

# Optimizing Hospital Care for Elderly Cancer Patients: The Adelaide Geriatric Oncology Experience

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# The (new) Royal Adelaide Hospital



# South Australia

- 1.6m people
- Above (national) average numbers of elderly
- Average age at admission to RAH predicted to be 75 years
- 4 Local Health Networks
  - 3 metropolitan
  - 1 Rural/Remote
- City State

# Cancer in Elderly

- Like all western countries we face the grey tsunami
  - Which means a cancer tsunami
- Coupled with increasing
  - Indications for treatment
  - Lines of treatment
  - New (expensive) treatments
- Resulting in a major risk of cost blow-outs in health

# Factors Guiding Cancer Management in Elderly Patients

- Disease factors
  - Cellular type
  - Staging
- Patient factors
  - Fitness
  - Comorbidities
  - Functional status
  - Mental status
  - Family/social support
- Decision
  - If and how to treat

(Balducci)

# Elderly Rights

- No retirement age in Australia
- Age discrimination is increasingly called out
- Elder abuse likewise

# Decision Making in Australia

- When competence is impaired
  - Family
  - Enduring Power of Guardianship
  - Advanced Directive
  - Appointed Medical Attorney

# Health Reform

- IHI Triple Aim:
  - Improved patient experience
  - Improved population outcome
  - Improved cost-efficiency
- Healthcare funding
  - State/Federal mix
  - Out of pocket expenses increasing but still small
  - People resent any attempt to limit health spending



The Adelaide Geriatric Oncology  
Model:  
Screening for all and intervention for  
the select

(established 2008)

- Aim:
  - To optimise the physical health, emotional wellbeing and social supports of older cancer patients and their carers by means of supportive interventions by:
    - Screening for all older cancer patients
    - Case review in a Multi-disciplinary meeting to develop individualised care plan
      - recommendations for treating oncologist
      - tailored interventions
      - Referral to specialised medical & allied health team

# MDM members

- Geriatrician\*
- Social Work
- Clinical Psychology
- Dietetics\*
- Occupational therapy\*
- Pharmacology review
- Case management (GeriOnc Nurses)
- Palliative Care
  
- \*continuing members of team

# Survey sent prior to first visit

- Covers issues of:
  - perception of overall health,
  - presence of co-morbidities,
  - concerns regarding memory,
  - self-reported deficiencies in
    - hearing and vision and
    - their impact
  - falls history
  - social support,
  - depressive symptoms
  - distress and pain scores
  - functional status and
  - experiences of exhaustion.

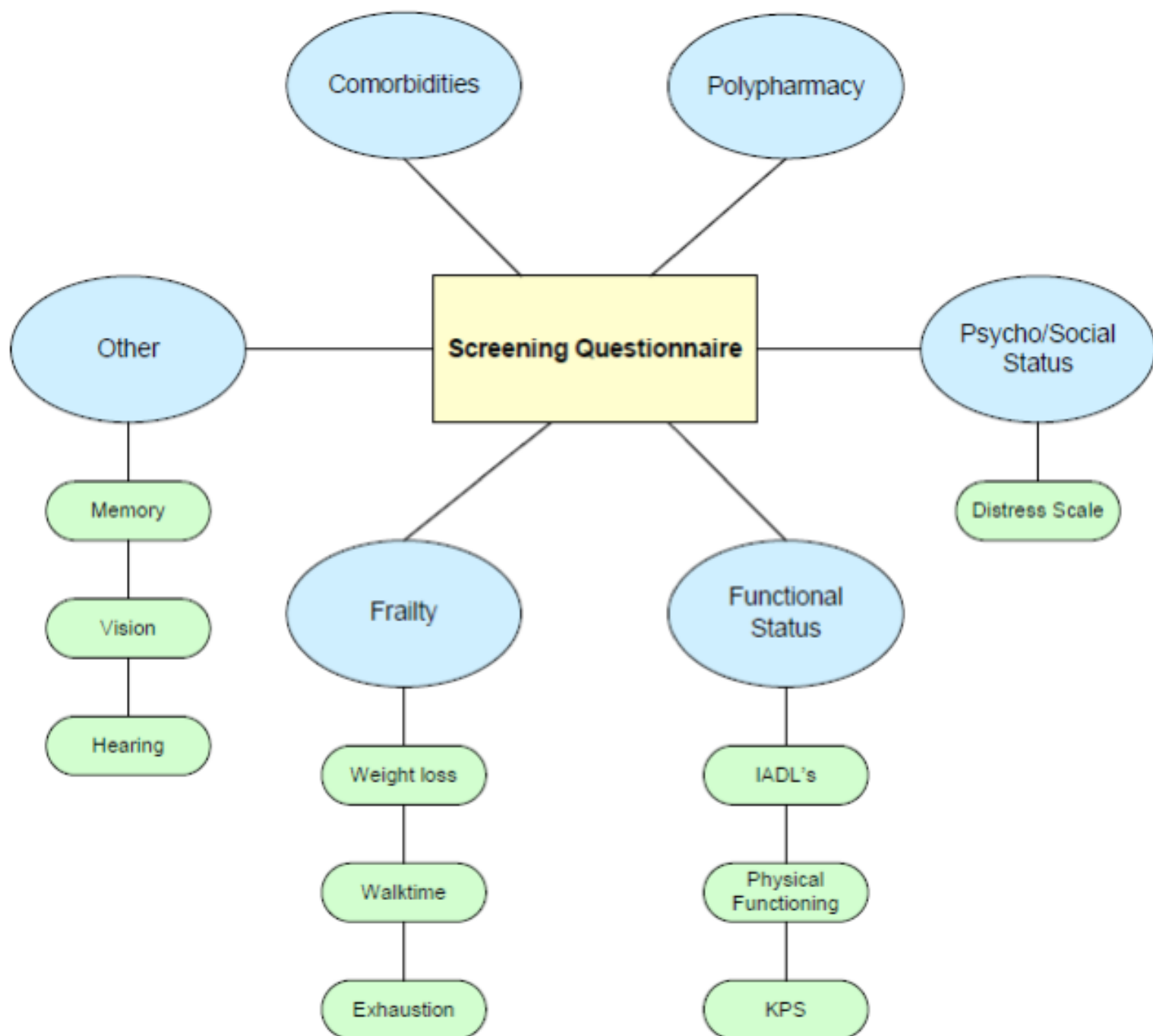
# The Adelaide Tool

- Composite of validated instruments
  - Fried Frailty Scale
  - Charlsson Comorbidity Index
  - Lawton-Brody IADL scale
  - Cognition questions (local)
  - Not formally validated prior to funding loss

# Strengths and Limitations

Limited ability to measure *small* increments of change

But useful in creating an easy to administer & short screening tool which quickly highlights areas of “concern”



# Summary

- Criteria based on
  - ADL dependence
  - IADL dependence
  - KPS < 70%
  - Exhaustion
  - Weight loss >5%
- Classification
  - **Fit** - No criteria met
  - **Vulnerable** - 1-3 criteria
  - **Frail** - 4-5 criteria



# Activities of GeriOnc Team

- Case Management
  - Case Co-ordination
  - Diversions
- Specialised Oncology Clinic
  - Octagenia (over 80s)
- Geriatric Oncology Training
  - Education
  - Fellows / Consultants (dual training with Medical Oncology)
  - Nurse Practitioners

# GeriOnc Nurses

- Backbone of the service
- Elderly patients have complex and specific needs that require care coordination, and these patients can have extended length of inpatient admissions and clinic visits
  - Referrals to address issues before treatment
  - Sitting in with clinic reviews during treatment with non-GeriOnc oncologists
  - Post-clinic reviews
    - At chemo chair
    - Via phone
  - Diversions
  - Assistance with Rural/Remote communication

# Rural Issues

- 600 000 people live outside the metropolitan area
- Rural patients may have to travel long distances at great expense (patient, health system)
  - Establish local contacts and review options
  - Co-ordinate share care arrangements with GP, Palliative Care, Rural oncology services
- “Gap” issues
  - Triage-by-phone
  - Trigger community services

# Octagenia Clinic

- Triage of patients over 80years to a specialist clinic
  - Staffed by
    - Geriatric Oncologist
    - Geriatric Oncology Nurse(s)
  - Extended clinic visit times
  - Appropriate Room
    - Distance from waiting room
    - Full adjustable examination couch
    - Multiple chairs

# Rationale for Octagenia Clinic

- Easy to identify group during triage
- Research opportunities
- Most likely group to suffer age discrimination
- Inter-patient role models (waiting room phenomenon)
- Great starting place for a new “Geriatric” Oncologist

# Following Adelaide's lead

- Border Oncology (Albury – Wodonga)
- Prince of Wales (Sydney)
- COSA (Clinical Oncology Group of Australia)  
Geriatric Oncology Group
- Owing to funding cuts, Adelaide has been left somewhat behind

# The COSA Geriatric Oncology Group

- Aims to improve outcomes for older adults affected by cancer through:
  - Education
  - Support for clinical practice
  - Research
  - Advocacy
- Priority working groups in:
  - research
  - guideline development

# COSA: GO Resources

- eNewsletter
- Links to
  - SIOG Guidelines
  - SIOG e-learning
  - EviQ
  - Victorian Geriatric Medicine Training Program
    - e-Modules such as geriatric assessment, falls, pain
  - Workshop reports
  - ASM recordings





July 2018

**A message from COSA...**

## ***GO eNews***

### **Message from the Chair**

Welcome to another edition of *GO eNews*.

We are pleased to share information in this edition about new research and resources, upcoming events of interest, and recently published journal articles and guidelines.



The Geriatric Oncology Group is continuing its work to develop a guideline that will help improve the clinical management of older adults with cancer. Another research concept development round will open in late 2018, and I encourage all members to start thinking about any geriatric oncology research projects they are already working on or considering that would benefit from receiving expert review and feedback from our working group.

Many of you may recall a survey this Group conducted exploring the views of Australian medical oncologists regarding the perception of, and barriers to, incorporating geriatric screening tools, geriatric assessment and collaboration with geriatricians in routine clinical practice. We are pleased that the *Journal of Geriatric Oncology* has recently accepted the manuscript reporting these survey results. We look forward to sharing the published article in a future issue, which provides insights into the challenges to treating older patients and factors to consider when making treatment decisions.

Please get in touch if you have any information you would like included in *GO eNews*, or let us know if you would like to get involved with our Group activities.

Meera Agar  
Chair, COSA Geriatric Oncology Group  
[meera.agar@uts.edu.au](mailto:meera.agar@uts.edu.au)

# Geriatric Oncology

🕒 8hrs | 🔒 Login required | 📅 Review due: November 2018

This program is for nurses who work with older people affected by cancer. It uses evidence based and best practice guidelines to improve the knowledge and skills in caring for older people with cancer.

## About

This is the first online educational resource specific to the Australian context that supports nurses to deliver excellent care to older people with cancer. This course presents information about the implications for care of an older person with cancer with particular focus on communication.

## Modules

- 🔒 **Changes associated with ageing** 2hrs ▼
- 🔒 **Implications for care of an older person with cancer** 2hrs ▼
- 🔒 **Communicating with the older person with cancer** 2hrs ▼
- 🔒 **Professional issues for nursing practice** 2hrs ▼

## Additional Information

These Geriatric Oncology Nursing Education Modules have been developed in collaboration between Peter MacCallum Cancer Centre, The Royal Melbourne Hospital Queensland University of Technology (QUT) Western & Central Integrated Cancer Service (WCMICS), Western Health (Melbourne) Consumer representatives, The Royal Women's Hospital (Melbourne) The University of Melbourne.

This project has been funded by WCMICS and is generously supported by The Frances & Harold Abbott Foundation



## What you will achieve

- ✓ **Understand critical domains** of assessment of an older person
- ✓ **Describe the ageing process** and how this impacts cancer treatment
- ✓ **Reflect on communication strategies** when caring for an older person with cancer
- ✓ **Describe role in advocacy** and support of older people affected by cancer, their families and support network.

## Who is this course for?

This online program has been developed for nurses who work with older people affected by cancer and who wish to develop their knowledge and practice skills in geriatric oncology nursing care.

Support Care Cancer. 2018 Feb;26(2):451-460. doi: 10.1007/s00520-017-3843-0. Epub 2017 Aug 3.

# How do oncologists make decisions about chemotherapy for their older patients with cancer? A survey of Australian oncologists.

Moth EB<sup>1,2</sup>, Kiely BE<sup>1,3</sup>, Naganathan V<sup>2,4</sup>, Martin A<sup>3</sup>, Blinman P<sup>5,6</sup>.

⊕ Author information

Abstract

**PURPOSE:** Oncologists are making treatment decisions on increasing numbers of older patients with cancer. Due to comorbidities and frailty that increase with age, such decisions are often complex. We determined factors influencing oncologists' decisions to prescribe chemotherapy for older adults.

**METHODS:** Members of the Medical Oncology Group of Australia (MOGA) were invited to complete an online survey in February to April 2016.

**RESULTS:** Ninety-three oncologists completed the survey of which 69 (74%) were consultants and 24 (26%) were trainees, with most (72, 77%) working predominantly in a public hospital-associated practice. The three highest ranked factors influencing decisions about (a) adjuvant chemotherapy were performance status, survival benefit of treatment, and life expectancy in the absence of cancer and about (b) palliative chemotherapy were performance status, patient preference, and quality of life. Most geriatric health domains are reportedly assessed routinely by the majority of respondents, though few routinely use geriatric screening tools (14%) or geriatric assessments (5%). In hypothetical patient scenarios, oncologists were less likely to prescribe palliative and adjuvant chemotherapy as age and rates of severe toxicity increased.

**CONCLUSION:** Performance status was the most influential factor for oncologists when making a decision about chemotherapy for their older patients, and the importance of other factors differed according to treatment intent. Oncologists were less likely to recommend chemotherapy as patient age and treatment toxicity increased. The low uptake of geriatric assessments or screening tools provides scope for improved clinical assessment of older adults in treatment decision-making.

**KEYWORDS:** Chemotherapy; Decision-making; Elderly; Older adult; Oncologist

PMID: 28776149 DOI: 10.1007/s00520-017-3843-0



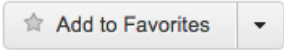
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Chemotherapy treatment decision-making experiences of older [Support Care Cancer. 2017]

**Review** Medical oncologists' views on communicating with patients [J Clin Oncol. 2007]

**Review** [Geriatric assessment and prognostic scores in older cancer patient [Bull Cancer. 2017]

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J Geriatr Oncol. 2018 Jun 20. pii: S1879-4068(18)30078-X. doi: 10.1016/j.jgo.2018.06.001. [Epub ahead of print]

# 'Pretty fit and healthy': The discussion of older people in cancer multidisciplinary meetings.

Lane HP<sup>1</sup>, McLachlan S<sup>2</sup>, Philip JAM<sup>3</sup>.

## ⊕ Author information

### Abstract

**INTRODUCTION:** Cancer multidisciplinary meetings (MDMs) are central to treatment decision making. The language used in MDMs may influence treatment decisions, yet has received little research attention. This study aimed to examine the terminology used to describe non-cancer items in the discussion of older people within cancer MDMs.

**METHODS:** MDMs of four tumour streams were attended over twelve weeks. For each person aged 70 or older discussed, the following was hand recorded: age, gender, and phrases describing non-cancer items and patient views. A qualitative thematic analysis was employed to examine the text.

**RESULTS:** Twenty cancer MDMs were attended, at which 71 people aged 70 or older were discussed. Age, comorbid medical conditions, and general descriptors emerged as the areas in which non-cancer information was presented. In contrast to the medical terminology used to describe comorbid medical conditions, non-specific general descriptors, such as 'fit', 'well', and 'good', were used to describe other aspects of older people. Adverbs, including 'very', 'pretty', and 'quite', often accompanied general descriptors. The, often subtle, intonation and context associated with these adverbs resulted in markedly different meanings.

**CONCLUSION:** Non-objective, potentially ambiguous general descriptors were commonly used to encompass non-disease aspects of older people in cancer MDMs. These descriptors may have the potential to sway treatment recommendations. However, their frequent use suggests team members recognise that non-disease aspects of a person, aside from chronological age, are considerations in treatment recommendations. Therefore, strategies to increase discussion of non-cancer items in a more objective manner may be acceptable to MDM attendees.

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**KEYWORDS:** Communication; Geriatric assessment; Geriatric oncology; Language; Multidisciplinary meeting; Older people

PMID: 29936076 DOI: [10.1016/j.jgo.2018.06.001](https://doi.org/10.1016/j.jgo.2018.06.001)



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**Review** Improving the effectiveness of multidisciplinary team [NIHR Journals Library. 2014]

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J Cancer Surviv. 2018 Aug;12(4):537-559. doi: 10.1007/s11764-018-0692-x. Epub 2018 May 4.

## Systematic review of self-reported cognitive function in cancer patients following chemotherapy treatment.

Bray VJ<sup>1</sup>, Dhillon HM<sup>2</sup>, Vardy JL<sup>3,4</sup>.

⊕ Author information

### Abstract

**PURPOSE:** Cognitive symptoms are common in cancer patients, with up to 70% reporting cognitive symptoms following chemotherapy. These symptoms can have a major impact on how an individual functions in all aspects of their lives. This review evaluates self-reported cognitive function and its associations with neuropsychological tests and patient-reported outcomes in adult cancer patients who received chemotherapy treatment for a solid cancer.

**METHODS:** A search of multiple databases (Medline, Ovid at Nursing, PsycINFO, Allied and Complementary Medicine) from 1936 to 2017 was conducted, identifying 1563 unique articles, of which 101 met inclusion criteria.

**RESULTS:** Of the 101 included studies, 48 (47%) were cross-sectional and 38 (38%) longitudinal in design, with 12 (12%) randomised controlled trials. A minority (26%) incorporated a healthy control arm in the study design, whilst the majority (79%) were in women with breast cancer. There was diversity in the assessment of self-reported cognitive symptoms. A total of 43 of 44 studies that sought an association between self-reported cognitive function and patient-reported outcomes found a moderate to strong association. Overall, 31 studies showed a lack of association between self-reported cognitive symptoms and neuropsychological results, whilst 14 studies reported a significant association between the two, but the association was often restricted to limited cognitive domains.

**CONCLUSION:** The review found widespread heterogeneity in the assessment of self-reported cognitive symptoms and consistently absent or weak association with neuropsychological test scores.

**IMPLICATIONS FOR CANCER SURVIVORS:** This research highlights the need for a standardised approach to measurement of self-reported cognitive symptoms in cancer patients.

**KEYWORDS:** Cancer; Chemotherapy; Cognition; Cognitive symptoms; Self-reported cognitive function

PMID: 29728959 DOI: [10.1007/s11764-018-0692-x](https://doi.org/10.1007/s11764-018-0692-x)



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Cell Rep. 2018 Jun 19;23(12):3512-3524. doi: 10.1016/j.celrep.2018.05.057.

## Age-Related Decline in Primary CD8<sup>+</sup> T Cell Responses Is Associated with the Development of Senescence in Virtual Memory CD8<sup>+</sup> T Cells.

Quinn KM<sup>1</sup>, Fox A<sup>2</sup>, Harland KL<sup>2</sup>, Russ BE<sup>3</sup>, Li J<sup>3</sup>, Nguyen THO<sup>2</sup>, Loh L<sup>2</sup>, Olshansky M<sup>3</sup>, Naeem H<sup>4</sup>, Tsyganov K<sup>4</sup>, Wiede F<sup>5</sup>, Webster R<sup>6</sup>, Blyth C<sup>6</sup>, Sng XYX<sup>6</sup>, Tiganis T<sup>5</sup>, Powell D<sup>4</sup>, Doherty PC<sup>7</sup>, Turner SJ<sup>8</sup>, Kedzierska K<sup>2</sup>, La Gruta NL<sup>9</sup>.

### Author information

#### Abstract

Age-associated decreases in primary CD8<sup>+</sup> T cell responses occur, in part, due to direct effects on naive CD8<sup>+</sup> T cells to reduce intrinsic functionality, but the precise nature of this defect remains undefined. Aging also causes accumulation of antigen-naïve but semi-differentiated "virtual memory" (T<sub>VM</sub>) cells, but their contribution to age-related functional decline is unclear. Here, we show that T<sub>VM</sub> cells are poorly proliferative in aged mice and humans, despite being highly proliferative in young individuals, while conventional naive T cells (T<sub>N</sub> cells) retain proliferative capacity in both aged mice and humans. Adoptive transfer experiments in mice illustrated that naive CD8 T cells can acquire a proliferative defect imposed by the aged environment but age-related proliferative dysfunction could not be rescued by a young environment. Molecular analyses demonstrate that aged T<sub>VM</sub> cells exhibit a profile consistent with senescence, marking an observation of senescence in an antigenically naive T cell population.

**KEYWORDS:** CD8(+) T cells; T cell dysfunction; aging; cellular senescence; exhaustion; naive CD8(+) T cells; virtual memory T cells

PMID: 29924995 DOI: [10.1016/j.celrep.2018.05.057](https://doi.org/10.1016/j.celrep.2018.05.057)

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Two separate defects affecting true naive or virtual memory T cell precursor [J Immunol. 2014]

**Review** Intrinsic versus environmental influences on T-cell responses [Immunol Rev. 2005]

Cell-intrinsic defects in the proliferative response of antiviral memory CD8 T cells [J Immunol. 2010]

Adoptively transferred effector cells derived from naive rather than [Proc Natl Acad Sci U S A. 2009]

**Review** Significance of senescence for virus-specific memory T cell response [Immunol Lett. 2005]

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*J Geriatr Oncol.* 2018 Jul;9(4):411-417. doi: 10.1016/j.jgo.2018.03.016. Epub 2018 Jun 9.

## Managing older patients with head and neck cancer: The non-surgical curative approach.

Iqbal MS<sup>1</sup>, Dua D<sup>2</sup>, Kelly C<sup>3</sup>, Bossi P<sup>4</sup>.

### ⊕ Author information

#### Abstract

Managing older patients with head and neck cancers poses a challenge due to the often reduced levels of physiological reserve, the frequent comorbidities and treatment related toxicity. These factors have implications on speech, breathing and swallowing functions. Treatment management plans in these patients may result in de-intensification strategies and as a result of this, use of non-standard treatments is increasing. There have been published reports that indicate the addition of concurrent systemic therapy to radiation in selected older patients is feasible, and produces outcomes comparable with younger patients. However, some other studies including meta-analyses suggest a lack of real survival benefit with the addition of chemotherapy. So, the key point appears to be the optimal patient selection. Appropriate geriatric and frailty assessments are required to help determine the optimal treatment for older patients with head and neck cancer. Treatment for this population still needs to be well defined and optimized in both modality and intensity. Qualitative studies are also required to address short and long-term post-treatment quality-of-life and survivorship issues in this specific patient population. This review summarizes the evidence available regarding the non-surgical management of older patients with head and neck cancers.

PMID: 29685382 DOI: [10.1016/j.jgo.2018.03.016](https://doi.org/10.1016/j.jgo.2018.03.016)





# 4 of 4 Predicting Chemotherapy Toxicity in Older Adults: Comparing the Value of the CARG Toxicity Score with Oncologists' Estimates of Toxicity Based on Clinical Judgement

E Moth<sup>1,2</sup>, B Kiely<sup>1,2</sup>, N Stefanic<sup>2</sup>, V Naganathan<sup>3,4</sup>, A Martin<sup>2</sup>, P Grimison<sup>5</sup>, M Stockler<sup>1,2</sup>, P Beale<sup>1,2</sup>, P Blinman<sup>1,2</sup>

<sup>1</sup>Concord Cancer Centre, Concord Repatriation General Hospital, Sydney, Australia

<sup>2</sup>University of Sydney, Sydney, Australia

<sup>3</sup>Centre for Education and Research on Ageing, Concord Clinical School, University of Sydney, Sydney, Australia

<sup>4</sup>Ageing and Alzheimer's Institute, Concord Repatriation General Hospital, Sydney, Australia

<sup>5</sup>Chris O'Brien Lifehouse, Sydney, Australia

**Background:** The Cancer and Ageing Research Group's (CARG) Toxicity Score was designed to predict grade  $\geq 3$  chemotherapy-related toxicity in adults  $\geq 65$  years commencing chemotherapy for any stage or type of solid cancer. We aimed to evaluate the CARG Score in an Australian setting and compare it to oncologists' estimates for predicting severe chemotherapy toxicity in older adults.

**Methods:** Patients aged  $\geq 65$  years starting chemotherapy for a solid organ cancer (any type/stage) had their CARG Score (range 0–23) calculated. Their treating oncologist, blinded to these results, independently estimated the patient's risk of severe chemotherapy toxicity (0–100%). Toxicities were captured prospectively. The predictive value of the CARG Score, oncologists' estimates and a combined measure was estimated using logistic regression and in terms of Area Under the Receiver Operating Characteristic curve (AU-ROC).

**Results:** One hundred and twenty-six patients from 10 oncologists at two sites participated. The median age was 72 years (range 65–84). The median CARG Score was 7 (range 0–17), and the median oncologist estimate of risk was 30% (range 3–80%), and these measures were not correlated ( $r = -0.01$ ). Sixty-four patients (52%) experienced grade  $\geq 3$  toxicity. Rates of severe toxicity in low-, intermediate- and high-risk groups by CARG Score were 58%, 47% and 58%, respectively, and 63%, 44% and 67% by oncologist estimate. Severe chemotherapy toxicity was not predicted well by the CARG Score (OR 1.04, 95% CI 0.92–1.18,  $P$ -value 0.54, AU-ROC 0.52), oncologists' estimates (OR 1.00, 95% CI



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0.98–1.02,  $P$ -value 0.82, AU-ROC 0.52) or a model combining the two (AUC-ROC 0.52).

**Conclusions:** The CARG Score, oncologists' estimates or a combination of the two were not good predictors of severe chemotherapy-related toxicity in our local population of older adults. Methods to improve risk prediction are needed.

**Note:** The results in this abstract have been previously presented in part at Clinical Oncology Society of Australia Annual Scientific Meeting, Sydney 2017 and published in the conference proceedings as abstract #189.



Prunella Blinman @drpru... · 2/8/18 ✓  
@ErinMoth1 on predicting chemotherapy toxicity in older adults with cancer by the CARG Score & clinicians' estimates #gerionc #MO...



1



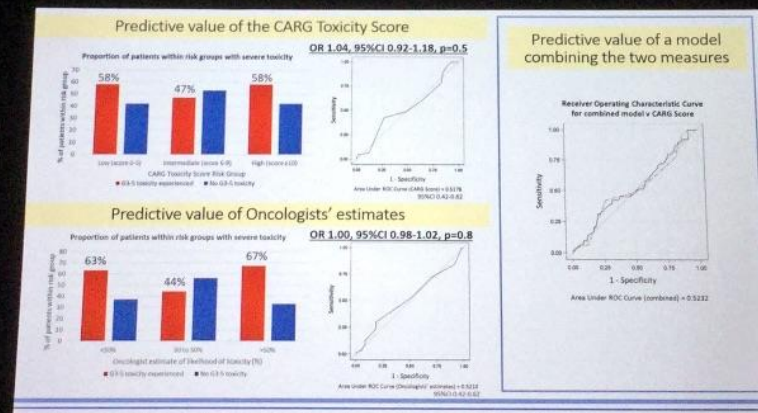
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13







**Prunella Blinman** @drpru... · 3/8/18 ✓  
@ErinMoth1 presenting her CARG Score study results. Neither the CARG Score nor oncologists' estimates nor a mixed model of bot...



# How can the new RAH help?

- Reduction in LOS
  - Admission prevention strategies
  - Discharge planning strategies
  - Care awaiting placement
  - Care awaiting discharge
  - Rehab in the home
  - Hospital in the home

# Inpatient Rooms

- Ensuite in every room with rails/guards
- Very modern beds
  - Easier to move/adjust
  - Easier to call
  - Easier to use cot-sides/height/torches
- Every room has window seat bed for family member to stay
- Trial of voice-activated nurse call
- Increased senior staff overnight

# Model of Care Changes

- Dispersed Allied Health
- Dispersed Imaging
- ADL kitchens throughout
- Gyms throughout
- Activities brought to patient rather than vice versa
- 70 outdoor spaces/gardens

# Other Enhancements

- Referrals
  - Health Pathways
  - Single electronic referral system for GPs
- Data
  - QIP Hub

# Summary

- We realise we need to enhance care of our increasing elderly (cancer) population
- Every new innovation needs to be mindful of this
- The new hospital and our health reform efforts are enhancing our ability to keep up with the needs of our population
- Communication with our population and clinical engagement are vital for success