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

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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.”

Clinical Integration Work Group (CIWG)

- **Charge:** Promote interdisciplinary integration of cancer rehabilitation services and shared decision making

- **GOALS:**
  1. Information and education about cancer rehabilitation
  2. Access to cancer rehabilitation care
  3. Patient engagement and shared decision making

- **CATEGORIES:**
  1. Education
  2. Clinical
  3. Research

There are many opportunities for stakeholders to become more engaged.

Growing Evidence-Base

“Cancer rehabilitation is an expanding area with a growing scientific production. The rapidly aging population, the higher number of cancer survivors, and the increasing need of resources for the after treatment of cancer patients contribute to explain the interest for this field.”

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

Many Gaps in Care

Conclusions from the Literature:

1. The majority of cancer survivors would benefit from rehabilitation medical care.
2. Most are not receiving it.

Cancer rehabilitation is medical care.

In a study of 329 older adults with cancer:

1. How many of these patients should have been sent for PT/OT for their functional deficits?
2. What percent received PT/OT?

Answers:

341 survivors (65%) had potentially modifiable functional deficits and needed PT/OT. 9% received OT/PT.


Distress & Disability

...physical symptom distress negatively affected all outcomes... *Physical performance and activity level were the only factors that correlated positively to QOL.*

The risk of psychological distress relates much more strongly to their level of disability.

Many more cancer survivors had poor QOL due to physical problems than emotional ones.
Shared Decision Making

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


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
All Clinicians 

Trained Interdisciplinary Team 

Value Based Care has Key 
Stakeholders and 

involve making the care relevant to:

1. Patients—so they 
have shared 
decision making and ask for this care. 
2. Doctors—so they 
see the benefits and it’s a seamless 
part of their workflow. 
3. Payers—so they 
see the positive outcomes and cost 
benefits.
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.
Limited capacity to train oncology, rehabilitation and other professionals

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.

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:
  - In the scientific literature
  - To describe outcomes in clinical trials
  - To describe patients in registries
  - For reimbursement of services
  - By government and other third party payers
  - By American Cancer Society & other organizations focused on translating science into accessible health information
Recommendation
(preliminary)

3. Educational courses and conference lectures on cancer rehabilitation should be given by subject matter experts in cancer rehabilitation who have formal training, licensure and/or board certification in rehabilitation medicine.
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.
Oncology teams may lack integration of cancer rehabilitation professionals

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

The 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 practice 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.

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

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.
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.

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

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