Peninsula Health

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Geriatric Oncology Model of Care at Peninsula Health

Both international and national guidelines which recommend extension of the cancer multidisciplinary team to include geriatric expertise and the integration of screening and assessment processes to support optimal care of the older person with cancer have been in place since the early 2000s. However, they have not translated into models of care in the Australian setting until recent years.

In Victoria there is one standalone geriatric oncology service at Monash Health that is not integrated into the cancer service. There are also geriatric oncology services at Flinders Medical Centre and the Royal Adelaide Hospital in South Australia. The introduction of this model would align Peninsula Health with international best practice care through an integrated oncology/geriatrics/rehabilitation medicine model of care offered for people with cancer aged 70 years and older.

This may involve the oncology team working closely with a geriatrician or partnering with rehabilitation medicine. For others, all three specialties would be involved in providing optimal care. In all instances, the patient's GP would be a key partner in the overall care provision as shown in the figure below and palliative care services would also be involved as a key partner where needed.

People aged 70 years and older represent almost half of the cancer diagnoses in Victoria and just under half of the current Peninsula Health oncology patient population. Data has shown older adults to be the most expensive patient group in the costs of cancer care and is growing with new therapies. There are issues of both under-treatment and over-treatment that have been demonstrated in this group and a range of complex issues that need to be considered in order to provide optimal care including co-morbidities, polypharmacy, functional status, the level of independence and support of the patient with respect to physical function, living situation, social supports and nutrition.

Extending the existing multidisciplinary team (MDT) and model of care represents an important opportunity to integrate expertise in oncology, geriatrics and rehabilitation medicine into routine care to optimise care and outcomes for older patients. This integrated approach has the dual purpose of improving care planning and delivery for those who are frail and vulnerable as well as to improve condition, coping and resilience of older patients who are well and who risk decline due to their cancer and the impacts of its treatment.

The solution proposed is to integrate geriatricians and rehabilitation physicians as core members of the Peninsula Health Oncology team. A geriatric oncology and rehabilitation medicine stream will be incorporated into the existing cancer services and pathway of care comprising:

- The routine screening of every new cancer patient aged 70 years and older using the Geriatric-8 (G8) screening tool (designed for and validated in oncology) prior to the initial MDT discussion

- Streaming of patients to either a comprehensive geriatric assessment (CGA) or rehabilitation medicine assessment and care
- Delivery of care and programs within each stream in conjunction with cancer management including referrals for palliative care, Advance Care Planning development or revision as required
- Coordination of care in consultation with all members of the multidisciplinary team involved in the care of each patient and also through active liaison with community-based services and GPs. The Nurse Coordinator role will undertake this coordination role, will attend all MDT meetings and ensure all relevant information is included for discussion, coordinate referrals, act as a key conduit for information gathering and communication as well as support data collection, monitoring and quality improvement activities.

There is the potential for substantial flow-on effects from a best practice geriatric oncology model of care. This includes reducing health care costs and impacts on patient wellbeing incurred in the administration of unnecessary treatments, through avoidable complications and side effects that may result in emergency department presentations and unplanned inpatient admissions. The integration of the GP as a partner in care and the active involvement of palliative care and other services in the hospital and community alleviates the burden on the acute setting and the medical oncology workforce.