

# Practical Model for Psychosocial Care

By Susan S. Hendrick, PhD, and Everardo Cobos, MD

Department of Psychology, Texas Tech University, and Department of Internal Medicine, Texas Tech University School of Medicine, Lubbock, TX

## Abstract

**Purpose:** Patients with cancer and their families need and deserve psychosocial services as part of their health care. It is critical for cancer service providers to find ways to deliver economically feasible psychosocial care.

**Methods:** A small counseling services program was introduced at a regional cancer center affiliated with a medical school and a county hospital in the southwestern United States. Development of the program over a 5-year period was documented.

**Results:** The Institute of Medicine (IOM) recognizes the provision of psychosocial care to patients with cancer as the first of 10 newly developed standards of care. Since 2004, a team of psychology graduate students and their supervisor/professor have provided counseling services to patients and families in a re-

gional, medical school–affiliated cancer center that serves a large catchment area of rural and semi-rural communities. The team began working in the outpatient clinic, infusion area, radiation area, and bone marrow transplantation unit. Additions to the services have included increased coverage of clinics, provision of consultation services to staff, and three Grand Rounds presentations on aspects of patient–health care provider communication. Research has shown that counseling services collocated with medical services are the most used and effective, so a trans-disciplinary approach has been taken throughout. In addition, assessment, intervention, and follow-up as well as effective communication between patients, families, and care providers have characterized the counseling team.

**Conclusion:** With creative partnering, comprehensive cancer care—including psychosocial care—can be delivered effectively and efficiently to patients with cancer and their families.

## Introduction

### Importance and Challenge of Psychosocial Care

The importance of psychosocial care for patients with cancer—and to some extent their families—has recently emerged as a prime item on the agenda of the Institute of Medicine (IOM), signaled by the report *Cancer Care for the Whole Patient: Meeting Psychosocial Needs*.<sup>1</sup> This report defines and details a standard of care or best practice for delivering psychosocial care for all cancer care providers. Psychosocial care and psychosocial health services involve intervention and/or treatment for many factors, ranging from depression to transportation, that can influence whether and how a patient accesses and optimally uses all biomedical resources available. The detailed report contains 10 substantive standards or recommendations, each one complex. However, the first standard is the subject of the current article. This standard states:

“All cancer care should ensure the provision of appropriate psychosocial health services by:

- Facilitating effective communication between patients and care providers
- Identifying each patient’s psychosocial health needs
- Designing and implementing a plan that: links the patient with needed psychosocial services  
coordinates biomedical and psychosocial care  
engages and supports patients in managing their illness and health
- Systematically following up on, re-evaluating and adjusting plans”<sup>1</sup>

Although the thoughtful writers of the IOM report<sup>1</sup> understand that delivery of appropriate and adequate psychosocial services is a process rather than an event, the sheer breadth of the

report can overwhelm the individual cancer treatment provider or cancer center trying to best serve patients. The report offers examples of psychosocial service delivery in a range of clinical settings. These include highly funded and staffed university-based programs as well as small centers in modestly sized communities that may employ one or two oncologists who are supported by a hospital-based team of social workers, oncology nurses, and physical therapists. The team delivers a variety of services, referring patients to community providers as needed. Still other programs serve patients in remote sites through telephone hotlines or Internet information sites and support groups. Although referring patients to community resources and, more recently, Internet or telephone resources are appropriate and often effective strategies, there is also a great deal of slippage between giving patients the referrals and having the patients actually follow up on those referrals. As oncologist John Silver noted in a recent *Journal of Oncology Practice* commentary<sup>2</sup> on the IOM report, despite the wealth of suggestions and models in the report, each oncologist, group practice, or medical center must find its own particular way of providing services. “Screening for social and psychological issues, adapting local algorithms for the continuum of care, finding appropriate local services and professionals for referrals, and funding care and ancillary staff—all are huge problems that need to be addressed locally.”

## Approach

### Partnering in a Novel Way to Deliver Care

We describe here one local approach—a practical partnering model for delivering many of the services articulated in the first standard of the IOM report.<sup>1</sup> The Southwest Cancer Treatment and Research Center (SCTRC) is an oncology and hema-

tology treatment center located in Lubbock, Texas. The SCTRC is administered jointly by University Medical Center, a county and university teaching hospital, and the Texas Tech University School of Medicine (part of the Texas Tech University Health Sciences Center). The SCTRC had more than 19,000 patient visits in 2007 and even more in 2008.

A variety of types of adult and pediatric cancers are treated at the SCTRC, with chemotherapy and radiation therapy, patient education, research and clinical trials, and social and financial services provided as needed. The SCTRC is accredited by the American College of Surgeons; is a member of the Southwest Oncology Group, Children's Oncology Group, Gynecologic Oncology Group, and Cancer Trials Support Unit; and participates in numerous clinical trials as well as in National Surgical Adjuvant Breast and Bowel Project prevention trials. It also administers an adult bone marrow transplantation (BMT) unit.

The SCTRC had previously made periodic but inconsistent psychosocial services available to patients and families, but that changed in summer 2004 with a new and innovative partnering arrangement with the Department of Psychology of Texas Tech University. Initially funded by a federal grant, advanced doctoral students in clinical and counseling psychology supervised by a psychology faculty member began providing services at the SCTRC. Identified as the counseling team and composed of just a couple of students and the second author, the counselors initially worked largely in the infusion area, shadowed physicians during clinics, and attended selected rounds. To maintain continuity of services even after the eventual ending of the grant, negotiations began to create a University Medical Center–funded graduate student position for 10 hours per week, to be matched by a practicum student in psychology, who would work unfunded for the same amount of time weekly. Whether called matching or partnering, this system has grown and prospered. The grant ended in early 2007, but the SCTRC now has three funded graduate student positions. Although the paid positions are now simply absorbed by the SCTRC as part of its mission to serve the whole patient, if in the future a supervisor could be present in the SCTRC full time, or close to full time, most clinical services provided by the counseling team would be billable under current procedural terminology codes. Typically, three to four additional graduate students participate in unpaid practicum experiences at the SCTRC at any given time. It is considered a desirable practicum site because of the range and depth of clinical involvement.

As noted elsewhere, “counselors are...useful on site in real time where they can be seen as a natural part of the treatment team. Being part of the team during clinic visits legitimizes the role of the counselor. When the counselor or psychologist is off site and patients get referred to them, there is less likelihood the patient will follow-up. When the counselor is right there in the exam room or chemo area, the patient is more likely to open up about feelings, fears, and so on.”<sup>3</sup>

### Counseling Team and the IOM Standard

In a number of ways, the work of the counseling team matches the properties of the first standard in the IOM report.<sup>1</sup> The

growth of the team is reflected not just in numbers but also by services offered. In addition to informal assessment of anxiety and depression during clinic visits and formal psychosocial assessments of all pre-BMT patients, the team provides on-site supportive and psycho-educational counseling to outpatients and family members during medical clinics, in the chemotherapy infusion area (using individual treatment rooms in particularly sensitive situations), and in the radiation area. Similar services, often with more in-depth counseling, are provided to inpatients in the BMT unit and hospitalized oncology patients. Patients and family members can also make appointments for more traditional counseling sessions, which are offered on a short-term basis (eg, two to eight sessions) and take place in the counselors' office. Referral lists for specialized services, such as help for addiction, and for services in the regional area are provided.

Counselors serve as both observers and translators, sometimes intervening to help the patient and physician communicate more effectively. The physician is focused on the medical aspects of the patient, whereas the counselor observes physician-patient interaction, particularly noting the patient's body language for indications of anxiety or confusion. “The counselor can then help the physician be attuned to the reactions, essentially serving as the physician's ‘seventh sense.’”<sup>3</sup> That said, it is also important that the counselor understand the medical situation and roadmap for treatment developed by the team.

The activities outlined relate directly to the mandate of facilitating communication, identifying patient needs, and helping patients and provider teams meet those needs and best manage patient illness in the first standard of the IOM report.<sup>1</sup> Coordinating patient psychosocial and biomedical care comes largely from working with the direct treatment team, including the patient educator (a nurse) and patient navigator (a social worker). Teamwork is never more evident than in the weekly interdisciplinary oncology conference, during which medical and surgical specialists and other professionals discuss particularly complex cases in an open group format. Medical oncology, radiology, and pathology departments present the cases, and opinions and suggestions are then sought from this high-powered group. A counselor is always present. The meeting is essentially a second opinion in exponential terms.

One of the growth areas for the team has been in performing follow-up and helping patients adjust and readjust their treatment, recovery, and survivorship. Weekly group supervision and intragroup communication help the team maintain continuity with patients. In addition, the SCTRC has implemented a survivor follow-up appointment for each patient 1 month after completing active treatment, with a special emphasis on psychosocial assessment. A palliative care program has also been initiated. The counseling team has presented several grand rounds on patient-provider communication, and research on patient satisfaction is under way.

### Discussion

We believe that our partnering model goes a long way toward meeting the first IOM psychosocial standard of care,<sup>1</sup> and the

program has been viewed positively in American College of Surgeons reaccreditation. Although we are constantly growing and changing, we realize how much work remains. Two unanticipated benefits of the partnering model deserve mention. First, the team is perceived as a support to the health care team itself as well as to patients and families. Such support occurs in many forms, and this sentiment has been expressed by physicians, physician assistants, nurses, and other providers. Second, the support goes both ways. The SCTRC has become a rich source of training and validation for all counselors who have worked there. Several counselors have sought health psychology (including oncology) internships, postdoctoral positions, and permanent positions in health care settings.

This win-win partnering model is one that could be implemented in a variety of settings, virtually anywhere oncology services coexist with a local college or university that has stu-

dents and faculty in appropriate specialty areas (eg, psychology and social work) and who are interesting in psychosocial oncology. The model is here, and the future is open.

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**Authors' Disclosures of Potential Conflicts of Interest**

*The authors indicated no potential conflicts of interest.*

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*Corresponding author: Susan S. Hendrick, PhD, Department of Psychology, Texas Tech University, Lubbock, TX 79409; e-mail: s.hendrick@ttu.edu.*

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