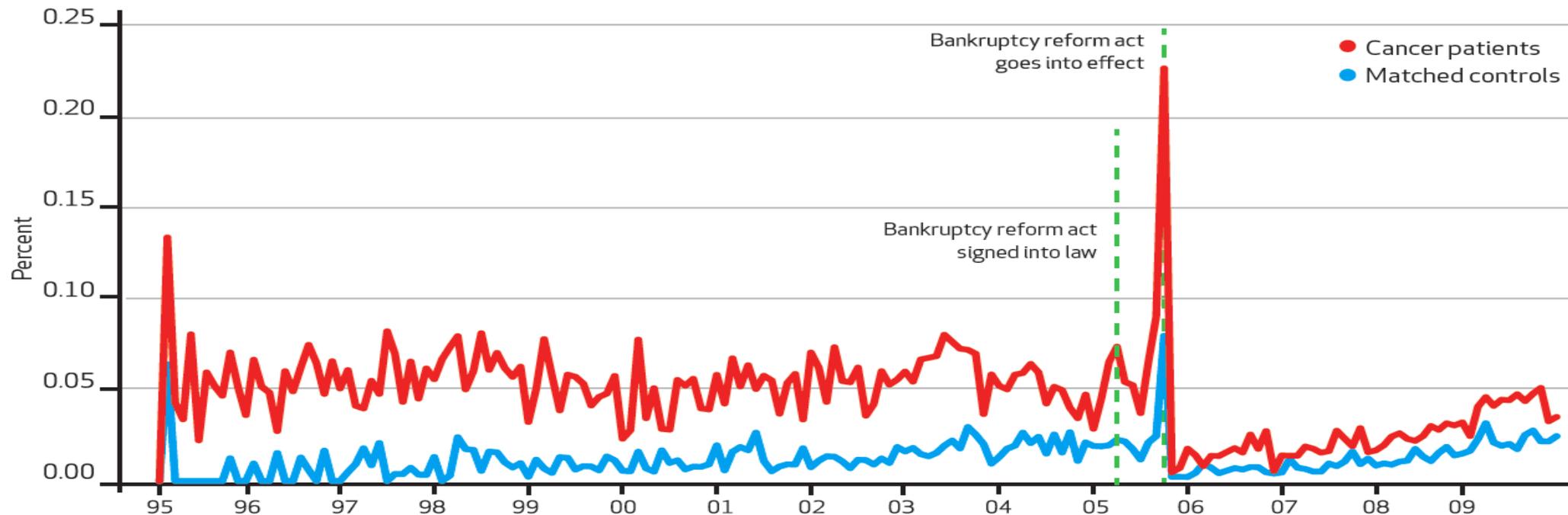
# Important Issues that Emerged after the 2008 report

- Rapid growth in the number of cancer survivors
- Increasing complexity of cancer therapy, including expansion of targeted therapies, with increasing cost burden
- Incorporation of palliative care as part of primary cancer care delivery
- Financial toxicity as an additional psychosocial risk factor
- However, research on psychosocial distress screening in cancer care has been limited



# Washington State Cancer Patients Found To Be At Greater Risk For Bankruptcy Than People Without A Cancer Diagnosis

Monthly Rate Of Bankruptcies For Cancer Patients And Matched Group Without Cancer, Western Washington State, 1995–2009



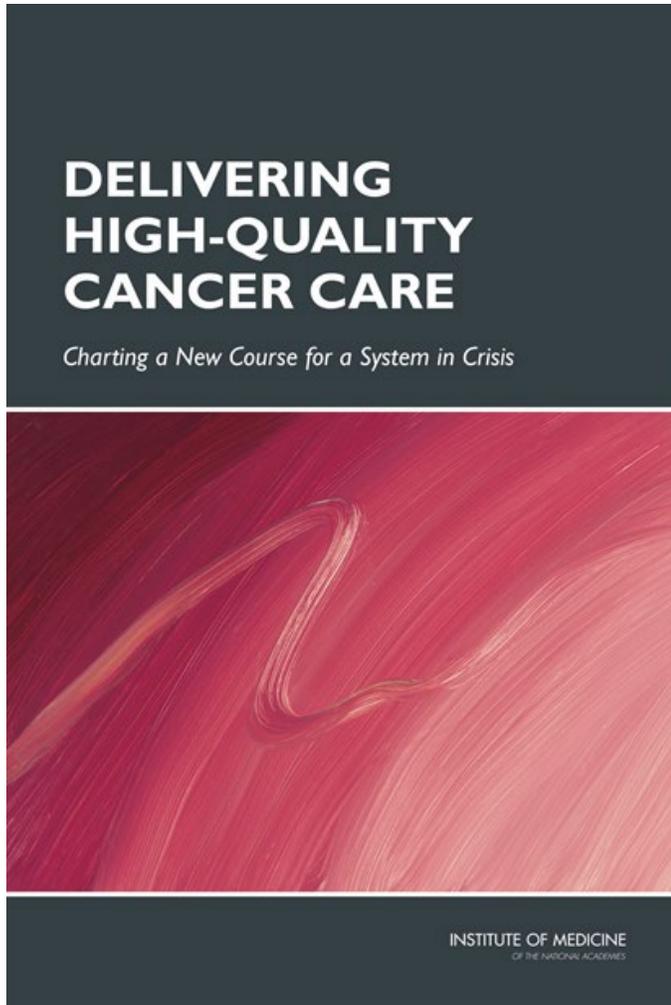
**SOURCE** Authors' analysis. **NOTE** People in the group without cancer were matched to cancer patients by age, sex, and ZIP code of residence.

## A New Quality Standard: The Integration of Psychosocial Care Into Routine Cancer Care

*Paul B. Jacobsen and Lynne I. Wagner*

- Guidelines have been developed by many organizations, even preceding the IOM report
- Quality indicators have been validated and implemented (ASCO-QOPI) but adherence to measures had been poor up to that time
- Audit and feedback can be helpful, but referral to counseling services is limited

# 2013 IOM Report on Delivering High Quality Cancer Care Provided some reinforcement for 2008 recommendations.....



## GOAL 1

The cancer care team should provide patients and their families with understandable information on:

- Cancer prognosis
- Treatment benefits and harms
- Palliative care
- Psychosocial support**
- Estimates of the total and out-of-pocket costs of care

## Information in a Cancer Care Plan

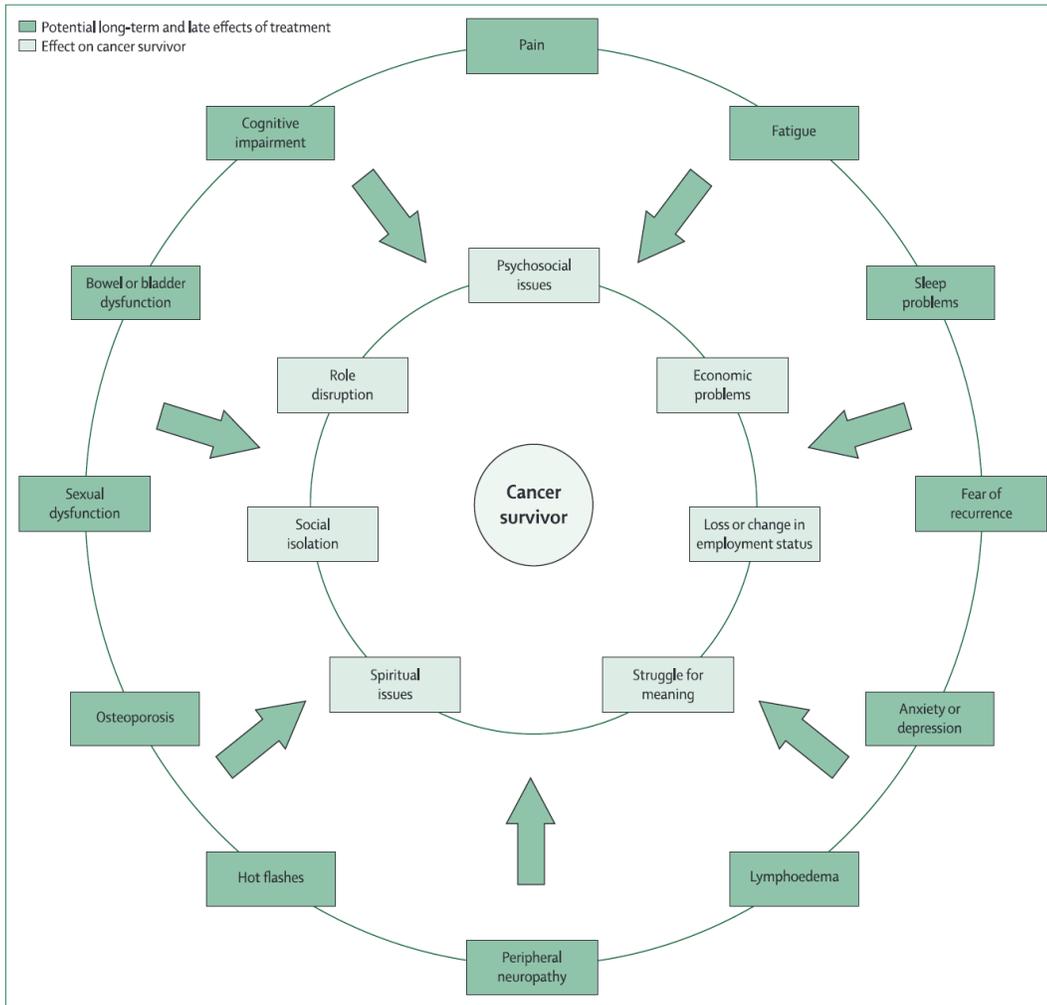
- Patient information
- Diagnosis
- Information on quality of life and a patient's likely

CMS responds with bundled payment experiment called the Oncology Care Model (OCM) that provides extra funding to implement the care plan elements.

harms

Survivorship plan

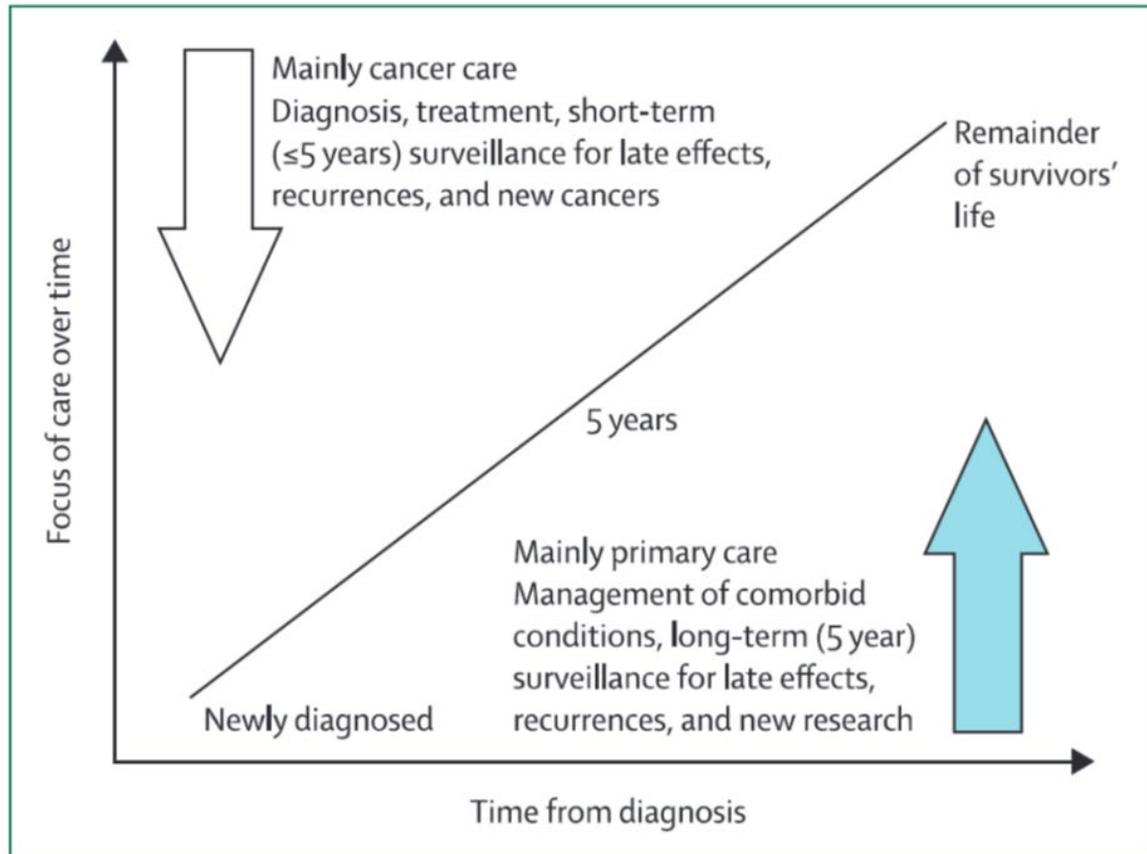
# Meeting the Psychosocial Needs of **Cancer Survivors**



- Interplay between the physical and psychosocial needs
- Survivors with greater physical burden e.g. transplant patients, complex and extended treatment regimens, have greater psychosocial needs
- Meta-analyses show that 15-20% of cancer survivors have persistent anxiety and depressive symptoms

Figure 1: Potential long-term and late effects of treatment and how they affect cancer survivors  
Potential long-term and late effects of treatment, any and all of which can affect the personal characteristics of the cancer survivor.

# Clinical Site of Survivor Care Shifts over Time

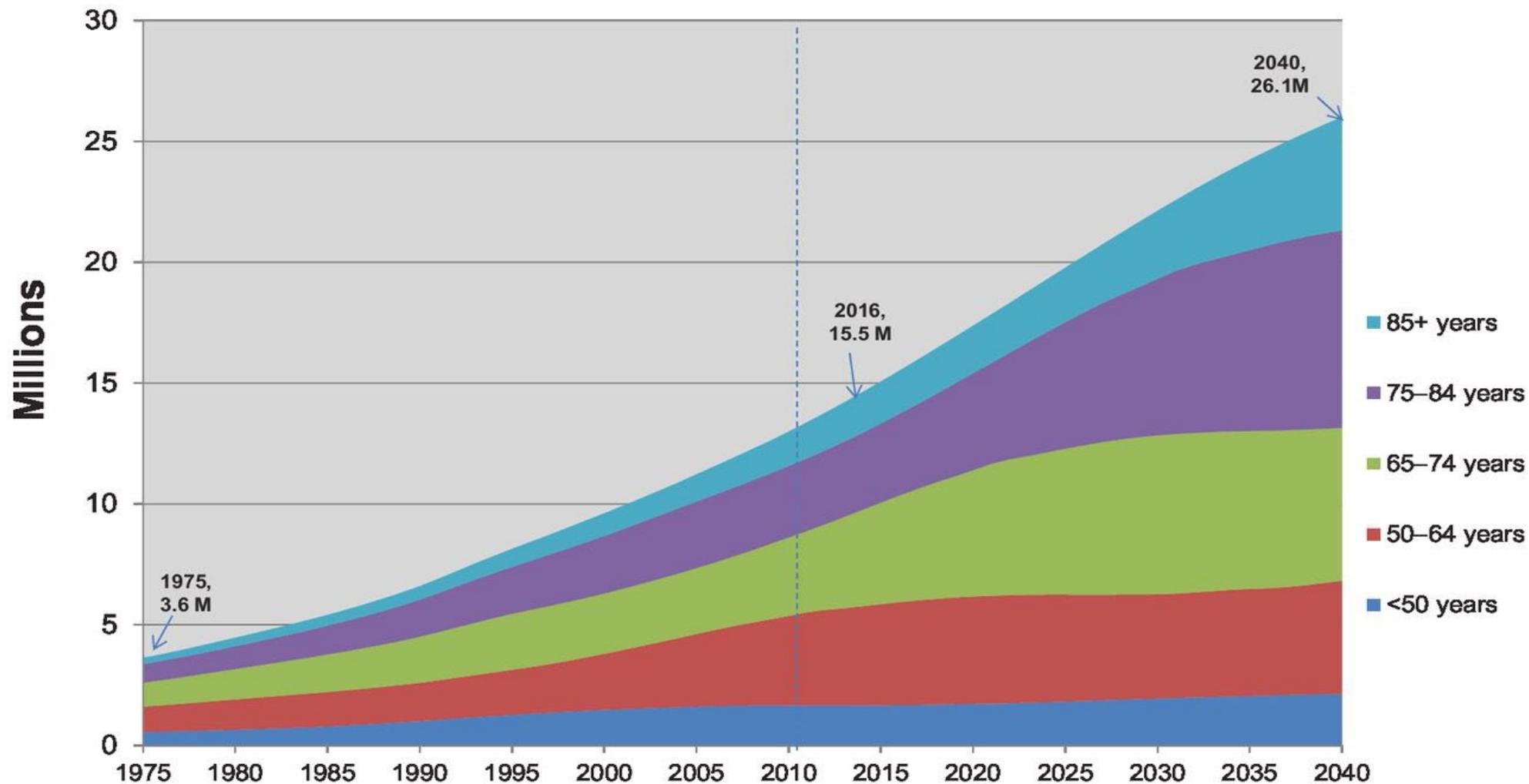


**Figure 2: Focus of care shifts over time based on survivors' needs**  
This scenario is for most survivors who are in complete remission after treatment and would be modified for those living with ongoing active cancer.

Mayer, Nasso, Earp, Lancet Oncol 2017

- Ongoing challenges of integrating psychosocial care into routine oncology care.
- Will active psychosocial intervention early in the disease trajectory make a difference for survivors?
- What happens when more care occurs in general medical settings, and there is increased risk for comorbid conditions?  
**My case presentation.**
- How will we address the rapid growth in the number of cancer survivors in the next two decades?

# Estimated cancer prevalence by age in the U.S. population from 1975 (216 M) to 2040 (380 M).



----- Signifies the year at which the first baby boomers (those born 1946-1964) turned 65 years old

Shirley M. Bluethmann et al. Cancer Epidemiol Biomarkers  
Prev 2016;25:1029-1036

# Cancer survivorship in the USA 4

## Provision of integrated psychosocial services for cancer survivors post-treatment

Christopher J Recklitis, Karen L Syrjala

*Lancet Oncol* 2017; 18: e39–50

- Summarizes consensus reports/clinical guidelines, as well as models for integration of care
- Between 15-40% of survivors have prominent psychosocial needs
  - Psychological symptoms
  - Social and vocational adjustment
  - Lifestyle changes
  - Stress caused by off-treatment transitions
  - Coping with late effects of medical treatment
- Detailed recommendations for integration of psychosocial care as an essential component of survivorship care

# Adolescent and Young Adult (AYA) Survivors: A Vulnerable Population

- AYA defined as 15-39 years of age—includes multiple developmental stages; 90,000 new cancer patients each year
- Substantial impact of cancer on financial burden, education and work, relationships and family planning, and physical and mental health
- Large burden of chronic illness, second malignancies, and other late effects, from greater intensity of treatments
- Greater psychological morbidity than in older adults with cancer

Barnett M, et al. Psychosocial outcomes and interventions among cancer survivors diagnosed during adolescence and young adulthood (AYA): a systematic review. *J Cancer Surviv*. 2016 PMID: PMC5001943.

Smith AW, et al; AYA HOPE Study Collaborative Group. Understanding care and outcomes in adolescents and young adult with Cancer: A review of the AYA HOPE study. *Pediatr Blood Cancer*. 2019 PMID: 30294882;

# National Health Interview Study (NHIS) 2019 Demographics

		AYA Survivors N=664	Adult Survivors N=3099	p-value
Age (mean) at survey- yrs (SD)		52.8 (16.4)	70.4 (10.2)	<0.001
Sex	Male	169 (25.5%)	1387 (44.8%)	<0.001
	Female	495 (74.5%)	1712 (55.2%)	
Race/ethnicity	NHW	539 (81.2%)	2702 (87.2%)	<0.001
	Hispanic	58 (8.7%)	134 (4.3%)	
	NHB	38 (5.7%)	165 (5.3%)	
	NH Asian	5 (0.8%)	41 (1.3%)	
	Am Ind/Alaska	7 (1.1%)	15 (0.5%)	
	Multiple/other	17 (2.6%)	42 (1.4%)	
Comorbid conditions	0	207 (31.2%)	401 (12.9%)	<0.001
	1	157 (23.6%)	638 (20.6%)	
	2	125 (18.8%)	734 (23.7%)	
	3+	175 (26.4%)	1326 (42.8%)	

Baclig, personal communication

# National Health Interview Study (NHIS) 2019 Psychosocial Data

		AYA Survivors N=664	Adult Survivors N=3099	p-value
GAD7, total-anxiety	Mean (SD)	3.1 (4.6)	1.8 (3.6)	<0.001
PHQ8, total-depression	Mean (SD)	3.8 (5.0)	2.8 (4.1)	<0.001
Took med for mental health	Yes	23 (4.6%)	49 (2.0%)	<0.001
Received counseling/therapy past 12mo	Yes	101 (15.4%)	275 (9.0%)	<0.001
Delayed counseling/therapy due to cost past 12mo	Yes	55 (8.4%)	59 (1.9%)	<0.001
Needed counseling/therapy, did not get it due to cost past 12mo	Yes	51 (7.8%)	66 (2.2%)	<0.001

# What about implementation of depression screening as a standard of care?

Special Communication | **USPSTF RECOMMENDATION STATEMENT**

## Screening for Depression in Adults

## US Preventive Services Task Force Recommendation Statement

Albert L. Siu, MD, MSPH; and the US Preventive Services Task Force (USPSTF)

**RECOMMENDATION** The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

*JAMA*. 2016;315(4):380-387. doi:10.1001/jama.2015.18392

Figure 2. Screening for Depression in Adults: Clinical Summary

Population	Adults aged $\geq 18$ y
Recommendation	Screen for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Grade: B

Risk Assessment	<p>Women, young and middle-aged adults, and nonwhite persons have higher rates of depression, as do persons who are undereducated, previously married, or unemployed. Persons with chronic illnesses, other mental health disorders, or a family history of psychiatric disorders are also at increased risk.</p> <p>Risk factors in older adults include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and history of depression. Risk factors during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal anxiety, life stress, decreased social support, single/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.</p>
Screening Tests	Commonly used depression screening instruments include the Patient Health Questionnaire in various forms and the Hospital Anxiety and Depression Scales in adults, the Geriatric Depression Scale in older adults, and the Edinburgh Postnatal Depression Scale in postpartum and pregnant women. Positive screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems, alternate diagnoses, and medical conditions.
Screening Interval	The optimal timing and interval for screening for depression is not known. A pragmatic approach might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.
Balance of Benefits and Harms	The net benefit of screening for depression in the general adult population is moderate.

A recent example of implementation of depression screening in women with breast cancer.....

# Effect of a Community-Based Medical Oncology Depression Screening Program on Behavioral Health Referrals Among Patients With Breast Cancer

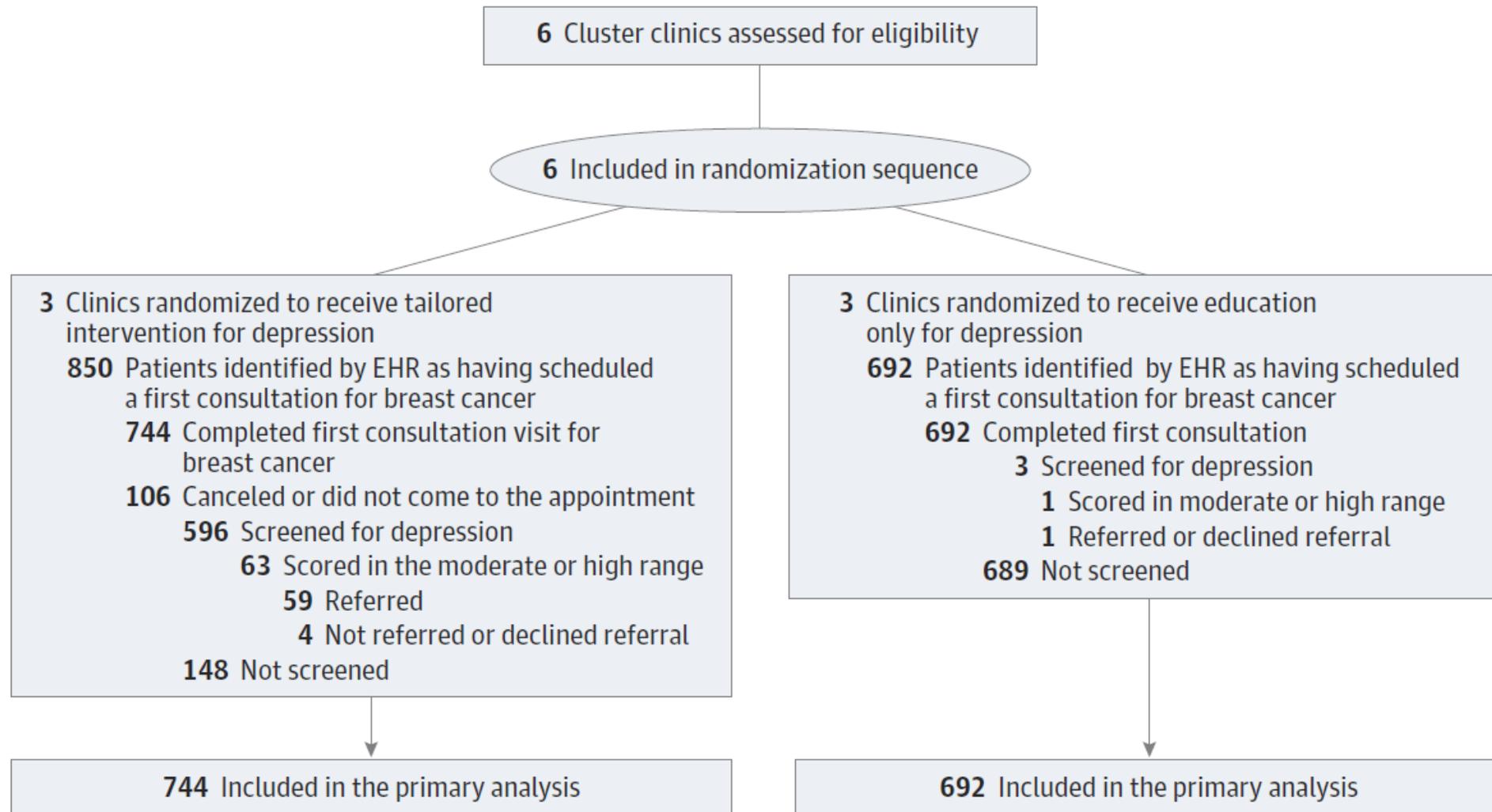
## A Randomized Clinical Trial

JAMA. 2022;327(1):41-49. doi:10.1001/jama.2021.22596

Erin E. Hahn, PhD, MPH; Corrine E. Munoz-Plaza, MPH; Dana Pounds, MS; Lindsay Joe Lyons, LVN; Janet S. Lee, MS; Ernest Shen, PhD; Benjamin D. Hong, MS; Shannon La Cava, PsyD; Farah M. Brasfield, MD; Lara N. Durna, MD; Karen W. Kwan, MD; David B. Beard, MD; Alexander Ferreira, MD; Aswini Padmanabhan, MD; Michael K. Gould, MD, MS

- A pragmatic, cluster-randomized clinical trial at Kaiser Permanente Southern California at 6 medical centers and including 1436 patients with newly-diagnosed breast cancer
- Medical centers randomized 1:1 to tailored implementation of depression screening with the PHQ-9, algorithm based scoring with referral to behavioral health services based on score vs. education only
- Clinical teams at intervention sites received education, audit and feedback on performance and assistance with implementation
- Primary outcome: percent of eligible patients screened and referred at intervention and control groups examined at the patient level
- Secondary outcomes: outpatient healthcare utilization for behavioral health, primary care, oncology, urgent care and ED

Figure 1. Flow of Participants Through the Trial



**Table 2. Percent of Eligible Participants Screened and Referred (Based on 9-Item Patient Health Questionnaire Score) at Tailored Intervention vs Education-Only Sites**

Primary outcome	Tailored intervention sites (n = 744)	Education-only sites (n = 692)	Risk difference (95% CI)
Received a referral to behavioral health services, No. (%)	59 (0.079)	1 (0.001)	0.078 (0.058-0.097)
PHQ-9 score distribution (% based on No. screened) <sup>a</sup>			
Low	533 (89)	2 (67)	
Moderate	57 (10)	1 (33)	
High	6 (1)	0	

**Table 3. Total Number of Referrals and Visits Made to Behavior Health, Depression Care Management, Psychiatry, and Social Services (Services Provided by Licensed Clinical Social Worker) From Initial Consult to May 2019 by Group**

	Referrals <sup>a</sup>			Visits		
	No. (%)		Difference, % (95% CI)	No. (%)		Difference, % (95% CI)
	Tailored intervention (n = 744)	Education only (n = 692)		Tailored intervention (n = 744)	Education only (n = 692)	
Any behavioral health <sup>b</sup>	135 (18)	74 (11)	7.5 (3.7 to 11.2)	75 (10)	36 (5)	4.9 (2.0 to 7.7)
Depression care management	70 (9)	18 (3)	6.8 (4.3 to 9.4)	24 (3)	1 (<1)	3.1 (1.6 to 4.5)
Psychiatry	29 (4)	23 (3)	0.6 (-1.5 to 2.6)	16 (2)	10 (1)	0.7 (-0.8 to 2.2)
Social services	61 (8)	33 (5)	3.4 (0.8 to 6.1)	44 (6)	27 (4)	2.0 (-0.4 to 4.4)
Behavioral health, external referral <sup>c</sup>	0	13 (2)	-1.9 (-3.0 to -0.7)			

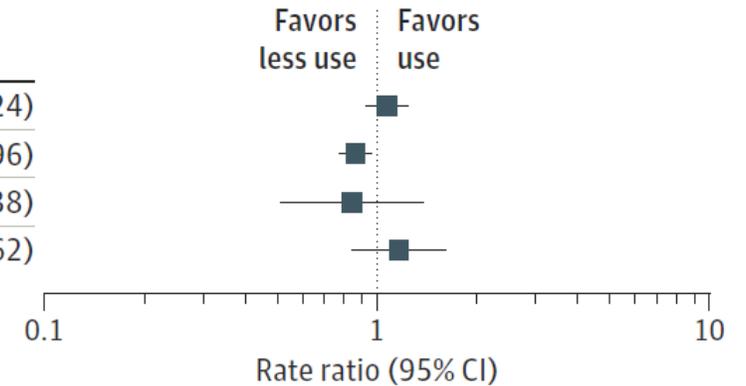
<sup>a</sup> Percent derived from the group total, and row counts are patient level (post hoc analysis).

<sup>b</sup> Patients may have received referrals and visits to more than one behavioral health resource.

<sup>c</sup> External referrals to non-Kaiser Permanente clinicians.

Figure 2. Adjusted Rate Ratios for Outpatient Utilization of Primary Care, Medical Oncology, Urgent Care, and Emergency Department Visits

Type of visit	Tailored intervention group No. of visits/total follow-up year	Education-only group No. of visits/total follow-up years	Difference in mean visits per year (95% CI)	Adjusted rate ratio (95% CI) <sup>a</sup>
Primary care	3750/837.7	3471/781.7	0.036 (-0.17 to 0.24)	1.07 (0.93 to 1.24)
Oncology	7265/837.7	8195/781.7	-1.81 (-2.11 to -1.51)	0.86 (0.77 to 0.96)
Urgent care	642/837.7	738/781.7	-0.18 (-0.27 to -0.09)	0.84 (0.51 to 1.38)
ED total	542/837.7	474/781.7	0.041 (-0.036 to 0.12)	1.16 (0.84 to 1.62)



Visits were compared between intervention and control group, restricted to those with at least 100 days of Kaiser Permanente insurance membership from the date of their cancer diagnosis; models were adjusted for age, race and ethnicity, marital status, Charlson Comorbidity Index score, and cancer stage;

the median follow-up time per patient in the tailored intervention group was 1.14 years (IQR, 0.89-1.39 years) vs 1.12 years (IQR, 0.89-1.40 years) in the education-only control group.

- Tailored Intervention patients did not have increased health care utilization as a result of screening.
- Tailored Intervention patients had a 14% decrease in Oncology visits.

Are there intervention strategies available to help manage depressive symptoms in cancer survivors?

original reports

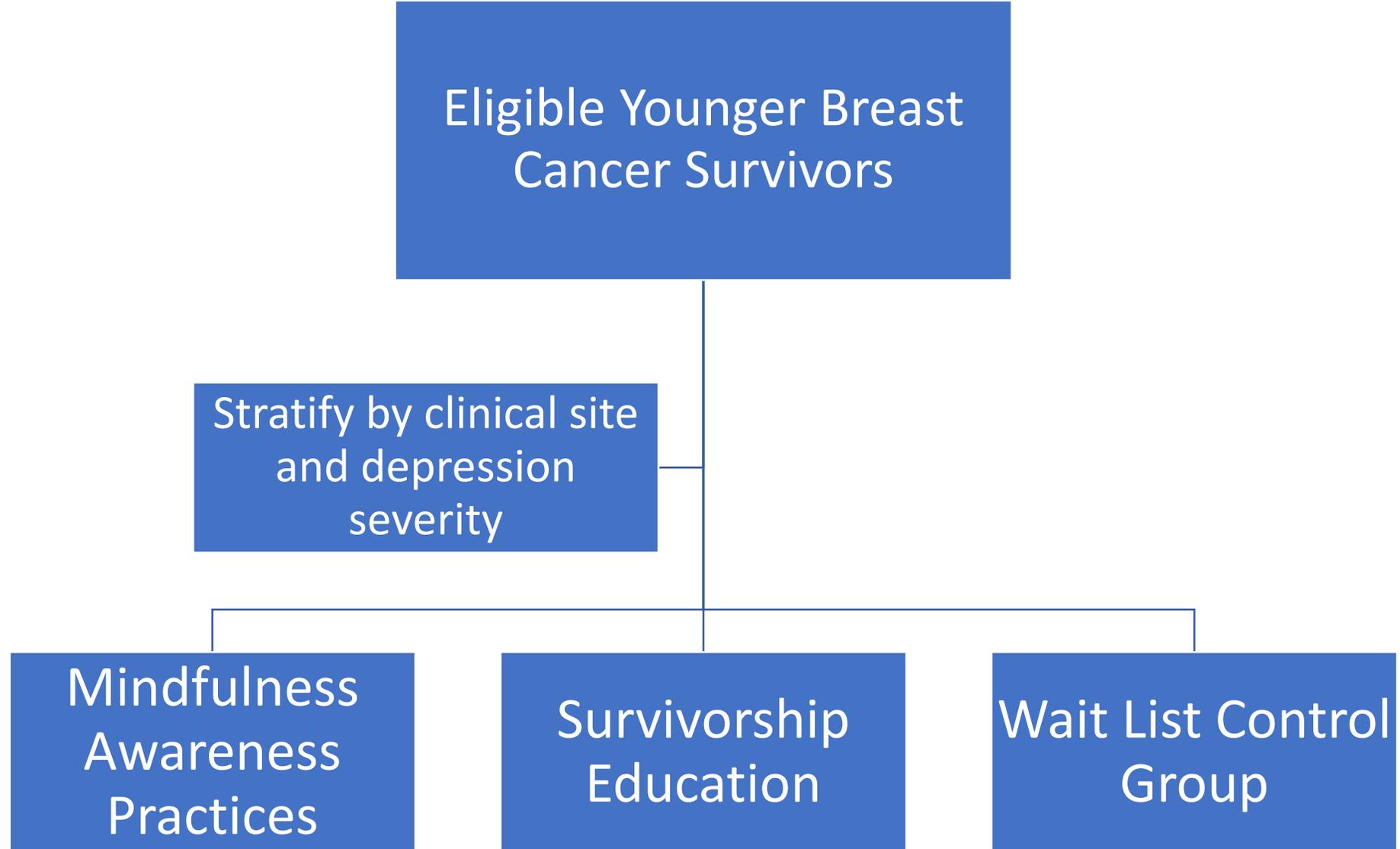
# Targeting Depressive Symptoms in Younger Breast Cancer Survivors: The Pathways to Wellness Randomized Controlled Trial of Mindfulness Meditation and Survivorship Education



Julienne E. Bower, PhD<sup>1,2,3,4</sup>; Ann H. Partridge, MD<sup>5,6,7</sup>; Antonio C. Wolff, MD<sup>8</sup>; Elissa D. Thorner, MHS<sup>8</sup>; Michael R. Irwin, MD<sup>1,2,3,4</sup>; Hadine Joffe, MD<sup>9,10,11</sup>; Laura Petersen, MS<sup>4</sup>; Catherine M. Crespi, PhD<sup>4,12</sup>; and Patricia A. Ganz, MD<sup>4,13,14</sup>

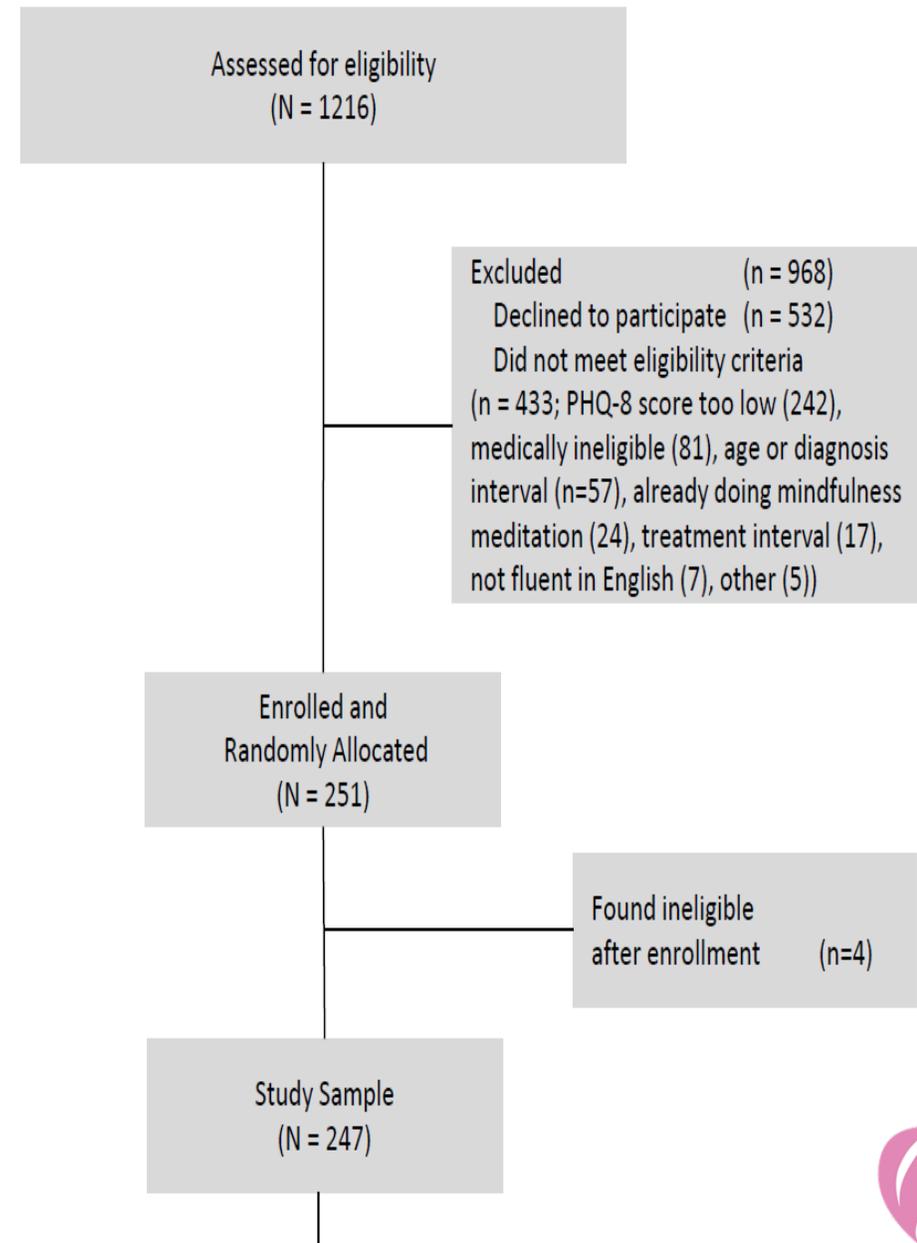
- Phase III, randomized, multi-institution trial testing efficacy of two interventions targeting depressive symptoms in younger breast cancer survivors
- Interventions were compared to a concurrent wait list control (WLC) group
- Interventions were 6-week group programs
  - Mindfulness Awareness Practices (MAPS)
  - Survivorship Education (SE)
- Site instructors delivered 2-hour structured content at each session with monitoring of fidelity

# PTW Study Schema



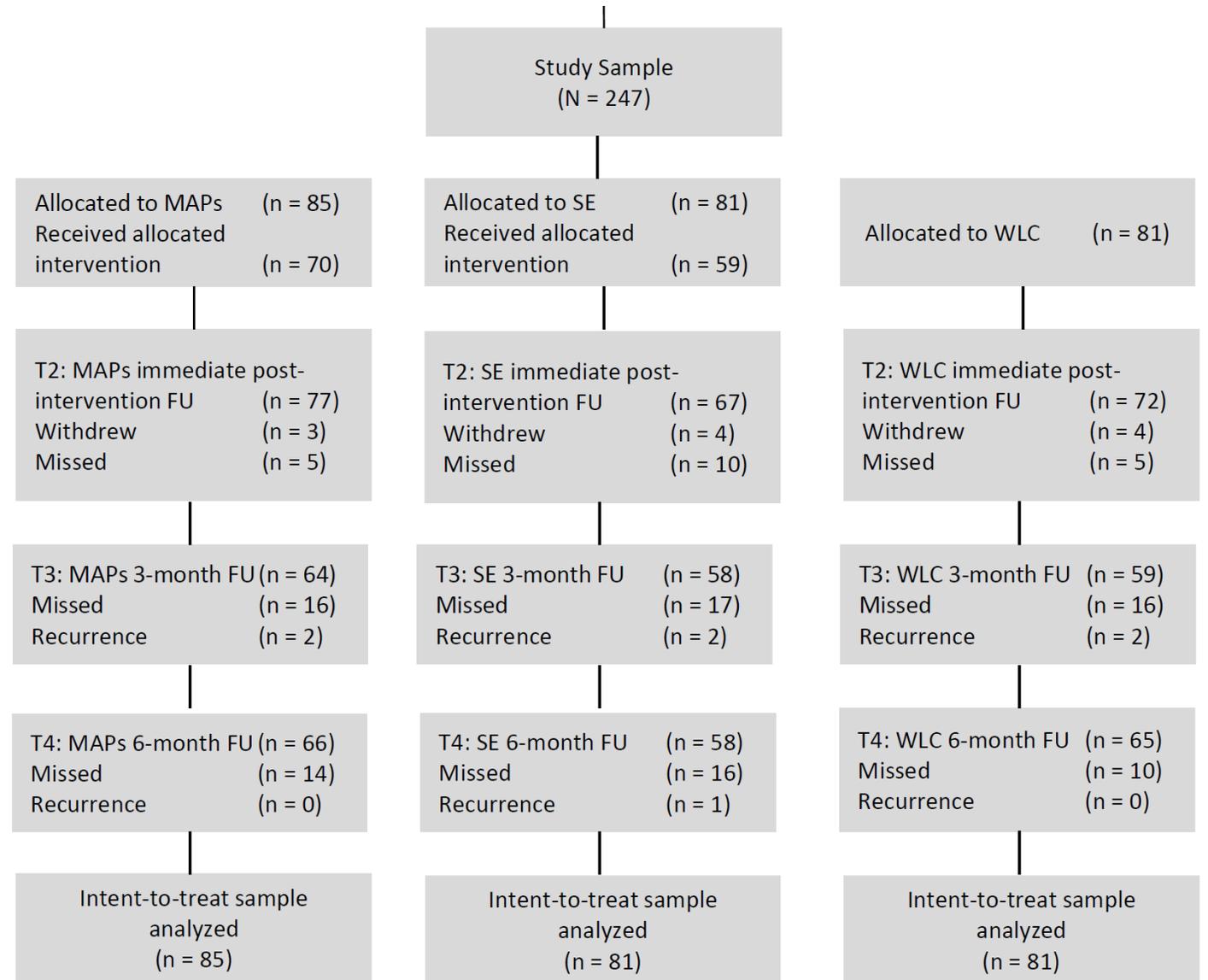
# Eligibility Screening by telephone

- 50 years or younger at diagnosis of stage 0, I, II, III breast cancer
- Between 6 months and 5 years after primary treatment
- No metastatic disease
- Not practicing meditation
- Minimum level of depressive symptoms on PHQ-8
- Willing to be randomized and able to participate in group program for 6 weeks



# Consort Diagram: Allocation of Patients and Sample over Time

- Randomization 1:1:1 with ITT analysis, N=247
- More participants attended MAPS than SE
- T2 data collection completed by 87% -Primary Endpoint
- 18 had cancer recurrence or withdrew
- T4 data collection completed by 83% of those eligible



# Demographic Characteristics

	MAPS n=85	Survivor Ed n=81	Wait List Control n=81	Total Sample n=247	p-value
Age, mean yrs (SD)	44.5 (7.7)	45.8 (5.6)	45.9 (5.6)	45.4 (6.4)	.30
Race,* n (%)	....	....	.....	....	.....
<i>White (incl Hisp)</i>	75 (88%)	58 (73%)	68 (82%)	201 (82%)	.02
<i>Non-White</i>	10 (12%)	22 (27%)	12 (18%)	44 (18%)	
Marital Status, n (%)	.....	.....	.....	.....	.....
<i>Married/partnered</i>	58 (68%)	41 (51%)	61 (75%)	160 (75%)	.003
<i>Not partnered</i>	27 (32%)	40 (49%)	20 (25%)	87 (25%)	
Employment, n (%)	.....	.....	.....	.....	.....
<i>Full-time</i>	54 (64%)	60 (74%)	54 (67%)	168 (68%)	.65
<i>Part-time</i>	14 (16%)	10 (12%)	11 (14%)	35 (14%)	
<i>Not employed</i>	17 (20%)	11 (14%)	16 (20%)	44 (18)	

\* Missing data n=2

# Clinical Characteristics

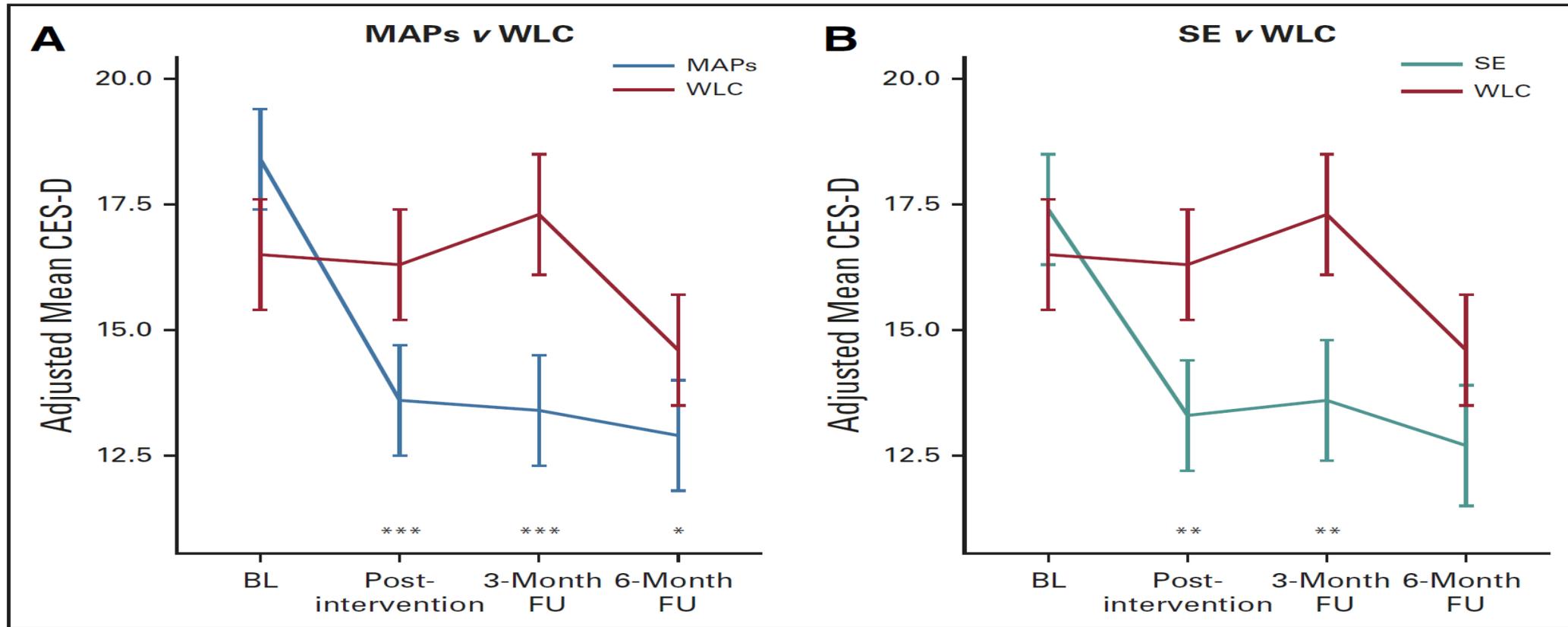
	MAPS n=85	Survivor Ed n=81	Wait List Control n=81	Total Sample n=247	p-value
Years since DX Mean (SD)	2.6 (1.1)	2.4 (1.0)	2.7 (1.2)	2.6 (1.1)	.17
Type of Surgery, n (%)	....	.....	.....	.....	....
<i>Lumpectomy</i>	38 (33%)	40 (49%)	31 (38%)	99 (40%)	.21
<i>Mastectomy</i>	52 (61%)	38 (47%)	48 (59%)	138 (56%)	
<i>No surgery</i>	5 (6%)	3 (4%)	2 (2%)	10 (4%)	
Had Chemotherapy	61 (72%)	46 (57%)	46 (57%)	153 (62%)	.07
Had Radiation Therapy	57 (67%)	(52 (64%)	53 (65%)	162 (66%)	.93
Current Endocrine Therapy	54 (64%)	53 (65%)	55 (68%)	162 (66%)	.93

# Hypothesis: Both MAPS and SE will significantly reduce depression and other symptoms compared to the WLC

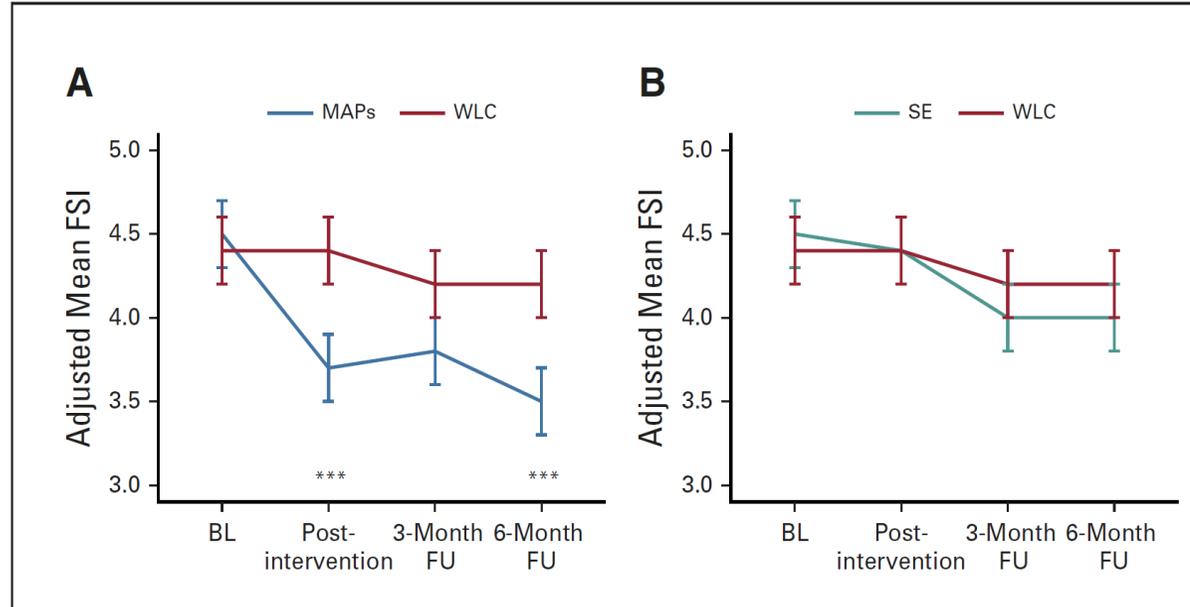
- Primary Endpoint: depressive symptoms as measured by the CES-D score at post-intervention (T2)
- Secondary Endpoints:
  - CES-D score at 6 months post-intervention (T4)
  - Other behavioral symptoms at T2 and T4
- All analyses controlled for study site, marital status, race. Data shown are adjusted means for symptoms by group and time. A CES-D score of 16 or greater indicates moderately severe depressive symptoms.



# Primary Outcome: Change in Depressive Symptoms from Baseline to Post-Intervention

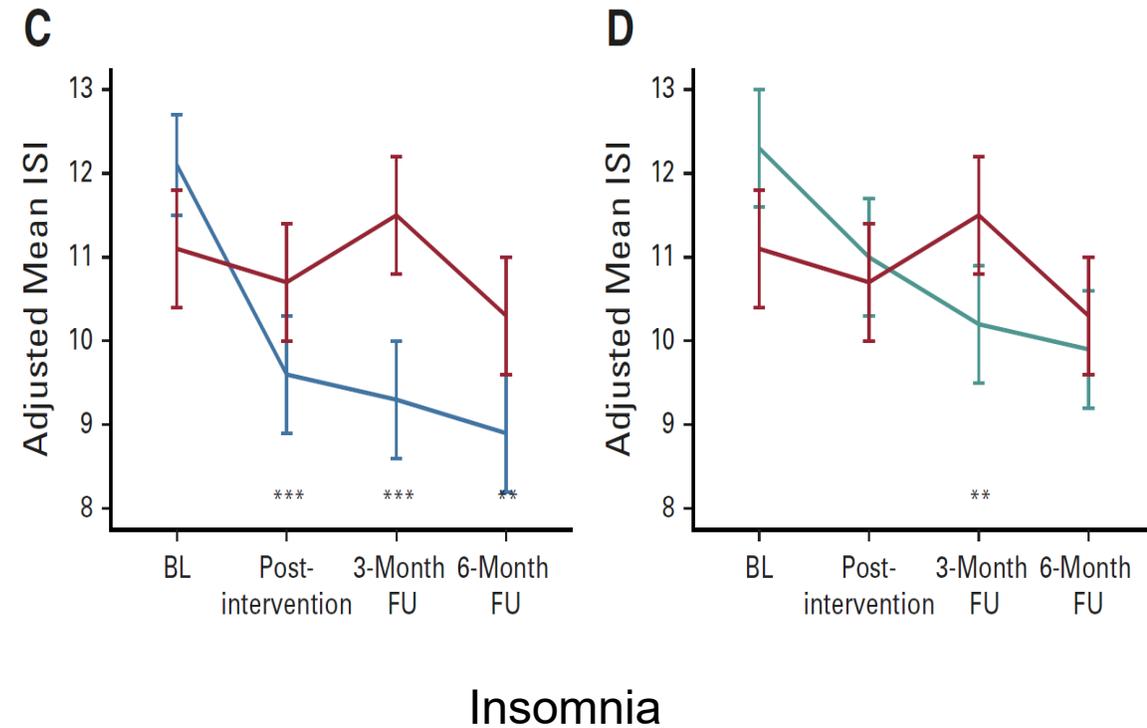
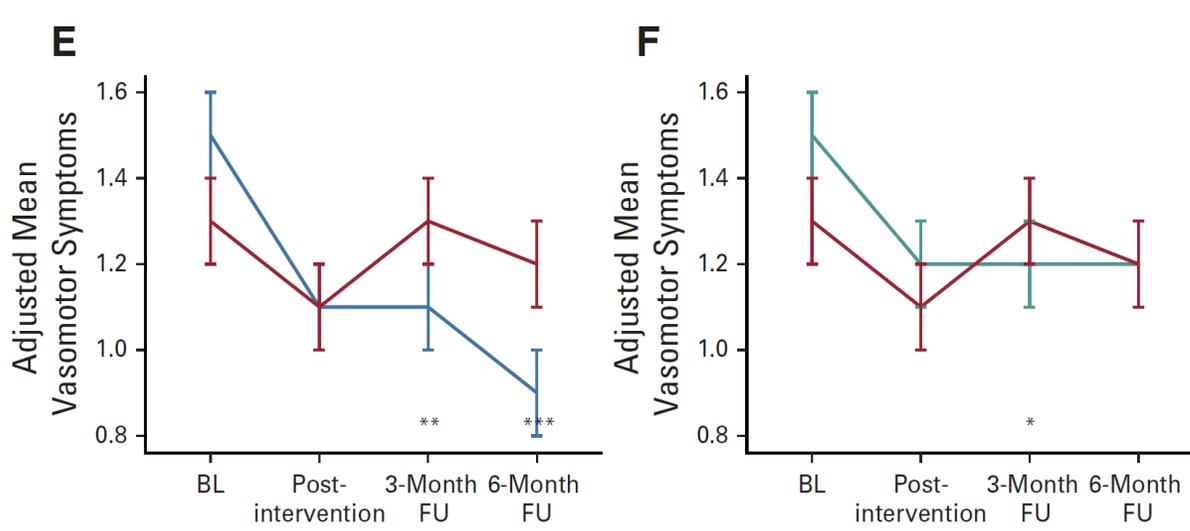


# Fatigue



# Secondary Outcomes: Greater benefit with MAPS

## Vasomotor Symptoms



## Insomnia

\*P < .027; \*\*P < .01; \*\*\*P < .001

# Summary

- Both interventions significantly reduced depressive symptoms in the immediate post-treatment period compared to control
- MAPs participants had sustained significant reduction in depressive symptoms 6 months after intervention
- MAPs participants had improvements in fatigue severity, sleep disturbance, and vasomotor symptoms that persisted at 6-month follow-up



# Key Takeaway Messages

- PTW participants had high levels of depressive symptoms **an average of 2.6 years after diagnosis**
- Both interventions significantly reduced depressive symptoms, with additional symptom reduction benefit in MAPS group
- Both interventions were standardized and successfully delivered at 3 clinical sites by community-based instructors
- **There are many other evidence-based psychosocial interventions that can be deployed to address depressive symptoms in cancer survivors—we must find a way to end the suffering!**



What are the **opportunities** and **challenges** today in implementing the recommendations of the 2008 IOM report?

## Key opportunities in 2023

- There are even more psychosocial resources for cancer patients and survivors today than in 2008
- Many are free or low cost
- The internet and social media expansion in the last decade makes finding these resources even easier
- Some improvements re: mental health parity and collaborative care for behavioral health in primary care
- Expansion of telehealth and teletherapy as a result of the pandemic

# Key challenges in 2023

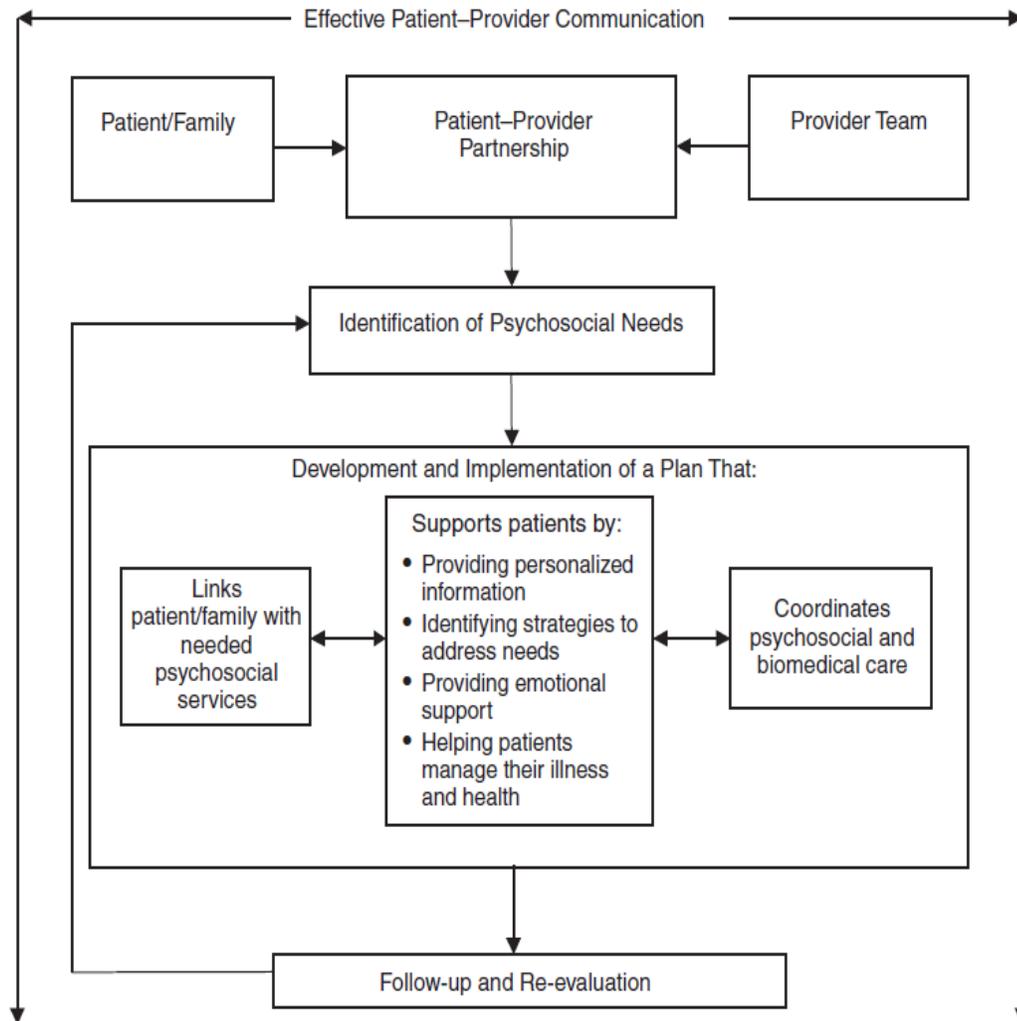


FIGURE S-1 Model for the delivery of psychosocial health services.

- Identification of psychosocial needs is still not performed systematically near time of diagnosis AND rarely in cancer survivors
- Plans are seldom developed and implemented
- Follow-up and re-evaluation is rare

# My dream for cancer survivors....

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns:  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_  
Somewhat difficult \_\_\_\_\_  
Very difficult \_\_\_\_\_  
Extremely difficult \_\_\_\_\_

- **Oncology team administers PHQ-9 at the end of primary treatment**
  - Identifies problems with mood, fatigue, sleep, appetite, cognition; **discusses expected trajectory of recovery from treatment**
  - Referrals made for help managing these symptoms—many exist: yoga, CBT, Tai Chi, mindfulness, exercise
  - Refer to mental health clinician if severely depressed or suicidal
- **Oncology team administers PHQ-9 at 6 month follow-up and then annually**
  - Detect persistent depressive symptoms and other long term problems that have not resolved, such as fatigue, insomnia, cognitive changes, and energy balance issues

## Feasibility....

- Many health systems have the PHQ-9 embedded in their electronic health records, ready to be deployed; available in multiple languages
- Can avoid the 9th question if resources to manage patients with suicidal ideation/plans are not available—but should be important to know!!!
- Screening with only the first 2 items for depression is not enough, because you miss out on the other symptoms frequent in cancer survivors
- For a busy clinician, replaces a longer symptom checklist; face validity and is easy to use

## Making it happen...

- Require reporting of the PHQ-9 score at regular intervals, like Hemoglobin A1C
- Pay for reporting
- Track scores over time as a quality metric
- Support a collaborative care model for behavioral health in oncology, similar to what has occurred in primary care

## Will it ever happen?

- Oncologists are optimists, but I am not sure I would bet on this one.
- I have tried to share what I have learned over a 40+ year career, in hopes that survivors in the future will have their psychosocial needs met as part of routine cancer care.

# Appreciation

- Recent thoughtful conversations with Julia Rowland and Carol Alter
- All of my colleagues and collaborators at UCLA, as well as in the larger cancer survivorship community
- NCI and BCRF for long-term funding of my research program

Arigato

Gracias

Thank  
You

Merci

T.U.

Danke

T.U.

Grazie