Optimal care pathway for older people with cancer

Quick reference guide

This quick reference guide provides advice to health practitioners and service planners on optimal care for older people with cancer, across the cancer continuum. Refer to the relevant cancer-specific optimal care pathways on the Cancer Council website www.cancer.org.au/OCP.

The optimal care pathways describe the standard of care that should be available to all people with cancer treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

In Australia, government organisations consider people aged 65 and people of Aboriginal and Torres Strait Islander origin from the age of 50 as older. Older people with cancer are very diverse and may have age-related issues which can add complexity to their cancer care. This quick reference guide provides a summary of the *Optimal care pathway for older people with cancer*.

Key considerations to support optimal care for older people with cancer

- **Providing age friendly care**. Ensure healthcare is accessible, inclusive for older people with varying needs and capacities, and delivers care aligned with a person's values, preferences, and goals. This OCP has been designed around addressing the 4M priority areas[1] – What **M**atters most, **M**entation, **M**edications and **M**obility to reduce risks and ensure optimisation of intrinsic capacity.

- **Recognising and addressing ageism**. Ageism includes attitudes and behaviours held about older people such as negative stereotypes, prejudice or discrimination, and can compromise treatment provided. Regardless of age, older people have a right to know about all treatment options available and to be treated with respect.

- **Incorporating timely geriatric medicine and aged care referrals** provides specialised expertise to address the challenges of ageing and comorbidities, ensuring treatment aligns with patient goals and supports functional independence and quality of life.

- **Delivering appropriate models of care.** Optimal care for older people requires geriatric assessment and management to guide appropriate cancer treatment and to meet the supportive and geriatric care needs of older people; utilising better integration of oncology services with geriatric medicine services and community based aged care services, with cancer services considering what multidisciplinary model is possible in their setting.

- **Including carers and family**. Carers and families may play an important role and should be involved in communication and decision-making in line with a person's preferences. Many older people with cancer also have caring roles themselves.

- **Ensuring effective communication.** Effective communication is two-way. It encourages a person's involvement and asks what matters most to them, involves family or carers to the extent a person wishes, uses age-inclusive language, and minimises potential barriers to communication.

Please note that not all patients will follow every step of the pathway.

Step 1 Prevention and early detection

Prevention

Encourage older people to:

- quit smoking
- maintain a healthy body weight
- be physically and socially active
- reduce frailty with strength and balance exercises
- avoid or limit alcohol intake
- eat an adequate, healthy diet
- encourage immunisation
- reduce ultraviolet light exposure and adopt SunSmart practices

Risk factors

- Older age
- Extended exposure to possible carcinogens, both environmental and pharmaceutical
- Cognitive impairment
- Lack of a carer or health advocate
- Malnutrition

Early detection

- Ensure access to health advocate or carer
- Have regular GP and dental reviews
- Work closely with the GP to consider ongoing participation in relevant cancer screening e.g. colorectal, breast, prostate and lung cancer
- Encourage medical assessment for any possible tumour specific symptoms
- Consider a cancer diagnosis in an older person with
    - New or progressive frailty
    - New or progressive malnutrition
    - New or progressive cognitive impairment
    - New or progressive functional decline

Screening recommendations checklist

- ❑ Monitor for recent weight changes and record this in patient record
- ❑ Discuss alcohol intake and record this in patient record; refer for alcohol reduction support if appropriate
- ❑ Discuss and document smoking status and consider brief smoking cessation advice
- ❑ Discuss and document physical activity and consider referral to a local rehabilitation specialist / unit, physiotherapist or exercise physiologist.
- ❑ Discuss and document social activity and consider referral to local community aged care activity centre.
- ❑ Discuss and document social supports and care.

- ❑ Discuss and document nutrition and consider referral to a dietitian (e.g for malnutrition and sarcopenia).
- ❑ Recommend routine cancer screening (BreastScreen Australia, National Bowel Cancer Screening Program, National Cervical Screening Program). Discuss suitability for lung cancer screening and prostate cancer early detection.
- ❑ Discuss and document community support options through government aged care program(s) referral(s)
- ❑ Discuss and document advance care planning and medical treatment decision making wishes
- ❑ Ask about, and facilitate, access to transport

Step 2 Presentation, initial investigations and referral

Presentation

- Cancer may present with typical symptoms but also as an ageing-associated syndrome; such syndromes include new or progressive functional impairment, cognitive impairment, frailty, or social isolation, with symptoms carefully assessed given association with older age and cancer prevalence.
- Older individuals are more likely to present with advanced cancer than younger individuals and to have delayed diagnosis.
- Collaborative information should, where possible, be collected from carers.

Referral options

The GP or other referring doctor should advise the older person, and if applicable, their carer(s) about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available including access to allied health and geriatric services. This will enable patients to make an informed choice of specialist and health service.

For those older people with a confirmed diagnosis in primary care, general practitioners should consider referral to a comprehensive cancer centre with expertise in managing older individuals with cancer.

Communication

The GP's responsibilities include:

- explaining to the older person and their carers who they are being referred to and why
- supporting the older person and their carers while waiting for specialist appointments
- ensuring physical and psychosocial symptoms are managed
- informing the older person and their carers that they can contact Cancer Council on 13 11 20.

Checklist

- ❑ Signs and symptoms recorded
- ❑ Basic investigations performed; specialised investigations may be considered following discussion with a specialist clinician
- ❑ Geriatric and supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required

- ❑ Patient notified of support services such as Cancer Council 13 11 20
- ❑ Referral options discussed with the older individual and, if applicable, their carer, including cost implications

Timeframe

Prompt initial assessment is important. Older people with proven or suspected cancer should be referred to a cancer clinician within two weeks. Timeframes for completing investigations and referral should be informed by evidence-based guidelines and cancer specific OCPs (where available) recognising that shorter timeframes for appropriate consultations may improve clinical and patient-reported outcomes.

Step 3 Diagnosis, staging and treatment planning

Diagnosis and staging

The appropriate, multidisciplinary care of older people with cancer should be guided by an adequate geriatric assessment in addition to an assessment of the cancer. This should include determination of the patient's goals and priorities and ability to cope with investigations and treatment prior to embarking upon invasive procedures. If deemed appropriate a tissue biopsy remains crucial to guide care and should not be withheld based on age alone.

Genetic testing

Anyone diagnosed with cancer should have a detailed personal and family cancer history taken. Certain subtypes of cancer may suggest an underlying inherited cancer predisposition. A decision to refer to a familial cancer service should not be based on age alone.

Treatment planning

All newly diagnosed patients should be discussed at a multidisciplinary team (MDT) meeting prior to treatment. Treatment decisions should not be made on the basis of age alone. Information vital to enable adequate discussion includes:

- Histological diagnosis
- Tumour stage
- Patient performance status

A multidimensional geriatric assessment can inform the MDT of ageing-related issues and guide treatment decisions and supportive care and includes consideration of: life expectancy, comorbidities and concurrent medications, an estimate of frailty including mobility, decision-making capacity including presence of cognitive impairment, social supports, presence of sensory deficits (vision/hearing) and knowledge of patient preferences and goals of care.

MDT membership and responsibilities

The multidisciplinary team should comprise the core disciplines that are integral to providing best practice and relevant expertise for the specific cancer type. Members with a familiarity of the needs of older people and the ability to respond to the findings of a geriatric assessment will enhance the decision-making process. A lead clinician [2] should be nominated to guide discussion.

Research and clinical trials

Older people are underrepresented in clinical trials. Patients should be encouraged to participate in clinical trials where possible. Older age alone is not an exclusion criteria for enrolment on a clinical trial. Search for a trial <www.australiancancertrials.gov.au>.

Communication

The lead clinician's responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the older person and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, and their ability to comprehend the communication
- supporting decisions about goals of care, clarify the patient's wishes, needs, beliefs and expectations, including advance care planning.
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs)

Checklist

- ❑ Diagnosis confirmed
- ❑ Full histology obtained
- ❑ Performance status and comorbidities measured and recorded
- ❑ Adequate multidimensional assessment of geriatric domains prior to and informing treatment decision-making
- ❑ Patient discussed at an MDM and decisions provided to the patient and/or carer
- ❑ Clinical trial enrolment considered
- ❑ Geriatric supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ❑ Patient referred to support services (such as Cancer Council) as required
- ❑ Treatment costs discussed with the patient and/or carer

Timeframe

Timeframes for completing investigations and referral should be informed by evidence-based guidelines and cancer specific OCPs (where available) recognising that shorter timeframes for appropriate consultations can reduce distress. Extra time may be required for geriatric screening and/or geriatric assessment and/or obtaining specialist opinions regarding management of comorbidities.

Step 4 Treatment

Establish intent of treatment

• Curative

• Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure

• Symptom palliation

Treatment options

Treatment options for older people need to take into account the older person's goals and preferences, life expectancy from comorbid conditions and treatment related toxicities. Shared decision-making involving family and carers should be guided by a person's preference. Treatment plans should be modified if indicated based on patient preference or issues identified on geriatric assessment including:

- Refer for geriatric assessment and management if indicated
- Optimise health status before treatment through involvement of a multidisciplinary team
    - Cognition
    - Comorbid chronic disease
    - Medication usage
    - Mood
    - Nutrition
    - Physical function
    - Sensory function
    - Social support

Geriatric and aged care:

Referral to geriatric medicine teams and aged care services can be essential for optimising care for older adults with cancer. These teams provide expertise to address the challenges of cancer, ageing, and comorbidities, ensuring treatment aligns with patient goals and supports functional independence and quality of life

Palliative care:

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website www.palliativecare.org.au

Communication

The lead clinician and team's responsibilities include:

• discussing treatment options with the older person and/or carer including the intent of treatment as well as risks and benefits

• discussing advance care planning with the older person and/or carer and appointment of a substitute decision maker

• communicating the treatment plan to the patient's GP

• helping patients to find appropriate support for allied health, geriatric management, prehabilitation, rehabilitation and exercise programs where appropriate to improve treatment outcomes

Checklist

- ❑ Geriatric screening +/- assessment conducted
- ❑ Health status optimised pre-treatment

- ❑ Intent of treatment determined
- ❑ Treatment plan provided to GP
- ❑ Early referral to palliative care considered based on need
- ❑ Advance care plan discussed with patient and/or carer

Timeframe

Timeframes for starting treatment should be informed by evidence-based guidelines and cancer-specific OCPs (where available), recognising that shorter timeframes for appropriate consultations and treatment can promote a better experience for patients.

Step 5 Care after initial treatment and recovery

Follow-up arrangements

Responsibility for follow-up care and shared care arrangements should be agreed and communicated clearly between the lead clinician, the person's general or primary practitioner, relevant members of the multidisciplinary team, and the person and their family or carers, if appropriate.

Treatment summary

A treatment summary and plan for recovery/survivorship, developed in conjunction with the older person, and provided to the GP and other relevant health professionals should include.

- Diagnosis, including stage, prognostic or severity score
- Tumour characteristics
- Treatments received (types, cumulative doses, dates)
- Current toxicities (severity, management and expected outcomes)
- Potential long-term and late effects of treatment
- Outcomes of geriatric screening and assessment
- Interventions and treatment plans from other providers
- Supportive care services
- Advance care planning
- Medication changes
- Contact information for key healthcare providers
- A follow-up cancer surveillance schedule, including tests required and timing
- A process for rapid re-entry to medical services for suspected recurrence or serious complication of cancer treatment

Recovery/ survivorship care

At the end of cancer treatment and follow-up, high priority should be given to recovery and survivorship care, and a survivorship care plan developed as appropriate

Carers

Carers of older people with cancer have unique health, information and psychosocial needs separate to those of the person with cancer. Family members and carers should be provided with information and access to support services extending into the follow-up care phase.

Communication

There should be an identified member/s of the healthcare team (usually a nurse or care coordinator) with responsibility for:

- explaining the treatment summary and follow-up care plan to the older person and, if applicable, their carer
- Providing information about healthy living, rehabilitation and wellness
- discussing the follow-up care plan with the older person's GP.

Checklist

- ❑ The preferences, values and goals of the older person have been established and what matters to the person is documented and communicated across all healthcare providers.
- ❑ On completion of treatment and follow-up, a treatment summary and survivorship care plan are developed with the older person, provided to the GP, older person, and if applicable the carer
- ❑ Geriatric supportive care needs assessment and discussion about Advance Care Planning completed, recorded and shared across all care providers
- ❑ Referrals made to all support services, including the need for referral for additional community-based services and supports, Aboriginal and Torres Strait Health workers and ACCHO controlled health services where indicated

Step 6 Managing recurrent, residual or metastatic disease

Detection

Most residual or recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms.

For older people with multimorbidity, symptoms of recurrent or metastatic disease can be harder to recognise or made worse by existing health conditions. Worsening of existing symptoms may be attributed to a range of medical conditions including the metastatic cancer.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences and goals.

The older person should be actively involved in decisions about their care in the setting of metastatic or recurrent disease. Ideally, carers should be participants in discussions about treatment and care to facilitate accurate understanding about goals of care and anticipated outcomes, as well as assessing carer capacity and the need for services to ensure safe management in the community.

Where cognitive impairment has been formally assessed and documented, clarity about a legally defined substitute decision maker (Power of Attorney or Enduring Guardian) is essential in all decisions about treatment.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences, and consider if they wish to appoint a substitute decision making in event they are unable to make decisions for themselves. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early in the setting of metastatic or recurrent disease. Early referral to palliative care can improve quality of life, reduce physical and symptom burden, enhance prognostic awareness, reduce unnecessary health care use and in some cases may be associated with survival benefits. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, possible outcomes, likely adverse effects and the supportive care options available to the patient and/or carer and the patient's GP.

Checklist

- ❑ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- ❑ Supportive care needs and geriatric assessments completed and recorded and referrals to allied health services actioned as required
- ❑ Advance care planning discussed with the patient and/or carer
- ❑ Patient referred to palliative care if appropriate
- ❑ Routine follow-up visits scheduled

Step 7 End-of-life care

Shared decision making should guide end-of-life care planning for older people with cancer and involve a multidisciplinary team including the persons general practitioner. For older people with comorbidities these may significantly contribute to prognosis and end of life needs. Care should be proactive to address potential future issues which may occur as end-of-life approaches and extend into bereavement after the older person has died.

Palliative care

Clinical care should be guided by regular individualised clinical assessment for physical, psychosocial, spiritual and existential needs.

A specific needs assessment for carer(s) should also be undertaken and regularly re-evaluated, with tailored support provided.

Consider a referral to palliative care. Ensure an advance care directive and appointment of a substitute decision maker if the older person was unable to make decisions for themselves is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- facilitating transition plans to ensure the patient's needs and goals are considered in the appropriate environment.
- discuss the role of ongoing cancer therapies, investigations and treatment for intercurrent medical issues.

Voluntary assisted dying

A person who has advanced cancer who meets strict criteria (which varies by state and territory) can request access to voluntary assisted dying. It must be voluntary and requested by the person themselves.

Checklist

- ❑ Palliative and end of life care needs assessment and carer needs assessment completed and recorded, and tailored plan in place
- ❑ Referrals for older person and/or carer to interdisciplinary clinicians and support services actioned as required
- ❑ Older person referred to palliative care
- ❑ Advance care plan and appointment of substitute decision maker in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.

[1] https://forms.ihi.org/hubfs/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf
[2] lead clinician – the clinician nominated as responsible for overseeing and coordinating a patient's care. The lead clinician may change over time depending on the stage of the care pathway and the setting where care is being provided