Clinical Oncology Society of Australia

Geriatric Oncology Clinical Professional Day Workshop Report

Adequate Assessment: Appropriate Treatment- Practical ways to incorporate geriatric assessment and intervention into the oncology clinic

Monday 11th November 2013
Riverbank Room 1,
Adelaide Convention Centre,
North Terrace
South Australia

Report prepared by Jane Phillips and Kate Whittaker

Introduction:

In theme with the COSA Annual Scientific Meeting (ASM), the Geriatric Oncology Group held a clinical professional day (CPD) on Monday 11th November 2013 in Adelaide which focussed on *'Adequate Assessment: Appropriate treatment- practical ways to incorporate geriatric assessment and intervention into the oncology clinic'*. TCPD workshop was targeted to clinicians, health practitioners and researchers involved or interested in cancer care in the elderly. The theme addressed the importance of geriatric assessment and intervention to enable the appropriate treatment of older people with cancer.

It was attended by approximately 35 people, including national and international representation and featured models of geriatric oncology and assessment presentations from representatives across various jurisdictions around Australia including a regional centre perspective.

Background:

A COSA Geriatric Oncology Concept Development Day was held on 22nd March 2013, which attracted seven research proposals (Refer to COSA Website for full report) and generated much debate about the ideal 'gold standard' model for either geriatric screening or assessment. As much of the discussion at this workshop focussed on the various geriatric oncology screening and assessment approaches a decisions was made to host a CPD workshop at the November ASM to align with the ASM Geriatric Oncology focus and provide an opportunity for the approaches to geriatric oncology assessment adopted in several Australian cancer care units to be showcased..

Aim:

The aim of the Geriatric Oncology Clinical Professional Day was to:

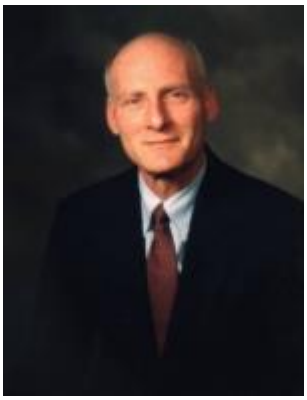
- Explore the different international and national geriatric oncology operating in a range of settings, including large metropolitan tertiary teaching hospitals through to a regional private clinic;
- Develop practical strategies to enable integration of geriatric oncology principles into the all cancer care clinical setting
- Make delegates aware of the different geriatric oncology models of cancer care in Australia
- Make delegates aware of the current application of geriatric oncology assessment and intervention in Australian centres
- Describe the model of geriatric screening, assessment and intervention in Australian centres. Able to consider the implementation of a model of geriatric assessment screening and intervention
- Identify possible collaborators in research and service delivery.

An overview of the program is detailed in Appendix 1.

Invited ASM International speakers in geriatric oncology, Prof Harvey Jay Cohen and Dr Janine Overcash, both attended and presented at the CPD.

Prof Harvey Jay Cohen

Duke University School of Medicine, North Carolina, USA



Harvey Jay Cohen, MD, is Walter Kempner Professor, Director, Center for the Study of Aging and Human Development, Chair Emeritus, Department of Medicine at Duke University Medical Center.

Prof. Cohen co-chairs the Cancer in the Elderly Committee for The Alliance for Clinical Trials in Oncology and is PI of the Partnership for Anaemia: Clinical and Translational Trials in the Elderly (PACTTE). He is past President of the American Geriatrics Society, the Gerontologic Society of America and the International Society of Geriatric Oncology. He has published extensively with more than 300 articles and book chapters, with special emphasis on geriatric assessment, biologic basis of functional decline, and cancer and hematologic problems in the elderly. He is co-editor of *Geriatric Medicine, 4th Edition; Practical Geriatric Oncology*; and author of the book *Taking Care After 50*.

Dr Janine Overcash

James Cancer Center; Solove Research Institute; and Ohio State University, Ohio, USA

Janine Overcash is currently the Director of Nursing Research at the James Cancer Center and Solove Research Institute and Clinical Associate Professor at The Ohio State University, College of Nursing. Dr. Overcash is a geriatric nurse practitioner specializing in the care of the older cancer patient. She has assisted in the design and management of one of the first geriatric oncology programs located at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, Florida.

Dr. Overcash has authored over 35 peer reviewed journal articles in the area of geriatric assessment. A book entitled, The Older Cancer Patient: A Guide for Nurses and Related Professionals by Janine Overcash and Lodovico Balducci highlights principles of care of the older person with cancer and received book of the year award by the American Journal of Nursing. Dr. Overcash has completed a post doctorate with the John A. Hartford Building Academic Geriatric Nursing Capacity Program. Dr. Overcash participated in the Geriatric Nurse Educational Consortium sponsored by the American Academy of Colleges of Nursing (AACN) and the John A. Hartford Foundation which instructed over 500 faculty from all over the United States.
Dr. Overcash is currently interested in maintaining functional status of older women undergoing chemotherapy. Other research interests include understanding falls, performance status and independence in older cancer patients.

Clinical Professional Day, 11th November 2013

Dr Christopher Steer, Chair of the COSA Geriatric Oncology Group, welcomed delegates and invited their participation throughout the day. He acknowledged the mix of national and international representation in the room allowing the cohort to draw upon varied experience and practice in care for the older cancer patient.

Dr Steer is a medical oncologist from Border Medical Oncology in Albury- Wodonga situated on the border of New South Wales and Victoria. He is a leader in recognising the impact of geriatrics and oncology as a dual discipline to improve patient outcomes.

He is the Chair of the International Society of Geriatric Oncology (SIOG) Membership and National Representative Committee and sits as the Australian representative on this Committee. This Committee consists of 40 members representing many nations. Dr Steer acknowledged France as the most advanced nation for geriatric oncology practice. They lead the way in organising geriatric oncology focused activities, and research to establish and promote the integration of geriatric oncology into cancer care through overarching principles.

Dr Steer is also a member and Co-Chair of the Multinational Association of Supportive Care in Cancer (MASCC) Geriatric Oncology Study Group which aims to assist in the partnership between supportive care and geriatric oncology.

He opened the workshop by acknowledging the worldwide struggle to search for a 'gold standard' tool for Comprehensive Geriatric Assessment. Clinicians involved in geriatric oncology do not collectively agree on one particular model, and essentially screening and assessment must to be relevant at a location and cancer centre level to be effective.

Geriatric Oncology Models

International Perspective:

Dr Janine Overcash, Director of Nursing Research at James Cancer Centre and Solone Research Institute, and Clinical Research Associate at the Ohio State University College of Nursing.

Dr Overcash presented the practicality of geriatric oncology models of care within three settings; outpatient ambulatory care, inpatient hospital care, and home care, and the associated considerations for integrating geriatric care into oncology practice.

Geriatric assessment conducted in the *outpatient ambulatory* setting supports the assessment of chemotherapy toxicity in older patients, assessment of geriatric conditions while treating the cancer diagnosis and, considers social support elements for the older cancer patient. Assessment can be done at each clinical visit, and prior, during and following cancer treatment, therefore identifying trends across the cancer continuum.

Geriatric care for *hospitalised* patients post-screening requires a multidisciplinary team. Members of the team must be identified to provide all aspects of care and support required for the patient. This setting supports the reduction of geriatric syndromes by adequately addressing specific problems including comorbidity, and discharge planning supporting ongoing care needs.

Dr Overcash advised that assessment of the older patient with cancer should begin slowly by using two or three assessment tools such as for the patient such as depression screening, balance/fall, and functional status for example, prior to introducing questionnaires. *Pre-screening* is important to identify patients who require a full geriatric assessment. The process reduces the number of patients undergoing unnecessary screening. *Comprehensive geriatric assessment* is provided within the emergency room and if admitted, the assessment needs to be continued potentially through a discharge plan to reduce rehospitalisation.

Integrating assessment and intervention at home following discharge from an emergency department can improve health for older people at risk of re-admission. However, there are barriers to establishing a complete service, such the cost required to provide home based visits. Improving communication by using phone follow up and technology, such as smart phone and tablet applications could assist to overcome some barriers. In some studies, patients have shown a preference to using smart device applications on their phones or tablets as well as email or in person communication with their health care provide however, clinicians prefer telephone communication.

Patient's adherence to recommended referrals can be another barrier to effective home based models of geriatric oncology care.

For a service to be successful, the following elements of geriatric care must be considered for each patient:

- Toxicity associated with cancer treatment
- Preservation of independence
- Impact of support services
- Multidisciplinary teamwork
- Comorbidity

Dr Overcash concluded her presentation by challenging delegates to consider assessing the practicality of integrating geriatric assessment within the limitations of current resourcing and infrastructure within their setting of care. They should consider the following:

- What type of assessment is used
- Who does the assessment
- How long it takes to do the Comprehensive Geriatric Assessment
- How are the outcomes documented so colleagues can see this
- Who are your referrals
- Communicate with primary care providers
- Disciplines addressed in team approach

Partnering with Geriatricians:

Dr Robert Prowse, Geriatrician at Royal Adelaide Hospital Geriatric Oncology Clinic, and is the geriatrician representative on the COSA Geriatric Oncology Group.

Oncologists and geriatricians have similar values when considering the needs of their patient which includes; whole patient assessment, creating adherence to care plans, support, and care across the cancer continuum from diagnosis to survivorship or palliative care. Considering this, he discussed the need for integrated training covering geriatric medicine, oncology and palliative care for trainees in Australia. As there are many domains to geriatric medicine it is increasingly important that an older patient with cancer has a multidisciplinary team meeting regularly to assess their care needs and consisting of both a geriatrician and oncologist when a geriatric oncologist is not accessible.

Currently in Australia, there are more oncologists than geriatricians, and therefore oncologists are driving the integration of the two disciplines as a means to understand the complete care needs of the older patient with cancer. There are increasing demands on geriatric medicine, not just in oncology services but across the health care system due to an ageing population and population living longer with and after cancer. Australia has an opportunity to integrate principles of geriatric medicine into all models of care.

At the Royal Adelaide Hospital geriatricians see an increasing number of young, fit elderly patients in their clinics. Geriatricians and medical oncologists create a cross fertilisation of multidisciplinary teams to discuss treatment and care plans for their shared patients, however the question remains 'how do we set up and sustain geriatric oncology services within the public system?'

Western Australia, Perth:

Dr Andrew Kiberu, Medical Oncologist with geriatric medicine training based at Royal Perth Hospital.

Dr Kiberu attended the COSA Geriatric Oncology Concept Development Day earlier in 2013, meeting with many other oncologists and health professionals across Australia with an interest in geriatric oncology. He acknowledged that everyone had the same issue - identifying and implementing the

best tool for screening, what does this look like and is this the most appropriate for a particular setting of care?

His review of the literature demonstrates that when the same Comprehensive Geriatric Assessment e.g. VES-13 or G8 is used, the individual tools to assess the geriatric domains within of the Comprehensive Geriatric Assessment do not necessarily produce the same measurement. Variations also occur from country to country. Both these factors make it difficult to capture the same data in studies assessment geriatric oncology and use of assessment and screening tools.

At Royal Perth Hospital, determining an appropriate screening tool and an appropriate geriatric assessment (comprehensive; multidimensional; multi-domain; abbreviated) are the main areas of discussion for developing a cooperative geriatric program. This program is supportive of professional partnerships across disciplines including geriatric medicine, oncology, palliative care, allied health services and geriatric oncology nursing. Financing a comprehensive service and demonstrating sustainability continues to remain an issue.

South Australia, Adelaide:

Dr Jonathan Hogan-Doran, Medical Oncologist with special interest in geriatric oncology based at Royal Adelaide Hospital. He trained in geriatric medicine and then in oncology.

In 2008, Royal Adelaide Hospital piloted a geriatric oncology program based on the use of a self-completed screening tool. They identified disciplines for a geriatric focused multidisciplinary team and screening tools to be used in each domain. This team included: geriatrician, registered nurse, nurse practitioner candidate, social worker, pharmacist and psychologist. The self- completed tool provided the geriatrician with the patient's perception of their overall physical health and wellbeing. Such tools allow practitioners to adapt these questionnaires as required. After understanding the patient's physical health and wellbeing the assessor can identify any areas of concern or that the patient has identified, and with an appropriate treatment plan, can make considered referrals.

The pilot study found that the self-completed tool was too cumbersome for the patient to complete. Phase two of its introduction focused on a broad way of thinking about a patient by categorising them into three areas; fit, vulnerable or frail. Nurse practitioners, consumers and other key stakeholders were consulted on the practicality of the tool and funding considerations including, the cost of resources such as nursing staff to undertake the screening and use of tool to identify complex patients who would benefit from screening.

Three lessons were learnt from this:

- The need for good case management. Older patients with cancer are generally more complex cases than the general population and using local clinics should be encouraged where appropriate to manage the patient's treatment and supportive needs
- Use of specialised clinics to triage patients over 80 years old. Resource use can be lowered with a reduction in over screening
- Importance of geriatric oncology training for continued specialised services. Introducing formal geriatric oncology training and education for nurse practitioners can assist in creating

a plan for the treatment of the older population as this number continues to grow and present with co-morbidities.

Queensland, Brisbane:

A/Professor Alexandra McCarthy, Principal Research Fellow at Queensland University of Technology and Princess Alexandra Hospital.

Associate Professor Alexandra McCarthy, Principal Research Fellow at Queensland University of Technology and Princess Alexandra Hospital.

Princess Alexandra Hospital in Brisbane has implemented a nurse led Geriatric Oncology model. A Comprehensive Geriatric Assessment Nurse completes the assessment with a patient, sends a summary of the assessment to the relevant oncologist, and where appropriate, refers to social support etc.

A/Prof McCarthy presented results from their study which indicated that a current 'one-step' screening process to determine an older cancer patient's fitness has limitations. However, screening tools can be modified and, by adding relevant items can enhance predictive properties in cancer care to determine whether a patient should undergo a comprehensive geriatric assessment.

Princess Alexandra Hospital has introduced a modified version of the VES-13 into their Geriatric Oncology model of care, which includes an increase in the age cut off and screen for depression. Data from Princess Alexandra Hospital and related studies identified Quality of Life and Body Mass Index as other important predictors and therefore included in the screening process.

In practice, positive results from the screening test will trigger the need for a comprehensive geriatric assessment and appropriate multidisciplinary team intervention for the patient's cancer care needs. An oncogeriatric model of care must be able to identify fit, vulnerable and frail people so then vulnerable and frail people can undergo appropriate comprehensive geriatric assessment.

Princess Alexandra continues to trial various screening tools to identify areas of care including depression, comorbidity, social support needs etc. There are many validated tools available to use but these must be appropriate to the individual service.

Regional Cancer Centre & Summary of National Geriatric Oncology Models:

Dr Christopher Steer, Medical Oncologist at Border Medical Oncology.

A very small number of clinicians have completed training in both geriatrics and oncology and only 3 of these currently work in the geriatric oncology sphere.

The majority of oncology service providers in Australia do not interact with geriatric services at a formal level. The geriatric oncology clinic at the Royal Adelaide Hospital has pioneered a service based on a nurse-led screening test and multidisciplinary discussion and intervention. This service is unable to see all older patients with a diagnosis of cancer at their institution and thus needs to be

targeted towards the most needy and/or oldest-old. An “over 80’s clinic” is currently being run on a limited basis at the same institution. This service remains the only formal geriatric oncology service in an Australian Health care setting.

Other centres have approached the issue of providing care for older patients in a less resource-intensive fashion. The Care Coordination in the Older Adult with Cancer project (CCOAC) at Border Medical Oncology utilised the geriatric supportive care screening tool developed by the Royal Adelaide Hospital team. This self-filled questionnaire was then scored by a cancer care coordinator who then made streamlined referrals to existing community-based organisations (e.g. aged care assessment teams and carer support agencies). This model was found to be feasible and cheap, with a cost of $42.50 per patient screened. This model relies on relatively cheap screening process with the more comprehensive assessments then made by the appropriately funded agencies in the community aged care sector. By definition this model does not create another “geriatric oncology silo” but utilises existing services in a more streamlined manner.

Geriatric oncology service delivery needs to be reactive to local needs and resources. Teams in Perth, Brisbane and Melbourne are exploring the best way to integrate geriatrics and oncology services within their local healthcare frameworks.

Models and Potential Barriers to Opportunities: How can we overcome the barriers to implementation?

Facilitated by **Jane Phillips**, Professor Palliative Nursing, the Cunningham Centre for Palliative Care, and the University of Notre Dame, Sydney.

The aim of this session was for the group, as professionals involved in or interested in geriatric oncology, to identify how to implement or grow geriatric oncology services in their institution. Delegates were challenged to generate ideas about how these barriers can be turned into opportunities to develop strategies to support the implementation or growth of geriatric oncology services. Delegates were asked to individually identify three areas restricting services, then each table group was asked to agree on three and present these points to the workshop. These barriers were clustered into the following themes: funding, access to specialised care, justification of the service, consumer and, starting a service, and a theme was allocated to each table to explore further. Discussion around these areas are outlined below:

1. **Funding the service:**

Appropriate resourcing and infrastructure must be in place to adequately support the introduction of services to address geriatric syndrome into a hospital or clinic setting. Having the support from funding decision makers is key, as well as the support of colleagues who see the value in a geriatric oncology service.

As this diverts money away from another service, it is important to demonstrate the costs associated with the service and the benefits which can be presented as overall cost saving or non-monetary e.g. improved efficiency, patient outcomes. Decision makers are interested in quantitative evidence, therefore an important step in building a business case is turning qualitative data and analysis into

quantitative outcomes. Knowing how decisions about services are provided in the system, and the language decision makers speak, can assist in strengthening a case put forward in support of a geriatric oncology program.

Tips for gaining the support of funding decision makers:

- Start dialogue with funders: Find out what is important to them and develop a business case around this including data collection
- Use existing information (if no evidence), e.g. from expert opinion
- Show the problem, demonstrate the potential impact

Tips for gaining the support of colleagues who would be involved:

- Identify people who would benefit from the service or be involved
- Use allies and champions to build momentum
- Start with presenting the beneficial endpoints and effect of intervention
- Generate evidence to gain tangible benefits

2. Access to specialised care:

- Role of **Primary Care**- utilising Medicare funding through General Practitioner's and nurse based roles
- **Oncology**- improving education of aged care issues to oncology services
- **Geriatrics**- accessing available oncology services for their elderly cancer patients; better education about cancer as a chronic disease
- **Cancer Care Coordinator and Nursing staff**- Priority of their role with patients is to coordinate referral pathways between services and breaking down silos of each service involved, such as having a geriatric team meeting and database of services. The use of 'champions' can represent consumer needs
- **Allied Health**- using available community/hospital services

3. Consumer:

Older patients with cancer require a specialist cancer service and if available, a geriatric oncology service. The introduction of a geriatrician into the care model for these patients, and what this means for their care must be communicated effectively with the patient. Providing education to the patient about the care they require keeps the patient informed and they can communicate their individual supportive needs. It also allows the patient to feel empowered when a choice relating to their treatment or care is presented to them. They can be advocates for cancer services and their experiences and outcomes can provide evidence to gain ongoing support or improved quality for geriatric oncology programs. Carers of cancer patients are just as important in this process especially as frail cancer patients may not have the capacity to communicate their needs to a clinician. The Cancer Care Coordinator or Nurse can play a vital role in creating smooth transitions in care for the patient.

4. Justification of the service:

- Funding –cost verses benefit of a geriatric oncology service and, impact on additional services
- Demonstrate need – clinical and consumer support

Strategies:

- Increase public profile through media, awareness campaigns, consumer ownership
- Research: need verses want, cost effect, dissemination of information and knowledge
- Develop and utilise standardised tools including Key Performance Indicators for program evaluation and ongoing service improvement.

Also see, 'Funding the service' for more tips.

5. Starting a service:

The easiest way to begin a geriatric oncology program is to introduce a screening process. This can act as a baseline to improve and built upon as colleagues become more familiar with the service and impact on older cancer patients. Having the support of colleagues can strengthen a business case when the service grows and requires increased resources and investment.

Colleagues must firstly understand why it is important to consider this demographics care needs in a different way to other patient groups. Educating them on geriatric syndromes including, cognition, presence of comorbidity and interaction of multiple therapies, can engage their greater awareness of increasing the quality of care and outcomes to the older cancer patient. Take the opportunity to understand how current geriatric oncology services have been implemented, run and grow. Networking with colleagues through COSA workshops or membership, site visits and observation of current services can support the development of a site specific service addressing particular institutional requirements and needs of people.

Implementing tele-health, self-reported screening tools and nurse led models can be ways to know more about the patient.

How to get your new services funded: what do health service administrators want to know?

Professor Dorothy Keefe, Service Director at South Australia Cancer Service.

Health service providers must determine the cost associated with and benefit of implementing a new service. The current state of the health care system means decision makers are interested in strategies which improve patient care at no or little additional cost and therefore getting more value per health dollar spent. This also may mean redirecting funds away from another area of service.

Quantifiable data will assist to communicate effectively with health service decision makers, for example; how many nurse coordinators are there per patient across the cancer journey, and how do we make a cancer nurse coordinator accessible to all and throughout a patient's cancer journey. This data can then be translated into a cost analysis of the service as a means to convince health service decision makers that it is the best strategy going forward. They have an obligation to the tax payer

and consumer to spend money wisely therefore showing the benefit of implementing the service verses not can demonstrate the cost effectiveness of the service.

Professor Keefe provided additional advice to present reasonable costs:

- An advantage for clinicians is to know and use Activity Based Funding (ABF) principles to account for costs where applicable.
- Build in evaluation into pilot projects to demonstrate that it has practically worked in the given environment.
- Costs of nursing staff are particularly hard to show if not within the department budgets as these look at the whole service.
- Demonstrate what is required: why does a nurse need to do this position? Why can't this be another discipline e.g. occupational therapist.

She finished her presentation by acknowledging the American Society of Clinical Oncology's (ASCO) 'Top Five List' of ways to reduce wasteful healthcare expenditure in 2012. It included recommendations relating to chemotherapy use for breast cancer patients, PSA testing, targeted therapies and presence of biomarkers, and use of imaging technologies to monitor reoccurrence.

Opportunities for Collaboration and Evaluation

Collaborative Research- the US Model

Prof Harvey Jay Cohen, Director of the Center for the Study of Ageing and Human Development; Chair Emeritus, Department of Medicine at Duke University Medical Center, presented on the opportunities for collaborative research in geriatric oncology and how this is currently supported in the United States.

The National Cancer Institute in the United States has a Clinical Trials Cooperative Group Program which engages individual investigators and institutions with a focus in conducting research within a medical speciality, tumour specific or groups of related cancers, or therapy.

Geriatric oncology principles could be supported within this program. Clinical Trials could incorporate Comprehensive Geriatric Assessment to screen patients, advisory groups could include geriatric oncology representatives, or the development of a geriatric oncology focused clinical trials group. Comprehensive Geriatric Assessment could be implemented across trial groups with a purpose to gain and develop information which might be useful in predicting patient needs and the capacity of collaborative, multi-institutional trials to support elderly cancer patient outcomes. Additionally, this may assist in the growth of junior investigators with the opportunity to conduct research and gain experience in clinical cancer trials, while considering the needs of the older patient.

Dual training of oncology and geriatric medicine is mostly based within oncology and is tumour specific. Geriatric oncology as a dual discipline is supported by groups such as Cancer in the Elderly Committee, and the Cancer and Aging Research Group. These groups engage clinicians in the fields of pharmacy, nutrition, nursing, and allied health and a trial coordinator. Cancer and Ageing Research Group is currently focused on the development of a toxicity prediction algorithm to show

the ability of data collected from Comprehensive Geriatric Assessment to improve toxicity outcomes in older patients.

To advance collaborative research in geriatric oncology, research groups must to begin the conversation with cooperative trials groups to engage a geriatric oncology specialist on their Scientific Advisory Committee.

Outcome Measures

Dr Kheng Soo, Medical Oncologist and Geriatrician at Eastern Health, Melbourne.

Dr Soo provided an overview of some basic measures and considerations in design and study outcomes for conducting clinical trials and research related to elderly patients with cancer.

Consider exploring:

- Survival outcomes: mortality; morbidity
- Psychological outcomes e.g. depression
- Clinical outcomes: patient reported; clinician reported; proxy reported (on behalf of patient)
- Economic outcomes/ evaluation

Standardisation of outcomes which have undergone process of evaluation to consider:

- Validity
- Reliability
- Sensitivity to change
- Interpretability: how is this information clinically useful

End Points and Trial Design:

- Survival: disease specific, quality of life, functional capacity
- Number of primary outcome measures:
    - Single primary end point
    - Co-primary endpoint e.g. p-value
    - Composite end points
- Proximal: closely related to patients
- Distal: influenced by personal and environmental factors

Comprehensive Geriatric Assessment G8 questionnaire measures include:

- OARS or LAWTON IADL: activities of daily living
- MINDS: social situations
- EQ-5D, SF36: quality of life measures in geriatric oncology
- FACT, EORTC/QLQ: quality of life in cancer specific studies

Decision as to appropriate measures to use in the study are based on:

- Study question
- Study population
- Mode of administration of the intervention
- Permission granted/ costs and resources

Tools and measures used to conduct this research are usually validated in geriatric medicine or oncology however, not as a dual discipline. Going forward, the validation of tools used in geriatric oncology research and assessment must occur in conditions supporting the dual discipline to provide confidence that these are appropriate tools to use to provide the most appropriate treatment outcomes for older patients with cancer.

Appendices:

Appendix 1: Registrations and Attendance

Appendix 2: Program

Appendix 3: Feedback/Evaluation

Appendix 1: Registrations

First Name	Surname	Organisation
Pawan	Bajaj	Townsville Hospital
Fiona	Barry	RAH
Robyn	Berry	Geriatric Oncology CNC, Princess Alexandra Hospital
Anne	Booms	Albury Wodonga Health
Maree	Burmeister	Ringwood Private Hospital
Victoria	Busch	CCLHD
Michelle	Camus	Eli Lilly
Howard	Chan	St Vincent's Hospital
Alexandre	Chan	National University of Singapore
Phinchai	Chansiwong	Mahidol University
Michael	Chapman	Centre for Palliative Care, St Vincent's Hospital
Harvey	Cohen	Duke University
Michael	Coney	The Northern Hospital
Bianca	Devitt	St Vincent's Hospital
Tracey	Dunlop	St George and Sutherland Hospitals
Subhash	Gupta	AIIMS
Jane	Hill	Riverina Cancer Care Centre
Jonathon	Hogan- Doran	Royal Adelaide Hospital
Mikaela	Jorgensen	University of Sydney
Mandy	Kavanagh	Ringwood Private Hospital
Dorothy	Keefe	Sansom Institute, University of Adelaide
Richard	Khor	Peter MacCallum Cancer Centre
Andrew	Kiberu	Royal Perth Hospital
Ganessan	Kichenadasse	Flinders Medical Centre/ Flinders University
Lisa	King	Cancer Institute NSW
Vikki	Knott	University of Canberra
Heather	Lane	St Vincent's Hospital, Melbourne
Peter	Lau	Royal Perth Hospital
Alexandra	McCarthy	Queensland University of Technology
Janine	Overcash	The Ohio State University, James Cancer Hospital
Sagun	Parakh	The Canberra Hospital
Dainik	Patel	LMH
Jane	Phillips	Cunningham Center for Palliative Care; University of Notre Dame Sydney
Janette	Prouse	Royal Adelaide Hospital
Robert	Prowse	Royal Adelaide Hospital
Geeta	Sandhu	Princess Alexandra Hospital
Nimit	Singhal	Royal Adelaide Hospital
Wee-Kheng	Soo	Eastern Health, Melbourne
Christopher	Steer	Border Medical Oncology
Leanne	Stone	Princess Alexandra Hospital
Tim	To	Repatriation General Hospital
Kerrie	Vaughan	Mackay Base Hospital
Margaret	Wallington	ECU
Kate	White	Sydney Cancer Centre, RPAH
Kate	Whittaker	Clinical Oncology Society of Australia
Annie	Wong	Wellington Hospital; Capital and Coast District Health Board

Appendix 2: Program

Geriatric Oncology Program

Adequate Assessment: Appropriate Treatment- Practical ways to incorporate geriatric assessment and intervention into the oncology clinic

Clinical Oncology Society of Australia

Monday 11th November 2013, 11am
Riverbank 1, Adelaide Convention Centre, South Australia

The workshop will commence with a minute's silence in respect for Remembrance Day

11:00- 11:10am	Welcome to Country Introduction: summary of previous workshops	Christopher Steer
11:10- 11:25am	Geriatric Oncology Models: *International Perspective*	Janine Overcash
11:25-11:35am	Partnering with Geriatricians	Robert Prowse
11:35-11:45am	Geriatric Oncology Models: *Perth*	Andrew Kiberu
11:45-11:55am	Geriatric Oncology Models: *Adelaide*	Jon Hogan Doran
11:55am – 12:05pm	Geriatric Oncology Models: *Brisbane*	Alexandra McCarthy
12:05- 12:15pm	Geriatric Oncology Models: *Regional Cancer Centre*	Christopher Steer
12:15- 12:30pm	Summary of National Geriatric Oncology Models	Christopher Steer
12:30- 1:30pm	Lunch	
1:30- 2:30pm	Models and Potential Barriers to Opportunities: *how can we overcome the barriers to implementation?*	Jane Phillips
2:30-3:00pm	How to get your new services funded: *what do health service administrators want to know?*	Dorothy Keefe
3:00-3:30pm	Afternoon Tea	
3:30- 4:00pm	Opportunities for collaboration and evaluation: *Collaborative Research- the US Model*	Harvey J Cohen
4:00-4:30pm	Opportunities for collaboration and evaluation: *Outcome Measure*	Kheng Soo
4:30-4:35pm	Summary and Close	Christopher Steer

Appendix 3: Feedback & Evaluation

Feedback: N= 11

Q1. In what discipline do you currently work?

Discipline	**Responses**
Medical Oncology (adult)	5
Geriatric Medicine	5
Haematology	1
Surgery	1
Cancer Nursing	2
Palliative Care Nursing	1
Project/Program Management	2
Academia/ Research	2
Geriatric Oncology Nurse	1
Palliative Medicine Nurse	1

Q2. Do you currently work in a dedicated geriatric service?

	Responses
Yes	5
No	6

Q3. What was/were you reasons for attending this workshop?

Statement	**Responses**
Opportunity to hear from international speakers	9
To speak and provide information to the delegation	5
Opportunity to extend my knowledge	11
Opportunity to network with likeminded professionals	11
Other	0

Q4. Overall, what was the main highlight of the clinical professional day?

Session	**Responses**
Geriatric Oncology Models: International	2
Geriatric Oncology Models: Australia (Perth; Adelaide; Brisbane; Regional Centre)	5
Models and Potential Barriers to Opportunity: *how can we overcome the barriers to implementation?*	1
How to get your new service funded: *what do health service administrators want to know?*	3
Opportunities for Collaboration and Evaluation: *collaborative research*	2
Opportunities for Collaboration and Evaluation: *outcome measures*	2

Q5. The following aspects of the workshop were rated:

Statement	Rating and Responses			
	Excellent	Very Good	Satisfactory	Unsatisfactory
Overall workshop relevance and quality of content	6	4	1	0
Overall length of workshop	6	4	1	0
Appropriateness of speakers and their topics	5	4	2	0
Applicability of information provided to your needs	5	4	2	0

Q6. Involvement in Areas of Geriatric Cancer Care

Area	Responses
Research	9
Support Groups	3
Academia	5
Clinical Care	9
Allied Health Services	2
Other, please specify	1, service development

Q7. What would you like to see the Geriatric Oncology Group do in 2014?

- Standardise models of care
- Adopt geriatric screening process so we can benchmark
- Attract funding for nurse practitioner roles in older patient care
- Regular networking meeting
- Support and establish new collaborations with other services
- Focus on patient wishes and decision making
- More collaborative work on outcome measures
- Nominate a project, find a position and a fellow
- Set up a national database to collect data on geriatric oncology
- Build some research
- Organised research
- Publish existing data
- Lobby government for change
- Lobby RACP for training program
- Reforms
- Present at meetings
- Collaborative research program
- How can we use and integrate geriatric assessment/screening into standard practice and keep it there
- Consider a collaborative approach regarding funding opportunities
- Reconsider ways of working with older people in clinical trials

COSA Geriatric Oncology Group aims to improve outcomes for older people affected by cancer through:

- Education
- Support for clinical practice
- Research
- Advocacy

Website https://www.cosa.org.au/groups/geriatric-oncology/about.aspx

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