




**CANCER REHABILITATION
SYMPOSIUM
JUNE 8-9, 2015**

Work group 4: Clinical Integration

Work Group 4: Interdisciplinary integration of rehabilitation and shared decision making

- Work Group Co-Chairs:
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- Work Group Members:
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“Operationally, we define this field as any rehabilitation assessment, diagnosis, or functional intervention needed by and provided for any cancer patient at any moment along the continuum of their cancer care.”

Gamble GL, Gerber LH, et al. The future of cancer rehabilitation. Am J Phys Med Rehabil. Vol 90, No. 5 (Suppl), May 2011.

Despite the Growth of the Evidence Base

- Many gaps exist
 - use a “best practices” approach
 - that incorporates the current evidence-base combined with knowledge gleaned from other models of rehabilitation care such as stroke and clinical programmatic/service-line leadership from cancer rehabilitation experts
 - promote and support future research
 - that fosters studying the most important issues in cancer rehabilitation medical care

Medical Knowledge

“From the rehabilitation professional perspective, treatment options are continually changing, requiring maintenance of current knowledge for a large array of cancer types, treatments, and level of disability.”



Aromatase inhibitors may cause physical impairments in:

- A. Joints
- B. Tendons
- C. Nerves

How does this tie to CMS initiatives?

Drug-induced tendinopathy is an underestimated problem

- 4 classes of drugs cause problems—recent addition is **aromatase inhibitors (AI)** (AIs, statins, glucocorticoids and quinolones)

- 50% of patients may have musculoskeletal (MSK) problems
- 20% may discontinue drug due to MSK problems
- 60% of symptoms in the hands and wrists
- 90% or more show periarticular changes on ultrasound
- 50% may have baseline problems that worsen with starting an AI
- 2 months—mean time from treatment initiation to symptom onset or worsening
- Prior chemotherapy, particularly a taxane, increases the risk of MSK problems
- MSK problems include trigger fingers, DeQuervain’s tenosynovitis, and tenosynovitis of finger extensors and flexors

Kirchgesner T, Larbi A, Omoumi P, et al. Drug-induced tendinopathy: from physiology to clinical applications. *Joint Bone Spine*. Dec 2014;81(6):485-492.

Shared Decision Making

Among cancer survivors, shared decision making is associated with improved patient satisfaction, decreased anxiety, and improved quality of life.

1. Gamellari M, Butow PN, Tattersall MH. Sharing decisions in cancer care. *Soc Sci Med.* Jun 2001;52(12):1865-1878.
2. Hack TF, Degner LF, Watson P, Sinha L. Do patients benefit from participating in medical decision making? Longitudinal follow-up of women with breast cancer. *Psychosomatics.* Jan 2006;15(1):9-19.
3. Mandelblatt J, Kreling B, Figueiredo M, Feng S. What is the impact of shared decision making on treatment and outcomes for older women with breast cancer? *J Clin Oncol.* Oct 20 2006;24(30):4908-4913.
4. Whelan T, Levine M, Willan A, et al. Effect of a decision aid on knowledge and treatment decision making for breast cancer surgery: a randomized trial. *JAMA.* Jul 28 2004;292(4):435-441.

Clinical Integration Work Group (CIWG)

- Cancer rehabilitation medical care is a critical component of high quality oncology services.
 - Need for services
 - Large gaps in the delivery of services
 - Results in unnecessary disability
 - Negatively affects patients, families, U.S. workforce and society

Clinical Integration Work Group (CIWG)

- Capacity & Technology
 - Affect all aspects of clinical integration
 - Educate healthcare workforce
 - Identify the patients who would benefit
 - Expand the ability to deliver services
 - Inform survivors/caregivers about benefits
 - Promote cancer rehabilitation research

GOAL #1

Provide oncology and other healthcare professionals with evidence-based or best practices information and education about the benefits of rehabilitation services to improve outcomes across the cancer survivorship continuum and in all domains of health. This includes cognitive and physical impairments, functional limitations, and other factors that restrict participation in social and vocational roles.

GOAL #2

Systematically identify cancer survivors who could benefit from referral to rehabilitation services across the continuum of care and in the context of different treatment settings, along with strategies to improve access to this care in an efficient and timely manner.

GOAL #3

Promote patient engagement and shared decision making in oncology care and include cancer rehabilitation.

Recommendation (preliminary)

1. All institutions involved in the education of healthcare professionals should assess their current training and evaluate opportunities to improve and expand the cancer rehabilitation training while at the same time recognizing the practice scope issues surrounding the treatment of medically complex cancer patients for their rehabilitation medical care needs.

Barrier

- Limited capacity to train oncology, rehabilitation and other professionals

Example

Physiatrist Example

- Raj et al. surveyed PM&R residency program directors
 - 32% of the programs did not have any dedicated cancer rehab faculty
 - physicians in training did not receive adequate exposure to cancer rehab
- ABPMR Maintenance of Certificate (MOC) examination combines cardiovascular, pulmonary and cancer rehabilitation into a single category
 - ~4% of the test

Note: There is a lack of formal training in cancer rehabilitation among all rehabilitation professionals.

Raj VS, Bolouch J, Norton JH. Cancer rehabilitation education during physical medicine and rehabilitation residency: preliminary data regarding the quality and quantity of experiences. Am J Phys Med Rehabil 2014;93: 445-52.
Maintenance certificate booklet of information 2014-2015. ABPMR.

Opportunities

- Rehabilitation professionals need to be trained to deliver the care
- Oncology and other professionals need to be trained to recognize and triage patients appropriately for cancer rehabilitation services

This is not meant to be a complete list.

Stakeholder Opportunities

What can you or your organization do to support education in cancer rehabilitation for:

- rehabilitation clinicians
- oncology & other healthcare professionals
- survivors & caregivers
- payers
- others



Recommendation (preliminary)

2. The development of cancer rehabilitation clinical training materials should include subject matter experts, including but not limited to, physicians trained in Physical Medicine and Rehabilitation (physiatrists).

Understanding Impairments

- It is the language used:

Investigation of cognitive impairments in people with brain tumours
www.elsevier.com/locate/S0167527210000000
- In the scientific literature

Prevalence and treatment patterns of physical impairments in patients with metastatic breast cancer.
doi.org/10.1016/j.annonc.2014.05.001
- For reimbursement of medical care as dictated by gov't and other third party payers (e.g. ICD, impairment group coding, utilization review)

ICD-9-CM-PCS
 Code Files - Centers for Medicare & Medicaid Services
- By American Cancer Society & other organizations focused on translating science into accessible health information

Impairment-Driven Cancer Rehabilitation: An Essential Component of Quality Care and Survivorship

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Local Treatment & Survivorship Programs

Impairment-Driven Cancer Rehabilitation

Recommendation
(preliminary)

4. All institutions involved in delivering oncology care should evaluate their current gaps in rehabilitation care.

Barriers

- Limited capacity to provide cancer patients with adequate rehabilitation support (e.g. cancer rehab programs tend to be small and underdeveloped)
- Rehabilitation programs often disconnected from systems of oncology care

This is not meant to be a complete list.

Opportunities

- Increase the size and capacity of interdisciplinary cancer rehabilitation programs and service lines
- Implement strategies to ensure patients are adequately screened for impairments and rehabilitation needs

This is not meant to be a complete list.

Barrier

- Healthcare organizational leadership may lack knowledge about the benefits of cancer rehabilitation care and therefore not support these services to the extent needed for high quality oncology care and cost-effective treatment

This is not meant to be a complete list.

Opportunities

- Invite hospital and health system leaders to formal and informal discussions about value-based oncology care and provide information about the role of cancer rehabilitation

This is not meant to be a complete list.

**Recommendation
(preliminary)**

5. High-quality cancer care should incorporate trained rehabilitation professionals on interdisciplinary oncology teams who are knowledgeable about cancer rehabilitation medical care utilizing both the current evidence base and best practices to diagnose and treat the many physical, cognitive and functional impairments in this medically complex population.

Barriers

- Oncology teams may lack integration of cancer rehabilitation professionals

This is not meant to be a complete list.

Opportunities

- As feasible, include rehabilitation professionals in multidisciplinary oncology teams
- Help promote a better understanding of the role of rehabilitation across the continuum of cancer care:
 - prehabilitation
 - patient support
 - diagnosis & treatment of impairments
 - functional outcomes

This is not meant to be a complete list.

Stakeholder Opportunities

- Commission on Cancer (CoC) has an opportunity to better define "rehabilitation representative" for standard E11 that would support including a rehabilitation physician (physiatrist) on cancer committees to help educate colleagues about evidence-based/best practices cancer rehabilitation clinical care within the hospital or system; and, if not available, then another rehabilitation clinician such as a physical, occupational or speech therapist or rehabilitation nurse.

CoC membership is comprised of more than 100 individuals representing the multidisciplinary professionals of the cancer care team. Members include representatives from the ACOS and 47 national professional member organizations. The complete listing of CoC member organizations can be found on the Cancer Programs page of the American College of Surgeons website (www.facs.org)

Professional rehabilitation organizations may apply to join.

What can you or your organization do to support this important goal?

Recommendation
(preliminary)

6. Patients/survivors, providers, and payers need to be educated that meeting rehabilitation, psychosocial, and palliative needs is an integral part of quality cancer care. For providers, this training needs to be incorporated into initial professional education, certification examinations and ongoing continuing education.

Barriers

- Lack of understanding re who is responsible for providing rehabilitation services
- Confusion re what different rehabilitation professionals provide

This is not meant to be a complete list.

Opportunities

- Use screening tools so patients/survivors can better identify and communicate their clinical needs and seek appropriate therapies
- Identify cancer rehabilitation services available in a given setting/catchment area
- Empower patients to raise concerns and self-advocate for their clinical needs

This is not meant to be a complete list.

**Recommendation
(preliminary)**

7. Research granting agencies should identify opportunities to support the urgent need to increase the cancer rehabilitation workforce and aim to include on all grants at least one formally trained rehabilitation medicine professional.

**Recommendation
(preliminary)**

8. Research granting agencies should identify opportunities to support the integration of cancer rehabilitation clinical services in the delivery of high quality oncology care.

**Recommendation
(preliminary)**

9. Research granting agencies should fund studies quantifying the benefits of patient engagement, self-advocacy, and shared decision making on patient outcomes. Agencies should also fund intervention research designed to provide shared decision making skills to both patients and providers, particularly regarding side effects of cancer and cancer treatment, and on the influence of rehabilitation care on cancer outcomes.

Barriers

- Lack of appreciation of potential for rehabilitation approaches to reduce cancer impairments and treatment side effects, improve treatment efficacy, improve cancer outcomes, and support cancer survivors
- Subject matter experts with formal training in PM&R may not be included in cancer rehabilitation grant proposals and in peer-review panels
- Support for research addressing cancer rehabilitation is distributed across diverse NIH institutes and centers
- Providers may fail to ask or screen survivors about new or persistent symptoms, secondary complications, and functional problems

This is not meant to be a complete list.

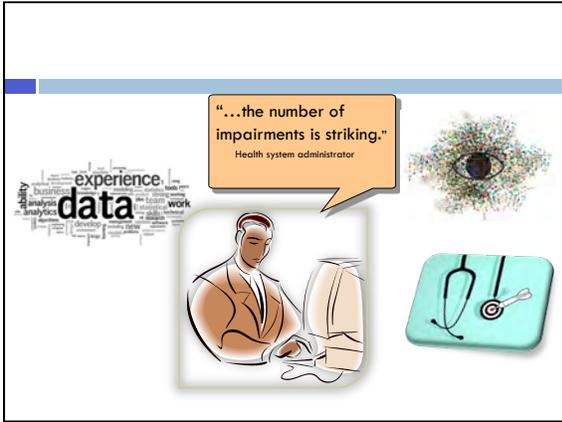
Opportunities

- Identify provocative questions in cancer rehab research
- Support greater involvement of relevant subject matter experts - in particular those with formal training in physical medicine and rehabilitation - in cancer rehabilitation grants, research teams, and review panels
- Provide training to behavioral scientists and health psychologists working in oncology about the role of cancer rehabilitation
- Support research to examine effects of rehab treatments on cancer treatment efficacy, side effects and secondary conditions, patient support, and even cancer mortality

This is not meant to be a complete list.

Stakeholder Opportunities

- Conduct NIH-wide portfolio analysis to better support a coordinated and proactive approach to cancer rehabilitation research



In summary...

- Stakeholders focus on the urgent need to expand the delivery of high-quality cancer rehabilitation medical care by
 - identifying gaps in:
 - educational training
 - clinical integration
 - research
 - working with formally trained rehabilitation healthcare professionals
 - building capacity
 - incorporating technology