

Victorian Integrated Cancer Services Statewide Geriatric Oncology Scoping Project

The Integrated Cancer Services are supported by the Victorian Government

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Abbreviations

Abbreviation	Meaning
CGA	comprehensive geriatric assessment
EWG	expert working group
GA	geriatric assessment
GP	general practitioner
ICS	Integrated Cancer Services
MDT	multidisciplinary team
MOOC	Massive Open Online Course
MPCCC	Monash Partners Comprehensive Cancer Consortium
NPOP	nurse practitioner – older persons
RCT	randomised controlled trial
SMICS	Southern Melbourne Integrated Cancer Service
VES-13	Vulnerable Elders Survey
VICS	Victorian Integrated Cancer Services

Acknowledgements

The Statewide Geriatric Oncology Scoping Project was supported by the Victorian Government.

Special thanks are given to the many stakeholders, including patients and carers, clinicians and managers, who contributed to this project.

Key messages

- There are currently very few geriatric oncology-specific services or models of care in Victoria, particularly ongoing initiatives, despite the mounting evidence of the need for geriatric oncology screening and services.
- Establishing a geriatric oncology service is feasible but requires significant resourcing.
- A multidisciplinary approach is required to address the various needs of older people with cancer.
- A geriatric assessment is recommended to evaluate a patient's overall health and supportive care needs and to identify potential areas of vulnerability among older adults with cancer.
- The use of geriatric oncology screening tools is inconsistent across Australia, thus suggesting the need for standardisation so that comprehensive datasets can be established and maintained, which can be used as evidence for future funding initiatives.
- Clinicians lack confidence in the management and referral of older patients with cancer, yet currently, clinicians caring for patients with cancer receive little to no formal training in caring for older adults with cancer.
- The high level of attendance and engagement in the project's statewide stakeholder workshop indicates the need for formalising a statewide response to better address the needs of older Victorians with cancer and the health professionals caring for them.
- Limited quantitative data is available to support the adoption of geriatric oncology screening and services in health services.

Executive summary

The key recommendations derived from the Geriatric Oncology Statewide Scoping Project are:

1. The use of geriatric oncology screening tools becomes standardised across Victoria.
2. Wherever possible, a multidisciplinary approach be provided in services for older people with cancer.
3. More educational opportunities are offered for both clinicians and older patients with cancer.

Background

Treatment of cancer in older adults is more complex than in younger people because of comorbidities, competing risks of death, potentially altered treatment tolerance and variable patient preferences (Singh & Lichtman, 2015). Cancer in older patients may exist or occur with one or more comorbidities. This can influence an older oncology patient's physical and psychological ability to cope with treatment (Maddison, Wong & Gibbs, 2013).

A high proportion of geriatric oncology patients who are prescribed chemotherapy suffer significant side effects and toxicity (Hurria et al., 2016). There remains a lack of evidence to guide best practice for prescribing chemotherapy and the dosage required for effective treatment while reducing the likelihood of toxicity and complications (Shachar, Hurria & Muss, 2016).

A geriatric assessment (GA) is recommended to evaluate a patient's overall health and supportive care needs and to identify potential areas of vulnerability among older adults with cancer. It can determine a patient's fitness for cancer treatment and help develop targeted, holistic interventions to address impairments and optimise quality of life (Magnuson et al., 2016).

As there is mounting evidence of the need for geriatric oncology screening and services, and with increasing interest from the oncology sector, the Victorian Integrated Cancer Services (VICS) required a comprehensive understanding of the current geriatric oncology guidelines, the services available to older patients, and the various screening and assessment tools available for use. VICS subsequently funded the Southern Melbourne Integrated Cancer Service (SMICS) to undertake a statewide scoping project. The project findings were used to inform a proposal to VICS for statewide project funding.

Aim

The project aim was to gain a comprehensive understanding of the 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.

Methods

SMICS undertook the Geriatric Oncology Statewide Scoping Project with funding from the VICS. The methodology used for the project included:

- a high-level international literature review comprising geriatric oncology guidelines, models of care, multidisciplinary geriatric oncology approaches, geriatric assessments, health professional and patient and carer education and current/recent Victorian research studies
- national mapping of current geriatric oncology services or models of care and associated resources including screening tools
- a stakeholder workshop designed to receive feedback on the scoping results and generation of future geriatric oncology project ideas
- a VICS funding proposal project prioritisation process.

Program of work outcomes

Literature review

The literature review identified that pockets of research have been undertaken in Australia in recent years and that further studies are currently being undertaken. There are a handful of current guidelines for geriatric oncology, with the major guideline being developed by the American Society of Clinical Oncology in 2018. It provides advice regarding the practical assessment and management of vulnerabilities in older patients undergoing chemotherapy. The National Comprehensive Cancer Network's Clinical Practice Guidelines in Oncology: Older Adults Oncology (2019) are a comprehensive set of guidelines that include algorithms for the approach to decision making in older adults and considerations of older adults undergoing cancer treatments, including the use of systemic therapy.

The literature suggests there are several international models incorporating geriatrics into oncology care, including a consultative geriatric assessment, a geriatrician 'embedded' within an oncology clinic, and primary management by a dual-trained geriatric oncologist (Magnuson, Dale & Mohile, 2014). There are also newer clinical roles that have emerged in more recent years that can help to implement geriatric oncology interventions such as nurse practitioners. A number of 'nurse-led' geriatric oncology models of care currently exist within Australia (Morgan & Tarbi, 2016).

The literature overwhelmingly identified that a multidisciplinary approach to the care of older people with cancer is preferable to single- or dual-clinician approaches. Establishing a multidisciplinary geriatric oncology service was considered feasible, but its requirement for significant resourcing was noted in more than one study.

A GA is recommended to evaluate a patient's overall health and supportive care needs and to identify potential areas of vulnerability among older adults (Magnuson et al., 2016). However, the literature varied as to what a GA and a comprehensive geriatric assessment (CGA) specifically refers to. For the purposes of this review, GA is used as a generic reference for screening. CGA refers to a more comprehensive assessment involving formal testing with a clinician. The majority of studies reviewed involved GA screening.

Currently, clinicians caring for patients with cancer receive little to no formal training in caring for older adults with cancer (Hsu, 2016), yet clinicians lack confidence in the management and referral of older patients with cancer. There were no specific studies identified in the literature on the education needs and practical strategies for older people with cancer. However, it was noted in some of the literature that even simple supportive care interventions and education provided to older people with cancer can improve their wellbeing. It can help them to make treatment decisions and to accept treatments to which they consent.

Services and resources mapping

The project's services and resources mapping consisted of a review of 11 current or recently operating Australian geriatric oncology models of care. Of these, nine are still operating, with two operating in part following their original establishment. The models of care implemented varied considerably, particularly in terms of their staffing structures and their processes for undertaking GAs. Some comprised a single nurse only, or a medical oncologist and a geriatrician; others comprised these clinicians, as well as allied health clinicians. GAs were undertaken before the patient's hospital appointment via post or telephone, while others were performed in the waiting room or in the consultation with the clinician. Three models of care were implemented as survivorship grant projects, with interventions taking place following active treatment. Feedback received advised that geriatric oncology care needs to be implemented earlier in the patient's care plan. In Victoria, the only geriatric oncology service currently operating is at Monash Health.

In terms of GAs, most of the services mapped used either the Vulnerable Elders Survey, the G8 and/or the Screening Questionnaire for Assessment of Older People with Cancer as screening tools, or a combination of these. At Monash Health, additional tools were used to assess the level of social support and physical activity, risk of falls, diagnostic understanding, assessment of future planning and caregiver strain as part of a CGA. The vast number of screening tools available for use with older people with cancer and the inconsistency of their use across the services mapped, highlights the challenge of standardising the screening tools to be used in the future as more geriatric oncology services become available in Australia.

Few Australian educational resources for health professionals, patients and carers were also identified in the geriatric oncology scoping, suggesting a limited number were available. Resources for health professionals included an online geriatric oncology educational resource for oncology nurses hosted by Cancer NSW on the eviQ platform. In it, four web-based interactive modules were developed and included topics on screening, CGA, pathophysiology of ageing, polypharmacy and communication. This resource, which hasn't been taken up well, will be reviewed in light of the release in June 2020 of a Massive Open Online Course developed by the Victorian Comprehensive Cancer Centre. This is a four-week course that will include a module on 'Cancer in the Lifespan' that will cover older people. Although open to anyone, it will be micro-credentialed and will accrue relevant health professional member organisation continuing professional development points.

In terms of patient/carer education resources, Cancer Council Victoria offers 'Living with Cancer' programs. Two video resources are also available – one with a specific geriatric

oncology focus and another aimed at rural people with cancer and their carers, which includes a focus on older people. The [WeCan website](http://www.wecan.org.au) <www.wecan.org.au> offers cancer-related resources (particularly about supportive care) and information about services for patients and carers of people with cancer. With an ageing population facing an increased risk of developing cancer, there is clear need for more educational opportunities for health professionals and for patients and carers in the field of geriatric oncology.

Statewide stakeholder workshop

In November 2019, 55 people attended a statewide stakeholder workshop. Attendees sat around tables in small groups to workshop responses to a series of discussion questions/prompts provided by a professional facilitator. The information gathered further informed the scoping activities to date, and a series of project ideas for future funding were developed, refined and then prioritised. Seven specific project ideas were generated at the workshop, which were then considered by the project's expert working group for inclusion in a VICS funding proposal.

Future actions

The expert working group used a prioritisation process to agree on a single project to be submitted to VICS for further funding. The project, titled 'Implementation of routine geriatric screening for people over 70 with cancer', incorporates components of five of the other projects: Project 1: Forum/analysis of the lived experience of patients and carers; Project 3: Health professional education; Project 4: Informing, educating and empowering patients and carers; Project 6: Identifying existing services that could add value for people with cancer over 70 years; and Project 7: Data project, understanding the cancer experience of people over 70, diagnosis, treatment, outcomes.

Future consideration of the remaining project ideas is recommended once additional data is available to support implementation.

It is recommended that the Integrated Cancer Services keep abreast of emerging evidence and services.

Geriatric Oncology Statewide Scoping Project

Background

Treatment of cancer in older adults is more complex than in younger people because of comorbidities, competing risks of death, potentially altered treatment tolerance and variable patient preferences (Singh & Lichtman, 2015). Cancer in older patients may exist or occur with one or more comorbidities. The Australian National Health Survey estimates that 80 percent of older patients have three or more chronic comorbidities that require active management and have an impact on health outcomes and mortality. This can influence an older oncology patient's physical and psychological ability to cope with treatment (Maddison, Wong & Gibbs, 2013).

A high proportion of geriatric oncology patients who are prescribed chemotherapy suffer significant side effects and toxicity (Hurria et al., 2016). There remains a lack of evidence to guide best practice for prescribing chemotherapy and the dosage required for effective treatment while reducing the likelihood of toxicity and complications (Shachar, Hurria & Muss, 2016).

A geriatric assessment (GA) is recommended for oncologists to evaluate a patient's overall health and supportive care needs and to identify potential areas of vulnerability among older adults with cancer. It can determine a patient's fitness for cancer treatment and help to develop targeted, holistic interventions to address impairments and optimise quality of life (Magnuson et al., 2016).

A GA in the cancer setting can ensure that:

- those patients who are amenable to intensive chemotherapy (after their deficits are identified and remedied) are appropriately treated
- vulnerable patients more suited to modified or supportive regimens are determined
- frail individuals who would benefit most from palliative regimens, or no treatment at all, are also identified and offered the appropriate level of care (Massa et al., 2008; Singhal & Rao, 2008).

As there is mounting evidence of the need for geriatric oncology screening and services, and with increasing interest from the oncology sector, the Victorian Integrated Cancer Services (VICS) recognised a need to explore possible initiatives to improve outcomes and experiences for older people diagnosed with cancer and subsequently submitted a VICS funding proposal, which enabled this project.

In order for the Integrated Cancer Services (ICS) to have a comprehensive understanding of the current geriatric oncology guidelines, the services available to older patients, and the various screening and assessment tools available for use, VICS funded the Southern Melbourne Integrated Cancer Service (SMICS) to undertake a statewide scoping project. The project findings will inform a planned proposal for statewide project funding to ensure that existing efforts and activity are not duplicated and that lessons from previous work undertaken in this area are not overlooked.

Aims

The overall aim of the project was to gain a comprehensive understanding of the current geriatric oncology services (or models of care), guidelines and other resources available for use with older people with cancer to inform future geriatric oncology initiatives in Victoria.

Objectives

The objectives of the project were to:

- bring together clinicians, patients and carers who have an interest in the management of older patients with a cancer diagnosis to develop and drive a statewide initiative to provide best practice in the treatment and care of older people in the oncology setting
- scope existing geriatric oncology guidelines, services and resources
- engage with key stakeholders, including general practitioners (GPs), community health practitioners, aged care workers, patients and carers to explore existing and possible new referral pathways between sectors
- identify educational opportunities for oncology clinicians, GPs, community health practitioners, aged care workers and patients.

Methods

The Geriatric Oncology Statewide Scoping Project was undertaken by SMICS with funding from the VICS. SMICS employed a senior project manager for six months, beginning in July 2019. The methodology used for the project comprised a literature review, services and resources mapping, a stakeholder workshop and a VICS funding proposal project prioritisation process.

Literature review

The project began with a high-level international literature review to highlight the major initiatives that have been undertaken in geriatric oncology to date and to help identify the gaps in geriatric oncology care and potential solutions to address them.

The inclusion criteria for the literature review were:

- geriatric oncology-related publications
- international publications
- publications from 2014 onwards.

The exclusion criteria were:

- publications not relevant to cancer in older people
- publications prior to 2014.

The literature review comprised 31 sources of literature, of which eight were Australian or included an Australian focus. The Monash Health library databases were used for the initial

literature search, which yielded 72 results, of which 28 were examined in detail. Of these 28, five were included in the literature review. As this was a high-level review, several articles found in each literature theme were not included because they did not add new information to that already collated. Four articles were included from the final report of an earlier Monash Health project: Specialised Oncology Care and Research of the Elderly (SOCARE) at Monash Health. General online keyword searching for published research and 'grey' literature was also conducted, of which 14 publications were also included in the literature review, including relevant guidelines. The project's expert working group (EWG) members and other stakeholders also provided literature sources including research studies and reports/reviews, of which five were included. Three of these were current (not yet published) studies involving stakeholders consulted within the project.

The relevant literature was analysed according to the following themes:

1. Geriatric oncology guidelines
2. Geriatric oncology models of care
3. Multidisciplinary geriatric oncology
4. Geriatric assessments
5. Geriatric oncology education
6. Victorian research studies.

Services and resources mapping

The services and resources mapping was undertaken concurrently with the literature review. Australian geriatric oncology services (or models of care), relevant tools and other resources were included. The mapping comprised a desktop review of health services (models of care), screening assessment resources and consultation with relevant staff identified in geriatric oncology services and the health and education sectors, including the EWG members. These various stakeholders either provided information about current services or models of care and/or resources, and/or recommended additional stakeholders.

The inclusion criteria for the mapping were:

- Australian services/resources only
- current or recently operating geriatric oncology services or models of care, including those established as time-limited projects such as survivorship grant projects
- geriatric oncology pilot projects
- geriatric oncology screening tools and referral guidelines
- geriatric oncology-focused educational resources for health professionals
- geriatric oncology educational resources for patients and carers, including face-to-face and online programs and videos.

The exclusion criteria were:

- general oncology services or models of care that didn't have a specific older person focus

- cancer-related resources that weren't relevant or considered appropriate for older people
- aged care services that may or may not have integration with oncology services.

Stakeholder workshop

Following the above phases of the project, a statewide stakeholder workshop was convened in Melbourne on 28 November 2019 to further identify gaps and potential solutions in current Victorian geriatric oncology care, and to inform a VICS proposal for funding of future geriatric oncology projects. A professional facilitator was engaged for the workshop. Potential initiatives were identified and workshopped before being prioritised by attendees. Further refinement and prioritisation of projects was then undertaken by the project EWG to determine the statewide funding proposal to VICS.

Scope

Table 1 shows what was in and out of scope for the project.

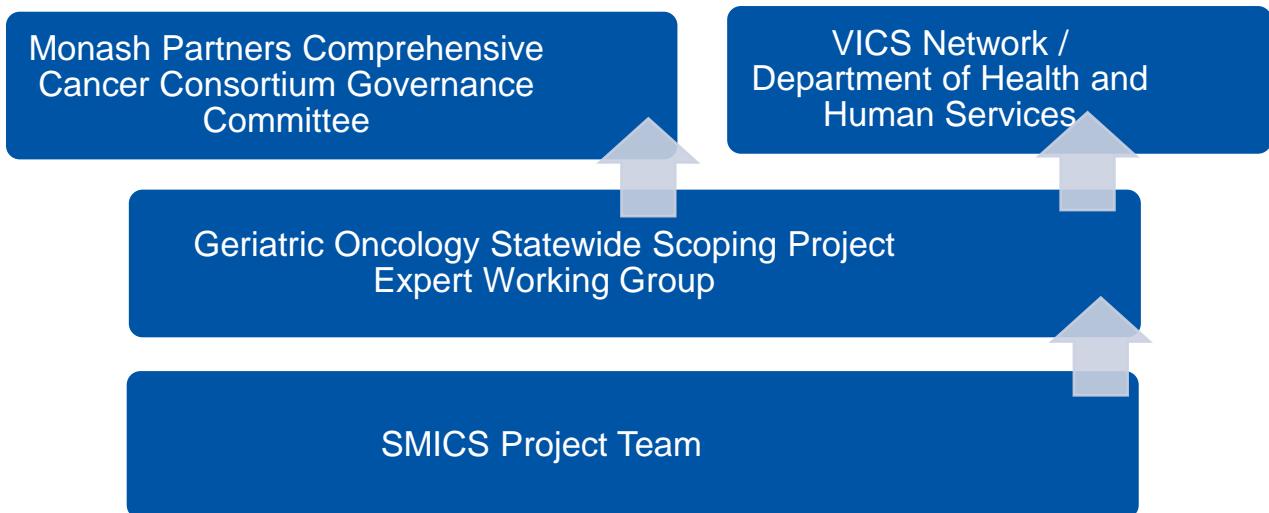
Table 1: Project scope

In scope	Out of scope
Establishing an expert working group	Implementing screening or assessment
Consultation across the sector, including hosting of a statewide stakeholder workshop with experts and individuals with an interest in geriatric oncology	Delivery of education
Scoping of geriatric oncology services and models of care, guidelines and other resources currently being undertaken in this area	Establishing a geriatric oncology service
Recommendations for a statewide geriatric oncology project(s)	Undertaking cost-benefit analyses

Governance

The project governance is depicted graphically in Figure 1.

Figure 1: Project governance



SMICS team

- SMICS Manager (0.1 EFT)
- SMICS Project Officer (0.6 EFT)

Expert working group

An EWG was established to provide guidance on project activities and to endorse project documentation. The EWG comprised a range of relevant Victorian clinicians, managers and a consumer representative (see Table 2) who met via teleconference on four occasions between September 2019 and January 2020. Several members also attended the statewide stakeholder workshop held in November 2019.

Table 2: Expert working group membership

Name	Position
Dr Ranjana Srivastava (Co-Chair)	Geriatric Oncologist, Monash Health & Safer Care Victoria; Care of Older People Clinical Network representative
Dr Zee Wan Wong (Co-Chair)	Clinical Director, SMICS & Director Oncology, Peninsula Health
Ms Helen Bolger-Harris	Senior Project Manager, Geriatric Oncology Statewide Scoping Project, SMICS
Ms Jude Bulten	Older People Nurse Practitioner, Castlemaine Health
Ms Joanne Gell	Strategic Manager, Grampians ICS

Name	Position
Dr Sachin Joshi	Clinical Director, Gippsland Regional ICS
Ms Lea Marshall	Cancer Service Improvement Coordinator, Grampians ICS
Ms Eleanor Sawyer	Project Lead, Care of Older People Clinical Network, Safer Care Victoria
Ms Seleena Sherwell	Program Manager, SMICS
Ms Ilana Solo	Strategic Manager, Loddon Mallee ICS
Dr Christopher Steer	Medical Oncologist, Border Medical Oncology
Mr Ian Storey	Consumer representative – metropolitan Victoria
Dr Irene Wagner	Geriatrician, Monash Health

Implications and recommendations

Current evidence and stakeholder feedback warranted formal scoping of the current Victorian geriatric oncology services and models of care, guidelines and other resources to inform further work in this emerging specialty. Specifically, the identification of the needs of older people diagnosed with cancer, as well as the gaps and issues in their service delivery, was required. The undertaking of subsequent projects is recommended to address the needs and issues identified in this project.

Communication and collaboration

Being a scoping project, communication and collaboration were key mechanisms used to source relevant information about existing services, resources and stakeholder feedback. Communication occurred with many stakeholders including the VICS, ICS managers, the EWG and various other clinicians, consumer representatives, researchers and managers. The communication was either in person, via email or telephone, with individuals and groups, as was the case with the statewide stakeholder workshop.

Formal written communication occurred via:

- VICS newsletter
- VICS Network
- Monash Partners Comprehensive Cancer Consortium (MPCCC) newsletter
- reports to MPCCC governance
- MPCCC annual report
- Clinical Oncology Society of Australia newsletter.

Program of work outcomes, lessons, challenges and enablers

Literature review

The literature review (**Appendix A**) identified that pockets of research have been undertaken in Australia in recent years and that more studies are currently being undertaken (see Theme 6 below for details). The majority of the international studies identified were carried out in the United States, where much of the geriatric oncology research has been undertaken to date. Other international studies were from Europe, South America, Canada and New Zealand.

The types of literature included published research studies (including a systematic literature review and pilot studies), guidelines, series papers, consensus papers, reports and reviews. Three current or recently completed Victorian research studies not yet published were also included.

Findings from the review of the literature are discussed per review theme.

Theme 1: Geriatric oncology guidelines

The major guideline for geriatric oncology was developed by the American Society of Clinical Oncology and released in 2018. It provides advice regarding the practical assessment and management of vulnerabilities in older patients undergoing chemotherapy. An expert panel was convened to develop clinical practice guideline recommendations based on a systematic review of the medical literature (Mohile et al., 2018).

The guideline stipulates that a GA should be performed to identify vulnerabilities that are not routinely captured in oncology assessments in patients aged 65 years or older receiving chemotherapy. GA results should be applied to develop an integrated and individualised plan that informs cancer management and to identify non-oncological problems amenable to intervention (Mohile et al., 2018).

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
- undertake malnutrition screening
- assess cognitive capacity.

The National Comprehensive Cancer Network's Clinical Practice Guidelines in Oncology: Older Adults Oncology (2019) are a comprehensive set of guidelines detailing the sequential management decisions and interventions that currently apply to 97 percent of cancers

affecting patients in the United States. They include algorithms for the approach to decision making in older adults and considerations of older adults undergoing cancer treatments, including the use of systemic therapy. The National Comprehensive Cancer Network believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

In France, a consensus paper was developed by the Taskforce of the International Society of Geriatric Oncology, which recommends and encourages all healthcare professionals involved in cancer care to place greater focus on the quality of life of older people living with cancer (Scotte et al., 2018). 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
- identifying required resources
- estimating survival prognosis
- prioritising issues
- proposing a therapeutic program (oncology and non-cancer)
- establishing a comprehensive care plan.

No studies were found in the literature that identified the implementation rates of these guidelines and the impact of their use.

Theme 2: Geriatric oncology models of care

A geriatric oncology model of care consists of constructing a multilevel clinical and organisational system that:

- provides cancer-specific, fitness-appropriate and individualised geriatric care
- provides strong integration between medical care, supportive care and social services
- can design and implement age-appropriate healthcare policies and practices (Dale, Chow & Sajid, 2016).

The literature suggests there are several existing models for incorporating geriatrics into oncology care, including a consultative geriatric assessment, a geriatrician ‘embedded’ within an oncology clinic, and primary management by a dual-trained geriatric oncologist (Magnuson, Dale & Mohile, 2014). There are also newer clinical roles that have emerged in more recent years that can help implement geriatric oncology interventions, such as the nurse practitioner, in both the care of older people and in oncology. In addition, a number of ‘nurse-led’ geriatric oncology models of care currently exist within Australia (Morgan & Tarbi, 2016).

Some studies conducted in the United States suggested that the cost and burden associated with older cancer patients from rural areas travelling to and from metropolitan-based health centres can result in them not receiving medical care, leaving them more vulnerable to under-treatment (Chien et al., 2019). A few studies trialled using telehealth to counteract this, which included providing electronic tablets to older patients with cancer who did not have access to computers, allowing them to interface with providers through telehealth. The results of one such study showed a reduction in costs and a decrease in hospital readmission rates (Chien et al., 2019). The authors concluded that providing multidisciplinary care through telehealth is an alternative requiring further exploration. Barriers include the availability of a reliable internet service, privacy concerns, scepticism and the cost to institutions.

Currently, there is no evidence that geriatric oncology services per se reduce cost or healthcare utilisation for patients. However, healthcare utilisation can be better directed by: identifying patients at increased risk of chemotherapy toxicity receiving more appropriate chemotherapy dosing; avoiding unnecessary aggressive therapy; medical education; and providing patient-centred care, which includes a focus on identifying and addressing unmet supportive care needs (Magnuson, Dale & Mohile, 2014). These services also facilitate the opportunity for holistic patient care and improved doctor–patient communication, and services can become standard bearers for other services.

The consensus in the literature appears to be that it is not feasible to have individual geriatric oncology clinics provide cancer care for all older patients, although ideally, this would be the case. This then suggests the need instead for global cooperation in education, research and training so the care of all older patients with cancer can be improved worldwide, given aged disease forms part of usual care (Soto-Perez-de-Celis et al., 2017).

Theme 3: Multidisciplinary geriatric oncology

A systemic literature review in New Zealand found that a lack of information on comorbidity in multidisciplinary teams (MDT) impedes the ability of MDT members to make treatment recommendations, and for those recommendations to be implemented among patients with comorbidity. MDT members are likely to be unaware of the extent to which issues such as comorbidity are ignored (Stairmand et al., 2015). Therefore, MDTs need to undertake decision making that appropriately addresses comorbidity in a systematic way.

The literature reviewed overwhelmingly identified that a multidisciplinary approach to the care of older people with cancer is preferable to single- or dual-clinician approaches. There was a range of preferred clinician types indicated, with the majority identifying collaboration between medical oncologists, surgeons, radiation oncologists, nurses, geriatricians, allied health professionals such as occupational therapists, physiotherapists and other rehabilitation specialists, social workers, dieticians, pharmacists and psychosocial support professionals. It was considered that these allied health professionals contribute expertise, particularly in areas such as functional status, malnutrition, polypharmacy and psychosocial support. Social support professionals can link older adults and caregivers to resources and support such as transport, medical equipment, financial services and insurance resources, and they can provide counselling and referrals to support groups and psycho-educational programs (Nightingale et al., 2019).

Establishing a multidisciplinary geriatric oncology service was considered feasible, but its requirement for significant resourcing was noted in more than one study. Challenges in establishing collaboration in geriatric oncology were largely considered to include: evaluating the resources required for a geriatric oncology service; confirming the role of each member of the team; establishing good communication both within the team and with patients; determining referral criteria; and using screening tests to select which patients would benefit the most from multidisciplinary evaluation and a more thorough GA (Karnakis et al., 2016).

Theme 4: Geriatric assessments

A GA is recommended to evaluate a patient's overall health and supportive care needs and to identify potential areas of vulnerability among older adults with cancer (Magnuson et al., 2016). However, the literature varied as to what a GA and a CGA specifically refers to. For the purposes of this review, GA is used as a generic reference to screening or a CGA, whereas a CGA refers to a more comprehensive geriatric assessment involving more formal testing with a clinician.

Incorporating GA into the care of older patients with cancer was shown in several studies to be feasible and predictive of outcomes. It can assist with and/or prevent under-treatment in those older people with cancer who are otherwise well and over-treatment among frail older people, particularly via chemotherapy and surgical treatments (Magnuson, Dale & Mohile, 2014). The literature findings did vary in relation to the degree that GA results actually altered treatment plans, from not at all to up to a third of patients. Schmidt et al. (2017) state that, in several studies, it triggered further diagnosis and/or specific supportive therapy such as nutritional counselling, high-caloric supplements, physiotherapy or psycho-oncologic counselling.

The most frequent model of care that incorporates GA into oncology practice is its administration as screening in the outpatient setting, in an attempt to minimise the impact of acute illness on functional and cognitive measures (Magnuson, Dale & Mohile, 2014). The majority of studies involved nurses administering the GA screening and undertaking data collection to provide input into integrated care plans, implementation and monitoring of the care plan, coordinating referrals and providing patient and family education regarding the GA results (Nightingale et al., 2019).

Some studies recommended that any CGA should be performed only by geriatricians to avoid under-interpretation. Other models considered that any MDT member can perform the CGA, such as a nurse practitioner or allied health clinician, and that the team therefore does not require a fully dedicated geriatrician (Karnakis et al., 2016). Due to lack of time and resources, performing a CGA in all older patients with cancer is not feasible in many services. Referral criteria can help define eligible patients, but even this must be well established by geriatricians and oncologists to avoid unnecessary or futile evaluations (Karnakis et al., 2016).

Theme 5: Geriatric oncology education

Currently, clinicians caring for patients with cancer receive little to no formal training in caring for older adults with cancer (Hsu, 2016) and clinicians lack confidence in the

management and referral of older patients with cancer. One study conducted in Canada involved undertaking a Geriatric Oncology and Frailty Needs Assessment to identify the perceived learning needs of cancer staff when caring for older patients. The questions included current and desired knowledge level and opinions on barriers to care. The results identified a large variation between current and desired level of knowledge in relation to treatment toxicities, polypharmacy, cognitive changes, symptom management, geriatric services/assessments, geriatric syndromes and dietary needs. Specific topics of educational interest included time-efficient GA tools, dementia and cognitive decline with ageing, community supports and resources, and polypharmacy (Rittberg et al., 2018).

Nurses were a particular focus for educational needs and provision in the literature, suggesting that an educational need exists for oncology nurses about the special needs of older patients. This is because nurses are the key healthcare professional who interface with older patients. Currently, the education of oncology nurses focuses primarily on oncology itself rather than geriatric information, and geriatric oncology training is not part of the standard nursing curriculum (Burhenn, 2019).

An American report analysed the development and implementation of a national education curriculum in geriatric oncology for 400 oncology nurses delivered via national workshops in the United States. This curriculum filled the gap in knowledge through a multidisciplinary, interactive, targeted curriculum, which culminated in nurse teams developing their own plans to integrate geriatric oncology principles and practices into their home organisations. Most teams met their goals (Burhenn, 2019).

There were no specific studies identified in the literature on the education needs and practical strategies for older people with cancer. However, it was noted in some of the literature that even simple supportive care interventions and education provided to older people with cancer can improve their wellbeing and assist them in their treatment decisions and acceptance of treatments to which they consent.

Theme 6: Victorian research studies

Three current or more recently completed Victorian research studies were identified as part of the project's stakeholder consultation. One project, conducted at Eastern Health, involved a randomised controlled trial (RCT) in which patients receiving cytotoxic chemotherapy, targeted therapy or immunotherapy in the intervention arm received a CGA and management, integrated with their standard oncology care. In addition to seeing their oncologists, these patients were also seen by a geriatrician at specific times during their treatment, while the control arm received standard care with their oncologist. The results were positive and publications are pending.

Another research study, currently underway at the University of Melbourne, involves developing an online supportive care resource for older cancer patients, co-designed with representative older cancer patients. Accessible information and tools to help older adults communicate important aspects of their health and wellbeing are being developed and provided to participants to communicate to members of their healthcare team. The aim is to promote their health, wellbeing and self-management capability through tailored evidence-based resources.

Another current study, conducted by the University of Melbourne and Melbourne Health and beginning in 2018, involves a prospective three-year RCT to assess the utility of CGAs in older patients in terms of their quality of life, functional abilities, survival, rates of admission to hospital and healthcare-related costs. Patients over the age of 65 years with a new diagnosis of advanced lung cancer receiving treatment at the Royal Melbourne Hospital are randomly allocated to receive current clinical care or a CGA and intervention plan.

Services and resources mapping

Geriatic oncology services

The project services and resources mapping (**Appendix B**) consisted of a review of 11 current or recently operating Australian geriatric oncology models of care (see Figure 2). Three of these are/were located in the regional areas of Albury/Wodonga, Castlemaine and the Wimmera in Victoria and one operates in the Gold Coast region. Seven services are/were offered in the capital cities of Melbourne, Brisbane, Adelaide, Perth and Canberra, with two services operating in each of Melbourne and Adelaide. The mapping process did not identify geriatric oncology services in Sydney, Tasmania or Northern Territory.

Figure 2: Current/recently operating Australian geriatric oncology services



Green stars = current services; amber stars = services partially ongoing; red stars = services not currently operating

Map source: mapsof.net

Of the 11 models of care, seven are currently operating (Table 3).

Table 3: Geriatric oncology models of care throughout Australia

Geriatric model of care location	Model of care site	Operating status
Adelaide	Royal Adelaide Hospital	Ongoing
Adelaide	Flinders Medical Centre	Ongoing
Albury/Wodonga	Border Medical Oncology	Ceased operation
Brisbane	Royal Princess Alexandra Hospital	Ongoing
Canberra	Canberra Hospital	Ongoing
Castlemaine	Castlemaine Health	Ongoing
Gold Coast	Gold Coast University Hospital	Ongoing
Melbourne	Monash Health	Ongoing
Melbourne	Peninsula Health	Elements ongoing
Perth	Royal Perth Hospital	Ceased operation
Wimmera	Wimmera region	Elements ongoing

The geriatric oncology models of care implemented across Australia vary considerably, particularly in terms of their staffing structures and their processes for undertaking GAs. The first geriatric oncology service established in Australia was at the Royal Adelaide Hospital. Beginning 12 years ago, it was staffed by an MDT, but due to reduced funding over time, the service has now become a nurse-led clinic staffed by two registered nurses. In this clinic, the nurses screen the patients during the consultation before the patient is seen by a medical oncologist from the general oncology department. The nurses follow up patients via telephone indefinitely and make referrals as needed to other services including palliative care and GPs.

In contrast to this model is the multidisciplinary geriatric oncology service offered at the Gold Coast University Hospital, which provides care for patients aged over 80 years. The clinical nurse consultant performs the screening test the day before the clinic appointment. At the clinic appointment, the patient is seen by the nurse, the oncology registrar, the pharmacist and the dietitian if required. These clinicians regularly meet for MDT meetings to discuss patients; the treating oncologist then discusses the treatment/outcome plan with the patient, who is then followed up in their usual clinic. Different again is the service provided at Canberra Hospital, in which a social worker coordinator conducts the GA and then meets with fellow MDT members. Patients are reviewed by medical oncologists and geriatricians on the same day. This service operates with existing funding and staff resourcing.

The model of care established in Perth was located at the Royal Perth Hospital and was the second established in Australia, operating between September 2013 and October 2014 as part of a prospective pilot study. Treatment plans for patients incorporated the expertise of a physiotherapist, pharmacist, dietitian, occupational therapist and social worker, along with

specialised oncology and geriatric input. The model of care applied a process whereby the GA screen was posted to patients before their first clinic review.

Another geriatric oncology pilot project was that undertaken by Border Medical Oncology, a specialist medical practice in Albury/Wodonga that ceased operation due to lack of ongoing funding after the project. In the Care Coordination in the Older Adult with Cancer project undertaken in 2010–11, a model of supportive care screening of newly diagnosed cancer patients aged over 70 years was developed, linking them, where appropriate, to assessment by aged care or community services. The model was shown to be feasible and accessible, providing evidence that it made a positive difference to the patient's cancer journey.

Three geriatric oncology models of care in Victoria were initiated as survivorship grant projects funded via the Australian Cancer Survivorship Centre. The service established in the Wimmera has a regular supportive care MDT meeting, which forms part of the local geriatric care service. The service at Peninsula Health involved developing an individualised survivorship care program for each patient, with the aim of helping them regain pre-treatment levels of functionality in terms of both physical and psychosocial levels. This service also has some ongoing elements in terms of patients in the hospital's chemotherapy day unit undergoing GA screening.

The third project funded as a survivorship grant project involved establishing a cancer rehabilitation and survivorship service at Castlemaine Health. This was achieved by reorienting and upskilling existing allied health and nursing staff into a cancer-specific stream within the community rehabilitation centre. In this ongoing service, patients aged 70 years or older are referred into the Nurse Practitioner Older People (NPOP) Clinic via central intake. Referral into the NPOP Clinic is in addition to usual care. If needs are identified, a comprehensive needs assessment is performed and interventions are developed to address those needs. Therapeutic intervention, education and information is provided by the nurse practitioner.

As part of the consultation process, common feedback received from staff involved in models of care established via the survivorship grants has been that geriatric oncology interventions should be offered at the time of diagnosis rather than later in the clinical pathway – for example, in the survivorship phase. The staff considered that earlier intervention for geriatric as well as cancer-related issues could potentially improve the outcomes for older people with cancer.

In Victoria, the only identified ongoing geriatric oncology service operates at Monash Health. The service began as a 12-month pilot project undertaken in 2017–18, which was able to demonstrate the feasible and effective implementation of a CGA within the clinic and the value of CGA-guided care processes for older cancer patients.

Patients aged 70 years or older attend the clinic. Patients under 70 years with multiple complex chronic comorbidities may also be referred to the clinic. The GA paperwork is undertaken by patients at the time of their appointment while waiting to be seen by the medical oncologist. Over the past three years, approximately 1,000 older patients with cancer have been managed in the clinic, which comprises a medical oncologist and a consultant geriatrician. However, further resourcing is required including dedicated space

and additional staff to be able to deliver a more comprehensive, multidisciplinary, standalone geriatric oncology service.

Geriatric oncology screening tools

In addition to mapping Australian geriatric oncology services and models of care, geriatric oncology resources such as screening tools used in the various services and relevant educational resources were also mapped. The majority of the services used either the Vulnerable Elders Survey (VES-13), the G8 and/or the Screening Questionnaire for Assessment of Older People with Cancer (the ‘Adelaide Tool’) as screening tools, or a combination of these.

The VES-13 is a simple function-based tool for screening community-dwelling populations to identify vulnerability in people aged 65 years or older 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 is a brief clinician-administered tool comprising eight questions that takes five to 10 minutes to perform. It assesses age, appetite, weight loss (BMI), mobility, mood, cognition, the number of medications used and patient-related health. Abnormal scores are 14 or less out of a possible score of 17, which suggests vulnerability and the need for further assessment.

The ‘Adelaide Tool’ was developed by the Royal Adelaide Hospital. It comprises a number of screening tools to collect information on patient demographics, comorbidities, medications and physical function, which includes hearing, vision, falls, social supports, exhaustion, pain and psychological distress. It uses the Karnofsky Performance Scale to assess functional ability and assesses for Instrumental Activities of Daily Living and Activities of Daily Living.

Components of the Adelaide Tool were used individually in several of the geriatric oncology services and included the Instrumental Activities of Daily Living and Activities of Daily Living. The Adelaide Tool is used at the Royal Adelaide Hospital; a modified version is used in the Wimmera Supportive Care MDT meeting; and the Border Medical Oncology pilot project in Albury/Wodonga also used a modified self-administered version of the Adelaide Tool.

Other screening tools used by some of the services included:

- the Eastern Cooperative Oncology Group to assess level of functioning in terms of self-care and physical ability
- the Geriatric Depression Scale
- the Mini Mental State Examination to evaluate for cognitive difficulties
- the Mini Nutritional Assessment to assess nutritional levels
- ‘Timed Up and Go’ to assess mobility and ‘Cumulative Illness Rating Scale – Geriatric’ used to assess for additional medical and psychiatric needs (comorbidities) in older adults

- chemotherapy toxicity prediction model tools.

A validated chemotherapy toxicity prediction tool is used at Monash Health. The service also uses other tools including the VES-13 and the Rowland Universal Dementia Assessment Scale. In addition, tools to assess the level of social support and physical activity, risk of falls, diagnostic understanding, assessment of future planning and caregiver strain are also used – for example, at Monash Health as part of a CGA.

Flinders Medical Centre in Adelaide uses the G8 as an initial screen and then, if required, additional screens as per those listed above. A polypharmacy screen is also used whereby five or more medications is a trigger for referral for optimisation.

Peninsula Health in its Survivorship Grants project used a variety of screens to make up a CGA ‘pack’. This included several of the above screens, a ‘quality of life’ tool and the Short Physical Performance Battery Protocol, which assesses balance, gait speed and ability to stand from sitting, similar to the Timed Up and Go test. The screen now used in the hospital’s chemotherapy day unit is the G8.

The NPOP Clinic at Castlemaine Health performs routine screening using the Edmonton Frail Scale to identify frailty and carer needs. If needs are identified, a comprehensive needs assessment is performed using the Carers Support Needs Assessment Tool and interventions developed to address these needs.

The vast number of screening tools available for use with older people with cancer, and the inconsistency of their use across the services mapped, highlights the challenge of standardising the screening tools to be used in the future as more geriatric oncology services become available in Australia. One of the reasons this standardisation is required is so that comprehensive datasets can be established and maintained, which can be used as evidence for future funding initiatives.

Geriatric oncology educational resources

Few Australian educational resources for health professionals, patients and carers were also identified in the geriatric oncology mapping, suggesting only a limited number were available.

Health professional education resources

A resource for nurses was developed as part of the 2015 WCMICS project: 'Development of an online education resource to improve nursing care of older people with cancer'. The project involved developing an online educational resource for oncology nurses hosted by Cancer NSW on the eviQ platform. In it, four web-based interactive modules were developed comprising screening tools, patient videos, case studies and interactive self-assessment quizzes.

Topics included screening, CGA, the pathophysiology of ageing, polypharmacy and communication. The learning outcomes were mapped to the individual learner's needs and best available evidence guidelines. End-user pilot testing was undertaken to assess usability and satisfaction among nurses in a variety of settings across Melbourne. Unfortunately, the uptake of this resource has been low, largely thought to be due to a lack of marketing of the course. It is planned for this resource to be reviewed in terms of either updating it and marketing it more extensively or replacing it with the geriatric oncology Massive Open Online Course (MOOC) currently in development by the Victorian Comprehensive Cancer Centre, which is open to anyone.

This MOOC, due for completion in June 2020, will be a four-week course. It will include a module on 'Cancer in the Lifespan' that will cover older people. It will be micro-credentialed and will accrue relevant health professional member organisation continuing professional development points. This is one of four MOOCs that together will form a subject in the Master of Cancer Services program at the University of Melbourne, which will incur an enrolment fee. The MOOC is likely to include a series of patient case studies, interactive presentations, interviews, readings, online discussions, quizzes and peer-reviewed assessments.

Patient/carer education resources

Cancer Council Victoria offers some educational resources that are suitable for older people with cancer, although not specifically for use by them. One is their Living with Cancer Education Program, which is delivered by health professionals, carers and survivors. The health professionals are trained by Cancer Council Victoria as program facilitators. Currently there are 250 trained facilitators across 70 Victorian health services. The program supports those recently diagnosed or undergoing oncology treatments and provides participants with useful skills, validated resources and the opportunity to connect with others.

Another relevant Cancer Council Victoria program is the Cancer Wellness and Exercise Program, which links exercise and education sessions together over eight weekly sessions. Programs are offered at community and acute health services across Victoria and sessions

are delivered by exercise specialists, health professionals and program facilitators at the health service. The program can also be delivered via telehealth in regional areas.

A video, A Common Path: Facing Cancer Later in Life, has been produced by North Eastern Melbourne ICS. 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. The video is available for [viewing online](#).

<<https://www.youtube.com/watch?v=clvfUdmMIXA>>. Another video resource suitable for older people with cancer, although not specifically geriatric oncology-focused, is Rural Cancer Stories – a series of videos developed by the University of South Australia with funding from Cancer Council South Australia. Rural patients, survivors and their carers share their stories about their cancer experiences, and provide practical advice for those living in a rural areas with a new cancer diagnosis. The video series is available [online](#) <<https://www.youtube.com/channel/UCFsw52vCWSdxUnkCdNLNx7A/videos>>.

Another general patient/carer-focused cancer resource is the [WeCan website](#) <www.wecan.org.au>, an Australian supportive care initiative designed to help people affected by cancer find the information, resources and support services they may need following a diagnosis of cancer. 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.

With an ageing population facing an increased risk of developing cancer, there is clear need for more educational opportunities for health professionals and for patients and carers in the field of geriatric oncology.

Stakeholder workshop

A key component of the project was convening a statewide stakeholder workshop that aimed to bring together a wide range of clinicians, managers and patients and carers with an interest in geriatric oncology. Attendees considered the findings from the initial stages of the project and discussed perspectives on cancer care for older people in Victoria.

The workshop was attended by 55 stakeholders from across Victoria comprising:

- patient/carer advocates with a lived experience of cancer
- health professionals, including medical (oncology, geriatrics and rehabilitation medicine), nursing and allied health from services across the health sector
- state government (cancer, aged care, Safer Care Victoria) and local government representatives (community services)
- ICS representatives from rural and metropolitan Victoria
- cancer and other non-government organisation representation (Victorian Comprehensive Cancer Centre; Cancer Council Victoria; Southern Melbourne Regional Palliative Care Consortium).

Prior to the workshop, attendees received a one-page ‘Main Messages’ information sheet ([Appendix D](#)) as preparation for the workshop discussions.

The attendees were seated around tables in small groups to workshop responses to a series of discussion questions/prompts provided by the facilitator. Responses to some of the questions were then prioritised by the whole group via an online polling tool (Table 4).

Table 4: Prioritised questions from the statewide stakeholder workshop

Question	Most popular theme identified	Response rating
What are the most important gaps or unmet needs of people over 70 with cancer?	Holistic individualised care	43% of attendees
What is your vision for cancer care in older Victorians?	An integrated multidisciplinary geriatric oncology program for cancer patients aged 70 years or older across all health services	19 'likes'

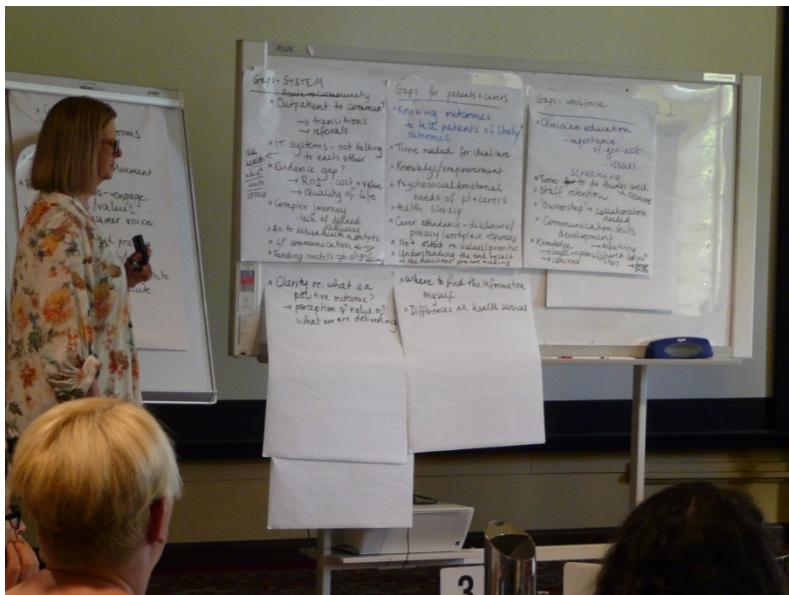
Stakeholder workshop polling of discussion questions and responses

Open-ended questions for discussion that weren't polled included:

- What are other practice examples or sources of evidence that need to be considered in the scoping project?
- Reflecting on the models that participants are aware of, what works well?
- Reflecting on the models that participants are aware of, what doesn't work so well?
- Reflecting on the models that participants are aware of, why aren't they working? What are the barriers that are encountered?
- What are the gaps and unmet needs for patients and carers; the healthcare workforce; the system?
- What are the opportunities to improve cancer care in older people?
- What should be the key principles that frame the identification of project ideas that arise from this workshop?

Whole-group discussions were recorded on butchers' paper by the facilitator (Figure 3) which, along with a summary of the tabletop small group discussions, were then compiled in a workshop report (**Appendix E**).

Figure 3: Stakeholder workshop facilitation process



Following these discussions, a series of project ideas for future funding were developed, refined and then prioritised. The process included:

- a tabletop discussion in small groups as an initial brainstorm of potential project ideas
- feeding back each project idea to the whole group.

The various project ideas were then refined into seven ideas and allocated to a single table each. Participants were invited to join the table that most interested them (Figure 4).

Tabletop discussions further refined each idea and considered the following dimensions:

- What is the project idea?
- Is it feasible?
- If this was successfully implemented, what are the anticipated outcomes?
- What would enable this project's success?
- What would be the barriers to success?
- What would the return on investment look like i.e. the value generated relative to the scale of cost?

Figure 4: Stakeholder workshop project idea prioritisation



The seven project ideas were then ranked (Table 5).

Table 5: Stakeholder workshop prioritised project ideas and rankings

Project No.	Project focus	Poll voting %
1	Forum/analysis of the lived experience of patients and carers	50%
2	Mapping gold standard services to inform a case for change, measurement and continuous quality improvement for Victoria	60%
3	Health professional education	24%
4	Informing, educating and empowering patients and carers	43%
5	Implementation of routine geriatric screen for people over 70 with cancer	57%
6	Identifying existing services that could add value for people with cancer over 70 years – development of guidance to increase awareness of and uptake of services	50%
7	Data project – may link to a VICS Summit – what can we understand about the cancer experience of people over 70: diagnosis, treatment, outcomes	26%

These projects were then discussed by the EWG in order to develop project proposal(s) to be submitted to VICS for consideration of future funding.

The high levels of attendance and engagement in the workshop were indications of the need for formalising a statewide response to better address the needs of older Victorians with cancer and the health professionals caring for them. Therefore, a submission to VICS for further project funding as a completion of this scoping project is both timely and well supported.

VICS funding proposal project prioritisation

Following the statewide stakeholder workshop, the EWG met to discuss the seven project ideas generated in the workshop and their rankings. The group agreed that the projects that scored less than 50 percent (projects 3, 4 and 7) would not be included in the VICS proposal as discreet projects. However, if appropriate, elements of them may be incorporated into other projects such as health professional education. The group also decided not to progress with Project 2 at this stage due to current insufficient ‘sector readiness’ in terms of the infrastructure required for establishing gold standard services.

The group overwhelmingly voted Project 5: ‘Implementation of routine geriatric screening for people over 70 with cancer’ as the appropriate next project to progress. The group also considered that it should be supported with elements of Project 1: ‘Forum/analysis of the lived experience of patients and carers’; Project 3: ‘Health professional education’; Project 4: ‘Informing, educating and empowering patients and carers’; Project 6: ‘Identifying existing services that could add value for people with cancer over 70 years’; and Project 7: ‘Data project, understanding the cancer experience of people over 70, diagnosis, treatment, outcomes’.

Recommendations and future actions

Key recommendations

The key recommendations derived from the Geriatric Oncology Statewide Scoping Project are:

- The use of geriatric oncology screening tools becomes standardised across Victoria.
- Wherever possible, a multidisciplinary approach be provided in services for older people with cancer.
- More educational opportunities are offered for both clinicians and older patients with cancer.

Future actions

The EWG used a prioritisation process to agree on a single project to be submitted to VICS for further funding. The project, titled ‘Implementation of routine geriatric screening for people over 70 with cancer’ incorporates components of five of the other projects: Project 1: ‘Forum/analysis of the lived experience of patients and carers’; Project 3: ‘Health professional education’; Project 4: ‘Informing, educating and empowering patients and carers’; Project 6: ‘Identifying existing services that could add value for people with cancer over 70 years’; and Project 7: ‘Data project, understanding the cancer experience of people over 70, diagnosis, treatment, outcomes’.

Future consideration of the remaining project ideas is recommended once additional data is available to support implementation.

It is recommended that the ICS keep abreast of emerging evidence and services.

Appendices

Appendix A: Literature review

Appendix B: Services and resources mapping document

Appendix C: Statewide stakeholder workshop facilitation notes

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Literature Review Methodology

Literature Search Terms	
Geriatric Oncology	Geriatrics
Cancer	Geriatric assessment
Oncology	Geriatric assessment – guided interventions
Best practice care for older oncology patients	Comprehensive geriatric assessment
Models of care	Medical oncology
Frailty	Elderly
Older people	Older adults
Guidelines	Tools
Resources	Referral

Inclusion Criteria	Exclusion Criteria
Geriatric oncology related	Publications not relevant to cancer in older people
International publications	Publications prior to 2014
Publications from 2014 onwards	

Literature Review Results

Literature Source	Number included in Literature Review
Monash Health library databases	5 (from 28 examined in detail out of an initial 72 results)*
<i>Specialised Oncology Care and Research of the Elderly (SOCARE) at Monash Health Project Final Report</i>	4
General online keyword searching for published research and 'grey' literature	14, including relevant guidelines
Project Expert Working Group and other stakeholders	5 – published research studies and reports/reviews 3 – current (not yet published) studies involving stakeholders consulted in the project Total = 31 entries

*As this was a high-level review, several articles found in each literature theme have not been included as they did not add new information to that already collated.

No.	Author/s	Title	Year	Research/ Publication Setting	Publication	Key e.g. review, qualitative, quantitative	Notes/Themes/Barriers/Conclusions
Theme 1: Geriatric Oncology Guidelines							
1	Mohile SG, Dale W, Somerfield MR, et al	<u>Practical assessment and management of vulnerabilities in older patients receiving chemotherapy: ASCO Guideline for Geriatric Oncology</u>	2018 36 (22): 2326-2347	U.S.	Journal of Clinical Oncology	Guideline	<ul style="list-style-type: none"> This guideline provides advice regarding the practical assessment and management of vulnerabilities in older patients undergoing chemotherapy. An expert panel was convened to develop clinical practice guideline recommendations based on a systematic review of the medical literature. A total of 68 studies met eligibility criteria and form the evidentiary basis for the recommendations. In patients ≥ 65 years receiving chemotherapy, GA should be used to identify vulnerabilities that are not routinely captured in oncology assessments. Guidelines minimum criteria: <ul style="list-style-type: none"> Predict chemotherapy toxicity Estimate non-cancer life expectancy Functional assessment Burden of co-morbidities Falls screening Malnutrition screening Cognitive capacity GA results should be applied to develop an integrated and individualised plan that informs cancer management and to identify

							<ul style="list-style-type: none"> non-oncologic problems amenable to intervention. Collaborating with caregivers is essential to implementing GA-guided interventions.
2	National Comprehensive Cancer Network (NCCN)	NCCN Clinical Practice Guidelines in Oncology: Older Adult Oncology	Version 1 2019: January 8, 2019	U.S.	NCCN.org	Clinical Guideline	<ul style="list-style-type: none"> The NCCN Guidelines® are a comprehensive set of guidelines detailing the sequential management decisions and interventions that currently apply to 97 percent of cancers affecting patients in the United States. The NCCN Older Adult Oncology Guidelines include a summary of the guidelines updates since the previous update in 2018; algorithms for the approach to decision-making in the older adult; and considerations of older adults undergoing cancer treatments, including the use of systemic therapy. The NCCN believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.
3	Scotte 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	2018 29:1718-1726	France	Annals of Oncology	Consensus Paper	<ul style="list-style-type: none"> The Taskforce of the International Society of Geriatric Oncology (SIOG) recommends and encourages all healthcare professionals involved in cancer care to place greater focus on the Quality of Life (QoL) of older people living with cancer. Principles of geriatric evaluation and care should include: <ul style="list-style-type: none"> Obtain diagnostic certainty (disease & domains of QoL)

							<ul style="list-style-type: none"> ○ Identify comorbidities and estimate their severity ○ Identify and manage any geriatric syndromes ○ Assess and address medical-social factors ○ Identify required resources ○ Estimate survival prognosis ○ Prioritize issues ○ Propose a therapeutic program (oncology and non-cancer) ○ Establish a comprehensive care plan <ul style="list-style-type: none"> ● Elderly cancer patients with particular QoL needs <ul style="list-style-type: none"> ○ Isolated patients ○ Patients with cognitive impairments/complaints ○ Patients with mood/psychiatric disorders ○ Patients with difficulty expressing themselves ○ Patients with altered functional autonomy ○ Hospitalised patients ○ Aged care facility residents ○ Patients with chronic diseases/several comorbidities ○ Patients undergoing active treatment with specific treatments ○ Patients with very advanced cancer and minimal anti-cancer treatment options
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Theme 2: Geriatric Oncology Models of Care							
1	Soto-Perez-de-Celis E, de Glas N, Hsu T, et. al.	Global Geriatric Oncology: Achievements and Challenges	2017 (8): 374-386	International	Journal of Geriatric Oncology	Report	<ul style="list-style-type: none"> To date, various initiatives aimed at providing adequate clinical care for older adults, increasing the geriatric skills and knowledge of healthcare professionals, and developing geriatric oncology research, have been successfully implemented. However, most developments in geriatric oncology have taken place in high-income countries, and there are still large inequalities in the availability of clinical, educational, and research initiatives across different regions of the world. An overview of geriatric oncology initiatives in Asia, Europe, Australia and New Zealand, Latin America, and the United States and Canada is provided. It is not feasible to have individual geriatric oncology clinics provide cancer care for all older patients. Only through global cooperation in education, research, and training will the care of all older patients with cancer be improved worldwide.
2	Magnuson A., Dale W. & Mohile S.	Models of Care in Geriatric Oncology	2014 (3):182-189	Current Geriatric Reports	Report	<ul style="list-style-type: none"> Incorporating GA into the care of the older patient with cancer has been shown to be feasible and predictive of outcomes There are several existing models of incorporating geriatrics into oncology care, including a consultative geriatric assessment, geriatrician “embedded” within an oncology clinic, and primary management by a dual-trained geriatric oncologist. Although a geriatrician or geriatric oncologist leads the GA, it is truly a multidisciplinary assessment, and often 	

						<p>includes evaluation by a PT, OT, pharmacist, social worker and nutritionist.</p> <ul style="list-style-type: none"> • The most frequent model of care which incorporates GA into oncology practice is its administration in the outpatient setting in an attempt to minimise the impact of acute illness on functional and cognitive measures. • In the ELCAPA study, a consultative clinic design was used in which patients were evaluated by a med onc and an initial treatment plan was developed. They were then referred for GA with a multidisciplinary team lead by a geriatrician. Authors found that the initial treatment plan was modified in 20.8% of patients based on their GA results. • Cites another study by Horgan et al., who also trialled a consultative model, in which patients 70 years+ were assessed by their primary oncologists and referred for geriatric assessment. Authors found that the majority of eligible patients were not referred for GA (71%). Of the 30 who were, findings influenced treatment decisions in only 6 patients. The majority (83%) occurred in patients where the initial treatment plan by the primary oncologist was not established prior to the consultation. • In the consultative clinic design, potential drawbacks include that the final treatment plan will be determined by the primary oncologists and may not reflect the recommendations by the geriatric consultant. The consultative geriatric team may not continue to follow the patient during active treatment and may not be
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						<p>available for guidance if further geriatric-related issues develop. However, the geriatric team is typically able to evaluate a larger number of patients and influence care for more patients given their consultative role. Several cancer centres have adapted a consultative clinic design by 'embedding' a geriatrician into their existing oncology clinic. Some centres have utilised a geriatric-trained nurse practitioner in this role.</p> <ul style="list-style-type: none"> • Alternative models incorporate a geriatric oncologist as the primary provider, who are dual trained in haematology and/or med onc as well as geriatric medicine. In the primary provider model, a geriatric oncologist performs the initial assessment, develops the oncology treatment plan and follows the patient throughout their treatment, managing any potential adverse side effects. This model is limited by the relatively few number of dual-trained geriatric oncologists. • With increasing number of older patients with cancer and the limited availability of geriatric-trained providers, screening tools are an option for selecting those older patients who are most likely to derive benefit from referral to a geriatrician or geriatric oncologist. However, the screening tool is not intended to replace geriatric evaluation and cannot provide a thorough assessment of an older individual's health status. More information is also needed on how screening tools are related to outcomes, including chemo toxicity, functional decline and survival.
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							<ul style="list-style-type: none"> At present, there are no studies evaluating the impact of GA-guided interventions in older patients with cancer. Currently, there is no evidence that geriatric oncology clinics reduce cost, healthcare utilisation or improve outcomes for patients. However, other rationale for developing a GO clinic include identification of patients at increased risk of chemotherapy toxicity; reduce the time required by the med onc to manage the complexity of older patients; fellow, resident and medical student education; marketing value for the service and provision of patient-centred care.
3	Morgan, B. & Tarbi, E.	<u>The role of the advanced practice nurse in geriatric oncology care</u>	2016 32 (1): 33-43	U.S.	Seminars in Oncology Nursing	Report	<ul style="list-style-type: none"> Advanced practice nurses (APNs) play a role in prevention, screening and diagnosis of older adults with cancer through evidence-based gero-oncology care during cancer treatment and in designing tailored survivorship care models. APNs are well-positioned to help understand the complex relationship between risk factors, geriatric syndromes, and frailty and translate research into practice. APNs should continue to establish multidisciplinary survivorship models across care settings with a focus on primary care.
4	Dale W., Chow S. & Sajid S.	<u>Socioeconomic Considerations and Shared-Care Models of Cancer Care for Older Adults</u>	2016 32: 35-44	U.S.	Clinical Geriatric Medicine		<ul style="list-style-type: none"> Older adults currently account for the most expensive segment of the population in overall costs of cancer care, which is growing with the advent of costly new therapies. Specific models of care exist to implement a geriatric oncology approach into clinical practice that can optimise and improve

						<p>quality, reduce costs, and optimise care for older adults with cancer.</p> <ul style="list-style-type: none"> • Broadly speaking, there are two common errors made in treating older patients: under-treatment and over-treatment. Under-treatment results from ageism – making management choices based on chronologic age rather than physiologic age. Conversely, over-treatment results from inappropriately aggressive cancer-directed therapy while ignoring patient vulnerability, remaining life expectancy and treatment toxicities. Delivering high-value care requires avoiding both errors. • Creating care models based on a geriatrics approach and using geriatrics tools are the most economical way to deliver care to older patients with cancer. • A geriatric oncology model of care consists of constructing a multi-level clinical and organisational system that: <ul style="list-style-type: none"> ◦ Provides cancer-specific, fitness appropriate, and individualised geriatric care ◦ Provides strong integration between medical care, supportive care, and social services ◦ Can design and implement age-appropriate health care policies and practices • Over the last two decades, four distinct GO clinical models have been described <ul style="list-style-type: none"> ◦ Screen and referral model – typically takes place at a university setting with comprehensive assessments undertaken ◦ Primary-provider model – formally trained geriatric oncologist,
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							<p>geriatrician and palliative medicine provider as the primary medical care provider for older patients with cancer</p> <ul style="list-style-type: none"> ○ Multidisciplinary consultative model – the use of cancer-specific GA is the bases for these clinics with self-reported assessments and in-clinic evaluations ○ Embedded, geriatrics-driven, comprehensive care model – geriatricians are either embedded within the oncology clinics or perform the GA assessments within their own separate location. Some of these models can overlap and blended care models are possible.
5	Steer C.B., Chia, P.L., O'Connor, J., Underhill, C., et al.	<u>Utilising Existing Community-based Supportive Care and Aged Care Resources for Older Persons with Cancer - Updated Results of the CCOAC Project</u>	2012 (3), S26-32	Australia	Journal of Geriatric Oncology	Pilot project	<ul style="list-style-type: none"> ● The model was shown to be feasible, relatively inexpensive, accessible, and provided evidence that it made a positive difference to the patient's cancer journey. ● It is possible to use existing community-based resources not previously accessed by oncology services on a routine basis and the oncology and aged-care sectors can successfully collaborate in a community setting. ● A significant number of supportive care agency referrals were made. ● Engaging GPs within this model was problematic and reflected the issue in the health sector more generally. ● Ongoing and effective change management and relationship building is key to the sustainability of this model.

							<p>Published study results: https://asclepiusopen.com/journal-of-clinical-research-in-oncology/volume-1-issue-1/9.php</p> <p>Results indicated that older patients seen in a dedicated geriatric oncology clinic with CGA had reduced rates of unplanned hospital admissions and average length of hospital stay compared with patients seen through a general medical oncology clinic. A strength of the study was considered to be its prospective nature but there were many limitations identified, including that patients were not randomised and the sample size was small.</p>
6	Tan, R., Khattak, M., Diwakarla, C., et al.	Impact of a Dedicated Geriatric Oncology Service on Rate of Unplanned Hospital Admissions and Length of Stay in Older Cancer Patients: Results of a Pilot Study	2018 1 (1): 1-7	Australia	Journal of Clinical Research in Oncology	Prospective pilot study	<p>Results indicated that older patients seen in a dedicated geriatric oncology clinic with CGA had reduced rates of unplanned hospital admissions and average length of hospital stay compared with patients seen through a general medical oncology clinic. A strength of the study was considered to be its prospective nature but there were many limitations identified, including that patients were not randomised and the sample size was small.</p>

Theme 3: Multidisciplinary Geriatric Oncology							
1	Schmidt H., Boese S., Lampe K., Jordan K., et al.	<u>Trans sectoral care of geriatric cancer patients based on comprehensive geriatric assessment and patient-reported quality of life - Results of a multicenter study to develop and pilot test a patient-centered interdisciplinary care concept for geriatric oncology patients (PIVOG)</u>	2017 (8): 262-270	Germany	Journal of Geriatric Oncology	Quantitative	<ul style="list-style-type: none"> The results show feasibility and potential benefit of the combination of CGA and HRQOL to complement standard assessments Patient-reported symptoms and functioning indicate the need for intensified supportive therapy during aftercare Comparison with the standard documentation showed that the assessments provided additional information on individual risk factors and resources. This information was rated clinically relevant by the involved clinicians. <p>The results of the assessments did not lead to any changes in the oncologic therapy but triggered further diagnosis and/or specific supportive therapy e.g. nutritional counselling, high caloric supplements, physiotherapy or psycho-oncologic counselling.</p>
2	Nightingale G., Burhenn P.S., Puts M., et al.	<u>Integrating Nurses and Allied Health Professionals in the care of older adults with cancer: A report from the International Society of Geriatric Oncology Nursing and</u>	2019 (article in press)	Not Available (N/A)	Journal of Geriatric Oncology	Report	<ul style="list-style-type: none"> Report discusses interprofessional collaboration for Geriatric Oncology (GO) care between nurses, allied health professionals, such as occupational therapists (OTs), physical therapists (PTs) & other rehabilitation specialists, social workers, nutritionists, psychosocial support professionals & pharmacists It cites previous studies on the role of nurses in CGA administration, data collection to provide input into integrated care plans, implementation & monitoring of the care plan, coordinating referrals and

		<u>Allied Health Interest Group</u>					<p>providing patient & family education re: CGA results</p> <ul style="list-style-type: none"> • Allied health professionals whose expertise includes areas such as functional status, malnutrition, polypharmacy & psychosocial support are well placed to provide care for older persons with cancer • The latest ASCO, NCCN & SIOG guidelines support integration of polypharmacy as part of the geriatric assessment • Social support professionals are able to link the patient & caregivers to resources, support e.g. transport, medical equipment, financial services, insurance resources, and provide counselling and referrals to support groups and psycho-educational programs.
3	Karnakis T., Gatas-Vernaglia I.F., Saraiva M.D., et al.	<u>The Geriatrician's perspective on practical aspects of the multidisciplinary care of older adults with cancer</u>	2016 (7): 341-345	Brazil	Journal of Geriatric Oncology	Review	<ul style="list-style-type: none"> • Establishing a GO service is feasible but requires significant resourcing. • The major challenges in establishing collaboration in GO include evaluating the resources required for a GO service, confirming the role of each member of the team, establishing good communication both within the team and with the patients, determining referral criteria, and using screening tests to select which patients can benefit the most from multidisciplinary evaluation and a more thorough Geriatric Assessment (GA). • Some multidisciplinary team models recommend GA should be undertaken by a geriatrician to avoid under-interpretation of the data. Other models consider that any Multidisciplinary Team (MDT) member can perform the GA, such as a Nurse Practitioner (NP), & that the team thus

							<p>does not require a fully dedicated geriatrician.</p> <ul style="list-style-type: none"> • Due to lack of time & resources, performing a full GA in all elderly patients with cancer is not feasible in many services. Referral criteria can help define eligible patients but even this must be well established by the geriatricians and oncologists to avoid unnecessary or futile evaluations. • Geriatricians regard these screening strategies with some caution because they are reductionist strategies for very complex patients.
4	Chien L., Roberts E., Soto-Perez-de-Celis E., et al.	<u>Telehealth in Geriatric Oncology: A novel approach to deliver multidisciplinary care for older adults with cancer</u>	2019 (article in press)	U.S.	Journal of Geriatric Oncology	Review	<ul style="list-style-type: none"> • The cost and burden of older persons from rural areas with cancer travelling to and from metropolitan based health centres can result in them going without medical care and they are more vulnerable to under treatment. • In 2016, the Department of Veteran Affairs (VA) conducted a pilot program providing electronic tablets to veterans who did not have access to computers, allowing the participants to interface with providers through telehealth. The results of this VA telehealth consultation program were a reduction in costs and a decrease in hospital readmission rates. • A prospective longitudinal study has commenced to examine the feasibility of delivering GA-based interventions via telehealth to older patients with cancer at two City of Hope community sites in California. A cancer-specific GA, which includes a chemotherapy toxicity risk score is utilised to identify patients at high risk for chemotherapy toxicity and to generate

							<p>referrals to a MDT. This study utilises an advanced practice nurse-driven model to implement the interventions based on the recommendations triggered from the results of the GA. MDT members include a geriatric NP, OT, physical therapist, social worker, pharmacist and nutritionist. Anecdotal information suggests that patients and local healthcare workers appreciate the care provided in the study and the use of telehealth.</p> <ul style="list-style-type: none"> • Providing multidisciplinary care through telehealth is certainly an alternative that needs to be further explored. Barriers include the availability of a reliable internet service, privacy concerns, scepticism, and cost to institutions.
5	Stairmand J., Signal L., Sarfati D., et al.	<u>Consideration of comorbidity in treatment decision making in multidisciplinary cancer team meetings: a systematic review</u>	2015 26: 1325-1332	New Zealand	Annals of Oncology	Systematic literature review	<ul style="list-style-type: none"> • Multidisciplinary team meetings (MDTs) are increasingly the context within which cancer treatment decisions are made internationally. • Systematic literature review was conducted to evaluate previous evidence on consideration, and impact, of comorbidity in cancer MDT treatment decision making. 21 original studies were included. • Results showed that lack of information on comorbidity in MDTs impedes the ability of MDT members to make treatment recommendations, and for those recommendations to be implemented among patients with comorbidity. Where treatment is different from that recommended due to comorbidity, it is more conservative, despite evidence that such treatment may be tolerated and effective. MDT members are likely to be

							<ul style="list-style-type: none"> unaware of the extent to which issues such as comorbidity are ignored. MDTs should therefore systematically consider treatment of patients with comorbidity. However, further research is required to assist clinicians to undertake MDT decision making that appropriately addresses comorbidity.
Theme 4: Geriatric Assessments							
1	Feng A., Daniel T., Crowell K., Muss H., et al.	Geriatric Assessment in Surgical Oncology: A Systematic Review	2015; 193 (1): 265-272	N/A	Journal of Surgical Research	Review	Across a variety of surgical oncologic populations and cancer types, components of the CGA appear to be predictive of post-operative complications and discharge to a non-home institution. These results argue for inclusion of focused geriatric assessments as part of routine pre-operative care in the geriatric surgical oncology population.
2	Puts M., Santos B., Hardt J., Monette J., Girre V., et al.	An update on a systematic review of the use of geriatric assessment for older adults in oncology	2014; 25 (2): 307-315	N/A	Annals of Oncology	Review	<ul style="list-style-type: none"> Although evidence is sparse and of moderate strength, these studies suggest that GA may influence treatment decisions in up to 23% of older patients There were conflicting findings with regard to the ability of GA to predict adverse outcomes The studies in this review had mixed findings regarding the impact of comorbidity No studies examined the impact of conducting GA on the outcome of quality of life No studies described the interventions that were carried out due to the results of the GA

3	To T., Soo W.K., Lane, H., et al.	<u>Utilisation of geriatric assessment in oncology - a survey of Australian medical oncologists</u>	2019 (10): 216-221	Australia	Journal Geriatric Oncology	Review	<ul style="list-style-type: none"> • Study explored the views of Australian medical oncologists regarding the incorporation of geriatric screening tools, GA and collaboration with geriatricians into routine clinical practice • Medical Oncology Group of Australia members were invited to complete an online survey. Sixty-nine responses were received (response rate 11%) and nominated comorbidities, polypharmacy, and poor functional status as the most frequent challenges in caring for older patients with cancer. Physical function, social supports and nutrition were the most frequent factors influencing treatment decision-making. • Only 19% of respondents used geriatric screening tools in routine practice and the most frequently used tool was the Mini-Mental State Examination. • The majority of respondents perceived value in GA and geriatrician review, although access was a barrier for referral and only 30% had referred to a geriatrician. Such services would need to be responsive, providing reports within two weeks for the majority of respondents. • It is likely there is a degree of responder bias, with those with an interest in geriatric oncology likely over-representative in the sample.
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4	Kirkhus L., S'altyt.e Benth J., Rostoft S., Grønberg B., Hjermstad, M., et al.	<u>Geriatric assessment is superior to oncologists' clinical judgement in identifying frailty</u>	2017; 117(4): 470-477	Norway	British Journal of Cancer	Quantitative	<ul style="list-style-type: none"> • Results demonstrate that a CGA can aid the oncologists in identifying otherwise unrecognised frail older patients with poor prognosis, as well as those non-frail patients without geriatric deficits and thus a better prognosis. • The oncologists using their clinical judgement are good at evaluating cancer related prognostic factors, but may need training in geriatric assessment to better assess patients' overall vulnerability and prognosis • A GA may thus provide information contributing to oncologists making more appropriate treatment decisions for their elderly cancer patients.
5	Huria A., Mohile S., Gajra A., Klepin H. Muss H., Chapman A.	<u>Validation of a Prediction Tool for Chemotherapy Toxicity in Older Adults With Cancer</u>	2016; 34(20): 2366-2371	U.S.	Journal of Clinical Oncology	Quantitative	<p>External validation of a chemo toxicity predictive model for older adults with cancer. This predictive model should be considered when discussing the risks and benefits of chemotherapy with older adults.</p> <p>(A modified version was used in the Monash Health SOCare project)</p>
6	Hamaker M.E., Te Molder M., Thielen N., et al.	<u>The effect of a geriatric evaluation on treatment decisions for older cancer patients—a systematic review</u>	2018; 9(5): 430-440	N/A	Journal of Geriatric Oncology	Review	<ul style="list-style-type: none"> • Review focussed on the effect of a geriatric evaluation on the multidisciplinary treatment of older cancer patients, particularly on oncologic treatment decisions, the implementation of non-oncologic interventions, and the impact on treatment outcome • 36 publications from 35 studies were included. After a geriatric evaluation,

							<p>the oncologic treatment plan was altered in a median of 28% of patients, primarily to a less intensive treatment option. Non-oncologic interventions were recommended in a median of 72% of patients, most commonly involving social issues (39%), nutritional status (32%), and polypharmacy (31%). Effect on treatment outcome was varying, with a trend towards a positive effect on treatment completion (positive effect in 75% of studies) and treatment-related toxicity/complications (55% of studies).</p> <ul style="list-style-type: none"> • A GA affects oncologic and non-oncologic treatment and appears to improve treatment tolerance and completion for older cancer patients. Fine tuning this process will require more specific data on relevant oncologic and non-oncologic outcomes such as survival and quality of life.
7	Magnuson A., et al.	<u>Geriatric assessment with management in cancer care: current evidence and potential mechanisms for future research.</u>	2016	N/A	Journal of Geriatric Oncology	Research priorities	<ul style="list-style-type: none"> • A CGA is recommended to evaluate a patient's overall health, supportive care needs and identify potential areas of vulnerability of older adults with cancer. It can determine a patient's fitness for cancer treatment and develop targeted, holistic interventions to address any impairments • A CGA and the resultant medical decisions and interventions implemented in response to the assessment has been shown to improve a variety of outcomes, such

							as reducing functional decline and health care utilisation
8	Mohile S., Velarde, C., Hurria, A., Magnuson A., et al.	Geriatric Assessment Guided Care Processes for Older Adults: A Delphi Consensus of Geriatric Oncology Experts	2015		Journal National Compr Cancer Network	Delphi/qual	<ul style="list-style-type: none"> Limited number of studies have shown that GA-guided care processes are feasible to implement in oncology The ELCAPA study found that the initial oncology treatment plan was modified in 21% of patients based upon GA conducted by a geriatrician-led multidisciplinary team. In addition, geriatric consultation led to other non-oncologic interventions including a change in prescribed medications (31%), social support assistance (46%), physiotherapy (42%), nutritional care (70%), psychological care (36%), and memory evaluation (21%)
9	McCarthy A.L., Peel N.M., Gillespie K. M., et al.	Validation of a frailty index in older cancer patients with solid tumours	2018; 18:892-899	New Zealand	BMC Cancer	Prospective cohort study	<ul style="list-style-type: none"> Involved a consecutive series sample of 175 cancer patients aged 65 and older with solid tumours. A frailty index was calculated using an accumulated deficits model, coding items from the comprehensive geriatric assessment tool administered prior to chemotherapy decision-making. The domains of physical and cognitive functioning, nutrition, mood, basic and instrumental activities of daily living, and comorbidities were incorporated as deficits into the model. The FI-CGA had a right-skewed distribution, with median (interquartile range) of 0.27 (0.21–0.39). The 99% limit to deficit

							accumulation was below the theoretical maximum of 1.0, at 0.75. The FI-CGA was significantly related ($p < 0.001$) to vulnerability as assessed by the Vulnerable Elders Survey-13 and to medical oncologists' assessments of fitness or vulnerability to treatment. Baseline frailty as determined by the FI-CGA was also associated with treatment decisions (Treatment Terminated, Treatment Completed, No Planned Treatment) ($p < 0.001$), with the No Planned Treatment group significantly frailer than the other two groups.
10	Hoogendojk, E.O., Afilalo J., Ensrud K.E., et al.	<u>Frailty: implications for clinical practice and public health</u>	2019 394:1365-75	Netherlands	The Lancet	Series Paper	<p>Paper provides an overview of the global impact and burden of frailty, the usefulness of the frailty concept in clinical practice, potential targets for frailty prevention, and directions that need to be explored in the future.</p> <p>Key Messages:</p> <ul style="list-style-type: none"> • The condition of frailty is associated with adverse outcomes and increased health-care costs • Frailty occurs in adults at any age, but it is more prevalent in older adults • The global impact of frailty is expected to increase due to

							<ul style="list-style-type: none"> • population ageing, particularly in low-income and middle-income countries • Risk factors for the onset of frailty span across a wide range of sociodemographic, clinical, lifestyle-related, and biological factors • Considering the degree of frailty of a person in clinical practice could result in more patient-centred care and avoidance of harm in primary, secondary, and tertiary prevention of disease • Although the concept of frailty is increasingly being used in primary, acute, and specialist care, the translation from research to clinical practice remains a challenge for the coming years; specificity and standardisation of frailty measures is essential for progress • Longitudinal research on trends and trajectories is a high priority for the frailty research agenda, as well as randomised controlled trials focused on prevention or treatment of frailty • Using a life-course approach might increase our understanding of how frailty and its risk factors develop in earlier life stages, and could contribute to the development of public health strategies for frailty prevention
11	Dent E., Martin, F.C., Bergman H., et al.	Management of frailty: opportunities, challenges, and future directions	2019 394:1376-86	Australia	The Lancet	Series Paper	<p>Key Messages:</p> <ul style="list-style-type: none"> • Although presence of frailty might seem like an ideal way to identify people who need additional support services, there is a shortage of substantial research evidence to

								<p>support this strategy and to identify the most effective instruments to detect frailty</p> <ul style="list-style-type: none"> • In clinical practice, the management of an older adult with frailty is complex because of the inadequate evidence base for individual and health-system interventions to manage the condition • More knowledge needs to be accrued about which intervention strategies are effective for frailty, and to determine whether they are feasible and cost-effective • High quality clinical trials are needed that take into account the perspectives and needs of health-care providers, older people with frailty, and their carers • In the absence of a firm evidence base for interventions, strategies to manage frailty in daily practice can be based on existing consensus guideline recommendations • It is important that frailty does not become a new aspect of ageism that prevents access to interventions that could be appropriate
Theme 5: Geriatric Oncology Education								
1	Burhenn P.	An R25 Grant to educate oncology nurses in the principles of gerontology	2019 (article in press)	U.S.	Journal of Geriatric Oncology	Report on Geriatric Oncology educational model		<ul style="list-style-type: none"> • An educational need exists for oncology nurses regarding the special needs of older patients, as nurses are the key healthcare professional who interface with older patients.

							<ul style="list-style-type: none"> • Currently, the education of oncology nurses focuses primarily on oncology itself rather than geriatric information and geriatric oncology training is not part of standard nursing curriculum. • The program goal was to develop and implement a national education curriculum in geriatric oncology for 400 oncology nurses delivered via national workshops • This curriculum filled the gap in knowledge through a multidisciplinary, interactive, targeted curriculum, which culminated in nurse teams developing their own plans to integrate geriatric oncology principles and practices into their home organisations. • The majority of teams met their goals and the results are pending publication.
2	Rittberg R., Sutherland J., Huynh E., et al	Assessing the learning needs of the multidisciplinary team on geriatric oncology and frailty	2018 (article in press)	Canada	Journal of Geriatric Oncology	Quantitative	<ul style="list-style-type: none"> • Physicians lack confidence in management and referral of older patients with cancer and many training programs provide minimal training in geriatric oncology. • CancerCare Manitoba undertook a Geriatric Oncology and Frailty Needs Assessment to identify the perceived learning needs of provincial cancer staff when caring for older patients. The questions included current and desired knowledge level and opinions on barriers to care.

							<ul style="list-style-type: none"> • 12.6% response rate, with 42% of respondents being nurses; 11% were psychosocial oncology physicians; and physicians made up 10%. • A large discordance was found between current and desired level of knowledge in relation to treatment toxicities, polypharmacy, cognitive changes, symptom management, geriatric services and assessments, geriatric syndromes, and dietary needs. • Specific topics of educational interest included time efficient GA tools, dementia and cognitive decline with ageing, community supports and resources, and polypharmacy.
3	Hsu, T	<u>Educational initiatives in geriatric oncology – Who, why, and how?</u>	2016 7: 390-396	Canada	Journal of Geriatric Oncology	Quantitative	<ul style="list-style-type: none"> • Currently, clinicians caring for patients with cancer receive little to no formal training in caring for older adults with cancers. • Key strategies to accelerate the uptake and impact of educational initiatives to address this gap include the use of effective educational strategies, broad dissemination of educational material that is freely available, and the integration of GO topics into teaching, curriculum, assessments and exams.

	Victorian Research Studies					
	Research Study Title	Research University/Research Partners	Research Location	Chief Investigator/Contact Person	Research Methodology	Preliminary Findings/Additional Comments
1	<i>INTEGRATE: Is Integrated Geriatric Assessment and Treatment Effective in older adults with cancer receiving cytotoxic chemotherapy, targeted therapy or immunotherapy? A Randomized Controlled Study</i>	Eastern Health/Monash University	Melbourne (Eastern Health catchment)	<ul style="list-style-type: none"> Chief Investigator – Professor Ian Davis, Professor of Medicine, Monash University and Eastern Health Project Manager – Dr Wee-Kheng Soo, Medical Oncologist, Eastern Health 	Integrated oncogeriatric care consists of comprehensive geriatric assessment and management, integrated with standard oncology care. In addition to seeing their oncologists, participants receiving integrated oncogeriatric care will have a comprehensive assessment and management by a consultant physician in geriatric medicine within 3 weeks from randomisation,	<ul style="list-style-type: none"> The trial is now closed and completed. The results were positive and publications are in progress.

					followed by reviews at 12 and 24 weeks from randomisation. After 24 weeks from randomisation, participants in the intervention arm may continue to receive integrated oncogeriatric care but will not be required to complete further study assessments.	
2	<i>Older and Wiser Project: Development of a co-designed, online, supportive care resource for older adults affected by cancer.</i>	Melbourne University/Cancer Australia	Victoria	<ul style="list-style-type: none"> • Chief Investigator – Professor Mei Krishnasamy, Chair in Cancer Nursing, Department of Nursing, University of Melbourne Centre for Cancer Research • Project Manager– Catherine Devereaux 	<p>Aim is to deliver an Australian-first, co-designed resource that will provide accessible information and tools to help older adults communicate important aspects of their health and wellbeing to members of</p> <ul style="list-style-type: none"> • Resources need to be ‘consumer-facing’ with no duplication (use of existing resources only) 	<p>Design workshops/interviews held to date with older persons with a live experience of cancer and relevant experts have identified three major support requirements for older persons with cancer:</p> <ul style="list-style-type: none"> • Resources need to be ‘consumer-facing’ with no duplication (use of existing resources only)

					<p>the health care team, and promote health and wellbeing self-management capability through tailored evidence-based resources.</p> <p>Involves a 3-year study which commenced in July 2018.</p> <p>Won't involve creating a new resource portal but the decision is still to be made about where the resources will be housed.</p>	<ul style="list-style-type: none"> • Resources should be differentiated into the 3 older age groupings i.e. younger, older and older older, so they are targeted appropriately. • These resources should be downloadable/available as paper-based <p>Potential resource topics include:</p> <ul style="list-style-type: none"> • Informing health professionals re: their health status/profile e.g. personal 'cancer health record' that would include information about co-morbidities, etc. • Sourcing emotional support re: their cancer, including experiences of acute depression and/or social isolation e.g. video or podcast resource; peer support 1:1 and in groups • Requirements of a 'supportive' GP
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3	<p><i>The CGA-Oncology Study: Comprehensive geriatric assessment and intervention in older lung cancer patients</i></p>	<p>Melbourne University/Melbourne Health</p>	<p>Melbourne</p>	<ul style="list-style-type: none"> • Chief Investigator – Professor Andrea Maier, Professorial Fellow of Aged Care, Department of Medicine & Radiology, Melbourne University • Project Manager – Dr Claire Maddison, Consultant Geriatrician and Medical Oncologist, Royal Melbourne Hospital, VCCC 	<p>Prospective 3-year RCT to assess the utility of CGA in older patients in terms of their quality of life, functional abilities, survival, rates of admission to hospital and health care related costs.</p> <p>Patients over the age of 65 years with a new diagnosis of advanced lung cancer receiving treatment at the Royal Melbourne Hospital are randomly allocated to receive current clinical care or a CGA and intervention plan.</p>	<ul style="list-style-type: none"> • This is the first RCT investigating CGA use internationally • Commenced in 2018.
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Mapping Methodology

- Desktop review of Geriatric Oncology services/models of care and resources, including screening tools
- Consultation with relevant stakeholders in health services/organisations and universities
- Mapping of Geriatric Oncology resources provided by relevant stakeholders

Resource Mapping Inclusion Criteria

- Australia only
- Current or recent Geriatric Oncology services/models of care, including those established as time-limited projects e.g. Survivorship grant projects
- Medical oncology focus
- Geriatric Oncology pilot projects
- Geriatric Oncology screening tools and referral guidelines
- Geriatric Oncology focussed educational resources for health professionals
- Geriatric Oncology focussed educational resources for consumers

Resource Mapping Exclusion Criteria

- Cancer related resources that weren't relevant/considered appropriate for older persons
- Aged care services that may or may not have established pathways with oncology services
- Radiation oncology, surgical oncology and anaesthetics focus

Geriatric Oncology Statewide Scoping Project

Service & Resource Mapping

Service/Resource Type	Organisation	Location	Service/Resource Contact Person	Service/Resource Details	Evaluation findings (if available)	Further Information/ Additional Comments
Geriatric Oncology Service	Monash Health	Dandenong	Dr Ranjana Srivastava https://monashhealth.org/gps/outpatients1/	<ul style="list-style-type: none"> The clinic sees elderly patients >70 yrs. Patients under 70 with multiple complex chronic comorbidities may also be referred. Involves a CGA & referrals as required Referral guidelines: https://monashhealth.org/wp-content/uploads/2019/06/201906_Monash-Health_ONCOLOGY_Referral-Guidelines.pdf 	<p>The pilot project demonstrated the feasible and effective implementation of a CGA within the Monash Health Geri Onc clinic and illustrated the value of CGA-guided care processes for older cancer patients.</p> <p>Further resourcing is required including dedicated space and staff resourcing to deliver a comprehensive, multidisciplinary, stand-alone Ger Onc service.</p>	The initial appointment is 1 hour.

Geriatric Oncology Statewide Scoping Project

Service & Resource Mapping

Geriatric Oncology Service	Royal Adelaide Hospital	Adelaide	Rebecca Drake, Geriatric Oncology Nurse	<ul style="list-style-type: none"> • Nurse-led clinic with two RNs (1.8 EFT combined) • Referrals made to the nurses re: patients 70 years+ and 65 years+ if Indigenous • Initial consultation is 45 mins and nurses screen the patients during the consultation prior to the patient being seen by the medical oncologist • Nurses will follow up patients via phone indefinitely and make referrals as needed to Palliative Care, GP, etc. 	Not available.	Clinic was the first in Australia, commencing 12 years ago, initially with a multi-disciplinary team but now only staffed with two nurses due to funding cessation.
Geriatric Oncology Service	Royal Perth Hospital	Perth	Dr Andrew Kiberu, Medical Oncologist	<ul style="list-style-type: none"> • A cooperative unit comprising specialised oncology and geriatric input, a pharmacist and access to an allied health team to provide social, nutritional, physiotherapy and 	<p>Published study results: https://asclepiusopen.com/journal-of-clinical-research-in-oncology/volume-1-issue-1/9.php</p> <p>Results indicated that older patients</p>	<p>Clinic operated between September 2013 and October 2014, as part of a prospective pilot research study.</p> <p>Publication prior to the study:</p>

				<ul style="list-style-type: none"> occupational therapy support • Patients 75 years and older were seen. • All patients were screened using a modified version of the 'Adelaide Tool', which was posted to participants prior to their first clinic review. If not completed prior to the appointment, the screening was undertaken in the reception area or in the appointment with the oncologist with a geriatric interest. 	<p>seen in a dedicated geriatric oncology clinic with CGA had reduced rates of unplanned hospital admissions and average length of hospital stay compared with patients seen through a general medical oncology clinic. A strength of the study was considered to be its prospective nature but there were many limitations identified, including that patients were not randomised and the sample size was small.</p>	https://www.geriatriconcology.net/article/S1879-4068(13)00232-4/fulltext
Geriatric Oncology Service	Royal Princess Alexandra Hospital, Brisbane	Brisbane	Ms Robyn Berry, Cancer Nurse Coordinator	<ul style="list-style-type: none"> • A nurse led model in which a Cancer Nurse Coordinator completes the assessment with the patient and then sends a summary of the assessment to 	Not available	Data from Princess Alexandra Hospital and related studies identified Quality of Life and Body Mass Index as other important predictors and

				<p>the relevant oncologist. Where appropriate, she also refers to social support services, etc.</p> <ul style="list-style-type: none">• Uses a modified version of the VES-13, which includes an increase in the age cut off and screen for depression.• In practice, positive results from the screening test trigger the need for a comprehensive geriatric assessment and appropriate multidisciplinary team intervention for the patient's cancer care needs.• Princess Alexandra is continuing to trial various screening tools to identify areas of care including depression, comorbidity, social support needs etc.		therefore included them in the screening process.
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Geriatric Oncology Statewide Scoping Project Service & Resource Mapping

Geriatric Oncology Service	Gold Coast University Hospital	Gold Coast, QLD	Dr Jasotha Sanmugarajah, medical oncologist	<ul style="list-style-type: none"> • An “over 80’s” multi-disciplinary fortnightly clinic. • The clinical nurse consultant (CNC) performs the screening test the day prior to the clinic appointment. • The patient is seen by the nurse, the oncology registrar and pharmacist and the dietician if required. • The ‘mini’ MDT discussion – team includes the CNC, geriatrician, 2 oncologists, pharmacist & oncology registrar. • Oncologist then discusses MDT results treatment/outcome/plan with the patient. • Patient is then followed up at their usual clinic. 	Not available	
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Geriatric Oncology Statewide Scoping Project

Service & Resource Mapping

Geriatric Oncology Service	Canberra Region Cancer Centre, based at the Canberra Hospital	Canberra	Dr Divyanshu Dua (medical oncologist), Icon Centre, Canberra; Katie Carlson, Canberra Region Cancer Centre	<ul style="list-style-type: none"> • All patients >80 years with newly diagnosed solid cancers referred to Department of Medical Oncology are directed to the Geri Onc Service • All patients are assessed by the social worker coordinator using geriatric screening and are discussed in a multidisciplinary team meeting • Patients are reviewed by medical oncologists and geriatricians on the same day 	<p>This social worker led model of care has been shown to be a feasible service utilising existing resources in the centre in providing specialist multidisciplinary care to geriatric oncology patients. However, this needs further validation in ongoing studies and analysis of outcome data.</p>	Utilises existing resources.
Geriatric Oncology Service	Flinders Medical Centre, South Australia	Adelaide	Caroline Richards, Cancer Care Coordinator	<ul style="list-style-type: none"> • Geri Onc clinic initially started as a 12-month pilot project in 2017. Initial G8 screening was performed by the CNC upon clinic referral. If score <14, and the patient was 	<ul style="list-style-type: none"> • Pilot project evaluation showed that without a coordinator flagging those >70 yrs and placing the screening forms with the patient 	CNC leave is not covered, so issues can then arise in terms of maintaining the service

				<p>proceeding to systemic treatment, then they were referred to a geriatrician for CGA.</p> <ul style="list-style-type: none">• Additional screening tools used were Eastern Cooperative Oncology Group (ECOG), Cancer & Ageing Research Group (CARG), & Cumulative Illness Rating Scale-Geriatrics (CIRS-G)• Service re-commenced in August 2019 as a quality improvement initiative, with the same process as in 2017 but with addition of referrals to allied health and/or for comprehensive medical assessment as needed.	<p>slips, the screening often didn't occur.</p> <ul style="list-style-type: none">• It was also found to be challenging for a CGA to be completed by the geriatrician prior to treatment	.
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Geriatric Oncology Statewide Scoping Project Service & Resource Mapping

Australian Cancer Survivorship Centre (ACSC) Survivorship Grant Project	Peninsula Health	Frankston	Dr Zee Wan Wong, medical oncologist	<ul style="list-style-type: none"> • Project title: <i>Addressing survivorship needs of an elderly population with cancer: A pilot study of care co-ordination.</i> • Project commenced in May 2018 and included patients from the Frankston Hospital Chemotherapy Day Unit, outpatient clinics and from practitioners around the region. Involved the development of an individualised survivorship care program for each patient, with the aim of helping them regain pre-treatment levels of functionality in terms of both physical and psychosocial levels. The nurse care 	Not available	Currently investigating how to make the model of care sustainable with the intention to develop a business case for continued funding.
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				<p>coordinator assisted patients with a comprehensive screening questionnaire, which included assessing their mobility, frailty, co-morbidities, quality of life and functional well-being.</p>		
ACSC Survivorship Grant Project	Castlemaine Health	Castlemaine, LMICS	Kerryn James, Director of Allied Health & Community Programs	<ul style="list-style-type: none"> • Project Title: <i>Pathways in a supportive care model for optimising cancer survivorship care for all older people in a rural health facility</i> • In 2017, a Cancer Rehabilitation and Survivorship service commenced by reorienting and upskilling existing allied health and nursing resources into a cancer-specific stream within the Community Rehabilitation Centre. 	<ul style="list-style-type: none"> • Clients provided positive feedback about the NPOP clinic and had needs met around medication reviews, referrals, information/education provision and liaison with GP and other medical specialist teams. • Project highlighted that carers of older people with cancer have a 	<ul style="list-style-type: none"> • Referral into the NP Clinic is in addition to usual care. • Service is currently trialling a simpler/quicker frailty screening tool to improve screener acceptability.

				<ul style="list-style-type: none"> Patients 70 yrs+ are referred into the Nurse Practitioner Older Persons (NPOP) Clinic via central intake following routine screening using the Edmonton Frail Scale, to identify frailty and carer needs. If needs are identified, a comprehensive needs assessment is performed using the Carers Support Needs Assessment Tool (CSNAT) and interventions are developed to address these needs. Therapeutic intervention, education and information is provided by the NP. 	broad range of needs, and are often older in age themselves with their own health concerns. <ul style="list-style-type: none"> Many carers had never been asked about their own needs before. 	
ACSC Survivorship Grant Project	GICS	Ballarat	Lea Marshall, Cancer Services	<ul style="list-style-type: none"> Project Title: <i>Making the most of this: improving experience</i> 	Ongoing: <ul style="list-style-type: none"> Wimmera Supportive Care 	

Geriatric Oncology Statewide Scoping Project Service & Resource Mapping

			Improvement Coordinator	<p><i>and outcomes for Western Victoria cancer survivors aged over 70</i></p> <ul style="list-style-type: none"> • Multi-strategy project that focused on cross-sector medical, nursing and allied health involvement starting near diagnosis and moving into survivorship. Quality improvement methodologies were used as a framework with a focus on workforce education and cross-sector improvement initiatives. 	<p>MDM – patients complete an older person screening tool and the results are presented at the MDM and referrals etc. are implemented after discussion with patient.</p> <ul style="list-style-type: none"> • A foot health presentation is now in the 8-week Cancer Council Victoria Exercise and Education Program <p>Other activity:</p> <ul style="list-style-type: none"> • Health professional current awareness survey feedback captured identified issues experienced by older people, and the most 	
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					<ul style="list-style-type: none"> • identified gaps & solutions. • A regional older person with cancer symposium was held • An accessible education reference page has also been created. 	
Pilot Project	Border Medical Oncology	Albury-Wodonga	Dr Christopher Steer, medical oncologist	<ul style="list-style-type: none"> • Project Title: <i>Care Coordination in the Older Adult with Cancer (CCOAC) Project.</i> • Project was undertaken in 2010-2011 and involved development of a model of supportive care screening of newly diagnosed cancer patients over 70 yrs, linking them, where appropriate, to assessment by aged care or community services. 	<p>Published study results: https://www.geriaticoncology.net/article/S1879-4068(12)00280-9/fulltext</p> <p>The model was shown to be feasible, relatively inexpensive, accessible, and provided evidence that it made a positive difference to the patient's cancer journey.</p>	<ul style="list-style-type: none"> • The service not sustained as no ongoing funding for the GCCC was able to be secured.

				<ul style="list-style-type: none"> • A Geriatric Cancer Care Coordinator role was created for the project and was carried out by staff with nursing, counselling and social work backgrounds. • A multidimensional CCOAC self-administered screening tool was developed for use, based on the tool used at Royal Adelaide Hospital. It comprised a composite of validated screening tools and was self-administered. • Its domains include: IADL's, medications, social supports, cognition, psychological state, vision and hearing, falls, weight loss, comorbidities, the distress 	<ul style="list-style-type: none"> • It is possible to use existing community-based resources not previously accessed by oncology services on a routine basis and the oncology and aged-care sectors can successfully collaborate in a community setting. • A significant number of supportive care agency referrals were made. • Engaging GPs within this model was problematic and reflected the issue in the health sector more generally. • Ongoing and effective change management 	
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Geriatric Oncology Statewide Scoping Project Service & Resource Mapping

				<p>thermometer, a pain scale, performance status and caregiver concerns.</p> <ul style="list-style-type: none"> The CCOAC tool was sent to all new patients 70 yrs + prior to their first appointment with an oncologist. 	<p>and relationship building is key to the sustainability of this model.</p>	
Western & Central Melbourne Integrated Cancer Service (WCMICS) Service Development Project	WCMICS	Victoria: St Vincent's Hospital Melbourne, Peter MacCallum Cancer Centre, Melbourne Health & Western Health	Ms Kathy Quade, WCMICS Manager	<ul style="list-style-type: none"> Project Title: <i>A pilot study examining the feasibility and utility of incorporating a screening geriatric assessment questionnaire (sGAQ) into discussion at multidisciplinary cancer meetings for patients ≥70.</i> Project was conducted in 2013-15 by Dr Bianca Devitt (medical oncologist) and focused on the breast, lung and Upper GI tumour streams. Involved piloting a self- 	<ul style="list-style-type: none"> Median time to complete the CSGA was 13 minutes (range 6-27) and the VES-13 was 3 minutes (range 2- 4). No participants were able to use the tablet independently, with four requiring significant assistance. Investigators noted participants had difficulty 	<ul style="list-style-type: none"> Contrary to published literature, a self-administered tablet- based CGA was not feasible in that population. This study highlights the need to ensure questionnaires remain valid when used with older people in electronic formats.

				<p>administered tablet-based version of two screening geriatric questionnaires in patients >70 to determine feasibility.</p> <ul style="list-style-type: none"> • Participants, with the assistance of accompanying friends/family members, were asked to complete both the Cancer Specific Geriatric Assessment (CSGA) and Vulnerable Elders Survey 13 (VES-13) using an electronic tablet or paper version if unable to operate the tablet. • Feasibility was set at 80% of participants completing the electronic questionnaire independently. Participants were timed on questionnaire 	<p>operating the tablet</p> <ul style="list-style-type: none"> • and consequently, gave conflicting responses for similar questions on the CSGA and the VES-13. Due to this discrepancy, the VES-13 identified 3 patients as vulnerable/frail and the CSGA categorised five patients as vulnerable/frail. • Participants however found the tablet as easy to use and reported no clear preference for either screening tool. 	
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				completion, observed while answering the questionnaire, and questioned on the suitability and ease of use of both the tablet and questionnaire.		
WCMICS Project	WCMICS	Victoria: Peter MacCallum Cancer Centre, Melbourne Health, Western Health & Royal Women's Hospital	Ms Kathy Quade, WCMICS Manager/Kyleigh Smith, VCCC Manager, Education Development	<ul style="list-style-type: none"> • Project title: <i>Development of an online education resource to improve nursing care of older people with cancer.</i> • Project involved the development of an online educational resource for oncology nurses hosted by Cancer NSW on the eviQ platform. • Four web-based interactive modules were developed, which comprised screening tools, 3-4 patient videos, case studies and interactive self-assessment quizzes. • Topics included screening, 	<ul style="list-style-type: none"> • The uptake of this resource has been low since its launch in March 2015, largely thought to be due to a lack of marketing of the course. Since September 2018, only 111 page views have been logged. 	<p>It is planned for this resource to be reviewed in terms of either updating it and marketing it more extensively or replacing it with the Geri Onc Massive Open Online Course (MOOC) currently in development (see below).</p>

				<p>comprehensive geriatric assessment, pathophysiology of ageing, polypharmacy and communication.</p> <ul style="list-style-type: none"> The learning outcomes were mapped to the individual learner's needs and best available evidence guidelines. End user pilot testing was undertaken to assess usability and satisfaction amongst nurses in a variety of settings across Melbourne. 		
Geriatric Oncology-related online educational resource	VCCC	Australia	A/Prof Kyleigh Smith, VCCC Manager, Education Development	<ul style="list-style-type: none"> A 4-week MOOC is currently being developed that will include a module on "Cancer in the Lifespan", which will include older people. This is a free resource available to anyone, including non-health 	Due for release in June 2020.	

				<p>professionals. However, it will be micro-credentialled and will accrue relevant health professional member organisation CPD points.</p> <ul style="list-style-type: none"> • It's one of four MOOCs that together will form a subject in the Master of Cancer Services program at Melbourne University, which will be fee-paid. • The MOOC is likely to include a series of patient case studies, interactive presentations, interviews, readings, online discussions, quizzes and peer reviewed assessments. 		
Patient education/health resource	Cancer Council Victoria (CCV)	Victoria	Jane Auchettl, Education and Training Coordinator	<p>Two specific CCV programs are relevant for older people with cancer:</p> <ol style="list-style-type: none"> 1. <i>Living with Cancer Education Program,</i> 	Not available.	

				<p>delivered by health professionals, carers and survivors. The health professionals are trained by CCV as program facilitators. Currently there are 250 trained facilitators across 70 Victorian health services. The program supports those recently diagnosed or undergoing oncology treatments. The program provides participants with useful skills, validated resources and the opportunity to connect with others.</p> <p>2. <i>Cancer Wellness & Exercise Programs</i>, which links exercise and education sessions together over 8 weekly sessions. Programs are offered at</p>		
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				<p>community and acute health services across Victoria and sessions are delivered by exercise specialists, health professionals and program facilitators at the health service. The program can be delivered via telehealth in regional areas.</p>		
Patient education/health resource: <i>A Common Path: Facing Cancer Later in Life</i>	Victorian Care of Older People Clinical Network (VCOP) and North Eastern Melbourne Integrated Cancer Service (NEMICS)	Developed in Victoria but international availability	Melissa Shand, Service Improvement Facilitator, NEMICS	<p>A video produced by North Eastern Melbourne Integrated Cancer Services, which provides an overview of geriatric oncology issues from the consumer perspective, including strategies they found useful to help them cope with their cancer later in life.</p> <p>Available for viewing at https://www.youtube.com/watch?v=clvfUdmMIXA</p>	Not available	

Geriatric Oncology Statewide Scoping Project

Service & Resource Mapping

Patient education/health resource: <i>Rural Cancer Stories</i>	University of South Australia with funding from Cancer Council South Australia.	Developed in South Australia but international availability	Dr Kate Fennell, Research Fellow and Clinical Psychologist, Sansom Institute for Health Research	A series of videos suitable for older persons with cancer, although not specifically geriatric oncology focused. Comprises stories of several rural patients, survivors and their carers, who share about their cancer experiences, and practical advice for those living in a rural areas with a new cancer diagnosis. The video series is available at https://www.youtube.com/channel/UCFsw52vCW_SdxUnkCdNLNx7A/videos .	Not available.	
Supportive care website: <i>WeCan</i>	Cancer Nursing Research Group, University of Melbourne	Australia-wide	Enquiries-CNRG@unimelb.edu.au	An Australian supportive care initiative designed to help people affected by cancer (not geriatric oncology specifically) find the information, resources and support	Not available.	



Geriatric Oncology Statewide Scoping Project Service & Resource Mapping



				<p>services they may need following a diagnosis of cancer. The site provides 'one stop shop' access to various services, evidence-based information and specific resources developed by other organisations who specialise in cancer and community support.</p>		
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Outcomes of the Victorian Geriatric Oncology Statewide Scoping Project Planning Workshop

On 28th November 2019, 55 people gathered to consider the findings from the initial stages of the Victorian Integrated Cancer Services (VICS) Geriatric Oncology Statewide Scoping Project and to discuss perspectives on cancer care for people over 70 years of age in Victoria. Participants included representation from the following groups (with some wearing multiple ‘hats’):

- Consumer advocates with a lived experience of cancer themselves or as a carer
- Health professionals: medical (oncology, geriatrics and rehabilitation medicine), nursing and allied health from services across the health sector
- Government: state government representatives (cancer, aged care, Safer Care Victoria); local government (community services)
- Integrated Cancer Service representatives from rural and metropolitan Victoria
- Cancer and other non-government organisation representation: Victorian Comprehensive Cancer Centre; Cancer Council Victoria; Southern Melbourne Regional Palliative Care Consortium.

Participants discussed challenges and opportunities culminating in the identification and prioritisation of critical projects to progress the care of older persons with cancer in Victoria which will form the basis for a proposal to VICS for the next stage of focussed work.

This document summarises the outcomes of a series of discussions on the day informed by notes taken by the facilitator in whole of group discussions, supplemented with notes taken by scribes from table-top discussions and polling results captured during the workshop using Slido, an online polling tool that all participants accessed on their mobile devices or laptops. The agenda for the workshop is included as Attachment 1 of these notes.

Why we need a focus on geriatric oncology

Irene Wagner, Geriatrician presented a perspective on cancer care in people over 70 years of age. This included the description of key principles and practices to guide decision making about treatment choices, clarifying goals of care and patient values. Irene presented a case study that reflected the challenges and risks that can manifest when a comprehensive assessment of needs and goals that extends beyond the treatment of the cancer is not considered.

Preliminary findings from the Geriatric Oncology Statewide Scoping Project

Helen Bolger-Harris, Project Manager, presented the preliminary findings from the scoping project reflecting Victorian, national and international models that had been identified in the desktop review and through stakeholder consultations. The key messages from this presentation were provided as pre-reading for workshop participants and are included in Attachment 2 of these notes.

Slido poll

What are the most important gaps or unmet needs of people over 70 with cancer?

Reflecting on the presentations, the workshop participants were invited to submit responses to an initial online poll question. Fifty-one respondents submitted one or more answers to the question with 73 responses in total. Answers were coded and themed and are presented in order of frequency below.

Theme identified	Dimensions described (if relevant)	Number of respondents (%)
Holistic individualised care	<ul style="list-style-type: none"> • Recognising the whole of the patient's health and life • Their wishes, vulnerabilities and needs – their agenda, what matters most to them • Functional goals 	22 (43%)
Adequate communication and information provision	<ul style="list-style-type: none"> • Communication of risks/possible functional outcomes and implications of treatment • Support for decision making • Knowing the options and choices that can be made • Understanding the intention of treatment – curative, quality of life, length of life • Effective two-way communication 	19 (37%)
Integrated care	<ul style="list-style-type: none"> • Across sectors – acute, aged care, community services, primary care, home care • Coordination of services • Effective, timely communication between health professionals 	5 (10%)
Access to psychological and emotional support services	<ul style="list-style-type: none"> • Consistent access 	5 (10%)
Assessment	<ul style="list-style-type: none"> • Early and holistic • Screening and assessment 	5 (10%)
Support people	<ul style="list-style-type: none"> • Engagement and support for the patient's family/supporters 	5 (10%)
Quality versus quantity	<ul style="list-style-type: none"> • A balanced approach to quality of life and survival/ quantity 	3 (6%)
Early intervention		2 (4%)
Adequate funding		2 (4%)
Multidisciplinary care		2 (4%)
Patient factors	<ul style="list-style-type: none"> • Worry about partner's needs • Cost of treatment/financial capacity • Travel to and from treatment 	2 (4%)
Other issues coded as individual responses – one respondent each	<ul style="list-style-type: none"> • Access to appropriate palliative care • Access to appropriate rehabilitation • Advance Care Planning • Advocacy for treatment to be modified AND for adequate treatment for the fit older person 	1 (2%)

VICS Geriatric Oncology Statewide Scoping Project: Planning workshop outcomes

Theme identified	Dimensions described (if relevant)	Number of respondents (%)
Other issues coded as individual responses – one respondent each (continued)	<ul style="list-style-type: none"> • Behavioural stage of change approach that is inclusive of the family and carer team • Clinician engagement • Evidence-based care • Health literacy • Health professional education in evidence-based best practice care • Rural programs • Screening tools – knowing the best tool to use • Social support • Support after treatment is completed • Systematic pathways 	

Discussion question:

Other practice examples or sources of evidence that need to be considered in the scoping project

The following were identified by participants for consideration as part of the Statewide Scoping Project:

- The Victorian Cancer Survivorship Program Phase II project undertaken in the Grampians region and led by Ballarat Health Service whereby a comprehensive geriatric assessment by an older persons nurse practitioner and a supportive care multidisciplinary meeting has been integrated as standard care and has been sustained beyond the completion of the Project
- The recommendations and outcomes from the Royal Commission into Aged Care Quality and Safety
- European models of care with specific examples mentioned: multidisciplinary clinic approaches; Italy; Belgium; Brazil; France (geriatric oncology identified as a national priority, screening using G8 is universal and a close working relationship between geriatricians and oncologists is demonstrated); USA (models from large cancer centres)
- Other Australian models with specific example mentioned: Princess Alexandra Hospital Brisbane; Royal Adelaide Hospital (original model and 'the Adelaide tool'); Patient-Reported Outcome Measures (PROMs) work in New South Wales; models of care in the community in general extending beyond those that are oncology-specific – care coordination, opportunities for increasing referrals to existing services; and examples where people maintain their own health record
- Cost benefit analyses of models of care: What does best practice cost and what are the benefits that flow for patients, services and the system? Can we save money by treating the right people in the right way? Do patients benefit in areas where nurse coordinators are present across tumour streams?
- The COSA Geriatric Interest Group systematic review findings
- Models of care that extend beyond medical oncology with specific mentions of: nurse-led models; social work-led models; models that could inform this work that are outside of oncology e.g. orthogeriatric and cardiogeriatric models of care
- The consumer and carer voice and perspective needs to be considered with specific mention of: quality of life; clinical trials; palliative care; consent issues; the role of support people in decision making; and surveying patients post-cancer treatment as to whether they would have proceeded with treatment had they understood the implications
- More information about what is happening in primary care
- Examples of how to care for people with multiple morbidities.

Discussion question

Reflecting on the models that participants are aware of: What works well?

Theme identified	How described/examples provided
Care coordination	<ul style="list-style-type: none"> Having coordinators available for people moving between metropolitan and regional areas as part of their treatment
Other complex and chronic disease models	<ul style="list-style-type: none"> Heart Diabetes
Model of care components	<ul style="list-style-type: none"> Multidisciplinary clinics/models with the early flagging of issues for consideration in treatment planning Prehabilitation as standard of care Supportive care multidisciplinary meeting for older persons Screening using validated tools and a multidisciplinary approach Comprehensive geriatric assessments Access to support groups Advance care planning integrated into usual care
Recognition of geriatric oncology as a system priority	<ul style="list-style-type: none"> French model – national priority and a centralised geriatric oncology service

Discussion question

Reflecting on the models that participants are aware of: What doesn't work so well?

Theme identified	How described/examples provided
Sub-optimal multidisciplinary team processes	<ul style="list-style-type: none"> When meetings don't occur in a timely way and prior to key treatment decisions being made When a multidisciplinary assessment of the patient has not been undertaken prior to the multidisciplinary meeting When issues, needs and preferences are not considered in a fulsome way – <i>'tokenistic'</i> or paying <i>'lip service'</i> Where supportive care discussions occur separate from and outcomes are not integrated into tumour stream multidisciplinary meeting discussions Communication issues – having the right people in the right place to consider all needs
Challenges in making proactive choices about treatment	<ul style="list-style-type: none"> The sense of treatment being a <i>'merry go round'</i> that can be very difficult to step off from once started Being supported when opting not to have treatment
Treatment commencing before due consideration of values and needs	<ul style="list-style-type: none"> Patients being seen by someone with expertise in geriatrics early enough to make proactive decisions
Responding to needs identified	<ul style="list-style-type: none"> 'No treatment' doesn't equate to no care at all – what are the options re: palliative or other services that can support the patient and their family?

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Theme identified	How described/examples provided
	<ul style="list-style-type: none"> • The lack of timely access to psycho-oncology to respond to identified needs • Ethical concerns about conducting screening and assessment processes where there may not be adequate resources or services in place to respond to identified needs (counter argument offered about not being able to know the needs and unmet needs of patients without doing this and that some needs may be addressed without the need for specialist services if understood)
Points in the pathway or practice approaches that can be sub-optimal	<ul style="list-style-type: none"> • Where support people are not actively involved • After treatment is completed – a time of risk and can be inadequately considered or supported • Preparing for end of life – the huge burden of emotion for the patient and impacts on their family

Discussion question

Reflecting on the models that participants are aware of: Why aren't they working? What are the barriers that are encountered?

Theme identified	How described/examples provided
Time constraints	<ul style="list-style-type: none"> • Actual time available to complete geriatric assessments well and consistently within the patient pathway • Staff time to deliver optimal care (resourcing)
The perspective of patients not being considered	<ul style="list-style-type: none"> • May not be asking and understanding patient needs, wants, values and preferences • May not be involving support people • May not be conducting comprehensive assessments that extend beyond self-reports • Low health literacy can impact on understanding of what is being proposed, what the implications are and impeded empowered, informed decision making
Workforce capacity	<ul style="list-style-type: none"> • The skills, capacity and knowledge of the workforce relating to: the needs of the elderly; communication techniques; referral options, criteria and pathways • Access to: <ul style="list-style-type: none"> ◦ specialist nurses across all tumour streams ◦ psycho-oncology • Education to support specific skills development for medical, nursing and allied health professionals
Cost	<ul style="list-style-type: none"> • System resources and personnel • Costs to patients and support people
System barriers	<ul style="list-style-type: none"> • The complexity of referrals systems e.g. My Aged Care • Cancer-focussed or centric approaches that don't consider the wider system options and capacity to respond to needs that may be common to other health areas or conditions and are more holistic
Lack of evidence base	<ul style="list-style-type: none"> • Lack of knowledge and evidence of outcomes from clinical trials to influence decision making and resource allocation

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Theme identified	How described/examples provided
Cultural issues	<ul style="list-style-type: none"> • ‘Ageism’ – assumptions that can be made about fitness or capacity of older persons that may influence treatment recommendations positively or negatively

Discussion question	
<i>What are the gaps and unmet needs for: Patients and carers; The healthcare workforce; The system?</i>	

Area of focus	How described/examples provided
Patients and carers	<ul style="list-style-type: none"> • Not being asked what their values and priorities are • Understanding the outcomes that may result from treatment choices that are offered or recommended – What would a positive outcome look like? What are the possible implications? What does the worst case scenario look like? • Time within the system for ideal care to be delivered • Ensuring that patients and support people have the required knowledge, are empowered and have psychosocial, practical and emotional needs considered • People with low health literacy as an area requiring focussed attention and effort • How and where people can find the information they need themselves • The meaningful involvement of support people: <ul style="list-style-type: none"> ◦ Issues of disclosure and privacy ◦ Workplace responses/support to enable attendance e.g. carer's leave provisions • Effective discharge planning • The potential that health professionals could be responding to key performance indicators or targets e.g. time from diagnosis to surgery rather than providing optimal care that might reflect different timing or different treatment choices including the choice not to have surgery • Inconsistencies across the system in terms of services that are available and how services operate and what a person's eligibility might be • Access to services in the public system for people who are being treated in private sector services - a lack of information about what's availability and eligibility/mechanisms to access
The healthcare workforce	<ul style="list-style-type: none"> • Clinician education: <ul style="list-style-type: none"> ◦ issues relating to cancer in people over 70 years of age ◦ the importance of geriatric screening and assessment ◦ communication skills development that supports practice that can achieve shared decision making – deep skills ◦ legal responsibilities ◦ consent • Understanding that not having treatment is a reasonable option and having the skills to navigate that as an option and support people to access supports that they may require • Having the resources and time to provide optimal care in a system and workforce under pressure • Staff retention challenges and the impact of turnover on the provision of consistent high quality care

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Area of focus	How described/examples provided
	<ul style="list-style-type: none"> • Issues of operating in silos of patient 'ownership' across clinical disciplines – needing a shift to collaborative care in partnership • Inconsistencies across the system in terms of models, resources and disciplines available with particular challenges for the rural workforce and systems
The system	<ul style="list-style-type: none"> • Transitions between sectors (may not be well coordinated, may not understand what is available, may not be referring, referrals may not be straightforward to implement) <ul style="list-style-type: none"> ◦ from acute inpatients to community ◦ from acute outpatients to community • IT systems that don't speak with each other across the whole health system within and between services and across disciplines, units and programs/services • The evidence gap re: efficacy of optimal geriatric oncology care and the cost benefits (cost of care and value that can be generated) that provide the basis for a case for resource investment. Dimensions of value including: experience and outcomes for patients and support people including quality of life dimensions; cost to the health system from unnecessary treatment, complications, loss of independence, disability; cost to individuals and families • The complexity of the cancer experience for older persons and the lack of defined pathways • Access to allied health in outpatient oncology services • Two-way, meaningful and effective communication with GPs • Funding models within our health services that do not align with best practice care – a misalignment

Discussion question

What are the opportunities to improve cancer care in older persons?

Area of focus	How described/examples provided
Improving engagement with patients and support people	<ul style="list-style-type: none"> • From diagnosis, engage meaningfully to understand values and wishes • Mobilise the consumer voice to influence how we improve the system and practices
Building the evidence base	<ul style="list-style-type: none"> • A registry of outcomes for older cancer patients • Mining existing data sources and linking datasets from multiple sources to understand what we can about cancer in people over 70 years of age and to influence: care provision; policy makers and advisors • Adjusting data on key performance indicators by casemix to inform appropriate determinations of performance against targets
Supporting information flow and exchange	<ul style="list-style-type: none"> • Patient-held records that are consistent (within the state and nationally) and effective (support the information flow and exchange that is required for optimal care)
Enhancing multidisciplinary team processes	<ul style="list-style-type: none"> • Integrating geriatric medicine into all streams of cancer care as a priority and a necessity • Geriatric screening as routine practice as early as possible in the pathway of care

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Area of focus	How described/examples provided
	<ul style="list-style-type: none"> Geriatric assessment incorporated into the multidisciplinary team framework and discussion that informs treatment planning Involvement of allied health in cancer multidisciplinary team meetings
Improving and integrating primary care engagement	<ul style="list-style-type: none"> Increase the proactive, meaningful and continuous involvement of GPs across the pathway of care including in the early stages to inform key considerations in treatment planning Engage with primary care providers (GPs, practice nurses, community health) re: what happens prior to entry into the acute system – opportunities extend beyond cancer in terms of geriatric screening and referrals to assessment in parallel with or prior to oncology referrals
Start with what already exists in the system and is underutilised or unknown	<ul style="list-style-type: none"> Models of care that have successfully integrated chronic or complex conditions and geriatrics Existing clinics that could be accessed by cancer patients e.g. falls clinics GEM – Geriatric Evaluation and Management Community services Health Independence Programs

Discussion question

What should be the key principles that frame the identification of project ideas that arise from this workshop?

The following principles and areas for consideration in identifying project ideas were identified:

- Policy
- Advocacy
- Skills development
- Reorientation of health services
- Creating supportive environments
- Community action
- Building the evidence base: research; systems; the case for investment/priority
- Special Interest Group formation to enable collaboration
- All Integrated Cancer Services working on the same project at once and sharing ideas
- A Geriatric Oncology Summit (following the VICS Tumour Stream Summits format)
- Consistency
- Collaboration
- Collective effort
- Oversight of all activities
- Identify the first thing – a meaningful next step.

Online poll question:
What is your vision for cancer care in older Victorians?

Participants were invited to articulate their vision for cancer care in Slido as free text. The vision statements listed were visible to all participants and they could also ‘like’ statements that resonated with them. The statements that were listed and the frequency of ‘likes’ is included in the table below.

Vision statement	Number of ‘likes’
Integrated multidisciplinary geriatric oncology program for cancer patients aged 70 years and older across all health services	19
Statewide multidisciplinary patient-centric model of assessment, care coordination and guided intervention where possible using existing aged care resources	16
Comprehensive assessment from diagnosis with provides supportive care through the care trajectory	15
A system that from diagnosis recognises a person and their family’s values and goals and lets these guide the process from treatment to survivorship	14
Care which patients and families/carers will not regret having even if worst outcome occurs i.e. informed consent was obtained pre-treatment	11
Optimal care pathway for older people with cancer i.e. like the ones we have for actual tumour streams and patient versions	11
That older people with cancer would have access to professional health advocates, who will consider ALL their needs and issues	11
A personal plan set out from diagnosis with various future pathways dependent on patient needs. This would be updated over time as treatment continues	10
Holistic approach that empowers the patient and their carers, focussing on goals of care. Equal access to resources and appropriate support services	10
Integrated assessment of older people and management into standard oncological care	10
Educated workforce	8
Appropriate care in the right time and place	7
Best care is not dependent on where you go, who you see or what day you come	7
A holistic streamlined system that considers all aspects from the patient and carer’s life position	6
Holistic approach and say ‘no’ to ageism	6
A consumer-directed integrated well resourced best practice service system	5
Easy access to consistent, accurate information for everyone	5
Providing all possible outcomes of diagnosis and treatments from survivorship to death	5
Standardised processes for all patients regardless of cancer diagnosis and location	5
Consistent best practice experienced by all	4

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Vision statement	Number of 'likes'
Don't overboil the egg	4
Equity across cancer streams and access within metropolitan, rural and regional areas	4
Integrated system model. Full multidisciplinary team availability. Individualised care	4
Recognition that the aged population is entitled to receive access to appropriate care whether acute, community or facility-based	4
Carers as part of the whole package	3
Integration of a broad range of resources into one central platform	3
Patient-centred	3
Patient-centred inclusive of families and carers and equal access to services and resources	3
Individualised care based on evidence	2
Routine interdisciplinary care	1
Central information portal	0
Multidisciplinary meeting program for anyone diagnosed with cancer	0
Provide clients the same honour as provided to my grandmother	0
Referral to a multidisciplinary program once diagnosed	0

The following responses to the vision question were entered by participants in a different part of Slido which means they were not available for people to consider and 'like'.

- Integrated system that supports older people to receive appropriate cancer treatment according to their values and goals of care
- Case sensitive assessment and individualised management plan
- Health professionals trained to assist older patients understand and make informed decisions regarding ongoing treatment versus no treatment
- Integrated longitudinal person centred care
- Highly standardised screening, followed by assessment and interventions. Measuring non-cancer outcomes after anti-cancer therapy is crucial!
- Tailored to individual needs and multi-dimensional assessment and management
- Older Victorians with cancer are at peace with their circumstances and care plan
- Appropriate timing of screening and then inclusive discussions with patient/family to agree to treatment and care. Then a system that supports that.
- Integrated, person centred, holistic, individualised approach to care of older people
- Individualised care based on evidence
- Not age related but rather patient centred care that is holistic and multifaceted
- A consistent national model
- Equity of care, communication and support
- A person-centric standardised evidence based approach.

Developing project ideas

In the final discussions of the day, a series of project ideas were developed, refined and then prioritised. The process undertaken included:

- A tabletop discussion in small groups as an initial brainstorm of potential project ideas
- Feed back to the whole group of each project idea until exhausted
- Each of the project ideas were then refined into seven ideas and allocated to a single table each
- Participants then chose which project idea they wished to discuss and a final round of tabletop discussions further refined each idea and considered the following dimensions:
 - What is the project idea?
 - Is this feasible?
 - If this was successfully implemented, what are the anticipated outcomes?
 - What would enable this project's success?
 - What would be the barriers to success?
 - What would the return on investment look like – the value generated relative to the scale of cost?

Each project idea and the responses to these questions are summarised in the tables below.

Project 1 – Forum/analysis of the lived experience of patients and carers	
What is the project idea?	<ul style="list-style-type: none"> • Understanding the lived experience of patients and carers – a forum, measures, addressing dimensions of equity of access • Require a forum to learn what the issues are and how to address them • It is important to know what is done well and provide feedback to agencies that are providing good services
Is this feasible?	<ul style="list-style-type: none"> • Yes, a one-off meeting for interested patients and carers
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> • An understanding of pathways that have worked • Identify gaps and obstacles • Patients, carers and health professionals will be better informed • Health professionals will be enabled to provide support for patients and carers
What would enable this project's success?	<ul style="list-style-type: none"> • Strong patient and carer participation
What would be the barriers to success?	<ul style="list-style-type: none"> • Poor engagement of consumers • Venue location • Language barriers • Cost
What would the return on investment look like – the value generated relative to the scale of cost?	<ul style="list-style-type: none"> • Outcomes will guide input to the other six projects (referring to the other project ideas from this workshop)

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Project 2 – Mapping gold standard services to inform a case for change, measurement and continuous quality improvement for Victoria	
What is the project idea?	<ul style="list-style-type: none"> • Global mapping models of care of geriatric oncology for Australian populations
Is this feasible?	<ul style="list-style-type: none"> • Yes
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> • Agreed intervention and outcome measures identified
What would enable this project's success?	<ul style="list-style-type: none"> • Project Manager
What would be the barriers to success?	<ul style="list-style-type: none"> • Lack of Project Manager resources
What would the return on investment look like – the value generated relative to the scale of cost?	<ul style="list-style-type: none"> • Standardised approach of measuring outcomes across the state

Project 3 – Health professional education	
What is the project idea?	<ul style="list-style-type: none"> • Education for health care professionals • Topics identified: <ul style="list-style-type: none"> ◦ Services and support available specific to geriatric oncology and supportive care portal ◦ Communication skills ◦ Geriatric oncology issues • Promotion of what's already out there e.g. EviQ geriatric oncology with a focus on communication aimed at nurses; Cancer Council Victoria Effective Cancer Communication training (not currently offered but could be reactivated) • Identification of gaps to inform course development if needed
Is this feasible?	<ul style="list-style-type: none"> • Yes
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> • Increased uptake of education • An educated workforce • Sensitive health care professionals that effectively communicate information and enable shared decision making
What would enable this project's success?	<ul style="list-style-type: none"> • Project structure • Health service engagement and senior buy-in • Establish a Community of Practice with a broad base of health care professionals • Pressure to have health care professionals improve their communication skills through quality programs e.g. Australian Commission for Safety and Quality in Health Care
What would be the barriers to success?	<ul style="list-style-type: none"> • Reliance on purely online training – can be hard to achieve behaviour change

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Project 3 – Health professional education	
	<ul style="list-style-type: none"> • Doing this within existing resources – need resources to support capacity building
What would the return on investment look like – the value generated relative to the scale of cost?	<ul style="list-style-type: none"> • Improved care • Fairly cheap to implement

Project 4 – Informing, educating and empowering patients and carers	
What is the project idea?	<ul style="list-style-type: none"> • Informing, educating and empowering people with cancer and their support people to be able to communicate their values and ensure these guide treatment decisions
Is this feasible?	<ul style="list-style-type: none"> • Yes, with: <ul style="list-style-type: none"> ◦ Resources and referrals to appropriate places and adequate time for health professionals ◦ System to identify new cancer diagnoses and follow-up ◦ Follow-up and referral ◦ IT integration ◦ Access to people who may not be diagnosed as yet but there is a suspicion of cancer ◦ Knowing how to refer and how to be culturally-sensitive ◦ Informed consent • Can link with Cancer Council Victoria for consumers and health care professionals, promotion of Cancer Council Victoria initiatives in acute and subacute areas • Yes, if advanced care planning occurs at diagnosis and if workshops for people with cancer, family members and health professionals can be offered
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> • Early advance care planning • Empowered and health literate consumers
What would enable this project's success?	<ul style="list-style-type: none"> • Consumer engagement • Health care professional engagement • Project Manager • Facility engagement (hospital, community health service)
What would be the barriers to success?	<ul style="list-style-type: none"> • Integration of IT systems • Sustainability
What would the return on investment look like – the value generated relative to the scale of cost?	<ul style="list-style-type: none"> • Decreased cost to the health system with people receiving treatment tailored to their values • Stronger patient and carer engagement in the system • More educated and informed consumers

Project 5 – Implementation of routine geriatric screen for people over 70 with cancer	
What is the project idea?	<ul style="list-style-type: none"> • Routine screening of all patients with cancer over 70 years of age across all tumour streams

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Project 5 – Implementation of routine geriatric screen for people over 70 with cancer	
	<ul style="list-style-type: none"> Determine which screening tool to use: Geriatric 8 (G8) or Vulnerable Elders Survey (VES-13) with the purpose of the screen to identify people needing a comprehensive geriatric assessment
Is this feasible?	<ul style="list-style-type: none"> Yes, the implementation of supportive care screening across all cancer patients provides an example of successful implementation of screening in Victoria
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> Early screening Collection of statewide data to characterise older Victorian cancer patients to inform discussions re: funding and demonstrate the need for models of care
What would enable this project's success?	<ul style="list-style-type: none"> Health service commitment Adequate workforce
What would be the barriers to success?	<ul style="list-style-type: none"> Getting people to complete the screen People from culturally and linguistical diverse backgrounds, non-English speakers, those with low literacy
What would the return on investment look like – the value generated relative to the scale of cost?	<ul style="list-style-type: none"> Accurate data describing the needs of older cancer patients and that would inform the development of models of care and lead to further studies

Project 6 – Identifying existing services that could add value for people with cancer over 70 years – development of guidance to increase awareness of and uptake of services	
What is the project idea?	<ul style="list-style-type: none"> Identification of services in the acute, subacute, community and NGO sectors that could be of value for the older cancer patient Development of guidance re: potential referrals, pathways, linkages, checklists and programs to increase uptake and awareness of what's available
Is this feasible?	<ul style="list-style-type: none"> Yes, with: <ul style="list-style-type: none"> Coordination by a Project Manager Contributions from each ICS re: identification of services
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> Easier and more timely access to services Consistency Identification of best practice approaches Streamlined journey Increased uptake of existing services – better use of existing resources and avoidance of duplication of effort Identification of where and what the gaps are
What would enable this project's success?	<ul style="list-style-type: none"> Coordination Steering Committee Champions Consideration of how it would be sustained and currency maintained Pilot Clear definitions and auditing tool Engagement with statewide and national programs

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Project 6 – Identifying existing services that could add value for people with cancer over 70 years – development of guidance to increase awareness of and uptake of services	
What would be the barriers to success?	<ul style="list-style-type: none"> • Inconsistencies • Costs • Speed of change • Different language/terms
What would the return on investment look like – the value generated relative to the scale of cost?	<ul style="list-style-type: none"> • BIG • Increased knowledge • Efficiencies • Swift response for health professionals • Great benefits to the consumer

Project 7 – Data project – may link to a VICS Summit – what can we understand about the cancer experience of people over 70 – diagnosis, treatment, outcomes	
What is the project idea?	<ul style="list-style-type: none"> • Utilising existing data across multiple organisations/sources to explore outcomes of care for people over 70: <ul style="list-style-type: none"> ○ A. Hospital discharge data: ICU admissions, number of admissions, discharge destination, length of stay ○ B. Death register ○ C. Cancer notifications (VCR) ○ D. Biogrid/WEHI registries ○ E. EMR: number of medications • Explore the care needs of people over 70: <ul style="list-style-type: none"> ○ A. Cancer Council Victoria Helpline data: demographics, distress, geriatric screen added to phone protocols and data derived from that re: needs identified
Is this feasible?	
If this was successfully implemented, what are the anticipated outcomes?	<ul style="list-style-type: none"> • Contribution to the evidence base • Wide availability of data for analysis/research
What would enable this project's success?	<ul style="list-style-type: none"> • Accessibility • Quality • Capacity to link datasets
What would be the barriers to success?	<ul style="list-style-type: none"> • Data quality issues • Consent/ethics issues
What would the return on investment look like – the value generated relative to the scale of cost?	

Prioritising project ideas

A spokesperson from each of the seven project discussion groups fed back the outcomes of the discussion (reflected in the tables in the previous section of these notes) to the whole group. A final Slido poll was then run with participants having the opportunity to vote for their three favourite project ideas to enable a final ranked listing of the projects to be generated. Forty-two participants submitted their votes to the poll with the final project rankings reflected below.

Final project rankings

Project number and title	Percentage of total votes
Project 2 Mapping gold standard services to inform a case for change, measurement and continuous quality improvement for Victoria	60%
Project 5 Implementation of routine geriatric screen for people over 70 with cancer	57%
Project 1 Forum/analysis of the lived experience of patients and carers	50%
Project 6 Identifying existing services that could add value for people with cancer over 70 years – development of guidance to increase awareness of and uptake of services	50%
Project 4 Informing, educating and empowering patients and carers	43%
Project 7 Data project – may link to a VICS Summit – what can we understand about the cancer experience of people over 70 – diagnosis, treatment, outcomes?	26%
Project 3 Health professional education	24%