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QUALITY IMPROVEMENT

Distress Screening in a Cancer Survivorship Clinic: Impact on Psychosocial Referrals

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Abstract

Head and neck cancer is a life-changing experience. Treatment can be single-modality or multimodality therapy, including surgery, radiation, chemotherapy, or clinical trials. All cancer survivors experience distress, but head and neck cancer survivors are more likely to experience it due to the bodily functions affected by this disease. Distress screening is now a part of routine cancer care at diagnosis, treatment, and pivotal times of the journey. However, in a survivorship clinic in this study, a distress screening tool was not implemented at routine follow-up appointments after completing treatment. Head and neck cancer survivors were followed for cancer surveillance by specialists or primary care providers on a 6- to 12-month basis, where patients could routinely self-report any distress. The purpose of this quality improvement (QI) project was to determine how the use of a distress screening tool over a 12-week period affected referrals for psychosocial needs among head and neck cancer patients who were 2 or more years post-treatment. The sample consisted of head and neck cancer survivors in a survivorship clinic (n = 260). This study found that using the NCCN Distress Thermometer (DT) screening tool to measure distress in survivorship patients significantly (p = .0001) increased the number of referrals for psychosocial needs, with 0 referrals made pre-intervention compared with 12 referrals made post-intervention. Screening for psychosocial distress using the DT screening tool was effective in identifying head and neck cancer survivors in this clinic who were candidates for a referral to address psychosocial needs.

Head and neck cancer (HNC) will affect approximately 60,480 people in the United States in 2026 (American Cancer Society, 2026). This cancer is three times more common in men than women and has been steadily increasing in frequency (American Cancer Society, 2026). Sixty percent of HNC patients are over 60 years old, 70% are over 65 years old, and 50% are over 70 years old (Kouka et al., 2023). Head and neck cancer can affect the oral cavity, oropharynx, nasal cavity, nasopharynx, sinus cavities, hypopharynx, larynx, salivary glands, or thyroid.

The National Comprehensive Cancer Network (NCCN) guidelines recommend the treatment of HNC based on location and histology. The most common HNC is squamous cell carcinoma, which can be metastatic. Treatment of HNC can be single-modality or multimodality therapy, including surgery, radiation, chemotherapy, or clinical trials. The 5-year survival rate for HNC is 70% (National Cancer Institute, 2026). In 1986, the National Coalition for Cancer Survivorship (now renamed Cancer Nation) established an organization to change the cancer experience. The goal was to have those dealing with a cancer diagnosis and treatment be referred to as cancer survivors, rather than cancer victims, to increase cancer awareness and the challenges faced by these individuals.

The life-changing event of cancer does not end when treatment is completed. The post-treatment experience and side effects are lifelong. Some of the side effects head and neck survivors experience include cognitive changes, dysphagia, aspiration, stricture, xerostomia, altered or loss of taste, speech disturbance, fatigue, shoulder dysfunction, muscle spasms, neuropathies, trismus, gastroesophageal reflux, lymphedema, hearing loss, dental decay, hypothyroidism, osteoradionecrosis, altered body image, depression, and anxiety depending on the treatment, primary site, and possible metastasis. In 2006, the National Research Council published a report, "From Cancer Patient to Cancer Survivor: Lost in Transition," which recommended addressing three trends for adult cancer survivors who often experience long-term and late treatment effects. These trends for survivors focused on cancer as a chronic condition, survivors living longer due to screening, diagnosis, and effective treatments, and the need for complex and patient-centered care (National Research Council, 2006). This report established that essential components of survivorship care should include prevention, surveillance, intervention, and coordination (National Research Council, 2006).

BACKGROUND

In 1997, the NCCN developed a task force to address distress because of increasing numbers of cancer survivors with long-term treatment side effects. The NCCN panel defined distress as "a multifactorial unpleasant experience of a psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and physical nature that may interfere with the ability to cope effectively with cancer, its feeling of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis" (Riba et al., 2019, p. 1,230). Distress can occur during a survivor's journey and is considered the sixth vital sign in oncology (Ownby, 2019).

In 2016, the American Cancer Society (ACS) created a guideline for HNC survivorship care. The guidelines were intended for cancer surveillance providers, including primary care clinicians, otolaryngologists, oncologists, speech therapists, physical therapists, dietitians, mental health providers, and dentists. The guidelines focused on five areas: (1) surveillance for HNC recurrence, (2) screening for second primary cancers, (3) assessment and management of physical and psychosocial long-term and late effects of HNC and treatment, (4) health promotion, and (5) care coordination and practical implications (Cohen et al., 2016). The guideline promoted multidisciplinary care for survivors. The survivorship care plan (SCP) is a document that contains the diagnosis, treatment received, recommended cancer screenings, health promotional activities, and cancer resources. After the survivor completes treatment, the SCP is provided to them and their care team members to guide surveillance follow-up. Survivorship begins at the time of cancer diagnosis and continues until the end of life (Goyal et al., 2022).

The treatment of HNC can have a significant impact on survivors and their psychosocial

function because of the post-treatment visibility and physical impairments from this cancer. The American Head and Neck Society (AHNS) notes that this visible disfigurement and concern for recurrence can increase psychosocial morbidity in the form of body image disturbance, distress, depression, and anxiety (Goyal et al., 2022). The AHNS supports the use of periodic screening for distress and the use of a validated tool for high-risk survivors.

LITERATURE REVIEW

A literature review was conducted using PubMed and CINAHL databases through Northern Michigan University's Lydia Olsen Library. Peer-reviewed articles, research articles published within the last 10 years, and professional guidelines were preferred for this project. Terms used in the database search included: head and neck cancer, survivorship, distress, cancer survivor, post-treatment, anxiety, NCCN, American Cancer Society, MDASI-HN, GAD-7, PHQ-9, and distress thermometer.

Distress Screening

The NCCN recommended distress screening for all cancer patients in 1999 (Ownby, 2019). In 2015, the American College of Surgeons Commission on Cancer (CoC) required all institutions accredited by the CoC to implement distress screening (Lazenby et al., 2015). This mandated that accredited cancer institutions have a psychosocial screening process. In 1999, the NCCN published Clinical Practice Guidelines in Oncology for distress management. The NCCN defined distress and recognized the risk factors that can decrease the likelihood of successful disease treatment. Some of these risk factors include a history of psychiatric disorder, current depression, substance use disorder, cognitive impairment, severe comorbid illness, uncontrolled symptoms, communication barriers, young age, living alone, having young children, and prior trauma or abuse (Riba et al., 2019). The Standards of Care for Distress Management provided a benchmark in oncology care and has guided evaluation and treatment. Distress is experienced by 20% to 52% of all cancer survivors, and HNC survivors are more likely to experience distress because of the bodily functions it affects (Riba et al., 2019).

Dysphagia

Dysphagia is a symptom that can occur related to active HNC or be the result of treatment. Dysphagia is an impairment of the swallowing function and can result in coughing or choking on food or fluids while eating, possibly resulting in aspiration pneumonia. These symptoms can increase distress related to the need to change diet or consider an alternate method of nutrition, cause embarrassment, and lead to weight loss or isolation. Dysphagia in the general population and all oncology patients ranges from 1.7% to 11.3% but is found to be higher in HNC survivors (Eastburn et al., 2022). Eastburn et al. (2022) studied the relationship between dysphagia and distress in HNC survivors. The sample included 228 patients 18 years old and older. Dysphagia was measured using the Eating Assessment Tool (EAT-10). Anxiety was measured with the Generalized Anxiety Disorder-7 (GAD-7). Depression was measured with the Patient Health Questionnaire-8 (PHQ-8). The average time since treatment was completed was 6.28 years. The GAD-7 found increased anxiety in survivors with advanced-stage cancer who were men and had a single marital status. The PHQ-8 found that survivors who were unmarried and had advanced-stage cancer were more likely to have depression. Survivors with surgery alone had the least depressive symptoms. 70% of the survivors in this study were found to have dysphagia. Survivors with mild dysphagia had less anxiety and depression than those with moderate to severe dysphagia. They concluded that HNC survivors who self-reported dysphagia had a higher likelihood of distress.

Body Image

Head and neck cancers are usually visible to others. This can threaten one's internal representation of self from alteration in physical appearance because there is a difference from baseline. It is difficult to conceal from others because humans are attuned to looking at faces and eyes for communication. Head and neck cancer treatment can have long-term effects on breathing, speaking, swallowing, taste, vision, or hearing. Cerea et al. (2022) performed a study to examine the relationship between body image distress and quality of life (QOL) in HNC survivors. Coping strategies, social anxiety, self-esteem, pain control, and intolerance of uncertainty

were some of the psychological variables identified in this study. Body image alteration can affect QOL, and decreased QOL can increase distress. The study had 50 participants, 37 males and 13 females. They were provided surveys to complete before radiation therapy; some were completed at home, and others were completed at the radiation facility. The measurement information collected included sociodemographic information form, personal medical history, Body Image Scale (BIS), Short Form-12 Health Survey Physical Component Score (PCS) and Mental Component Score (MCS), Rosenberg Self-Esteem Scale (RSES), Intolerance of Uncertainty Scale-12 (IUS-12), Social Interaction Anxiety Scale (SIAS), Coping Responses Inventory Adult Form (CRI-Adult), Depression Anxiety Stress Scale-21 (DASS-21), and Brief Pain Inventory (BPI). This study found that body image distress negatively affects PCS, and pain negatively affects mental QOL. Females were found to have more body image distress, social anxiety, general distress, pain, and inability to cope with HNC than males. Males were found to have better mental QOL and self-esteem compared to females. The results of their study indicated that female survivors experience higher body image distress than males.

Psychosocial

The NCCN (2019) defines psychosocial distress as an unpleasant emotional experience of a cognitive, behavioral, emotional, social, or spiritual nature. Ineffective psychosocial experiences may interfere with the ability to cope with cancer, symptoms, and treatment. Brauer et al. (2022) performed a study to evaluate the prevalence of psychosocial distress in routine cancer care. Head and neck cancer patients underwent a psychosocial distress screening protocol at the Head and Neck Cancer Program at the University of California Los Angeles. The screening instrument created for the study consisted of three screening tools: the NCCN Distress Thermometer (DT), a modified problem list from the DT, and the Patient Health Questionnaire-4 (PHQ-4). A total of 298 psychosocial questionnaires were completed. The instrument was administered at patients' first clinic visit. The average DT score was 4.51. The modified problem list had an average of four problems reported, and the top four were related to physical pain, fatigue, and sleep concerns. The PHQ-4 identified 81 positive screenings for anxiety and 39 positives for depression. They found that if the multidisciplinary care team identified physical and psychological problems that cause distress early, intervening on the same day the patient was in the clinic helped address concerns and may have contributed to better outcomes. They concluded that longitudinal assessment of distress in HNC survivors through survivorship would be the next step in cancer care.

Tools for Distress Screening

In 2022, Gascon et al. performed a study to determine the optimal distress screening tool for HNC that would offer the best psychometric properties to survivors and to examine emotional and distress screening related to cancer survival. This study was interested in using longer and more thorough tools than the DT within 3 months of diagnosis. The sample was composed of adults with HNC at Princess Margaret Cancer Center (PM) in Toronto. It was a retrospective observational study that was conducted over 6 years at PM. The study used the Distress Assessment and Response Tool (DART), which is a comprehensive screening tool that included the PHQ-9 for depression, GAD-7 for anxiety, the Edmonton Symptom Assessment System revised (ESAS-r), the MD Anderson Symptom Inventory Head and Neck (MDASI-HN), Eastern Cooperative Oncology Group (ECOG) functional status, the Social Difficulties Inventory (SDI-21), the Informational and Spiritual Problem domain of the Canadian Problem Checklist (CPC), interest in smoking cessation, living situation, psychiatric history, and need for support. These screening tools had a staggered administration within two separate groups from 2010 to 2013 and 2014 to 2016. Anxiety was not related to survival. Survivors who completed the DART had more referrals to psychiatry and psychology visits than those who did not complete the tool; measurements of moderate or severe depressive anxiety were lowest with PHQ-9 and GAD-7. Equivalence was found between the ESAS-r and MDASI-HN for emotional distress. The shorter screens, ESAS-r and MDASI-HN, reduced the screening burden. The MDASI-HN was found to have the highest number of patients with depression at 28.1%, and it was

recommended for assessment of symptoms for HNC survivors. Those who completed the DART assessment had less mortality than those who did not complete the tool, indicating that screening techniques allow for earlier distress identification and intervention. They recommended that all positive screenings be followed up with appropriate psychosocial resources.

The purpose of this quality improvement (QI) project was to determine how the use of a distress screening tool over a 12-week period affected referrals for psychosocial needs among HNC patients who were 2 or more years post-treatment.

METHODS

Intervention

This project was performed in a clinic for HNC survivors. Patients seen in this clinic had a history of HNC treatment at least 2 or more years before this research started. Before conducting this project, no formal tool was used to measure distress in this clinic. Patient-provider interaction during the clinic visits determined the assessment of psychosocial needs. No specific questions related to distress were consistently asked of each patient. A psychosocial assessment was completed within the head and neck survivorship clinic with screening questions, but no specific tool was used to measure distress. This lack of consistent assessment for distress led to further investigation into the need for formal population screening.

At this institution, a DT was used at the time of diagnosis, during treatment, and at other pivotal times. A comparison was made between psychosocial referrals from October through December 2023 and October through December 2024. The tool used for this study was the NCCN DT (Figure 1), the same assessment tool used during diagnosis and treatment. This tool requires patients to self-report using a Likert scale shaped like a thermometer with values from 0 to 10; 0 equals no distress and 10 indicates extreme distress. The instructions define distress and then ask the patient to rate the level of distress they have experienced during the past week, including that day, by filling in the thermometer to a specific level or circling the number. The patient then returns the tool to the provider, who evaluates the self-rating. NCCN recommends referrals for psychosocial needs if the DT has a value of 4 or greater. The DT is a validated NCCN tool with a sensitivity of 81% and specificity of 72% at a cutoff score of 4 (Riba et al., 2019). The DT is translated into many languages and is quick to administer. Typically, the DT is used at diagnosis, pivotal times during treatment, or cancer recurrence. The site of this study was a large, multidisciplinary head and neck clinic with a full-time social worker on staff who was available for survivorship referrals. Therefore, using the DT allowed patients to connect to onsite services.

The Institutional Review Board (IRB) of the health system determined this QI project was not considered human subjects research before it began. From October through December 2024, the medical assistant provided all patients in the survivorship clinic with the DT upon their arrival at their clinic visit when they checked in. They completed a paper copy of the NCCN DT in either the waiting or exam room while waiting for their appointment. It usually took less than 5 minutes to complete the form, and all patients completed it except one with a visual impairment. The medical assistant scanned the result into the patient's electronic medical record and placed the DT outside the door so the advanced practice provider (APP) could review it before the visit began. Upon starting the visit, the DT was reviewed with each patient. The patients were informed that the tool was being trialed for a QI project to determine if a distress assessment tool is beneficial. The score was addressed regardless of the value, and all scores of four or greater were explored further. Patients were referred to the multidisciplinary clinic social worker if they scored four or higher.

Sample and Setting

This QI project was implemented in a multidisciplinary HNC survivorship clinic in the western United States. The sample was comprised of patients who completed HNC treatment 2 or more years from the start of this research. This ambulatory clinic had cancer surveillance conducted by an APP. Survivorship care involves screening for recurrence, monitoring for late treatment effects, risk reduction and early detection, and psychosocial functioning based on the combined use of ACS head and neck survivorship guidelines,

NCCN survivorship guidelines, and MD Anderson Cancer Center (MDACC) head and neck survivorship algorithms. Referrals to social work were previously based on the APP's judgment during the clinical visit. This QI project design was an observational cohort comparing referrals made with and without using a tool to measure distress. The distress assessment tool was administered to head and neck survivorship patients (n = 106) over 12 weeks.

The comparison pre-intervention group used a sample (n = 154) from the same 12 weeks of the prior year. No personal identifying information was collected. Demographic comparisons were performed between the pre-intervention and post-intervention groups for gender, age, cancer type, and years since completing cancer treatment.

Theoretical Framework

Head and neck cancer survivorship care is complex and includes cancer surveillance, monitoring for late treatment effects, risk reduction, early detection, and assessment of psychosocial functioning (MD Anderson Cancer Center, n.d.). This project focused on Nola Pender's Health Promotion Model (HPM) concepts: individual characteristics and experience, behavior-specific cognitions and affect, and behavioral outcomes to guide the care needs of HNC survivors. Tools such as the DT and the use of NCCN (2024a) survivorship assessment guidelines assist health-care providers in identifying patients' needs to promote health.

Every survivor has a unique journey from diagnosis, treatment, and continued monitoring through survivorship. Prior related behavior in

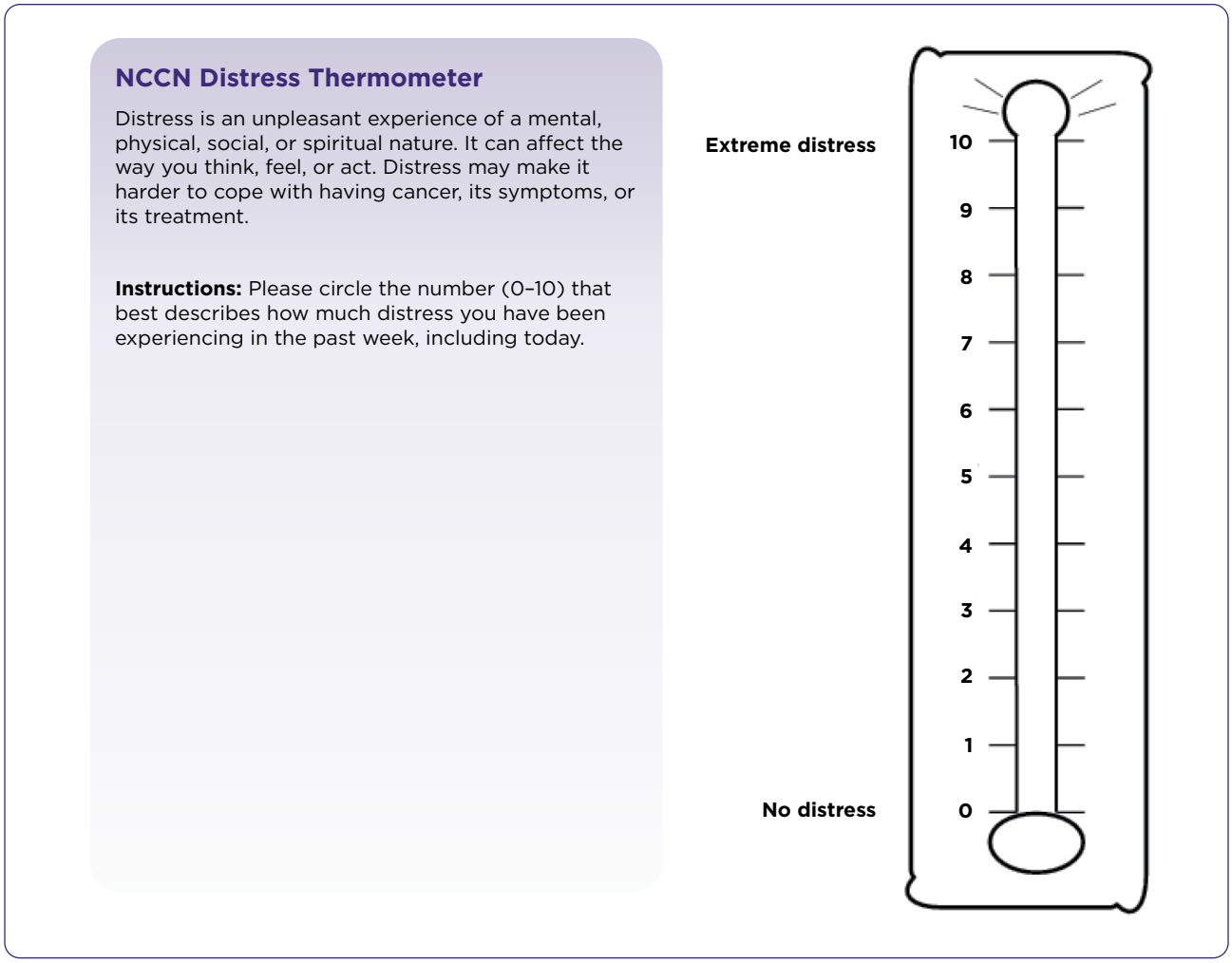

Figure 1. NCCN Distress Thermometer. Adapted from NCCN (2026).

HNC survivors could be underlying addictions and lifestyle choices, which have increased their predisposition for developing HNC. Some of these risk factors may include smoking, drinking alcohol, use of betel nut, poor self-care, and human papillomavirus (HPV) infection. Behavior can contribute to habit formation if it is repetitively used. Prior behavior indirectly influences health-promoting behavior through self-efficacy, benefits, barriers, and activity-related effects (Murdaugh et al., 2019). The health-care team can help intervene by providing education and referrals for survivors related to drug addiction, smoking cessation, alcohol abuse, betel nut education, and HPV vaccination when appropriate. Personal factors can be biological, psychological, and sociocultural, which must be considered to influence a desired target behavior (Murdaugh et al., 2019). Depending on the survivor's need to aid behavioral change, these factors should be considered independent.

RESULTS

Demographic Data

This project included a total of 260 patients, all over 18 years old, composed of males (n = 175, 67.3%) and females (n = 85, 32.7%). No personal identifying data were collected. The patients were HNC survivors who completed single-modality or multimodality therapy at least 2 years before this project. The sample was enrolled from an urban institution in the western United States with a HNC survivorship clinic. For comparison, a retrospective search of patient charts was completed from October through December 2023 to obtain the total number of referrals for psychosocial concerns without using a clinic tool over 12 weeks. The results from October through December 2023 (n = 154) and 2024 (n = 106) were compared to determine if using the DT tool for distress measurement affected the number of referrals for psychosocial needs (Figure 2). Other demographic information collected included age, cancer diagnosis (oral cavity, oropharynx, larynx/hypopharynx, nasopharynx, unknown primary, salivary gland, thyroid, sinus), and years since completing cancer treatment.

Statistical Methods

Fisher's exact test was performed to compare the pre-intervention and post-intervention groups' respective proportions of referrals. The results were

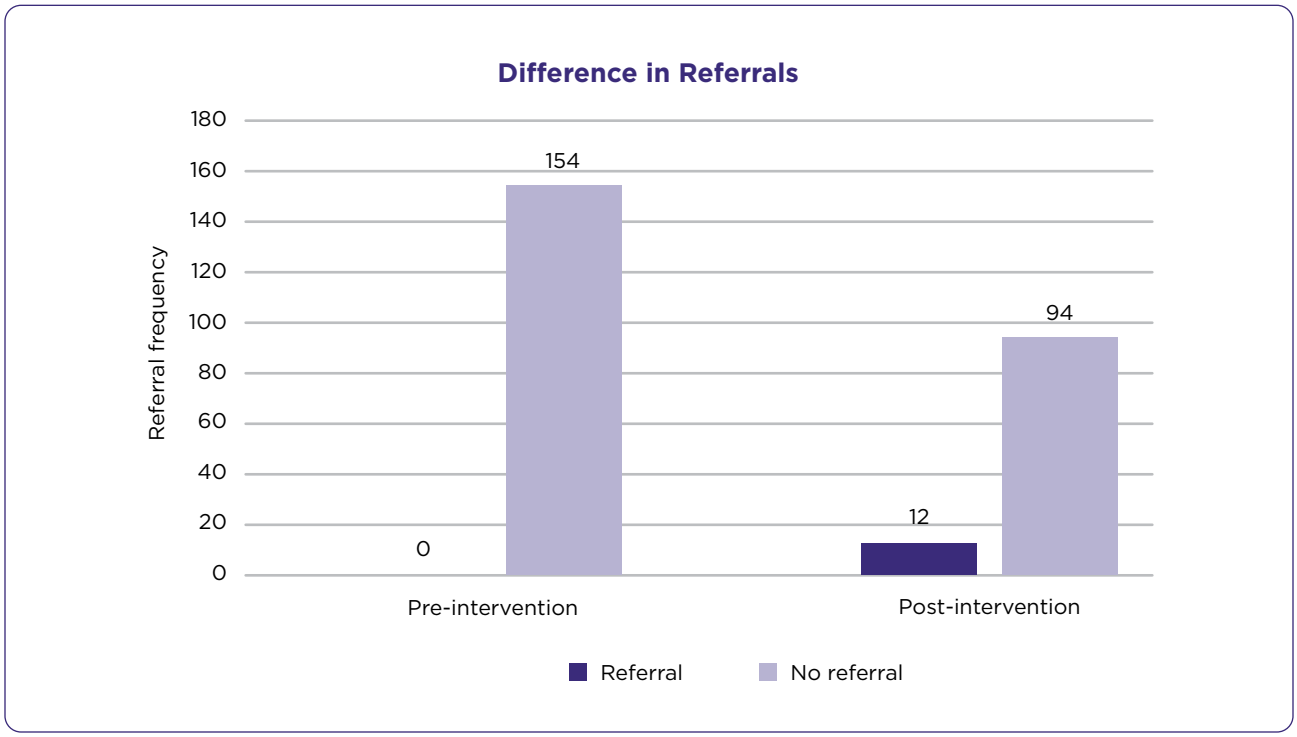

Figure 2. Difference in referrals pre- and post-intervention.

presented as a cross-tabulation table with frequencies and percentages for the 2 × 2 analysis. Statistical significance was assumed at a two-sided alpha value of 0.05, and all analyses were performed using SPSS Version 29 (Armonk, NY: IBM Corp.).

Statistical Results

This QI project determined that using the DT to measure distress in HNC survivors at least 2 years post-treatment resulted in a statistically significant increase in referrals for psychosocial support compared to utilizing no tool.

There was a total of 154 participants in the pre-intervention group and 106 in the post-intervention group. In terms of demographic comparisons between the pre-intervention and post-intervention groups, there were no significant differences for gender, age, cancer type, or years since completing cancer treatment (Table 1).

For the primary outcome, there was a statistically significant increase in the proportion of referrals from pre-intervention (n = 0, 0.0%) to post-intervention (n = 12, 11.3%). The Fisher's exact test indicated an association between tool use and referrals (p = .0001). The analysis results are presented in tabular form in Tables 1 and 2 and graphically in Figure 2.

DISCUSSION

This QI project found that using the DT to screen for distress in survivorship patients resulted in significantly more referrals for psychosocial needs. In this study, survivors scoring a four or higher on the DT were referred to the social worker within the multidisciplinary clinic. The reasons for increased distress were variable and did not always have to do with the survivor's cancer journey but with other distress. Some of the reasons patients scored a four or higher on the DT included fear of recurrence, altered body image, need for medical supplies, pending imaging results, death of a pet, being a caregiver of a drug-abusing sibling, illness of a spouse, holiday stress, political elections, and a neighbor stealing their possessions. Of all the referrals in the post-intervention group, 7 of the 12 deferred referrals. Anecdotally, the reason for the deferral was explored further and evaluated by the provider. Some reasons patients deferred referrals included already having a therapist, having a social worker, having a spouse complete the form, feeling better after the test result was provided, and not feeling they needed it or wanted to meet with a social worker.

The social worker followed up on the five patients agreeable to the referral. The other seven patients who deferred referral were informed to call the clinic anytime and contact the social worker if needed. They were offered handouts if interested or applicable. The handouts were provided from the NCCN books on Survivorship Care for Healthy Living or Survivorship Care for Cancer-Related Late and Long-Term Effects. Some of the handouts provided were on fatigue and healthy sleep habits. There was no relationship between

Table 1. Demographic Comparisons

Variable	Pre-intervention	Post-intervention
Age, mean (SD)	67.18 (11.47)	67.48 (11.70)
Years since cancer treatment completed, mean (SD)	6.12 (4.20)	6.61 (4.05)
Female gender, no. (%)	54 (35.1%)	31 (29.2%)
Type of cancer, no. (%)		
Oral cavity	63 (40.9%)	45 (42.5%)
Oropharynx	32 (20.8%)	23 (21.7%)
Larynx/hypopharynx	26 (16.9%)	14 (13.2%)
Nasopharynx	13 (8.4%)	13 (12.3%)
Unknown primary	1 (0.6%)	1 (0.9%)
Salivary gland	17 (11.0%)	11 (10.4%)
Thyroid	7 (4.5%)	4 (3.8%)
Sinus	2 (1.3%)	2 (1.9%)

Table 2. Cross-Tabulation for Referrals

Group/level	Referral	No referral	*p* value
Pre-intervention	0 (0.0%)	154 (100.0%)	
Post-intervention	12 (11.3%)	94 (88.7%)	.0001

Note. Statistically significant ($p < .05$).

referral and type of cancer, years since treatment, or gender.

Implications for Advanced Practice

The results of this QI project support using a distress screening tool in a survivorship clinic. This tool provided another form of communication between the survivor and the provider, offering an opening to begin a conversation, further evaluation, or intervention.

Strengths and Limitations

Some of the project's strengths were the sample size and data collection being performed at the same time of year in 2023 and 2024, which may have included some of the same patients because the usual follow-up schedule is every 6 to 12 months. Another strength of the study is that the formalized tool provided consistent and objective information collection, giving the patient another form of communication and allowing the provider the opportunity for further assessment. A limitation could be the level 4 cutoff on the DT used in the survivorship population, since this is the same level throughout acute cancer treatment. This cutoff could have contributed to picking up more of everyday life distress rather than cancer-related distress. When the DT was used at a cutoff of 4, it was found to have a negative predictive validity of 77% to 97% and a positive predictive validity of 38% to 71% (Girgis et al., 2018). This 2018 review found that the DT was more likely to exclude distress than to identify it clinically.

Recommendation for Future Projects

Future QI projects could include using a different cutoff level on the DT or administering a tool that is more specific to anxiety and depression, like the GAD-7, PHQ-9, or the MDASI-HN if a level of 4 was found on the DT. Anxiety and depression tend to occur together and have been found to occur more often in long-term cancer survivors up to age 70 than in the general population (Götze et al., 2020). Screening tools such as the GAD-7 or PHQ-9 would be more specific for patients who are suspected of or have a history of anxiety or depression. While this QI project showed the usefulness of a distress screening tool, a tool such as the MDASI-HN, a patient-reported outcome to assess the burden and severity of symptoms in HNC survivors, may help identify the source of distress in this population of cancer survivors (Townes et al., 2020). Additionally, a longitudinal follow-up would be helpful in determining referral outcomes.

CONCLUSION

Head and neck cancer is a particularly distressing cancer due to the disfigurement and ongoing complications of treatment often faced by cancer survivors. As part of the National Research Council (2006) recommendations, health-care providers should provide ongoing support for cancer survivors. Cancer is a life-changing event that does not end when treatment is completed. The post-treatment experience and side effects are lifelong, and health-care providers are responsible for identifying distress and making appropriate referrals effectively. Screening cancer survivors who are 2 years or more past cancer treatment by using the DT proved to be an effective way to identify patients in need of psychosocial referral. The continued assessment of distress as the sixth vital sign is essential to multidisciplinary care for cancer survivors. If distress is identified early, it can improve health-care efficiency, cost savings, and quality of survivorship care for cancer survivors and help meet the National Standards for Cancer Survivorship Care established in 2024.

Dedication

H. S. dedicates this to her family, whose love and support made this project possible, and to the survivors of HNC, whose strength is an inspiration.

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Disclosure

The authors have no conflicts of interest to disclose.

References

American Cancer Society. (2026). Cancer facts and figures. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2026/2026-cancer-facts-and-figures.pdf

Brauer, E. R., Lazaro, S., Williams, C. L., Rapkin, D. A., Madnick, A. B., Dafter, R., Cheng, G., Porter, A., Abemayor, E., Wanxing, C., Morasso, E., Erman, A., Chhetri, D., St. John, M., & Wong, D. J. (2022). Implementing a tailored psychosocial distress screening protocol in a head and neck cancer program. *The Laryngoscope, 132*(8), 1600–1608. https://doi.org/10.1002/lary.30000

Cancer Nation. (n.d.). Our history. https://www.canceradvocacy.org/about/our-history

Cerea, S., Sansoni, M., Scarzello, G., Groff, E., & Ghist, M. (2022). Psychological variables associated with quality of life in patients with head and neck cancer: The role of body image distress. *Supportive Care in Cancer, 30*(9), 9127–9139. https://doi.org/10.1007/s00520-022-07334-6

Cohen, E. E. W., Lamonte, S. J., Erb, N. L., Beckman, K. L., Sadeghi, N., Hutcheson, K. A., Stubblefield, M. D., Abbott, D. M., Fisher, P. S., Stein, K. D., Lyman, G. H., & Pratt-Chapman, M. L. (2016). American Cancer Society head and neck cancer survivorship care guideline. *CA: A Cancer Journal for Clinicians, 66*(3), 203–239. https://doi.org/10.3322/caac.21343

Eastburn, K., Lyu, L., Harrison, C., Atchison, K., Moore, K., Pomfret, S., Johnson, J., & Nilsen, M. L. (2022). Association between patient-reported symptoms of dysphagia and psychological distress in head and neck cancer survivors. *Oncology Nursing Forum, 49*(1), 81–89. https://doi.org/10.1188/22.ONF.81-89

Gascon, B., Panjwani, A. A., Mazzurco, O., & Li, M. (2022). Screening for distress and health outcomes in head and neck cancer. *Current Oncology, 29*(6), 3793–3806. https://doi.org/10.3390/currentoncoll29060304

Girgis, A., Smith, A. B., & Durcinoska, I. (2018). Screening for distress in survivorship. *Current Opinion in Supportive and Palliative Care, 12*(1), 86–91. https://doi.org/10.1097/SPC.0000000000000328

Götze, H., Friedrich, M., Taubenheim, S., Dietz, A., Lordick, F., & Mehnert, A. (2020). Depression and anxiety in long-term survivors 5 and 10 years after cancer diagnosis. *Supportive Care in Cancer, 28*(1), 211–220. https://doi.org/10.1007/s00520-019-04805-1

Goyal, N., Day, A., Epstein, J., Goodman, J., Graboyes, E., Jalisi, S., Kiess, A. P., Ku, J. A., Miller, M. C., Panwar, A., Patel, V. A., Sacco, A., Sandulache, V., Williams, A. M., Deschler, D., Farwell, D. G., Nathan, C. A., Fakhry, C., & Agrawal, N. (2022). Head and neck cancer survivorship consensus statement from the American Head and Neck Society. *Laryngoscope Investigative Otolaryngology, 7*(1), 70–92. https://doi.org/10.1002/lio2.702

Kouka, M., Hermanns, I., Schlattmann, P., & Guntinas-Lichius, O. (2023). The association between patient's age and head and neck cancer treatment decision: Population-based nationwide study in Germany. *Cancers, 15*(6), 1780. https://doi.org/10.3390/cancers15061780

Lazenby, M., Ercolano, E., Grant, M., Holland, J. C., Jacobsen, P. B., & McCorkle, R. (2015). Supporting Commission on Cancer–mandated psychosocial distress screening with implementation strategies. *Journal of Oncology Practice, 11*(3), e413–e420. https://doi.org/10.1200/JOP.2014.002816

MD Anderson Cancer Center. (n.d.). Cancer survivorship algorithms. https://www.mdanderson.org/for-physicians/clinical-tools-resources/clinical-practice-algorithms/survivorship-algorithms.html

Murdaugh, C. L., Parsons, M., & Pender, N. J. (2019). *Health promotion in nursing practice* (8th ed.). Pearson.

National Cancer Institute. (2026). Cancer Stat Facts: Oral Cavity and Pharynx Cancer. https://seer.cancer.gov/statfacts/html/oralcav.html

National Comprehensive Cancer Network. (2020). Survivorship care for cancer-related late and long-term effects (Version 2.2020).

National Comprehensive Cancer Network. (2026). NCCN Guidelines Version 1.2026. Distress Management. https://www.nccn.org/docs/default-source/patient-resources/nccn_distress_thermometer.pdf

National Comprehensive Cancer Network. (2024b). NCCN Clinical Practice Guidelines in Oncology: Head and Neck Cancer. NCCN Evidence Blocks (Version 3.2024). https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1437

National Comprehensive Cancer Network. (2024a). *Survivorship*, Version 2.2024. https://www.nccn.org/professionals/physician_gls/pdf/survivorship.pdf

National Research Council. (2006). *From cancer patient to cancer survivor: Lost in transition*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11468

Ownby, K. K. (2019). Use of the distress thermometer in clinical practice. *Journal of the Advanced Practitioner in Oncology, 10*(2) 175–179. https://doi.org/10.6004/jadpro.2019.10.2.7

Riba, M. B., Donovan, K. A., Andersen, B., Braun, I., Breitbart, W. S., Brewer, B. W., Buchmann, L. O., Clark, M. M., Collins, M., Corbett, C., Fleishman, S., Garcia, S., Greenberg, D. B., Martin, S., McGuffey, L., Mitchell, W., Morrison, L. J., Pailler, M., Palesh, O., Parnes, F., Pazar, J. P., Ralston, L., McMillian, N. R., & Darlow, S. D. (2019). Distress management. *Journal of the National Comprehensive Cancer Network, 17*(2), 1229–1249. https://doi.org/10.6004/jnccn.2019.0048

Townes, T. G., Navuluri, S., Pytynia, K. B., Gunn, G. B., Kamal, M. J., Gilmore, K. R., Chapman, P. H., Bell, K. V., Fournier, D. M., Janik, M. A., Joseph, L. M., Zendehdel, S., Hutcheson, K. A., & Goepfert, R. P. (2020). Assessing patient-reported symptom burden of long-term head and neck cancer survivors at annual surveillance in survivorship clinic. *Head & Neck, 42*(8), 1919–1927. https://doi.org/10.1002/hed.26119