



Decision Making with Pre-existing Cognitive Dysfunction

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Disclosure

I do not have any conflict of interest to declare.

OBJECTIVES

1. Dementia and cancer treatment
2. Decision-making capacity
3. Shared-decision making

Case of Mr Burke

- Mr. Burke is a 78 year old retired accountant, married for 10 years to Madeline (his second wife). His son, Henry, is from his first marriage.
- Mr. Burke loves to read, although he has had difficulty understanding written material for the last two years. His wife helps him with his medications and she took over the task of paying the bills.
- He is always been a vibrant man, enjoys socializing with friends, traveling with his wife and visiting his grandchildren.



Case of Mr. Burke



- Mr. B has locally advanced tonsil cancer diagnosed 6 months ago. Completed chemoradiation 2 months ago severe side effects, now improved. F/u imaging showed suspicious lung mets, now biopsy proven.
- PMH: HTN, HL, 40 py smoker.
- Geriatric syndromes: MCI diagnosed 2 years ago. One episode of delirium while in the ICU for chemo-related N, V and hypotension with some residual further cognitive decline.
- Patient is independent for ADLs but dependent for most IADLs.

Case of Mr. Burke – Current visit



- Patient came with his son and daughter-in-law to your office to further discuss treatment options
- You have already explained to Mr. B and his wife last week that palliative chemo is his only option – no curative options.
- Mr B does not want any more chemotherapy. He cannot tolerate any more side effects. His wife agrees with him.
- Mr B's son and daughter-in-law think that he does not understand the extent of the problem and tell you “Are you going to let him just die?”

Concerns



- **Mr. Burke's concerns:**

- I just want to live a life without hospitals. I don't want to throw up. I want to see my friends. I want to visit my grandchildren.

- **Wife's concerns:**

- We ended up in the ICU during his past chemo and he almost died. How will his quality of life be with this one?
- He is already forgetful. His memory cannot get any worse!

- **Henry's concerns:**

- Look doc, my dad is a tough guy. He can endure whatever chemo you put him on.
- My wife, my children, and I want him to live as long as possible.
- I don't think he gets it. If he does not take the chemo he is going to die.

What are the issues?

1. Dementia and cancer treatment
2. Decision-making capacity
3. Shared-decision making

1. Dementia and Cancer Treatment

Psycho-Oncology

Psycho-Oncology 25: 1137–1146 (2016)

Published online 13 July 2016 in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/pon.4185

Review

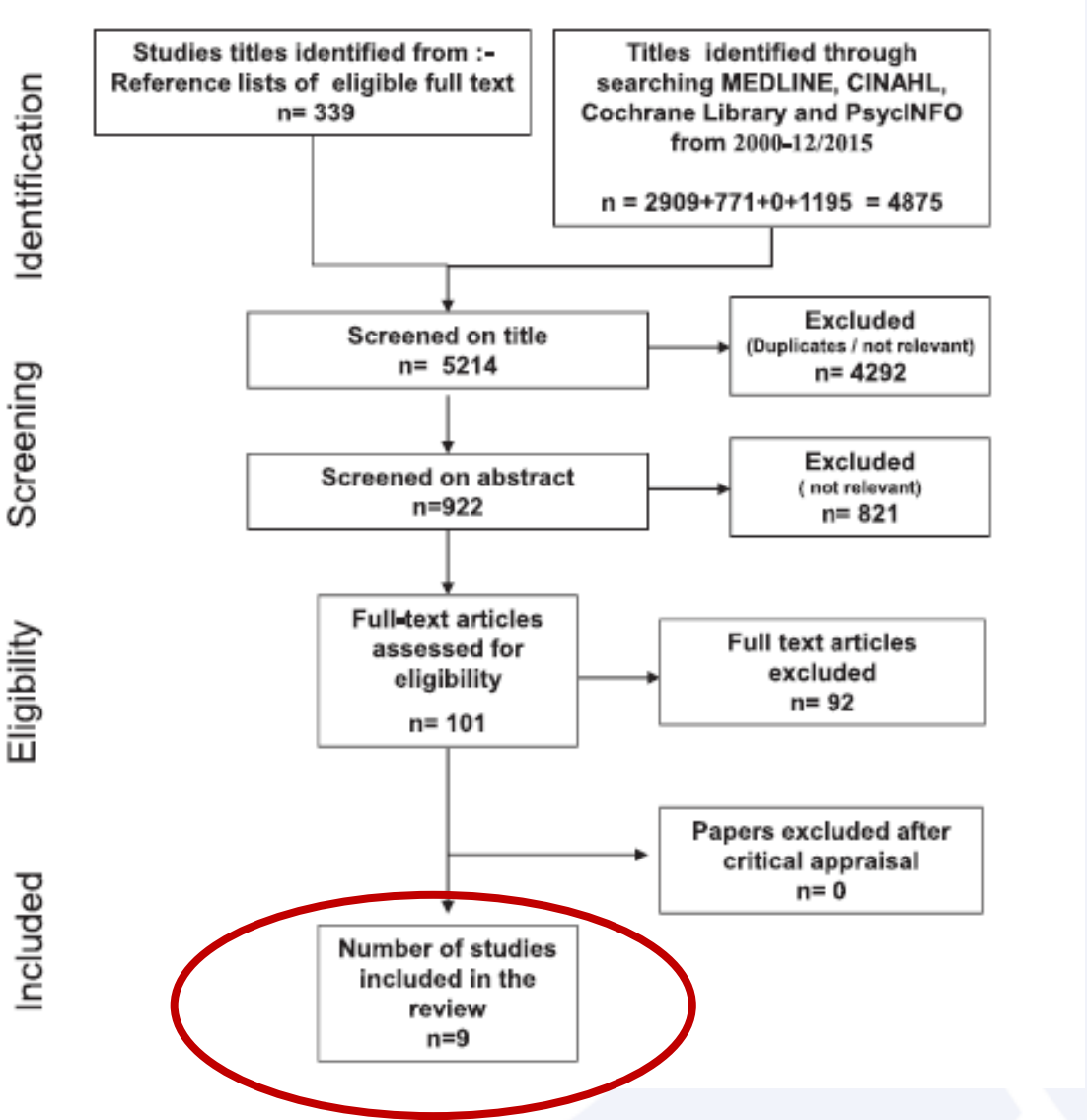
People with dementia: what is known about their experience of cancer treatment and cancer treatment outcomes? A systematic review

J. B. Hopkinson^{1*}, R. Milton², A. King¹ and D. Edwards¹

¹*School of Healthcare Sciences, Cardiff University, Cardiff, UK*

²*School of Medicine, Cardiff University, Cardiff, UK*

Flow of information through the phases of the systematic review



What was found?

People treated for cancer who have a pre-existing dementia:

- ✓ Are diagnosed at a later or unknown stage
- ✓ Receive less treatment
- ✓ Are more likely to experience complications from treatment
- ✓ Only 1/9 studies reported how the oncology team managed the needs of seven people with dementia.
- ✓ Have poorer survival

What was NOT found?

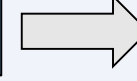
- ✓ There were no reports investigating the supportive care needs and preferences of people with dementia in receipt of cancer treatment
- ✓ There were no reports on the role of family caregivers in spite of the known importance of informal support in the lives of people with dementia
- ✓ There were no studies of clinical outcomes (other than survival)
- ✓ There were no studies of quality of life outcomes, such as physical function
- ✓ There were no studies of impact of cancer on symptoms of dementia

APPROACH TO DECISION-MAKING IN THE OLDER ADULT

Is the patient at moderate or high risk of dying or suffering from cancer considering his or her overall life expectancy?



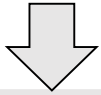
NO



Symptom management/ supportive care



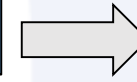
YES



Does this patient have decision-making capacity? Patients must have the ability to understand the relevant information about proposed diagnostic tests or treatments, appreciate their situation (including their underlying values and current medical situation), use reason to make a decision communicate their choice

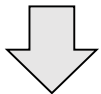


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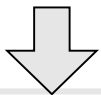


Obtain information from patient's proxy

- Advance directives
- Living will
- Health care providers
- power of attorney
- Clinician's documentation
- Consider consult from ethics committee or social worker or consider Palliative Care



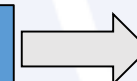
YES



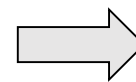
Assess the patient's goals and values regarding management of the cancer
Are the patient's goals and values consistent with wanting anticancer therapy?



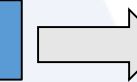
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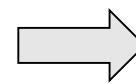
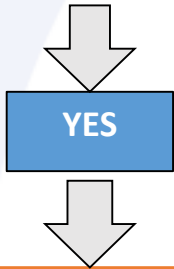
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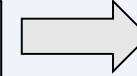
Assessment of Risk Factors

APPROACH TO DECISION-MAKING IN THE OLDER ADULT

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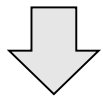


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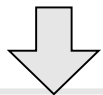


Symptom management/ supportive care

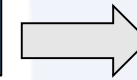
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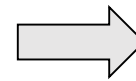
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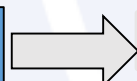
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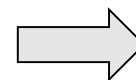
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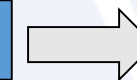
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Symptom management/ supportive care



YES



Assessment of Risk Factors

Practical Assessment and Management of Vulnerabilities in Older Patients Receiving Chemotherapy: ASCO Guideline for Geriatric Oncology

RECOMMENDATIONS

1. Patients ≥ 65 yo receiving chemotherapy, GA should be used to **identify vulnerabilities** or geriatric impairments that are not routinely captured in oncology assessments
2. Validated and practical GA –based tools can be used to **predict adverse outcomes**
 - a. **At a minimum: assessment of function, comorbidities, falls, depression, cognition and nutrition**
 - b. Recommended IADLs for function, GDS for depression, Mini-Cog or BOMC for cognitive impairment and assessment of unintentional weight loss for nutrition
 - c. Either the CARG or the CRASH tool recommended to be used to estimate risk of chemotherapy toxicity
3. Clinicians should use the Schonberg or Lee Index (ePrognosis) to **estimate life expectancy** ≥ 4 years
 - a. Answer NO to “presence of cancer” to obtain an estimation of competing(non-cancer) risks of mortality
4. Approaches for implementing GA in older adult with cancer
 - a. Apply results of GA to **develop individualized plan**
 - b. Take into account GA when recommending treatment
 - c. Implement targeted GA-guided targeted interventions to manage non-oncologic problems

Assessment of Cognitive Status in Older Cancer Patients

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.^{1,2} 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 (0/30). Hand lengths 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.

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Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day? Month?"
5		"Where are we now? State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

MONTREAL COGNITIVE ASSESSMENT (MOCA)

Version 7.1 Original Version

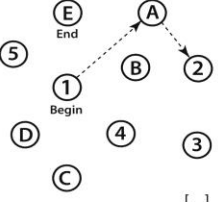
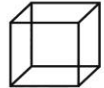
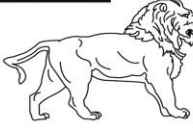
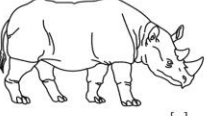
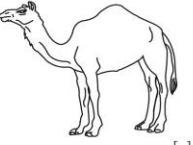
NAME: _____

Education: _____

Date of birth: _____

Sex: _____

DATE: _____

VISUOSPATIAL / EXECUTIVE		Copy cube	Draw CLOCK (Ten past eleven) (3 points)	POINTS				
		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contour Numbers Hands	___/5				
NAMING								
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/3				
MEMORY		FACE	VELVET	CHURCH	DAISY	RED	No points	
Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.		1st trial						
		2nd trial						
ATTENTION		Subject has to repeat them in the forward order [] 2 1 8 5 4					___/2	
Read list of digits (1 digit/sec).		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		___/3	
		4 or 5 correct subtractions: 3 pts. 2 or 3 correct: 2 pts. 1 correct: 1 pt. 0 correct: 0 pt						
LANGUAGE		Repeat: I only know that John is the one to help today. []					___/2	
		The cat always hid under the couch when dogs were in the room. []					___/1	
Fluency / Name maximum number of words in one minute that begin with the letter F		[]	____ (N ≥ 11 words)					
ABSTRACTION		Similarity between e.g. banana - orange = fruit [] train - bicycle [] watch - ruler					___/2	
DELAYED RECALL		FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUEDE recall only	
Has to recall words WITH NO CUE		[]	[]	[]	[]	[]	___/5	
Optional		Category cue						
		Multiple choice cue						
ORIENTATION		[] Date	[] Month	[] Year	[] Day	[] Place	[] City	___/6
© Z.Nasreddine MD		www.mocatest.org		Normal ≥ 26 / 30		TOTAL	___/30	
Administered by: _____						Add 1 point if ≤ 12 yr edu		

2. Assessment of Decision-Making Capacity in Older Adults with Cancer

Challenges of Decision-Making in Older Cancer Patients

- Great variability in functional and cognitive status **many times unrecognized !!!!**
- High prevalence of sensory impairments
- Lack of available health care decision-making surrogates
- Relative lack of evidence indicating a certain medical procedure/treatment would be clearly beneficial for the elderly patient **very high complexity of decisions that patients are faced with.**

CAPACITY ASSESSMENT is the first step in decision-making of the elderly cancer patient

A diagnosis of cognitive impairment, dementia or delirium does **NOT determine a lack of decision making capacity.**

Capacity assessments are decision and time-specific

Pillars of Decision-Making Capacity

- ✓ Understanding **the relevant information**
- ✓ Appreciating **the current situation and its consequences**
- ✓ Manipulating the information rationally
- ✓ Communicating a consistent choice

[Grisso & Appelbaum, 1998a; Roth, Meisel, & Lidz, 1977](#)

3. Shared Decision-Making

EFFECTIVE COMMUNICATION

Communication Challenges

- Oncologists often face **difficult conversations** with patients relating to prognosis, code status, transition to palliative care, and other sensitive topics
- **Emotions**, such as anger, shock, denial, or sadness, run high during such conversations.
- **Conflicts** arise when patient, caregiver and/or provider are unable to agree on goals and expectations
- Many doctors **lack nuanced skills** necessary to engage in challenging conversations effectively

Barriers to Communicate with the Geriatric-Oncology Patient

- **Cognitive Deficits**

- Clinicians often fail to detect mild dementia and delirium.
- Evaluating cognition with a validated instrument is crucial
- Cognitive deficits make the assessment of symptoms difficult
- Cognitively impaired patients often over or under express their symptoms, which cause distress for families and clinicians
- Some older patients have poor health literacy or language barriers
- Family members and caregivers become surrogate decision makers
- Having a surrogate increases the complexity of communication and decision making.
- Surrogates may be reluctant to make sensitive decisions without first consulting other family members, which create delay.
- Decision making by surrogates is particularly challenging when the patient has not engaged in advance care planning.

- **Functional Deficits**

- Hearing impairment
- Visually impaired
- Physical frailty and limited mobility
- Functional dependency

- **Medical Comorbidities**

- Frail, ill geriatric patients require close medical supervision, and their providers must negotiate goals of care strategically in order to avoid undue toxic effect

Communication Skills Training in Geriatric Oncology

VOLUME 30 • NUMBER 11 • APRIL 10 2012

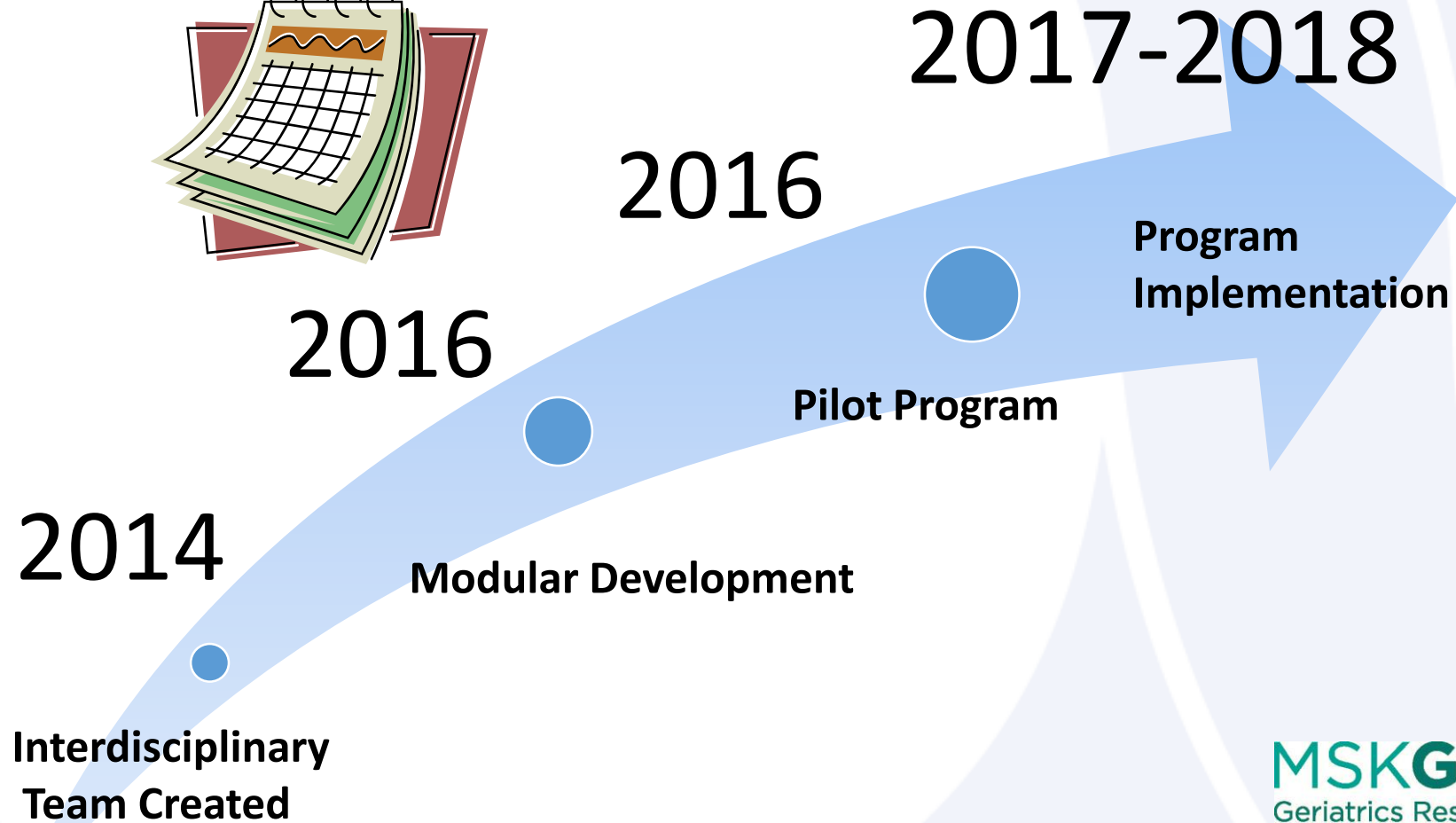
JOURNAL OF CLINICAL ONCOLOGY

REVIEW ARTICLE

Communication Skills Training for Oncology Professionals

*David W. Kissane, Carma L. Bylund, Smita C. Banerjee, Philip A. Bialer, Tomer T. Levin, Erin K. Maloney,
and Thomas A. D'Agostino*

Development Timeline



Geriatric Communication Skills Training to Improve the Care of Older Cancer Patients

Geriatrics 101

- Recognize ageism
- Become familiar with the concept of Geriatric Syndromes and the role of CGA in the evaluation of the older adult with cancer

Cognitive Syndromes

- Recognize and assess for cognitive syndromes in older adults with cancer
- Appreciate decision-making challenges when considering the possibility of cognitive decline.

Shared Decision Making

- Understand the principles of shared decision making
- Practice the skills for facilitating shared decision making w/ an older adult with cancer and his or her caregiver

Geriatric Communication Skills: Geriatrics 101 Module

MSKGRIP: Geriatrics Resource Interprofessional Program

Beatriz Korc-Grodzicki, MD, PhD
Yesne Alici, MD
Christian Nelson, PhD
Koshy Alexander, MD
Ruth Manna, MPH
Natalie Gangai, BS
Megan J. Shen, PhD
Smita C. Banerjee, PhD
Patricia A. Parker, PhD

Geriatric Communication Skills: Cognitive Syndromes Module

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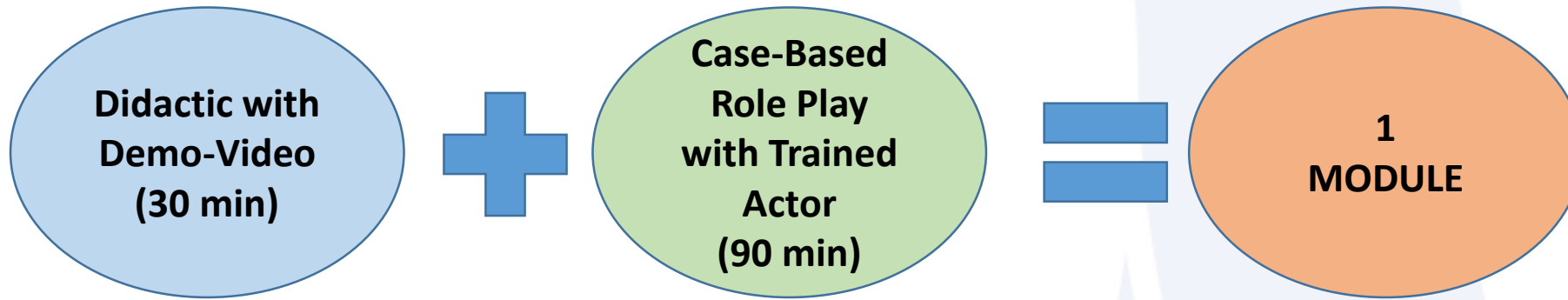
Geriatric Communication Skills: Geriatric Shared Decision Making Module

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PROGRAM

Modules consist of a **didactic presentation followed by experiential role play** with standardized patients (SPs).
Interactions are videotaped, and feedback is led by trained facilitators



Facilitators include geriatric clinicians and Comskil faculty
Learners performed pre and post standardized patient assessments (SPAs)—**video recorded mock consultations** with SPs



Concerns



- **Mr. Burke's concerns:**

- I just want to live a life without hospitals. I don't want to throw up. I want to see my friends. I want to visit my grandchildren.

- **Wife's concerns:**

- We ended up in the ER twice during his past chemo and he almost died. How will his quality of life be with this one?
- He is already forgetful. His memory cannot get any worse!

- **Henry's concerns:**

- Look doc, my dad is a tough guy. He can endure whatever chemo you put him on.
- My wife, my children, and I want him to live as long as possible.
- I don't think he gets it. If he does not take the chemo he is going to die.

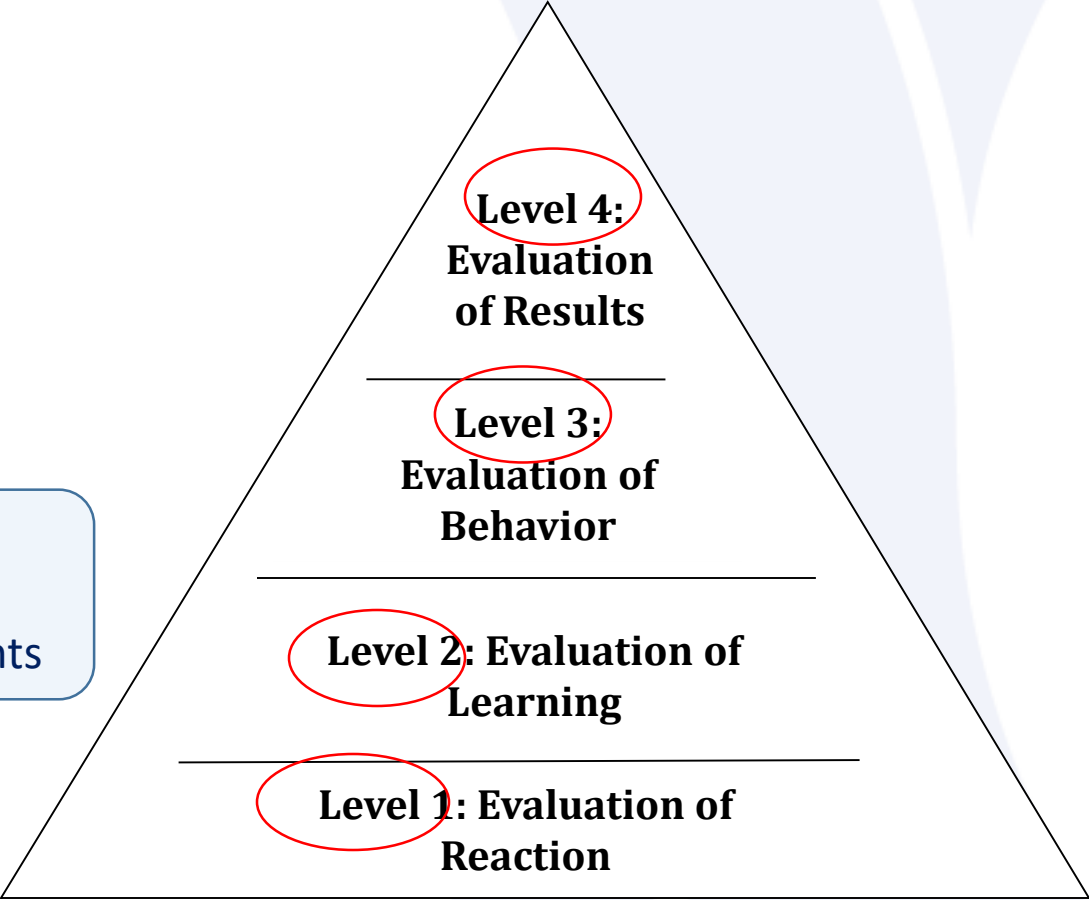
Model for Evaluation: Kirkpatrick Triangle

Evaluation of Results
Patient Outcomes

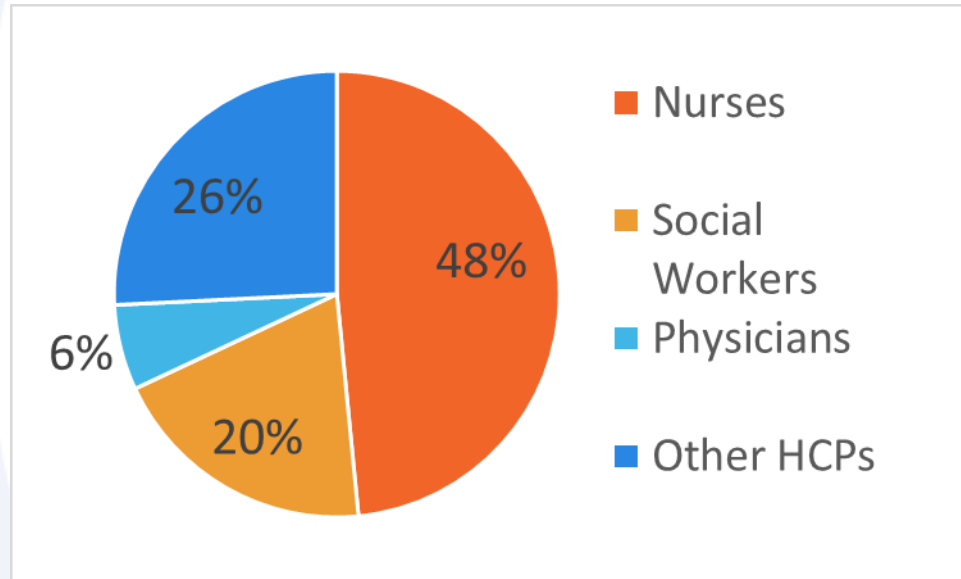
Evaluation of Behavior
Clinic Consultation Recordings

Evaluation of Learning
1. Pre/Post Self Efficacy
2. Standardized Patient Assessments

Evaluation of Reaction
Course Evaluations



RESULTS: PARTICIPANTS



- ✓ Ninety-seven (N = 97) HCPs completed Geriatric Communication Skills Training in groups of 10–12
- ✓ Ages ranged from 26-83 years (M= 42)
- ✓ Participants were predominantly female (87.6%)
- ✓ More than half were White (56.3%), 24% Black 12.5% Asian, and 7.2% others racial groups.

RESULTS: COURSE EVALUATION

- **Course evaluations:** over 85% felt role play “aided their learning a lot” across 3 modules
- **Self-efficacy:** significant improvements in all self-efficacy items before- and after-training
- **SP Assessments:** significant uptake of several communication skills categories from pre to post training SPAs

Participant Evaluation of Geriatrics 101 Communication Skills Training Module (N = 97)

Course Evaluation Items	M (SD) ^a	Agree or Strongly Agree N (%)
1. I feel confident that I will use the communication skills I learned today.	4.60 (.54)	93 (95.9%)
2. The skills I learned today will allow me to provide better geriatric patient care.	4.56 (.54)	93 (95.9%)
3. The workshop prompted me to critically evaluate my own communication skills.	4.63 (.51)	94 (96.9%)
4. The experience of observing the large group role play was helpful to the development of my skills.	4.57 (.54)	93 (95.9%)
5. The skills I learned were reinforced through the feedback I received as a participant in the large group role play. ^b	4.67 (.51)	57 (98.3%)
6. The large group facilitators were effective.	4.60 (.51)	94 (96.9%)

Note. ^a These 6 items were scored on a 5-point Likert scale with anchors at (1) Strongly disagree to (5) Strongly agree.

^b only 58 participants (out of 97) responded to this item.

RESULTS FOR SELF-EFFICACY

*p<.05 **p<.01 ***p<.001

I feel confident in my...	Pre-Training M (SD)	Post-Training M (SD)	df (t)
1. understanding of what "ageism" is	4.06 (.89)	4.45 (.75)	85 (-3.81)***
2. ability to appreciate how ageism might interfere with the medical care of older adults with cancer.	3.60 (1.18)	4.46 (.75)	84 (-5.45)***
3. understanding of what the Comprehensive Geriatric Assessment (CGA) is.	3.31 (1.22)	4.23 (.71)	85 (-7.84)***
4. ...understanding of the role of the Comprehensive Geriatric Assessment (CGA) in the evaluation of elderly cancer patients with geriatric syndromes such as functional or cognitive decline.	3.42 (1.18)	4.12 (.80)	85 (-5.90)***
5. ...ability to differentiate between functional changes due to hearing, vision or gait impairments that present themselves as cognitive changes or depressive symptoms.	3.63 (.93)	4.16 (.68)	86 (-7.08)***
6. ...ability to recognize cognitive syndromes in older adults with cancer.	3.82 (.91)	4.50 (.57)	86 -7.28)***
7. ...ability to appreciate communication challenges in the decision-making process when the patient is cognitively impaired.	3.42 (1.37)	4.55 (.70)	82 (-6.79)***
8. ...understanding of the principles of shared decision making.	2.85 (1.70)	4.52 (.73)	80 (-7.88)***
9. ...understanding of the importance of family-centered care and the complexity of facilitating a family meeting, including the concept of the "third person."	2.88 (1.68)	4.54 (.74)	80 (-7.99)***
10. ...understanding of the challenges of engaging and supporting the family in the care around pivotal cancer-care decisions.	2.59 (1.72)	4.53 (.76)	80 (-9.25)***
11. ...understanding of the core communication components of conducting a family meeting with a geriatric patient.	2.54 (1.65)	4.43 (.93)	79 (-8.72)***
12. ...facilitation of shared decision-making with an elderly cancer patient via a family meeting.	3.58 (1.57)	4.55 (.72)	83 (-5.28)***

Results for Pre-Post STANDARDIZED PATIENT ASSESSMENT

*p<.05 **p<.01 ***p<.001

Communication Skill Categories	Pre-training M (SD)	Post-training M (SD)	t (df = 45)
Agenda setting	.24 (.48)	.94 (1.06)	-3.96***
Declare agenda	.22 (.42)	.52 (.51)	-3.12**
Invite agenda	.02 (.15)	.33 (.60)	-3.29**
Negotiate agenda	.00 (.00)	.09 (.29)	-2.07*
Take stock	--	--	--
Checking	1.11 (1.83)	1.28 (1.43)	-.65
Check understanding	.80 (1.41)	.80 (1.13)	.00
Check preference	.30 (1.26)	.48 (.62)	-.81
Questioning	6.09 (4.66)	6.24 (3.33)	-.24
Ask open questions	4.48 (3.47)	4.00 (2.37)	.88
Clarify	.74 (.88)	.76 (.99)	-.12
Restate	.57 (1.26)	.93 (1.22)	-1.92†
Endorse question asking	.11 (.32)	.11 (.38)	.00
Invite questions	.30 (.70)	.54 (.81)	-1.63
Information organization	.48 (.75)	.91 (.99)	-3.01**
Preview	.00 (.00)	.07 (.25)	-1.77†
Summarize	.09 (.29)	.17 (.44)	-1.16†
Transition	.17 (.49)	.33 (.52)	-1.86†
Review next steps	.22 (.47)	.35 (.60)	-1.23
Empathic communication	3.54 (2.68)	3.30 (2.22)	.57
Encourage expression	.96 (1.13)	1.07 (1.25)	-.46
Acknowledge	.76 (.82)	.70 (.96)	.37
Validate	1.39 (1.50)	1.04 (1.07)	1.55
Normalize	.13 (.34)	.22 (.47)	-1.00
Praise patient efforts	.30 (.63)	.28 (.66)	.18
All skills	11.46 (5.57)	12.67 (5.47)	-1.48



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Decision Making with Pre-existing Cognitive Dysfunction

Beatriz Korc-Grodzicki, MD, PhD

Memorial Sloan Kettering Cancer Center

November 17th, 2018

THANK YOU!