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

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• 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
  • Octagena (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
Octagena Clinic

- Triage of patients over 80 years 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 Octagena 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
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
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Geriatric Oncology

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)

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 people with cancer
- Describe role in advocacy and support of older people affected by cancer, their families and support network.

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.

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

Meth EB, Kially BE, Naganathan V, Martin A, Blinman P.

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

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

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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

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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/s11764-018-0882-x
Age-Related Decline in Primary CD8⁺ T Cell Responses Is Associated with the Development of Senescence in Virtual Memory CD8⁺ T Cells.

Quinn KM¹, Fox A², Harland KL², Russ BE³, Li J³, Nguyen THC², Loh L², Oshanksy M³, Naeem H⁴, Tsuyanov K⁴, Wieder F⁵, Webster R⁶, Blyth C⁶, Sng XYZ⁶, Tiganis T⁷, Powell D⁷, Doherty PC⁸, Turner SJ⁹, Kedzierska K⁷, La Ginta NL⁹.

Abstract

Age-associated decreases in primary CD8⁺ T cell responses occur, in part, due to direct effects on naive CD8⁺ T cells to reduce intrinsic functionality, but the precise nature of this defect remains undefined. Aging also causes accumulation of antigen-naive but semi-differentiated “virtual memory” (TVM) cells, but their contribution to age-related functional decline is unclear. Here, we show that TVM cells are poorly proliferative in aged mice and humans, despite being highly proliferative in young individuals, while conventional naive T cells (Tn 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 TVM 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

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

Iqbal MS¹, Dua D², Kelly C³, Bossi P⁴.

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

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Background: The Cancer and Ageing Research Group’s (CARG) Toxicity Score was designed to predict grade ≥3 chemotherapy-related toxicity in adults ≥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 ≥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 ≥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

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...
@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