Socioeconomic Considerations and Shared-Care Models of Cancer Care for Older Adults

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KEYWORDS

• Models of care • Geriatrics • Oncology • Geriatric oncology • Aging • Cancer

KEY POINTS

- Older patients are the largest and fastest-growing group of patients with cancer.
- Older adults currently account for the most expensive segment of the population in overall costs of cancer care, which is growing with the advent of costly new therapies.
- Principles of care and assessment tools from geriatrics can be used to assessment life expectancy, identify age-associated deficits, and target therapies to optimize care for older patients with cancer.
- Specific models of care exist to implement a geriatric oncology approach into clinical practice that can optimize and improve quality, reduce costs, and optimize care for older adults with cancer.

GERIATRICS APPROACH TO CANCER CARE CAN IMPROVE THE DELIVERED VALUE

The geriatrics approach to the care of older adults is centered on decision-making for complex patients in the face of uncertainty, based on 2 fundamental principles:

1. Using the highest-quality evidence available appropriately applied to clinical circumstances
2. Incorporating patients' goals to maximize quality of life.

By matching the available evidence to those goals, then communicating clearly with the patient, an informed and shared decision guides all management. These principles must be kept clearly in mind when treating older patients with cancer.

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What challenges currently prevent an evidence-based care for older adults with cancer? First, there is a dearth of sufficient high-quality evidence on which to base management decisions. Too often, older patients are excluded from clinical trials. Even when included, those older adults are typically not representative, being sicker and frailer, and therefore not generalizable, to older adults most commonly being treated. Management decisions are typically made in a busy clinical setting with little time to weigh treatment alternatives, making subtle decisions even more difficult.

Although better evidence is awaited, a practical approach to cancer care for older adults with cancer is necessary. Such an approach will bring the "art" of geriatrics to the oncology clinic, providing an approach for providers to use based on current evidence. Broadly speaking, there are 2 common errors made in treating older patients: undertreatment and overtreatment. Undertreatment results from ageism—making management choices based on chronologic age rather than physiologic age. Medical decisions for fit older adults should be indistinguishable from any other patient with cancer—they should be treated with the most appropriate treatment compatible with their care goals. Conversely, overtreatment results from inappropriately aggressive cancer-directed therapy while ignoring patient vulnerability, remaining life expectancy (RLE), and treatment toxicities. Treating older adults with cancer requires navigating between undertreatment due to ageism—denying life-enhancing treatment to fit older patients with cancer—and overtreatment—giving toxic therapy to vulnerable older patients and lowering the quality of their survival. Delivering high-value care requires avoiding both errors.

With this is mind, the authors recommend the following a 3-step approach to deliver such high-value care and guide care models. First, a clinician should use geriatric assessment (GA) to estimate remaining life-expectancy for an older adult with cancer. Estimating remaining life-expectancy is done through the application of the validated tools from GA to older patients, allowing the assignment of patients into 3 categories: fit, vulnerable, or frail. This categorization avoids undertreating the fit elderly, avoids overtreating the frail elderly, and targets further assessment for the vulnerable. Second, it is important to both stage the cancer and "stage the aging" to predict the likelihood of complication and toxicities from possible treatment. Finally, one must match the available care options with the preferences and goals of patients, communicating carefully to reach an informed, shared decision. In taking such an approach, one can be sail safely through the troubled waters of caring for older adults with cancer.

SOCIOECONOMIC CONSIDERATIONS OF PROVIDING HIGH-VALUE CANCER CARE

It has long been recognized that age is associated with increased costs of care. According to the 1992 to 1998 Medicare Current Beneficiary survey data, older adults in better health had a longer RLE than those in poorer health, but had similar cumulative health care expenditures until death.[1] A person with no functional limitations at 70 had an RLE of 14.3 years and expected cumulative health care expenditures of $136,000, whereas a person with a limitation in at least one activity of daily living had a life expectancy of 11.6 years and expected cumulative expenditures of $145,000. Expenditures varied little according to self-reported health at the age of 70. Persons who were institutionalized at the age of 70 had cumulative expenditures that were much higher than those for persons who were not institutionalized. Age is clearly an important contributor to the costs of care.

Medicare's expenditures on cancer care are substantial and vary by phase of care, tumor site, stage at diagnosis, and survival. A SEER (Surveillance, Epidemiology, and End Results) database review (2008) found the mean net costs of cancer care were