Geriatric Oncology:

Educating Nurses to Improve Quality Care

February 25th-27th, 2019

Pasadena, CA

Funded by the National Institute of Health #R25CA183723-01A1

We dedicate this conference in loving memory of Dr. Arti Hurria, our fearless leader and dearly missed friend.

Arti Hurria, MD
Professor and Director of the Center for Cancer and Aging
City of Hope Comprehensive Cancer Center

Arti Hurria, MD was a geriatrician and oncologist who also served as the Vice Provost of Clinical Faculty and Director of the Center for Cancer and Aging at City of Hope. She dedicated her career to improving the care of older adults with cancer. Under Dr. Hurria's leadership, the Cancer and Aging Research Program developed and executed over 29 geriatric oncology protocols, enrolling over 4,500 participants on studies focused on cancer and aging. Dr. Hurria served as principal investigator on 8 NIH-funded grants, including the R25 grant that supports this educational conference. Additionally, she received research support from the Breast Cancer Research Foundation, UniHealth Foundation, and Hearst Foundation. Dr. Hurria led national and international efforts to improve the care of older adults with cancer. She served on the Institute of Medicine, Committee on "Improving the Quality of Cancer Care: Addressing the Challenges in an Aging Population." Dr. Hurria was the recipient of the B.J. Kennedy Award from the American Society of Clinical Oncology, which recognizes scientific excellence in geriatric oncology. Dr. Hurria was the founding editor for the *Journal of Geriatric Oncology* and served on the Board of Directors for the American Society of Clinical Oncology. In 2017, Dr. Hurria was the recipient of an endowed chair in geriatric oncology (The George Tsai Geriatric Oncology Chair) and the recipient of the International Society of Geriatric Oncology Paul Calabresi Award. In addition to being a world-class researcher and brilliant clinician, Dr. Hurria was a loving wife and mother, and was beloved by her patients, colleagues, research team, and the geriatric oncology community world-wide. It is our honor to carry on her work through this conference, and to pay tribute to her legacy by continuing to improve care for older adults with cancer.

Geriatric Oncology: Educating Nurses to Improve Quality Care

Abstract

The overarching goal of this R25 grant is to develop and implement a national educational curriculum in geriatric oncology for oncology nurses. There is an urgent need for this initiative because cancer is a disease associated with aging. The number of "baby boomers" age 65 and older is expected to double by the year 2030 leading to a projected 67% increase in cancer incidences in this age group. The Institute of Medicine highlights the current and projected future shortages of nurses with experience in geriatrics who will be needed to care for this growing population of older adults. Less than 1% of nurses and less than 3% of advance practice nurses are certified in geriatrics. This grant will fill this gap in knowledge through a multidisciplinary, interactive, targeted curriculum in geriatric oncology for competitively selected oncology nurses nationwide. It will culminate in teams of nursing participants developing their own plans to integrate geriatric oncology principles and practices into their home organizations.

The specific aims of this grant are:

1. To develop a comprehensive geriatric oncology curriculum for nurses, with input from top-level multidisciplinary faculty from around the country, which will advance nurses' knowledge, attitudes, and skills related to caring for older adults with cancer.
2. To implement this geriatric oncology curriculum with national workshops for competitively selected nurses nationwide.
3. To evaluate the effectiveness of a comprehensive interactive geriatric oncology curriculum for nurses based on knowledge acquired from pre- to post-conference.
4. To evaluate the impact of a comprehensive geriatric oncology curriculum on the development of geriatric oncology nursing initiatives nationwide by measuring the progress and outcomes of workshop activities and changes initiated by the participants in their home settings.
5. To disseminate the findings from these conferences.

These aims will be achieved through four annual conferences (followed by monthly conference calls open to all participants) which will train a total of 400 competitively selected oncology nurses across the nation who will attend in teams (a manager, educator, and direct care provider) from their institution. This 2 ½ day conference consists of a comprehensive yet targeted educational curriculum delivered by nationwide experts in geriatrics, oncology, and nursing education. Conference attendees will use this information and develop plans for integration of this knowledge into their own organizations. We will follow their progress at 6, 12, and 18 months post-conference. This grant unites the fields of nursing, geriatrics, and oncology through the creation of an educational curriculum of geriatric principles geared to oncology nursing professionals who are caring for an aging oncology population with the ultimate goal of improving the knowledge of evidence-based care of older adults with cancer.

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2019 Geriatric Oncology: Educating Nurses to Improve Quality Care

February 25th, 2019

Time	Topic	Presenter
7:00-8:00	**BREAKFAST**	
8:00-8:30	Welcome, In Memoriam Arti Hurria, MD, Opening Remarks, and Pre-Test	Peggy Burhenn, MS, AOCNS William Dale, MD, PhD
8:30-9:00	Lessons from a Career in Geriatric Nursing	Mathy Mezey, EdD, RN, FAAN
9:00-9:30	Introduction to Goal Implementation	Carolina Uranga, MSN, AGCNS-BC, OCN
9:30-10:00	Aging Trends and Comprehensive Geriatric Assessment	William Dale, MD, PhD
10:00-10:15	**BREAK**	
10:15-10:45	Physiological Changes and Comorbidities Associated with Aging: Relation to Risk of Cancer Therapy Toxicity	Supriya Mohile, MD, MS
10:45-11:15	Assessing Functional Status, Frailty, and Fall Risk in the Older Adult with Cancer	Janine Overcash, PhD, ARNP-BC
11:15-11:45	Exercise Screening and Prescription for Older Adults with Cancer	Karen Mustian, PhD, MPH
11:45-12:15	Functional Assessment Practice Session	Group Breakout
12:15-1:15	**LUNCH**	
1:15-1:45	Identifying and Addressing Distress in the Older Adult	Matthew Loscalzo, LCSW
1:45-2:15	Navigating the Medical-Legal Concerns in the Care of Older Adults	June McKoy, MD, MPH, JD, MBA
2:15-2:45	Community Legal Resources for the Older Adult with Cancer	Stephanie Fajuri, JD
2:45-3:00	**BREAK**	
3:00-3:30	Nursing Initiatives at the Hartford Institute: Nursing Making a Difference	Mathy Mezey, EdD, RN, FAAN
3:30-4:15	Past R25 Participant Experience Goal Implementation-Group Work on Goals	Carolina Uranga, MSN, AGCN Past Participants: Ashley White, BSN, RN Nimian Bauder, MSN, AGCNS, RN
	Day One Evaluations/Adjourn	Group

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2019 Geriatric Oncology: Educating Nurses to Improve Quality Care
February 26th, 2019

Tim	Topic	Presenter
7:00-7:45	**BREAKFAST**	
7:45 am	Welcome Back and Raffle	Peggy Burhenn, MS, AOCNS
8:00-8:30	The Path to Implementing Change: Integrating Geriatrics into Oncology	Sarah Kagan, PhD, RN
8:30-9:00	Nutrition and Aging throughout the Cancer Journey	Wendy Demark-Wahnefried, PhD, RD
9:00-9:15	Interactive Case Study and Q & A	Group Breakout
9:15-10:00	Pain Management and EOL Care in the Older Adult	Denice Economou, PhD, RN
10:00-10:15	**BREAK**	
10:15-11:00	Assessment and Management of Cognitive Impairment in Older Adults	Beatriz Korc-Grodzicki, MD, PhD
11:00-11:15	Interactive Case Study and Cognitive Assessments	Group Breakout
11:15-11:45	The Interdisciplinary Team: Implementing an Evidence-Based Model in Cancer Care	Betty Ferrell, PhD, MA, FAAN, FPCN
11:45-12:15	Goal Development Exercise	Peggy Burhenn Carolina Uranga Denice Economou
12:15-1:15	**LUNCH**	
1:15-1:45	Polypharmacy and Medication Adherence in the Older Adult	Tim Synold, PharmD
1:45-2:15	Predicting Chemotherapy Toxicities in Older Adults	Supriya Mohile, MD, MS
2:15-2:45	Case Study: Application of Polypharmacy and Chemotherapy Toxicity Prediction Tool	Group Breakout
2:45-3:00	**BREAK**	
3:00-3:30	Working with Leadership to Impact Positive Change	Shirley Johnson, RN, MS, MBA
3:30-4:00	Empowering Nurses to Advocate for the Older Adult	Sarah Kagan, PhD, RN
4:00-4:30	Faculty Q&A, Goal Development Discussion	Group Breakout
4:30	Day Two Evaluations/Adjourn	Group

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2019 Geriatric Oncology: Educating Nurses to Improve Quality Care
February 27th, 2019

Time	Topic	Presenter
7:00-7:45	**BREAKFAST**	
7:45am	Welcome back and Raffle	Peggy Burhenn, MS, AOCNS
8:00-8:30	Sleep Management in the Older Adult	Peggy Burhenn, MS, AOCNS
8:30-9:15	Supporting the Caregiver of the Older Adult with Cancer: Lessons Learned	Denice Economou, PhD, RN
9:15-10:00	Tapping into Community and Web-based Resources Tailored to the Older Adult	Carolina Uranga, MSN, AGCNS-BC, OCN
10:00-10:15	**BREAK**	
10:15-10:45	Responsible Conduct of Research	Daneng Li, MD
10:45-11:15	Post-Test	Peggy Burhenn, MS, AOCNS
11:15-12:00	Review Goals and Sharing of Individual Plans Final Draft of Goals/ Day 3 Evaluations	Denice Economou, PhD, RN
12:00	**BOX LUNCH AND ADJOURN**	

Speaker Bios Tab

Peggy Burhenn, MS, CNS, RN-BC, AOCNS
Clinical Nurse Specialist
City of Hope Comprehensive Cancer Center

Peggy Burhenn is a Clinical Nurse Specialist (CNS) in geriatric oncology. She holds certifications as an Oncology Certified Nurse (OCN), Advanced Oncology CNS (AOCNS) and is a board certified RN in gerontology. She is a co-investigator for the R25 grant that supports this educational conference.

In her current role as Clinical Nurse Specialist for Geriatric Oncology at City of Hope in Duarte California, she is involved in education, research, and care management of the older adult with cancer. Her focus has been to teach nurses about caring for the older adult with cancer. She has developed a group of geriatric resource nurses. She was the principal investigator for a study to evaluate nurses' knowledge, attitudes and perceptions of caring for older adults. She is also co-investigator for a protocol evaluating reasons for readmissions in the older adult with cancer. Her work focuses on a diversity of geriatric related issues such as: geriatric assessment, delirium, sleep promotion, fall prevention, cognition, pain in the older adult, and guided imagery. She has served as a preceptor for CNS students at local universities.

In 2013 she received the Margo McCaffery Excellence in Pain Management award and the Values in Action award at City of Hope for Intellectual Curiosity and in 2014 the Advanced Oncology Certified Nurse of the Year from the Greater Los Angeles Oncology Nursing Society. In April 2015 she received the Oncology Nursing Society national award for Excellence in Caring for the Older Adult with Cancer.

Disclosures: None

William Dale, MD, PhD
Arthur M. Coppola Family Chair in Supportive Care Medicine
City of Hope National Medical Center

William Dale completed his MD/PhD (Health Policy) training at the University of Chicago, with a dissertation topic focused on preventive behavior in men at-risk for or with prostate cancer. Following his residency in internal medicine and his fellowship training in geriatrics at the University of Pittsburgh, he returned to the University of Chicago as an Assistant Professor. He is also Board-certified in Hospice and Palliative Medicine. He is a Beeson Fellow (K23; 2004-2009), who served as the Section Chief of Geriatrics and Palliative Medicine (2008-2017), the Director of the John A. Hartford Center of Excellence, and the Founding Director of the award-winning Specialized Oncology Care and Research in the Elderly (SOCARE) Clinic at the University of Chicago. He is currently the Coppola Family Chair of Supportive Care Medicine at City of Hope (COH; Start date: April 2017) and is the Deputy Director of Social Sciences for the Center for Cancer and Aging at City of Hope, founded by Dr. Hurria. He is an international expert with consistent funding and over 120 publications in geriatrics, medical decision-making, behavioral economics, quality of life assessment, and health policy in older adults with cancer. He is an active member and leader of CARG, has led the American Geriatrics Society (AGS) Special Interest Group in Cancer and Aging for several years, an Associate Editor of the *Journal of Geriatric Oncology,* and is a co-leader of the Society for Medical Decision Making's Annual meeting in 2018. He is the lead Co-PI, along with Dr. Supriya Mohile, on a recently awarded R21/R33 NIA grant, Geriatric Oncology Research Infrastructure to Improve Clinical Care. He also serves as Co-PI on this R25 nursing education grant.

Disclosures: None

Wendy Demark-Wahnefried, PhD, RD
Professor and Webb Chair of Nutrition Sciences
Associate Director, UAB Comprehensive Cancer

Wendy Demark-Wahnefried, PhD, RD is Professor and Webb Endowed Chair of Nutrition Sciences. Dr. Demark-Wahnefried began her career as a cancer researcher at Duke University where she was on faculty for 17 years, then was recruited to MD Anderson and then came to UAB in 2010 as the Associate Director for Cancer Prevention and Control in the Cancer Center.

Her research in nutrition and cancer control and survivorship has produced over 200 scientific publications, and recognition as a Komen Professor of Survivorship and an American Cancer Society Clinical Research Professor. Dr. Demark-Wahnefried serves on several committees, including the American Cancer Society's Guidelines Panel for Nutrition and Physical Activity, World Cancer Research Fund, American College of Sports Medicine Guidelines Panel for Physical Activity in Cancer Survivors, American Society of Clinical Oncology Committee on Cancer Survivorship and Energy Balance, and the National Cancer Policy Forum of the Institute of Medicine.

Dr. Demark-Wahnefried was PI of the Reach-Out to ENhancE Wellness in Older Cancer Survivors trial - a telephone and tailored mailed material intervention which effectively improved diet quality, physical activity, weight status and physical functioning in 641 older cancer survivors (the largest behavioral intervention trial among older cancer survivors to date).

Disclosures: None

Denice Economou, RN, PhD, CHPN
Senior Research Specialist
City of Hope Comprehensive Cancer Center

Denice Economou has been in oncology nursing for 35 years and has focused her clinical expertise and research in pain management, palliative care and Cancer Survivorship. Denice is a senior research specialist at the City of Hope and the Project Director for the NCI grant funded *Survivorship Education for Quality Cancer Care* educational program, P.I.- Dr. Marcia Grant.

Dr. Economou has participated in the training of over 200 teams and 420 nurses in survivorship care. She lectures to healthcare professionals as well as cancer survivors on components of care and survivorship care planning. She was formerly with Aptium Oncology in the Department of Clinical Affairs where she oversaw pain & palliative care activities for the company. Dr. Economou was the nurse coordinator for the cancer pain management service at Cedars-Sinai Comprehensive Cancer Center for seven years, and an Oncology Nurse Educator providing education to nurses, patients and administrators on specific symptoms and pain management. Denice is an oncology faculty member for the End of Life Nursing Education Consortium (ELNEC).

She is a lecturer for the Genentech Speakers Program in Cancer Survivorship and Oncology Case Management. Dr. Economou is a past president of the Greater Los Angeles chapter of the Oncology Nursing Society. She has authored chapters in the Oxford Textbook of Palliative Nursing and Oncology Nursing Advisor. She is an Associate Editor for the Journal of the Advanced Practitioner in Oncology as well as an Assistant Clinical Professor for the School of Nursing-UCLA, Los Angeles.

Disclosures: None

Stephanie Fajuri, JD
Director of Disability Rights
Disability Rights Legal Center –
Cancer Legal Resource Center

Stephanie Fajuri is the Director of the Disability Rights Legal Center's Cancer Legal Resource Center (CLRC) in Los Angeles, California. As CLRC Director, Ms. Fajuri provides legal services to people with cancer-related legal issues, and has presented over 100 educational trainings on behalf of the CLRC, primarily focusing on topics such as health care reform, employment rights, access to health care and government benefits, and advance planning. Furthermore, she has overseen the counseling of thousands of cancer patients, caregivers, and health care professionals on the CLRC's national telephone assistance line, and works to develop educational handouts and publications covering a wide range of cancer-related legal issues.
Prior to this position, Ms. Fajuri was the CLRC's Supervising Attorney, Staff Attorney with the CLRC, Development Coordinator with Disability Rights Legal Center, and spent summers in law school working at the Illinois Human Rights Commission and at the US Department of Housing and Urban Development's Office of Fair Housing and Equal Opportunity. Ms. Fajuri is a member of the American Bar Association's Breast Cancer Advocacy Task Force, the American Cancer Society's Los Angeles Regional Leadership Council, the Orange County Cancer Coalition, and was a 2015-2016 health team fellow in the Women's Policy Institute, a leadership and public policy training program sponsored by the Women's Foundation of California.
Ms. Fajuri earned her J.D. at Chicago-Kent College of Law, and her B.A. in History at the University of Michigan- Ann Arbor. She is a member of the State Bars of California and New York. She is also a member of Legal Voices, the chorus of the Los Angeles Lawyers Philharmonic.

Disclosures: None

Betty Ferrell, PhD, MA, FAAN, FPCN, CHPN
Professor and Director, Division of Nursing Research & Education
City of Hope Comprehensive Cancer Center

Betty Ferrell, RN, PhD, MA, FAAN, FPCN, CHPN has been in nursing for 37 years and has focused her clinical expertise and research in pain management, quality of life, and palliative care.

Dr. Ferrell is the Director of Nursing Research & Education and a Professor at the City of Hope Medical Center in Duarte, California. She is a Fellow of the American Academy of Nursing and she has over 370 publications in peer-reviewed journals and texts. She is Principal Investigator of a Research Project funded by the National Cancer Institute on "Palliative Care for Patients with Solid Tumors on Phase 1 Clinical Trials" and Principal Investigator of the "End-of-Life Nursing Education Consortium (ELNEC)" project. She directs several other funded projects related to palliative care in cancer centers and QOL issues. Dr. Ferrell is a member of the Board of Scientific Advisors of the National Cancer Institute and was Co-Chairperson of the National Consensus Project for Quality Palliative Care.

Dr. Ferrell completed a Masters degree in Theology, Ethics and Culture from Claremont Graduate University in 2007. She has authored ten books including the Oxford *Textbook of Palliative Nursing* published by Oxford University Press (4th edition published in 2015). She is co-author of the text, *The Nature of Suffering and the Goals of Nursing* published in 2008 by Oxford University Press and *Making Health Care Whole: Integrating Spirituality into Patient Care* (Templeton Press, 2010). In 2013 Dr. Ferrell was named one of the 30 Visionaries in the field by the American Academy of Hospice and Palliative Medicine.

Disclosures: None

Shirley Johnson, MS, MBA, RN
Senior Vice President Nursing Services, Chief Nursing Officer
Roswell Park Cancer Institute

Shirley Johnson, R.N., M.S., M.B.A., is the senior vice president for patient care and nursing services and the chief nursing officer at Roswell Park Cancer Institute in Buffalo, New York. She guides the strategic direction of nursing and patient-care services and leads Roswell Park's efforts to continually enhance care provided to patients, giving special attention to the humanistic aspects of medicine. Johnson joined Roswell Park in late 2016 and previously served in senior leadership roles at City of Hope and Barnes-Jewish Hospital and Washington University School of Medicine in St. Louis. Shirley has extensive experience in building cancer programs and expanding operations to keep pace with the ever evolving changes in the healthcare landscape. Johnson is a past president of the Association of Cancer Executives and past chair of the BMT Program Administrator's Steering Committee for the American Society of Blood and Marrow Transplantation. She completed a six-year term on the Commission on Cancer of the American College of Surgeons and was a member of its Program on Approvals Committee. She was the 2013 Healthcare category winner for the California Women of the Year Award bestowed by the State of California. She is a frequent invited speaker on topics of cancer care delivery and nursing practice and has authored numerous papers related to strategies to reduce falls and cancer program development She currently serves on the Audit Committee of the Oncology Nursing Society and is on the Executive Council for the Association of Dedicated Cancer Centers. Johnson received her Master of Business Administration degree, Master of Science degree in management and bachelor's degree in nursing from Maryville University in St. Louis.

Since joining Roswell Park Cancer Institute, Shirley has fostered the expansion of an Assessment and Treatment Center, which provides after-hours care for cancer patient symptom management and instituted an after-hours nurse triage phone line. In collaboration with the Chief of Bone Marrow Transplant, she is developing an out-patient bone marrow transplant program. She is re-establishing the focus on gerontology oncology care within the organization, and will be pursuing NICHE designation with the Roswell Park team this fall.

Shirley counts it a privilege to serve in a role to support the driving vision for the future of cancer care delivery. Married to Gary, a human resource and leadership development consultant, she enjoys spending time with her two daughters, every chance she gets with one in the Los Angeles area, and one Montana.

Disclosures: None

Sarah Kagan, PhD, RN
Lucy Walker Honorary Term Professor of Gerontological Nursing
School of Nursing, University of Pennsylvania

Sarah H. Kagan is the Lucy Walker Honorary Term Professor of Gerontological Nursing at Penn, Gerontological Clinical Nurse Specialist in the Living Well Program at the Joan Karnell Cancer Center – Pennsylvania Hospital. She is currently holds several international appointments in Nursing and in Public Health including Visiting Professor at the School of Nursing and Midwifery, University College Dublin; Honorary Professor at Queen Margaret University in Edinburgh; Adjunct Professor at the American University of Armenia; Visiting Professor at the Oxford Brookes University Faculty of Health and Life Sciences; and Honorary Professor in Public Health and in Nursing at the University of Hong Kong.

Professor Kagan is Editor in Chief of the *International Journal of Older People Nursing.* She serves on the Editorial Boards of four journals – *Cancer Nursing, Geriatric Nursing, Research in Gerontological Nursing, and PTJ: Physical Therapy*. Additionally, Professor Kagan writes regularly for the lay press as a contributor to Calkins Media, writing the monthly column *Myths of Aging* for newspaper and online content. Professor Kagan's education and training includes a Bachelor of Arts in Behavioral Science from the University of Chicago, a Bachelor of Science in Nursing from Rush University, and a Master's Degree in Gerontological Nursing and a PhD from the University of California San Francisco.

Since arriving at the University of Pennsylvania some two decades ago, Professor Kagan has focused her scholarship on undergraduate nursing education, care of older people, and qualitative research. She currently directs the University of Pennsylvania Undergraduate Nursing Honors Program and two clinically-based undergraduate international exchange programs in nursing – one in the United

Kingdom and one in Australia. In addition, Professor Kagan teaches short term study abroad for the University of Pennsylvania in partnership with the University of Hong Kong. Professor Kagan maintains an active program of clinical scholarship and practice in gero-oncology which serves as a wellspring for her undergraduate pedagogy and anchors her understanding of the clinician-patient relationship and provision nursing care. Professor Kagan's work is acknowledged nationally and internationally as innovative, sophisticated, and clinically relevant. She is a fellow of the Gerontological Society of America and the American Academy of Nursing. Professor Kagan has held numerous visiting posts at many notable institutions nationally and internationally. Among the awards she has received for her practice, research, and teaching are the Sigma Theta Tau International Founders Award for Excellence in Nursing Practice and the John D. and Catherine T. MacArthur Fellowship. Professor Kagan received an Honorary Doctorate of Science from Oxford Brookes University in June 2013.

Disclosures: None

Beatriz Korc-Grodzicki, MD, PhD
Chief of Geriatrics Service
Memorial Sloan-Kettering Cancer Center

Beatriz Korc-Grodzicki, MD, PhD is currently the Service Chief of the Geriatrics at the Memorial Sloan- Kettering Cancer Center (MSKCC) and Professor of Clinical Medicine at Weil Cornell Medical College, New York, NY.

As an internist with a specialty in Geriatrics, she has expertise in treating complex cases with multiple health conditions, and provides comprehensive guidance that can help prevent avoidable complications. As an attending in the Geriatrics Division at University of Rochester, Director of Clinical Services at Mount Sinai Medical Center Department of Geriatrics, NY, and as the Chief of the Geriatrics Service in the Department of Medicine at Memorial Sloan Kettering Cancer Center, NY, she has been involved in the teaching of geriatric principles to multiple health care providers, students, house staff and the community. Over the last 6 years she has been dedicated to the care of older adults with cancer, has been panel member of the NCCN Senior Adult Oncology Guidelines has belonged to the Cancer and Aging Interest Group at the American Geriatric Society as well as the Geriatric Oncology Special Interest Group at ASCO.

She is the recipient of a recent large Geriatric Workforce Enhancement Program (GWAP) grant which will provide funding over the next 3 years for the education of oncologists and primary care physicians about the care of the geriatric cancer patient. She both spearheads clinical research and collaborates with oncologists and geriatricians nationwide in the hunt for best practices in caring for older patients with cancer.

Disclosures: None

Dan Li, MD
Assistant Professor, Center for Cancer and Aging
City of Hope Comprehensive Cancer Center

Dan Li, MD is a medical oncologist with training and expertise in the field of geriatric oncology at City of Hope. Dr. Li was awarded the Medical Student Training in Aging Research Fellowship (MSTAR) from the American Federation of Aging Research. This research fellowship allowed him to work with leading geriatric oncologist, Dr. Arti Hurria, on research to integrate geriatric assessment into oncology practice and also to evaluate predictors of distress among older adults with cancer. Dr. Li's passion for geriatric oncology continued during his early oncology career through research into the administration of intraperitoneal chemotherapy in older adults with gynecologic malignancies as well as an analysis of treatment, outcomes, and clinical trial participation in elderly patients with metastatic pancreas cancer at Memorial Sloan-Kettering Cancer Center.

Dr. Li joined City of Hope as an Assistant Clinical Professor in the Department of Medical Oncology in order to further expand the Cancer and Aging Research Program, a multidisciplinary team dedicated to the goal of optimizing care among older adults with cancer through both clinical practice and academic research. Current research initiatives include investigation of geriatric assessment guided interventions into routine medical oncology care, exploring the safety and tolerability of immune checkpoint inhibitors in older adults with cancer, determination of risk factors for cancer treatment toxicity in older adults with cancer, and identification of novel biomarkers of aging. At a national level, Dr. Li serves as a member of the Alliance Cancer in the Older Adult Committee and a member of the Cancer and Aging Research Group.

Disclosures: None

Matthew Loscalzo, LCSW
Executive Director and Professor, Department of Supportive Care
Professor Population Sciences
Administrative Director, Sheri & Les Biller Patient and Family Resource Center
City of Hope Comprehensive Cancer Center

Matthew J. Loscalzo is the Liliane Elkins Professor in Supportive Care Programs in the Department of Supportive Care Medicine and Professor in Department of Population Sciences. He is also the Executive Director of the Department of Supportive Care Medicine and the Administrative Director of the Sheri & Les Biller Patient and Family Resource Center at the City of Hope-National Medical Center, Duarte California. He serves as Co-PI on this R25 nursing education grant with Dr. William Dale.

Professor Loscalzo has held leadership positions at Memorial Sloan-Kettering Cancer Center, the Johns Hopkins Oncology Center, the Rebecca and John Moores Cancer Center at the University of California at San Diego and now at the City of Hope. He has created a number of highly integrated interdisciplinary biopsychosocial programs based on a unique staff leadership model. In, October 2014, Professor Loscalzo was recognized for a lifetime achievement award in clinical care by the International Psycho-Oncology Society. In August 2015, he received the Jimmie Holland Life Time Leadership Award from the American Psychosocial Oncology Society.

Professor Loscalzo has over 35 years of experience in caring for cancer patients and their families. He is recognized internationally as a pioneer in the clinical, educational, and research domains of psychosocial aspects of cancer. Professor Loscalzo was the President of the American Psychosocial Oncology Society and the Association of Oncology Social Workers. He is highly recognized and sought after for his strategic mentorship of leaders across disciplines. Professor Loscalzo has focused pain and palliative care, the implementation of problem-based screening programs, gender-based medicine and problem solving therapies.

He is the PI on two 5 year NIH R25E training grants (teaching health care professionals how to build supportive care programs and biopsychosocial screening programs) and a site PI for a new third R25E to teach advanced cognitive behavioral skills. He is also on the editorial boards or a reviewer for a number of professional journals and has over 100 publications. His clinical interests are gender medicine; strengths based approaches to psychotherapies, problem-based distress screening and the creation of supportive care programs.

Disclosures: None

June McKoy, MD, MPH, JD, MBA
Associate Professor of Medicine
Director of Geriatric Oncology
Robert H. Lurie Comprehensive Cancer Center

June M. McKoy, MD, MPH, JD, MBA is an Associate Professor of Medicine and Preventive Medicine at Northwestern University Feinberg School of Medicine, an academic geriatrician on the staff of Northwestern Memorial Hospital, a licensed Illinois Attorney, and a NIH-funded clinical cancer/health services researcher whose focus is on utilizing and interweaving research into daily practice in order to ensure better health for aging individuals.

As Director of Geriatric Oncology at the Robert H. Lurie Comprehensive Cancer Center of Northwestern University, she co-founded the Senior Oncology Outcomes Advocacy and Research (SOAR) program that translates research on cancer health measures into advocacy based interventions to improve health-related quality of life and survivorship for older individuals.

Dr. McKoy is a strong proponent of holistic healthy aging, believing that to age well one must balance mind, body, and spirit. She has been featured in multiple print and electronic media, including (but not limited to) the New York Times, the Chicago Tribune, Talking Points Memo, The Guardian, Public Television, and NBC news. She is the Program Director for the Geriatric Medicine Fellowship Program at Northwestern University, an NIH Study Section Reviewer and co-chair, a 2015 Impact Center Women's Leadership Fellow, a member of the NCCN Senior Adult Panel, an appointed member of the NCI's National Council of Research Advocates and most importantly, a member of the Cancer and Aging Research Group (CARG) based at *City of Hope* and led by Dr. Arti Hurria.

Disclosures: None

Mathy Mezey, EdD, RN, FAAN
Professor Emerita and Founding Director of the Hartford Institute for Geriatric Nursing
New York University College of Nursing

Mathy Mezey, holds a BSN from Columbia University Nursing (1960) and an MEd, (1973) and EdD (1977) from Teachers College, Columbia University. She has spent the last 50 years in nursing, first working in home care (at the Visiting Nurse Service of New York) and at a city hospital in New York (Jacobi Hospital, NY Health and Hospitals Corporation), and then having a career as a nurse educator, at Lehman College, City University of New York (1973 to 1980), at the University of Pennsylvania (1980-1991), and at New York University, beginning 1991. She is currently Emerita Professor at NYU.

The focus of Dr. Mezey's interest and scholarship has been on care of older adults, and assuring that nurses have the necessary skills and knowledge to provide quality care to this potentially vulnerable population. She has directed 2 major national initiatives focused on care of older adults, the Robert Wood Johnson Foundation Teaching Nursing Home Program (1981 to 1987) and the Hartford Institute for Geriatric Nursing, NYU College of Nursing (Founding Director from 1996-2009).

She has written or edited 16 books and written over 75 articles on topics related to geriatric nursing, the education and practice of geriatric nurse practitioners, care in nursing homes, and ethical decision making at the end of life.

Among her many recognitions, Dr. Mezey holds honorary degrees from Case Western Reserve and Fairfield University, is a Fellow of the American Academy of Nursing and the Gerontological Society of America. She is Emerita on the Board of Directors of the Visiting Nurse Service of New York, and is Trustee Emeritus, Columbia University.

Disclosures: None

Supriya Mohile, MD, MS
Director, Geriatric Oncology Clinic
Professor of Medicine
University of Rochester

Supriya Gupta Mohile, M.D., M.S. is a board-certified geriatrician and oncologist. Dr. Mohile has developed a clinical and research program in geriatric oncology by strengthening the links between geriatrics and oncology. She completed internship, residency and fellowships in hematology/oncology and geriatrics at University of Chicago Medical Center, where she also earned a Master's degree in health outcomes research. Mohile's fellowship was funded by an American Society of Clinical Oncology and John Hartford Foundation initiative to train oncologists in the care of the elderly.

Dr. Mohile's research interests include the evaluation of patterns of care, health outcomes, and quality of life related to treatment for systemic cancer in older patients. She has previously received an American Society of Clinical Oncology Young Investigator Award and Merit Awards. Mohile was a Hartford Geriatrics Health Outcomes Research Scholar sponsored by the American Geriatrics Society and was a Clinical and Translational Science Institute K-L2 Awardee. She was awarded a Patient Centered Outcomes Research Institute Award and a NCI R01 to evaluate whether geriatric assessment can improve outcomes of older patients with cancer. She directs the Specialized Oncology Care & Research in the Elderly (SOCARE) geriatric oncology clinic at the University of Rochester/Highland Hospital and is an integral member of the University of Rochester National Community Oncology Research Program (NCORP) Research Base which is directed by Dr. Gary Morrow. She leads the Cancer Care Delivery Research (CCDR) efforts in the Research Base and is a member of the NCI's CCDR Coordinating Committee.

Dr. Mohile is an expert in geriatric oncology with over 100 publications in this area. She serves on the editorial board of the Journal of Clinical Oncology and is Deputy Editor of the Journal of Geriatric Oncology. She also serves on the *American Society of Clinical Oncology* Geriatric Oncology Special Interest Group and Clinical Guidelines committees. Her contribution to moving the geriatric oncology field forward is noted in her leadership with developing research priorities and guidelines (publications below, mentees underlined).

Disclosures: Dr. Mohile is a consultant for Seattle Genetics.

Karen M. Mustian, PhD, MPH
Director, PEAK Human Performance Laboratory
Deputy Director URCC NCORP Research Base Associate Professor Department of Surgery
University of Rochester Medical Center Wilmot Cancer Institute

Karen M. Mustian, PhD, M.S., MPH, ACSM, FSBM. Dr. Mustian is an Associate Professor in the Departments of Surgery, Radiation Oncology and Public Health Sciences and the Wilmot Cancer Institute at the University of Rochester Medical Center. Dr. Mustian is Director of the URMC PEAK Human Performance Clinical Research Lab and Deputy Director of the NCI URCC NCORP Research Base. Internationally and nationally, Dr. Mustian is Chair of the Multinational Association of Supportive Care in Cancer Fatigue Study Group and Chair of the National Cancer Institute (NCI) Symptom Management and Quality of Life Steering Committee. She is a member of the NCI Community Oncology and Prevention Trials Research Group's Community Oncology Cardiotoxicity Task Force and the NCI National Clinical Trials Network Disease Steering Committee Chairs Group.

Dr. Mustian is an international leader in the fields of Cancer Control and Survivorship, Exercise Oncology, Behavioral Oncology, Exercise Physiology and Exercise Psychology. Dr. Mustian's research is in the area of cancer control and survivorship with primary foci on investigating the influence of physical activity and exercise on toxicities and side effects (acute, chronic and late) stemming from cancer and its treatments including translational foci investigating psychoneuroimmunological (e.g., cytokines and circadian rhythm) and genetic (nuclear and mitochondrial) mechanistic pathways. Currently, Dr. Mustian has over 36M dollars in research funding, 100 peer-reviewed publications and 39 distinguished research awards and honors. Dr. Mustian also serves on editorial boards and reviews for many excellent peer-review professional journals, as well as, grant review committees for the NCI, American Cancer Society, Patient Centered Outcomes Research Institute and others.

Disclosures: None

Janine Overcash, PhD, ARNP, BC
Clinical Associate Professor and Director of the Adult/Gerontological Nurse Practitioner and Clinical Nurse Specialist Programs
Ohio State University

Janine Overcash is a Clinical Associate Professor and the Director of Adult/Gerontological Nurse Practitioner program and the Clinical Nurse Specialist programs at The Ohio State University, College of Nursing. Dr. Overcash is also a nurse practitioner in the Senior Adult Oncology Program at the James Cancer Hospital, CompreJensive Breast Center specializing in the care of the older person. Previously, Dr. Overcash was an Associate Professor of Nursing at the University of South Florida and assisted in the design and management of one of the first geriatric oncology programs located at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, Florida.

Dr. Overcash has authored over 40 peer reviewed journal articles in the area of geriatric assessment. A book entitled, *The Older Cancer Patient: A Guide for Nurses and Related Professionals* by Janine Overcash and Lodovico Balducci highlights principles of care of the older person with cancer and received Book of the Year award by the *American Journal of Nursing*. Dr. Overcash has completed a post doctorate with the John A. Hartford Building Academic Geriatric Nursing Capacity Program. Dr. Overcash participated in the Geriatric Nurse Educational Consortium sponsored by the American Academy of Colleges of Nursing (AACN) and the John A. Hartford Foundation which instructed over 500 faculty from all over the United States.

Dr. Overcash research interests include understanding falls, performance status and independence in older cancer patients. Dr. Overcash speaks nationally and internationally on aspects of geriatric assessment and care of the older person diagnosed with cancer.

Disclosures: None

Timothy Synold, Pharm D.
Professor, Department of Cancer Biology
Director, Clinical Immunobiology Correlative Studies Laboratory
Co-Director, Analytical Pharmacology Core
City of Hope Comprehensive Cancer Center

Tim Synold, Pharm.D. is a Professor in the Department of Cancer Biology at the City of Hope. Following graduation from UC Santa Barbara with a bachelor's degree in chemistry, he received his doctor of pharmacy UC San Francisco. He then completed a post-doctoral fellowship at St. Jude Children's Hospital. He is a clinical and molecular pharmacologist who serves as Director of the Analytical Pharmacology and Clinical Immunology Laboratories. He is also the Scientific Leader of the COH Phase I Clinical Trial team and Director of Pharmacology for the NCI-supported California Cancer Consortium (CCC).

Dr. Synold has over 25 years' experience in chemistry and pharmacology, and he is an expert in the fields of pharmacokinetics and pharmacodynamics. His current focus involves the role of the blood-brain-barrier in CNS penetration of drugs. He is an expert reviewer for the Department of Defense and the National Cancer Institute, as well as for multiple medical journals. He has over 200 publications related to his research and has authored numerous book chapters.

Disclosures: None

Carolina Uranga, MSN, AGCNS-BC, RN-BC, OCN
Clinical Nurse Specialist
Center for Cancer and Aging
City of Hope

Carolina Uranga is an adult gerontology clinical nurse specialist (CNS) working in geriatric oncology. She holds certifications as an Oncology Certified Nurse (OCN) and is board certified as an adult gerontology clinical nurse specialist and gerontology nurse. She has been working in oncology for almost 20 years. She is currently the coordinator for Nurses Improving Care of Healthsystem Elders (NICHE) and is also the R25 project director for the Geriatric Oncology: Educating Nurses to Improve Quality Care program. Her efforts are focused on educating nursing staff on issues related to older adults with cancer and to advance and improve care in geriatric related issues (delirium, fall prevention, mobility, and functional status).

Disclosures: None

DAY 1 TAB

Lessons from a Career in Geriatric Nursing

Mathy Mezey, EdD, RN, FAAN
Professor Emerita and Founding Director of the Hartford Institute for Geriatric Nursing
New York University College of Nursing

Objectives:

1. Cite statistics about older adults
2. Evaluate the importance of life expectancy in older adults
3. State how geriatric care improves patient outcomes
4. Cite the importance of an age-friendly environment

Things I Want to Remember:

Mathy Mezey, EdD, RN, FAAN
Professor Emerita and Founding Director of the Hartford Institute for Geriatric Nursing
New York University College of Nursing

References:

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7. Van Cleave J. A Research Agenda for Gero-Oncology Nursing. *Science Direct*, 2016; 32(1):55-64

Introduction to Goal Development
Carolina Uranga, MSN, AGCNS-BC, RN-BC, OCN
Clinical Nurse Specialist

Things I Want to Remember:

S…	Strategic Specific	What would be seen as a "success" that matters? Who will do what, with or for whom?
M….	Measurable	Is it measurable and can WE measure it? Are there existing measures we can use?
A…	Achievable/Attainable	Can we get it done in the proposed timeline with the resources that we have?
R…	Realistic	Will this objective be "do-able". Does the project fit with the overall strategy and goals of the organization? Devise a plan for getting there which makes the goal realistic. Set a bar high enough for a satisfying achievement.
T…	Time-framed	Must have a clear target to work towards. Time must be measurable, attainable and realistic.

Adapted from smart goals information at www.goal-setting-guide.com/smart-goals.html

Examples of goals:

Within 6 months I will present an overview of physiologic changes and comorbidities associated with aging to the general nursing staff.

Will develop a protocol to add geriatric assessment parameters to admission assessment for all patients 70 years and older within 12 months. This will include: function, nutrition, cognition, social support, comorbidity, and psychological state upon admission.

Will coordinate an interdisciplinary team to review cases of oncology patients 75 years and older to evaluate needs and resources available to improve their care by 12 months.

We will pilot the use of a chemotherapy toxicity predictive plan for patients 70 years and older who are anticipated to receive chemotherapy.

Will provide a Timed-Up-and-Go (TUG) to all inpatient admissions for patients 70 years or older to assess functional status and fall risk within 12 months

Institution:_____ **City & State:**_____

Names: 1)_____

2)_____

3)_____

Email Reminders will be sent for

Online Post Course Goals and Team Follow Up:

- 6 Months (Due Aug 1, 2019)
- 12 Months (Due Feb 1, 2020)
- 18 Months (Due Aug 1, 2020)

Please Print Clearly

Goal 1	

Goal 2	

Goal 3	

Goals will be posted on the http://www.mycarg.org/r25 under 2019 Sessions Materials > 2019 R25 Conference Participants

Aging Trends and Comprehensive Geriatric Assessment

William Dale, PhD, MD
Arthur M. Coppola Family Chair in Supportive Care Medicine

City of Hope National Medical Center

Objectives:

1. Understand the association between cancer and aging
2. Describe the components of a comprehensive geriatric assessment
3. Describe the utility of performing a geriatric assessment in the oncology population

Things I Want to Remember:

Geriatric Assessment:
Healthcare Professional Questionnaire - Example

I. This form completed by: ***(Mark all that apply with an X.)*** Assessment Period (as applicable to this study)

☐ Physician ☐ Nurse ☐ CRA

☐ **Mark box with an "X", if form was not completed at specified timepoint and specify reason:**

(Mark one with an X.) ☐ Patient refused ☐ Patient withdrew consent ☐ Not done

☐ Other, specify _____

(For assessment date, record approximate date form was to be completed.)

I) Medical Characteristics:

a) Cancer type _____

b) Disease stage _____

c) Chemotherapy Regimen _____

NAME OF DRUG	DOSE	CIRCLE ONE
1)		mg/m^2 or mg/kg or other:_____
2)		mg/m^2 or mg/kg or other:_____
3)		mg/m^2 or mg/kg or other:_____
4)		mg/m^2 or mg/kg or other:_____

II) Karnofsky Performance Status:_____%

DEFINITION	%	CRITERIA
Able to carry on normal activity and able to work. No special care is needed.	100	Normal: no complaints; no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal Activity with effort; some signs or symptoms of disease.
Unable to work. Able to live at home, and for most personal needs. A varying amount of assistance is needed	70	Cares for self. Unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his needs
	50	Requires considerable assistance and frequent medical care
Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly	40	Disabled; requires special care and assistance
	30	Severely disabled; hospitalization is indicated although death not imminent.
	20	Very sick; hospitalization necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly
	0	Dead.

III) Timed "Up and Go"

Instructions: The timed "Up & Go" measures, in seconds, the time it takes for an individual to stand up from a standard arm chair (approximate seat height of 46 cm), walk a distance of 3 meters (approximately 10 feet), turn, walk back to the chair, and sit down again. The subject wears his/her regular footwear and uses their customary walking aid (none, cane, walker). No physical assistance is given. The subject starts with his back against the chair, his arm resting on the chair's arm, and his walking aid at hand. He is instructed that, on the word "go," he is to get up and walk at a comfortable and safe pace to a line on the floor 3 meters away (approximately 10 feet), turn, return to the chair, and sit down again. The subject walks through the test once before being timed in order to become familiar with the test. Either a wrist watch with a second hand or a stop-watch can be used to time the performance.

Time to perform "Up and Go":_____

IV) Cognition: Orientation-Memory-Concentration Test

	Patient's Errors	Maximum Score	Weight		Score		Final	Response
1. What year is it now? [without looking at a calendar]	☐☐☐☐	1	☐	x	4	=	☐☐	
2. What month is it now? [without looking at a calendar]	☐☐	1	☐	x	3	=	☐☐	
Memory Phrase Repeat this phrase after me: 'John Brown, 42 Market Street, Chicago'.								
3. About what time is it [within 1 hour – without looking at your watch]	☐☐:☐☐	1	☐	x	3	=	☐☐	
4. Count backwards from 20 to 1.		2	☐	x	2	=	☐☐	
5. Say the months in reverse order.		2	☐	x	2	=	☐☐	
6. Repeat the memory phrase		5	☐	x	2	=	☐☐	
					Total Score:		☐☐	

Scoring: For items 1 to 3, the response is either correct (score 0) or incorrect (score 1). For items 4 to 6, subtract one point for each error (item 4 and 5 maximum error is 2; for item 6, maximum error is 5); total all scores in "Final Score" column. Total score of 11 or greater indicates cognitive impairment; please notify MD and assist patient in completing questionnaires. Maximum score = 28

V) Nutrition

a) What is the patient's height? _____

b) What is the patient's current weight? _____

c) What is the patient's weight approximately 6 months ago? _____

d) Calculated Body Mass Index: _____

Body Mass Index=Weight/(Height)^2

Example

e) Percent Unintentional Weight Loss: _____

% unintentional weight loss =

(unintentional weight lost in last 6 months/baseline body weight) x 100

VI) Labs: (performed within 4 weeks of this assessment)

a) Creatinine:_____

b) Hemoglobin:_____

c) Albumin:_____

d) Liver Function Tests: Normal or Not normal_____

e) WBC: _____

f) CA125 (Gynecological patients ONLY):_____

g) Blood Urea Nitrogen: _____

VII) Scoring

a) Did the patient score ≥ 11 on the Blessed Orientation-Memory-Concentration Test (see previous page)?

☐ No

☐ Yes (if yes, notify the patient's treating physician)

VIII) Was the patient able to complete "Geriatric Assessment – Patient Questionnaire" on his/her own?

□Yes □No

If no, why? *(Mark all that apply with an X.)*

□ Not literate (does not read or write)
□ Visual problem
□ Fatigue
□ Questions too difficult (above the patient's reading ability)
□ Other: specify_____

IX) Time to complete

a) Appendix I (Data to be gathered by the healthcare team)

Start Time:_____

End Time: _____

b) Appendix II (Questionnaires to be completed by the study participant)

Start Time:_____

End Time: _____

Total time to complete Appendix I and II: _____

Name of person completing this document: _____

Signature: _____

Date: _____

Self Geriatric Assessment Measure:
Patient Questionnaire – Example

Responsible person name (*Physician, Nurse, or CRA*) _____
Assessment Period (as applicable to this study):
☐ Timepoint 1 ☐ Timepoint 2

Patient Instructions: If you are unable to complete the questionnaire, a member of your health care team will assist you. Please do not have a family member complete the questionnaire for you.

A. BACKGROUND INFORMATION

1. What is the highest grade you finished in school? *(Mark one with an X.*
   - ☐ 8th or less
   - ☐ 9-11th grade
   - ☐ High school graduate/GED
   - ☐ Associate degree/some college
   - ☐ Vocational/technical school
   - ☐ Bachelor's degree
   - ☐ Advanced degree
   - ☐ I prefer not to answer

2. What is your marital status? *(Mark one with an X.)*
   - ☐ Married
   - ☐ Domestic partnership
   - ☐ Widowed
   - ☐ Divorced
   - ☐ Separated
   - ☐ Never married
   - ☐ I prefer not to answer

3. With whom do you live? *(Mark all that apply with an X.)*
   - ☐ Spouse / partner
   - ☐ Girlfriend / boyfriend
   - ☐ Children aged 18 years or younger
   - ☐ Children aged 19 years or older
   - ☐ Parent(s)/ parent(s)-in-law
   - ☐ Live alone
   - ☐ Other specify _____
   - ☐ Other relative specify _____

4. What is your current employment status? *(Mark one with an X.)*
   - ☐ Employed 32 hours or more per week
   - ☐ Employed less than 32 hours per week
   - ☐ Homemaker
   - ☐ Disabled
   - ☐ On medical leave
   - ☐ Unemployed
   - ☐ Retired
   - ☐ Full-time student
   - ☐ Part-time student
   - ☐ Other specify _____

5. How old are you? _____ years old

6. What is your race? (Mark one with an X)
   - ☐ White
   - ☐ Black or African American
   - ☐ Native Indian or Alaskan Native
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Unknown

7. What is your ethnicity? (Mark one with an X)
   - ☐ Hispanic or Latino
   - ☐ Non-Hispanic
   - ☐ Unknown

B. DAILY ACTIVITIES*

PATIENT INSTRUCTIONS: Indicate your response by marking an X in one box per question.

1. Can you use the telephone…
   - ☐ without help, including looking up and dialing;
   - ☐ with some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the phone number or dialing); or
   - ☐ are you completely unable to use the telephone?

2. Can you get to places out of walking distance…
   - ☐ without help (can travel alone on busses, taxis, or drive your own car);
   - ☐ with some help (need someone to help you or go with you when traveling) ; or
   - ☐ are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

3. Can you go shopping for groceries or clothes (assuming you have transportation) …
   - ☐ without help (taking care of all shopping needs yourself, assuming you have transportation);
   - ☐ with some help (need someone to go with you on all shopping trips); or
   - ☐ are you completely unable to do any shopping?

4. Can you prepare your own meals…
   - ☐ without help (plan and cook full meals yourself);
   - ☐ with some help (can prepare some things but unable to cook full meals yourself) ; or
   - ☐ are you completely unable to prepare any meals?

5. Can you do your housework…
   - ☐ without help (can clean floors, etc);
   - ☐ with some help (can do light housework but need help with heavy work); or
   - ☐ are you completely unable to do any housework?

6. Can you take your own medicines…
   - ☐ without help (in the right doses at the right time);
   - ☐ with some help (able to take medicine if someone prepares it for you and/or reminds you to take it); or
   - ☐ are you completely unable to take your medicines?

7. Can you handle your own money…
   - ☐ without help (write checks, pay bills, etc.);
   - ☐ with some help (manage day-to-day buying but need help with managing your checkbook and paying your bills); or
   - ☐ are you completely unable to handle money?

* OARS IADL – Fillenbaum, G.G. and Smyer, M.A., 1981

Example

C. PHYSICAL ACTIVITIES*

1. The following items are activities you might do during a typical day. Does your health limit you in these activities? **(*Mark an X in the box on each line that best reflects your situation.*)**

Activities	Limited a lot	Limited a little	Not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than a mile	☐	☐	☐
h. Walking several blocks	☐	☐	☐
i. Walking one block	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

* MOS, Physical Functioning Scale – Stewart, A.L. and Ware, J.E., 1992

D. CURRENT HEALTH RATING*

Which one of the following phrases best describes you at this time? *(Mark one with an X.)*

- ☐ Normal, no complaints, no symptoms of disease
- ☐ Able to carry on normal activity, minor symptoms of disease
- ☐ Normal activity with effort, some symptoms of disease
- ☐ Care for self, unable to carry on normal activity or do active work
- ☐ Require occasional assistance but able to care for most of personal needs
- ☐ Require considerable assistance for personal care
- ☐ Disabled, require special care and assistance
- ☐ Severely disabled, require continuous nursing care

* Patient KPS – Loprinzi, C.L., et al., 1994

E. FALLS

How many times have you fallen in the last 6 months? __ __ __

F. YOUR MEDICATIONS

Are your taking medications?

☐ Yes ☐ No

How many prescribed medications are you taking? ___ medications

How many over-the-counter medications are you taking? ___ medications

How many herbs and vitamins are you taking? ___ herbs and vitamins

---

G. YOUR HEALTH

1. Your General Health*

Patient Instructions: Do you have any of the following illnesses at the present time, and if so, how much does it interfere with your activities: **Not at All, A Little or A Great Deal?** *(Mark an X in the box that best reflects your answer.)*

Illness	No	Yes		If you have this illness: How much does it interfere with your activities? Not at all	A little	A great deal
a. Other cancers or leukemia	☐	☐	→	☐	☐	☐
b. Arthritis or rheumatism	☐	☐	→	☐	☐	☐
c. Glaucoma	☐	☐	→	☐	☐	☐
d. Emphysema or chronic bronchitis	☐	☐	→	☐	☐	☐
e. High blood pressure	☐	☐	→	☐	☐	☐
f. Heart trouble	☐	☐	→	☐	☐	☐
g. Circulation trouble in arms or legs	☐	☐	→	☐	☐	☐
h. Diabetes	☐	☐	→	☐	☐	☐
i. Stomach or intestinal disorders	☐	☐	→	☐	☐	☐
j. Osteoporosis	☐	☐	→	☐	☐	☐
k. Liver disease	☐	☐	→	☐	☐	☐
l. Kidney disease	☐	☐	→	☐	☐	☐
m. Stroke	☐	☐	→	☐	☐	☐
n. Depression	☐	☐	→	☐	☐	☐

* OARS IADL – Fillenbaum, G.G. and Smyer, M.A., 1981

2. How is your eyesight (with glasses or contacts)? *(Mark one with an X.)*
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ Totally blind

3. How is your hearing (with a hearing aid, if needed)? *(Mark one with an X.)*
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ Totally deaf

4. Do you have any other physical problems or illnesses *(other than listed in questions 1-4)* at the present time that seriously affect your health?
   - ☐ No
   - ☐ Yes *(If yes),* specify _____

   (If yes), how much does this interfere with your activities? *(Mark one with an X.)*
   ☐ Not at all ☐ Somewhat ☐ A great deal

* OARS IADL – Fillenbaum, G.G. and Smyer, M.A., 1981

H. NUTRITIONAL STATUS

1. Have you lost weight involuntarily over the past 6 months?
   - ☐ No
   - ☐ Yes

   If yes, how much?
   _____ pounds

2. What is your weight now?
   _____ pounds

3. What was your weight 6 months ago?
   _____ pounds

I. HEALTH QUESTIONNAIRE*

INSTRUCTIONS: These questions are about how you have been feeling within the past month. Please mark an "X" in the box on each line that best reflects your situation.

How much of the time during the past month:	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
1. has your daily life been full of things that were interesting to you?	☐	☐	☐	☐	☐	☐
2. did you feel depressed?	☐	☐	☐	☐	☐	☐
3. have you felt loved and wanted?	☐	☐	☐	☐	☐	☐
4. have you been a very nervous person?	☐	☐	☐	☐	☐	☐
5. have you been in firm control of your behavior, thoughts, emotions, feelings?	☐	☐	☐	☐	☐	☐
6. have you felt tense or high-strung?	☐	☐	☐	☐	☐	☐
7. have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
8. have you felt emotionally stable?	☐	☐	☐	☐	☐	☐
9. have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
10. have you felt restless, fidgety, or impatient?	☐	☐	☐	☐	☐	☐
11. have you been moody, or brooded about things?	☐	☐	☐	☐	☐	☐
12. have you felt cheerful, light-hearted?	☐	☐	☐	☐	☐	☐
13. have you been in low or very low spirits?	☐	☐	☐	☐	☐	☐
14. were you a happy person?	☐	☐	☐	☐	☐	☐
15. did you feel you had nothing to look forward to?	☐	☐	☐	☐	☐	☐
16. have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
17. have you been anxious or worried?	☐	☐	☐	☐	☐	☐

* MHI-17 – Stewart, A.L. and Ware, J.E., 1992

J. SOCIAL ACTIVITIES*

1. During the past 4 weeks, how much time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
   (Mark one with an X.)

   ☐ All of the time
   ☐ Most of the time
   ☐ Some of the time
   ☐ A little of the time
   ☐ None of the time

2. Compared to your usual level of social activity, has your social activity during the past 6 months decreased, stayed the same, or increased because of a change in your physical or emotional condition? *(Mark one with an X.)*

   ☐ Much less socially active than before
   ☐ Somewhat less socially active than before
   ☐ About as socially active as before
   ☐ Somewhat more socially active as before
   ☐ Much more socially active than before

3. Compared to others your age, are your social activities more or less limited because of your physical health or emotional problems? *(Mark one with an X.)*

   ☐ Much more limited than others
   ☐ Somewhat more limited than others
   ☐ About the same as others
   ☐ Somewhat less limited than others
   ☐ Much less limited than others

* MOS, Social Activities – Stewart, A.L. and Ware, J.E., 1992

K. SOCIAL SUPPORT*

INSTRUCTIONS: People sometimes look to others for companionship, assistance or other types of support. How often is each of the following kinds of support available to you if you need it? (*Mark an X in the box on each line that best reflects your situation.*)

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
1. Someone to help you if you were confined to bed.	☐	☐	☐	☐	☐
2. Someone you can count on to listen to you when you need to talk.	☐	☐	☐	☐	☐
3. Someone to give you good advice about a crisis.	☐	☐	☐	☐	☐
4. Someone to take you to the doctor if you needed it.	☐	☐	☐	☐	☐
5. Someone to give you information to help you understand a situation.	☐	☐	☐	☐	☐
6. Someone to confide in or talk to about yourself or your problem.	☐	☐	☐	☐	☐
7. Someone to prepare your meals if you were unable to do it yourself.	☐	☐	☐	☐	☐
8. Someone whose advice you really want.	☐	☐	☐	☐	☐
9. Someone to help you with daily chores if you were sick.	☐	☐	☐	☐	☐
10. Someone to share your most private worries and fears with.	☐	☐	☐	☐	☐
11. Someone to turn to for suggestions about how to deal with a personal problem.	☐	☐	☐	☐	☐
12. Someone who understands your problems.	☐	☐	☐	☐	☐

* MOS Social Support Survey – Sherbourne, C.D. and Stewart, A.L., 1991

Example

L. SPIRITUALITY/RELIGION*

Directions: Please answer the following questions about your religious beliefs and/or involvement. (Please mark an "X" in the box on each line that best reflects your situation.)

1. How often do you attend church, synagogue, or other religious meetings? *(Mark one with an X.)*
   - ☐ More than once per week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ A few times a year
   - ☐ Once a year or less
   - ☐ Never

2. How often do you spend time in private religious activities, such as prayer, meditation or Bible study? *(Mark one with an X.)*
   - ☐ More than once a day
   - ☐ Daily
   - ☐ Two or more times per week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ Rarely or never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

3. In my life, I experience the presence of the Divine (i.e., God). *(Mark one with an X.)*
   - ☐ Definitely true of me
   - ☐ Tends to be true
   - ☐ Unsure
   - ☐ Tends *not* to be true
   - ☐ Definitely *not* true

4. My religious beliefs are what really lie behind my whole approach to life. *(Mark one with an X.)*
   - ☐ Definitely true of me
   - ☐ Tends to be true
   - ☐ Unsure
   - ☐ Tends *not* to be true
   - ☐ Definitely *not* true

5. I tried hard to carry my religion over into all other dealings in my life. *(Mark one with an X.)*
   - ☐ Definitely true of me
   - ☐ Tends to be true
   - ☐ Unsure
   - ☐ Tends *not* to be true
   - ☐ Definitely *not* true

* DUREL: Duke University Religion Index – Koenig et al., 1997

Example

M. YOUR FEELINGS*

1. Do you often feel sad or depressed? *(Mark one with an X.)*

☐ No ☐ Yes

2. How would you describe your level of anxiety, on the average? Please circle the number (0-10) best reflecting your response to the following that describes your feelings **during the past week, including today**.

0	1	2	3	4	5	6	7	8	9	10
No anxiety										Anxiety as bad as It can be

* Mahoney et al., 1994; LASA – Locke et al., 2007

N. FACT-G

Below is a list of statements that other people with your illness have said are important**. Please circle or mark one number per line to indicate your response as it applies to the past 7 days.**

	PHYSICAL WELL-BEING	Not At All	A Little Bit	Some -What	Quite A Bit	Very Much
GP 1	I have a lack of energy……..	0	1	2	3	4
GP 2	I have nausea…….	0	1	2	3	4
GP 3	Because of my physical condition, I have trouble meeting the needs of my family……...	0	1	2	3	4
GP 4	I have pain……...	0	1	2	3	4
GP 5	I am bothered by side effects of treatment…….	0	1	2	3	4
GP 6	I feel ill……..	0	1	2	3	4
GP 7	I am forced to spend time in bed…….	0	1	2	3	4

	SOCIAL/FAMILY WELL-BEING	Not At All	A Little Bit	Some -What	Quite A Bit	Very Much
GS 1	I feel close to my friends……	0	1	2	3	4
GS 2	I get emotional support from my family……...	0	1	2	3	4
GS 3	I get support from my friends…….....	0	1	2	3	4
GS 4	My family has accepted my illness……..	0	1	2	3	4
GS 5	I am satisfied with family communication about my illness…….	0	1	2	3	4
GS 6	I feel close to my partner (or the person who is my main support)……	0	1	2	3	4
Q1	*Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box and go to the next section.* ☐					
GS 7	I am satisfied with my sex life……..	0	1	2	3	4

Example

Please circle or mark one number per line to indicate your response as it applies to the past 7 days.

	EMOTIONAL WELL-BEING	Not At All	A Little Bit	Some -What	Quite A Bit	Very Much
GE 1	I feel sad……..	0	1	2	3	4
GE 2	I am satisfied with how I am coping with my illness.	0	1	2	3	4
GE 3	I am losing hope in the fight against my illness…….	0	1	2	3	4
GE 4	I feel nervous……..	0	1	2	3	4
GE 5	I worry about dying……	0	1	2	3	4
GE 6	I worry that my condition will get worse……..	0	1	2	3	4

	FUNCTIONAL WELL-BEING	Not At All	A Little Bit	Some -What	Quite A Bit	Very Much
GF 1	I am able to work (include work at home)……	0	1	2	3	4
GF 2	My work (include work at home) is fulfilling…….	0	1	2	3	4
GF 3	I am able to enjoy life……..	0	1	2	3	4
GF 4	I have accepted my illness……..	0	1	2	3	4
GF 5	I am sleeping well……	0	1	2	3	4
GF 6	I am enjoying the things I usually do for fun……	0	1	2	3	4
GF 7	I am content with the quality of my life right now…	0	1	2	3	4

Example

O. QUESTIONS CONCERNING THE QUESTIONNAIRE

1. Were there any questions difficult to understand? ☐ No ☐ Yes
   (If yes), which questions were they?

2. Was the time it took to answer all the questions too long, just right or too short?
   ☐ Too short → How long would you have liked the questionnaire to be? __ __ minutes
   ☐ Just right
   ☐ Too long → How long would you have liked the questionnaire to be? __ __ minutes

   Which items would you remove?

3. Did you find any of the questions upsetting? ☐ No ☐ Yes
   (If yes), which questions were they?

   Could you tell me why they were upsetting?

4. Do you think the questionnaire left out any questions that were important to ask?

Thank you for your participation.

NICHE
NURSES IMPROVING CARE FOR HEALTHSYSTEM ELDERS

SPICES

Sleep	• Ask about sleep. • Observe sleep patterns.
Problems with eating or feeding	• Evaluate appetite and food preferences. • Evaluate ability to feed self.
Incontinence	• Observe voiding and bowel patterns. • Evaluate for causes of incontinence.
Confusion	• Establish baseline cognitive status. • Monitor for cognitive changes.
Evidence of falls	• Ask about a history of falls. • Evaluate for additional risk factors.
Skin breakdown	• Identify any skin breakdown. • Evaluate risk factors for skin breakdown.

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Geriatric Assessment **G8**[1, 2]			
	Items	**Possible Answers**	**Score**
A	Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	0 = severe reduction in food intake 1 = moderate reduction in food intake 2 = normal food intake	
B	Weight loss during the last 3 months?	0 = weight loss >3kg 1 = does not know 2 = weight loss between 1 and 3 kg 3 = no weight loss	
C	Mobility	0 = bed or chair bound 1 = able to get out of bed/chair but does not go out 2 = goes out	
E	Neuropsychological Problems	0 = severe dementia or depression 1 = mild dementia or depression 2 = no psychological problems	
F	Body Mass Index (weight in kg/height in m)²	0 = BMI <19 1 = 19 ≤BMI < 21 2 = 21 ≤BMI < 23 3 = BMI > 23	
H	Takes more than 3 medications per day	0 = yes 1 = no	
P	In comparison with other people of the same age, how does the patient consider his/her health status?	0.0 = not as good 0.5 = does not know 1.0 = as good 2.0 = better	
	Age	0 = >85 1 = 80-85 2 = <80	
	Total score (0-17)		

Interpretation

0-14 = presence of a geriatric risk profile

>14 = absence of a geriatric risk profile

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Aging Trends and Comprehensive Geriatric Assessment
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Physiological Changes and Comorbidities Associated with Aging:
Relation to Risk of Cancer Therapy Toxicity

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Objectives:

1. To Describe how natural aging processes can facilitate the development of cancer and impact physiologic reserve
2. To depict how comorbidity influences outcomes in older patients with cancer as well as the challenges with measurement of comorbidity in research
3. To describe how comorbidity and physiologic reserve can impact toxicities of cancer treatment in older patients
4. To review key ways of how to reduce/prevent toxicity in older patients receiving treatment for cancer

Things I Want to Remember:

Comorbidity Scoring

Instructions for completing THE CHARLSON COMORBIDITY INDEX:

1. Complete all patient/institution information or affix RTOG patient-specific label.
2. Follow the "Rules for Completing The Charlson Comorbidity Index" in this appendix.
3. Complete the Charlson Comorbidity Index by noting "yes" or "no" for each disease.
4. Disease that are "no" get zero points. Diseases marked "yes" score the number of points designated in the far right column. Total the points at the bottom of the scoring sheet.
5. The completed form will be submitted to RTOG Headquarters

Instructions for completing THE COMORBIDITY RECORDING SHEET:

1. Complete all patient/institution information or affix RTOG patient-specific label.
2. Extract all comorbidity elements you can identify and note them on the Recording Sheet. Place the elements in the most appropriate category. Be comprehensive. The rater *(Dr. Gore)* will determine the relevant diseases and modify the category if needed.
3. Include past surgeries, diseases, smoking history, and functional problems, such as incontinence or constipation.
4. For each condition include:
    a. When (e.g., 6 months ago, 5 years ago, etc.);
    b. Current symptoms;
    c. Related treatment (e.g., surgery, stent placement, hearing aides, glasses, etc.);
    d. Related laboratory values (e.g., CR, bilirubin, Hgb);
    e. Medications (scheduled/prn).
5. If a functional problem appears to be related to tumor or treatment, place **TR** after the diagnosis.
6. Specify as much as possible the dose/frequency of medications; the rater may use this information to rate the severity of a disease.
7. Leave the scoring column blank.

Contact Elizabeth Gore, M.D. at 414-805-4465 or egore@radonc.mcw.edu if you have questions.

Rules for Completing the Charlson Comorbidity Index (CCI) (Charlson et al. *J Chron Dis*. 40:373-383, 1987)
Adaptation: Do not count non-melanotic skin cancers or in situ cervical carcinoma.

Myocardial infarct	Hx of medically documented myocardial infarction
Congestive heart failure	Symptomatic CHF w/ response to specific treatment
Peripheral vascular disease	Intermittent claudication, periph. arterial bypass for insufficiency, gangrene, acute arterial insufficiency, untreated aneurysm (>=6cm)
Cerebrovascular disease (except hemiplegia)	Hx of TIA, or CVA with no or minor sequelae
Dementia	chronic cognitive deficit
Chronic pulmonary disease	symptomatic dyspnea due to chronic respiratory conditions (including asthma)
Connective tissue disease	SLE, polymyositis, mixed CTD, polymyalgia rheumatica, moderate to severe RA
Ulcer disease	Patients who have required treatment for PUD
Mild liver disease	cirrhosis without PHT, chronic hepatitis
Diabetes (without complications)	diabetes with medication
Diabetes with end organ damage	retinopathy, neuropathy, nephropathy
Hemiplegia (or paraplegia)	hemiplegia or paraplegia
Moderate or severe renal disease	Creatinine >3mg% (265 umol/l), dialysis, transplantation, uremic syndrome
2nd Solid tumor (non metastatic)	Initially treated in the last 5 years exclude non-melanomatous skin cancers and in situ cervical carcinoma
Leukemia	CML, CLL, AML, ALL, PV
Lymphoma, MM...	NHL, Hodgkin's, Waldenström, multiple myeloma
Moderate or severe liver disease	cirrhosis with PHT +/- variceal bleeding
2nd Metastatic solid tumor	self-explaining
AIDS	AIDS and AIDS-related complex Suggested: as defined in latest definition

Completing the Comorbidity Recording Sheet

Examples of conditions in each category are listed below. The list is not all-inclusive. Please list other conditions that are present. All conditions, including ab values, are before the start of therapy.

Heart: MI, Arrhythmia, CHF, Angina, Pericardial disease, Valvular disease
Vascular/Hematopoietic: Hypertension, Peripheral vascular disease, Aneurysms, Blood abnormalities (anemia, leukopenia, etc.)
Respiratory: Bronchitis, Asthma, COPD, Tobacco history (pack/year)
HEENT: Vision impairment, Sinusitis, Hearing loss, Vertigo
Upper GI (esophagus, stomach, duodenum): Reflux, PUD
Lower GI (intestines, hernia): Constipation/Diarrhea, Hemorrhoids, Diverticulitises
Liver/Pancreas/GB: Cholelithiasis/Cholecystectomy, Hepatitis/pancreatitis
Renal: Creatinine, Stones
GU (ureters, bladder, urethra, prostate, genitals, uterus, ovaries): Incontinence, UTI, BPH, Hysterectomy, Abnormal PAP smear, Bleeding
Musculoskeletal/Skin: Arthritis, Osteoporosis, Skin cancer, Psoriasis
Neurological: Headaches, TIAs/Stroke, Vertigo, Parkinson's Disease/MS/ALS
Endocrine (record height and weight): Diabetes, Hypo/hyperthyroid, Obesity
Psychiatric: Dementia, Depression

Physiological Changes and Comorbidities Associated with Aging:
Relation to Risk of Cancer Therapy Toxicity

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Assessing Functional Status, Frailty, and Fall Risk in the Older Adult with Cancer

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Objectives:

1. Define and relate functional status, frailty, and falls to oncology care of the older person
2. Identify functional status, frailty, and fall risk screening tool appropriate for clinical practice
3. Identify three types of recommendations based on functional status, frailty, and fall risk screening tools

Things I Want to Remember:

Study ID _____ Date _____ Tester Initials _____

SHORT PHYSICAL PERFORMANCE BATTERY PROTOCOL AND SCORE SHEET

All of the tests should be performed in the same order as they are presented in this protocol. Instructions to the participants are shown in bold italic and should be given exactly as they are written in this script.

1. BALANCE TESTS

The participant must be able to stand unassisted without the use of a cane or walker. You may help the participant to get up.

> ***Now let's begin the evaluation. I would now like you to try to move your body in different movements. I will first describe and show each movement to you. Then I'd like you to try to do it. If you cannot do a particular movement, or if you feel it would be unsafe to try to do it, tell me and we'll move on to the next one. Let me emphasize that I do not want you to try to do any exercise that you feel might be unsafe.***
>
> ***Do you have any questions before we begin?***

A. Side-by-Side Stand

1. ***Now I will show you the first movement***.

2. (Demonstrate) ***I want you to try to stand with your feet together, side-by-side, for about 10 seconds.***

3. ***You may use your arms, bend your knees, or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.***

4. Stand next to the participant to help him/her into the side-by-side position.

5. Supply just enough support to the participant's arm to prevent loss of balance.

6. When the participant has his/her feet together, ask ***"Are you ready?"***

7. Then let go and begin timing as you say, ***"Ready, begin."***

8. Stop the stopwatch and say ***"Stop"*** after 10 seconds or when the participant steps out of position or grabs your arm.

9. If participant is unable to hold the position for 10 seconds, record result and go to the gait speed test.

Study ID _____ Date _____ Tester Initials _____

B. Semi-Tandem Stand

1. ***Now I will show you the second movement***.

2. (Demonstrate) ***Now I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.***

3. ***You may use your arms, bend your knees, or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.***

4. Stand next to the participant to help him/her into the semi-tandem position

5. Supply just enough support to the participant's arm to prevent loss of balance.

6. When the participant has his/her feet together, ask ***"Are you ready?"***

7. Then let go and begin timing as you say ***"Ready, begin."***

8. Stop the stopwatch and say ***"Stop"*** after 10 seconds or when the participant steps out of position or grabs your arm.

9. If participant is unable to hold the position for 10 seconds, record result and go to the gait speed test.

C. Tandem Stand

1. ***Now I will show you the third movement***.

2. (Demonstrate) ***Now I want you to try to stand with the heel of one foot in front of and touching the toes of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.***

3. ***You may use your arms, bend your knees, or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.***

4. Stand next to the participant to help him/her into the tandem position.

5. Supply just enough support to the participant's arm to prevent loss of balance.

6. When the participant has his/her feet together, ask ***"Are you ready?"***

7. Then let go and begin timing as you say, ***"Ready, begin."***

8. Stop the stopwatch and say ***"Stop"*** after 10 seconds or when the participant steps out of position or grabs your arm.

Study ID _____ Date _____ Tester Initials _____

SCORING:

A. Side-by-side-stand

Held for 10 sec ❒ 1 point
Not held for 10 sec ❒ 0 points
Not attempted ❒ 0 points
If 0 points, end Balance Tests

Number of seconds held if less than 10 sec: ___._ _sec

If participant did not attempt test or failed, circle why:

Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify) _____	6
Participant refused	7

B. Semi-Tandem Stand

Held for 10 sec ❒ 1 point
Not held for 10 sec ❒ 0 points
Not attempted ❒ 0 points *(circle reason above)*
If 0 points, end Balance Tests

Number of seconds held if less than 10 sec: ___._ _sec

C. Tandem Stand

Held for 10 sec ❒ 2 points
Held for 3 to 9.99 sec ❒ 1 point
Held for < than 3 sec ❒ 0 points
Not attempted ❒ 0 points (circle reason above)

Number of seconds held if less than 10 sec: ___._ _sec

D. Total Balance Tests score_____(sum points)

Comments: _____

Study ID _____ Date _____ Tester Initials _____

2. GAIT SPEED TEST

Now I am going to observe how you normally walk. If you use a cane or other walking aid and you feel you need it to walk a short distance, then you may use it.

A. First Gait Speed Test

1. ***This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the store.***

2. Demonstrate the walk for the participant.

3. ***Walk all the way past the other end of the tape before you stop. I will walk with you. Do you feel this would be safe?***

4. Have the participant stand with both feet touching the starting line.

5. ***When I want you to start, I will say: "Ready, begin."*** When the participant acknowledges this instruction say: ***"Ready, begin."***

6. Press the start/stop button to start the stopwatch as the participant begins walking.

7. Walk behind and to the side of the participant.

8. Stop timing when one of the participant's feet is completely across the end line.

B. Second Gait Speed Test

1. ***Now I want you to repeat the walk. Remember to walk at your usual pace, and go all the way past the other end of the course.***

2. Have the participant stand with both feet touching the starting line.

3. ***When I want you to start, I will say: "Ready, begin."*** When the participant acknowledges this instruction say: ***"Ready, begin."***

4. Press the start/stop button to start the stopwatch as the participant begins walking.

5. Walk behind and to the side of the participant.

6. Stop timing when one of the participant's feet is completely across the end line.

Study ID _____ Date _____ Tester Initials _____

GAIT SPEED TEST SCORING:

Length of walk test course: Four meters ❒ Three meters ❒

A. Time for First Gait Speed Test (sec)

1. Time for 3 or 4 meters __ __.__ __sec
2. If participant did not attempt test or failed, circle why:

Tried but unable	1
Participant could not walk unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (Specify) _____	6
Participant refused	7

Complete score sheet and go to chair stand test

3. Aids for first walk.....None ❒ Cane ❒ Other ❒

Comments:_____

_____

_____

B. Time for Second Gait Speed Test (sec)

1. Time for 3 or 4 meters __ __.__ __ sec
2. If participant did not attempt test or failed, circle why:

Tried but unable	1
Participant could not walk unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (Specify)	6
Participant refused	7

3. Aids for second walk..... None ❒ Cane ❒ Other ❒

What is the time for the faster of the two walks?
Record the shorter of the two times __ __.__ __ sec
[If only 1 walk done, record that time] __ __.__ __ sec

If the participant was unable to do the walk: ❒ **0 points**

For 4-Meter Walk:		**For 3-Meter Walk:**	
If time is more than 8.70 sec:	❒ **1 point**	If time is more than 6.52 sec:	❒ **1 point**
If time is 6.21 to 8.70 sec:	❒ **2 points**	If time is 4.66 to 6.52 sec:	❒ **2 points**
If time is 4.82 to 6.20 sec:	❒ **3 points**	If time is 3.62 to 4.65 sec:	❒ **3 points**
If time is less than 4.82 sec:	❒ **4 points**	If time is less than 3.62 sec:	❒ **4 points**

Study ID _____ Date _____ Tester Initials _____

3. CHAIR STAND TEST

Single Chair Stand

1. ***Let's do the last movement test. Do you think it would be safe for you to try to stand up from a chair without using your arms?***

2. ***The next test measures the strength in your legs.***

3. (Demonstrate and explain the procedure.) ***First, fold your arms across your chest and sit so that your feet are on the floor; then stand up keeping your arms folded across your chest.***

4. ***Please stand up keeping your arms folded across your chest.*** (Record result).

5. If participant cannot rise without using arms, say ***"Okay, try to stand up using your arms."*** This is the end of their test. Record result and go to the scoring page.

Repeated Chair Stands

1. ***Do you think it would be safe for you to try to stand up from a chair five times without using your arms?***

2. (Demonstrate and explain the procedure): ***Please stand up straight as QUICKLY as you can five times, without stopping in between. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I'll be timing you with a stopwatch.***

3. When the participant is properly seated, say: ***"Ready? Stand"*** and begin timing.

4. Count out loud as the participant arises each time, up to five times.

5. Stop if participant becomes tired or short of breath during repeated chair stands.

6. Stop the stopwatch when he/she has straightened up completely for the fifth time.

7. Also stop:
   - If participant uses his/her arms
   - After 1 minute, if participant has not completed rises
   - At your discretion, if concerned for participant's safety

8. If the participant stops and appears to be fatigued before completing the five stands, confirm this by asking ***"Can you continue?"***

9. If participant says "Yes," continue timing. If participant says "No," stop and reset the stopwatch.

Study ID _____ Date _____ Tester Initials _____

SCORING
Single Chair Stand Test

		YES	NO	
A.	Safe to stand without help	❒	❒	
B.	Results:			
	Participant stood without using arms	❒		→ Go to Repeated Chair Stand Test
	Participant used arms to stand	❒		→ End test; score as 0 points
	Test not completed	❒		→ End test; score as 0 points

C. If participant did not attempt test or failed, circle why:

Tried but unable	1
Participant could not stand unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (Specify) _____	6
Participant refused	7

Repeated Chair Stand Test

		YES	NO
A.	Safe to stand five times	❒	❒

B. If five stands done successfully, record time in seconds.

Time to complete five stands __ __.__ __ sec

C. If participant did not attempt test or failed, circle why:

Tried but unable	1
Participant could not stand unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (Specify)	6
Participant refused	7

Scoring the Repeated Chair Test

Participant unable to complete 5 chair stands or completes stands in >60 sec:	❒ 0 points
If chair stand time is 16.70 sec or more:	❒ 1 points
If chair stand time is 13.70 to 16.69 sec:	❒ 2 points
If chair stand time is 11.20 to 13.69 sec:	❒ 3 points
If chair stand time is 11.19 sec or less:	❒ 4 points

Study ID _____ Date _____ Tester Initials _____

Scoring for Complete Short Physical Performance Battery

Test Scores

Total Balance Test score	_____ **points**
Gait Speed Test score	_____ **points**
Chair Stand Test score	_____ **points**
Total Score	_____ **points (sum of points above)**

Assessing Functional Status, Frailty, and Fall Risk in the Older Adult with Cancer

Janine Overcash, PhD, ARNP, BC
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Ohio State University

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Exercise Screening and Prescription for Older Adults with Cancer

Karen Mustian, PhD, MPH

Director, PEAK Human Performance Laboratory
Associate Professor, Department of Surgery

University of Rochester Medical Center
Wilmot Cancer Institute

Objectives:

1. Participants will learn and become familiar with the ACSM Exercise Guidelines for Cancer Patients and Survivors
2. Participants will learn how to screen cancer patients and survivors for level of exercise risk and perform appropriate referrals

Things I Want to Remember:

Exercise Screening and Prescription for Older Adults with Cancer

Karen Mustian, PhD, MPH

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Associate Professor, Department of Surgery

University of Rochester Medical Center
Wilmot Cancer Institute

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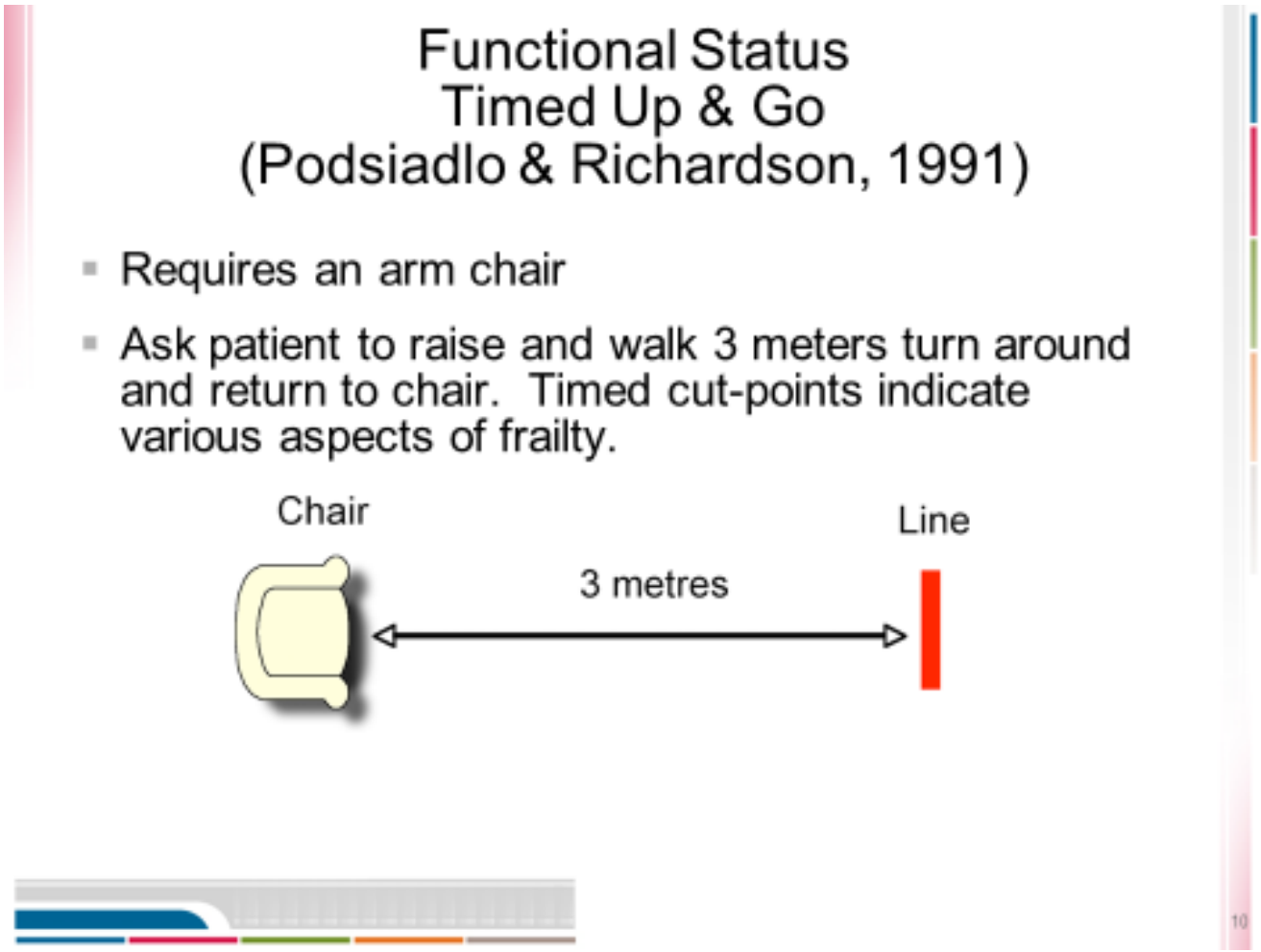
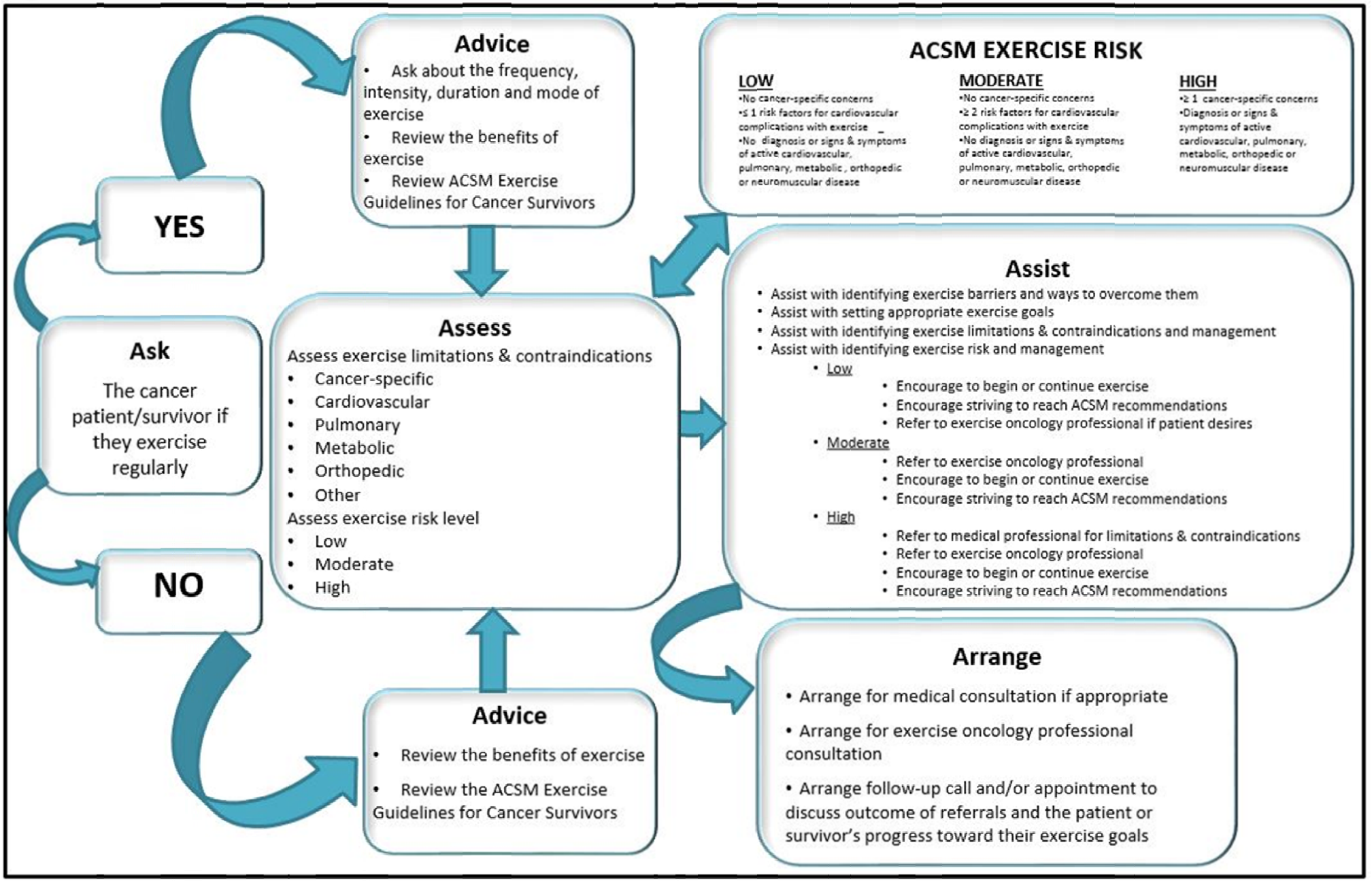
Group Breakout: Functional Assessment Practice Session

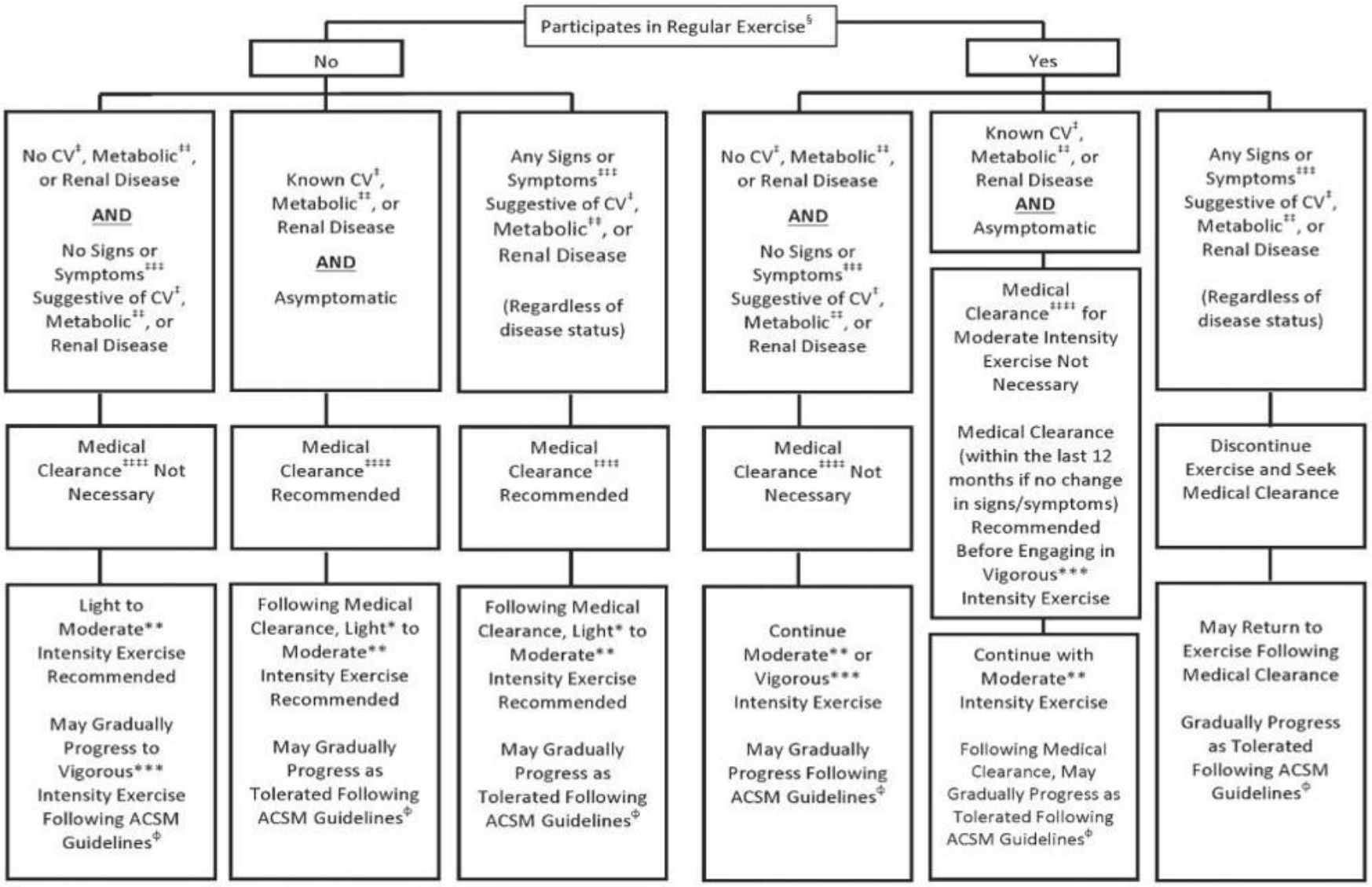
Things I Want to Remember:



Pearls for Practice

1. The timed Up & Go test has been found to be correlated with falls (Shumway-Cook, Brauer, & Woollacott, 2000).
2. TUAG helps predict falls (Thrane, 2007).
3. TUAG Help predict probably of fracture (Zhu, 2011).
4. Poor TAUG is also associated with mortality (Tice, 2006).
5. The tests are timed (under 10 seconds the patient is freely independent and over 30 seconds the patient is dependent on the assistance of others) (Podsiadlo & Richardson, 1991).


Advice
• Ask about the frequency, intensity, duration and mode of exercise
• Review the benefits of exercise
• Review ACSM Exercise Guidelines for Cancer Survivors
YES
Ask
The cancer patient/survivor if they exercise regularly
NO
Assess
Assess exercise limitations & contraindications
• Cancer-specific
• Cardiovascular
• Pulmonary
• Metabolic
• Orthopedic
• Other
Assess exercise risk level
• Low
• Moderate
• High
ACSM EXERCISE RISK
LOW
•No cancer-specific concerns
•≤ 1 risk factors for cardiovascular complications with exercise
•No diagnosis or signs & symptoms of active cardiovascular, pulmonary, metabolic , orthopedic or neuromuscular disease
MODERATE
•No cancer-specific concerns
•≥ 2 risk factors for cardiovascular complications with exercise
•No diagnosis or signs & symptoms of active cardiovascular, pulmonary, metabolic, orthopedic or neuromuscular disease
HIGH
•≥ 1 cancer-specific concerns
•Diagnosis or signs & symptoms of active cardiovascular, pulmonary, metabolic, orthopedic or neuromuscular disease
Assist
• Assist with identifying exercise barriers and ways to overcome them
• Assist with setting appropriate exercise goals
• Assist with identifying exercise limitations & contraindications and management
• Assist with identifying exercise risk and management
• Low
• Encourage to begin or continue exercise
• Encourage striving to reach ACSM recommendations
• Refer to exercise oncology professional if patient desires
• Moderate
• Refer to exercise oncology professional
• Encourage to begin or continue exercise
• Encourage striving to reach ACSM recommendations
• High
• Refer to medical professional for limitations & contraindications
• Refer to exercise oncology professional
• Encourage to begin or continue exercise
• Encourage striving to reach ACSM recommendations
Arrange
• Arrange for medical consultation if appropriate
• Arrange for exercise oncology professional consultation
• Arrange follow-up call and/or appointment to discuss outcome of referrals and the patient or survivor's progress toward their exercise goals
Advice
• Review the benefits of exercise
• Review the ACSM Exercise Guidelines for Cancer Survivors


Participates in Regular Exercise§
No
Yes
No CV‡, Metabolic‡‡, or Renal Disease
AND
No Signs or Symptoms‡‡‡ Suggestive of CV‡, Metabolic‡‡, or Renal Disease
Known CV‡, Metabolic‡‡, or Renal Disease
AND
Asymptomatic
Any Signs or Symptoms‡‡‡ Suggestive of CV‡, Metabolic‡‡, or Renal Disease
(Regardless of disease status)
No CV‡, Metabolic‡‡, or Renal Disease
AND
No Signs or Symptoms‡‡‡ Suggestive of CV‡, Metabolic‡‡, or Renal Disease
Known CV‡, Metabolic‡‡, or Renal Disease
AND
Asymptomatic
Any Signs or Symptoms‡‡‡ Suggestive of CV‡, Metabolic‡‡, or Renal Disease
(Regardless of disease status)
Medical Clearance‡‡‡‡ Not Necessary
Medical Clearance‡‡‡‡ Recommended
Medical Clearance‡‡‡‡ Recommended
Medical Clearance‡‡‡‡ Not Necessary
Medical Clearance‡‡‡‡ for Moderate Intensity Exercise Not Necessary
Medical Clearance (within the last 12 months if no change in signs/symptoms) Recommended Before Engaging in Vigorous*** Intensity Exercise
Discontinue Exercise and Seek Medical Clearance
Light to Moderate** Intensity Exercise Recommended
May Gradually Progress to Vigorous*** Intensity Exercise Following ACSM Guidelines¢
Following Medical Clearance, Light* to Moderate** Intensity Exercise Recommended
May Gradually Progress as Tolerated Following ACSM Guidelines¢
Following Medical Clearance, Light* to Moderate** Intensity Exercise Recommended
May Gradually Progress as Tolerated Following ACSM Guidelines¢
Continue Moderate** or Vigorous*** Intensity Exercise
May Gradually Progress Following ACSM Guidelines¢
Continue with Moderate** Intensity Exercise
Following Medical Clearance, May Gradually Progress as Tolerated Following ACSM Guidelines¢
May Return to Exercise Following Medical Clearance
Gradually Progress as Tolerated Following ACSM Guidelines¢

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

SECTION 1 - GENERAL HEALTH

	Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1.	Has your doctor ever said that you have a heart condition OR high blood pressure?	☐	☐
2.	Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
3.	Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4.	Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	☐	☐
5.	Are you currently taking prescribed medications for a chronic medical condition?	☐	☐
6.	Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.	☐	☐
7.	Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.

Go to Section 3 to sign the form. You do not need to complete Section 2.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow the Canadian Physical Activity Guidelines for your age (www.csep.ca/guidelines).
- You may take part in a health and fitness appraisal.
- If you have any further questions, contact a qualified exercise professional such as a CSEP Certified Exercise Physiologist® (CSEP-CEP).
- If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered YES to one or more of the questions above, please GO TO SECTION 2.

Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better
- You are pregnant – talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the PARmed-X for Pregnancy before becoming more physically active OR
- Your health changes – please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

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SECTION 2 - CHRONIC MEDICAL CONDITIONS

Please read the questions below carefully and answer each one honestly: check YES or NO.			YES	NO
1.	Do you have Arthritis, Osteoporosis, or Back Problems?		☐ If yes, answer questions 1a-1c	☐ If no, go to question 2
	1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/ or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	☐	☐
	1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	☐	☐
2.	Do you have Cancer of any kind?		☐ If yes, answer questions 2a-2b	☐ If no, go to question 3
	2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?	☐	☐
	2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	☐	☐
3.	Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm		☐ If yes, answer questions 3a-3e	☐ If no, go to question 4
	3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial brillation, premature ventricular contraction)	☐	☐
	3c.	Do you have chronic heart failure?	☐	☐
	3d.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer YES if you do not know your resting blood pressure)	☐	☐
	3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	☐	☐
4.	Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes		☐ If yes, answer questions 4a-4c	☐ If no, go to question 5
	4a.	Is your blood sugar often above 13.0 mmol/L? (Answer YES if you are not sure)	☐	☐
	4b.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet?	☐	☐
	4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	☐	☐
5.	Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome)		☐ If yes, answer questions 5a-5b	☐ If no, go to question 6
	5a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	5b.	Do you also have back problems affecting nerves or muscles?	☐	☐

Please read the questions below carefully and answer each one honestly: check YES or NO.			YES	NO
6.	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure		☐ If yes, answer questions 6a-6d	☐ If no, go to question 7
	6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	6b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	☐	☐
	6c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	☐	☐
	6d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	☐	☐
7.	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia		☐ If yes, answer questions 7a-7c	☐ If no, go to question 8
	7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	7b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	☐	☐
	7c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	☐	☐
8.	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event		☐ If yes, answer questions 8a-c	☐ If no, go to question 9
	8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	8b.	Do you have any impairment in walking or mobility?	☐	☐
	8c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	☐	☐
9.	Do you have any other medical condition not listed above or do you live with two chronic conditions?		☐ If yes, answer questions 9a-c	☐ If no, read the advice on page 4
	9a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?	☐	☐
	9b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	☐	☐
	9c.	Do you currently live with two chronic conditions?	☐	☐

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

PAR-Q+

If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active:

- It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP) to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually – 20-60 min. of low- to moderate-intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate-intensity physical activity per week.
- If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered YES to one or more of the follow-up questions about your medical condition:

- You should seek further information from a licensed health care professional before becoming more physically active or engaging in a fitness appraisal.

Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise profesional, and/or complete the PARmed-X for Pregnancy before becoming more physically active OR
- Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The Canadian Society for Exercise Physiology, the PAR-Q+ Collaboration, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.
- Please read and sign the declaration below:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact:
Canadian Society for Exercise Physiology
www.csep.ca

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The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or BC Ministry of Health Services.

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THE GOLD STANDARD IN EXERCISE SCIENCE AND PERSONAL TRAINING

Identifying and Addressing Distress in the Older Adult

Matthew Loscalzo, LCSW
Executive Director and Professor – Department of Supportive Care
Professor Population Sciences
Administrative Director – Sheri & Les Biller Patient and Family Resource Center
City of Hope

Objectives:

1. Participants will know how to screen for biopsychosocial problems endemic to older adults with cancer
2. Participants will understand the link between noxious physical symptoms and negative psychosocial impact
3. Participants will be aware of the barriers and opportunities related to new distress screening standards

Things I Want to Remember:

Journal of the National Comprehensive Cancer Network

Jimmie C. Holland, MD

Jimmie C. Holland, MD, recognized internationally as the founder of the subspecialty of psycho-oncology, is Attending Psychiatrist and holds the first endowed chair in Psychiatric Oncology, the Wayne E. Chapman Chair at Memorial Sloan Kettering Cancer Center. She is Professor of Psychiatry at Weill Medical College of Cornell University. She began the first full-time Psychiatric Service in a cancer hospital in 1977 at Memorial Sloan Kettering Cancer Center, and in 1996 she became the first woman Chair of a clinical department at Memorial. Dr. Holland was PI of the first research training grant in psycho-oncology which has continued uninterrupted for 34 years.

Dr. Holland established the first committee studying psychological and quality of life issues in a cooperative group, the Cancer Leukemia Group B. In the 1980s she became the Founding President of the International Psycho-oncology Society (1984) and of the American Psychosocial Oncology Society (1986). She has been senior editor of multiple textbooks, and in 1992, she started the first international journal in the field, Psycho-Oncology, and continues as co-editor. Dr. Holland has chaired the NCCN Panel on Management of Distress since its beginning in 1997. She was elected to the Institute of Medicine in 1995 and served on the panel that established a new standard of quality cancer care which demands that the psychosocial domain be integrated into routine cancer care. Dr. Holland has received numerous awards from the ACS, ASCO, AACR, and other national and international associations.

Was There a Patient in Your Clinic Today Who Was Distressed?

Jimmie C. Holland, MD; Mark Lazenby, PhD, APRN; and Matthew J. Loscalzo, LCSW

Most who work in an outpatient clinic or office would likely answer yes to the question asked in the title of this commentary. Data from as long ago as the 1970s confirm that, indeed, approximately one-third of patients with cancer experience significant distress, primarily anxiety or depression.[1] A landmark study in 1976 noted the value of identifying distress early in patients, during the first 100 days after a cancer diagnosis, when patients are very vulnerable.[1] In this study, researchers screened patients for distress and provided psychosocial counseling, which significantly reduced distress levels. Patients were then better able to cope with the subsequent hassles associated with their illness and treatment.

However, we clinicians can be slow learners. NCCN led the way in addressing this issue, 20 years ago, by suggesting that routine screening for distress in newly diagnosed patients would improve overall care. Then, in 1997, the first NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for the management of distress in patients with cancer were formulated by a multidisciplinary panel.[2,3] The panel noted that oncologists were reluctant to ask patients about psychological and psychiatric problems—and patients were equally reluctant to answer—because of the stigma associated with psychological issues. The panel said, "Find a better word that, one is not stigmatized, to use with patients when asking about psychological problems."

The word "distress" was chosen and, using a principle successful in pain management, the panel recommended asking patients, "How is your distress level on a scale of 0 to 10?" Distress is normal among people with cancer, and patients have come to accept the term. This simple question has provided a way to "red flag" patients who are distressed beyond the expected. Someone on the cancer care team can then further query patients with distress as to the nature of the problem and, when necessary, formulate an appropriate psychosocial treatment plan, which may include a referral for mental health services, either in the hospital or in the community.

The Institute of Medicine (IOM) built on these first distress management guidelines, finding a strong evidence base for a wide range of psychosocial interventions (psychotherapeutic, behavioral, and psychopharmacologic).[4] Based on the strength of the evidence, the IOM concluded that quality cancer care today must integrate the psychosocial domain into routine cancer treatment. After this decision by the IOM, the American College of Surgeons Commission on Cancer (CoC) added a standard for accreditation for 2015 that requires clinics to develop an onsite psychosocial program to identify patients with distress and triage them to appropriate psychosocial health care resources.[5]

This standard has put pressure on clinics to comply. Implementation of a new procedure is always difficult, but implementation in the psychosocial realm is even harder because it requires the cooperation of all disciplines working in cancer care. The good news is that cooperative efforts are being formulated. For example, the Association of Community Cancer Centers and the American Psychosocial Oncology Society (APOS) are working to provide consultation to cancer centers. Also, there are 2 NCI-funded educational grants to train cancer center staff in all disciplines and from across the country in the "how to" of developing a program to identify and triage patients with distress. One program is in its third year and has trained 132 individuals to provide strategic support using Web-based, onsite, and telephone-based

methods (www.supportivecaretraining.com). The other is beginning its second year and will, by 2016, have trained 54 cancer centers around the country using in-person workshops and follow-up calls of support (www.apos-society.org/screening). These efforts are paying off, but implementation is slow and requires persistence and staff commitment.[6]

Although change is slow, it is clearly happening, and the oncologist, through attitude and participation, plays a major role in the success or failure of any effort to put distress screening and triage to psychosocial health care resources in place for the first time in a clinic or center.

Oncologists Can Help in Multiple Ways

Advocate with staff on the value of screening. As the senior medical professional in the clinic or office, the oncologist is key in providing leadership and enthusiastic support for the development of a screening program that must engage the administrator, nurse, social worker, mental health professional, and chaplain in the planning. This planning phase is critical because it involves changing attitudes and procedures about psychosocial care. The more cohesion that can be attained in this phase, the more likely the success.

Participate in the planning. Most centers are in the planning phase, which must be conducted methodically and by ensuring that all disciplines "buy in," since the program does not belong to one discipline. Adequate care must be taken to assure that each discipline has a role that is defined and clear. Assignment of the new procedures must take into account that there is fair distribution and that the outcome is worth the effort. It is wise to pilot procedures in a small area in order to smooth out the kinks and revise as needed. Leadership from the oncologist is important to ensure the full cooperation of all disciplines.

Create a culture in which innovation is exciting and acceptable. Research on implementation of new policies shows how difficult effecting change is when that change requires altering or adding a new procedure, and particularly when it adds to the workload of team members. This requires the understanding that the goal is worth the time and effort. In addition, many places are developing a program that has dual use as a clinical and research tool, which gives it even greater impetus for implementation.

Recognize that there are no gold standards. Each center has different patient populations and its own mix of disciplines. A new program is free to develop a model that works for its own center; however, using the experiences of other centers is helpful, as more centers are now experimenting with innovative approaches. Contacting the 2 educational programs described previously can be helpful.

Note that patient-centered care is now central to reimbursement, and reimbursement is beginning to depend more on value-driven aspects of care. Adding a routine practice to identify and triage patients with distress early in treatment addresses patient-centered care. It also saves time later when patients' distress levels lead them to make frantic calls and emergency department visits. The prevention of severe distress is an outcome that benefits the patient, saves time and stress for the oncologist and other care providers, improves patient satisfaction, and reduces the costs of visits.

Understand that the oncologist is the center of hope and trust for patients who are frightened and feel vulnerable and uncertain. The more patients sense that the clinician is caring for them as a whole person, the more secure they feel.[7] In a CALGB study conducted in the 1980s patients were asked why they chose to take chemotherapy.[7] Their reply was often simple: "I trusted the doctor" was a key reason.

Mark Lazenby, PhD, APRN

Mark Lazenby, PhD, APRN, is Associate Professor of Nursing at Yale. He holds joint appointments on the Divinity and Middle East Studies faculties. His work centers on bringing whole-patient care to underserved populations. He and colleagues in Botswana are working to put into place routine distress and symptom screening among patients with cancer in Botswana, and he is developing a spiritually sensitive palliative care intervention for Muslims who are in treatment for advanced cancer.

The ideas and viewpoints expressed in this editorial are those of the author and do not necessarily represent any policy, position, or program of NCCN.

Matthew J. Loscalzo, LCSW

Matthew J. Loscalzo, LCSW, is the Liliane Elkins Professor in Supportive Care Programs in the Department of Supportive Care Medicine and Professor in Department of Population Sciences. He is also the Executive Director of the Department of Supportive Care Medicine and the Administrative Director of the Sheri & Les Biller Patient and Family Resource Center at the City of Hope-National Medical Center.

Mr. Loscalzo has held leadership positions at several major academic cancer centers. In, October 2014, he was recognized for a lifetime achievement award in clinical care by the International Psycho-Oncology Society. In August 2015, he received the Jimmie Holland Life Time Leadership Award from the American Psychosocial Oncology Society.

Mr. Loscalzo has more than 35 years' experience caring for cancer patients and families and is recognized internationally as a pioneer in the psychosocial aspects of cancer. Professor Loscalzo was the President of the American Psychosocial Oncology Society and the Association of Oncology Social Workers.

He is the PI on two 5 year NIH R25E training grants and a site PI for a new third R25E. He is also on the editorial boards or a reviewer for a number of professional journals and has over 100 publications. His clinical interests are gender medicine; strengths based approaches to psychotherapies, problem-based distress screening, and the creation of supportive care programs.

Communication that bolsters this sense of caring develops during repeated clinic visits. Patients then begin to feel that the doctors and other care providers "care about me as a person." Early identification of distress helps assure patients that the care provided by their oncologist, as the leader of the oncology team, includes attention to the whole person.

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Special Feature

SupportScreen: A Model for Improving Patient Outcomes

Matthew Loscalzo, MSW;[a] Karen Clark, MS;[a] Jeff Dillehunt;[b] Redmond Rinehart;[b] Rex Strowbridge;[b] and Daniel Smith;[b] *Duarte, California*

Key Words

Biopsychosocial, screening, technology, personalized medicine, clinical efficiency

Abstract

As demands on physician time mount, and patients and families increasingly expect accommodation and understanding of their specific, personal situations, care providers must boost efficiency and minimize the expense of their clinic processes and draw on connections with community resources. Third-party payors may also expect that the biopsychosocial needs of patients and families be addressed as an essential part of cancer care. Quality of care, cost, patient satisfaction, adherence to treatment, safety, and allocation of limited resources are all related to the identification and effective management of the psychosocial elements of cancer care. Experts suggest that health care has lagged far behind other industries in using technology to improve efficiency, and slow adoption of this technology means that critical information about the biopsychosocial needs of patients fails to reach the right professionals in a timely way. Systematic and automated screening can promote physician control in managing time, the efficiency of the clinical encounter, and rapid triage to other professionals and community resources. (*JNCCN* 2010;8:496–504)

Identifying Distress to Enhance Whole-Patient–Centered Care

As many as 47% of cancer patients have been shown to experience emotional distress at the level of a diagnosable psychiatric disorder.[1,2] However, patients have distress that is caused by more than psychiatric problems. Informational, educational, social, psychological, spiritual, financial, and practical problems, in the absence of mental illness, also can cause disabling distress. The psychosocial impact of physical symptoms, alone or in combination with issues such as depression, anxiety, and financial vulnerability, also influence the ability to cope and manage the many demands endemic to the cancer experience. Identifying and managing the biopsychosocial domains may seem to be a time-consuming and daunting task for physicians when they have increasingly less time to spend with patients. This is true in both large academic cancer centers and small community practices.

Several studies show the financial-offsetting advantages of addressing biopsychosocial issues, despite the effort and cost of establishing an automated screening/triage system.[3–5] These include cost benefits to hospitals providing psychosocial care,[3] and the potential for psychological distress screening to predict and intervene in patient treatment noncompliance, appointment-breaking,[4] and clinical trial discontinuation.[5]

The early identification of biopsychosocial problems is essential to relieve distress, prevent crises, and minimize system disruption. Potential barriers preventing identification of these problems include stigma, lack of a common language, health care professional avoidance of emotional content, lack of professional training to acquire this information, and the belief that these problems are less important than physical care. In addition to the barriers endemic to identification and communication of biopsychosocial vulnerabilities, system-based barriers also exist, such as the lack of a standardized comprehensive approach to the identification of biopsychosocial problems. Supported by the literature,[6–8] the NCCN[9] and the Institute of Medicine (IOM) 2007

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Mr. Loscalzo and Ms. Clark have disclosed that they have a financial interest in the sale of this licensed technology via City of Hope. Mr. Dillehunt, Mr. Rinehart, Mr. Strowbridge, and Mr. Smith have disclosed that they have no financial interests, arrangements, or affiliations with the manufacturers of any products discussed in this article or their competitors.

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Report (*Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*)[10] recommend psychosocial distress screening for all patients to address problems before a crisis develops and necessitates higher levels of intervention. An increasing number of screening instruments are now in use, such as the Distress Thermometer[9] and the Edmonton Symptom Assessment Scale.[11]

However, patients may still express considerable hesitation to discuss distress based on social stigma and fear associated with cancer. Although the stigma related to the vulnerabilities of cancer is decreasing, the emotional, psychosocial, psychiatric, and financial problems endemic to cancer have been much more resistant to change. Physicians and nurses, however, can play a major role in encouraging patients to voice illness-related concerns. Instituting biopsychosocial screening for all patients early in the clinical encounter can communicate an openness and sense of hope that patients and families can manage any barriers related to their medical care. In the authors' experience, patients do not expect physicians and nurses to fix all illness-related problems, but do expect them to be knowledgeable about mental health and other essential resources in the community. An efficient and reliable way to identify the essential needs and barriers for patients is through biopsychosocial screening.[9,10] The authors have taken this process a step further by automating biopsychosocial screening through the use of touch-screen technology.[12]

SupportScreen

Improved Patient Outcomes "At Your Fingertips"

The authors' team developed a new touch screen automated program called *SupportScreen* (www.supportscreen.com), based on more than 15 years of screening experience in academic cancer centers and a small community hospital. *SupportScreen* is an inexpensive, patient-friendly automated process that identifies, triages, and provides educational information in real time. This program covers the entire process of biopsychosocial screening, from initiation of patient responses to the generation of referrals and provision of educational information. The program is designed to facilitate patient, physician, and specialist communication and to maximize the effectiveness of clinical encounters and overall cancer care. *SupportScreen* was also designed to run on simple network systems and to be adapted to a variety of settings, including small clinical practices.

From Paper to Automation: Increased Efficiency and Communication

Historically, biopsychosocial screening was performed with paper and pencil, but paper screening tools can be time-consuming for staff to review, analyze, and use to make referrals, limiting their use. In addition, information on paper was not consistently delivered to the physician in time for discussion during the clinical encounter. The authors and others[3,11] have shown that automation can decrease resource intensity while creating systems that provide enhanced timely communication, tailored interventions, clinical summaries, and real-time triage. In the longer term, automation can also create a database that is immediately updated and available. This article discusses the *SupportScreen* tool and the specific benefits it, and other programs like it, can bring to patients and their families, physicians, and clinical settings, as well as how City of Hope integrated it into their systems.

Benefits to Patients and Families, Physicians, and Clinical Settings

Physician time is increasingly consumed with seeing more patients because of decreased reimbursement and with administrative demands, such as authorizations and use review. As a result, physicians spend less time with each individual patient. Research has shown,[13] however, that the quality of the clinical encounter, not just the time spent with the patient, is associated with better health outcomes and higher patient satisfaction. Automated screening programs such as *SupportScreen* have the potential to optimize the time physicians spend with patients.

Patients experience clinical encounters as stressful and emotionally charged. Within this context, patient–physician communication is primarily focused on disease-directed information at the expense of critical biopsychosocial domains. Programs like *SupportScreen* can alert both patients and physicians to barriers to medical care. It can provide a common language, a normalization of problems, and a decrease in concerns about stigma. For the health care team (physicians, nurses, support staff) the information is neatly organized and documented electronically, and provides cues for referrals to other services in real time.

Table 1 Potential Benefits of *SupportScreen*

For Patients and Families	For Physicians and Staff	For Clinical Settings/Institutions
• Provides a user-friendly electronic interface	• Increases control over the clinical encounter	• Raises the standard of clinical care
• De-stigmatizes requests for help	• Maximizes efficiency of the time spent taking a history and physical	• Increases patient satisfaction
• Teaches patients about common problems	• Reduces time needed to anticipate and manage barriers to medical care	• Minimizes disruption of clinic processes and systems
• Gives patients a voice and common language to partner with their health care providers	• Avoids distraction on areas outside of medical expertise	• Increases patient safety
• Identifies barriers to medical care	• Assures communication among multispecialists	• Decreases clinic no-shows
• Gives sense of control, direction, and plan of action	• Enhances medical charting through automated links to ICD-9 codes	• Automates identification and triage to other institutional services
• Tailors education materials printed out in real time	• Screens all patients quickly and efficiently as standard of clinical care	• Increases revenue through automated links to ICD-9 codes
• Enhances communication and trust with health care team	• Enhances communication and trust with patient	• Maximizes internal resources
• Prioritizes immediate needs	• Identifies high-risk patients for disruption of clinic processes	• Creates linkages to external community resources
• Accelerates timely referrals to supportive services	• Identifies high-risk patients for lack of compliance	• Reduces administrative costs
• Tailors support services	• Automates, summarizes, and prioritizes problems	• Increases staff efficiency
• Raises the expectations of psychosocial services being provided	• Streamlines triage and referral to appropriate resources	• Increases staff satisfaction and retention
• Improves continuity of care	• Reduces data entry and verification burden	• Serves as model for other institutions
	• Provides invaluable data for grants, publications, and program development	• Enhances competitiveness in the market place
	• Exports easily to commonly used software applications	• Creates funding opportunities
	• Creates more efficient data interpretation	

The benefits patients and families, physicians, nurses, and other health care professionals may derive from *SupportScreen* are shown in Table 1. Although this program focuses on patients with cancer, the implications for other chronic illnesses are transparent. People dealing with serious illness must be able to effectively communicate with their health care team to adapt to the reality of illness, make difficult decisions, identify barriers to care, and actively participate in rehabilitation and palliation. Programs like *SupportScreen* can become the foundation for an evolving partnership through systematic electronic communication among patients, their primary health care team, and the specialists involved in their medical care.

Automating Processes in the Clinic

SupportScreen is an automated touch-screen system (See Figure 1) that identifies, summarizes, and triages patient biopsychosocial problems in real time. It can facilitate patient, physician, and specialist communication through an electronic interface built to be user-friendly and compatible with most standard patient software systems. *SupportScreen* also provides customized reports for clinical, educational, and research purposes. Figure 2 outlines the screening process in the clinic, and Table 2 details the specific features as they relate to professional users.

Patient-Friendly Content

The content of *SupportScreen* is based on screening data (both paper-based[14–16] and electronic[11]) from more than 10,000 cancer patients. The present 53-question screening instrument uses simple language to address the most common physical, practical, social, psychological, nutritional, physical rehabilitation, and spiritual problems encountered by patients with cancer.[17] Depending on the focus and resources of the clinic setting, items can be modified, added, or deleted. The language is patient-friendly and has been tested in various clinical settings to en-

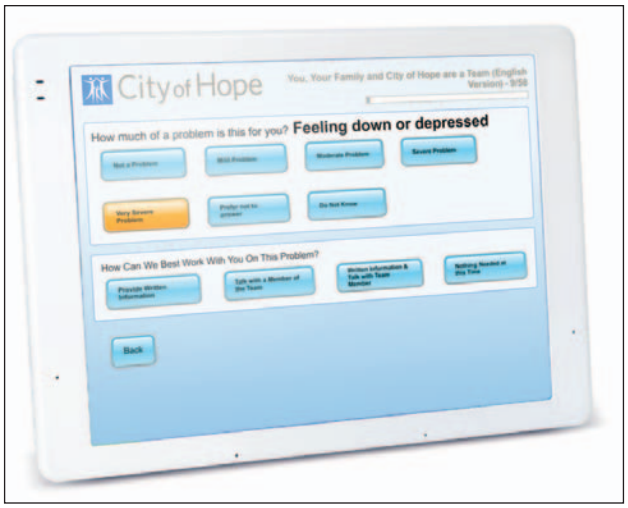

Figure 1 *SupportScreen* Tablet.

sure that the content is easily understood and relates directly to the question being asked. According to the Flesch-Kincaid readability test, the content of *SupportScreen* items scores at a fourth-grade reading level.[18] Patients are given the opportunity to rate how much of a problem each of the 53 items is on a 5-point scale from *Not a Problem* to *Very Severe Problem* (Table 3). In addition, patients are asked if they are requesting to *Talk with a Member of the Team*, to have the team *Provide Written Information*, or *Nothing Needed at this Time*. *SupportScreen* is presently available in English and Spanish and takes approximately 15 to 20 minutes to complete.

To minimize patient and staff burden, demographic variables are prepopulated in the screening database from the medical record system to avoid a need to repeat basic patient information. To help the patient understand the context and value of the screening process, a standard introductory letter from the patient's physician appears on the first screen of *SupportScreen*. The letter includes a picture of the physician or team, and explains how the screening process can enable the patient to partner with the health care team and that the information can be helpful in planning care. Finally, the introductory letter guides the patient to start *SupportScreen* by pushing the *Touch Here To Begin* button.

Items are framed to reflect how most people relate to common problems and challenges of daily life in order to provide a sense of comfort and hope based on patients' ability to solve problems in the past. In this context, *SupportScreen* identifies specific problems and, importantly, helps determine patients' perception of their ability to manage problems. The number and types of problems and the perceived ability to manage these problems are related to levels of overall distress. Being able to label specific problems in common language in itself can help reduce distress. Patients with a history of poor problem-solving or who believe that they are poor problem-solvers will require additional psychosocial support.[19,20]

The City of Hope Model: Identifying and Summarizing Barriers to Medical Care

At City of Hope, a process was implemented that can serve as a model for other settings. Consecutive patients seen in the outpatient clinics complete *SupportScreen* as the standard of care before meeting with the physician. As a result of patients' answers, the system generates 5 potential outputs in real time: 1) a summary report for the physician (printed and/or electronic); 2) tailored, written educational information for patients; 3) personalized resources for patients; 4) criteria-driven referrals to professionals and community-based resources; and 5) individual patient responses recorded into a database for analysis.

The summary report, tailored educational information (e.g., talking with your doctor, fertility), and personalized resources requested (e.g., transportation, finances) are automatically printed immediately after completion of the questions. An e-mail of the summary report is simultaneously sent to the patient's primary care physician and other health care team professionals as indicated. The report is designed for easy identification of problems requiring timely intervention. *SupportScreen* is modifiable to identify problems or symptoms requiring immediate attention; for example, *Thoughts of ending my own life* and *Pain* can be programmed as "hot buttons." This enables the physician to focus on the concerns that are most salient during clinical encounter.

The summary report information is filed in the medical chart and individual patient responses are recorded electronically into a database for analysis. The raw data are available on a secure password-protected server and can only be accessed through a Web-based administrative screen. The system can also generate a cumulative report, which includes basic frequencies of 5 categories: 1) patient demographics; 2) problems that are distressing (rated ≥ 3); 3) patients who want to *Talk with a Member of Team*; 4) patients who request *Provide Written Information*;

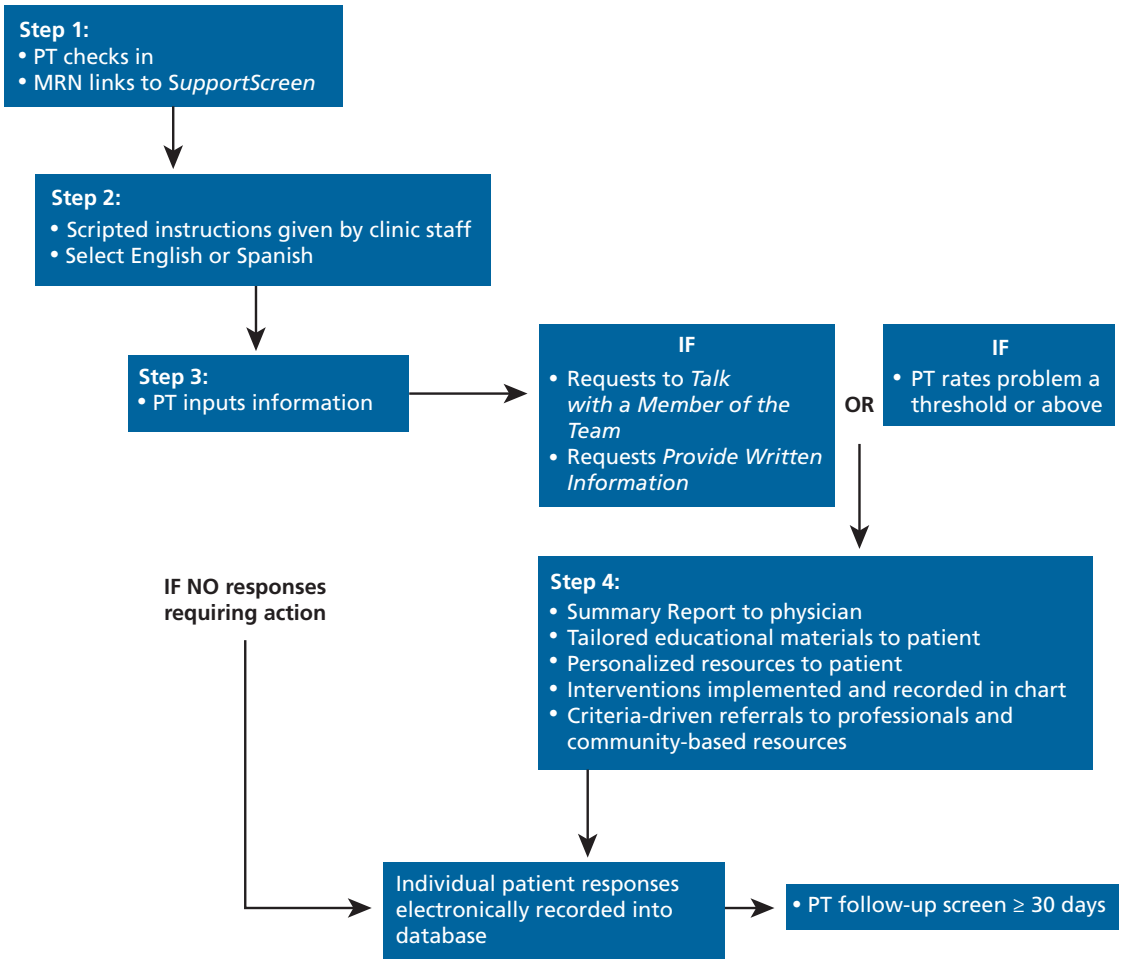

Figure 2 *SupportScreen* in action.
Abbreviations: MRN, medical record number; PT, patient.

and 5) patients who both want to *Talk with a Member of Team* and request *Provide Written Information*.

Using Technology to Enhance Personalized Medical Care

SupportScreen automates the triage and referral process using criteria determined by the physician and health care team. The primary physician is still able to manage all referrals to consultants whenever necessary. Triage and referral criteria are based on the specific needs of patients, current resources available, and staffing levels. In *SupportScreen*, each item is precoded and electronically transmitted to a specific professional or resource in real time. In addition, a copy of the notification is sent to the patient's physician, nurse, and social worker to ensure effective ongoing communication.

SupportScreen is designed to be flexible and easily changed to direct the electronic triage and referral information. At City of Hope, the NCCN Clinical Practice Guidelines in Oncology: Distress Management[9] (in this issue; to view the most recent version of these guidelines, visit the NCCN Web site at www.NCCN.org) are one source of information used to develop the triage, referral, and intervention processes.

Each item on *SupportScreen* is linked to one or more specific professionals. For example, a pain distress level of 4 or greater is immediately sent to the identified physician, nurse, and social worker. Problems related to physical symptoms such as nausea or recent weight change are referred to a physician and/or nurse. Problems related to emotional, social, and practical concerns, such as *Feeling down or depressed* or *Feeling hopeless*, are triaged to a social worker for assessment and potential referral to psychology or psychiatry.

Each designated health professional is copied on all e-mails regarding the patient. This electronic transfer of information helps ensure timely commu-

Table 2 *SupportScreen*: Features and Professional Users at City of Hope

Features of SupportScreen
Automated Features
Summary Report for physician, printed and electronic
Tailored educational written information, printed
Personalized resources, printed
Interventions implemented and recorded in chart
Criteria-driven referrals to professionals and community-based resources
Individual patient responses electronically recorded into a database for analysis
Customized reports (i.e., diagnosis, stage, demographics)
Re-screen alert (≥ 30 days)
Ongoing improvement feedback mechanism for all users
Security Features
Controlled levels of access
Firewall protected
Medical record number encrypted
Patient security: requires medical record number, patient name, and date of birth
Database Features
Clinical research
Data easily exportable
Prepopulated demographic and clinical information
Professional Users
Primary Health Care Team
Physicians
Nurses
Social workers
Consultants
Clinical nutritionists
Cosmetologists
Health educators
Patient navigators
Pain and palliative care team
Psychologists
Psychiatrists
Physical therapists
Pharmacists
Researchers
Spiritual counselors

nication and clear delineation of responsibility for follow-up. This is especially important given the difficulty in maintaining ongoing and consistent communication with the number of specialists potentially involved in the patients' care. However, the authors' experience in screening patients with cancer suggests that most requests for assistance relate to educational materials that can be now provided automatically by *SupportScreen*.

Most triage and referrals do not require immediate attention; these can almost always be addressed within a reasonable time. Additionally, most actions required by *SupportScreen* are addressed by the psychosocial team and nursing. At City of Hope, only 15% of the items are triaged to the physician for attention.

A Model for Transprofessional Practice in Patient-Centered Care

Any biopsychosocial screening process must be tailored to the individual needs of the clinical setting. City of Hope has made elevating whole-patient–centered care part of its strategic plan. The construction of the Sheri & Les Biller Patient and Family Resource Center (Biller Resource Center) and the creation of the Department of Supportive Care Medicine are manifestations of this commitment. Creating the "best program of supportive care services in the world" is the vision statement for the department.

The Biller Resource Center was started with seed money from philanthropists Sheri and Les Biller. This contribution was based on a long-term commitment by City of Hope to create a comprehensive integrated program of psychosocial and palliative care services. The goal was to unite and integrate compassionate professionals who had expertise in helping patients, families, faculty, and staff to manage the challenges of serious illness and find personal meaning in the experience.

To better focus on the needs of patients, all supportive care services were brought under one departmental infrastructure. Highly interactive relationships with other departments were also built, regardless of administrative governance. All programs and professional interactions are based on the direct and indirect benefits of the clinical, research, and educational programs on patients and families. To ensure improvement and maintain a focus on the mission, systematic program evaluation is at the core of all departmental initiatives.

City of Hope subsequently created the Department of Supportive Care Medicine and recruited a chair to advance the academic foundation for

Table 3 *SupportScreen* 53-Questions Screening Instrument*

Problems	
• Ability to have children	• Needing practical help at home
• Becoming too ill to communicate my choices about medical care	• Pain
• Being unable to take care of myself	• Physical appearance
• Bowel movement/constipation	• Providing care for someone else
• Controlling my urine or stool	• Questions and fear about end of life
• Eating, chewing, or swallowing difficulties	• Recent weight change
• Fatigue (feeling tired)	• Seriously considering taking my own life
• Fear of medical procedures	• Sexual function
• Feeling anxious or fearful	• Side effects of treatments
• Feeling down or depressed	• Sleeping
• Feeling hopeless	• Solving problems because of my illness
• Feeling irritable or angry	• Speech
• Feeling isolated, alone, or abandoned	• Spiritual or religious concerns
• Finances	• Substance use: you or your environment
• Finding community resources near where I live	• Swelling
• Finding meaning or purpose in my life	• Talking with doctor
• Finding reliable information about complementary or alternative practices	• Talking with family, children, and friends
• Getting medicines	• Talking with the health care team
• Health insurance	• Talking with the health care team about use of food/herbal supplements while on treatment
• How my family will cope	• Thinking clearly
• Joint limitations	• Tobacco use
• Losing control of things that matter to me	• Transportation
• Managing my emotions	• Understanding my treatment options
• Managing work, school, or home life	• Understanding the importance of physical activity even during treatment
• My ability to cope	• Walking climbing stairs
• Nausea and vomiting	• Worry about the future
• Needing help coordinating my medical care	

*Items can be added, modified, and/or deleted, and tailored to the individual setting.

the program. The authors believe this patient-centered—rather than profession-centric—paradigm of transprofessional care more accurately reflects the way patients and families experience the need for services.

Patient-centered care is also built into the *SupportScreen* system at many levels. Although the program can identify problems and link patients to the support and education they need on an individual level, programs are also available to systematically evalutate the patient and family experience at a macro level across the entire health care system. For example, a Patient Advisory Council meets monthly to bring in the patient and family experience to better-inform programs and processes within the wider hospital system. The Patient Advisory Council is a consistent voice for the patient and family perspective—part focus group and part committed consultants—and has been found to be honest, frank, and helpful. Having patient and family involvement from the beginning, and at this level of detail, has been invaluable to the success of this program.

The Biller Resource Center is also designed to serve as the focal point of whole-patient care. It is strategically located at the center of the hospital's main lobby. Disease and treatment information, education, counseling, advocacy, mental health, palliative care, and spiritual services are all available in

one place. Navigators, health educators, psychiatrists, psychologists, social workers, palliative care physicians, nurses, spiritual care counselors, cosmetologists, program evaluators, researchers, and volunteers all use the Biller Resource Center as a nexus. It is also a place to learn about and provide consent for clinical trials. In addition, nurses are available to help patients and family members search the Internet to retrieve and interpret scholarly articles. As an added benefit, patients, families, and community members have formed spontaneous, natural support groups while waiting to meet with professionals or search the Internet. The *SupportScreen* program serves as the connective tissue for these supportive care services.

Conclusions

Whole-person patient-centered care creates a supportive environment where patients and their families, caregivers, and health care professionals can work together as partners. Because of the ever-increasing demands on physician time and heightened expectations of patients and families, health care professionals must use technology to maximize the limited time of the clinical encounter.

Systematic screening automates processes that enhance physician control, efficiency of the clinical encounter, quality of care, patient satisfaction, adherence to treatment, and safety, and makes an essential connection to supportive care services. Automating screening also decreases disruptions to the clinic setting, misuse of physician and staff time, unnecessary suffering of patients and families, and staff-related distress resulting from the unmet supportive care needs of patients and families.

Based on a history of screening experience in multiple settings, the authors developed *SupportScreen* to be a model of biopsychosocial screening for whole-patient–centered care, from initiation of patient responses to the generation of referrals and provision of educational information. *SupportScreen* facilitates patient, physician, and specialist communication and is designed to maximize the effectiveness of clinical encounters and overall cancer care. The program is easily adaptable to a wide variety of clinical settings and has implications for the development of tailored educational programs and for research. The cost of the program depends on the number of licensed sites and users and the extent of the training, support, and other services, but generally ranges from $15,000 to $40,000 per year.

Therapeutic relationships between patients and their health care providers is being redefined by technology and proposed major changes in the health care system. The speed of technological advances is only expected to increase, but ultimately caring for and healing patients will always be about trusting and respectful relationships. Screening for problems such as distress creates an environment in which communication and unified action leads to a sense of direction and connection that promotes whole-patient–centered care and improved outcomes.

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Identifying and Addressing Distress in the Older Adult

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Navigating the Medical-Legal Concerns in the Care of Older Adults

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Objectives:

1. To illustrate the impact of the socio-legal challenges faced by older individuals living with cancer
2. To increase knowledge among oncology nurses of existing federal and state laws that can equip them to be effective advocates for their aging patients, focus on advance directives, elder abuse and neglect, and financial concerns.
3. To provide a platform for open discussion of the challenges faced by aging patients living with cancer and to utilize case presentations to cement attendees' understanding of how to navigate the legal terrain to assist their patients

Things I Want to Remember:

Navigating the Medical-Legal Concerns in the Care of Older Adults

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Community Legal Resources for the Older Adult with Cancer

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Disability Rights Legal Center – Cancer Legal Resource Center

Objectives:

1. Recognize legal issues that geriatric oncology patients face
2. Identify community resources available to assist geriatric oncology patients with legal issues they face

Things I Want to Remember:

Community Legal Resources for the Older Adult with Cancer

Resource	Contact
Cancer Legal Resource Center (CLRC)	www.cancerlegalresourcecenter.org
CLRC National Telephone Assistance Line	www.clrcintake.org /1-866-THE-CLRC (1-866-843-2572)/
CLRC Webinars	www.youtube.com/CancerLRC
Local State Health Insurance Assistance Program (SHIP) Office	www.shiptacenter.org
Medicare Rights Center	www.medicarerights.org
Local Legal Aid organization	www.lsc.gov
US Department of Housing and Urban Development	1-800-569-4287 www.hud.gov
AARP Foundation	1-800-209-8085
National Housing Law Project	www.nhlp.org
Free Advance Directive forms for every state	www.caringinfo.org
End of life counseling	www.compassionandchoices.org
American Cancer Society "Road to Recovery"	www.cancer.org
National Patient Travel Center	www.patienttravel.org
Area Agency on Aging	www.n4a.org
Elder Care Locator	www.eldercare.gov
American Associate of Retired Persons	www.aarp.org
Caregiver Action Network	www.caregiveraction.org
Family Caregiver Alliance	www.caregiver.org
Lotsa Helping Hands	www.lotsahelpinghands.com
NeedyMeds	www.needymeds.org

Cancer Legal Resource Center
A DRLC PROGRAM

DIRECT LINE: 866-THE-CLRC (866-843-2572)
ONLINE INTAKE FORM : www.CLRCintake.org
EMAIL: CLRC@DRLCenter.org
Fax : 213-736-1428
Video Relay Phone : 213-908-1079
www.CancerLegalResourceCenter.org

National Financial Assistance Resources

The Cancer Legal Resource Center (CLRC) has designed this information sheet to answer commonly asked questions regarding the availability of possible financial assistance. However, this handout may be just a starting point for you to find out additional information. Please feel free to contact the CLRC at (866) THE-CLRC if you need additional information or to answer other questions you may have.

The American Cancer Society (ACS) is a nationwide, community based, voluntary health organization. With over 3,400 local offices, the ACS provides information on all aspects of cancer through its toll-free information line (800) ACS-2345, website at www.cancer.org and through published materials.

To find financial assistance resources in your area:

(1) Log on to www.cancer.org, click 'Find Support & Treatment' in the middle of the homepage, and under 'Find Support & Treatment Topics' click 'Find Support Programs and Services in Your Area'
(2) Click 'Search for Support Programs and Services in Your Area" and type in your zip code or city in the prompt box, and then click 'SEARCH.'
(3) You can also narrow down the type of resources you are looking for under "Program Type"

If you have additional questions, simply call the ACS toll free information line at (800) ACS-2345 and ask specifically about financial assistance resources available in your area.

Cancer*Care* is a national non-profit organization that provides free professional support services to anyone affected by cancer including patients, caregivers, children, loved ones and the bereaved. Cancer*Care* programs include counseling, education, and financial assistance.

Cancer*Care* typically provides financial assistance in two ways: The Cancer*Care* Co-Payment Assistance Foundation provides help for those who cannot afford their medication co-payments. Please check their website for covered diagnoses and medications. Cancer*Care* also provides limited financial assistance to help with the costs of treatment-related transportation, child care, and home care, for all types of cancer. Financial assistance does not cover basic living expenses like rent, mortgages, utility payments, or food. To qualify, and individual must have a diagnosed cancer and be in active treatment. An applicant must also meet Cancer*Care's* income guidelines. An applicant must call for a brief interview and submit an application. You can view the application online but must call in order to apply.

To apply for CancerCare's financial assistance:

Call toll free (800) 813-HOPE (4673); or visit www.cancercare.org

Beginning **August 6,** 2013 CancerCare will only accept requests for assistance for men who meet one of the following criteria:

1. Men diagnosed with **multiple myeloma** (through our Door-to-Door program) in all 50 states and Puerto Rico.
2. Men who **reside in the five boroughs of NYC**: Manhattan, Bronx, Brooklyn, Queens or Staten Island.
3. Men residing in **San Diego** and **Imperial counties in California**.

AVON FOUNDATION

AVON Cares Program for Medically Underserved Women provides financial assistance to low-income and uninsured women throughout the country. The Avon Cares program will provide the following service for women in the United States and Puerto Rico with breast or gynecological cancer and their families: financial assistance, emotional support for individuals and families, education and outreach, information about cancer and treatment, and referrals to other services. AVON Cares also offers patient navigation one-on-once coordination with a bicultural, bilingual patient navigator.

Individuals must be in active treatment or within a year of active treatment of some kind. For information on the AVON Cares, **contact CancerCare at 1-800-813-HOPE (4673) or visit** www.cancercare.org.

Susan G. Komen FOR THE CURE

Through a partnership between Susan G. Komen for the Cure and CancerCare, qualified, low income, under-insured or uninsured breast cancer patients may be eligible for financial assistance under the **Linking A.R.M.S**. program. Grants to cover the costs of oral cancer treatment medications, pain and anti-nausea medications, lymphedema support and supplies, prostheses, and durable medical equipment may be available. There are no citizen or residency requirements, and services are offered in English and Spanish. **For more information call toll free (800) 462-9273 or visit** www.cancercare.org**. For the Linking A.R.M.S. program, call (800) 813-HOPE.**

PSI Making the gift of health a lifetime benefit.®

Patient Services Incorporated (PSI) is a non-profit organization dedicated to subsidizing the high costs of health insurance premiums and pharmacy co-payments for individuals with a very limited number of specific chronic illnesses and rare disorders. Through private and corporate donations, PSI offers assistance to families based on the severity of the medical and financial need. PSI also has a breast cancer screening program for women with a family history of breast cancer or who

have tested positively for the BRCA gene mutation and financial assistance for an MRI. **To request an application, call toll free (800) 366-7741.** If approved, assistance will be granted for a maximum of two years pending the availability of PSI funds. For more information, visit www.patientservicesinc.org/.

PATIENT ADVOCATE FOUNDATION
CO-PAY RELIEF

The Patient Advocate Foundation Co-Pay Relief program offers personal services to patients diagnosed with breast cancer, kidney cancer, lung cancer, prostate cancer, sarcoma, and muscular degeneration. Assistance may also be available to patients who are experiencing secondary issues as a result of cancer treatment.

The Co-Pay Relief program offers personal services to all patients through the use of call counselors. These counselors will assist you throughout the entire application process and screen for eligibility (by collecting financial and medical information) from everyone who calls to apply for the program. **For information about this Co-Pay Relief program, log on to www.copays.org.**
To find a comprehensive list of resources for specific types of cancer:

(1) Call toll free (800) 532-5274 or (866) 512-3861; or
(2) Log on to www.patientadvocate.org, click on 'Resources,' then click on 'National Financial Resources Guide'

COLORECTAL CareLine

Patient Advocate Foundation's Colorectal CareLine is a patient/provider hotline designed to provide assistance to patients who have been diagnosed with colorectal cancer and are seeking education and access to care. **For more information about the Colorectal CareLine, log on to www.colorectalcareline.org or call (866) 657-8634.**

LIHEAP

If you are having difficulties paying your utilities, your local **Low Income Home Energy Assistance Program** (LIHEAP) may be able to assist you with bill payment. The program also assists families with bills related to energy crises, weatherization and energy-related minor home repairs. **To apply, contact the LIHEAP program in your community or call the National Energy Assistance Referral Project at toll free (866) 674-6327 for more information.**

The Leukemia & Lymphoma Society®
Fighting Blood Cancers

The Leukemia & Lymphoma Society offers patients who reside in the United States and Puerto Rico and have difficulty paying for or simply cannot afford their private or public health insurance premiums or co-pay obligation, a possibility that they may be eligible for this program. It is available to patients with chronic myelogenous leukemia, chronic lymphocytic leukemia, Hodgkin lymphoma, Non-Hodgkin lymphoma, myelodysplastic syndromes, Myeloma, and Waldenstrom macroglobulinemia. Individuals must meet strict financial guidelines in order to be eligible. **To apply, contact the Co-Pay Assistance Program at (877) 557-2672 or contact the information resource center at (800) 955-4572 or log on to** www.lls.org/copay **or email** copay@lls.org

HEALTHWELL FOUNDATION®

The **HealthWell Foundation** provides copayment and premium payment assistance to eligible individuals. This means that if you've been prescribed a medication, but are unable to afford the copayment required by your insurer, they may be able to help by paying some or all of your copayment. Also, if you are eligible for health insurance, but cannot afford the insurance premium, they may be able to help by paying some or all of your insurance premium. They are currently able to provide assistance to patients undergoing treatment in several disease areas. **To apply for the program log on to** www.healthwellfoundation.org**. For questions, contact the HealthWell Foundation at (800) 675-8416.**

Patient Access Network foundation

The **Patient Access Network Foundation** is a non-profit 501(c)(3) organization dedicated to supporting the needs of patients that cannot access the treatments they need due to out-of-pocket health care costs. **To apply, call (866) 316-PANF (7263) or visit** www.panfoundation.org**.** A Patient Access Network Foundation counselor will work with you directly to assist you in completing the application and assess your eligibility for assistance. Individuals must meet certain financial, insurance, and medical criteria to be eligible.

BE THE MATCH®

The **National Marrow Donor Program** (NMDP) offers financial assistance through its Be The Match Foundation Patient Assistance Program (the fund-raising partner of the NMDP). The Patient Assistance Program helps patients pay for searching the NMDP Registry and/or for some post-transplant costs. Applications for Patient Assistance Program funds must be submitted by an NMDP transplant center. Eligible patients may ask their transplant center coordinator to apply for one or both programs (search assistance and/or transplant support assistance). **For more information, call (888) 999–6743 or log on to** www.bethematch.org/patient

United Way

United Way engages the community to identify the underlying causes of the most significant local issues, develops strategies and pulls together financial and human resources to address them, and measures the results. **To apply for financial assistance, log on to** www.unitedway.org**.**

The **Association of Jewish Families and Children's Agency** is a vital force in Jewish life; providing social and human services to the most vulnerable in our community. **For more information, call (410) 843-7573 or (800) 634-7346 or log on to** www.ajfca.org**.**

The **Cancer Fund of America** helps cancer patients by providing items such as liquid nutritional supplements and vitamins, lotions and ointments, food items, various medical supplies, and non-prescription medicine, toys, clothing, and hygiene items. **For more information, visit** www.cfoa.org **or call (800) 578-5284.**

The **Chronic Disease Fund** is a nonprofit charitable organization that helps underinsured patients with chronic disease, cancer, or life-altering conditions obtain the expensive medications they need. They assist patients throughout the United States who meet income qualification guidelines and have private insurance or Medicare Part D plan but cannot afford the co-payments for their specialty therapeutics. **For more information, visit https://patientsandpros.cdfund.org// or call (877) 968-7233.**

The **National Leukemia Research Association** provides financial assistance to leukemia patients of all ages for x-ray therapy, chemotherapy, and leukemia drugs, as well as for laboratory fees associated with leukemia. **For more information, visit** www.childrensleukemia.org **or call (516) 222-1944.**

HelpHOPELive provides fundraising assistance to cancer patients in need of transplants. Additionally, the HelpHOPELive provides fundraising guidance and some financial assistance. **For more information, visit** www.helphopelive.org **or call (800) 642-8399 or (610) 727-0612.**

Sensational in Survival provides financial assistance, essential services and quality life enhancements during treatment to those battling breast cancer and living in the Rodchester, New

York area. They provide grants for financial support for housing, utility expenses, transportation, groceries, wigs and pharmacy co-pays. **For more information, visit** http://www.helpsis.org **or call (585) 662-5812.**

Modest Needs provides assistance for small, emergency expenses which an individual could not have anticipated or prepared for. **For more information, visit** www.modestneeds.org **or call (212) 463-7042.**

The **Cancer Financial Assistance Coalition** (CFAC) is a coalition of organizations helping cancer patients manage their financial challenges. Patients can search their online resource directory to find assistance based on their diagnosis or the type of assistance they are looking for. **For more information, visit** www.cancerfac.org/.

The **National Foundation for Transplants** (NFT) provides fundraising for transplants. Their trained fundraising consultants help patients raise money to help with transplant expenses. The NFT can help with different costs related to transplant procedures including hospital bills and deposits, doctors' appointments, pharmacy needs, caregiver expenses, insurance premiums, temporary mortgage assistance, travel, food and lodging expenses, and co-pays. Since its founding, NFT's fundraising campaigns have raised almost $60 million to assist patients with transplant procedures. **To sign up for the NFT's fundraising assistance program, contact them at (800) 489-3863 or email** info@transplants.org**. You can also fill out an application on their website** www.transplants.org.

The **Assistance Fund** offers financial assistance programs to patients diagnosed with critical or chronic illnesses. Applicants must be US citizens or permanent residents and meet financial criteria. **To apply to one of their programs, visit** www.theassistancefund.org **or call (855) 845-3663.**

Triple Step Toward the Cure provides financial assistance to women undergoing treatment for triple negative breast cancer. They can provide financial support for meal delivery services, emergency funds for rent, groceries and utilities, transportation related to treatment, housekeeping services, childcare, co-pay assistance, prosthetics and wigs. **You can fill out an application online at** www.triplesteptowardthecure.org **or call (510) 562-1889 or (424) 258-0313.**

Sisters Network is committed to increasing local and national attention to the devastating impact that breast cancer has in the African American Community. Their Breast Cancer Assistance Program (BCAP) provides financial assistance for medical related lodging, co-pay, doctor's appointments, mammograms, and prosthetics**. To download an application visit** www.sistersnetworkinc.org **or call (718) 781-0255 for more information.**

The SAMFund provides young adult cancer survivors with tools and resources to overcome financial challenges and more forward with their lives. Since 2005 they have awarded $900,000 in grants to hundreds of young adults throughout the country. They also offer free webinars on a variety of topics including reducing medical debt, family building options, and employment challenges. The 2013 grant application process will open in June. Patients must be between the ages of 17 and 35, finished with active treatment, and residents of the United States. **Visit** www.thesamfund.org **for more information.**

The **Lois Merrill Foundation** funds research for new treatments, provides financial support for patients and their families, and promotes awareness and education for rare cancers, but carcinoid cancers are its main focus. **Medical Assistance Grants** provide patients with medical expense assistance. This grant is based on financial need. The foundation accepts applications year-round but only reviews applications once a year. The next grant review deadline is July 1, 2013. **Foundation Assistance Grants** provide non-profit organizations with funds to support research and education in conjunction with the goals of the foundation. For an application, go to www.thelmf.com/ or email info@theloismerrillfoundation.org.

Assistance with Medications

NeedyMeds is a non-profit information resource that seeks to find assistance programs to help patients afford their medications and costs related to health care. The NeedyMeds Drug Discount Card can be used by people with or without insurance and get help reduce medication costs. There are no income, insurance, or residency requirements, and no fees or registration process needed to use the card. **For more information go to** www.needymeds.org **or call 1-800-503-6897.**

The Partnership for Prescription Assistance helps qualifying patients without prescription drug coverage get medications free or at a lower cost. You can apply online at www.pparx.org or call 1-888-4PPA-NOW or 1-888-477-2669.

RxHope helps patients obtain free or low-cost medications. **You can fill out a patient assistance request on their website www.rxhope.com or call (877) 267-0517.**

RxAssist offers a free comprehensive database of patient assistance programs fun by pharmaceutical companies. These programs provide free medications to patients who cannot afford to buy their medicine. **To access the database, visit www.rxassist.org.**

Together Rx offers a free prescription savings card for patients who are not eligible for Medicare, do not have prescription drug coverage, and meet income eligibility levels. Cardholders generally save between 25 and 40 percent on their prescriptions. To enroll in the program visit www.togetherrxaccess.com or call (800) 444-4106

Food Assistance

The **Supplemental Nutritional Assistance Program** (formerly known as Food Stamps) helps low-income individuals and families buy the food they need for good health. You apply for benefits by completing a state application form. Benefits are provided on an electronic card that is used like an ATM card and accepted at most grocery stores. **For more information, visit www.fns.usda.gov and to apply contact your local SNAP office of call your state's SNAP hotline. Some states also allow you to apply online.**

Meals on Wheels provides home-delivered meals and services to seniors. **For more information or to find a local affiliate, visit www.mowaa.org or call 1-888-998-6325**

Feeding America network provides food assistance to more than 25 million low income people facing hunger in the US. They have a network of more than 200 food banks serving all 50 states,

the District of Columbia and Puerto Rico. **For more information, visit** www.feedingamerica.org **or call (800) 771-2303.**

Credit and Medical Debt Counseling

Families USA is a national nonprofit dedicated to the achievement of high-quality, affordable health care for all Americans. They have a free, online consumers guide to coping with medical debt that can be found at: http://familiesusa.org/product/shortchanged-medical-debt.

The National Foundation for Credit Counseling is the nation's largest financial counseling organization. The NFCC Member Agency Network includes more than 700 community-based offices located in all 50 states and Puerto Rico. More than three million consumers annually receive financial counseling and education from NFCC Member Agencies in person, over the phone, or online. **To locate an NFCC Member Agency in your area call 800-388-2227 or visit** www.nfcc.org.

Medical Billing Advocates has advocacy programs, consumer education programs, and expert advocates focused on the healthcare industry. Their website connects patients with private companies or individuals for hire that work with medical providers on their behalf to get their bills reduced. They can help people find errors or overcharges in your medical bills, appeal coverage denials with insurers, or negotiate lower fees with medical providers. **For more information visit** www.billadvocates.com

Nursing Initiatives at Hartford Institute: Nursing Making a Difference

Mathy Mezey, EdD, RN, FAAN

Objectives:

1. Describe the relevance of geriatric assessment
2. Identify how to use the Hartford Institute *Try This* Series
3. Describe the purpose of the NICHE hospitals
4. Identify aspects of inter-professional practice

Things I Want to Remember:

HARTFORD INSTITUTE FOR GERIATRIC NURSING
NYU RORY MEYERS COLLEGE OF NURSING

The Hartford Institute for Geriatric Nursing (HIGN)

Since its start in 1996, the singular mission of the Hartford Institute has been to shape the quality of health care of older adults. The commitment to this mission exhibited by the dedicated Hartford Institute leadership, staff and affiliate organizations has made the HIGN today a globally recognized geriatric presence. The Hartford Institute for Geriatric Nursing is the geriatric arm of the NYU Rory Meyers College of Nursing, and has become, over the years, a beacon for all those who wish to advance geriatric care through nursing leadership and interprofessional team care.

Learn more about our programs on HIGN.org.
Access our tools and resources on our
clinical website www.ConsultGeri.org!

Resources on ConsultGeri.org include:

- **Try This® Assessment Series:** evidence-based geriatric assessment tools (https://consultgeri.org/tools/try-this-series)
  - ✓ General Assessment Series
  - ✓ Dementia Assessment Series
  - ✓ Specialty Practice Assessment Series
  - ✓ Quality Assurance and Performance Improvement in Healthcare for Older Adults Series
- **Primary Care of Older Adults Program (PCOA) Series**: e-Learning modules to improve the knowledge and skill sets of primary care providers, RNS and the interprofessional team with patient- and family-centered and evidence-based care that is responsive to the particular needs of older adults
- **Interprofessional Education and Practice (IPEP) ebooks**
- **Oral Health Webinars: in partnership with OHNEP and NICHE**
- **ConsultGeri iPod and iPad Apps**: Covering topics such as Delirium, Agitation, Confusion, Fall Prevention and Post Fall Evaluation
- **Gerontological Nursing Certification Review Course**
- **Geriatric Interdisciplinary Team Training- GITT Kit and GITT 2.0: Inter-professional Resources** Developing teams of professionals to manage the complex health care issues of older adults
- **Geropsychiatric Nursing Initiative:** online learning modules coverings topics such as Depression and Delirium Modules
- **Evidence Based Nursing Protocols**
- **And much more!**

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Best Practices in Nursing Care to Older Adults with dementia

alzheimer's association

From The Hartford Institute for Geriatric Nursing, New York University Rory Meyers College of Nursing, and the Alzheimer's Association

Issue Number D2, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
New York University Rory Meyers College of Nursing

Assessing Pain in Older Adults with Dementia

By: Ann L. Horgas, RN, PhD, FGSA, FAAN, University of Florida College of Nursing

WHY: Pain in older adults is very often undertreated, and it may be especially so in older adults with severe dementia. Changes in a patient's ability to communicate verbally present special challenges in treating pain, since self-report is considered the gold standard of pain assessment.

As with all older adults, those with dementia are at risk for multiple sources and types of pain, including chronic pain from conditions such as osteoarthritis and acute pain from surgery, injury, and infection. Untreated pain in cognitively impaired older adults can delay healing, disturb sleep and activity patterns, reduce function, reduce quality of life, and prolong hospitalization.

BEST TOOLS: Several tools are available to measure pain in older adults with dementia. Each has strengths and limitations (Herr, Decker, & Bjoro, 2006). The American Medical Directors Association has endorsed the Pain Assessment in Advanced Dementia Scale (PAINAD) (Warden, Hurley, & Volicer, 2003).

The American Society for Pain Management Nursing's Task Force on Pain Assessment in the Nonverbal Patient recommends a comprehensive, hierarchical approach to pain assessment that incorporates the following steps:

- Ask older adults with dementia about their pain. Even older adults with mild to moderate dementia can respond to simple questions about their pain.
- Use a standardized tool to assess pain intensity, such as the numerical rating scale (NRS) (0-10) or a verbal descriptor scale (VDS) (Herr, Coyne, et al., 2006). The VDS asks participants to select a word that best describes their present pain (e.g., no pain to worst pain imaginable) and may be more reliable than the NRS in older adults with dementia.
- Use an observational tool (e.g., PAINAD) to measure the presence of pain in older adults with dementia.
- Ask family or usual caregivers as to whether the patient's current behavior (e.g., crying out, restlessness) is different from their customary behavior. This change in behavior may signal pain.
- If pain is suspected, consider a time-limited trial of an appropriate type and dose of an analgesic agent. Thoroughly investigate behavior changes to rule out other causes. Use self report and observational pain measures to evaluate the pain before and after administering the analgesic.

TARGET POPULATION: Older adults with cognitive impairment who cannot be assessed for pain using standardized pain assessment instruments. Pain assessment in older adults with cognitive impairment is essential for both planned or emergent hospitalization.

VALIDITY AND RELIABILITY: The PAINAD has an internal consistency reliability ranging from .50 (for behavior assessed at rest) to .67 (for behaviors assessed during unpleasant caregiving activities). Interrater reliability is high (r = .82 - .97). The PAINAD scale is reported to have moderate to high concurrent validity, depending on whether the patient was at rest or involved in pleasant or unpleasant activities (r = .76 - .95).

STRENGTHS AND LIMITATIONS: Pain is a subjective experience and there are no definitive, universal tests for pain. For patients with dementia, it is particularly important to know the patient and to consult with family and usual caregivers.

BARRIERS to PAIN MANAGEMENT in OLDER ADULTS with DEMENTIA: There are many barriers to effective pain management in this population. Some common myths are: pain is a normal part of aging; if a person doesn't verbalize that they have pain, they must not be experiencing it; and that strong analgesics (e.g., opioids) must be avoided.

There are also some barriers to using the PAINAD to assess pain in this population. First, the PAINAD has not been evaluated for use in people with mild to moderate dementia. Second, some of the PAINAD scale behaviors, such as breathing, may be difficult to assess. Third, some studies have reported that the brevity of the PAINAD (only 5 items) makes it easy to complete, but limits its utility by restricting the range of behavioral pain indicators that may be observed in this population (Zwakhalen, Hamers, & Berger, 2006). Finally, there are no clear guidelines on the treatment of pain according to the PAINAD final scores (Horgas & Miller, 2008).

An effective approach to pain management in older adults with dementia is to assume that they do have pain if they have conditions and/or medical procedures that are typically associated with pain. Take a proactive approach in pain assessment and management.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeri.org.

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Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	*Normal*	*Occasional labored breathing. Short period of hyperventilation.*	*Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.*	
Negative vocalization	*None*	*Occasional moan or groan. Low level speech with a negative or disapproving quality.*	*Repeated troubled calling out. Loud moaning or groaning. Crying.*	
Facial expression	*Smiling or inexpressive*	*Sad. Frightened. Frown.*	*Facial grimacing.*	
Body language	*Relaxed*	*Tense. Distressed pacing. Fidgeting.*	*Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.*	
Consolability	*No need to console*	*Distracted or reassured by voice or touch.*	*Unable to console, distract or reassure.*	
			*Total***	

* *Five-item observational tool (see the description of each item below).*

** *Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").*

BREATHING

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, or wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

NEGATIVE VOCALIZATION

1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or murmuring sounds, wails or laments much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

FACIAL EXPRESSION

1. Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

BODY LANGUAGE

1. Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.
5. Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).
6. Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).
8. Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.
9. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

CONSOLABILITY

1. No need to console is characterized by a sense of well being. The person appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure is characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

Reprinted from Journal of the American Medical Directors Association, 4(1), 9-15. Warden, V., Hurley, A.C., & Volicer, L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) Scale.

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Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University Rory Meyers College of Nursing

Issue Number 32, 2015

Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
New York University Rory Meyers College of Nursing

The Palliative Performance Scale (PPSv2) Version 2

By: Tara A. Cleary, DNP, GNP-BC, CHPN
South Nassau Communities Hospital, Oceanside, New York

WHY: Worldwide the population of older adults is growing at unprecedented rates (Institute of Medicine, 2008). Advanced age is commonly marked by increased cancer risk, chronic disease, co-morbidities, the complexity of dementia, and increasing frailty. Geriatric palliative care is an approach in the management of chronic illness and frailty in older adults (Matzo, 2008). Geriatric palliative care differs from palliative care delivered to other patient populations in regard to overall disease trajectory and prognostication with chronic illness (WHO, 2011). Health care providers' recognition of who might benefit from symptom management, advanced care planning, and care coordination is further hindered by the lack of formal training in recognition and management of advancing illness and functional decline in older adults (Evers, Meier, and Morrison, 2002). This can thereby delay the ability to identify and convey prognosis to patients and their families. Communication of prognosis is essential for informed decision making.

BEST TOOL: The Palliative Performance Scale (PPSv2) Version 2 is a communication tool for quickly describing a person's current functional level. The PPSv2 allows more common language about performance status than the Karnofsky Performance scale from which it is based. The PPSv2 uses five observer rated domains: ambulation; activity & evidence of disease; self-care; intake; and conscious level.

TARGET POPULATION: The PPSv2 is appropriate for use in all health care settings and for older adults with various diseases. It is appropriate to be used with adults of any age, with various language, culture, and literacy levels. Presently, it is translated into nine languages (English, French, Japanese, German, Thai, Arabic, Spanish, Portuguese and Dutch). There is limited data regarding the use of the PPSv2 in pediatric populations.

VALIDITY AND RELIABILITY: The PPSv2 is intended for use by any health care professional such as physicians, nurses, respiratory therapists, physical and occupational therapists, dietitians, chaplains, or trained volunteers. As such the scoring is subject to individual variation and interpretation. Although intended as a professional tool, there are many families, and some patients, who have used PPS. Ho et al. (2008) demonstrated strong inter and intra-rater reliability for the PPS among 2 groups with intraclass correlation coefficients for absolute agreement of 0.959 and 0.964 for group 1 at times 1 and 2, 0.951 and 0.931 for group 2 at times 1 and 2, respectively. Additionally, validity was established based on content validation through interviews of palliative care experts (Ho et al., 2008).

STRENGTHS AND LIMITATIONS: The PPSv2 identifies potential needs of people with advanced illness. This is particularly useful in those with disease progression and functional decline. A succinct reporting of performance status allows for communication about the amount of support the person may need with decreases in scores indicating a progressing condition. Although initially designed for 'palliative' adults with advanced illness, the PPSv2 has been utilized across various settings and is translatable for others based on performance or functional status.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

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The Palliative Performance Scale (PPSv2) Version 2

Victoria Hospice

Palliative Performance Scale (PPSv2) version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

   Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

   Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'
3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.
4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Palliative Performance Scale (PPSv2) version 2. Medical Care of the Dying, 4th ed.; p.120. ©Victoria Hospice Society, 2006.

Definition of terms and instructions for use of the PPS available at:
http://www.victoriahospice.org/sites/default/files/imce/PPS%20ENGLISH.pdf

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Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, NYU Rory Meyers College of Nursing

Issue Number 7, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
NYU Rory Meyers College of Nursing

Pain Assessment for Older Adults

By: Ellen Flaherty, PhD, APRN, BC, Dartmouth-Hitchcock Medical Center

WHY: Studies on pain in older adults (persons 65 years of age and older) have demonstrated that pain is a common problem. In one study, 50% of adults 65 years of age and older said they experienced pain in the previous 30 days (U.S. Dept. of Health and Human Services, 2006). Up to 80% of nursing residents experience pain regularly. Yet, the undertreatment of pain is pervasive (Zanocchi et al., 2008). Reasons for this include the belief that pain is a normal part of aging, misconceptions about addiction to pain medications, and a lack of routine pain assessment. Persistent pain has been associated with functional impairment, falls, slow rehabilitation, depression, anxiety, decreased socialization, sleep disturbance, as well as increased healthcare utilization and costs. In an effort to improve the detection and management of pain, the Joint Commission on Accreditation of Healthcare Organizations has mandated pain screening noting pain "the fifth vital sign." A proactive, consistent approach must be taken to screen for pain and assess older adults for persistent pain.

BEST TOOL: Identifying and measuring pain begins with self report. This can be challenging in a population with sensory deficits and disparities in cognition, literacy, and language. Simply worded questions and tools, which can be easily understood, are the most effective. The most widely used pain intensity scales used with older adults are the Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS) and the Faces Pain Scale-Revised (FPS-R). The most popular tool, the NRS, asks a patient to rate their pain by assigning a numerical value with zero indicating no pain and 10 representing the worst pain imaginable. The VDS asks the patient to describe their pain from "no pain" to "pain as bad as it could be." The FPS-R asks patients to describe their pain according to a facial expression that corresponds with their pain.

TARGET POPULATION: All three scales are used with both community and older adults in acute and long term care settings. While there are specific tools designed to capture pain in non-verbal cognitively impaired older adults, studies have shown that the Faces, Numeric Rating and Verbal Descriptor scales may be used effectively with cognitively impaired older adults. The choice of a scale may depend on institutional preference or the presence of a particular language or sensory impairment. The most important consideration is the consistent use of the same scale with each individual patient.

VALIDITY AND RELIABILITY: All three scales have demonstrated good internal consistency with Cronbach's α coefficients of 0.85 to 0.89. Test-retest reliability for each ranged from 0.57 to 0.83 for the NRS, from 0.52 to 0.83 for the Verbal Descriptor Scale, and from 0.44 to 0.94 for the FPS-R. A factor analysis found that all three scales were valid, although the FPS-R was the weakest (Herr, Spratt, Mobily, & Richardson, 2004).

STRENGTHS AND LIMITATIONS: The overall strengths of these scales are their ability to quickly and reliably screen for pain. These scales should not be substituted for a more comprehensive pain assessment that would include obtaining a pain history and a physical exam leading to the etiology of pain. For cognitively intact older adults all three scales are effective screening tools, with the NRS being the most widely used tool. Studies have shown that cognitively impaired nursing home residents were most likely able to complete the VDS and less likely to be able to complete the NRS or the FPS-R. These scales have been used successfully used with a variety of ethnic populations however the research is limited. Language barriers may facilitate the use of the FPS-R when communication is limited.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeri.org.

American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. (2009). AGS Clinical practice guideline: Pharmacological management of persistent pain in older persons (2009). *JAGS, 57*, 1331-1346. Available at the AGS website, http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2009/.

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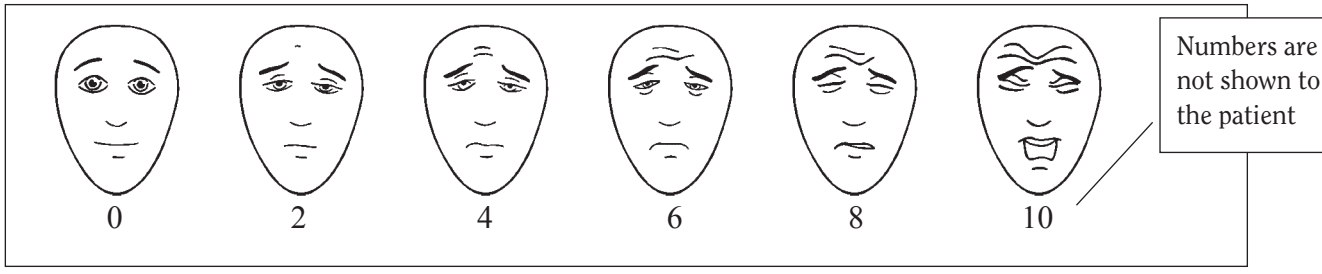
Faces Pain Scale – Revised

From "The Faces Pain Scale – Revised. Toward a Common Metric in Pediatric Pain Measurement," by C.L. Hicks, C.L. von Baeyer, P.A. Spafford, I. van Korlaar, & B. Goodenough, 2001, Pain, 93, 173-183. Reprinted with permission of the International Association for the Study of Pain.

Note: This is a smaller sample of the actual scale. For further instructions on the correct use of the scale and more information, please go to www.painsourcebook.ca

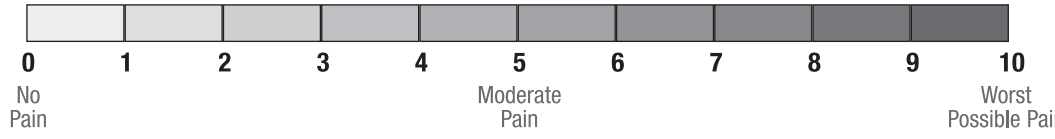


Numeric Rating Scale

Please rate your pain from 0 to 10 with 0 indicating no pain and 10 representing the worst possible pain.

_____

Adapted from Jacox, A., Carr, D.B., Payne, R., et al. (March 1994). Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.



Verbal Descriptor Scale

Ask the patient: Please describe your pain from "no pain" to "mild", "moderate", "severe", or "pain as bad as it could be." _____

_____

_____

_____

Adapted from Jacox, A., Carr, D.B., Payne, R., et al. (March 1994). Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.

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DAY 2 Tab

The Path to Implementing Change: Integrating Geriatrics into Oncology

Sarah Kagan, PhD, RN
Lucy Walker Honorary Term Professor of Gerontological Nursing
School of Nursing, University of Pennsylvania

Objectives:

1. Analyze barriers limiting integration of gerontological knowledge and skills in oncology nursing
2. Synthesize the role of gero-competence in integrating appropriate knowledge and skills to improve care for older people living with cancer

Things I Want to Remember:

The Path to Implementing Change – Some Useful Resources

Resource	Link
The John A. Hartford Foundation	http://www.jhartfound.org/
The Hartford Institute of Geriatric Nursing	http://www.hartfordign.org/
The Reynolds Foundation	http://www.dwreynolds.org/Programs/National/Aging/Aging.htm
Portal of Geriatrics Online Education	http://www.pogoe.org

The Path to Implementing Change: Integrating Geriatrics into Oncology

Sarah Kagan, PhD, RN
Lucy Walker Honorary Term Professor of Gerontological Nursing
School of Nursing, University of Pennsylvania

References:

The following works (Angus & Reeve, 2006; Calasanti, 2015; Chasteen & Cary, 2015; Clegg, Young, Iliffe, Rikkert, & Rockwood, 2013; Gendron, Welleford, Inker, & White, 2015; Kagan, 2012, 2015, 2016; Kagan & Melendez-Torres, 2015; Maben, Adams, Peccei, Murrells, & Robert, 2012; McCormack, 2004; McCormack & McCance, 2006; Medicine, 2008; Organization, 2004, 2007, 2014; Resnick, 2007) shaped in my talks or are useful readings to learn more about ideas I present.

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Nutrition and Aging throughout the Cancer Journey

Wendy Demark-Wahnefried, PhD, RD
Professor and Webb Chair of Nutrition Sciences
Associate Director, UAB Comprehensive Cancer Center

Objectives:

1. Review reasons why nutrition is important from diagnosis and treatment, throughout survivorship, and in advanced disease
2. Identify conditions that signal poor nutritional status
3. Review interventions that address nutritional concerns
4. Identify existing gaps in knowledge

Things I Want to Remember:

2012 American Cancer Society (ACS) Nutrition & Physical Activity Guidelines for Cancer Survivors

Achieve and maintain a healthy weight

If overweight or obese, limit high calorie foods & beverages increase physical activity to promote weight loss

Engage in regular physical activity

- Avoid inactivity; resume normal activities as soon as possible following dx
- Exercise ≥150 minutes/week
- Include strength training exercises at least 2 days/week

Achieve a dietary pattern that is high in vegetables, fruits and whole grains

- Follow ACS Guidelines on Nutrition & Physical Activity for Cancer Prevention
  - Choose foods & beverages in amounts that achieve/maintain a healthy weight
  - Limit processed and red meat
  - Eat ≥ 2.5 cups of vegetables & fruits/day
  - Choose whole grains instead of refined grain products
  - If you drink ETOH, drink ≤1 drink/day for ♀ & 2 drinks/day for ♂

Supplements

- Try to obtain nutrients through diet, first.
- Consider only if a nutrient deficiency is biochemically or clinically observed, or if intakes fall persistently below recommended levels as assessed by an RD.

Rock et al.(2012) DOI.10.3322/CAAC.21142 www.cacancerjournal.com

Resources

- American Cancer Society: www.cancer.org
- American Dietetic Association: www.eatright.org
- American Institute for Cancer Research: www.aicr.org
- Centers for Disease Control: www.cdc.gov/HealthyLiving
- LIVESTRONG http://www.livestrong.com/myplate/
- National Center for Complementary & Integrative Health: https://nccih.nih.gov/health

Nutrition and Aging throughout the Cancer Journey

Wendy Demark-Wahnefried, PhD, RD
Professor and Webb Chair of Nutrition Sciences
Associate Director, UAB Comprehensive Cancer Center

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Interventions **– Main Outcomes –** *Secondary Analysis and Methods/Design Papers (if results still pending)*

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Group Breakout: Interactive Case Study and Q & A

Things I Want to Remember:

Interactive Case Study Nutrition and Aging

Henry is a 74-year old man who was recently diagnosed with metastatic prostate cancer. He is 6'0" and weighs 240 pounds and is sedentary. His medications include: Lovastatin, Coumadin, Hydrochlorothiazide, and Rosiglitazone. He will begin androgen deprivation therapy. He has been online and has started taking Prostate Health (contains zinc, selenium, copper, cranberry powder, saw palmetto, beta sitosterol, and lycopene), and calcium and vitamin D. He is very anxious and wants to know what else he should take.

You ask Henry what he ate yesterday and here is his recall (his wife chimes in that she is making Henry drink green tea between meals and pomegranate juice with each of his meals, she also has bought soy milk for Henry but "he hates it, but will eat Tofutti (soy-based ice cream 420 kcal/cup)"

Breakfast (He meets a bunch of his friends at McDonald's every weekday morning)

Sausage, Egg and Cheese Biscuit
Large Coffee
4 – Creamers/ 1 packet Splenda®

Lunch

5 oz. can of tuna on a bed of lettuce
Fresh tomatoes, cucumbers and carrot sticks
Olive oil and vinegar dressing 4T
Pomegranate Juice (16 oz)

Snack

Raw Almonds (1 cup)
Green Tea (16 oz)
Honey (2 T)

Dinner

8 oz. Salmon drizzled with olive oil and grilled
Roasted Peppers, Onions, Eggplant drizzled with olive oil and grilled
Sliced Tomatoes with Olive oil and vinegar dressing
Pomegranate Juice (16 oz)

Snack

Tofutti (1 pint)
Green Tea (16 oz)
Honey (2 T)

What dietary guidance can you provide Henry?

Pain Management and EOL Care in the Older Adult

Denice Economou
RN, PhD, CHPN
Senior Research Specialist
City of Hope Comprehensive Cancer Center

Objectives:

1. Increase understanding of the specific pain management needs of the aging
2. Identify common cultural and social barriers to effective pain management in the older adult
3. Emphasize the importance of a focus on safety when prescribing pain medication for the older adult
4. Identify most common management needs of the dying older adult

Things I Want to Remember:

Pain Management and EOL Care in the Older Adult

Denice Economou
RN, PhD, CHPN
Senior Research Specialist
City of Hope Comprehensive Cancer Center

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Assessment and Management of Cognitive Impairment in Older Adults

Beatriz Korc-Grodzicki, MD, PhD
Chief of Geriatrics Service
Memorial Sloan Kettering Cancer Center

Objectives:

1. To provide an overview on dementia and delirium, its detection and care
2. To review the impact of pre-existing cognitive impairment in the care of older adults with cancer
3. To discuss decision-making capacity

Things I Want to Remember:

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	**Version 2**	**Version 3**	**Version 4**	**Version 5**	**Version 6**
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

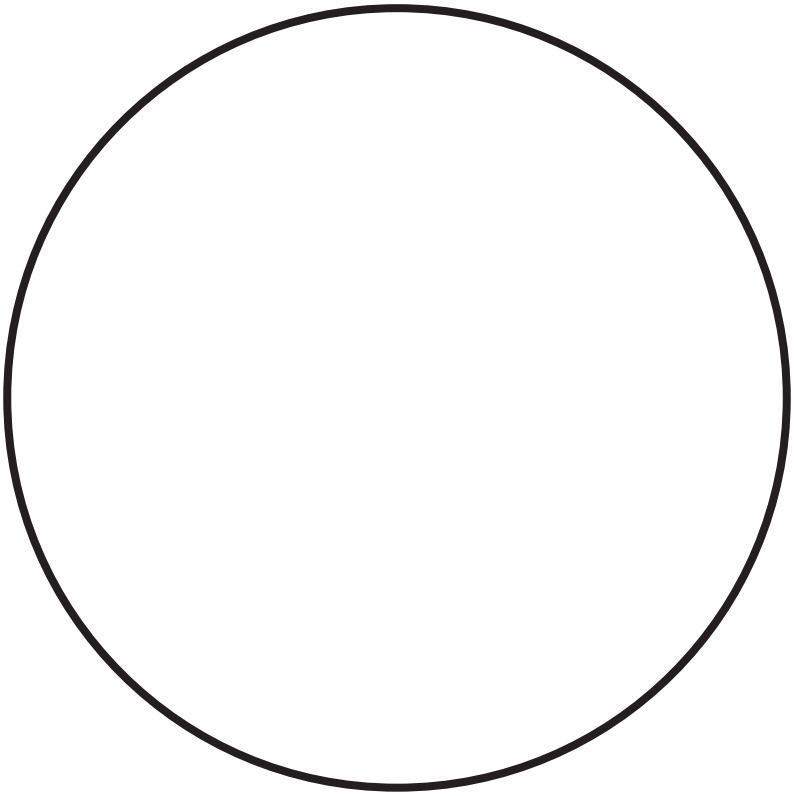
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID: _____ Date: _____



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Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 13, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC
New York University College of Nursing

The Confusion Assessment Method (CAM)

By: Christine M. Waszynski, MSN, APRN, BC, Hartford Hospital

WHY: Delirium is present in 10%-31% of older medical inpatients upon hospital admission and 11%-42% of older adults develop delirium during hospitalization (Siddiqi, House, & Holmes, 2006; Tullmann, Fletcher, & Foreman, 2012). Delirium is associated with negative consequences including prolonged hospitalization, functional decline, increased use of chemical and physical restraints, prolonged delirium post hospitalization, and increased mortality. Delirium may also have lasting negative effects including the development of dementia within two years (Ehlenbach et al., 2010) and the need for long term nursing home care (Inouye, 2006). Predisposing risk factors for delirium include older age, dementia, severe illness, multiple co-morbidities, alcoholism, vision impairment, hearing impairment, and a history of delirium. Precipitating risk factors include acute illness, surgery, pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal impaction, and exposure to high risk medications. Delirium is often unrecognized and undocumented by clinicians. Early recognition and treatment can improve outcomes. Therefore, patients should be assessed frequently using a standardized tool to facilitate prompt identification and management of delirium and underlying etiology.

BEST TOOL: The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM includes four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment. There is also a CAM-ICU version for use with non-verbal mechanically ventilated patients (See *Try This:*® CAM-ICU).

VALIDITY AND RELIABILITY: Both the CAM and the CAM–ICU have demonstrated sensitivity of 94-100%, specificity of 89-95% and high inter-rater reliability (Wei, Fearing, Eliezer, Sternberg, & Inouye, 2008). Several studies have been done to validate clinical usefulness.

STRENGTHS AND LIMITATIONS: The CAM can be incorporated into routine assessment and has been translated into several languages. The CAM was designed and validated to be scored based on observations made during brief but formal cognitive testing, such as brief mental status evaluations. Training to administer and score the tool is necessary to obtain valid results. The tool identifies the presence or absence of delirium but does not assess the severity of the condition, making it less useful to detect clinical improvement or deterioration.

FOLLOW-UP: The presence of delirium warrants prompt intervention to identify and treat underlying causes and provide supportive care. Vigilant efforts need to continue across the healthcare continuum to preserve and restore baseline mental status.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

The Hospital Elder Life Program (HELP), Yale University School of Medicine. Home Page: www.hospitalelderlifeprogram.org/
CAM Disclaimer: www.hospitalelderlifeprogram.org/private/cam-disclaimer.
Useful websites for clinicians including the CAM Training Manual:
www.hospitalelderlifeprogram.org/pdf/TheConfusionAssessmentMethodTrainingManual.pdf

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The Confusion Assessment Method Instrument:

1. ***[Acute Onset]*** Is there evidence of an acute change in mental status from the patient's baseline?

2A. ***[Inattention]*** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

2B. ***(If present or abnormal)*** Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?

3. ***[Disorganized thinking]*** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. ***[Altered level of consciousness]*** Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily], Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma; [unarousable]; Uncertain)

5. ***[Disorientation]*** Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?

6. ***[Memory impairment]*** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?

7. ***[Perceptual disturbances]*** Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?

8A. ***[Psychomotor agitation]*** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?

8B. ***[Psychomotor retardation]*** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?

9. ***[Altered sleep-wake cycle]*** Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: *Acute Onset or Fluctuating Course*
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: *Inattention*
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: *Disorganized thinking*
This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: *Altered Level of consciousness*
This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegal, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine*, *113*(12), 941-948.

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Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 3.2, Revised 2012

Series Editor: Marie Boltz, PhD, GNP-BC
Series Co-Editor: Sherry A. Greenberg, MSN, GNP-BC
New York University College of Nursing

Mental Status Assessment in Older Adults: Montreal Cognitive Assessment: MoCA Version 7.1 (Original Version)

By: Deirdre M. Carolan Doerflinger, CRNP, PhD
Inova Fairfax Hospital, Falls Church, VA

WHY: The incidence of mild cognitive impairment (MCI) increases with age ranging from 7% to 38% (2011 Alzheimer's disease Facts and Figures). Older adults with MCI have as high as 14% higher risk of developing Alzheimer's dementia (2011 Alzheimer's disease Facts and Figures). While studies have shown that treatment with an acetylcholinesterase inhibitor prior to progression has delayed dementia onset by 3 years, currently there is no endorsed treatment recommendations for MCI.

BEST TOOL: The Montreal Cognitive Assessment (MoCA© Version 7.1) was developed as a quick screening tool for MCI and early Alzheimer's dementia. It assesses the domains of attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. There are two alternative MoCA© forms (Version 7.2 and 7.3) available in an effort to decrease possible learning effects when used repeatedly (Phillips et al., 2011). The MoCA© has been tested extensively for use in a variety of disorders affecting cognition such as HIV, Huntington's chorea, Multiple Sclerosis, Parkinson's disease, stroke, vascular dementia, and substance abuse in addition to the well older adult. It has been tested in 14 different languages, ages ranging from as young as 49 in two reports to old-old (85+) with a variety of education levels. The total possible score is 30 points with a score of 26 or more considered normal. To better adjust the MoCA for lower educated individuals, 2 points should be added to the total MoCA score for those with 4-9 years of education and 1 point for 10-12 years of education (Johns et al., 2010). The score range for MCI is 19-25.2 and for Alzheimer's dementia 11.4-21. While the score ranges overlap, differentiation between the conditions is dependent upon associated functional impairment. A modified version, MoCA-B, has been developed for use in visual impairments.

TARGET POPULATION: The MoCA can be used in a variety of settings from primary care to acute care. It may be used in culturally diverse populations, a variety of ages and differing educational levels.

VALIDITY AND RELIABILITY: The MoCA detected MCI with 90%-96% range sensitivity and specificity of 87% with 95% confidence interval. The MoCA detected 100% of Alzheimer's dementia with a specificity of 87%.

STRENGTHS AND LIMITATIONS: The MoCA takes approximately 10 minutes to administer. It is accessible via the MoCA© website, http://www.mocatest.org/ with clear administration and scoring instructions (refer to website for copyright information). All these items, test, instructions and scoring are available in 36 languages. There is some recent research suggesting that lowering the threshold score to 23 may prevent over identification of normal individuals. It has been tested in a variety of settings and populations and displayed accuracy in identification of MCI and Alzhiemer's dementia.

FOLLOW-UP: The U.S. Preventative Services Task Force in 2003, made no formal recommendations for screening for dementia. The American Academy of Neurology (2001) determined that there is not sufficient evidence to recommend cognitive screening of asymptomatic individuals. This guideline is currently under revision. The American Medical Association (2003) and the American Academy of Family Physicians (2001) recommend that health care providers be alert for cognitive and functional decline in elderly patients for recognition of dementia in its early stages. Annual screening, as a component of the annual physical, is realistic.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.
MoCA website: http://www.mocatest.org/.
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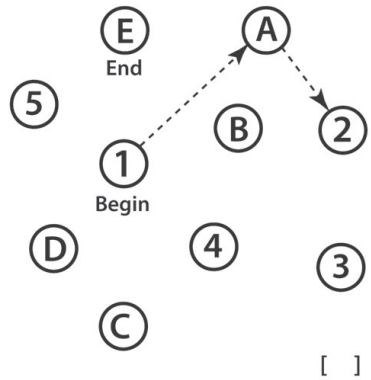
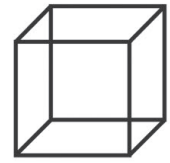
MONTREAL COGNITIVE ASSESSMENT (MOCA)

Version 7.1 Original Version

NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE





Copy cube

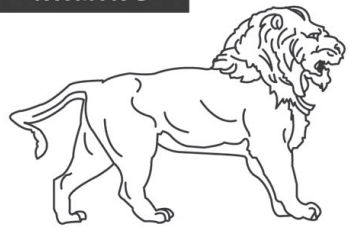
[ ] [ ]

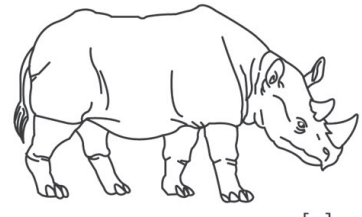
Draw CLOCK (Ten past eleven)
(3 points)

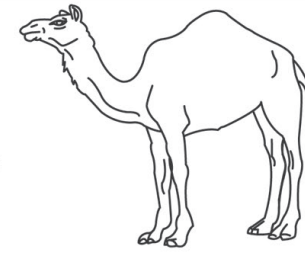
[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

NAMING







[ ] [ ] [ ]

___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

___/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

___/2

DELAYED RECALL

	FACE	VELVET	CHURCH	DAISY	RED	
Has to recall words **WITH NO CUE**	[ ]	[ ]	[ ]	[ ]	[ ]	Points for UNCUED recall only
Optional Category cue						
Optional Multiple choice cue						

___/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

___/6

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Normal ≥ 26 / 30

TOTAL ___/30

Add 1 point if ≤ 12 yr edu

Administered by: _____

Dementia vs. Delirium

Dementia

- Onset: Develops over time
- Course: Slow progression of cognitive decline
- Level of alertness typically not affected until late stages; able to focus on one idea or task
- Cause: Alz. D., Vascular dementia, etc
- Duration: Chronic, progressive, incurable
- Communication Abilities: Difficulties finding the right word, or inability to express themselves
- Activity Level: Usually not affected until late stages
- Treatment: Current FDA approved medications may slow progression of disease.

Delirium

- Onset: Develops abruptly
- Course: Rapid progression and fluctuating course
- Inattention is a hallmark of delirium, unable to focus and maintain attention.
- Cause: usually triggered by medical illness (such as infection, dehydration) or medications (additions or changes)
- Duration: a couple of days to several months. Almost always temporary.
- Communication Abilities: Incoherent, inappropriate, disorganized speech.
- Activity Level: Maybe hyperactive and restless or hypoactive and lethargic
- Treatment of underlying disease or medication change is urgent.

Assessment and Management of Cognitive Impairment in Older Adults

Beatriz Korc-Grodzicki, MD, PhD
Chief of Geriatrics Service
Memorial Sloan Kettering Cancer Center

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Group Breakout: Interactive Case Study and Cognitive Assessments

Things I Want to Remember:

The Interdisciplinary Team: Implementing an Evidence-Based Model in Cancer Care

Betty Ferrell, PhD, MA, FAAN,
Professor and Director, Division of Nursing Research & Education
City of Hope Comprehensive Cancer Center

Objectives:

1. Describe the importance of interdisciplinary teams in Geriatric Oncology
2. Identify strategies for most effective use of interdisciplinary teams in clinical practice and research
3. Describe a research program using interdisciplinary approaches in oncology

Things I Want to Remember:

The Interdisciplinary Team: Implementing an Evidence-Based Model in Cancer Care

Betty Ferrell, PhD, MA, FAAN,
Professor and Director, Division of Nursing Research & Education
City of Hope Comprehensive Cancer Center

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Polypharmacy and Medication Adherence in the Older Adult

Timothy Synold, PharmD
City of Hope

Objectives:

1. Differentiate among the multiple definitions of polypharmacy
2. Discuss data regarding prevalence, risks, and impact of polypharmacy
3. Discuss the relationship between polypharmacy and adherence
4. Define inappropriate medications for elderly patients
5. Describe tools used to screen for polypharmacy and improve adherence

Things I Want to Remember:

Polypharmacy and Medication Adherence in the Older Adult

Timothy Synold, PharmD
City of Hope

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Predicting Chemotherapy Toxicity in Older Adults

Supriya Mohile, M.D., M.S.
Professor of Medicine
University of Rochester

Objectives:

1. Describe the benefits of utilizing a chemotherapy toxicity prediction tool in oncology care
2. Review chemotherapy toxicity prediction tools:
    a. Cancer and Aging Research Group Chemotherapy Toxicity Tool
    b. Chemotherapy Risk Assessment Scale for High-Age Patients Tool
3. Describe the utility of a chemotherapy toxicity prediction tool to guide practical interventions

Things I Want to Remember:

CHEMOTHERAPY TOXICITY PREDICTION TOOL

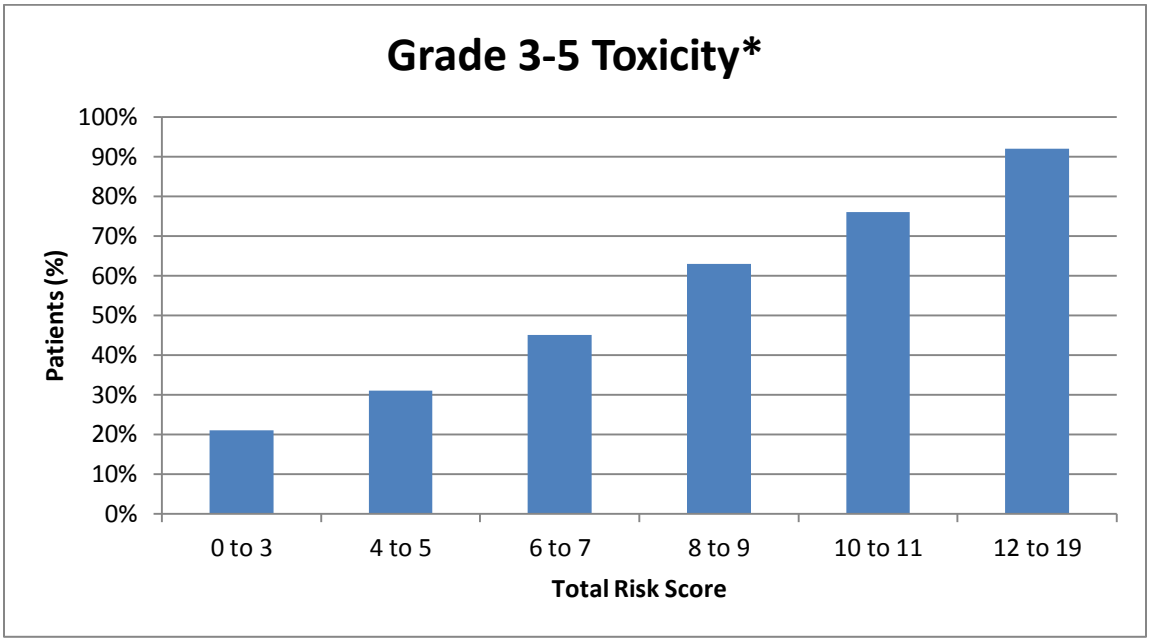
Available at: http://www.mycarg.org/Chemo_Toxicity_Calculator

Toxicity Factor/Question	Score		Value/Response
1. Age of Patient	2	❒	72 years of age or older
	0	❒	Younger than 72
2. Cancer Type	2	❒	Gastrointestinal
	2	❒	Genitourinary
	0	❒	Other cancer types
3. Dosage (Dose delivered with first dose for chemotherapy)	2	❒	Standard Dose
	0	❒	Dose reduced upfront
4. Number of chemotherapy agents	2	❒	Polychemotherapy
	0	❒	Monochemotherapy
5. Hemoglobin	3	❒	Male: < 11
	0	❒	≥ 11
	3	❒	Female: < 10
	0	❒	≥ 10
6. How is your hearing (with a hearing aid, if needed)?	0	❒	Excellent
	0	❒	Good
	2	❒	Fair
	2	❒	Poor
	2	❒	Totally deaf
7. Number of falls in the past 6 months	3	❒	1 or more
	0	❒	None
8. Can you take your own medicines?	0	❒	Without help (in the right doses at the right time)
	1	❒	With some help (able to take medicine if someone prepares it for you and/or reminds you to take it)
	1	❒	Completely unable to take you medicine
9. Does your health limit you in walking one block?	2	❒	Limited a lot
	2	❒	Limited a little
	0	❒	Not limited at all
10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	1	❒	All of the time
	1	❒	Most of the time
	1	❒	Some of the time
	0	❒	A little of the time
	0	❒	None of the time
11. Creatinine Clearance (Jeliffe formula with ideal weight)	3	❒	Less than 34
	0	❒	34 or greater

Total Score: _____

CHEMOTHERAPY TOXICITY PREDICTION TOOL

SCORING GUIDE



Scores between 0 and 5 are considered low risk, scores between 6 and 9 are considered medium risk, and scores between 10 and 19 are considered high risk. The above graph describes the percentage of patients experiencing grade 3-5 toxicity in each risk category. The below table summarizes the number of patients within each score in the Hurria et al study out of a total sample size of 500 patients.

Total Risk Score		%Risk	N
Low	0 to 3	25%	28
	4 to 5	32%	100
Mid	6 to 7	50%	136
	8 to 9	54%	91
High	10 to 11	77%	62
	12 to 19	89%	47

Predicting Chemotherapy Toxicity in Older Adults

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Professor of Medicine
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Group Breakout: Case Study – Polypharmacy and Predicting Chemotherapy Toxicity

Things I Want to Remember:

Case Study: Polypharmacy and Predicting Chemotherapy Toxicity

MH is a 79 year old woman with a recent diagnosis of stage IV bladder cancer. She met with her oncologist who recommended treatment with gemcitabine and carboplatin (dose reduced due to poor renal clearance).

On your review of her records, you note that her physician rated her Karnofsky Performance Status at 60%. She has a history of atrial fibrillation, hypertension, stroke, and depression. She takes 9 prescribed medications and 2 over-the-counter medications. Her medications include: ondansetron 8mg po twice daily prn nausea, oxycodone-acetaminophen 5mg-325mg po q 6 hours prn pain, metoprolol 50 mg po daily, rivaroxaban 20 mg po daily, furosemide 40 mg po daily, simvastatin 20mg po daily, aspirin 81 mg po daily, lorazepam 1mg po prn anxiety, zolpidem 5 mg po prn sleep, CoEnyzme Q-10 50 mg po daily, and a daily multivitamin.

You perform a geriatric assessment. She notes that she can take her own medications and handles her own finances without help, but she needs help getting to places outside of walking distance and with housework. She is limited a lot in walking one block. She could not do the Timed Up and Go as she is in a wheelchair due to leg weakness from a previous stroke. She has not fallen in the last 6 months. She states she has limited her social activities all of the time due to her physical or emotional problems. She reports her hearing as poor. She has had an unintentional weight loss of 40 pounds (15% of her body weight) in the last year.

You review her laboratory data: WBC 6.5, hemoglobin 12.5, BUN 29, serum creatinine 1.7, and albumin 3.9. You calculate her creatinine clearance to be 27 mL/min (height: 172cm, weight: 84.6kg).

Work in your teams and answer the following questions:

What are the goals of therapy?

What else do you want to know?

What is her chemotherapy toxicity score according to the CARG Chemotherapy Prediction Tool?

What recommended changes would you make to her medication list and why?

What interventions would you consider?

Working with Leadership to Impact Positive Change

Shirley Johnson, MS, MBA, RN
Senior Vice President Nursing Services, Chief Nursing Officer
Roswell Park Cancer Institute

Objectives:

1. Identify a minimum of three examples of strengths, weakness, opportunities, and threats within their own gerontology oncology program
2. Complete their own one minute description regarding the impact a gerontology oncology nursing focus would have on their hospital
3. Define two immediate steps they might take to engage leadership support in improving care of the older adult with cancer within their program

Things I Want to Remember:

Working with Leadership to Impact Positive Change

Shirley Johnson, MS, MBA, RN
Senior Vice President Nursing Services, Chief Nursing Officer
Roswell Park Cancer Institute

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Objectives: Empowering Nurses to Advocate for the Older Adult

Sarah Kagan, PhD, RN
Lucy Walker Honorary Term Professor of Gerontological Nursing
School of Nursing, University of Pennsylvania

1. Analyze the effects of ageism in delivering cancer care to older people
2. Develop strategies for creating age-friendly, gero-competent care for older people living with cancer

Things I Want to Remember:

Empowering Nurses to Advocate for the Older Adult

Sarah Kagan, PhD, RN
Lucy Walker Honorary Term Professor of Gerontological Nursing
School of Nursing, University of Pennsylvania

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Group Breakout: Goal Development Discussion

Things I Want to Remember:

Day 3 Tab

Sleep Management in the Older Adult

Peggy Burhenn, MS, CNS, AOCNS
Clinical Nurse Specialist
City of Hope

Objectives:

1. Describe evidence-based data related to insomnia and cancer
2. Assess a patient for sleep related problems
3. Learn non-pharmacologic strategies that may improve sleep quality in our patients

Things I Want to Remember:

Peggy Burhenn, MS, RN-BC, AOCNS
Clinical Nurse Specialist
City of Hope

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Supporting the Caregiver of the Older Adult with Cancer: Lessons Learned

Denice Economou, RN, PhD, CHPN
Senior Research Specialist
City of Hope Comprehensive Cancer Center

Objectives:

1. Define who family caregivers are and estimate the impact for the future
2. Identify family caregiver responsibilities and information needed to minimize their burdens
3. Describe interventions that can impact outcomes

Things I Want to Remember:

Caregiver Resources for Managing Geriatric Cancer Patients

Resource	Link
American Cancer Society	http://www.cancer.org/treatment/caregivers/index
American Geriatrics Society	www.americangeriatrics.org
American Gerontological Society Online Caregiver Guide	https://www.geron.org/search-results?searchword=caregivers&searchphrase=all
American Society of Clinical Oncology	http://www.cancer.net/coping-with-cancer/caring-loved-one
CancerCare	www.cancercare.org
Cancer Legal Resource Center	www.cancerlegalresourcecenter.org
Cancer Support Community	www.cancersupportcommunity.org
Caregiver Action Network	www.caregiveraction.org
Caregiver Resource Directory	www.caregiverresourcecenter.com
Center for Caregiver	www.centerforfamilycaregivers.org
Health in Aging	www.healthinaging.org
Medicare: Caregiving	www.medicare.gov/campaigns/caregiver/caregiver.html
National Alliance for Caregiving	www.caregiving.org
National Cancer Institute	www.cancer.gov
National Council on Aging	https://www.ncoa.org/public-policy-action/long-term-services-and-supports/caregivers/
National Family Caregiver Assn	www.thefamilycaregiver.org
Office on Aging	www.knoxseniors.org/caregiver.html
Rosalynn Carter Institute for Caregiving	http://www.rci.gsw.edu/
US Administration on Aging, National Family Caregiver Support Program	http://www.aoa.gov/

Supporting the Caregiver of the Older Adult with Cancer: Lessons Learned

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Family Leave Act (1993)- https://www.dol.gov/whd/regs/statutes/fmla.htm

Affordable Care Act (2010) - www.dpc.senate.gov/healthreformbill/healthbill04.pdf

2016 ICD-10-CM Diagnosis Code Z63.8

- Z63.8 is a specific ICD-10-CM code that can be used to specify a diagnosis.
- Reimbursement claims with a date of service on or after October 1, 2015 require the use of ICD-10-CM codes.
- This is the American ICD-10-CM version of Z63.8. Other international ICD-10 versions may differ.

Applicable To

- Family discord NOS
- Family estrangement NOS
- High expressed emotional level within family
- Inadequate family support NOS
- Inadequate or distorted communication within family

Approximate Synonyms

- Caregiver role strain
- Caregiver stress
- Family conflict
- Family disruption
- Family disruption issues in remission
- Family maladjustment
- Family stress
- Family tension
- Stress due to family tension

Tapping into Community and Web-based Resources Tailored to the Older Adult

Carolina Uranga, MSN, AGCNS-BC, OCN
Clinical Nurse Specialist
City of Hope

Objectives:

1. Review community resources available to support older adults
2. Identify local resources in your geographic area
3. Identify web-based resources that can support goals of the geriatric oncology program
4. Understand how to access the resources to achieve your goals

Things I Want to Remember:

Tapping into Community Resources Tailored to the Older Adult

Resources

Domains for which you may need resources in your home area:

- ❑ **Rehab services**
- ❑ **Nutrition services**
- ❑ **Mental health**
- ❑ **Supportive care services**
- ❑ **Geriatricians**
- ❑ **Legal resources**
- ❑ **Pharmacy support**
- ❑ **Home health**

Create a resource list that includes resources in your geographic area that covers the following:

- ❑ Senior Centers
- ❑ Geriatricians
    - ❑ www.theabfm.org
    - ❑ Healthinaging.org
- ❑ Nutritionists
- ❑ Mental Health
- ❑ Home health agencies
- ❑ Rehab (PT/OT/Speech/etc.)
    - ❑ National Institute on Aging
    - ❑ www.nia.nih.gov
- ❑ Pharmacy
    - ❑ www.MSKCC.org
    - ❑ Beers List of potential inappropriate medications (PIMs)

Geriatric Resources

Cancer and Aging Research Group: www.mycarg.org

- Geriatric Assessment online: http://www.mycarg.org/gapatient1en
- Chemotherapy Toxicity Tool: http://www.mycarg.org/Chemo_Toxicity_Calculator
- Mobile version of the Chemotherapy Toxicity Tool: http://www.mycarg.org/mctc
- Resources for Older Adults: http://www.mycarg.org/resources/geriatric_resources

American Cancer Society (ACS): www.cancer.org

- Eat Healthy and Get Active recommendations on their website

American Geriatrics Society: www.americangeriatrics.org

- Guiding Principles for the Care of Older Adults with Multimorbidity
- Beers list of potentially inappropriate medications in older adults

American Institute for Cancer Research (AICR): www.aicr.org

- Guidelines for Cancer Survivors
- Healthy Lifestyle Guidelines

Area Agency on Aging

- Elder Locator Resource Center: www.eldercare.gov
- Finding help in your community for a variety of services for older adults

The Hartford Institute for Geriatric Nursing - Try This Series: www.ConsultGeriRN.org

- Katz Index of Activities of Daily Living
- Lawton Instrumental Activities of Daily Living Scale
- Cognition tools: Mini-Cog and MoCA
- Geriatric Depression Scale (15 questions)
- Fulmer SPICES: An Overall Assessment Tool for Older Adults

Mini Nutritional Assessment

www.mna-elderly.com

National Cancer Institute

www.cancer.gov/cancertopics/pdq/supportivecare/nutrition/HealthProfessional/page4

- NCI Nutrition in Cancer Care (PDQ)

National Comprehensive Cancer Network (NCCN) Senior Adult Oncology Guidelines: www.nccn.org

- Life Expectancy chart
- Cognition guidelines
- Geriatric Assessment

International Society of Geriatric Oncology: www.siog.org

- Geriatric Assessments including G8

Tapping into Community and Web-based Resources Tailored to the Older Adult

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Responsible Conduct of Research

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Objectives:

1. Provide an overview of the following topics related to the responsible conduct of research: ethical considerations in research, responsibilities of the investigator, policies regarding human subjects, collaborative research, authorship and other publication issues, and institutional review board functions

Things I Want to Remember:

Determining If Your Project is Research vs. Quality Improvement (QI)

When determining whether a project requires IRB review depends on whether it constitutes research involving human subjects. The below table may be used as a reference when determining if a project is a research study or quality improvement project. If the project involves some characteristics of a research project, submission to the IRB for review is required.

Definitions:

Quality Improvement: QI is the systematic pattern of actions that is constantly optimizing productivity, communication, and value within an organization in order to achieve the aim of measuring the attributes, properties, and characteristics of a product/service in the context of the expectations and needs of customers and users of that product

Research: Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

Human Subject: Human subject means a living individual about whom an investigator conducting research obtains

1. Data through intervention or interaction with the individual, or
2. Identifiable private information

Table 1: Characteristics of Research Projects and Quality Improvement Projects

	Research	**Quality Improvement**
Intent	• Develop or contribute to generalizable knowledge (e.g., testing hypothesis) • Activity that involves a prospective study plan which incorporates data collection, both quantitative and qualitative, and data analysis to answer a study question	• Improve a practice or process within a particular department/clinic/ institution or ensure it confirms with expected norms • To assess or improve a process, program, or system OR to improve performance as judged by established/accepted standards • To determine success/effectiveness or failure of a given program or process and the information gained from that evaluation is used to improve the program
Design	• Designed to develop or contribute to generalizable knowledge • Designed to draw general conclusions (i.e., knowledge gained from a study may be applied to populations outside of the specific study population), inform policy, or generalize findings.	• Not designed to develop or contribute to generalizable knowledge. • Generally does not involve randomization to different practices or processes • May involve review of available literature and comparative data, or clinical programs, practices or protocols at other institutions in order to design

	• May involve control groups, randomization of individuals to different treatments, regimens or processes, statistical tests, etc.	improvement plan
Dissemination of Results	• Intent to publish or present generally presumed at the outset of project as part of professional expectations, obligations. • Dissemination of information usually occurs in research/scientific publications or other research/scientific fora. • Results expected to develop or contribute to generalizable knowledge by filling a gap in scientific knowledge or supporting, refining, or refuting results from other research studies	• Dissemination of information may occur in quality improvement publication/fora. • When published or presented to a wider audience, the intent is to suggest potentially effective models, strategies, assessment tools or provide benchmarks or base rates rather than to develop or contribute to generalizable knowledge. • Any publication should footnote that the project was carried out as QI and did not meet the definition of research per DHHS regulations.
Testing/Analysis	• Statistically prove or disprove hypothesis	• Compare a program/process/system to an established set of standards
Data Collection	• Systematic data collection	• Systematic data collection
Mandate or Endorsement	• Activities not mandated by institution or program	• Activity endorsed or mandated by the institution as part of its operations
Effect on Program	• Findings of the study are not expected to directly affect institutional or programmatic practice, however they may influence future policies	• Findings of the study are expected to directly affect institutional practice and identify corrective action(s) needed
Population	• Usually involves a subset of individuals. • Universal participation of an entire clinic, program or department is not expected. • Generally, statistical justification for sample size used to ensure endpoints can be met	• Information on all or most receiving a particular treatment or undergoing a particular practice or process expected to be included; exclusion of information from some individuals significantly affects conclusions. • Initial work can be limited to a smaller subgroup to identify and plan for implementation or feasibility etc with the expectation that the practice or process will be extended to the broader population
Benefits	• Participants may or may not benefit directly. Benefit, if any, to individuals are incidental or delayed	• Participants expected to benefit directly from the activities • Knowledge sought directly benefits a process/program/system.
Risk/Burdens	• May put participants at risk	• Does not increase risk to participants, with exception of possible privacy/confidentiality concerns

Use of Placebo	• Use of placebo may be planned	• Comparison of standard treatments, practices, techniques, processes. Placebo would not be used
Deviation from Standard Practice	• May involve significant deviation from standard practice	• Unlikely to involve significant deviation from standard practice

Additional Resources:
OHRP Quality Improvement Activities – FAQs: http://answers.hhs.gov/ohrp/categories/1569

Please contact the Office of Human Research Subjects Protection if you have any questions at x62700 or irbesubmit@coh.org.

Geriatric Oncology: Educating Nurses to Improve Quality Care

City of Hope

February 25-27, 2019

OCN® renewal candidates: 18.6 ILNA points may be applied toward:

Screening/Early Detection	Up to 0.5* points
Scientific Basis/Diagnosis, Psychosocial	Up to 3* points each
Treatment, End of Life	Up to 2* points each
Symptom Management	Up to 6* points
Survivorship	Up to 4* points
Professional	Up to 7* points

AOCNP® and AOCNS® renewal candidates: 18.6 ILNA points may be applied toward:

Screening/Early Detection	Up to 0.5* points
Scientific Basis/Diagnosis, Psychosocial	Up to 3* points each
Treatment, End of Life	Up to 2* points each
Symptom Management	Up to 6* points
Survivorship	Up to 4* points
Professional	Up to 4* points
Coordination of Care or Roles of the APN	Up to 5* points

*Note that some of the course content applies to **multiple content areas**. The numerical value indicates the **maximum amount** of points that can be claimed in each domain. **The total amount of ILNA points claimed may not exceed the total amount of CNE awarded from this course**.