Utilising existing community-based supportive care and aged care resources for older patients with cancer. Updated results of the Care Coordination in the Older Adult with Cancer (CCOAC) project.

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Aims of the Project

- to improve care coordination and access to supportive care for people over 70 years of age with a cancer diagnosis referred to an Australian regional oncology centre.
- develop a system for routine supportive care screening and streamlined referral for assessment and guided-intervention
- to utilise existing, community-based supportive care services in the oncology AND aged care sectors.

Conquering the Silo Mentality

Screening vs Assessment

\textbf{Screening} is a brief process for identifying the risk of requiring supportive care services.

\textbf{Assessment} is a more in-depth process that confirms the presence of supportive care needs.
Methods #1
Multidimensional CCOAC screening tool developed based on tool developed at Royal Adelaide Hospital.
Steering committee formed comprising oncology and aged care providers, community health organisations and consumers.
Development of a model tailored to local conditions and available resources.
Employment of a geriatric oncology cancer care coordinator to perform screening and referrals.

Methods #2 – The CCOAC Tool
• The CCOAC tool is a composite of validated screening tools. It is self-administered and printed on yellow paper.
• Domains include: IADL’s, medications, social supports, cognition, psychological state, vision and hearing, falls, weight loss, comorbidities, the distress thermometer, a pain scale, performance status and caregiver concerns.
• The CCOAC tool was sent to all new patients over the age of 70 prior to their first appointment with an oncologist.

Methods #3 – Model
• The care coordinator then phoned every patient to clarify supportive care needs and risks. The carer was also interviewed.
• Referral to a community-based service for further assessment and intervention. Services included community aged care, cancer care coordinators and carer support agencies. Where possible streamlined “eReferrals” were made using existing referral infrastructure.
• Some simple interventions were provided on the phone by the care coordinator e.g. practical information and reassurance.

Results – Patient Characteristics
• Between 3/2011 and 2/2012
• 155 patients over the age of 70 years underwent screening and guided intervention

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>N (n=155)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age (Range)</td>
<td>79 (70-96)</td>
<td></td>
</tr>
<tr>
<td>Male/Female</td>
<td>93/62</td>
<td>60% / 40%</td>
</tr>
<tr>
<td>Malignancy – Solid tumour</td>
<td>116</td>
<td>75%</td>
</tr>
<tr>
<td>- Haematological</td>
<td>39</td>
<td>25%</td>
</tr>
<tr>
<td>Treatment Intent - Curative</td>
<td>45</td>
<td>29%</td>
</tr>
<tr>
<td>- Palliative/Unclear</td>
<td>56/13</td>
<td>82% / 8%</td>
</tr>
<tr>
<td>Living Alone</td>
<td>43</td>
<td>28%</td>
</tr>
<tr>
<td>Charlson Score - 0-2</td>
<td>134</td>
<td>86%</td>
</tr>
<tr>
<td>- &gt;2</td>
<td>21</td>
<td>14%</td>
</tr>
<tr>
<td>Karnofsky PS &gt;70&lt;90</td>
<td>117/38</td>
<td>76% / 24%</td>
</tr>
</tbody>
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Results – Screening Test

<table>
<thead>
<tr>
<th>Screening test results</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients reporting problem with at least 1 IADL</td>
<td>45</td>
</tr>
<tr>
<td>Distress thermometer: Any / Score &gt;5</td>
<td>85 / 23</td>
</tr>
<tr>
<td>Pain score: Any pain / Score&gt;5</td>
<td>73 / 20</td>
</tr>
<tr>
<td>Patients identifying feeling depressed</td>
<td>39</td>
</tr>
<tr>
<td>Patients where memory was an issue</td>
<td>15</td>
</tr>
<tr>
<td>Patients unable to identify their tumour/stream/illness (n = 120)</td>
<td>59</td>
</tr>
</tbody>
</table>
Results #3 – Referrals made

Rescreening occurred at 6 and 12 weeks in all patients and resulted in a total of 15 extra referrals for supportive care; mainly carer support

Results – Cost analysis

- Cost of supportive care screening = AUD$42.40/patient

  • Includes preparation, delivery, collection, analysis and interpretation of the supportive care screening tool by cancer care coordinator (assuming time taken = 20mins per patient)^2

Conclusions

- The model is feasible, accessible and provides efficient screening and referral for supportive care needs. At $42.40 per patient, the process is relatively cheap.

- This is a model which linked patients to appropriate assessment by existing aged care and community services which were not previously accessed by oncology services on a routine basis.

- The needs of carers can be addressed concurrently with the supportive care needs of patients.

- The assumptions made about health literacy of this patient cohort, has an impact on the type of support sought and/or accepted, and needs to be further addressed.

- Ongoing and effective change management and relationship building is key to sustainability of this model. The Care Coordinator position is consequently a critical component.

Geriatric Oncology Initiative

The aim of this project is to improve care coordination and access to supportive care options for people over 70 years of age with a cancer diagnosis.

Acknowledgements

- Cancer Australia
- Hume RICS
- COSA
- BMO

Any Questions?