

Assessment of Health Care Professionals' Perspectives on Personalized Psychosocial Support Development in Routine Cancer Care

The article assesses health care professionals' perspectives on personalized psychosocial support (PPS) development in routine cancer care. Using the methodology of an explanatory longitudinal research design, the factors that condition the development of PPS in the organization are identified from a retrospective and prospective point of view. The results of the research support the evidence regarding the implementation of a person-centered approach in different cancer care settings around the globe and identifies the gaps in developing PPS in cancer care that may be applied to PPS development elsewhere in the country.

Keywords: personalization, psychosocial support development, cancer care.

Straipsnyje vertinamas onkologijos srities sveikatos priežiūros specialistų požiūris į personalizuotos psichosocialinės pagalbos (PPS) vystymą kasdienėje praktikoje. Naudojantis aiškinamojo tipo ilgalaikio tyrimo metodologija, retrospektyviniu ir perspektyviniu požiūriais identifikuojami veiksniai, sąlygojantys PPS vystymą organizacijoje. Atlikto empirinio tyrimo rezultatai patvirtina pasaulines į asmenį orientuoto požiūrio prieigos įgyvendinimo tendencijas ir nustato trukdžius, kurie gali būti svarbūs dėl PPS plėtojimo ir kitose srityse bei organizacijose, atsižvelgiant į integruojant PPS į rutininę įstaigų veiklą.

Raktiniai žodžiai: personalizacija, psichosocialinės pagalbos vystymas, onkologinių pacientų sveikatos priežiūra.

Introduction

Relevance of the topic. Modern health-care worldview has significantly moved from a traditional disease-based approach to person-centered care, that is based on Engel's biopsychosocial model (1977) theory which endorses a holistic approach and states that health consists of interacting biological, social and

psychological factors (Frazier, 2020; van Dulmen et al., 2015). The importance of such changes is prioritized for the people that have comorbidities, chronic conditions (Wagner et al., 2021) such as cancer patients. Up to date, the adoption of person-centered care is widely viewed as a vital step in creating high-quality care focused on treating patients as people (Moody et al., 2018).

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Conceptually, person-centered care is a model in which health-care providers are encouraged to partner with patients to co-design and deliver care that provides people with the high-quality care they need and improve health-care system efficiency and effectiveness (Santana et al., 2018, p. 430). One of the basic directions of change when creating a person-centered care model is the integration of psychosocial support that is targeted to complexity of physical, social, emotional, and spiritual needs of the patients and plays an important role in their care (Grassi et al., 2017, Scholl et al., 2014).

However, clinical health care services are not primed to meet psychosocial needs of the patient (Jacobsen, 2017; Patlak et al., 2011) even though the need to do so has been widely agreed. It is still usual practice when health care does 'to' or 'for' people rather than 'with' them, finds it difficult to include people in decisions, and views people's goals only in terms of particular clinical outcomes. Adopting person-centered care as a daily practice requires radical changes not only in service delivery but it also changes the roles of health care professionals and patients too making an important cultural shift in the first place (Coulter and Oldham, 2016; The Health Foundation, 2014). The search for ways how to implement all the changes in health and social care has been called as personalization which primarily started as an independent movement to achieve more choice and control over peoples with disabilities life and has been developed as a *wide-ranging public service reform* in social and health care in UK and many other countries (Carey et

al., 2018, Needham, Glasby, 2014; Pavolini and Ranci, 2008). In addition to this, personalization has been universally recognized as the best approach to meet the need for psychosocial support through a variety of practical tools and decisions (Person Centred Care/Coalition for Collaborative Care/Medical directorate, 2015; Spicker, 2012).

These fundamental changes are highlighted in the global strategy on integrated people-centred health services (World Health Organization, 2015) which is a call for every Western country to make radical changes in the way how health services are funded, managed and delivered. As a result, the search for an effective PPS model that fits the specific health care context is a priority. It should be noted that such transformation requires a radical mental shift as well as fundamental change in traditional healthcare service provision (EVEN et al., 2019, Berntsen et al., 2018). In the absence of a national framework, it is difficult to develop and establish this care as core to the clinical services that are now provided (Neamțiu et al., 2016). To support this development nationally, there is need for organizational level research which identifies the barriers and opportunities to integrate the clinical with psychosocial aspects of cancer care (Berntsen et al., 2018; Brummel et al., 2016).

The research problem: what are the HCP perspectives on PPS development in routine cancer care?

The research object is HCP' perspectives on PPS development.

The research aim is after providing theoretical background on PPS development in cancer care, to present the main

study results on HCP' perspectives on PPS development.

The research methods: scientific literature review, systematisation, generalisation, and comparison in the theoretical part, and explanatory longitudinal qualitative interviews analysis in the empirical part.

Personalization in cancer care

Cancer care is a great challenge for modern healthcare systems because of its complexity. After receiving a cancer diagnosis patient aside from physical health problems such as pain, disfigurement, long term treatment side effects also face with a variety of psychosocial issues including emotional stress, mental disorders, financial hardships and other that emerge throughout cancer journey and afterwards (Veeraiah, Kayser, Sudhakar, 2022; Lewandowska et al., 2020; Sender et al., 2020; Anuk et al., 2019). All the cancer related problems that occur in the patient's mental, physical, social, or spiritual nature is referred as psychosocial needs or psychosocial distress. According to the National Comprehensive Cancer Network (2023), distress may interfere with one's ability to cope effectively with cancer and disease related symptoms during treatment and afterwards. Distress in an individual extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis. As a result, high distress levels in cancer care associates with poorer health outcomes, poorer quality

of life, increased morbidity and mortality, increased health care costs, treatment noncompliance, and longer hospital stays (Cochrane et al., 2022; Carlson et al., 2020; Deshields et al., 2018). Thus, recognizing and reducing distress by developing personalized psychosocial support is an important component of cancer care (Ercolano et al., 2018; Schiel et al., 2014, Jacobsen et al., 2011).

N. E. Adler and A. Page (2008, p. 9) defines psychosocial support as a group of psychological and social services and interventions that aim to empower patients, their families and HCP to improve clinical outcomes and to address the psychosocial aspects of illness and its consequences to improve quality of patient life. The authors also have made a comprehensive overview of theoretical, practical and evidence-based psychosocial interventions and after integrating them, they determined common elements that point to a model for the effective psychosocial support service delivery which are:

- 1) identification of patients' psychosocial health needs and development of care plan;
- 2) linking patients to the services needed;
- 3) support in illness management;
- 4) coordination of psychosocial and biomedical care;
- 5) follow-up (Adler, Page, p. 153).

It should be noted that this study had a huge significance in the field and been developed over years up to date both on theoretical and practical domains. Up to date, delivering psychosocial support requires not only health and social care service integration, but also person-centeredness that aims to provide

patients with choice and control over the way holistic care is planned and delivered and is based on what matters to patients and their individual strengths and needs (Brummel et al., 2016). To deliver personalized care means assessing holistic needs of the patient, making individual care plans and navigating the care and support patient need through health and wellbeing support networks (Macmillan Cancer Support, 2020) which means that external resources and care continuity are important predictors of success in support delivery effectiveness.

Personalized psychosocial support that is targeted to the holistic needs of the patient has been recognized as an integral part of gold standard cancer care (Loscalzo, 2016; Travado et al., 2015). This is endorsed internationally and is evidenced in the literature (Travado et al., 2016; Borrás and Prades, 2014). As part of non-governmental organization activities in the field, most of cancer organizations, societies and accreditation bodies have now formally endorsed screening, monitoring, and treating distress as a fundamental component to high-quality cancer care (Pirl et al., 2020, Fradgley et al., 2019). But it should be highlighted that distress screening itself does not ensure personalized psychosocial support provision and its effectiveness (Mitchell, 2013) as there is a whole package of personalization initiatives that need to be adapted and more research is needed both nationally and locally.

Research methodology

Study design. It is important to note that personalization has always been a bottom-up initiative and through its engagement at a local level its lessons can be shared nationally to inform the future framework (Needham, 2014). By applying longitudinal research design at an organizational level, we can evaluate the success of the measures implemented to enable PPS development. This can also form the basis for continuous quality improvement in cancer care. To identify the processes and analyze causal factors that condition the development of PPS in the organization explanatory qualitative longitudinal research was conducted with a time lag of approximately 1,5 year. Given the need for in-depth knowledge about PPS from the people working in the clinical practice, a qualitative approach was chosen by interviewing the participants.

Data collection and analysis. Data was collected in 12/2017 – 04/2018 and 2020 August by utilizing semi-structured individual interviews. Referring to common components of models for delivering psychosocial health services (Adler, Page, 2008, pp. 155-158) and World health organization framework on integrated, people-centered health services (World Health Organization, 2016) interview questionnaire guidelines have been developed, including 20 questions on psychosocial distress screening and support planning, referring to psychosocial services, patient education and information sharing, attention to patient individual attributes, effectiveness of existing psychosocial support system and future perspectives. Interviews were audio recorded,

transcribed, encrypted and analyzed by using content analysis method. General categories and subcategories were developed. A total of 19 HCP were interviewed, and the average duration of an interview was approximately 20 min.

Procedure and participants. The research was conducted in the Department of Oncology at Klaipeda University Hospital, Lithuania. A non-probability sampling method based on a targeted selection system was used to choose this organization for the research by following criteria:

1. Provision of psychosocial support for cancer patients;
2. Community support infrastructure;
3. Volunteer participation in the study.

We specifically sought individuals experienced in the comprehensive care of cancer patients as the quality of interviewee participating in qualitative research is crucial (Flick, 2008). Participants were selected by using a non-random sampling based on an external criterion. The head of the Cancer Department referred to HCP for the interviews by taking into account their positions, work experience and competencies. Sample size: 9 (in 2017/2018) and 10 (in 2020) participants. In both studies

the same interviewees participated, only 3 HCP were unavailable to participate in the second flow (Table 1).

The sample was made of experienced HCP that provides health care services to cancer patients on a daily basis. A variety of specializations was involved to represent a holistic viewpoint on the research object from the setting. The external and internal validity of the interviews was ensured by limiting the number of interviews per day (maximum 3), avoiding prejudices and evaluations, and encouraging critical thinking. Credibility was ensured by the selection of the experts that have different background.

Research results

Distress screening and support planning

a) Psychosocial distress screening

Table 2 and Figure 1 show the results of the question whether all cancer patients are being screened for psychosocial distress routinely and if there is any systemic distress tool used for it. Importantly, the answers of participants in 2018 and 2020 shared in two campaigns: one group said that HCP do distress

Table 1. Sample size specifications

Profile	2018	2020
Clinical psychologist	1	1
Psychiatrist	1	1
Cancer Nurse	2	2
Medical oncologist	2	3
Radiation oncologist	2	2
Surgical oncologist	1	1
Total (n =)	9	10

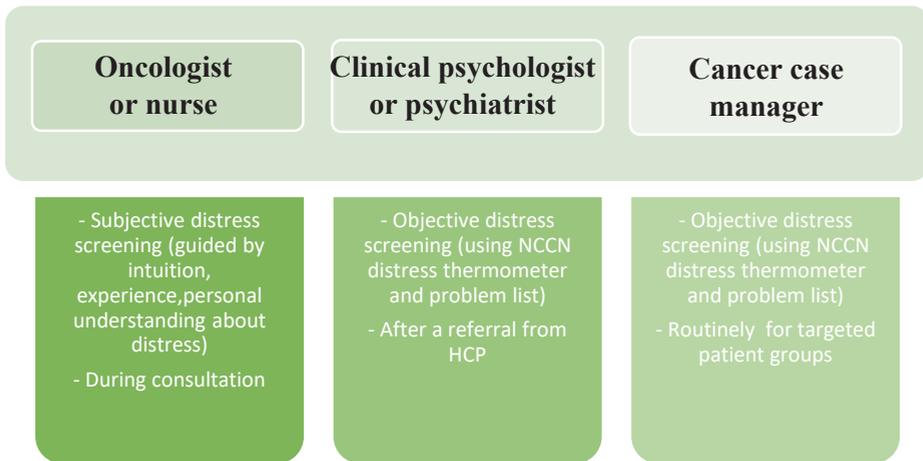


Fig. 1. Distress screening in cancer patients' characteristics

screening for all cancer patients on admission, meanwhile others said that distress is being discussed between the patient and the oncologist or nurse only when some kind of distress symptoms occur in the patient or the patient himself asks for support (Table 2).

When HCP described screening characteristics in routine cancer care, the results showed that in 2018 oncologist or nurse used subjectively assess distress in their patients based on intuition, experience and personal understanding of distress. Confusion, anxiety, listlessness, tearfulness in patients have been identified as major signs for HCP that patients most likely do experience high distress. When observing such symptoms,

patients were referred to clinical psychologist or psychiatrists, depending on patients' case. It should be noted that during the research in 2018, only clinical psychologist and psychiatrist used a distress assessment tool in their practice. Moreover, based on HCP answers, in the first study no standardized routine was established in distress screening, HCP only have expressed their need to have a dedicated professional who would be responsible for psychosocial distress screening in cancer patients routinely. Meanwhile after repeating the study in 2020, a radical shift in the area was recognized as all participants identified routine distress screening application for patients that are referred to Cancer Case

Table 2. Scope of distress screening

Category	Description
For all patients	During admission
For some patients	Patients with distress symptoms
	Patients visiting an oncologist for the first time
	Patients going through "Green corridor" registration system

manager (Figure 1). These patients are the ones who go through “Green corridor” registration system or patients who visit an oncologist for the first time and are referred to Cancer case manager afterwards, which shows that systematic distress screening is applied only for targeted patient groups.

In addition to this, the same as in 2018, oncologist and nurse took a gatekeeper’s role in distress screening and that was especially relevant for those patients that are not being coordinated by cancer case manager. Still, from the participants’ point of view it is important to meet those gaps and have more specialists (for example, nurse, clinical psychologist or oncologist) who would

be trained to objectively assess psychosocial distress in patients routinely.

b) Benefits of using a systematic distress tool

Participants in the study were also asked to express their subjective opinion on how the use of a systematic tool can benefit cancer care experiences (Table 3).

By comparing these results, we may conclude that after having a clinical practice when a standardized distress tool is being used on a wider scale among the patients, HCP are able to list much more benefits related to this tool and that shows their increased knowledge and positive experience in distress screening in organization.

Table 3. Benefits of having a standardized distress screening tool in routine cancer care according to HCP

	2018	2020
TO PATIENT	Targeted and timely support	Reduced sense of chaos
	Increased well-being	Targeted and timely support
		Increased well-being
		Increased knowledge in support available
TO HEALTH CARE PROCESS		Increased sense of security and trust in the organization
	Rational selection system for the support needed	Reduced number of untargeted patients' visits
	Targeted referrals to psychosocial support services	Better adherence to treatment
	Increased productivity of oncologists' consultations	Better cooperation with patient
	Scientific-based activities	Targeted referrals to psychosocial support services
		Valid reflection of patients' issues
TO HCP	Increasing their job satisfaction	Increased productivity of oncologists' consultations

c) Barriers of using a systematic distress tool

Distress assessment integration into routine cancer care usually face with a variety of barriers that more or less impacts the success of desired change. Regarding to this, HCP were asked to share their own insights around the challenges they see in their clinical practice. Based on the answers given in 2018 and 2020, it should be noted that when first the study was conducted in 2018, majority of HCP highlighted the absence of a competent professional responsible for the routine distress screening and the absence of a valid distress assessment tool as the main obstacles. HCP also noted that oncologist have very high workload, low competencies to use any toll and put an accent on that treatment is their priority and professional responsibility. Meanwhile in 2020 the tools integration issues were found to be different, related to the practical organization problems such as lack of professionals that perform screening, unavailability to re-assess distress among the pathway, patient selection and availability for screening as there is only one specialist at the clinic responsible for that. In addition to this, some HCP also mentioned the absence of registration software for distress screening and oncologists' workload which makes it difficult to do the screening routinely.

d) Psychosocial support planning

After distress screening, support planning is the second step to provide tailored care. In regard to this, participants were asked if there is an identified path of referral for patients who had high levels of distress. The results of the study

in 2018 have shown the practice when the oncologist directly used to refer a patient to psychosocial support professionals if needed. Generally clinical psychologist and psychiatrist were professionals to refer to on a first place, less frequently social worker, spiritual counsellor or non-governmental organizations. No individual psychosocial support plans were made initially at that time. In 2020, the results were surprisingly positive as the absolute majority of participants mentioned cancer case manager interventions when each patient's distress was assessed individually with an individual support plan provided to the patient. However, still the practice when oncologist refer patients directly to support services existed for those not having case manager or with high distress levels. One important note that the study showed the increase reference rates to clinical psychologist since cancer case manager recruitment.

e) Benefits of having an identified path of referral for patients with high level of distress

Planning psychosocial support from the participants point of view have many benefits both to the patient and the treatment pathway. In 2018, results stated that having an identified path of referral for patients with high level of distress increase patients' sense of security and awareness of support available, it also improves disease management skills and accessibility to holistic care. For the treatment pathway it is related to well-run processes, clear division of responsibilities, increased productivity of oncologists' consultation, emotional wellbeing and safety for the clinician. The results after repeating the research in 2020

showed only a slight change. Increased clarity and awareness of the support available for the patient, reduced sense of chaos, timely crisis assistance as well as well-run processes, increased quality of the care and productivity of oncologists' consultation were mentioned.

g) Barriers of having an identified path of referral for patients with high level of distress

When discussing the barriers of having an identified path for patients, the psychosocial support stigma was highlighted as well as the absence of professional who would be responsible for distress screening. The lack of favourable infrastructure, leadership and need for scientific research followed by in 2018. Meanwhile in 2020 the problems listed were basically related to the practical issues considering the lack of psychosocial support professionals, weak social worker's and spiritual counsellor's participation, poor support accessibility for remote patients and patients' closeness.

Promoting PPS development

a) Sources of information on psychosocial support

During the interviews, HCP were asked to share about where the patient can get the information on psychosocial support available. In 2018, an oncologist was mentioned as the main source for information whereas patient also can get the information from a nurse or a social worker. After repeating the question in 2020, the information provision was mentioned as a cancer case manager responsibility, meanwhile an oncologist and a nurse were mentioned again. Such

shift shows highly increased accessibility to the information needed for the patient support.

b) Information sharing among HCP

To understand better the depth of PPS development, HCP were asked in what kind of ways and how often do they share the information with their colleagues from a multidisciplinary team around psychosocial distress of an individual patient and the support provided to him. Responses from the research in 2018 showed that usually HCP communicate interpersonally if there is such a need, in some cases notes in medical records can be made or dialogue during team meetings. When the question was repeated in 2020 the same tendencies were identified, only the DT in medical records was excluded as a new way of seeing some personal data around psychosocial distress in 2020. However, the study revealed that discussions around psychosocial issues does not go on a regular basis and is usually initiated if there is something like "a red flag" that needs to pay attention to.

c) Benefits and problematic aspects of information sharing among HCP

In the studies HCP were also asked to share their perspectives on information sharing benefits and problems in promoting this. According to their answers in 2018, when sharing information it helps to improve patient-doctor relationships and increases knowledge among HCP about psychosocial support available, also it may increase effectiveness of the existing psychosocial support system, promote individualized approach. After comparing the results with

the data from 2020 research, the answers stayed the same.

Participants were also encouraged to share their ideas why the information about psychosocial distress, the needs of the patient and support available was not being shared so widely. Responses from the research in 2018 included confidentiality of information, medical treatment culture, lack of time, poor partnership with non-governmental organizations, absence of thematic team meetings as the major barriers. Meanwhile in 2020, HCP in addition to the problem of information confidentiality and the absence of thematic team meetings also mentioned lack of HCP motivation, health and social care fragmentation issue as important disturbances in improving the communication.

d) Patterns and drivers of PSS development

Finally, in the study it was aimed to find out how HCP see cancer pathway in their clinical practice from personalization point of view, what are the challenges and facilitators in terms of psychosocial support for cancer patients. Responses in 2018 and 2020 were different in terms of the progress that has been done in the area. In 2018, availability and timeliness of psychosocial support as well as the continuing development of cooperation in the area of psychosocial support were highlighted. Employees' initiative and shared vision around holistic care and the recruitment of clinical psychologist specifically for cancer patients seemed to be important things to be mentioned as well. In 2020, HCP expressed their strong satisfaction with establishment of cancer case manager

position as he works with the patient in a person-centered approach and takes all unofficial "responsibility" from the oncologists to assess the distress and refer to the support needed. In addition to this, mental shift among clinicians when more and more psychosocial support is taken into account when talking about cancer care was observed.

e) Future directions for improving the existing PPS system

The very last questions for HCP were around their vision how the existing psychosocial care could be improved. Data received in 2018 revealed that participants had a great wish for having a standardized psychosocial care system with such characteristics as: a) an application of a systematic distress assessment tool, b) having a specialist responsible for the distress assessment and coordination of the support, c) having a standardized referral system for the support services, d) having a routine practice to assess the distress in patients before their treatment. Additionally, responses included a wish for greater involvement of social worker, a need for scientific research in the area and specific training and education for the HCP. Meanwhile the insights shared during the research in 2020 were significantly different because of the progress made along the time. The participants mostly talked about improvement of the existing infrastructure by (a) hiring more case managers, (b) increasing the spectrum of support services available, (c) having more informational resources, (c) organizing trainings on distress assessment for nurses and oncologists, (d) developing more intense institutional partnership, (e) participating in

national project for cancer case management application in tertiary level. It can also be noted that more people than in 2018, again mentioned the need for greater involvement of social worker and scientific research conduction as well. When comparing the HCP views on the question it can be assumed that the PPS development tools previously described in the study can be considered successful and effective.

Conclusions

Assessing HCP perspectives and practical insights regarding PPS development has a high value as it opens the realistic view of the situation on organizational level and guide the PPS development path. From the retrospective view, the study shows that oncologist used to play gatekeepers role for psychosocial distress screening in patients when there is not any other responsible professional to refer to. As oncologists have very high clinical workload and are ill-equipped to assess the distress of patients in a person-centered way, being subjective when understanding patient distress and paying more attention for those with expressed distress symptoms used to be a usual clinical practice. In regard to this, from the perspective of HCP, to fill the gap and successfully develop PPS, the path would be first to establish a standardized psychosocial support system in organization. In such system the key element is a cancer case manager who is responsible for (a) assessing distress in patients by using a tool, (b) planning the support individually, (c) referring patients to the support needed. Recruiting cancer case

manager who coordinates the support highly reduce the risk to miss distress through lack of a systematic approach in identifying patient needs by HCP and therefore it increases the chances to do timely intervention and support management. In addition to this, the study shows the other important determinants of success in developing PPS on organizational level which are more related with organizational culture: strong leadership, employees initiative and shared vision around PPS, inter professional collaboration, routine HCP communication about patients psychosocial concerns, educational activities and scientific research that encourages mental shift in HCP awareness of the importance of distress and its management in clinical practice.

However, having a standardized psychosocial support system itself does not ensure comprehensive and effective PPS. HCP emphasised the need to also have adequate organizational capabilities to work in a personalized approach. The study suggested that in order to develop PPS that would be able to address the needs of all patients in need on a routine basis, it is essential to recruit adequate numbers of staff with professional expertise that take an active role in the support promotion and to have as wide spectrum of psychosocial services as possible. Moreover, to address a wide range of psychosocial needs of the patient, community level support inclusion with clear reference pathways should be developed as well. Prospectively, these are the improvements need to be done when developing PPS according to HCP.

The researchers recognize the limitations of the study as it only considered the views of HCP from one institution.

Therefore, it does not provide sufficient evidence for national application. Future research should be directed to a wider contingent working within different

cancer care settings. Also, it would be useful to include patients into the study as they are the best situated to identify the problems that we seek to resolve.

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SVEIKATOS PRIEŽIŪROS SPECIALIŲ POŽIŪRIO VERTINIMAS Į PERSONALIZUOTOS PSYCHOSOCIALINĖS PAGALBOS VYSTYMĄ KASDIENĖJE ONKOLOGINIŲ PACIENTŲ SVEIKATOS PRIEŽIŪROJE

Santrauka

Norint įveikti iššūkius, su kuriais susiduria sveikatos priežiūros sistemos, ir atliepti šiuolaikinius pacientų keliamus reikalavimus, tradicinį, tik į pavienės ligos gydymą orientuotą sveikatos priežiūros modelį keičia į asmenį orientuota prieiga, kurioje į sveikatą žiūrima sujungus psichologinius, socialinius ir biologinius paciento veiksnius. Tokios prieigos taikymas iš esmės reikalauja radikalių ne tik paslaugų teikimo, bet ir visos paslaugų teikimo kultūros pokyčių, nes reikšmingai keičiasi paciento kaip paslaugos vartotojo ir sveikatos priežiūros specialistų vaidmenys, prioritetas teikiamas paciento įgalinimui ir jo kompleksinių poreikių tenkinimui. Siekis holistiniu požiūriu organizuoti ir teikti sveikatos priežiūros paslaugas ypač aktualus pacientams, sergantiems lėtinėmis ir daugiabinėmis ligomis, turintiems ilgalaikių sveikatos ir socialinės priežiūros poreikių. Visa tai būdinga tokioms sritims kaip onkologija. Pabrėžtina, kad, norint teikti kompleksines, paciento poreikius efektyviai atliepiančias paslaugas, be gydymo paslaugų svarbu vystyti

ir personalizuotą psichosocialinę pagalbą (PPS), kuri padėtų mažinti individualų pacientų patiriamą ligos sukeltą psichosocialinį distresą. Vis dėlto, sveikatos priežiūros paslaugos skiria nepakankamai dėmesio pacientų psichosocialiniam distresui ir vis dar neretai vyrauja praktika, kai į pacientą žiūrima kaip į pasyvų paslaugos gavėją vien tik iš medicininės perspektyvos, arba psichosocialinės pagalbos organizavimo ir teikimo tvarka nėra personalizuota. Atkreiptinas dėmesys, kad šias nuostatas įtvirtinus tarptautiniu lygmeniu ir esant visuotiniam konsensusui dėl aptartų pokyčių poreikio, pavienės valstybės stebimas tyrimų poreikis ieškant tokio PPS modelio, kuris būtų efektyvus specifiniame kontekste. Personalizacijos iniciatyvos kyla „iš apačios į viršų“ principu, todėl atitinkamai reikalingi organizacinio lygmens tyrimai, kurie prisidėtų prie nacionalinių gairių kūrimo, kaip vystyti PPS prižiūrint pacientų sveikatą. Šio straipsnio tikslas – pateikus trumpą teorinį rakursą, pristatyti atlikto empirinio tyrimo rezultatus, kuriais identifikuojami

reikšmingi organizacinio lygmens faktoriai, skatinantys PPS vystymą kasdien stebint onkologinių pacientų sveikatą.

Išanalizavus ir apibendrinus ilgalaikio tyrimo rezultatus nustatyta, kad, siekiant vystyti PPS organizacijoje, pirmiausia reikalingas psichosocialinės pagalbos standartizavimas, kuris apima: a) standartizuoto distreso vertinimo instrumento taikymą, b) distreso vertinimą reikšmingais ligos etapais, c) individualaus plano sudarymą nustatytoms problemoms spręsti, d) pagalbos infrastruktūros formalizavimą, e) už šią veiklą atsakingo

specialisto numatymą. Remiantis gautais duomenimis galima išskirti, kad dauguma reikšmingų organizacinio lygmens problemų, stabdančių PPS plėtojimą, gali būti išspręsta įdarbinus specialistą, atsakingą už psichosocialinio distreso vertinimą, nukreipimą pagalbai ir procesų koordinavimą. Taip pat, kad PPS organizacijoje būtų suteikta laiku ir prieinama visiems onkologiniams pacientams jų ligos laikotarpiu, būtina didinti žmogiškuosius išteklius bei plėtoti psichosocialinės pagalbos infrastruktūrą, vienijančią ne tik vidinius įstaigos resursus, bet ir išorinės pagalbos galimybes.