



Meeting report

Improving implementation of psychological interventions to older adult patients with cancer: Convening older adults, caregivers, providers, researchers[☆]

Kelly M. Trevino^{a,*}, Charlotte Healy^a, Peter Martin^a, Beverly Canin^b, Karl Pillemer^c, Jo Anne Sirey^a, M. Cary Reid^a

^a Weill Cornell Medicine, NewYork Presbyterian Hospital, 525 E. 68th Street, New York, NY 10065, United States

^b Cancer and Aging Research Group, United States

^c Cornell University, 144 East Ave., Ithaca, NY 14853, United States

ARTICLE INFO

Article history:

Received 29 January 2018

Received in revised form 23 March 2018

Accepted 25 April 2018

Keywords:

Older adult

Cancer

Mental health

Implementation

ABSTRACT

Introduction: Older adults with cancer (OACs) are a large and growing population. Psychological distress is prevalent in this population yet few OACs receive evidence-based psychological care. The purpose of this project was to identify barriers and strategies for the implementation of psychological interventions to OACs from the perspective of OACs, OAC caregivers, researchers, clinicians, and advocacy organization members.

Methods: The Cornell Research-to-Practice (RTP) Consensus Workshop Model was used to organize and convene a consensus conference. The one-day conference consisted of small and large group discussions regarding barriers, facilitators, and strategies for the implementation of psychological interventions targeting OACs. A half-day roundtable meeting was subsequently conducted to organize data generated at the conference. De-identified transcriptions of the small group discussions were uploaded into NVivo 11 software and qualitatively analyzed using standard methods.

Results: Thirty-five participants attended the consensus conference from across stakeholder groups. Three themes related to implementation barriers were identified: lack of knowledge about psychological interventions in patients and providers; personal and social factors associated with being an OAC; and institutional-level factors. Themes related to implementation strategies focused on increasing awareness, tailoring interventions for older adults, and modifying institutional-level factors.

Discussion: Effective implementation of psychological interventions to OACs is complex and barriers exist across multiple levels of care. However, this project indicates that implementation can be improved in various ways that include all members of the healthcare system. Further clarification of implementation strategies and rigorous evaluation of their effectiveness is vital to improving care and care outcomes of OACs.

1. Introduction

Older adults (age ≥ 65 years) comprise 56% of new cancer diagnoses [1,2] and will account for approximately three quarters of all U.S. cancer survivors by 2040 [3]. Over 40% of older adults with cancer (OACs) report

elevated distress (e.g., anxiety, depression) [4–9] that is associated with poor quality of life [10,11]; reduced treatment adherence and response [12–14]; longer hospitalizations [15,16]; increased risk of an emergency department visit, overnight hospitalization, and 30-day readmission [17–19]; as well as shorter survival [20,21]. Yet, approximately half of all distressed cancer patients do not receive mental health care [22,23] and only 5% receive evidence-based psychological care [24].

Psychological interventions are efficacious, safe, and cost-effective [25–28]. Despite this, translation of research on psychological interventions into cancer care has been poor and data on effective implementation strategies are scarce [29–31]. Wide-spread implementation of efficacious psychological interventions has the potential to improve the mental health, quality of life, healthcare utilization, and treatment

[☆] Funding acknowledgement: This research was supported by the National Institute on Aging and American Federation for Aging Research (K23 AG048632; Trevino), American Federation for Aging Research (Beeson Scholars/Hartford Change AGEnts Action Fund; Trevino), the National Center for Advancing Translational Sciences (UL1 TR000457-06), and the National Cancer Institute Mentored Training for Dissemination and Implementation Research in Cancer Program grant (R25 CA171994, Brownson).

* Corresponding author at: 525 E. 68th Street, Box 39, New York, NY 10065, United States.
E-mail address: Ket2017@med.cornell.edu (K.M. Trevino).

response of the large and growing population of OACs. However, effective implementation requires an understanding of the context in which implementation will occur, including unique characteristics of the target population [32].

The Cornell Research-to-Practice (RTP) Consensus Workshop Model is an evidence-based strategy for bridging the gap between research and practice [32–35]. The RTP model includes clinical practitioners in the traditional consensus conference model to foster discussions between researchers and clinicians on current research-based knowledge and its application to clinical care [36,37]. The RTP model has been successfully applied to topics relevant to older adults and cancer patients including social isolation, elder abuse, and palliative care [37–39]. The current project applied the RTP model to psychological intervention implementation for OACs. The purpose of this project is to identify barriers and strategies for implementation of psychological interventions to OACs from the perspectives of OACs, OAC caregivers, clinicians, researchers, and advocacy organization members.

2. Methods

The RTP model consists of multiple steps employed in the current project as described below. An addition to the RTP model in this project included qualitative analysis of the discussions that occurred at the conference. Study methods were approved by the Weill Cornell Medicine Institutional Review Board and all participants provided informed consent.

2.1. Select a Topic

The topic of barriers, facilitators, and strategies for implementation of psychological interventions to OACs was selected based on research cited above that demonstrates a notable gap in the implementation of evidence-based psychological treatments to OACs.

2.2. Prepare a Nontechnical Literature Review

The project team prepared a written summary of relevant studies using language accessible to lay audiences that was sent to participants prior to the consensus conference. The literature review provided participants with common knowledge on rates and negative implications of distress in OACs, rates of unmet needs for psychological care in OACs, psychological treatments studied in cancer patients, and definitions and models of implementation.

2.3. Select a Panel of Experts and Recruit Conference Participants

A panel of six experts representing all stakeholder groups was selected. The expert panel provided feedback on the literature review and agenda for the consensus conference. Consensus conference attendees were recruited based on their expertise in geriatric mental health, oncology, and psychosocial oncology using strategies from prior consensus conferences [37,38,40].

2.4. Convene the Consensus Conference

The one-day conference consisted of a series of small and large group discussions on barriers, facilitators, and strategies for implementation. Small group discussions were audio-recorded and transcribed verbatim using United States Health Insurance Portability and Accountability Act (HIPAA)-compliant procedures including removal of identifying information. Due to overlap in content generated during discussions of facilitators and strategies, this content was merged into a single list (hereafter referred to as strategies).

2.5. Convene a Follow-up Roundtable

A subset of conference participants who were active during the consensus conference and represented all stakeholder groups were invited to participate in a follow-up roundtable meeting. The purpose of this half-day meeting was to review and collaboratively refine the list of recommendations generated at the conference to create a final list of barriers and strategies.

2.6. Data Analysis

Transcriptions were uploaded into NVivo 11 software and analyzed according to Braun, Clarke, and Terry's six-step process for thematic analysis [41]. This analytic approach is not associated with a particular theoretical orientation or methodology, allowing it to be applied to a range of approaches such as the RTP model [42]. The first step consisted of reading transcripts of the small group discussions to become familiar with the data and determine points of potential analytical interest. The transcripts were then coded with key descriptive phrases and similar codes were grouped into themes [42]. These themes were then reviewed and revised to develop a thematic map. A detailed analysis was conducted in which codes within each theme were reviewed for a coherent pattern. The themes were refined in the context of the entire data set to ensure the thematic map reflected the data set as a whole. Finally, the themes were refined and the scope and content of each were described [42].

2.7. Participants

Thirty-five participants attended the conference and included OACs ($n = 3$), an OAC caregiver ($n = 1$), researchers ($n = 13$), clinicians ($n = 10$), and advocacy organization members ($n = 8$). Conference participants were primarily female (80.0%), white (90.0%), and non-Latino (93.3%) with an average age of 47.7 years ($SD = 12.40$). Multiple disciplines were represented and included physicians ($n = 4$), social workers ($n = 8$), psychologists ($n = 8$), nurse practitioners ($n = 2$), sociologists ($n = 2$), and other ($n = 4$). Clinicians had been working an average of 16.55 years ($SD = 10.36$) in their selected discipline. The roundtable meeting was attended by ten consensus conference participants and included an OAC ($n = 1$), researchers ($n = 4$), clinicians ($n = 4$), and an advocacy organization member ($n = 1$).

3. Results

3.1. Barriers

Three key implementation barriers were identified: lack of knowledge about psychological interventions in patients and providers; personal and social factors associated with being an OAC; and institutional factors (see Fig. 1).

3.1.1. Lack of Knowledge

Participants noted that patients are often unaware of the relationship between physical and psychological symptoms and the nature and benefits of psychological interventions. Specifically, patients may have a poor understanding of: (1) the types of psychological interventions available; (2) differences among services provided by psychologists, psychiatrists, and social workers and; (3) that medical and psychological treatment can be provided concurrently. This lack of awareness can manifest uniquely in older adults who may experience psychological conditions as physical symptoms:

You know older people are...more likely to endorse not eating or feeling you know different sorts of...somatic pieces, rather than saying I'm anxious. It's not experienced as a psychological...phenomenon at all (Participant quotation).

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