Opportunities to Establish Inpatient and Outpatient Rehabilitation Therapy Programming

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Cancer Effects (McNeely ML, 2012)
- General
  - Deconditioning
  - CRF
- Neurologic
  - Cognitive
  - CIPN
  - Myelopathy
- Musculoskeletal
  - Fibrosis
  - Altered muscle tone
  - Osteoporosis
- Pain
  - Neuropathic
  - Biomechanical
  - Musculoskeletal
  - Phantom
- Cardiovascular
  - Cardiomyopathy
  - Deconditioning
  - Lymphedema
  - Volume overload
- Cognitive dysfunction
  - Bowel/bladder

Known Primary Cancer by Age Group (Gamble et al., 2011)
Drivers of Rehabilitation Needs

- Therapist
- Physician
- Patient

Therapist-driven
- EDUCATION for providers and patients
- In-service key referral sources on how rehabilitation services address functional impairments
- Teach physician/NP/nurses to listen to what patients say
- Provide screening tools specific for their patient population
- Request referrals and send updates to referring physicians with noted success
- Ask clarifying questions/collaborate on complex cases
- Utilize case studies/evidence-based medicine to demonstrate improvements
- Web-site information/videos
- Rehabilitation medicine partnerships

Physician-driven
- Patients report impairments they do not know how to address
  - Exercise prescription
  - Pain syndromes
  - Impaired mobility
  - Need to administer further treatment but patient deconditioned
    - Low Karnofsky ’s score delays or excludes chemotherapy or SCT
    - Need to perform procedures
      - Limitations in ROM delaying radiation
      - Limitations in pulmonary status delaying chemotherapy
      - Trismus
    - Lymphedema/edema
  - Rehabilitation medicine physicians drive therapy referrals
  - Survivorship programs have need for rehabilitation services
Patient-driven

- Dissatisfied with functional status acutely and long after treatment
- Internet savvy, social media
- Research ways to address impairments
- Seek out services and ask for referrals
- Support/post-treatment resource group
- Newsletters
- MSKCC website

ACUTE CARE PROGRAMMING

Overview of MSKCC Therapy Services

- Memorial Hospital founded in 1884 has 470 beds
- Acute care
  - Surgical
  - Medical
  - Transplant
  - ICU/SACU
  - Pediatrics
- Outpatient
  - PT/OT/Lymph @ Sillerman Center for Rehabilitation
  - Pediatric services at Main Campus
  - Lymphedema services at BAIC and Commack
- Do not offer sub-acute or inpatient rehabilitation
Acute Care: Background

- Pre-2005, basic services or “programs”:
  - “Rehab” - OOB mobility
  - Gait/Assistive device
  - Transfers/Functional training
  - Ther ex
  - Discharge disposition
- CPT
  - Percussion & vibration
  - Pulmonary toileting
  - Breathing exercises
- Breast Surgery Rehabilitation Group

Acute Care: Background

- What changed?
  - Rehab philosophy
  - Increased understanding of treatment/surgical complexity and special rehabilitation considerations
  - Recognized a need for:
    - A multidisciplinary rehab approach
    - Provide outcomes based programs
    - Efficiency

Acute Care Programs at MSKCC

- ICU PT/OT Early Mobility (Kress, 2013; Needham et al., 2010)
- Bone Marrow Transplant (BMT) (Morris et al., 2012)
- Post Operative Rehabilitation Program
- Geriatric Program
- Lymphedema/Edema
- Cognitive Rehabilitation (Harrington, 2010; Jansen, 2011)
- Splinting
Program Development

- Needs based – How to identify?
- Designing the program:
  - Demonstrate program feasibility
  - Identify and communicate with primary and secondary players
  - Obtain physician support
  - Collaborate with secondary “systems” players
  - Pilot the program
  - Educate/communicate/follow up
- Key words: improved patient care, decrease complication and LOS, decrease rate of readmission

Program Development

- Barriers
  - Personnel/resource
  - Clinical
  - Cultural change/shift
  - Technological
- Future directions
  - Outcomes/research
  - Prevention-based care
  - Follow-up

OUTPATIENT PROGRAMMING
Post-Treatment Needs

- Physical capabilities with decreased independence have significant emotional impact.
- Patients suffer from acute and late effects of cancer and its treatment.
- Outpatient services are critical in restoring or maximizing functional mobility and cognition.
- Lack of places for patients to go for rehabilitation oncology services in the community.
- Varied needs depending on severity of response to tx.
- Patients should be screened for rehabilitation needs.
  - Prospective surveillance
  - Special Edition: Cancer Supplement, April 2012

(Egan et al., 2013)

EBP for Cancer Rehab

- Use of exercise/physical rehabilitation to reduce fatigue for most cancers.
- Improve UE function following breast cancer.
- Pain.
- Sexual functioning.
- Cognitive functioning.
- Return to work.
- Neurotoxic effects of chemotherapy (Hile, 2010).

Definitions

- Acute effects: complications and toxicities associated with cancer treatment that subside over time.
- Long-term effects: complications or toxicities of treatment that begin during treatment and persist beyond the end of treatment.
- Late effects: unrecognized complications or toxicities absent or sub-clinical at the end of therapy, but become apparent months/years after completing treatment.

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Program Development Considerations

- Programs and space related to program
- Equipment
- Therapist competency/training
- Support staff
- Federal and state insurance regulations
- Documentation (EMR, what program)
- Compliance/Billing
- Emergency support/policy for medically complex population
- No show/cancellation policy

Program Development at MSKCC-Outpatient

- Small practice for many years with waitlist approximately 4-8 weeks
- Track referral volume/capacity, lost referrals
- Submit proposal to administration
- Justify need for increased space for mobility of patients & increased referral volume
- May 2010--22,000 sq. ft. outpatient center
- Staffed with 7 PT, 1 OT; now 21 PT, 2 OT
- Education/In-services to notify physicians regarding rehabilitation services

MSKCC Outpatient Programs

- Radiation fibrosis (Stubblefield, 2012)
- Trismus, Hodgkin Lymphoma-Head Drop Syndrome
- Pelvic floor (Yang et al., 2012; Bartlett, et al., 2011; Tienforti et al., 2011; Goode, 2012)
- Post-mastectomy syndrome (Stubblefield, 2012)
- Lymphedema/edema (Lavoie-Roelofs et al., 2012)
- Chemo-induced peripheral neuropathy (Stubblefield, 2012)
- Vestibular rehabilitation (Hardman et al., 1996)
- Cognitive retraining (Harrington, 2010; Jansen, 2011)
- Custom splinting
- Prospective surveillance (Stout, 2012)
MSKCC Outpatient Schedules

- 45 min sessions, 1:1 for PT and OT (38 per week)
  - 8 patients/day for 5 day, 7.5 hour/day work week
- 60 min (reduced from 75 min), 1:1 for lymphedema
  - 5 patients/day for 5 day, 7.5 hour/day work week
  - Garment fitting transitioning to vendors due to time-intensive process (some sites to keep garment fitting)
- PTA-lead exercise groups; 3 patients for 45 min
- Admin/Meeting time
  - 45 minute slot closed for rehab medicine rounds
  - 45 minute slot closed for therapy meetings/inservices
  - Documentation 45 min/day 5 days/wk

Barriers to Implementing Rehabilitation Programming

- Adequate Staffing
- Reimbursement Issues
- Referring providers believe rehab is not necessary
- Visibility
- Demonstrating feasibility and value of program
- Rotating residents/fellows

Core Competencies

- Invest in your core competencies
  - Therapist’s skills/training
  - Oncology rehabilitation knowledge
- Provide an environment where therapists feel they can make a difference
- Support staff education and professional development
- Referral sources
  - Ongoing education
Future Direction

- Create automatic referrals for outpatient population
- Increase pre-op/pre-treatment rehab intervention
- Prospective surveillance
- Annual MSKCC Cancer Rehabilitation Symposium
- Oncology Residency Program for PT’s
- Participate in research efforts/partner with academic institutions to develop research
- Dissemination of webinars/publications/educational

References


References


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References


Questions??