Background: Geriatric oncology offers specialized care that incorporates comprehensive geriatric assessment (CGA) and multidisciplinary teams (MDTs) with oncology care. Geriatric syndromes, comorbidities, and caregiver concerns are relevant to the oncology assessment in older adult patients to make treatment decisions, which should be based not on age but on health and functional status, as well as on life expectancy. Developing a geriatric oncology ambulatory care clinic (GOACC) requires numerous resources and entails planning for longer patient encounter times, devising collaboration strategies with community care providers, and establishing dedicated time for team members.

Objectives: The purpose of this article is to provide information regarding the construction and sustainability of a GOACC.

Methods: A comprehensive review of literature published from 1991–2015 was conducted using the following key words: geriatric oncology, comprehensive geriatric assessment, supportive care, multidisciplinary, and elderly.

Findings: Oncology primary care nurses and advanced practice nurses have a large role in the development and maintenance of GOACCs. Managing comorbidities, identifying patients who likely would benefit from a CGA, providing caregiver support, conducting a CGA, and creating an MDT are core elements of developing a sustainable GOACC.

More than 50% of new cancer diagnoses occur in people aged 65 years or older (National Cancer Institute [NCI], 2015). The median age of a cancer diagnosis in the United States is 65 years, and the median age of death associated with a malignancy is 72 years (NCI, 2015). Simply offering cancer care is insufficient to meet the healthcare needs of older adult patients and their families. Geriatric oncology offers cancer care and addresses relevant issues, such as preservation of independence, comorbid conditions, and caregiver support needs (Hurria, 2013; Tremblay, Charlebois, Terret, Joannette, & Lateille, 2012). Helping patients and families to understand that cancer treatment options are not exclusively based on chronological age but also on functional status and the existence of comorbidities (Hurria, 2013) can pave the way for more effective healthcare decisions.

Geriatric care extends beyond the general history and physical examination, assessing patients for the existence of geriatric syndromes (i.e., problems that have many causes, such as dementia and functional limitations), comorbidities, and psychosocial concerns (Hoffe & Balducci, 2012). For this reason, a geriatric oncology ambulatory care clinic (GOACC) is central to adequately treating older adults with cancer (Hurria et al., 2007; Marenco et al., 2008). Maintaining physical, mental, and social support status of older adult patients is critical to cancer treatment success (Balducci, 2005; Balducci, Colloca, Cesari, & Gambassi, 2010). In fact, geriatric oncology care may decrease three-year mortality in older adult patients because they are more likely to undergo surgery and receive chemotherapy (van de Water et al., 2014).

A GOACC often includes a comprehensive geriatric assessment (CGA) that can reveal various problems, such as cognitive, physical, and emotional changes (Klepín et al., 2011); postoperative complications (Fukuse, Satoda, Hijiya, & Fujinaga, 2005); toxicity to cancer chemotherapy treatment (Aaldriks et al., 2011; Freyer et al., 2005; Hurria & Lichtman, 2007); frailty (Kristjansson et al., 2010); and risk for falls (Overcash & Beckstead, 2008). A CGA is also helpful in identifying older
Navigating the Nonmalignant Conditions of Older Adults

Comorbid conditions or coexisting diagnoses are common with older age. The mean number of diagnoses for a person aged 70 years or older is 5.6 (Fried, Storer, King, & Lodder, 1991). Untreated comorbidities can increase the risk of chemotherapy toxicities (Chao et al., 2014), and addressing nonmalignant issues (e.g., cardiac problems) can help to lay a foundation for cancer treatment and reduce complications (e.g., congestive heart failure, cardiomyopathy) (Tsai, Pfeiffer, Warren, Wilson, & Landgren, 2015). Patients with moderate to severe comorbidities are likely to experience grade 3 or grade 4 nonhematologic toxicities from cancer treatment (Wildes et al., 2013). The likelihood of survival decreases with an increasing number of comorbidities (Koroukian, Bakaki, Schluchter, & Owusu, 2011).

After a cancer diagnosis, the focus of health care often becomes the malignancy, and many other comorbidities are put on hold until after cancer therapy. In reality, patients are more likely to succumb to cardiac problems than cancer-related problems (Centers for Disease Control and Prevention, 2015). If patients are receiving treatment from other providers for comorbidities, they should be encouraged to continue treatment and maintain appointments. In addition, medical records from the oncology visit concerning tumor and treatment type, as well as other relevant information, must be sent to patients’ primary care providers and other specialists. Adequate care of the older adult patient requires coordination among providers concerning medications, recommendations, and prescribed therapies to reduce duplicate billing, issues related to polypharmacy (excessive medications), and other problems associated with many prescribers (Holmes & Albrand, 2013).

For comorbidities discovered during oncology care, referrals to disease-specific services are necessary. Older adult women who develop comorbidities following a diagnosis of breast cancer have a higher all-cause mortality rate (Jordan et al., 2014). When considering the development of a GOACC, making connections with physicians who are willing to accept patients and work together to provide comprehensive care is vital. For academic medical centers, these connections may not be difficult to make, but for community clinics, establishing such relationships with referring physicians may be more difficult. Proactively seeking referral sources ensures that various practices are accepting new patients and are willing to work with cancer care providers.

Case Study: The Benefits of a Geriatric Oncology Team

M.R., a 74-year-old woman, presented to the geriatric oncology clinic for a second opinion and continued care for a diagnosis of stage IV breast cancer. She had been initially diagnosed four years ago, but in the past two years had been found to have metastases to her bones. While being treated with four cycles of paclitaxel at a local clinic, M.R. experienced bilateral neuropathy in her feet and hands, lost her sense of balance, and was unable to ambulate without assistance despite using a walker. She was assessed by a geriatric oncologist, a pharmacist, a geriatric nurse practitioner, a social worker, and physical therapists.

During her first visit to the geriatric oncology clinic, M.R. was unable to complete the timed up-and-go assessment (TUAG), screened positive for depression on the Geriatric Depression Scale (GDS), and was functionally compromised according to the activity of daily living (ADL)/instrumental activity of daily living (IADL) measures. The geriatric oncologist recommended that M.R. take a break from the paclitaxel, placed her on hormonal therapy, and referred her to physical therapy. M.R. and her family thought that her depression was a result of her functional status changes, and neither M.R. nor her family wanted her to be prescribed antidepressants.

Upon her return to the clinic three weeks later, M.R. was able to walk with a cane and without any additional assistance. She completed the TUAG test in 20 seconds, was not depressed according to the GDS, and reported only mild impairment on the ADL/IADL measures.

Patients like M.R., who have some limitations, are the types of people who can benefit from geriatric oncology care. Multidisciplinary team (MDT) members were able to enhance M.R.’s balance with physical therapy and essentially return M.R. to a level of independence that she experienced prior to cancer treatment. Assessments by the medical oncologist, pharmacist, and physical therapists revealed that M.R.’s gait and balance problems were associated with paclitaxel, and that ceasing the therapy was necessary for M.R. to regain her ability to walk. M.R. was then prescribed hormonal therapy, which she tolerated well.

Using a comprehensive geriatric assessment (CGA) and building an MDT can help to provide realistic interventions to cancer and nonmalignancy-related problems.
Conducting a Comprehensive Geriatric Assessment in Ambulatory Care

A CGA is a global evaluation that addresses issues often not included in patients’ general history and physical examination, and is recommended by the International Society of Geriatric Oncology in the care of older adult patients with cancer (Extermann et al., 2005). Geriatric considerations include physical reserve (i.e., the ability to endure a health insult and return to the same level of functioning as before a malignancy) (Balducci, 2013) and life expectancy (Hurria et al., 2014); both are central to cancer treatment discussions. Dementia and delirium, incontinence, depression, and functional status limitations are also assessed using a CGA. A CGA may affect cancer treatment decisions during the initial planning of cancer treatment and in subsequent follow-up visits (Horgan et al., 2012). In addition, a CGA can help to predict survival in patients with cancer (Klepin et al., 2013), as well as signs of toxicity if baseline assessments are conducted prior to beginning chemotherapy (Hamaker et al., 2014). CGAs have been performed as inpatient consultations (Morin et al., 2012) in academic medical centers (Liu & Extermann, 2012) and in community ambulatory care clinics (Williams et al., 2014).

However, not every older adult patient will benefit from a CGA. Older age, multiple medications, and comorbidities are features of patients who are more likely to benefit from a CGA than those who have higher overall levels of health and do not require medications (Stijnen et al., 2014). To target the older adults most likely to benefit from a CGA, several prescreening tools have been developed. Generally, the prescreening requires only a few minutes to conduct, and the scores can determine who is likely to benefit from a CGA. The abbreviated CGA regarding older adult patients with cancer was developed by determining the most predictive items on the activity of daily living (ADL)/instrumental activity of daily living (IADL) measures, on the Geriatric Depression Scale (GDS), and on the Mini-Mental State Examination (Overters, Beckmooy, Moody, & Cobb, 2006). In addition, the G-8 is a prescreening tool largely based on the Mini-Nutritional Assessment and age, and it is widely used internationally (Bella et al., 2012). These types of prescreening tools are developed with the ambulatory clinic in mind so patients who are in most need of a CGA can be targeted. Time-saving measures are important, and perhaps more clinics will be willing to conduct CGAs if they can be performed in a reasonable amount of time.

Some types of screening are self-report measures, and they include the ADL (Katz, Downs, Cash, & Grotz, 1970) and IADL (Lawton & Brody, 1969) measures. Other measures are performance-based, such as the timed up-and-go assessment (Podsiadlo & Richardson, 1991) and the hand-grip test (Giampaoli et al., 1999). One advantage of self-report measures is that they can be completed prior to the clinic visit or over the phone, as is the case with the GDS (Burke, Roccaforte, Wengel, Conley, & Potter, 1995). Performance measures tend to require little time to perform and render empirical data. Other self-report instruments screen for various issues, including sleep problems, anxiety, and caregiver distress. Limiting the number of instruments included in a CGA to three or four may be useful, particularly if the clinic is new and needs to refine some of its organizational processes. Some screening measures, particularly those with sensitive interview items, may require some practice before an effective technique for conducting them is acquired; however, the process is not complicated. Respondent burden should be considered because many patients who receive care at academic medical centers are approached to complete questionnaires; not exhausting patients and their families is important (Ulrich, Wallen, Feister, & Grady, 2005).

Creating a Multidisciplinary Team

Primary care nurses, nurse practitioners, and physicians can administer a CGA. Members of the MDT may administer discipline-specific screening tools, such as the Mini-Nutritional Assessment (Vellas et al., 2000) or the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (Beers, 1997); a physical therapist may conduct the Berg Balance Test (Berg, Wood-Dauphinee, Williams, & Maki, 1992). About 75% of patients require recommendations regarding their medications and request a pharmacist. Social workers provide assistance to about 50% of the older adult patients and their families seen in ambulatory oncology clinics (Chapman, Swartz, Schoppe, & Arenson, 2014). The more frail the older adult patient, the more likely a social worker will be required (Bouzereau et al., 2013). Dietitians are useful to an MDT in detecting actual and potential problems (Vandewoude, 2010) because malnutrition becomes more prevalent with aging (Hickson, 2006; Vandewoude, 2010); many patients and caregivers report the need for more information regarding nutrition (Pinto et al., 2014).

Assembling an MDT comprised of physicians, nurses, social workers, physical therapists, pharmacists, and dietitians can be difficult. Team development requires a great deal of negotiation...
with administration for allocation of resources and time. Clearly
defining and reserving time each week for the geriatric clinic
may avoid overburdening members of an MDT with geriatric
patients with cancer in addition to their regular responsibil-
ties. Each department must dedicate a percentage of its time
to the geriatric team, and realistic discussions about the time and
responsibilities required from each team member are important
to create a foundation for the geriatric oncology clinic. One per-
son should be designated as the clinic coordinator to direct
the team members, compile CGA data, and facilitate team discussion
concerning the interpretation of scores and the development of
recommendations. The coordinator can be any of the team mem-
bers but must be able to dedicate time to organizing the team,
assembling patient data, and offering follow-up communication
with patients and families, among many other responsibilities.
The coordinator role often falls to the primary care nurse or a
nurse practitioner, and protected time must be provided.

Patient navigators can help older adult patients and families
with the coordination of oncology and other healthcare services,
reducing the time required for resolution of the cancer diagnosis
(Lee et al., 2013). Navigators can help to organize oncology and
noncancer-related medical appointments and recommendations;
issues with self-managing various medical specialist appoint-
ments and knowledge deficits associated with cancer diagnoses
are barriers to care (Pieters, Heilemann, Grant, & Maly, 2011).
Navigators also can help to guide older adult patients through
the geriatric oncology medical process. In addition, the role
of the navigator includes helping with Medicare and other insur-
ance issues. Older adult patients with cancer often want prompt
information about Medicare coverage and supplemental insur-
ance (Pisu, Martin, Shewchuk, & Meneses, 2014).

Working as a team is not without challenges. Patience, ac-
ceptance of roles, clear leadership, and tolerance are essential
elements of effective teams. The team should meet regularly to
discuss patients and operational issues of the clinic. Developing
and maintaining the cohesiveness of the team is ongoing and
requires conflict resolution, trust, and respect among members
(Mellor, Davis, & Capello, 1997). Effective teams are nurtured
and educated about principles associated with team member-
ship (Fulmer, Flaherty, & Hyer, 2003). When identifying team
members, individuals who can work together and provide the
necessary expertise to support the efforts of the geriatric oncol-
ogy program should be selected.

Sustainable Geriatric Care

Numerous resources are required to manage complicated
issues associated with cancer and its treatment. Older adults
tend to have more costly diagnoses, and they make up a great
deal of the healthcare costs in the United States (Stanton, 2006).
However, the cost of MDTS may be small when compared to the
potential benefits (Simcock & Heatford, 2012). Administrators
and office managers must recognize that geriatric care may
not be as profitable as other services that manage less complex
cases. Understanding that fewer patients will be seen during
a clinic day as compared to other disease-specific services, as
well as that more professional full-time units will be required to
administer the CGA, is essential to sustain a geriatric clinic. The
median time to complete a CGA, excluding other tasks generally
performed in the oncology clinic, is 19 minutes in academic
medical centers and 22 minutes in community clinics (Williams
et al., 2014). Adding about 25–30 minutes to an oncology ambu-
latory care visit can practically double the time that an examina-
tion room is needed for one patient. Creating an infrastructure
that will support the additional time required to conduct the
CGA is important. Alloting 90 minutes of clinic time for new
patients and 30–45 minutes for established patients will pro-
duce a realistic clinic schedule and provide the time necessary
to conduct the CGA and create recommendations.

Being visible as a geriatric oncology clinic or provider can increase awareness of the clinic and the types of patients who
should be referred to it. Some services refer patients for a one-
time evaluation, whereas others fully refer patients for ongoing
care. Discussions with administration about how patients are
to be referred to the geriatric oncology clinic can help with scheduling and evaluating the patients who are in need, as well as
with promoting geriatrics in an oncology setting. Presenta-
tions at team meetings throughout the facility can help other professionals to understand the specialized care that is offered.
Many healthcare professionals are unaware of the benefits of
geriatrics, particularly in an oncology setting. Prominent po-
ositioning of CGA scores and recommendations in the medical
record may be welcomed by other specialists in the cancer cen-
ter. Documentation of the geriatric encounter is evidence that
geriatric care differs from traditional oncology care. Working
with those who are in charge of the medical record (electronic
or hard copy) to ensure that the geriatric encounter is included
in the health record and clearly labeled (e.g., “senior adult oncol-
ogy clinic,” “geriatric oncology clinic”) provides more visibility.

Implications for Practice

- Increase knowledge of geriatric oncology nursing by combin-
ing the principles of older adult care with cancer-specific best
practices.
- Understand that activities such as comprehensive assess-
ment, caregiver support, and preservation of independence
are central features of geriatric oncology.
- Recognize that the care of older adult patients often requires
more time in scheduling, comprehensive management strate-
gies, and organization of multidisciplinary team members.

Implications for Nursing

GOACCs are a good fit for nurses who like to provide educa-
tion, offer support, and truly engage in clinical assessment in
older adults. Geriatrics is focused on the evaluation of small
or covert problems that, if treated early, may prevent decline in
functional status or independence (Lichtman, Balducci, &
Aapro, 2007). Oncology nurses have excellent assessment skills
and can be trained to conduct components of a comprehensive
CGA. Documentation of the results of a CGA, MDT recommen-
dations, and communication with outside providers are tasks
primarily performed by the primary care or advanced practice
nurse. Another large and important responsibility of nurses is
coordinating care and communicating with families.
Within the scope of practice for primary care and advanced practice nurses is providing input into the development and management of geriatric oncology clinics. Nurses must be included in the development of the infrastructure to create sustainable clinics that work to address the needs of older adult patients with cancer. If nurses are to coordinate the MDT, they must participate in administrative discussions concerning the allocation of resources, as well as provide perspectives about clinic staffing and scheduling.

Promoting the role of the geriatric oncology nurse to undergraduate and graduate nursing programs can inspire curriculum development and interest at colleges and universities. Undergraduate assessment courses should include content to prepare nurses to conduct CGAs, particularly in regard to history taking, interviewing skills, and physical assessment. Geriatric care does not always take place in a nursing or long-term care facility; it is also provided in emergency rooms, intensive care units, and cardiology and oncology settings. Nurses are vital to geriatric oncology, and their training must include an understanding that the typical patient with cancer is aged 65 years or older (NCI, 2015).

**Conclusion**

Being aware of the issues of aging and the complexities of cancer care provides a holistic perspective for caring for older adults with cancer. Trained nurses will recognize and manage symptoms related to cancer care and identify toxicities associated with cancer treatment that may vary with the age of the patient. Developing a GOACC is more complex than simply adding assessment tools to the oncology clinic visit. The clinic needs to be prepared to address the needs of older adult patients and must be willing to schedule longer appointments, provide more professional full-time units, and ensure access to referrals for specialty services. Sustainable geriatric care must be cultivated, supported, and appreciated. Combining the geriatric specialty with oncology may mean that many older adult patients will receive more comprehensive assessment, appropriate interventions and referrals, and better quality of care.

**References**


1. What is the clinical problem that is addressed in the article? Why is the problem important to members of the journal club?

2. What would be the next steps in applying the information presented in the article in your setting?

3. Which of the recommendations would you consider implementing in your setting? Why or why not?

4. What would be the next steps in applying the information presented in the article in your setting?

5. What are the potential benefits and drawbacks of implementing the recommendations in your setting?

6. How would you measure the success of implementing the recommendations?

7. How would you address any challenges that may arise during implementation?

8. How might the results of this study impact the care of patients in your setting?

9. What are the implications of the findings for future research and clinical practice?

10. How might the results of this study influence the development of new policies or guidelines in your setting?

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