

ASSOCIATION OF COMMUNITY
CANCER CENTERS

GROWING NEED DEMANDS
NEW APPROACHES TO
CARING FOR OLDER ADULTS
WITH CANCER



Association of Community Cancer Centers

As the need to bring multidisciplinary approaches to cancer care for older Americans becomes increasingly evident, the Association of Community Cancer Centers (ACCC) is providing resources to identify barriers, share information and validated tools for screening and assessing older adults, and provide models that illustrate effective approaches in addressing the needs of this growing patient population. This article summarizes recent ACCC efforts in response to the growing concern among leading oncology organizations in the United States that cancer programs are ill-equipped to care for the 2.3 million adults projected to be diagnosed with cancer by 2030, with 70 percent of those cases presenting in adults aged 65 and above.¹⁻⁶

Current Recommendations

To improve treatment outcomes for older patients, the American Society of Clinical Oncology (ASCO) in 2018 issued clinical practice guidelines for utilizing validated and standardized clinical assessment tools to evaluate and manage age-related conditions not routinely captured in oncology assessments and associated with adverse outcomes in older patients with cancer.⁷ The ASCO expert panel found strong evidence that traditional oncology performance measures, such as the Karnofsky Performance Status, do not accurately predict which older adults are at highest risk of adverse outcomes when receiving chemotherapy. The panel identified a range of additional vulnerabilities or domains otherwise not well identified through standard oncology assessment.⁷⁻⁸ The ASCO recommendations call for conducting comprehensive geriatric assessments in patients being considered for chemotherapy age 65 and above. Evidence also supports use of these assessments in older adults receiving other treatment modalities. Patients with multiple comorbidities could benefit from assessment regardless of age, which could mean geriatric assessment of a 50 or 55-year-old patient.

Multiple Benefits of Comprehensive Geriatric Assessments

A comprehensive geriatric assessment provides a detailed evaluation of medical, psychosocial, and functional problems in older patients with cancer. It can:

- Identify areas of vulnerability
- Predict toxicity and survival
- Assist in clinical decision-making
- Guide the development of individualized treatment plans
- Improve provider-patient communication
- Predict treatment completion.

Several studies have shown that a comprehensive geriatric assessment may change treatment decisions—in 5% to 50% of older adults.⁷⁻¹⁰ Comprehensive geriatric assessment results can be provided to patients and caregivers to help guide shared clinical decision-making, as well as to identify additional interventions needed to support patient adherence and treatment completion.

ACCC Survey Highlights Challenges

As part of a recent education project, ACCC conducted an online survey in July and August 2018. Survey questions aimed to elicit information on the current landscape of cancer care delivery for older adults, including respondents' beliefs, barriers, and best practices. The survey received 332 responses from a diverse group of multidisciplinary professionals including pharmacists, administrators, physicians, psychologists, researchers, advanced practice providers, nurses and nurse navigators, and social workers.

The survey results showed a striking difference between beliefs and practice. Ninety-five percent of respondents "strongly agree" or "agree" that older adult cancer patients would benefit from a comprehensive geriatric assessment in addition to the oncology assessment before the start of treatment. However, only 17% of survey respondents reported that they routinely conduct a comprehensive geriatric assessment with their older adult patients. Very few respondents (26%) are currently using screening tools to identify at-risk patients appropriate for a comprehensive geriatric assessment.

The top three barriers survey participants noted were limited time (60%), limited familiarity with validated geriatric screening/assessment tools (49%), and limited personnel (46%). Only 32% of respondents said they were aware of oncology providers or other clinical staff in their cancer program who had received a board certification, specialty training, or research expertise in gerontology or geriatrics.

While most ACCC survey respondents (59%) reported some knowledge of the Shared Decision-Making Model and recognized its benefits (68%) in treatment-related communication, far fewer (37%) said they feel confident in using this collaborative process for engaging patients (and caregivers) in clinical decision-making.

For more survey results, turn to the infographic on pages 65–67.

Three Cancer Programs Share Valuable Insights

As another component of the education program, multidisciplinary providers from three ACCC Cancer Program Members participated in on-site focus groups during which they shared their challenges, successes, and strategies for improving care for older adults with cancer.

Each site illustrated diverse approaches to improving care for this population. A key message from these programs: there is no one-size-fits-all solution to improving care for the older adult population. Cancer care providers must consider their own resources, capacities, and patient needs, specific to their region and location.

City of Hope Comprehensive Cancer Center

City of Hope, an NCI-designated Comprehensive Cancer Center and founding member of the National Comprehensive Cancer Network (NCCN), is well known for leading-edge cancer treatment, research, prevention, and education. City of Hope is advancing knowledge, training, and resources to understand and improve care through its Center for Cancer and Aging (formerly known as the Cancer and Aging Research Program), and

its leadership in the Cancer and Aging Research Group (CARG). The CARG connects geriatric oncology researchers in a collaborative to design and implement clinical trials to improve the care of older adults with cancer.

The mission of the Center for Cancer and Aging at City of Hope is "to join investigators from all cancer disciplines to study biology, treatment, and survivorship issues that face older adults with cancer."

In 2015, under the leadership of Arti Hurria, MD, FASCO, the George Tsai Family Chair in Geriatric Oncology, director of the Center for Cancer and Aging at City of Hope, this program received a grant from the UniHealth Foundation, which is allowing the research team to study integration of a comprehensive geriatric assessment into routine practice.

As part of the study, a multidisciplinary team works to address patient needs identified through the comprehensive geriatric assessment, which is available for free and in nine languages on the CARG website, mycarg.org. The team meets weekly to discuss patients' health status, comprehensive geriatric assessment results, treatment recommendations, and referrals for patients.

Over time, the program has adapted to ensure that they are adding benefits to the patients without overly burdening providers. With the final data, the team is aiming to prove the model's viability and significance relative to improved patient outcomes.

In February 2019, City of Hope conducted its final training workshop of a five-year, R25 grant-funded program, "Geriatric Oncology: Educating Nurses to Improve Quality Care." The grant looks to create a ripple effect as these oncology nurses share their new awareness of comprehensive geriatric assessments and gerontology with their colleagues.

Ted and Margaret Jorgensen Cancer Center, Presbyterian Rust Medical Center

The Ted and Margaret Jorgensen Cancer Center at Presbyterian Rust Medical Center opened its doors in February 2016. The facility houses a holistically designed multidisciplinary clinic that includes gynecologic oncology, radiation oncology, surgical oncology, and supportive care services.

At the Jorgensen Cancer Center, the impetus to reassess care delivery for geriatric oncology patients began with nursing. Clinical professional educator Melissa McLaughlin, MSN, RN-BC, OCN, and her colleague, oncology clinic manager Chantel Tarin, BSN, RN, participated in the training program offered at City of Hope. They learned about various geriatric assessment tools and how these could be implemented to inform patient care. They also began to identify gaps and opportunities for improvement that could be translated into a feasible pilot project that would put their training into action.

Although Jorgensen Cancer Center has the elements of quality cancer care delivery in place, the challenge was to look at everything from the perspective of the senior adult cancer patient.

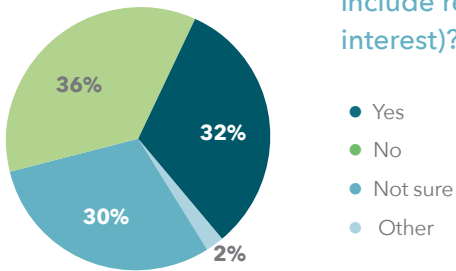
As a first step the nurse team began assessing the existing patient education materials to determine if they were elder

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Highlights from a 2018 ACCC Survey on Multidisciplinary Approaches to Caring for Geriatric Patients with Cancer

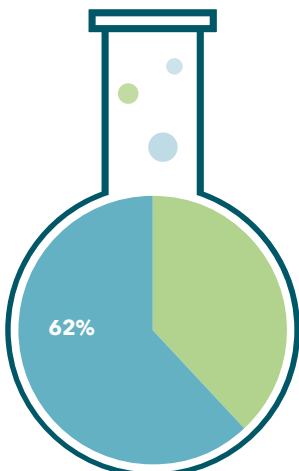
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Have any oncology providers or other clinical staff received a board certification in gerontology/geriatrics, taken specialty training, or have expertise in gerontology/geriatrics (may include research interest)?



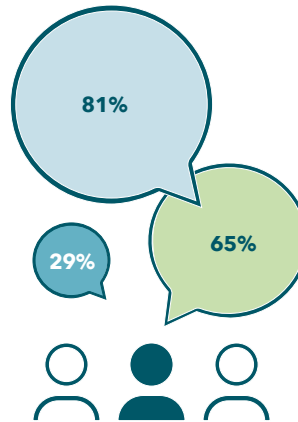
Top 5 barriers to conducting a comprehensive geriatric assessment

1. Time constraints
2. Limited familiarity with available validated geriatric screening/assessment tools
3. Limited personnel
4. No geriatric expertise at program
5. Limited resources to follow-up on abnormalities



Clinical trials

While cancer is more prevalent among those aged 65 and older, these patients are under-represented in clinical trials. Most respondents (62%) are not aware of efforts in place or planned at their cancer program to increase clinical trial participation among older adults.

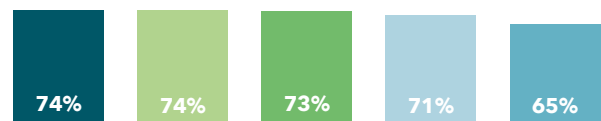
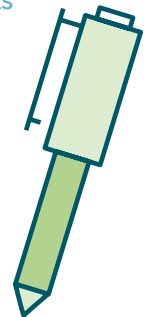


Respondents said that gaps or breakdowns in communication between medical oncology and other healthcare providers most likely occur when:

- Patients have multiple providers
- Patients go to a non-network ER
- Patients see their primary care provider

Prior to starting treatment, respondents most cited evaluating these 5 factors in their older adult patients:

1. Risk of falls
2. Evaluation of support system/caregivers
3. Transportation barriers
4. Polypharmacy/medication assessment
5. Financial toxicity

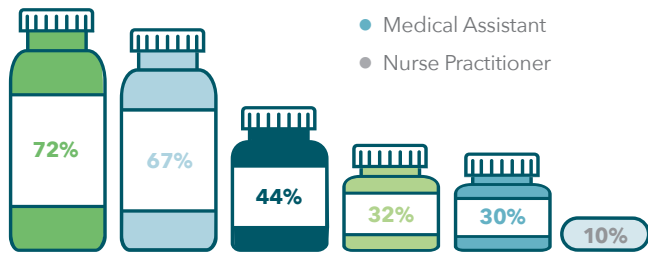


Health information technology (HIT) that supports screening patients for high-risk medications is underutilized:

- Only 36% report using HIT to identify medication/disease contraindications
- About 1/4 (26%) report using HIT to identify medications significantly associated with adverse events
- Only 1 in 5 report using HIT to identify treatment risks that outweigh benefits



Who is responsible for performing medication assessments?



- Physician
- Nurse
- Clinical Pharmacist
- Physician Assistant
- Medical Assistant
- Nurse Practitioner

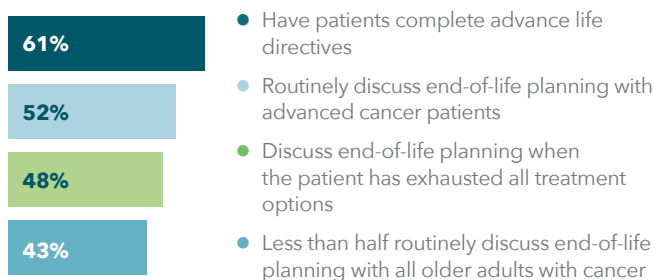
Top interventions that may occur based on abnormalities discovered in geriatric assessment:

- 83%** Refer patients to supportive services (e.g., nutritional consult, psychiatry, social work support, physical or occupational therapy, etc.)
- 72%** Discuss results with patients and caregivers/families
- 70%** Coordinate with appropriate specialist (e.g., cardiologist, diabetes specialist)
- 67%** Dose reduction of the treatment regimen or switch to an easier regimen
- 58%** Provide additional patient education based on the needs
- 53%** Coordinate with outside PCP
- 39%** Refer patients to a clergyman or mental health counselor

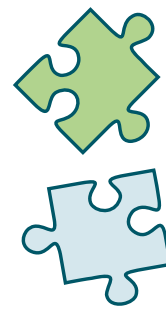


Less than half of respondents' cancer programs (44%) have a formal process for transitioning patients to post-treatment and survivorship care.

Respondents reported these as the most common end-of-life planning discussions, processes, and actions taking place with older patients in their cancer programs:

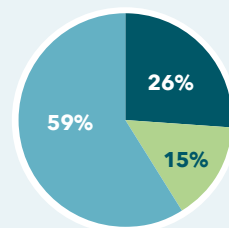


Respondents cited these challenges to palliative care referral:



- 68%** Patients don't understand the benefits of palliative care and/or think it's the same as hospice care
- 55%** Palliative care is thought of late in the treatment experience
- 40%** Physicians don't understand the benefits of palliative care
- 32%** There are not enough trained staff

Shared Decision-Making (SDM)

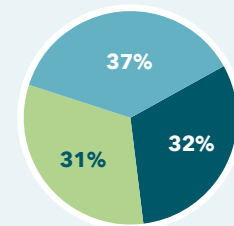
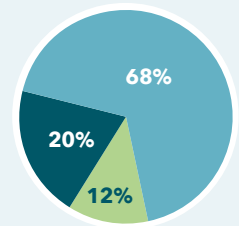


I am familiar with SDM model

- Strongly Agree/Agree
- Neutral
- Disagree/Strongly Disagree

I recognize benefits of using SDM model with older adult patients

- Strongly Agree/Agree
- Neutral
- Disagree/Strongly Disagree

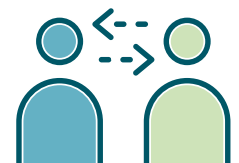


I feel confident using the model in care of older adult patients

- Strongly Agree/Agree
- Neutral
- Disagree/Strongly Disagree

I employ the SDM model in the care of older patients under the following circumstances:

- 54%** When discussing end-of-life care decisions
- 52%** When discussing palliative care
- 46%** Routinely with all older patients
- 43%** When discussing preference-sensitive decisions (i.e., multiple medically appropriate options)
- 41%** When family members are involved in the discussions
- 38%** When discussing whether to have chemotherapy for advanced-stage cancer
- 34%** When discussing whether to have chemotherapy for early-stage cancer
- 33%** When patients explicitly state—or demonstrate—they want to be more involved in making decisions about treatment



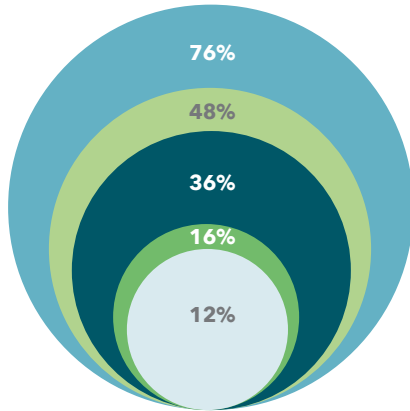


Challenges implementing and using the SDM model with older patients:

- 62%** Time constraints
- 49%** Support staff lacks training to implement, manage, and evaluate decision-aids
- 48%** Lack of patient education and information resources designed for older adults with cancer (e.g., with large fonts and well-contrasted backgrounds for readability)
- 44%** Insufficient knowledge and training to confidently utilize SDM
- 41%** Lack of educational resources such as visual aids and decision-aids
- 38%** Communication barriers (e.g., patient highly distressed, depressed, hearing loss, language)
- 34%** Low health literacy and limited numeracy skills

Techniques for evaluating fitness for treatment in older adults

- ECOG/Karnofsky performance status
- Evaluation of activities of daily living (ADLs)
- Review notes in medical record
- Do not formally evaluate
- Timed Up and Go (TUG)



Techniques for evaluating cognitive status of older adults



- 54%** Asking simple questions to assess orientation
- 36%** Mini mental status exam
- 27%** Don't formally evaluate cognition with older patients
- 16%** Montreal Cognitive Assessment (MOCA)
- 14%** Mini-Cog

Techniques for evaluating the psychological status/depression of older adults



- 55%** NCCN distress thermometer
- 36%** The patient interview
- 34%** Ask the patient directly if depressed
- 33%** Use feedback from caregivers
- 15%** Geriatric Depression Scale
- 12%** Hospital Anxiety and Depression Scale
- 12%** Don't formally evaluate

Techniques for evaluating comorbidities in older adults



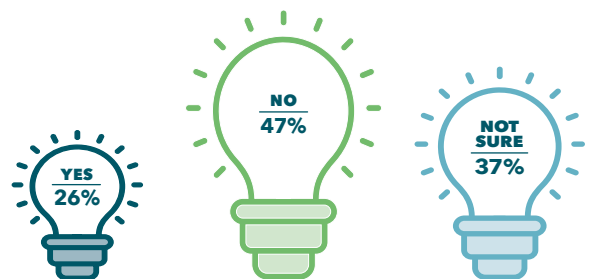
- 68%** History and physical exam by oncologist
- 55%** Check EHR for comorbidities
- 51%** PCP notes
- 50%** Patient interview
- 18%** Charlson Comorbidity Index, ePrognosis, or other
- 14%** Don't formally evaluate

Techniques for evaluating toxicity risk for proposed chemotherapy in older adults



- 37%** CARG (Cancer and Aging Research Group) Toxicity Calculator
- 23%** CRASH (chemotherapy risk age scale for high-risk patients) Score Calculator
- 46%** Not sure/no formal tool

Does your cancer program provide training or continuing education programs that have helped you be more aware of the potential for bias, and/or learned techniques to reduce implicit bias including age-related bias toward patients?



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friendly. Working with their marketing department, they are in the process of redoing the medication education materials for chemotherapy and oral oncolytics, reformatting these with larger fonts and more spacing. McLaughlin and Lauren Decarlo Ingersoll, RN, also collaborated with local dentists to create a trifold pamphlet that explains the importance of oral hygiene for overall health after an internal survey revealed awareness was lacking.

This pilot led to several changes in practice including the development of door hanger materials with basic information about oral health, as well as a more detailed trifold with patient education that can be given to every patient (also available in Spanish). The pamphlet has been approved for use with geriatric cancer patients and as an added benefit, with general oncology patients, including pediatric patients.

Sidney Kimmel Cancer Center at Jefferson Health, Thomas Jefferson University Hospitals

The Sidney Kimmel Cancer Center at Jefferson Health has nearly a decade of experience in delivery of comprehensive geriatric assessments through its multidisciplinary Senior Adult Oncology Center. Officially launched in 2010, Jefferson's model is a one-time multidisciplinary consultative service that is inter-professional and team-based. All providers see the patient in one visit. Each appointment requires about two to two-and-a-half hours. During the visit, the patient is seen by the core team: medical oncologist, geriatrician, social worker, pharmacist, and dietitian. Other specialists are added as needed (e.g., radiation oncologist, physical therapist).

At the conclusion of the conference, the providers meet to talk through and synthesize the information gathered through the evaluation appointment and reach consensus on recommendations. The full consultative report, with notes from each healthcare professional, is completed within 24-48 hours and is available in the EHR, including the patient portal.

The Jefferson Senior Adult Oncology Center collects data points for several domains within their work, in addition to the many validated assessment tools that are used on appointment day. Pharmacists also meet with patients to help them manage their medications and document this information along with the potential for any drug interactions. 

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More Tools and Resources Online Now

- ACCC's hub of resources and tools, including an expert-led on-demand webinar series is available at accc-cancer.org/geriatric.
- A comprehensive listing of validated geriatric assessment tools can be found at accc-cancer.org/GeriResources.
- Detailed case studies and additional guidance in the new ACCC publication "Multi-disciplinary Approaches to Caring for Older Adults with Cancer" can be downloaded at accc-cancer.org/geriatric.

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References

1. Smith BD, et al. Future of cancer incidence in the United States: burdens upon an aging, changing nation. *J Clin Oncol*. 2009;27:2758-2765.
2. Bluethmann SM, Mariotto AB, Rowland JH. Anticipating the "Silver Tsunami": Prevalence, trajectories and comorbidity burden among older cancer survivors in the United States. *Cancer Epidemiol Biomarkers Prev*. 2016. 25(7):1029-36. Available online at cebp.aacrjournals.org/content/25/7/1029. Last accessed July 11, 2019.
3. Chapman A, Mackenzie A, Parker I. Silver Oncologic Tsunami: Quality Issues in the Senior Adult Oncology Population. *J Oncol Pract*. 2015;11(3):190-192.

4. American Cancer Society. Cancer Treatment & Survivorship Facts & Figures 2016-2017. Available online at cancer.org. Last accessed July 11, 2019.
5. American Cancer Society. Cancer Facts & Figures 2019. Special Section: Cancer in the Oldest of the Old. Available online at cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-special-section-cancer-in-the-oldest-old-2019.pdf. Last accessed July 11, 2019.
6. Institute of Medicine. Delivering High Quality Cancer Care: Charting a New Course for A System in Crisis. Report Brief. National Academy of Medicine: 2013. Available online at nationalacademies.org/hmd/~media/Files/Report%20Files/2013/Quality-Cancer-Care/qualitycancer-care_rb.pdf. Last accessed July 11, 2019.
7. Mohile SG, et al. Practical assessment and management of vulnerabilities in older patients receiving chemotherapy: ASCO Guideline for Geriatric Oncology. *J Clin Oncol*. 2018;1;36(22):2326-2347.
8. Loh KP, et al. What every oncologist should know about geriatric assessment for older patients with cancer: Young International Society of Geriatric Oncology Position Paper. *J Oncol Pract*. 2018;14(2):85-94.
9. Ramsdale EE, et al. Improving quality and value of cancer care for older adults. ASCO Meeting Library. June 2017. Available online at meetinglibrary.asco.org/record/137881/edbook#fulltext. Last accessed July 11, 2019.
10. Politi MC, Studts JL, Hayslip JW. Shared-decision making in oncology practice: what do oncologists need to know? *Oncologist*. 2012;17(1):91-100.

A publication from the ACCC education program, "Multidisciplinary Approaches to Caring for Geriatric Patients with Cancer." Learn more at accc-cancer.org/geriatric.



The **Association of Community Cancer Centers (ACCC)** is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 25,000 multidisciplinary practitioners from 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit accc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn; read our blog, ACCCBuzz; and tune in to our podcast, CANCER BUZZ.

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