# Optimal care pathway for older people with cancer

## Quick reference guide

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

This quick reference guide summarises the *Optimal care pathway for older people with cancer*. Optimal care pathways (OCPs) describe the standard of care that should be available to all people with cancer treated in Australia. OCPs support patients and carers, health systems, health professionals and services and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

In Australia, government organisations typically classify people beyond 65 years of age as 'older', and people of Aboriginal and Torres Strait Islander origin as 'older' from the age of 50. Older people with cancer are very diverse. Some may have age-related issues that can add complexity to their cancer care. Refer to other cancer-specific OCPs on the Cancer Council website <www.cancer.org.au/OCP>.

**Key considerations to support optimal care for older people with cancer**

- **Providing age-friendly care.** Ensure health care is accessible, inclusive for older people with varying needs and capacities, and delivers care aligned with a person's values, preferences and goals. This OCP has been designed around addressing the 4M priority areas[1] – what Matters most, Medications, Mentation and Mobility.
- **Recognising and addressing ageism**. Ageism includes attitudes and behaviours held about older people such as negative stereotypes, prejudice or discrimination, which can compromise treatment. Regardless of age, older people have a right to know about all treatment options available and to be treated with respect.
- **Incorporating timely geriatric medicine and aged care referrals.** Providing specialised expertise to address the challenges of ageing and comorbidities ensures treatment aligns with a patient's goals and supports their functional independence and quality of life.
- **Delivering appropriate models of care.** The optimal care of older people requires geriatric assessment and management to guide appropriate cancer treatment and to meet their supportive and geriatric care needs. Cancer services should consider what multidisciplinary model of care is possible in their healthcare facility. Where possible, they should integrate oncology services with geriatric medicine and community-based aged care services.
- **Including carers and family.** Carers and families may play an important role and should be involved in communication and decision-making in line with a person's preferences. Many older people with cancer also have caring roles.
- **Ensuring effective communication.** Effective communication is two-way. It encourages a person's involvement and asks what matters most to them, involves family or carers to the extent a person wishes, uses age-inclusive language, and minimises potential barriers to communication.

**Note:** If not specifically stated it is assumed that the older person has the capacity to make decisions for themselves. Any person entrusted to make decisions on behalf of an older person with cancer who does not have competence or capacity must align with requirements of any relevant legislation and state and territory civil and administrative requirements.

**Please note that not all patients will follow every step of the pathway.**

## Step 1: Prevention and early detection

### Prevention and risk reduction

Encourage older people to:

- quit smoking
- maintain a healthy bodyweight
- be physically and socially active
- reduce frailty with strength and balance exercises
- avoid or limit alcohol intake
- eat an adequate, healthy diet
- take up recommended immunisation
- reduce ultraviolet light exposure and adopt SunSmart practices.

### Risk factors for cancer

- Older age
- Risk factors to consider more specifically in older people (e.g. frailty, comorbidities, malnutrition)
- Risk factors relevant to cancer in other age groups (e.g. smoking, alcohol, specific infections)
- Extended exposure to possible carcinogens, both environmental and pharmaceutical

### Checklist

- ❑ Monitor and record weight changes.
- ❑ Discuss and record alcohol intake.
- ❑ Discuss and document smoking status. Provide smoking cessation advice.
- ❑ Discuss and document nutrition. Consider referral to a dietitian (e.g. for malnutrition and sarcopenia).

1 <https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf>

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Cancer Australia

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## Step 1: Prevention and early detection continued

### Early detection

- Have regular GP and dental reviews.
- Work closely with the GP to consider ongoing participation in relevant cancer screening (e.g. colorectal, breast, cervical and lung cancer).
- Address issues that may delay health-seeking behaviour and early diagnosis (e.g. social isolation, no carer).
- Encourage medical assessment for possible tumour-specific symptoms.
- Consider a cancer diagnosis in an older person with new or progressive:
  - frailty
  - malnutrition
  - cognitive impairment
  - functional decline.

### Checklist

- ❑ Discuss and document physical activity. Consider referral to a rehabilitation specialist/unit, physiotherapist or exercise physiologist.
- ❑ Recommend routine cancer screening (BreastScreen Australia, National Bowel Cancer Screening Program, National Cervical Screening Program).
- ❑ Discuss suitability for lung cancer screening and prostate cancer early detection.
- ❑ Discuss and document social and community support options (e.g. government aged care programs and local community activities).
- ❑ Discuss and offer the opportunity to engage in advance care planning and medical treatment wishes and preferences.
- ❑ Ask about, and facilitate, access to transport.

## Step 2: Presentation, initial investigations and referral

### Presentation

- Cancer may present with typical symptoms but also as an ageing-associated syndrome. Such syndromes include new or progressive functional impairment, cognitive impairment, frailty and social isolation.
- Older people are more likely to present with advanced cancer than younger people and to have a delayed diagnosis.
- Collateral information from family or friends may be helpful.

### Referral options

The GP or other referring doctor should advise the older person and, if applicable, their carer(s) about their options for referral, waiting periods, expertise, out-of-pocket costs and the range of services available including access to allied health and geriatric services. This will enable patients to make an informed choice of specialist and health service.

For those older people with a confirmed diagnosis in primary care, GPs should consider referral to a comprehensive cancer centre with expertise in managing older people with cancer.

### Checklist

- ❑ Signs and symptoms recorded.
- ❑ Basic investigations performed. Specialised investigations may be considered on the advice of a specialist clinician.
- ❑ Geriatric and supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required.
- ❑ Patient notified of support services such as the Cancer Council on 13 11 20.
- ❑ Referral options discussed with the older person and, if applicable, their carer, including costs.

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## Step 2: Presentation, initial investigations and referral continued

### Communication

**The referrer's responsibilities include:**

- explaining to the older person and their carer who they are being referred to and why
- supporting the older person and their carer while waiting for specialist appointments
- ensuring physical and psychosocial symptoms are managed
- informing the older person and their carer that they can contact the Cancer Council on 13 11 20.

### Timeframe

Prompt initial assessment is important. Older people with proven or suspected cancer should be referred to a cancer clinician as soon as possible. Timeframes for completing investigations and referral should be informed by evidence-based guidelines and cancer-specific OCPs (where available), recognising that shorter timeframes for appropriate consultations may improve clinical and patient-reported outcomes.

## Step 3: Diagnosis, staging and treatment planning

### Diagnosis and staging

The appropriate, multidisciplinary care of older people with cancer should be guided by an adequate geriatric assessment as well as an assessment of the cancer. This should consider the patient's goals and priorities and their ability to cope with investigations and treatment before starting invasive procedures. If appropriate, a tissue biopsy is crucial to guide care and should not be withheld based on age alone.

### Genetic testing

Take a detailed personal and family cancer history. Certain subtypes of cancer may suggest an underlying inherited cancer predisposition which may have implications for the older person and their family. A decision to refer to a familial cancer service should not be based on age alone.

### Treatment planning

All newly diagnosed patients should be discussed at an MDT meeting before starting treatment. Treatment decisions should not be made on the basis of age alone. Vital information includes:

- histological diagnosis
- tumour stage
- patient performance status.

A multidimensional geriatric assessment can inform the MDT of ageing-related issues and guide treatment decisions and supportive care. This includes accounting for: life expectancy; comorbidities and concurrent medications; an estimate of frailty including mobility; decision-making capacity including any cognitive impairment; social supports; sensory deficits (vision/hearing); and knowledge of the patient's preferences and goals of care.

### Multidisciplinary team membership and responsibilities

The MDT should include the core disciplines that are integral to providing best practice and relevant expertise for the specific cancer type. Members with a familiarity of the needs of older people and the ability to respond to the findings of a geriatric assessment will enhance the decision-making process. Nominate a lead clinician[2] to guide discussions.

### Research and clinical trials

Older people are under-represented in clinical trials. Patients should be informed about opportunities to participate in clinical trials where possible. Older age alone is not an exclusion criteria for enrolment in a clinical trial. Search for a trial on the Australian Cancer Trials website <www.australiancancertrials.gov.au>.

### Checklist

- ❑ Diagnosis confirmed.
- ❑ Full histology obtained.
- ❑ Performance status and comorbidities measured and recorded.
- ❑ Adequate multidimensional assessment of geriatric domains to inform treatment decision-making.
- ❑ Existing advance care directives reviewed and considered in treatment decision planning.
- ❑ Patient discussed at an MDT meeting and decisions provided to the patient and/or carer.
- ❑ Clinical trial enrolment considered.
- ❑ Geriatric supportive care needs assessment completed and recorded and referrals to allied health services actioned as required.
- ❑ Patient referred to support services (such as the Cancer Council on 13 11 20) as required.
- ❑ Treatment costs discussed with the patient and/or carer.

2 Lead clinician – the clinician nominated as responsible overseeing and coordinating a patient's care. The lead clinician may change over time depending on the stage of the care pathway and the setting where care is being provided.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

## Step 3: Diagnosis, staging and treatment planning continued

### Communication

**The lead clinician's responsibilities include:**

- discussing a timeframe for diagnosis and treatment options with the older person and/or carer
- explaining the role of the MDT in treatment planning and ongoing care
- encouraging two-way discussion about the diagnosis and prognosis, including checking their understanding
- clarifying the patient's wishes, needs, beliefs and expectations, including their communication preferences
- supporting decisions about goals of care and advance care planning
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from MDT meetings.

### Timeframe

Timeframes for completing investigations and referral should be informed by evidence-based guidelines and cancer-specific OCPs (where available), recognising that shorter timeframes for appropriate consultations can reduce distress. Extra time may be required for geriatric screening and/or geriatric assessment and/or for getting specialist opinions about managing comorbidities.

## Step 4: Treatment

### Establish the intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation

### Treatment options

Treatment options for older people need to consider the older person's goals and preferences, life expectancy from comorbid conditions and (potential/possible) treatment-related toxicities. Shared decision-making involving family and carers should be guided by a person's preferences. Treatment plans should be modified if indicated based on the patient's preferences or issues identified on geriatric assessment including the following:

- Refer for geriatric assessment and management if indicated.
- Via the MDT, optimise the patient's health status before treatment including:
  - cognition
  - comorbid chronic disease
  - medication usage
  - mental health
  - nutrition
  - physical function
  - sensory function
  - social support.

### Geriatric and aged care

Referral to geriatric medicine teams and aged care services can be essential for optimising care for older people with cancer. These teams provide expertise to address the challenges of cancer, ageing and comorbidities, ensuring treatment aligns with the patient's goals and supports functional independence and quality of life.

### Palliative care

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

### Communication

**The lead clinician and team's responsibilities include:**

- discussing treatment options with the older person and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the older person and/or carer including appointment of a substitute decision-maker, if they choose to do so
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for allied health, geriatric management, prehabilitation, rehabilitation and exercise programs where appropriate to improve treatment outcomes.

### Checklist

- ❑ Geriatric screening +/- assessment conducted.
- ❑ Health status optimised pre-treatment.
- ❑ Symptoms managed as appropriate.
- ❑ Intent of treatment determined.
- ❑ Treatment plan provided to the person's GP.
- ❑ Early referral to palliative care considered based on need.
- ❑ Advance care planning explained and offered to the patient and/or carer.

### Timeframe

Timeframes for starting treatment should be informed by evidence-based guidelines and cancer-specific OCPs (where available), recognising that shorter timeframes for appropriate consultations and treatment can promote a better experience for patients.

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## Step 5: Care after initial treatment and recovery

### Follow-up arrangements

Responsibility for follow-up care and shared care arrangements should be agreed and communicated clearly between the lead clinician, the person's general or primary practitioner, relevant members of the MDT, and the person and their family or carers, if appropriate.

### Treatment summary

A treatment summary and plan for recovery/survivorship, developed in conjunction with the older person and provided to the GP and other relevant health professionals, should include:

- diagnosis, including stage, prognostic or severity score
- tumour characteristics
- treatments received (types, cumulative doses, dates)
- current toxicities (severity, management and expected outcomes)
- potential long-term and late effects of treatment
- outcomes of geriatric screening and assessment
- interventions and treatment plans from other providers
- supportive care services
- advance care planning
- medication changes
- contact information for key healthcare providers
- a follow-up cancer surveillance schedule, including tests required and timing
- a process for rapid re-entry to medical services for suspected recurrence or serious complication of cancer treatment.

### Recovery/survivorship care

At the end of cancer treatment and follow-up, prioritise recovery and survivorship care. Develop a survivorship care plan as appropriate.

### Carers

Carers of older people with cancer have unique health, information and psychosocial needs separate from those of the person with cancer. Family members and carers should be provided with information and access to support services extending into the follow-up care phase.

### Communication

**An identified member(s) of the healthcare team (usually a nurse or care coordinator) should be responsible for:**

- explaining the treatment summary and follow-up care plan to the older person and, if applicable, their carer
- providing information about healthy living, rehabilitation and wellness
- discussing the follow-up care plan with the person's GP.

### Checklist

- ❑ The preferences, values and goals of the older person have been established and what matters to the person is documented and communicated across all healthcare providers.
- ❑ A treatment summary and survivorship care plan has been developed with the older person and provided to the GP, older person and, if applicable, the carer.
- ❑ Geriatric supportive care needs assessment and discussion about advance care planning completed, recorded and shared across all care providers.
- ❑ Referrals made to all support services, including the need for referral for extra community-based services and supports, Aboriginal and Torres Strait Islander health workers and Aboriginal and Community Controlled Health Services where indicated.

## Step 6: Managing recurrent, residual or metastatic disease

### Detection

Most residual or recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms.

For older people with multimorbidity, symptoms of recurrent or metastatic disease can be harder to recognise or made worse by existing health conditions. Worsening of existing symptoms may be attributed to a range of medical conditions including the metastatic cancer.

### Treatment

Evaluate each patient for whether referral to the original MDT is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences and goals.

The older person should be actively involved in decisions about their care in cases of metastatic or recurrent disease. Ideally, if the person has carer or family support, they should be involved in discussions about treatment and care to ensure everyone understands the goals of care and anticipated outcomes. This also offers an opportunity to assess carer capacity and the need for services to ensure safe management in the community.

Where cognitive impairment has been formally assessed and documented, clarity about a legally defined substitute decision-maker (power of attorney or enduring guardian) is essential in all decisions about treatment.

### Checklist

- ❑ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP.
- ❑ Supportive care needs and geriatric assessments completed and recorded and referrals to allied health services actioned as required.
- ❑ Advance care planning explained and offered to the patient and/or carer.

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## Step 6: Managing recurrent, residual or metastatic disease continued

### Advance care planning and directives

Advance care planning is a voluntary, person-led process that is important for all patients but may be especially valuable for those with advanced disease. It allows them to think about and plan for their future health and personal care that is aligned with their values, wishes and preferences, and to consider if they wish to appoint a substitute decision-maker in the event they cannot make decisions for themselves.

An advance care directive is a legally binding document that a person prepares to let the loved ones and the healthcare team know about the treatment and care they wish or not wish to receive in case they become too unwell to make those decisions themselves. Advance care planning documents differ in each state and territory.

### Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early in the setting of metastatic or recurrent disease. Early referral to palliative care can improve quality of life, reduce physical and symptom burden, enhance prognostic awareness, reduce unnecessary health care use and in some cases may be associated with survival benefits. Referral should be based on need, not prognosis.

### Communication

**The lead clinician and team's responsibilities include explaining the treatment intent, possible outcomes, likely adverse effects and the supportive care options available to the patient and/or carer and the patient's GP.**

### Checklist

- ❑ Patient referred to palliative care if appropriate.
- ❑ Routine follow-up visits scheduled.

## Step 7: End-of-life care

Shared decision-making should guide end-of-life care planning for older people with cancer and involve an MDT including the person's GP. For older people with comorbidities these may significantly contribute to prognosis and end-of-life needs. Care should be proactive to address potential future issues that may occur as end-of-life approaches and extend into bereavement after the older person has died.

### Palliative care

Clinical care should be guided by regular individualised clinical assessments for physical, psychosocial, spiritual and existential needs.

A specific needs assessment for carer(s) should also be undertaken and regularly re-evaluated, with tailored support provided.

Consider a referral to palliative care. If a patient has completed an advance care directive and/or appointment of a substitute decision-maker, ensure these documents are available and shared with the treatment team so they can be considered in care planning.

### Communication

**The lead clinician's responsibilities include:**

- being open about the prognosis and discussing palliative care options with the patient
- facilitating transition plans to ensure the patient's needs and goals are considered in the appropriate environment
- discussing the role of ongoing cancer therapies, investigations and treatment for intercurrent medical issues.

### Voluntary assisted dying

A person who has advanced cancer who meets strict criteria (which varies by state and territory) can request access to voluntary assisted dying. It must be voluntary and requested by the person themselves.

### Checklist

- ❑ Palliative and end-of-life care needs assessment and carer needs assessment completed and recorded, and a tailored plan in place.
- ❑ Referrals for the older person and/or carer to interdisciplinary clinicians and support services actioned as required.
- ❑ Older person referred to palliative care.

**Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.**

Published in November 2025.