

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

ScienceDirect



# Feasibility of geriatric assessment in community oncology clinics



Grant R. Williams<sup>a,\*</sup>, Allison M. Deal<sup>a</sup>, Trevor A. Jolly<sup>a</sup>, Shani M. Alston<sup>a</sup>,  
Brittaney-Belle E. Gordon<sup>a</sup>, Samara A. Dixon<sup>a</sup>, Oludamilola A. Olajide<sup>b</sup>, W. Chris Taylor<sup>c</sup>,  
Michael J. Messino<sup>d</sup>, Hyman B. Muss<sup>a</sup>

<sup>a</sup>UNC Lineberger Comprehensive Cancer Center, 450 West Drive, Chapel Hill, NC 27514, USA

<sup>b</sup>Rex Cancer Center, 4420 Lake Boone Trail, Raleigh, NC, USA

<sup>c</sup>New Bern Cancer Center, 1010 Medical Park Ave, New Bern, NC, USA

<sup>d</sup>SECU Cancer Center at Mission Hospital, 509 Biltmore Ave, Asheville, NC 28801, USA

## ARTICLE INFO

### Article history:

Received 23 October 2013

Received in revised form

28 January 2014

Accepted 11 March 2014

Available online 3 April 2014

### Keywords:

Geriatric oncology

Geriatric assessment

Community oncology clinics

Aging

## ABSTRACT

**Objective:** Emerging results support the value of geriatric assessment (GA) in determining the risk and benefits of cancer treatment in older adults. A brief GA tool consisting of valid and reliable measures has been developed; however, little data exist on the ability to perform the GA in community oncology clinics. The objective of this study was to determine the feasibility of performing the GA in the community.

**Materials and Methods:** Patients aged  $\geq 65$  were eligible. The GA included a health care provider assessment of performance status, cognitive function, a Timed Up and Go test, and a self-administered patient questionnaire that evaluated measures of functional status, comorbidity, psychological state, social support, and nutritional status.

**Results:** From 2009 to 2013, 1088 patients were assessed including 339 (31%) from seven community clinics across North Carolina. The median amount of time to complete the patient-report portion of the GA was 19 min in the academic center versus 22 min in the community. The median amount of time to complete the entire GA was 23 min in the academic center and 30 min in community settings. Significantly more patients in the community required assistance completing the questionnaire (24% vs. 14%); however, most patients required no assistance (76%).

**Conclusion:** A brief GA can be performed in community oncology clinics. The time to complete the professional assessments and patient self-assessments were similar in both settings. Future studies are planned to determine if such assessments can improve cancer care for older patients.

© 2014 Elsevier Ltd. All rights reserved.

## 1. Introduction

Cancer is a disease of aging, with the incidence of cancer increasing dramatically with age.<sup>1</sup> The median age at diagnosis

of cancer is now 67 years and patients 65 years of age or older represent 60% of new cancer diagnoses and 70% of cancer deaths.<sup>2</sup> In 2030, the percentage of all cancers diagnosed in older adults is predicted to increase to as much as 70%.<sup>3</sup> Many studies

\* Corresponding author at: University of North Carolina at Chapel Hill, Physicians Office Building, 170 Manning Drive, 3rd Floor, Campus Box 7305, Chapel Hill, NC 27599-7305, USA. Tel.: +1 919 627 3221; fax: +1 919 966 6735.

E-mail address: [grwillia@unch.unc.edu](mailto:grwillia@unch.unc.edu) (G.R. Williams).

have shown that treatment of older patients with cancer can improve outcomes, including survival<sup>4,5</sup>; however, older patients are often at higher risk of treatment-related toxicities.<sup>6,7</sup> Moreover, the heterogeneous aging process limits the utility of chronological age as a sole determinant of treatment decisions, as older patients of the same age often differ widely in their mental and physical health. The geriatric assessment (GA) was created to capture information of key importance in the care of older adults and covers multiple domains, including functional status, comorbidity, cognition, nutritional status, social support, and psychological state. The GA detects problems not likely to be discovered in routine history and physical examinations and can inform interventions that can improve quality of life and mortality in older patients.<sup>8</sup> Recent evidence also shows that GA can predict the morbidity and mortality of older patients with cancer<sup>9</sup> as well as toxicities related to chemotherapy treatment.<sup>10,11</sup>

A traditional geriatric assessment may take several hours to complete and even longer for clinicians to review. Further, a shortage of trained geriatricians can lead to long delays in getting an appointment for the assessment, adding to the stress of a cancer diagnosis in an older patient. A brief yet comprehensive, primarily self-administered GA has been developed by Hurria and colleagues to address these issues and has been shown to be especially suited for use in busy academic medical centers.<sup>12</sup> In addition, this GA has been tested and shown to be feasible in the cooperative group setting,<sup>13</sup> but has not been tested in the community setting.

The primary goal of this study was to determine the feasibility of performing the GA in community oncology clinics. Additional goals were to compare academic medical center and community clinics with regard to time to completion, percent of patients needing help with the self-assessment portion of the instrument, and patient satisfaction with the instrument.

## 2. Materials and Methods

The study protocol LCCC 0916 “Carolina Senior: Registry for Older Patients” was approved by the institutional review board of the University of North Carolina (UNC) School of Medicine in 2009 (NCT01137825) as a registry to collect GAS

on patients 65 years or older. Informed consent meeting all federal, state, and institutional guidelines was required. The Registry includes data from patients enrolled solely in LCCC 0916 as well as patients enrolled in other clinical trials where the GA is administered. Due to the lack of validation of this GA instrument in other languages, eligibility was restricted to patients able to speak and read English. The GA used in this study is identical to the one developed by Hurria and colleagues.<sup>12</sup> Patients from academic centers were included in this study to serve as a reference group for comparison. The GA has two components (see Table 1 online). One component is completed by a health care professional and includes three measures: Karnofsky Performance Status (KPS),<sup>14</sup> Timed Up and Go (TUG) test (a performance measurement of function),<sup>15</sup> and Blessed Orientation-Memory-Concentration (BOMC) test (a screening tool for cognitive function).<sup>16,17</sup> The second component is completed by the patient, with help by a health care professional if needed, and includes validated self-reported measures of functional status,<sup>18,19</sup> comorbidity,<sup>19</sup> psychological state,<sup>20</sup> social support,<sup>21</sup> nutritional status,<sup>22,23</sup> and medications.

Community affiliates of the UNC Lineberger Comprehensive Cancer Center were invited to participate in the study. Community sites were required to have an infrastructure to support clinical research activities within their practices, including adequate staffing and facility space as deemed by the Cancer Center’s Clinical Protocols Office. All community sites were in North Carolina and included the Nash Cancer Treatment Center (Rocky Mount, NC), New Bern Cancer Center (New Bern, NC), Marion L. Shepherd Cancer Center (Washington, NC), REX Cancer Center (Raleigh, NC), REX Cancer Center at Wakefield (Wakefield, NC), Seby B. Jones Cancer Center (Boone, NC), and SECU Cancer Center at Mission Hospital (Asheville, NC). These community settings varied from small private practices with several members to larger hospital-based practices. Start-up meetings with the on-site principal investigator (PI) and clinical research associates (CRAs) were coordinated with community sites to discuss study protocol details including eligibility, data management, and regulatory requirements. The meetings were conducted via phone or video conference, and included teaching critical features of the GA such as the TUG and BOMC tests. A video regarding the correct performance of the TUG test was also provided to aid in the training of health

**Table 1 – Domains and measures of the geriatric assessment. Modified from Hurria et al.<sup>13</sup>**

Domain	Assessment measure	
	Assessed by health professional	Self-reported by the patient
Functional status	Timed Up and Go <sup>15</sup> Physician Rated Karnofsky Performance Status (KPS) <sup>14</sup>	Activities of Daily Living (ADL) <sup>18</sup> Instrumental Activities of Daily Living (IADL) <sup>19</sup> Karnofsky Self Reported Performance <sup>31</sup> No. of Falls in the last 6 months
Comorbidity		Number and type of comorbid conditions <sup>19</sup>
Medications		Comprehensive list of medications
Cognition	Blessed Orientation Memory Concentration Test (BOMC) <sup>16,17</sup>	
Psychological		Mental Health Index 17 <sup>20</sup>
Social		Social Activity Limitation Measure (MOS) <sup>18</sup> Social Support Survey (MOS) <sup>21</sup>
Nutrition	Body mass index <sup>32</sup>	Unintentional weight loss in 6 months <sup>22,23</sup>

Download English Version:

<https://daneshyari.com/en/article/1912713>

Download Persian Version:

<https://daneshyari.com/article/1912713>

[Daneshyari.com](https://daneshyari.com)