Care of the Older Person with Cancer:

TOOLKIT

The Integrated Cancer Services are supported by the Victorian Government

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Abbreviations

Abbreviation	Meaning
CGA	Comprehensive Geriatric Assessment
CNSA	Cancer Nurses Society of Australia
eRFA	Electronic Rapid Fitness Assessment
GICS	Grampians Integrated Cancer Service
HRICS	Hume Regional Integrated Cancer Service
MDM	Multidisciplinary Meeting
NEMICS	North Eastern Melbourne Integrated Cancer Service
RAHT	Rural Allied Health Teams
SIOG	International Society of Geriatric Oncology
SMICS	Southern Melbourne Integrated Cancer Service
SURC	Symptom and Urgent Review Clinics
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VICS	Victorian Integrated Cancer Services
WCMICS	Western and Central Melbourne Integrated Cancer Service

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Except where otherwise indicated, the images in this publication show models and illustrative settings only and do not necessarily depict actual services, facilities or recipients of services.

Available from the Victorian Integrated Cancer Services website www.vics.org.au/our-work.

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Introduction

The Australian population is ageing, and the risk of being diagnosed with cancer increases with age. With more Australians living to older ages, the number of cancer cases diagnosed each year continues to rise.[1] Nearly half of all Victorians diagnosed with cancer are over 70 years of age.[2] Older people can experience poorer responses to treatment and poorer outcomes due to:

- age-related vulnerabilities such as cognitive issues and functional deficits
- comorbidities that affect function and complicate management
- complex polypharmacy issues
- the risk of over- and under-treatment due to limited age-adjusted evidence (older people make up less than 10 per cent of trial participants).[3]

The development of the Care of the older person with cancer: toolkit supports the key focus areas of the Victorian Cancer Plan 2020–2024 and the Victorian Integrated Cancer Services (VICS) Implementation Plan and can connect with the priorities of local health service business and strategic plans.

Southern Melbourne Integrated Cancer Service (SMICS) and Hume Regional Integrated Cancer Service (HRICS) have created this toolkit to provide a reference point for Victorian health services considering implementing new approaches to caring for older people with cancer. The target audience includes oncologists, geriatricians, cancer care coordinators, nurse practitioners, allied health professionals and operational executive/managers.

This toolkit provides information on:

- using screening tools to help identify older, vulnerable cancer patients who will benefit most from a geriatric assessment
- comprehensive geriatric assessment (CGA) to identify areas of vulnerability, assist in clinical treatment decisions and guide interventions in routine oncology practice
- practical suggestions to identify and address existing barriers
- examples of geriatric oncology services that have been implemented and used in Australian health services
- key resources including links to calculators, how-to guides, guidelines, education opportunities, patient resources and further considerations.

The toolkit aims to start a conversation in health services about what services are currently available and what the possibilities are for first steps, moving ahead or a potentially larger focused effort. It provides an opportunity for health services to partner with their local ICS to identify local needs and implementation opportunities. Awareness and access to existing local hospital/community services should be a priority to determine how to effectively add value to the care of older people with cancer. Contact your local ICS for support.

This toolkit is designed to be a 'living document' and will be added to, edited and revised over time. As such, the document will only be up to date at the time of access or download. If users have additional information that would be beneficial to include, please email info@humerics.humehealth.org.au.

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[1] Australian Institute of Health and Welfare. Cancer in Australia 2021. Cancer series no. 133. Cat. no. CAN 144. AIHW, Canberra, 2021.

[2] Victorian Government. Victorian Cancer Plan 2020–2024: Improving cancer outcomes for all Victorians. Department of Health, Melbourne, 2020.

[3] Sedrak MS, Freedman RA, Cohen HJ, et al. Older adult participation in cancer clinical trials: a systematic review of barriers and interventions. CA Cancer J Clin. 2021; 71(1):78–92.

Background

In 2019 VICS funded SMICS to undertake a statewide geriatric oncology scoping project. The project aim was to gain a comprehensive understanding of current geriatric oncology services (or models of care), guidelines and other resources available for older people with cancer to inform future geriatric oncology initiatives in Victoria. The program of work included a literature review, services and resources mapping and a statewide stakeholder workshop.

Key recommendations from the project included:

- standardising the use of **geriatric oncology screening tools** across Victoria
- wherever possible, providing a **multidisciplinary approach** for older people with cancer
- offering more **educational opportunities** for both clinicians and older patients with cancer.

A proposed future action from the project was for **VICS to support implementation of routine geriatric screening for people over 70 years of age with cancer.**

VICS also commissioned NEMICS in 2019 to develop a scoping report Addressing Variation in Outcomes Related to Disadvantaged Groups.

This report examined key markers of 'disadvantage' including 'hard-to-reach' (or 'disadvantaged') groups in the context of cancer care, to provide a starting point in improving outcomes for disadvantaged groups, including older people, across Victoria.

The report identified several key issues for the elderly population (aged 80 years or older or particularly frail) including:

- late presentation and diagnosis and poor response to treatment contributing to poorer outcomes
- complicated management due to comorbidities and functional status
- polypharmacy issues
- exclusion from clinical trials
- social isolation.

Alignment

This toolkit aligns with the following plans and standards.

Victorian Cancer Plan 2020–2024

Long-term goal:

1. Achieve equitable outcomes for all Victorians.
2. Ensure Victorians have the best possible experience of the cancer treatment and care system.

Cancer plan principle: Person-centred care with equity of access and outcomes.

System support: Supporting and systematic scaling-up of innovative practice across regions and for priority groups.

Action area 3 – Treatment: Following a cancer diagnosis, all Victorians should get the best treatment and care, regardless of where they live or who they are. This is critical to ensure we achieve equitable cancer outcomes for all Victorians.

Cancer plan priority: Improve patients' experience of care.

VICS Implementation Plan 2021–2022

Focus Area 3: Address the needs of the older person in routine cancer care by supporting health services to implement geriatric oncology models of care.

National Safety and Quality Health Service Standards

Care of the older person with cancer aligns with the following National Safety and Quality Health (NSQHS) standards:

- Partnering with Consumers Standard – recognises the importance of involving patients in their own care and providing clear communication to patients.
- Comprehensive Care Standard – ensure patients receive comprehensive health care that meets their individual needs, and considers the impact of their health issues on their life and wellbeing. Validated screening tools can help identify older, vulnerable cancer patients who will benefit most from a geriatric assessment or from a referral to a geriatrician for further evaluation.

Screening tools

Validated screening tools can help identify older, vulnerable cancer patients who will benefit most from a geriatric assessment or from a referral to a geriatrician for further evaluation.

The Vulnerable Elders Survey (VES-13)[4] is a simple, function-based tool for screening community-dwelling populations to identify vulnerability in older people who may be at increased risk of death or functional decline. The components of the 13-item questionnaire include age, self-rated health, limitations in physical function and functional disabilities. While the VES-13 can be administered by a clinician, it tends to rely on patient self-reporting and takes less than five minutes to complete. A score of three or more is considered at risk for vulnerability.

The G8[5] is a brief, clinician-administered tool validated in adults with cancer aged 70 or older. It comprises eight questions and takes five to 10 minutes to complete. It assesses age, appetite, weight loss (BMI), mobility, mood, cognition, the number of medications used and patient-rated health. Abnormal scores are 14 or less out of a possible score of 17, which suggests vulnerability and the need for further assessment.

If screening scores are abnormal, geriatric assessment and guided multidisciplinary interventions are recommended.[6]

The Clinical Oncology Society of Australia's Geriatric Oncology Guideline Working Group published a systematic review investigating the evidence for using geriatric assessment screening tools in older adults with cancer. Findings indicate that the G8 and VES-13 have the most evidence to recommend their use in clinical practice to identify possible vulnerabilities in older people with cancer and to inform the need for geriatric assessment.[7] For screening to be meaningful, processes need to be in place to enable further evaluation, tailored interventions and some degree of follow-up.[8]

However, even in the absence of screening tools, there is broad consensus that a CGA should be offered to at-risk patients with cancer over the age of 65.[9,10,6]

For links to screening tools please see: https://siog.org/resources/resources-siog/comprehensive-geriatric-assessment/

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[4] Saliba D, Elliott M, Rubenstein LZ, et al. The Vulnerable Elders Survey: a tool for identifying vulnerable older people in the community. *J Am Geriatr Soc.* 2001; 49(12):1691–1699.

[5] Soubeyran P, Bellera C, Goyard J et al. Validation of the G8 screening tool in geriatric oncology: the ONCODAGE project. *J Clin Oncol.* 2011;29(suppl): abstr 9001.

[6] Decoster L, Van Puyvelde K, Mohile S, et al. Screening tools for multidimensional health problems warranting a geriatric assessment in older cancer patients: an update on SIOG recommendations. *Ann Oncol.* 2015; 26(2):288–300.

[7] Garcia MV, Agar MR, Soo W, et al. Screening tools for identifying older adults with cancer who may benefit from a geriatric assessment: a systematic review. *JAMA Oncol.* 2021; 7(4):616–627.

[8] Tremblay D, Charlebois K, Terret C, et al. Integrated oncogeriatric approach: a systematic review of the literature using concept analysis. *BMJ Open.* 2012; 2:e001483.

[9] Mohile SG, Dale W, Somerfield MR, et al. Practical assessment and management of vulnerabilities in older patients receiving chemotherapy: ASCO Guideline for Geriatric Oncology. *J Clin Oncol.* 2018; 36(22):2326–2347.

[10] Dotan E, Walter LC, Browner IS, et al. NCCN Guidelines® Insights: older adult oncology, version 1.2021. *J Natl Compr Canc Netw.* 2021; 19(9):1006–1019.

Comprehensive geriatric assessment

A CGA informs treatment planning and decision making in caring for older people with cancer. The primary benefit of undergoing a CGA is identifying vulnerabilities often missed in standard oncology assessments that may influence planned cancer treatment.

A CGA:

- is multidimensional and interdisciplinary
- aims to determine an older person's functional status, history of falls, comorbidity, cognition, continence, psychological status, social activity/ support, pharmacotherapy, general health, nutritional status and bone health (see Figure 1)
- includes both assessment and management/ guided interventions
- is person-centred, including patient goals and priorities, and may include discussions on advance care planning
- informs development of a coordinated and integrated plan for treatment and follow-up.

Targeted interventions can be prescribed to manage non-oncologic problems including social issues, poor nutrition, polypharmacy, mobility problems and cognitive impairment. A recent Australian study showed that intervention informed by CGA leads to better quality of life, reduced unplanned hospitalisation and reduced early treatment discontinuation for people receiving systemic anticancer treatment.[11]

[11] Soo WK, King MT, Pope A, et al. Integrated geriatric assessment and treatment effectiveness (INTEGERATE) in older people with cancer starting systemic anticancer treatment in Australia: a multicentre, open-label, randomised controlled trial. *Lancet Healthy Longevity*. 2022; 3(9):e617–627.

Figure 1: Domains of a comprehensive geriatric assessment

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As there is no agreed standardised set of geriatric assessment measures, health services can decide which assessments are appropriate for them depending on available workforce and resources (Table 1).

Table 1: Domains of a CGA, assessment examples and possible actions

CGA component	Assessment examples	Possible actions
Comorbidities	Older Americans Resources and Services (OARS) Cumulative Illness Rating Scale-Geriatric (CIRS-G) Charlson Comorbidity Index (CCI)	Determine if comorbidities are being managed appropriately
Cognition	Mini Cog cognitive assessment Mini-Mental State Exam (MMSE) Rowland University Dementia Assessment Scale (RUDAS) Montreal Cognitive Assessment (MoCA) Pain Assessment in Advanced Dementia (PAINAD)	Geriatrician, psychiatry of later life or neurologist referral if applicable Screen for organic causes of cognitive decline if appropriate
Nutrition	Malnutrition Screening Tool (MST) Mini Nutritional Assessment Body mass index (BMI)	Dietitian referral Consider anti-nausea medications Consider ceasing medications that may be adversely affecting appetite
Polypharmacy	Medication review	Pharmacist review of medications for interactions, duplications and appropriateness for use in older adults Medication education / assess patient adherence De-prescribe medications that may no longer be beneficial, having discussed with the patient and family
Social support	Supportive care screening tools	Home care supports, community programs My Aged Care referral Social work input
Mental health	Geriatric Depression Scale (GDS4) Generalized Anxiety Disorder-7 (GAD-7) NCCN Distress Thermometer Hospital Anxiety and Depression Score (HADS) Patient Health Questionnaire (PHQ-4 or 9)	Referral to social work or psychologist if applicable Psychosocial oncology programs/ clinics Cancer support groups

Table 1: Domains of a CGA, assessment examples and possible actions

CGA component	Assessment examples	Possible actions
Physical function	Karnofsky Performance Scale	Prehabilitation/rehabilitation
	Activities of daily living (ADL)	Physiotherapist / occupational therapist referral
	Instrumental activities of daily living (iADL)	Exercise program prescribed
	Timed Up and Go (TUG) Test	Home safety evaluation
	Short Physical Performance Battery (SPPB)	
	History/risk of falls	
	Questions about vision and hearing quality	
	Duke Activity Status Index (DASI)	
Continence	The 3 Incontinence Questions (3IQ)	Determine continence and support the patient with issues
	NSW Health Community Nursing Bladder Assessment	
Bone health	Bone density scan (DXA)	Dietary and lifestyle advice
	FRAX score	Calcium and vitamin D supplements and/or antiresorptive agents if appropriate

Below are some examples of composite forms that comprise the domains of a CGA.

- The 'Adelaide Tool' (developed by the Royal Adelaide Hospital Care Centre) comprises a number of screening tools to collect information on patient demographics, comorbidities, medications and physical function.[12,13]
- The Electronic Rapid Fitness Assessment (eRFA) categorises patients who are fit from those who are frail. The assessment includes questions related to a patient's functional status, level of social support/activity, emotional wellbeing, nutritional status, polypharmacy and cognitive assessment.[14] See website for access.
- The Cancer Specific Geriatric Assessment is a brief, comprehensive, mainly self-administered geriatric assessment questionnaire for older patients with cancer.[15]
- The Preoperative Assessment in Elderly Cancer Patients (PACE) is a brief tool to assess older patients' fitness prior to surgical intervention for their cancer.[16]

[12] To THM, Okera M, Prouse J, et al. Infancy of an Australian geriatric oncology program – characteristics of the first 200 patients. *J Geriatr Oncol.* 2010; 1(2):81–86.

[13] George M, Smith A. Use of an abbreviated geriatric screening tool in the assessment of older cancer patients' functional status, dependency, and comorbidities: cross-sectional audit and observations from a regional cancer center in Australia. *JMIR Cancer.* 2020; 6(1):e16408.

[14] Shahrokni A, Tin A, Downey RJ, et al. Electronic rapid fitness assessment: a novel tool for preoperative evaluation of the geriatric oncology patient. *J Natl Compr Canc Netw.* 2017; 15(2):172–179.

[15] Hurria A, Gupta S, Zauderer M, et al. Developing a cancer-specific geriatric assessment: a feasibility study. *Cancer.* 2005; 104(9):1998–2005.

[16] Audisio RA, Pope D, Ramesh HSJ, et al. Shall we operate? Preoperative assessment in elderly cancer patients (PACE) can help: a SIOG surgical task force prospective study. *Crit Rev Oncol Hematol.* 2008; 65(2):156–163.

Barriers and enablers

Barriers and enablers to the implementation of components of a Geriatric Oncology Service

Older people with cancer are a large and heterogeneous group.[17] Understanding your patient profile and an audit of existing appropriate services required to establish a geriatric oncology service are key activities to understanding local barriers and enablers to implementation.

The Geriatric Oncology Gap Assessment (developed by the Association of Community Cancer Centers) can support this process.

1. **Location**
   When considering barriers to the implementation of a geriatric oncology service first establish whether there is appropriate service availability at the nearest health service to the patient's home base. Find appropriate services through your local ICS and make contact via the VICS website. Referral to a health service with a full complement of the required services would be ideal if easily accessible for the patient.

   If appropriate services are not available at the patient's nearest health service or they cannot easily access the closest available service, Table 2 lists alternatives to a full geriatric oncology service. Several enablers are identified for each barrier. The most appropriate will depend on what is accessible at each health service or, in fact, each individual patient.

   It should be noted that smaller regional and rural health and community services may provide appropriate elements of a geriatric oncology service closer to the patient's own home, limiting their need to travel. Services include, but are not limited to, allied health professionals, pathology services, pharmacology and social support.

2. **Resources**
   There can be limited access to some allied health professionals on-site or locally due to long wait times following referral. Alternative services can be accessed through private or independent facilities advertised locally or student programs based in regional and metropolitan universities. Links to specific services listed in Table 2 are an example of those available. Note that these are not endorsements of the organisation, their expertise or competency in service delivery.

   Rural Allied Health Teams (RAHTs) are multidisciplinary services including the disciplines of nutrition and dietetics, occupational therapy, physiotherapy, podiatry, social work and speech pathology. The teams provide services at home or in the community to frail older people and people with disability and their carers. This includes education, treatment, therapy and self-care strategies to help manage a range of health conditions and meet individual needs.

3. **Financial implications**
   When planning support services and treatments for patients, consider other factors that may affect the patient's access to facilities. Financial limitations can affect a person's access to services provided outside the public system. Access to transport options is another factor.

4. **Service demographics**
   Other considerations should include cultural and linguistic barriers as well as those experienced by other diverse groups such as the LGBTIQ+ community, which can all affect the person's ability and ease in interacting with health services.

[17] Lowsky DJ, Olshansky SJ, Bhattacharya J, et al. Heterogeneity in healthy aging. *J Gerontol A Biol Sci Med Sci.* 2014; 69(6):640–649.

Considerations when determining funding requirements for implementing services to support older people with cancer include:

- if the service is provided through a public or private health service or a combination of public and private funding
- the clinicians involved and the components of the proposed service (see below for options/ inclusions to consider)
- consultation with your local health service finance department before developing your business case to identify the information requirements for completion
- information about the following, which could be important in supporting your case:
    - MBS-billed items# and billable clinicians involved and the prospective revenue for the clinician and/or health service
    - if an increase to health service activity funding is required
    - how to optimise existing services or clinician activity to include aspects of a geriatric oncology model
    - benefits to the patient – improved outcomes, health-related quality of life*
    - benefits to the health service – fewer presentations to ED, fewer unplanned admissions, reduced length of stay if admission required.*

* Local data and/or research references to support the assertions should be included.

Multidisciplinary clinics can be MBS-billed depending on whether they fulfill certain criteria – search in MBS Online. These clinics can also be block-funded – please check with your health service clinicians and finance department for which is most appropriate.

Grants can be secured for health services to research or provide education to nursing staff involved in services through The Victorian Nurse and Midwives Trust: https://www.vnmt.org/grants. Recent recipients have secured funding for research into nurse led oncology services for older patients: https://www.vnmt.org/recipients

Other options for grants funding could be accessed through your local ICS.

Medicare funding for multidisciplinary care can be accessed by the patient's GP completing a Chronic Disease Management Plan. Private services can be accessed via Medicare through a GP chronic disease and/or complex care management plan or through private health insurance. Gap fees may be payable depending on the service accessed and the provisions in the individual private health plan.

Full service components

- On-site coordinated service including discussion at a multidisciplinary meeting (MDM)
- Aboriginal and Torres Strait Islander health support
- Allied health – dietetics, exercise physiology, physiotherapy, occupational therapy, speech pathology, social work
- Substance use cessation
- Geriatrician
- Oncologists – medical and radiation
- Palliative care
- Pathology
- Pharmacy
- Psychology, psychiatry, psycho-oncology
- Service coordination
- Specialist nurses – tumour-specific, cancer care coordinator and geriatric
- Support for culturally and linguistically diverse people with cancer
- Support for LGBTIQ+ people with cancer
- Surgeons

Table 2: Barriers and enablers

Barrier	Enablers (information and education)	Enablers (established programs/tools)	Enablers (service options)

No local geriatric service or service capacity limited, therefore unable to access a timely local CGA and associated recommendations
 	
Assessment fact sheet
 	
Fact sheet references
	• Complete a geriatric oncology gap assessment to evaluate current geriatric oncology efforts and prioritise steps for improvement.	• Pilot a brief geriatric assessment for patients 70 years of age or older to determine geriatric needs or resources that could be offered (e.g. the Adelaide Tool or eRFA – see page 7 for more information).	• Implement a multidisciplinary service using validated tools to determine:
			  • medical health
			  • physical functioning
			  • psychological functioning
			  • social functioning.
			• Use results to guide activities to support the patient before, during and after treatment.

Limited availability of clinicians able to perform screening to identify vulnerable patients	• Education in using a validated screening tool such as G8 or VES-13 screening by all medical and nursing staff undertaking associated care within the acute service. • Note that improved familiarity with screening domains limits extra time required for screening. • Include geriatric-domain information at the MDM in treatment plans. • Extend education to primary care practitioners referring patients into the service – screen before admission.	• Develop referral criteria for patients aged 70 years or older from primary care to oncology services to include a geriatric screen.	• Integrate screening into the first specialist appointment. • Use a chemotherapy toxicity calculator for new patients aged 70 years or older who are likely to receive chemotherapy. • Adapt parameters that will generate a referral to fit local service availability – for example, age at initial screen or change of trigger score (G8 trigger score 14 lowered).

Barrier	Enablers (information and education)	Enablers (established programs/tools)	Enablers (service options)
No available staff or skills mix to undertake dedicated geriatric oncology service coordination		• Engage with service directors, medical staff, nurses, allied health professionals, admin staff and consumers to develop a sustainable pathway that is not person-dependent but is process-driven. • Develop a referral process and criteria as per the screening section above – trigger for CGA required.	
Limited access to local supportive care nurse(s) and/or tumour-specific specialist nurse(s)	• Supportive care nurses and tumour-specific specialist nurses provide support and education for patients with a diagnosis of cancer. Staff are funded either directly by health services, through foundations such as the Prostate Cancer Foundation of Australia and the McGrath Foundation or through other forms of community-based donations and sponsorship.	Tumour-specific online services, for example: • Prostate Cancer Foundation of Australia • McGrath Foundation – support for breast cancer patients • Bowel Cancer Australia • Lung Foundation Australia • Leukaemia Foundation	• 13 11 20 cancer support – Cancer Council Victoria • WeCan Cancer Supportive Care – for people affected by cancer
Allied Health Professionals			
The following sections relate to the limited access to allied health professionals involved in caring for older people with cancer	• Access to allied health services – Allied Health Professions Australia • National Health Services Directory		• Add geriatric assessment parameters to admission assessments such as measures of function, nutrition, cognition, social support, comorbidity and psychological state. **Specific elements are included for each allied health professional.**

Barrier	Enablers (information and education)	Enablers (established programs/tools)	Enablers (service options)
Exercise • Physiotherapy • Exercise physiology • Prehabilitation • Rehabilitation	• For prehabilitation components and support see the following services for implementing local service options: • Prehabilitation – Peter MacCallum Cancer Centre • Surgery School Presentation – patient resource	• Develop referral pathway and interventions through local community rehab service and/or RAHTs • Cancer Council Victoria programs and education: • Managing Cancer Program • Starting to exercise when you have cancer • PACE Living with Cancer Program • healthAbility – example of a community program to support people with a cancer diagnosis	• Develop referral pathway and interventions with other providers • Local private providers – Medicare scheme assessment and referral or insurance required: Find an accredited exercise professional Exercise for cancer – DNA Health Group Melbourne • Private mobile community providers (insurance required) Exercise for cancer – Guardian Exercise Rehabilitation • University programs – nominal fee: Clinical exercise and rehabilitation – Victoria University
Dietetics	Hospitalised patients aged 70 years or older with a BMI of 20 or below could be considered for a Mini-Nutritional Assessment and nutrition consult before discharge. Dietitians Australia Malnutrition Screening Tool CanEAT pathway and resources Cancer Council Victoria:	Develop referral pathway and interventions through local community rehab service and/or RAHTs.	• Develop referral pathway and interventions with other providers. • Local private providers – Medicare scheme assessment and referral or insurance required: • Dietitians – Oncology Clinics Victoria • Nutrition and diet for cancer patients – Melbourne Oncology

Barrier	Enablers (information and education)	Enablers (established programs/tools)	Enablers (service options)

Social work	• My Aged Care is the entry point for older Australians (aged 65 years or older; or 50 years or older **Aboriginal or Torres Strait Islander people**) to access government-funded aged care services including home care services, residential and respite care.
	• Australian Association of Social Workers – Victorian Branch
		• Community organisations providing support:
		  • Aged care – The Salvation Army Australia
		  • Housing – The Salvation Army Australia
		  • Financial assistance – The Salvation Army Australia
		• Develop referral pathway and interventions through local community services and/or RAHTs.
			• Other organisations providing support:
			  • 13 11 20 cancer support – Cancer Council Victoria
			  • Financial counselling – Department of Social Services, Australian Government
			  • Benefits and payments – Department of Social Services, Australian Government
			  • Seniors Connected Program – Department of Social Services, Australian Government

Occupational therapy (OT)	• For information:
	  • Occupational therapy – Peter MacCallum Cancer Centre
	  • Occupational Therapy Australia – representing occupational therapists
		Develop referral pathway and interventions through local community rehab service and/or RAHTs.
		Victoria - Independent Living Centres Australia (ilcaustralia.org)
		Yooralla | Home
			• Private OT service options – Medicare scheme assessment and referral or insurance required.
			• Mobile and virtual services:
			  • OT@Home – Quality Therapy Services
			  • Melbourne Wide Occupational Therapy – OT services
			  • Allied Therapy Services
			  • Community OT – Australia

Barrier	Enablers (information and education)	Enablers (established programs/tools)	Enablers (service options)
Pharmacy Limited access to a polypharmacy review program in which inpatients aged 70 years or older with more than five medications receives a pharmacist review of medications for interactions, duplication and appropriateness for use in older adults (using the Beers Criteria)	• Chemotherapy preparation – find a pharmacy – Pharmacies that prepare chemotherapy treatments can also offer other treatments including reviewing existing prescriptions.	• Private pharmacies offer medicine checks that can be government-funded depending on the individual circumstances. • Amcal Online – Medicine Review • MedsCheck – Ramsay Pharmacy	• Complementary medicines – tell your healthcare professionals – Better Health Channel Interaction between complementary and alternative medicine with conventional anti-cancer medicine[18]
Speech pathology	• Department of Health and Aged Care – Victoria speech pathology links	• Develop referral pathway and interventions through local community rehab service and/or RAHTs.	• Local private providers – Medicare scheme assessment and referral or insurance required: • Find a speech pathologist – Speech Pathology Aust.
Psychology **Psychiatry** **Psycho-oncology**	• For information: • Psycho-Oncology – Wiley Online Library • Psychosocial oncology – Peter MacCallum Cancer Centre • Psycho-oncology Co-operative Research Group (PoCoG)	• Local private providers Medicare scheme assessment and referral or insurance required: • Find a psychologist – Australian Psychological Society	• Cancer Mind Care – Exploring ways to look after your mind when you are affected by cancer • 13 11 20 cancer support – Cancer Council Victoria
Other Services			
Limited access to on-site palliative care services	Palliative care consortia – Department of Health	• Community services and consultancy services • Rural and regional palliative care consultancy services – Department of Health • Accessing a palliative care service – Better Health Channel • Palliative Care Advice Service	Palliative care services resources – Palliative Care Victoria Gwandalan – Aboriginal and Torres Strait Islander palliative care support

[18] Clarke S, Mclachlan A. Interaction between complementary and alternative medicine with conventional anti-cancer medicine. *Cancer Forum*. 2011;35.18–23.

Barrier	Enablers (information and education)	Enablers (established programs/tools)	Enablers (service options)
No trained smoking cessation facilitators Access to PBS supporting nicotine replacement therapies through GP prescription	• Training for health professionals in smoking cessation: • Training and resources for health services – Quit • Resources for pharmacists – Quit • Quit education FAQ • Supporting smoking cessation: a guide for health professionals – RACGP	• Quit	• How to quit smoking – Australian Government Department of Health • Smoking cessation – Lung Foundation Australia • Quit smoking – Amcal Online
Limited or no access to alcohol and other drug counselling on site	Telephone and online services – Department of Health	• Access through local community health services • DirectLine alcohol and drug counselling and referral in Victoria • Alcohol and other drug services – The Salvation Army Aust.	• SECADA • Adult drug and alcohol programs – Anglicare Victoria • Counselling Online – free drug and alcohol counselling in Australia
No Aboriginal health team on site For patients who identify as Aboriginal and/or Torres Strait Islander, the age for assessment is 50 or older	Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Cancer Australia https://www.ourmobandcancer.gov.au/	• Referral to Aboriginal Hospital Liaison Officer (AHLO) at nearest regional health service or metro health service. • Referral to local Aboriginal Controlled Community Health Organisations.	Service Directory – Deadly Story *For more information see section on:* Aboriginal and Torres Strait Islander people with cancer
Pre-treatment interventions	• Haematinics: nutrients required for the formation of blood cells including iron, B12 and folate. Deficiency in haematinics can lead to anaemia. • Management is required before surgery or chemotherapy. • https://publicpathology.org.au/	• Local public or private pathology service • Collection centres – Melbourne Pathology • Department Collection Centres – Austin Pathology • Dorevitch Pathology	• Hospitalised patients aged 70 years or older with a BMI of 20 or below could be considered for a Mini-Nutritional Assessment performed and nutrition consult before discharge. • Perform a preoperative assessment in patients aged 70 years or older to evaluate physical function and cognition before surgery to predict the risk for postoperative delirium, morbidity and mortality by using a clock drawing test (mini-COG) and TUG.

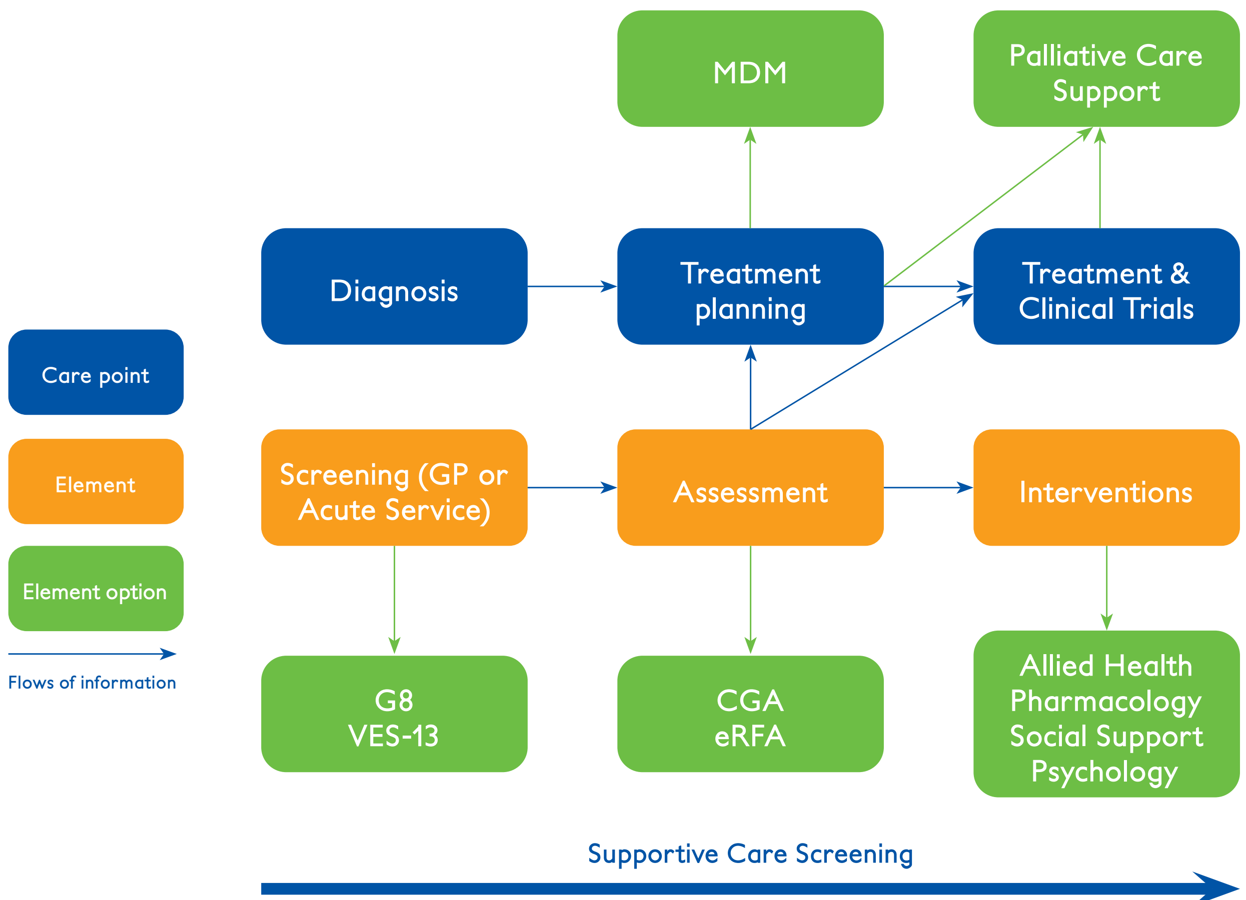
Examples of delivery

Geriatric oncology models of care include:

- oncologist refers patient to undergo a multidisciplinary CGA
- a geriatrician 'embedded' within an oncology clinic
- primary management by a dual-trained geriatric oncologist
- nurse-led program – administering screening and/or the geriatric assessment and undertaking data collection to provide input into integrated care plans, implementation and monitoring of the care plan, supportive care, coordinating referrals and patient communication
- comprehensive, multidisciplinary geriatric oncology service.

Each health service will be different on how they decide to implement depending on service availability (e.g. geriatrician, allied health) as per the **barriers and enablers** section. The flowchart below includes elements of service delivery and flows of information to support development of local tailored solutions.

Figure 2: Care of the Older Person with Cancer Flowchart



Below are a selection of examples from Australian health services that highlight care delivery options for older people with cancer. *This is not a complete list and has been included as examples only.*

Monash Health

Monash Health established a geriatric oncology service with initial support from SMICS. The service is run within an existing oncology clinic at Dandenong Hospital with a dual practicing general medicine/oncology specialist with a geriatrician. Patients are triaged based on age and vulnerability and identified either by the referring physician or at an MDM. Each patient undergoes a CGA, which identifies otherwise hidden problems and allows clinicians, patients and families to tailor cancer treatment so patients can benefit from modern therapies while protecting them from the risks. They are supported by a range of hospital-based and community allied health and supportive care services.

Refer also to:

- Australian Geriatric Oncology Clinic – Characteristics of the first 220 patients, the interventions and treatment recommendations made[19]
- Staging the ageing: vital lessons from the Monash Geriatric Oncology Service – YouTube

Albury Wodonga Health

Enhanced Supportive Care

The aim of this service is to screen, assess and provide extra support for those patients aged 70 years or older with a diagnosis of cancer (aged 55 or older for Aboriginal and Torres Strait Islander patients). Patients are screened using the G8 screening tool. For patients with a score of 14 or less, supportive care staff undertake a geriatric assessment (patients aged 85 or older are automatically assessed).

Patients are assessed using the electronic Rapid Fitness Assessment (eRFA), which can be clinician or patient/carer completed. A Timed Up and Go (TUG) test to assess mobility and 'Mini- Cog'/clock draw, which identifies changes in cognitive abilities, are also undertaken.

Results are discussed at a weekly supportive care meeting, with the clinician completing the assessment responsible for following up with appropriate referrals.

As of June 2023, 100 assessments have been completed. Although not always possible, the preference is to have this done before the first specialist oncology appointment. A formal education program, developed to support the service implementation, is in place as a reference and for education of newly employed staff and students.

The process has enhanced the ability of the team to deliver a sustainable program of personalised, age-friendly healthcare to older adults in the region.

The ESC program has been welcomed by the supportive care team who see it as a holistic approach to cancer care. Comments from team members include:

'Early identification of needs leads to patients being linked into multidisciplinary services earlier and subsequently receiving better care.'

'Sitting with patients and completing these assessments helps me gain a deeper understanding of them.'

'These assessments help prevent patients from falling through the gaps.'

For more information refer to the Cancer Nurses Society of Australia Annual Congress website.

A 2021 collaboration between Border Medical Oncology, the University of NSW and La Trobe University provided an opportunity to deliver patient-centred care for older people. Led by A/Prof. Christopher Steer, Photovoice project used photos shared by patients to represent themselves, their home, community and activities. The project showed that photos can be an effective way to identity what matters most to patients.

More recently, a further research collaboration is trialling 2 photographs and the 'This is me' tool in addition to the standard Enhanced Supportive Care model described above to further improve patient-centred, age-friendly health care at Albury Wodonga Regional Cancer Centre (AWRCC).

[19] Taylor C, Wagner I, Jaboury MS, et al. Australian Geriatric Oncology Clinic – Characteristics of the first 220 patients, the interventions and treatment recommendations made. *J Geriatr Oncol.* 2022; 13(4):530–540.

St Vincent's Hospital Melbourne

St Vincent's Hospital Melbourne established a geriatric oncology service offering specialised care to older Victorians with cancer via face-to-face and telehealth consults for patients.

This service provides Comprehensive Geriatric Assessment to appropriate patients with a diagnosis of cancer following screening with the G8 tool. Patients can undertake the CGA either face-to-face or via telehealth depending on their location or personal preference. The CGA recommendations support clinicians to optimise their patients general health and identify the most appropriate cancer treatment and care with their patients.

Both patient groups receive an hour-long consultant geriatrician assessment, with subsequent multidisciplinary coordination of care.

For guidance regarding the implementation of CGA via telehealth, please refer to Appendix 1 for information and options for delivery.

Peninsula Health

Peninsula Health ran a pilot geriatric survivorship project (funded by the Victorian Government). Cancer patients aged 70 years or older who had completed their cancer treatment were screened by a care coordinator using a CGA followed by geriatrician assessment. Referrals were made to a community cancer rehabilitation program and individualised elderly-specific survivorship care plans were sent to the patient's GP.

Northern Health

Northern Health launched its inaugural Haematology Geriatric Assessment service in September 2021. Newly diagnosed/relapsed lymphoma and myeloma patients over the age of 65 are assessed using the G8 screening tool. Patients who are considered to be frail (score < 14) follow a streamlined referral pathway to the geriatrics service for a CGA. Geriatricians aim to see patients within one month. Outcomes are communicated via MDM discussions or directly with treating clinicians.

Since the service began:

- 17 patients have been screened, with average G8 scores of 10
- 12 patients were referred to geriatricians, with nine receiving a CGA.

Clinicians and patients find the service useful in terms of raising awareness of the concept of frailty, as well as early geriatrics input into cognitive and nutritional assessment.

Castlemaine Health

Castlemaine Health has developed a supportive care model for optimising cancer rehabilitation and survivorship care for older people in a rural health facility.

In response to the need for improved service delivery for older people and to expand the reach of the service, Castlemaine Health incorporated new pathways into the existing model of care that target interventions for older cancer survivors and their carers/families.

Austin Health

The implementation and evaluation of a nurse-led, multidisciplinary (MDT) model of care for older persons with cancer project involves all older people newly diagnosed with lung, colorectal, upper gastrointestinal, and genitourinary cancers taking part in a nurse-led geriatric assessment before their initial consultation with the oncologist. Nurse-led assessments are primarily done in the patients' homes. Each patient is presented at a virtual MDT team meeting attended by a geriatrician, oncologist, palliative care physician/clinical nurse consultant, and the geriatric oncology nurse. At the MDT meeting an individual care plan is developed and the need for a geriatrician-led comprehensive geriatric assessment established.

The project has been running since September 2021. As of May 2023, 128 individuals have participated in the program. A formal evaluation of the program is currently underway including qualitative interviews with patients +/- caregivers and healthcare professionals involved in caring for older adults with cancer.

Eastern Health

Eastern Health has established two Ageing Resiliency in Cancer Clinics at Box Hill Hospital and Maroondah Hospital. The service offers health assessment by a geriatric oncologist to assist with treatment planning and optimise non-cancer health, functioning and quality of life. New cancer patients referred to the co-located Rapid Access Oncology clinics receive a screening assessment, and patients with identified risks are offered a CGA.

In addition, a NEMICS project is underway to implement brief frailty screening in the Box Hill Hospital Uro-Oncology Clinic, targeting men with a new diagnosis of prostate cancer aged 65 years or older. Patients who are identified as at-risk will be offered referral to the Ageing Resiliency Clinic or other services as appropriate.

Grampians Health – Horsham (Formerly Wimmera Health Care Group)

This service incorporates a supportive care model. A locally adapted version of the Adelaide Tool is used to screen all appropriate patients. A fortnightly supportive care MDM provides a supportive care plan from which recommended referrals and support are actioned following discussion with the patient. This project endures following funding from the Victorian Cancer Survivorship Program.

Metro North Hospital and Health Service (HHS), QLD

Metro North HHS provides screening, assessment and allied health and supportive interventions for people aged 60 years or older diagnosed with cancer. The service, led by nursing, allied health and medical oncology staff, is provided at Redcliffe Hospital, Caboolture Hospital and North Lakes Cancer Care Service.

Refer also to:

Our experience of nursing/allied health practitioner–led geriatric screening and assessment of older patients with cancer – a highly accessible model of care[20]

Princess Alexandra Hospital, QLD

This is a nurse-led model of care providing screening and assessment of older cancer patients. The Older Person Oncology Clinical Nurse Consultant completes a CGA with the referred patient. Planning of appropriate care and extra support with the patient ensures care is specific to each patient's needs. The model works closely with the multidisciplinary team including links with community services.

Liverpool Hospital, NSW

A traffic light prioritisation criteria developed for screening of patients with lung cancer. Those patients undergoing chemotherapy, chemo-radiation or radiation therapy with a Clinical Frailty Scale score ≥5 were screened.

An electronic G8 was created in MOSAIQ and completed by oncologists. An auto-generated geriatric referral is produced for patients with a G8 score ≤14 for CGA at the fortnightly Multidisciplinary Aged Care Cancer Service clinic. Appointments were undertaken with a physiotherapist, occupational therapist and geriatrician. There were no nursing resources to support the clinic.

A virtual MDM involving treating oncologists, geriatrician, physiotherapy, occupational therapy and lung cancer nurse coordinator was held to discuss the assessment and finalise oncology management. Approval of the notes recorded in MOSAIQ generated a letter for the GP, this was sent with a copy of the assessment.

For further information of this model of care: https://doi.org/10.1016/j.jgo.2023.101578

[20] Thaker DA, McGuire P, Bryant G, et al. Our experience of nursing/allied health practitioner led geriatric screening and assessment of older patients with cancer – a highly accessible model of care. *J Geriatr Oncol.* 2021;12(8):1186–1192.

Key Resources

The following links, relevant papers and guidelines provide additional information to support service implementation.

Networks/organisations

COSA Geriatric Oncology Group

The COSA Geriatric Oncology Group aims to improve outcomes for older adults affected by cancer through education, support for clinical practice, research and advocacy. Includes links to current activities, projects and webinars.

The group is currently developing guidelines/practice points to help improve the clinical management of older adults with cancer in Australia. This will include guidelines for screening tools for geriatric assessment; guidelines for referring older adults with cancer for systemic anti-cancer therapy, surgery and radiotherapy; and how geriatric assessment might be used to identify the unmet needs of older adults with cancer.

Cancer Nurses Society of Australia

Older Person's with Cancer – Cancer Nurses Society of Australia (CNSA)
Contact: olderpersonsspn@cnsa.org.au

The CNSA Older Person's with Cancer Specialist Practice Network, also known as the OPC SPN, was originally formed due to increased interest from the membership. The group recently transitioned to a Community of Practice with the inaugural event under development as of July 2023. CNSA provide a variety of professional development opportunities/webinars.

Safer Care Victoria

Safer Care Victoria works with clinicians and consumers to help health services deliver better, safer health care, including clinical guidance and driving improvement through targeted projects and training. The Care of Older Persons Clinical Network is one of 11 clinical networks at Safer Care Victoria.

A current improvement project is the Creating Age-Friendly Health Systems in Victoria, which aims to improve outcomes and experiences for older people in Victoria's health system by reliably assessing and acting upon the 4Ms:

1. What Matters: Know and act on each patient's specific health outcome goals and care preferences.
2. Mobility: Maintain mobility and function and prevent/treat complications of immobility.
3. Medication: Optimise use to reduce harm and burden, focusing on medications affecting mobility, mentation and what matters.
4. Mentation: Focus on delirium and dementia and depression.

This work builds on the Better Care Victoria–funded Building an age-friendly Indigo health system project

SIOG

The International Society of Geriatric Oncology, also called SIOG (Société Internationale d'Oncologie Gériatrique) in French, is a multidisciplinary membership-based society with members engaged in more than 80 countries around the world. The network includes geriatricians, medical oncologists, surgical oncologists, radiation oncologists, anaesthesiologists, nurses and allied health professionals. Journal of Geriatric Oncology

Association of Community Cancer Centres

The association provides a suite of resources to enhance care for older adults with cancer, including a Geriatric Oncology Gap Assessment to assess current efforts; a how-to guide for geriatric screening and assessment; a resource library; and webinars.

Cancer and Aging Research Group

The Cancer and Aging Research Group website contains links to resources, research and tools, including a **chemo-toxicity calculator.**

Hartford Institute for Geriatric Nursing

The Hartford Institute for Geriatric Nursing's 'Try this' series includes assessment/screening tools for best practice care for older adults.

Guidelines

Practical Assessment and Management of Vulnerabilities in Older Patients Receiving Chemotherapy: ASCO Guideline for Geriatric Oncology

- Developed by the American Society of Clinical Oncology.
- Geriatric assessment should be performed to identify vulnerabilities that are not routinely captured in oncology assessments in patients' aged 65 years or older receiving chemotherapy.
- The guidelines' minimum criteria for managing older patients with cancer are to:
    - predict chemotherapy toxicity
    - estimate non-cancer life expectancy
    - perform a functional assessment
    - assess the burden of comorbidities
    - perform falls screening
    - assess for depression
    - undertake malnutrition screening
    - assess cognitive capacity.

Addressing the quality of life needs of older patients with cancer: a SIOG consensus paper and practical guide[22]

- Developed by the Taskforce of the International Society of Geriatric Oncology.
- The paper advocates that the principles of geriatric evaluation and care should include:
    - obtaining diagnostic certainty (disease and domains of quality of life)
    - identifying comorbidities and estimating their severity
    - identifying and managing any geriatric syndromes
    - assessing and addressing medical-social factors
    - estimating survival prognosis
    - proposing a therapeutic program (oncology and non-cancer)
    - establishing a comprehensive care plan/ prioritising issues.

EORTC elderly task force position paper: approach to the older cancer patient[23]

- Developed by the European Organisation for Research and Treatment of Cancer.
- Treatment decisions should be based on patients' functional age rather than the chronological age.
- There is under-representation of older patients in cancer clinical trials.
- Use screening tools to identify patients with impairment who need further multidisciplinary evaluation.
- Recommends routine, structured CGA for cancer patients.

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[22] Scotté F, Bossi P, Carola E, et al. Addressing the quality of life needs of older patients with cancer: a SIOG consensus paper and practical guide. *Ann Oncol.* 2018; 29(8):1718–1726.

[23] Pallis AG, Fortpied C, Wedding U, et al. EORTC elderly task force position paper: approach to the older cancer patient. *Eur J Cancer.* 2010; 46(9):1502–1513.

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Education

The University of Melbourne and Victorian Comprehensive Cancer Centre Alliance

This online course will enhance understanding of cancer care for geriatric patients and help build confidence and knowledge to care for older people who have been diagnosed with or are undergoing treatment for cancer. This course draws on the world-leading knowledge of the University of Melbourne, the Royal Melbourne Hospital, the Victorian Comprehensive Cancer Centre and Sir Peter MacCallum Department of Oncology.

Topics covered include:

- demographics and prevalence
- communication and coordination of care
- diagnosis and treatment
- psychosocial and community-based support
- elder abuse
- vulnerable groups
- advance care planning.

The course is accredited by the Australian College of Nursing and The Royal Australian College of General Practitioners.

The University of Melbourne – Master of Cancer Sciences

This degree course includes an elective subject: Cancer across the Lifespan. To address the complex needs of different age groups, there is a need to look at the patient holistically to manage their complex medical conditions. In this subject, students will learn the specific factors associated with the care and treatment of children, adolescents, young, middle-aged and older adults and geriatrics with cancer, from the time of diagnosis to the time of death.

Graduate Certificate in Cancer Nursing

Nurses play a critical role in cancer care. The Graduate Certificate in Cancer Nursing will develop your capacity to work effectively within a multidisciplinary team and provide the highest level of cancer care.

The program, designed to be undertaken part-time over twelve months, combines flexible online study with immersive clinical learning and clinical competency assessment at your employing healthcare service. The course includes a module focusing on older people with cancer.

https://study.unimelb.edu.au/find/courses/graduate/graduate-certificate-in-cancer-nursing/

American Society of Clinical Oncology

The ASCO Patient-Centred Cancer Care for Older Adults course:

- includes older patients in clinical trials
- conducts geriatric assessments
- evaluates a patient's decision-making capacity.

The course also discusses the importance of considering treatment preferences and outcome priorities when planning cancer treatment for older adults.

SIOG

Courses – SIOG – SIOG Advanced Course in Geriatric Oncology

SIOG educational resources

European Society for Medical Oncology (ESMO)

ESMO E-Learning: Geriatric Oncology: An Introduction *(ESMO account/login required)*

eviQ

Cancer management of older Australians

Talking about elder abuse

The videos below have been developed by staff at the Peter MacCallum Cancer Centre and are available on their YouTube channel. They can serve as an educational resource for staff caring for older people or for health services to develop their own resources appropriate for the local context.

Emotional Elder Abuse - a sensitive conversation

Financial Elder Abuse: a sensitive conversation

Talking about Elder Abuse

Aboriginal and Torres Strait Islander people with cancer

The Victorian Cancer Plan 2020–2024 identifies the disparities in outcomes between Aboriginal and non-Aboriginal people in Victoria, with data showing higher cancer and mortality rates. The plan aims to reduce the inequalities in cancer care and outcomes experienced by Aboriginal Victorians through advancing self-determination and focuses on partnerships with Aboriginal organisations to effectively implement the Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer.

Older Aboriginal and Torres Strait Islander populations are determined to be those aged 50 years or older. The Aboriginal population is ageing, with the proportion aged 50 or older increasing over recent years. This growth is projected to continue, and by 2031 it is expected that one in five Indigenous people will be aged 50 or older (20 per cent).[24]

Many Aboriginal people with cancer need more support following a cancer diagnosis to achieve optimal outcomes. This will be realised through self-determined programs and services to improve communication, navigation and coordination of cancer care. This should be consistent with Korin Korin Balit-Djak and the Aboriginal and Torres Strait Islander cultural safety framework.[25,26]

Information and resources to support Aboriginal and Torres Strait Islander people who have cancer include:

- Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer
- Quick Reference Guide for Aboriginal and Torres Strait Islander People with Cancer
- Guide to Best Cancer Care for First Nations people – Cancer Council
- Improving outcomes for Aboriginal and Torres Strait Islander people with cancer requires a systematic approach to understanding patients' experiences of care[27]
- Aboriginal and Torres Strait Islander Health Performance Framework – AIHW
- Aboriginal Health – Creative Spirits
- Optimal Cancer Care for Aboriginal and Torres Strait Islander People: A Shared Approach to System Level Change.[28]
- Our Mob and Cancer
- VACCHO - Victorian Aboriginal Cancer Journey Strategy

'Hope and Connection - Bunjil'

[24] Australian Institute of Health and Welfare. *Older Australians, Older Aboriginal and Torres Strait Islander people.* AIHW, Australian Government, Canberra, 2021.

[25] Victorian Department of Health. *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027.* Department of Health Melbourne, 2017.

[26] Victorian Department of Health. *Aboriginal and Torres Strait Islander cultural safety framework – Part 1.* Department of Health, Melbourne, 2019.

[27] Green M, Cunningham J, O'Connell D, et al. Improving outcomes for Aboriginal and Torres Strait Islander people with cancer requires a systematic approach to understanding patients' experiences of care. *Aust Health Rev.* 2017; 41(2): 231–233.

[28] Chynoweth J, McCambridge M, Zorbas H, et al. Optimal cancer care for Aboriginal and Torres Strait Islander people: a shared approach to system level change. *JCO Global Oncology.* 2020: 6:108–114.

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Further considerations

Clinical trials

A key action area of the Victorian Cancer Plan 2020–2024 is to improve participation and reduce inequities in access to clinical trials. The plan notes certain groups of people are under-represented in cancer clinical trials including adults aged over 65 years with cancer.

Often, restrictive eligibility criteria including restrictions on age limits or exclusion as a result of comorbidities means that those who are included in trials often belong to a healthier subgroup. Under-representation of older cancer patients in trials could result in reduced treatment benefit compared with a younger, healthier study population as well as more toxicity or treatment-related complications.[29]

To gain the best evidence to guide treatment decisions for older adults with cancer, clinical trials need to consider broader eligibility criteria.

Examples of trials of treatment specific to older aged people with cancer are:

The GO2 Phase 3 Randomised Clinical Trial

ReViTALISE is a clinical trials program run through the Regional Trials Network located in a number of health services across regional Victoria. Funding has been provided to address inequities of access to clinical trials for patients living outside of Metropolitan Melbourne. This includes specific projects to improve access for Aboriginal and Torres Strait Islander people and older people with cancer.

Symptom and urgent review clinics

Symptom and urgent review clinics (SURCs) are an innovative approach to managing patients receiving chemotherapy who experience symptoms from their cancer or treatment. Clinics have been implemented across Victoria's public hospitals in metropolitan and regional areas. These nurse-led models of care address identified gaps within a chemotherapy day unit to support patients experiencing treatment-related toxicities during the period of active treatment. SURCs can support older patients with cancer by initiating care pathways, identifying care needs and linking patients to geriatricians, allied health professionals and My Aged Care services.

Advance care planning

Advance care planning involves planning for future health and personal care including instances where a person may lose their decision-making capacity. It captures peoples' values and wishes and enables them to continue to influence treatment decisions, even when they can no longer actively participate. Advance care planning includes:

- expressing personal values and preferences for treatment and care through conversations with family, friends and health practitioners
- documenting these values and preferences in an advance care directive
- appointing a medical treatment decision-maker.

Advance care planning puts the person at the centre of care, involving them, their family (if appropriate) and the clinicians responsible for their care. It has been shown to improve quality of care at the end of life and increase the likelihood of a person's wishes being known and respected, with benefits for the health practitioner and the broader health service system.

Priority groups that would benefit from help in articulating their wishes for future treatment and care include:

- older people
- people of any age with chronic progressive and life-limiting conditions
- people approaching end of life
- people with multiple comorbidities and/or at risk of conditions such as stroke or heart failure
- people with cognitive impairment or dementia
- people who are isolated or vulnerable.

Advance care planning highlights several separate but related treatment issues. As a result, its role and purpose can be confused with other decision-making, legal and communication concerns.

[29] Extermann M, Brain E, Canin B, et al. Priorities for the global advancement of care for older adults with cancer: an update of the International Society of Geriatric Oncology Priorities Initiative. *Lancet Oncol.* 2021; 22(1):e29–e36.

Advance care planning is not:

- a substitute for good, informed consent about current treatment options (although discussing the values and potential health outcomes of these may help decisions to be made)
- a tool for distributing fair and equitable healthcare resources across the wider community
- a replacement for clinical face-to-face communication and engagement.

For further information:

- Advance care planning – Department of Health
- Advance Care Planning Australia
- Making an advance care directive – Office of the Public Advocate
- End-of-life and palliative care services – Better Health Channel

Role of the GP

A GP can provide a picture of the patient over a period of time rather than at a specific time point during a specialist consultation. GPs can be involved in screening of older aged patients with a new diagnosis of cancer or cancer recurrence. Identifying and explaining the need and benefit for additional assessment (CGA) by a geriatrician can be facilitated through the GP's relationship with the patient. Geriatrician referral for CGA can be included in the request for oncology specialist review (see Figure 3 for referral options). Requesting a CGA referral from a GP retrospectively (i.e. following oncology review by the acute service) can cause significant delays to accessing the assessment. This can impact the efficacy of geriatric oncology interventions.

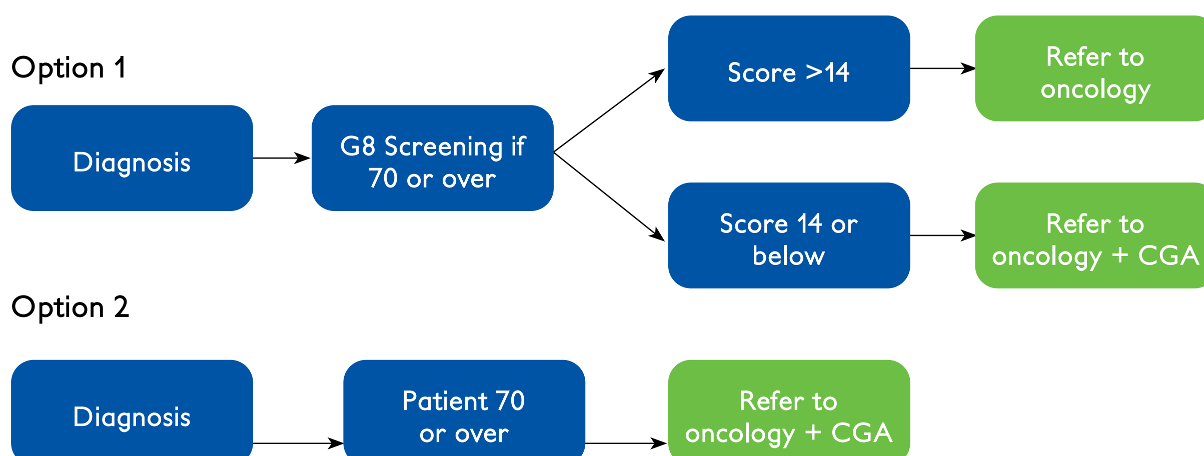
See Appendix 1 Implementation of a CGA via telehealth for more information about the GP's involvement in geriatric oncology models of care.

Metrics

Below are examples of common measures and indicators which health services could collect to support the evaluation of service provision.

- Percentage of new cancer patients aged 70 years and older who complete a validated screening tool
- Percentage of new cancer patients aged 70 years and older who complete a validated screening tool considered at risk for vulnerabilities.
- Percentage of new cancer patients completing a validated screening tool that are referred for a GA.
- Percentage of cancer patients referred for a GA who attend and complete the assessment.
- Percentage of MDTs in which a geriatrician is in attendance.
- The number of new referral pathways developed
- The number of referrals made including
    - Outpatients services
    - Community services, private, not for profit
    - Palliative care
    - Advanced care planning
- Unplanned hospital admissions
- Patient interviews/feedback

Figure 3: Primary to acute care diagnosis & CGA referral process options



Patient/Carer resources

Cancer Council Victoria

There are two Cancer Council Victoria programs suitable for (although not restricted to) older people with cancer:

1. The Managing Cancer Program (previously Living with Cancer Education Program) supports people during their treatment phase. The workshops empower people affected by cancer with useful skills and helpful information.

1. The Cancer Wellness Program supports those following the treatment phase and promotes self-management.

Both programs may include exercise sessions as part of the support from health professionals and are available across many Victorian health services.

Cancer Council Victoria has also developed an online referral form to improve access to support services.

With a patient's consent, health professionals can use the online form to refer patients for support. Once received, a cancer nurse will contact the patient directly and link them with appropriate support services.

Information and support is available on the Cancer Council website for people caring for someone with cancer. It includes details on the role of the carer, financial matters, looking after themselves and support services and resources.

Videos

A Common Path: Facing Cancer Later in Life has been produced by NEMICS. It provides an overview of geriatric oncology issues from the patient/carer perspective, including strategies they found useful to help them cope with their cancer later in life.

Another video resource suitable for older people with cancer, although not specifically geriatric oncology–focused, is Rural Cancer Stories. Rural patients, survivors and their carers share their stories about their cancer experiences and provide practical advice for those living in a rural area with a new cancer diagnosis.

The Cancer Council in collaboration with Swinburne University of Technology and Peter MacCallum Cancer Centre have developed a series of videos to offer support and information for those who are caring for someone with cancer.

Supportive care

A general patient/carer-focused cancer supportive care resource is the WeCan website. The site provides easy 'one-stop shop' access to various services, evidence-based information and specific resources developed by other organisations that specialise in cancer and community support.

Additional resources developed with and for older Australians affected by cancer (OlderCan) are housed on the WeCan website. The resources provide advice and support to help people (and older carers) make decisions about treatment and care. More specifically, 'This is ME' has been developed to share important information with a patient's GP and cancer team.

Carers Victoria

Carers Victoria is the statewide voice for family carers, representing and providing support to carers in Victoria. They also manage the delivery of programs, support and services for carers across Victoria.

Carerhelp

Carerhelp is a guide to end of life caring

Carers Couch

Carers Couch supports unpaid carers to make caring more manageable. Whatever you need, we can guide and connect you to services, solutions and emotional or community support.

Advocacy groups

The following links are for organisations which provide information and support to older people.

- https://opan.org.au/
- https://www.seniorsonline.vic.gov.au/elders-rights-advocacy
- https://seniorsrights.org.au/

Toolkit Quick Links

Domain	Link	Page
VICS		
Local support	Find Your Local ICS	2
Background:	Care of the older person with cancer Variation in outcomes related to disadvantaged groups	3
Governance	Victorian Cancer Plan VICS Implementation Plan NSQHS Standards	3
Screening & assessment		
Background	A Systematic Review	4
Tools	SIOG resources - screening tools eRFA Assessment fact sheet	4 7 10
Barriers & enablers		
Assessment	Geriatric Oncology Gap Assessment Assessment fact sheet	8 10
MBS	MBS online	9
Grants	The Victorian Nurse and Midwives Trust	9
Supportive Care	Supportive Care PCFA McGrath Foundation Bowel Cancer Australia Lung Foundation Australia Leukaemia Foundation 131120 – CCV cancer support WeCan – supportive care for people affected by cancer	11
Allied Health	Allied Health Professionals Australia National Health Services Directory	11
Exercise	Prehabilitation - PMCC Surgery school – The Christie Managing Cancer Program Starting to exercise when you have cancer PACE Living with Cancer Program Find an accredited exercise professional For service examples please refer to the toolkit	12

Dietetics	Dietitians Australia Malnutrition Screening Tool CanEAT pathway and resources For service examples please refer to the toolkit	12
Social work	My aged care Australian Association of Social Workers – VIC Salvation Army – Aged Care Salvation Army - Housing Salvation Army – Financial assistance Commonwealth Financial Counselling Benefits and Payments Seniors Connected Program	13
Occupational Therapy	Occupational Therapy Australia Occupational Therapy – PMCC Victoria - Independent Living Centres Australia (ilcaustralia.org) Yooralla | Home For service examples please refer to the toolkit	13
Pharmacy	The Pharmacy Guild of Australia Medicine review - Amcal Medicine review - Ramsay	14
Speech Pathology	Victoria Speech Pathology Links Speech Pathology Australia	14
Psychology/Psychiatry/Psycho-oncology	Psycho-oncology journal Psychosocial oncology – PMCC Psycho-oncology Co-operative Research Group (PoCoG) Australian Psychological Society – find a psychologist Cancer Mind Care	14
Other Services: Palliative care	Palliative care consortia Rural and regional palliative care consultancy services Accessing a palliative care service Palliative Care Advice Service Palliative Care Victoria Gwandalan – Aboriginal and Torres Strait Islander palliative care support	14
Smoking cessation	Training and resources for health services Quit – resources for pharmacists Quit education FAQ Quit RACGP guide for health professionals Commonwealth – How to quit smoking Lung Foundation Australia	15

AOD counselling	Telephone and online services (health.vic.gov.au) The Salvation Army - Alcohol and other drug services DirectLine alcohol and drug counselling and referral in Victoria For service examples please refer to the toolkit	15
Aboriginal Health	VACCHO - Victorian Aboriginal Community Controlled Health Organisation Inc Our Mob and Cancer | Cancer in Aboriginal and Torres Strait Islander People Services - Deadly Story	15
Pathology Services	Home - Public Pathology Australia For service examples please refer to the toolkit	15
Examples of Delivery		
Monash Health	Staging the ageing: vital lessons from the Monash Geriatric Oncology Service - YouTube Australian Geriatric Oncology Clinic - Characteristics of the first 220 patients, the interventions and treatment recommendations made	17
St Vincent's Hospital Melbourne	Onco-Geriatric Service - St Vincent's Hospital Melbourne and GV Health	17
Albury Wodonga Health	Cancer Nurses Society of Australia Annual Congress presentation Photos could unlock better cancer care for geriatric patients, world-first study finds - ABC News	17
Castlemaine Health	Cancer rehabilitation & survivorship service Pathways in a supportive care model for optimising cancer survivorship care for all older people in a rural health facility	19
Metro North HHS (QLD)	Our experience of nursing/allied health practitioner led geriatric screening and assessment of older patients with cancer – a highly accessible model of care	19
Liverpool Hospital (NSW)	Implementation and evaluation of a geriatric-oncology model of care for older adults with lung cancer	19

Key Resources		
COSA	The COSA Geriatric Oncology Group Geriatric Oncology Guideline Development	20
CNSA	Older Person's with Cancer - Cancer Nurses Society of Australia Congress & Events - Cancer Nurses Society of Australia	20
Safer Care Victoria	Creating Age-Friendly Health Systems in Victoria | Safer Care Victoria Building an age-friendly Indigo health system | Safer Care Victoria	20
SIOG	SIOG – International Society of Geriatric Oncology Journal of Geriatric Oncology (JGO) - SIOG Addressing the quality of life needs of older patients with cancer: a SIOG consensus paper and practical guide - Annals of Oncology	20
Association of Community Cancer Centers	Older Adults with Cancer (accc-cancer.org) Geriatric Assessment - How to Guide (accc-cancer.org)	20
Cancer and Aging Research Group	Cancer and Aging Research Group – Improving the care of older adults with cancer (mycarg.org)	20
Hartford Institute for Geriatric Nursing	Try This | Hartford Institute for Geriatric Nursing (hign.org)	20
ASCO	Practical Assessment and Management of Vulnerabilities in Older Patients Receiving Chemotherapy: ASCO Guideline for Geriatric Oncology | Journal of Clinical Oncology (ascopubs.org)	21
EORTC	EORTC elderly task force position paper: approach to the older cancer patient - PubMed (nih.gov)	21
Education		
University of Melbourne/VCCC	Cancer in the older person - Online Course (futurelearn.com)	22
University of Melbourne	Master of Cancer Sciences - The University of Melbourne (unimelb.edu.au) Graduate Certificate in Cancer Nursing	22
ASCO	Patient-Centered Cancer Care for Older Adults | ASCO Education	22
SIOG	Courses - SIOG Educational Resources - SIOG	22

ESMO	Geriatric Oncology: An Introduction | OncologyPRO (esmo.org)	22
eviQ	Cancer management of older Australians	22
Talking about elder abuse	Emotional Elder Abuse - a sensitive conversation - YouTube Financial Elder Abuse: a sensitive conversation – YouTube Talking about Elder Abuse - YouTube	22
Aboriginal and Torres Strait Islander people with cancer		
Cancer Council	OCP for Aboriginal and Torres Strait Islander people with cancer Quick reference guide for Aboriginal and Torres Strait Islander people with cancer Cancer - What to expect | Guide to best cancer care for First Nations people | Cancer Council	23
Research papers	Improving outcomes for Aboriginal and Torres Strait Islander people with cancer requires a systematic approach to understanding patients' experiences of care - PubMed (nih.gov) Optimal Cancer Care for Aboriginal and Torres Strait Islander People: A Shared Approach to System Level Change | JCO Global Oncology (ascopubs.org)	23
Commonwealth information	Aboriginal and Torres Strait Islander Health Performance Framework (HPF) - AIHW Indigenous HPF Our Mob and Cancer | Cancer in Aboriginal and Torres Strait Islander People - Our mob and cancer	23 15
VACCHO	VACCHO _ Victorian-Aboriginal-Cancer-Journey-Strategy-2023-2028 _ Web.pdf	23
Creative Spirits	Aboriginal health - Creative Spirits	23
Further considerations		
Clinical Trials	The GO2 Phase 3 Randomised Clinical Trial	24
Symptom and Urgent Review Clinics	Symptom and Urgent Review Clinic Initiative (health.vic.gov.au)	24
Advance Care Planning	Advance care planning (health.vic.gov.au) Advance Care Planning Australia Making an advance care directive - Office of the Public Advocate Palliative care and end of life services - Better Health Channel	25

Patient and Carer resources		
Cancer Council Victoria	Living with Cancer Education Program - Cancer Council Victoria (cancervic.org.au) Cancer Wellness Program - Cancer Council Victoria (cancervic.org.au) Cancer support referral - Cancer Council Victoria (cancervic.org.au)	26
Videos	A Common Path: Facing cancer later in life - YouTube Introduction to Rural Cancer Stories - YouTube Caring for someone with cancer | Cancer Council	26
Supportive Care	WeCan Cancer Supportive Care: for people affected by cancer OlderCan Resources Archive - WeCan Cancer Supportive Care This is me - WeCan Cancer Supportive Care	26
Support for Carers	Home | Carers Victoria Home - Carer Help Support for carers | Carers Couch	26
Advocacy groups	Older Persons Advocacy Network - OPAN - Australia wide support Elders Rights Advocacy | Seniors online Seniors Rights Victoria | Home	26

Appendix 1:

Provision of a Comprehensive Geriatric Assessment via telehealth: a guide to implementation

The purpose of this document is to support the implementation of a geriatrician-led Comprehensive Geriatric Assessment service for oncology patients using telehealth.

Date: July 2023

1. Executive Sponsor

The project sponsor provides necessary guidance and resources to the project team and manager, high project sustainability, strategic planning, and successful implementation of the project's objectives. Within health services, this person should operate at the organisation's executive level.

2. Rationale

Older aged patients often have a number of issues which can impact their ability to tolerate cancer treatments. By identifying those patients with particular vulnerabilities such as, nutritional, physical and psychological deficits patients can be prescribed tailored interventions by allied health and other health professionals to improve their ability to tolerate treatment.

While access to specialist geriatrician within the local health service is optimal, there can be limited access to this service, particularly in regional areas. Alternative methods of access may be required and as older patients often have difficulties accessing health services outside their local area telehealth is an option to facilitate the provision of Comprehensive Geriatric Assessment (CGA). A recent implementation of a telehealth process was undertaken supported by an ICS grant; the following information is based on this experience and learnings through the development of the service.

3. Scope

Patients aged 70 and over (or Aboriginal and Torres Strait Islander patients aged over 50) with a diagnosis of cancer receiving treatment in a Victorian-funded health service with limited access to a specialist geriatrician.

Patients which may be considered out of scope for inclusion in this type of service are those with significant physical or cognitive impairment.

4. Desired Outcome

To provide applicable patients access to a geriatrician-led CGA to support improved outcomes related to treatment for cancer.

5. Measuring

- Screening of patients aged 70 and over presenting for cancer treatment using a validated tool such as the G8 or VES-13.
- Audit to measure the number of patients who require geriatric assessment identified through the screening process and assess local capacity for provision of CGA.
- Funding requirements for the provision of clinical service provision of CGA both locally and through local/remote telehealth options

Gap Analysis at site level

Sites should complete a gap analysis of their data and evaluation of the service pre and post implementation of the project's solutions to ensure they are meeting the need of patients requiring CGA.

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6. Transition/Operational

It has been identified that project transition to business as usual relies heavily on the leadership and sponsorship of both the local and remote health service executives and clinicians including: Chief Executive Officers, Directors of Clinical Services/Operations, Medical Oncologists, Geriatricians, Nurse Unit Managers and Administrative Managers.

7. Learnings and Considerations

To effectively provide CGA via telehealth sufficient resources are required to support service implementation and sustainable processes at each site including:

- Specialist Geriatrician (off-site)
- Administrative support
- Clinical support for patient attending appointment
- Dedicated telehealth room
- New referral pathway development

Considerations when implementing this service are that funding for the assessment is dependent on the clinician providing the referral for CGA. GP referrals receive a higher level of MBS funding which can benefit sustainable provision of the specialist geriatric clinic. Developing new referral pathways into the local health service from the GP can facilitate early access to the CGA. Options include GPs being involved in geriatric screening processes to identify vulnerable patients or provision of a CGA referral as standard for all patients over the age of 70 (see flow chart in GP section page 25).

It should be noted that requesting a retrospective CGA referral from a GP will cause significant time impacts to accessing the assessment. This has consequences for treatment – either the treatment can be delayed or the treatment goes ahead without the support of the assessment and associated allied health and/or other interventions which can help prevent negative impacts of oncology treatments.

Difficulties with communication can be prevalent in older patients, particularly relating to hearing. Technology to support improvements in communications between geriatrician and patient can improve the outcomes and experience for the patient and save time. Consider use of translation services for patients whose first language is not English or access to specialist geriatricians who are able to communicate in languages other than English.

Other considerations are the support for patients at their appointments:

- The patient's GP and/or practice nurse could be part of the support team and facilitate the telehealth appointment at their primary care practice (see flow chart page 25). Their knowledge of the patient and their medical and social history is valuable information for the geriatrician during their assessment
- Cultural support for Aboriginal and Torres Strait Islander patients such as Aboriginal Liaison Officer, family member(s)and local Aboriginal elder
- Family support can be valuable for patients with mental health issues, speech and language difficulties as well as other communication issues, cultural considerations and anxiety due to their recent diagnosis.

8. Resources

Document Name	Outline
Care of the older person with cancer toolkit	Provides information and links to education and resources to support service implementation
Victorian Department of Health guidelines for implementing telehealth	Critical Success Factors: how to establish a successful telehealth service
Victorian Department of Health funding guidelines for telehealth	Funding policy (health.vic.gov.au)

9. Next Steps

Areas that will require completion prior to service implementation commencing:

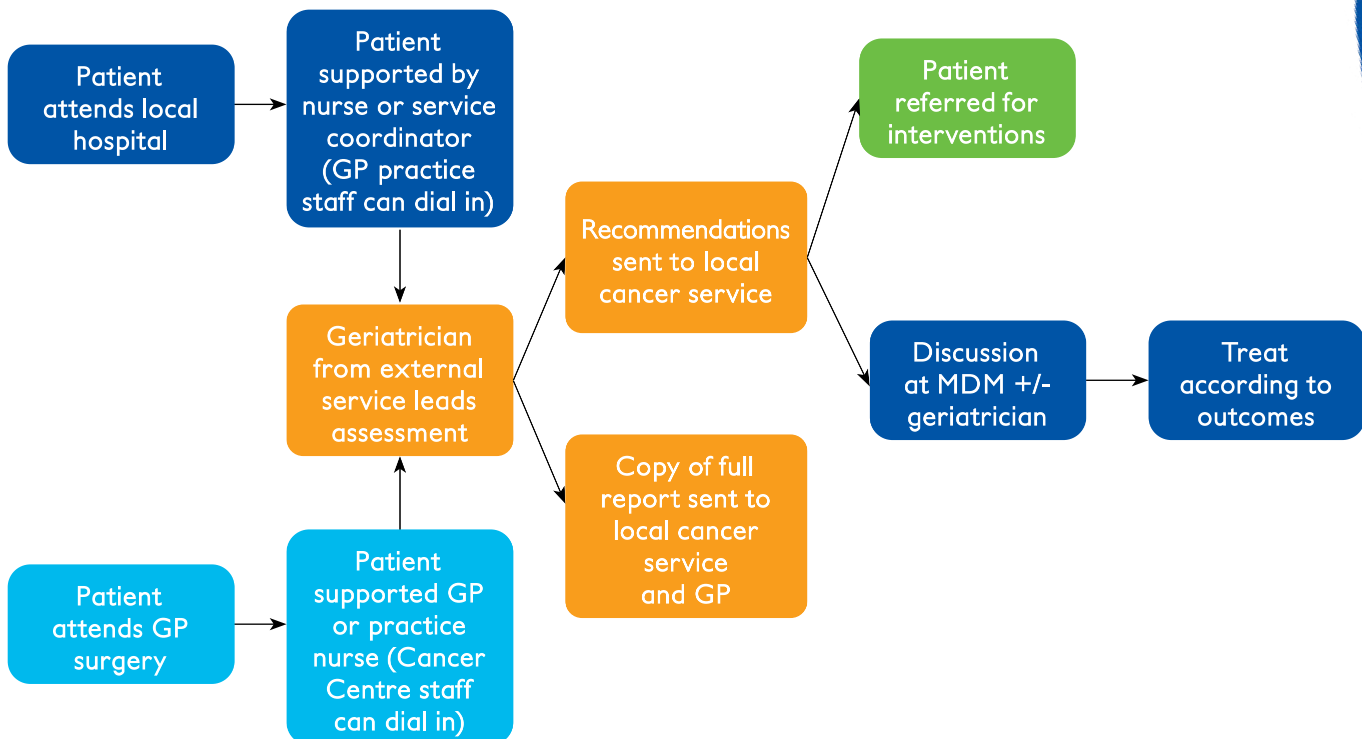
Item	Current Status
Secure sponsorship from hospital executives and develop steering group	
Identify source of funding for service implementation, if required	
Identify local geriatrician capacity	
Identify external geriatrician service to provide CGA via telehealth	
Identify need for additional project coordinator FTE for service implementation	
For additional steps towards and through service implementation see Project Manager's checklist on the following page.	

10. Reporting

Local reporting of implementation progress against agreed deliverables will be required to hospital executives according to their schedule

If external funding source secured, reporting of outcomes and experience will be required according to their schedule

Figure 4: Telehealth appointment to treatment



11. Project Manager's Checklist

TASK	✓
Familiarise yourself with the following documents: Care of the older person with cancer toolkit; Victorian guidelines for provision and funding for telehealth services (see Resources section above)	
Engage stakeholders including but not limited to: Nurse Unit Manager, geriatricians, medical oncologists, allied health managers, GPs and consumers develop working group	
Diagnose the current state of: local service capacity including specialist geriatrics, allied health, ongoing service coordination requirements and access to a dedicated telehealth space and associated technology • Include development of key performance indicators and evaluation criteria to support effective service implementation	
Determine geriatrician access requirements for service implementation: service can be wholly telehealth or a combination of telehealth and local provision	
Map referral pathway into oncology department and specialist geriatrician ensuring effective, efficient and sustainable processes (see flow chart in GP section page 25 for examples)	
Identify the health service professionals required for the interventions following assessment and map referral pathways ensuring efficacy and timeliness to access therapy	
Determine the role of the geriatrician and other health care professionals in other aspects of the service such as multidisciplinary meetings and facilitate inclusion in existing meetings as required	
Education of health service professionals and primary care staff relating to geriatric oncology, screening, assessment and effective communication via telehealth	
Collaborative development of patient facing resources with consumer involvement	
Engagement of primary care practices across the catchment to facilitate new referral processes	
Inclusion of new referral processes in PHN pathways	
Evaluation of service implementation and service provision	

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