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Geriatric Oncology Program Development and Gero-Oncology Nursing

Mary Pat Lynch, Dana Marcone DeDonato, and Ann Kutney-Lee

Objectives: *To provide a critical analysis of current approaches to the care of older adults with cancer, outline priority areas for geriatric oncology program development, and recommend strategies for improvement.*

Data Sources: *Published articles and reports between 1999 and 2015.*

Conclusion: *Providing an interdisciplinary model that incorporates a holistic geriatric assessment will ensure the delivery of patient-centered care that is responsive to the comprehensive needs of older patients.*

Implications for Nursing Practice: *Nursing administrators and leaders have both an opportunity and responsibility to shape the future of geriatric oncology. Preparations include workforce development and the creation of programs that are designed to meet the complex needs of this population.*

Key Words: *Geriatric oncology, oncology, cancer, older adults, administration.*

The role of health care administration includes preparing for current and future changes in the patient population. A prominent challenge facing health care administrators globally is the rapidly increasing number of older adults. Because cancer is a disease of aging, a significant increase in cancer cases among older patients is inevitable. By the year 2050, the majority of older adults will live in developing countries where the rise of chronic non-communicable diseases, like cancer, will far surpass the threat of the infectious diseases of a century ago.[1] The growth in the numbers of older adults in developed countries is also unprecedented, and it is estimated that by the year 2030, a 45% increase in cancer cases will occur.[2] As such, the capacity of health care systems will be challenged and necessary administrative preparations will include workforce development and the creation of clinical programs that are designed to meet the complex and diverse needs of older adults with cancer.

Although the field of geriatric oncology has grown substantially in recent years, much of the progress has been made in the form of bio-medical advancements, while unmet social, emotional, and spiritual needs remain.[3,4] In response, the Institute

Mary Pat Lynch, MSN, CRNP, AOCNP®: *Cancer Program Administrator, Abramson Cancer Center at Pennsylvania Hospital, Philadelphia, PA.* Dana Marcone DeDonato, MSW, LSW: *Geriatric Oncology Social Worker, Abramson Cancer Center at Pennsylvania Hospital, Philadelphia, PA.* Ann Kutney-Lee, PhD, RN, FAAN: *Assistant Professor, Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing, Philadelphia, PA.*

Address correspondence to Mary Pat Lynch, MSN, CRNP, AOCNP®, 230 W. Washington Square, Suite 102, Philadelphia, PA 19106. E-mail: lynchmp@pahosp.com

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of Medicine (IOM) report "Delivering High Quality Cancer Care: Charting a New Course for a System in Crisis" called for improvements in the delivery of patient-centered care that is responsive to the comprehensive needs of patients.[5] Yet, despite this recognition, there is no real consensus about how to move forward. Most geriatric oncology programs currently use a medical model using some form of geriatric assessment, specialist referrals, a dual-trained geriatric oncologist, or embedding a geriatric specialist within an existing oncology team.[6] These are practices that may not be sustainable or feasible to administrators in community cancer centers who are facing increasing demand in the context of tight budget constraints and limited resources.

The purpose of this article is to provide a different programmatic approach, that is, interprofessional, person-centered care, to meet the needs of aging cancer patients. With its holistic view of health and illness, nursing is well-positioned to inform such interdisciplinary models of care that are aligned with the physical, mental, emotional, and spiritual needs of older adults. As a profession, nursing has a social contract with the public, in which nursing is responsible for providing high-quality care that is responsive to the uniqueness of individuals and the changing health needs of society.[7,8] The existing literature offers very little guidance to administrators regarding the creation and implementation of interdisciplinary geriatric oncology programs. In this article, we provide a critical analysis of current approaches to the care of older adults with cancer, and outline priority areas for the development of geriatric oncology programs. These areas include the administrator role, the development of quality and safety metrics, the creation of interdisciplinary teams, and the avoidance of ageism. Skill-building, including educational models and geriatric competence, are also described in the context of team-building. A programmatic example illustrates application of the principles described. The article concludes with recommendations and future directions for the improvement of care for older adults with cancer.

Overview of Current Approaches to Geriatric Oncology

Because of a variety of factors, older adults often experience challenges and priorities that differ significantly from younger patients when facing a cancer diagnosis, including greater comorbidity burden, poorer functional status, lack of social and emotional support, and economic and transportation concerns.[9] The field of geriatric oncology was originally formulated to specifically address these factors using an interdisciplinary perspective.[10] Despite its original intent, the field has primarily relied on biomedical and specialty-based approaches to care.[6]

A decade ago, a task force of the International Society of Geriatric Oncology (SIOG) recommended that a comprehensive geriatric assessment (CGA) be integrated into the care of every older adult with cancer.[11] A process designed to be carried out by an interdisciplinary team, SIOG recommended that a CGA consist of three primary components: 1) assessment for problems, 2) evaluation of needs, and 3) the design of tailored interventions.[12] However, implementation of the recommendation in practice is currently quite modest[2,13] as health care administrators consider how best to implement such assessment measures while considering cost and feasibility.

The identification of "frail" older adults is another approach that has been used to identify individuals in need of targeted services. Frailty is a term widely used in the geriatrics literature, and frailty criteria have been developed for the geriatric oncology population.[14] Studies have sought to identify frailty screening tools that may be predictive of outcomes measured by the CGA. However, a recent systematic review[15] found that frailty screening measures were not effective predictors of patients for whom impairments would be found on the CGA. With that being said, cancer centers seeking alternate methods to the CGA may choose to use frailty in combination with other psychosocial measures as a way to quickly identify people who may need support.

Much focus has been placed on the development and usage of assessment tools to inform medical treatment decision making, with relatively little attention paid to psychosocial aspects of care and survivorship.[13] In a recent update to the SIOG recommendations, an expert panel identified three models for improving implementation of the CGA.[13] These models are: 1) specialty geriatric oncology units, 2) geriatric oncology consultation teams, or 3) referral of high-risk patients to outside geriatricians or to an interdisciplinary team within the cancer center.[13] While the SIOG taskforce acknowledged the potential of interdisciplinary teams