processes with flexible course corrections. Create options to insure screening despite barriers (literacy, language, culture, physical). Engage clinical teams through education and on-site beta testing. Recruit 'borrowed' talent and volunteers to increase capacity and minimize cost. Survey staff and patients to assess go-live experience. Monitor and support after go-live. RESULTS: Small implementation team better operationalized new processes. Embracing critiques and linking DS to meaningful outcomes decreased resistance. Proscribed appointment scheduling and documentation integrated into EMR facilitated implementation. Rapid go-live schedules with real-time course corrections created system-ness, helping clinics cope with burdens of change. Volunteers and 'borrowed' talent inspired clinical teams to do their best. Variations in quality of clinical skills and delivery systems were revealed. CONCLUSIONS: Successful implementation of Distress Screening in a diverse, dispersed Cancer Institute requires highly motivated leadership, persistent attention to detail, team members with a wide skill set, well-defined structure for the entire workflow, and gracious flexibility. Once implemented, Distress Screening provides a foundation for improving whole-patient care.

Research Implications: Further study is needed to determine which variables most contribute to efficient, effective, low cost, inclusive, comprehensive distress screening implementation.

Practice Implications: By following a methodical road map for creating a distress screening program, it is possible to efficiently implement effective, low cost, inclusive, comprehensive screening that facilitates patient care no matter where patients are being treated in a large healthcare system.

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Efficient Differentiation: Detecting the Ones Clinically Distressed and Most in Need for Help with the Distress Thermometer

[1]Bojoura Schouten, [1]Johan Hellings,
[2]Patrick Vankrunkelsven, [3]Elke Van Hoof
[1]*Hasselt University,* [2]*Catholic University Leuven,*
[3]*Free University of Brussels*

BACKGROUND/PURPOSE: In the context of a more efficient organization of cancer care, the question is if we are able to detect patients who desire for help the most when screening for distress as recommended. Distress and needs assessment results were studied to answer this question. METHODS: With a survey containing questions on patient characteristics, the Distress Thermometer (DT) and the Cancer Rehabilitation Evaluation System (CARES) data of 184 adult oncology patients were collected. A cutoff value of 5 was used for the DT. RESULTS: On average, participants were 50.54 years of age ($SD = 7.21$), female (69.20%) and in a relationship (87.20%). The problems and concerns participants experienced mainly were situated in the domain of physical, psychosocial and sexual functioning. Of the CARES problem statements presented to participants (min 93–max 132), on average 44 problems were experienced ($SD = 21.36$). Only for 11.04% of these problems help is desired. Median score on the DT was 4. According to the cutoff 78 participants (45.30%) were indicated to be moderately or highly distressed. These patients experience significantly more problems, a larger severity of problems and more desire for help than patients with low levels of distress (all p between 0.000 and 0.048). CONCLUSIONS: In this study all cancer patients experience problems on several life domains in a greater or lesser degree. However, only for a minority of these problems patients want help. According to the findings in this study the DT is a screening instrument not only able to differentiate between patients with low distress and higher distress, likewise patients experiencing more desire for help can be detected.

Research Implications: Internationally a lot of research is done on the validation of the DT and its cutoff values. This study adds insights about the distinctive ability of the DT, which likewise has the ability to detect patients with more desire for help.

Practice Implications: Since budgets in health care are limited efficiently tailoring of psychosocial care is needed. The DT seems to be a suitable screening instrument for a stepped-care approach, to detect distressed patients most in need for psychosocial care.

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Sources of Support and Posttraumatic Growth in Childhood Cancer Survivors

[1]Marina Grubic, [1]Ana Bogdanic, [1]Suncana Rokvic, [2]Zoran Cipek
[1]*University Hospital Centre Zagreb,* [2]*Firefly, Association for Helping Children and Families Faced with Malignant Diseases*

BACKGROUND/PURPOSE: Posttraumatic growth refers to positive psychological change in person's perspectives, life priorities and interpersonal relationships experienced as a result of the struggle with highly challenging life circumstances. Social support is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network. The main goal of this study is to examine the relationship