psycho-oncology service within a large academic medical center. Questionnaires included the Brief Resilience Scale (BRS), The NCCN Distress Thermometer, and a demographic form. RESULTS: Analysis revealed a significant, negative correlation between perceived resilience and reported distress, $r = -0.40$, $p < 0.01$, and perceived resilience and number of reported problems, $r = -0.33$, $p < 0.01$. CONCLUSIONS: Patients' perceived resilience may serve as a protective factor against distress in physical, practical, and emotional domains.

Research Implications: Future research in this area may assess the impact of psychosocial interventions to foster the development of resilience and measure the effects of improved resilience on psychosocial distress.

Practice Implications: Clinicians may focus on interventions to build resilience with patients reporting heightened distress.

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Translation and Validation of a Quality of Life and Needs Assessment Tool: The Cancer Rehabilitation Evaluation System and Its Short Form

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BACKGROUND/PURPOSE: Patient centeredness is an important aspect of quality care. The use of patient-reported outcome (PRO) tools to stimulate communication and patient involvement is encouraged. The Cancer Rehabilitation Evaluation System (CARES), a quality of life (QOL) and needs assessment tool, was translated and validated for use in the Dutch speaking part of Belgium. Psychometric properties of the full and short versions were examined. METHODS: Data were collected with questions on socio-demographic characteristics, the CARES and six concurrent measures in a first questionnaire. The CARES contains 139 problem statements (min.93-max.132 applicable per person) with a 5-point-Likert scale to obtain a QOL-rating and for each item the question 'Do you want help?' Five summary scores and a CARES Total can be computed. After 2 weeks the CARES was completed a second time. The CARES-Short Form contains 59 items. RESULTS: Data of 176 patients with divers cancer diagnosis were eligible for analysis. For both the long and short version internal consistency ratings of the summary scales and CARES Total were high (0.72–0.96). Test–retest correlations ranged from 0.70 to 0.91. Correlations with concurrent

measures were moderate to high (0.42–0.73). With principal component analysis the original factor solution was approximately replicated. CONCLUSIONS: The Flemish translations of the CARES and the CARES Short Form have excellent psychometric properties. Reliability and validity ratings are in the same range as in the original American instrument.

Research Implications: The CARES is a valuable PRO-tool for research in cancer patient populations, since it gives the opportunity to measure patients well-being in the physical, psychosocial, marital and sexual domains of life and on the topic of medical interaction. This study as well proves the reliability and validity of the instrument.

Practice Implications: If for implementation in clinical practice a shorter instrument is needed, the CARES Short Form is a good alternative for the full version. The psychometric qualities are equally robust.

P2-185

One Single Help Question versus Differentiated Needs Assessment and Their Potential Value for Quality Cancer Care

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BACKGROUND/PURPOSE: To improve quality of cancer care, screening for distress and supportive care needs is recommended. In the clinical field, screening is preferred to be short to be easy implementable in the busy everyday practice. In this study data obtained with 'one single help-question' is compared to the results of more extensive and differentiated needs assessment. METHODS: Three instruments were used to collect data from 176 adult oncology patients: (1) The Distress Thermometer (DT) joint with one single help-question, (2) the Care Needs Questionnaire (CNQ) posing help questions for eight distinguishable domains of life, and the Cancer Rehabilitation Evaluation System (CARES) with a help-question following each individual problem statement. RESULTS: On average, participants were 50.54 years of age ($SD = 7.21$), female (69.20%) and in a relationship (87.20%). On the single help-question 59.10% answered 'no', 31.30% 'maybe' and 7.4% 'yes'. From the 59.10% participants answering 'no', a fairly large group indicates they are in need in the differentiated needs assessment. On the several life domains presented in the CNQ 6.7–26.0% indicates to have care needs to a greater or lesser extent. As well in the needs assessment of the CARES 1–17.5% of them indicates

they would like to get help for specific concerns. CONCLUSIONS: Participants in this study indicating not to be in need for help when answering a single help-question, at the same time mention several care needs when differentiated needs assessment is applied.

Research Implications: In research and in clinical practice, a balancing act takes place in the development and choice of patient-reported outcome tools. For researchers, it is interesting to know that the chosen format of a needs assessment tool can influence the amount of supportive care needs that are revealed.

Practice Implications: Completeness and time investment for patients and staff to work with the instrument both play a major role in needs assessment. Although screening with one single help-question is interesting according to the time-criterion, results of this study seem to indicate that differentiated needs assessment could give more input for the organization of comprehensive quality cancer care.

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The PHQ-9 Scores in an Oncology Population: Why Some Cancer Patients Are Refusing Help

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BACKGROUND/PURPOSE: Taussig Cancer Institute has begun to use the PHQ9 as a distress screening tool in January 2015. After review of research and literature, it was determined that a threshold of 8 or higher would result in the offer of a face to face visit with a Social Worker (SW) with the goal of addressing patient distress. There has been a clear trend in refusals, namely patients who score in the 8 to 12 range on the PHQ9, for help or to see a Social Worker. METHODS: Nurses responsible for closing out the PHQ9 scores were required to page Social Workers, our first responders, with the PHQ9 score and whether the patient was receptive to meeting with a SW. Data were collected from pager over a 3-month period tracking responses to answers for questions numbers 3, 4, 5 and 8 on the PHQ9. Percentages and trends of responses using the PHQ-9 overall scores and questions 3, 4, 5 and 8 were deidentified and entered on an excel spreadsheet. RESULTS: Over 70% of the refusals are in the 8–12 range. We may be capturing more side effect distress in questions 3.4.5.and 8 that are upsetting but not true depression. CONCLUSIONS: Results may help cancer centers refine their use of PHQ-9 and offer some insight into why patients are refusing.

Research Implications: Surveying patients who refuse may help us better understand their reasons.
Practice Implications: May improve the use of the PHQ-9 with cancer patients and better understand common side effects versus true depression.

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Advice about Cancer-related Disclosure from Cancer Survivors in College

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BACKGROUND/PURPOSE: Cancer survivors experience challenges surrounding disclosure of their cancer history. Little guidance exists regarding this important topic; therefore, the purpose of this study was to elicit advice about disclosure from cancer survivors in college. METHODS: Thirteen women and seven men, ranging in age from 18 to 30 years ($M=21$ years) and attending college in the USA, participated in an individual, semi-structured interview conducted via video chat. As part of a larger qualitative study, we asked participants, 'What advice would you give to other young cancer survivors about sharing their cancer history?' RESULTS: Participants' responses fell into three thematic categories: (1) encouraging disclosure of cancer diagnosis and highlighting the benefits of disclosure, (2) offering support to other young cancer survivors, and (3) providing cautionary advice about cancer disclosure and warning about possible unwanted reactions to disclosure. Benefits of cancer disclosure mentioned by participants included connecting with other people and strengthening relationships, acknowledging and taking ownership of one's cancer survivor identity thereby enhancing personal development, contributing to a larger purpose, and making a positive impression. Four types of supportive advice were suggested: (1) finding courage and strength, (2) being comfortable with one's self and being unashamed of one's experience, (3) remaining cognizant that disclosure is one's decision, and (4) dealing with other people's reactions. Finally, participants cautioned against early cancer disclosure to avoid scaring people away. CONCLUSIONS: Cancer disclosure is a personal, highly individualized experience, but these words of wisdom from young survivors may provide useful guidance for other young cancer survivors.