The Role of Therapy across the Continuum of Palliative Care

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Objectives

- Identify classifications of “cancer rehabilitation”.
- Identify OT/PT/SLP role in symptom management, decreasing caregiver burden, and optimizing quality of life.
- Discuss underutilization of OT/PT/SLP within palliative care.
- Discuss the role of rehabilitation in discharge planning.
- Identify barriers to optimizing care plan approaching end of life.

Rehabilitation

Occupational Therapy: utilizes everyday life activities to promote health, well-being, and an individual's ability to participate in the important activities in one's life.

Physical Therapy: diagnose and manage movement dysfunction as it relates to the restoration, maintenance, and promotion of optimal physical function and the health and well-being of individuals, families, and communities.

Speech-Language Pathology: address areas of swallowing/feeding, communication, and cognition across the life span.

Goals to improve quality of life, enhance participation in meaningful and essential activities, and mitigate symptoms that impair function.

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Classifications of Rehab

Table 3
Dietz Classification of Cancer Rehabilitation[7–9]

Preventative Rehabilitation	Restorative Rehabilitation	Supportive Rehabilitation	Palliative Rehabilitation
Also referred to as prehabilitation or prospective surveillance Early intervention and exercise to identify potential impairments and prevent or delay complications related to cancer or therapies	For cancer patients with potential to attain a full functional recovery, restorative rehabilitation offers comprehensive therapy to regain function to return to work or school	For patients with temporary or permanent deficits from cancer and/or treatments, and patients with slowly progressive or chronic cancer, supportive rehabilitation can give the opportunity to re-establish and maintain functional independence	For patients with treatment refractory cancer or advanced disease, less intense palliative rehabilitation may play a role in assisting the patient and their family by maximizing patient comfort and reducing caregiver burden

[12]

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Preventive rehabilitation

Begins after the diagnosis of the potentially life-limiting illness and attempts to mitigate functional morbidity caused by the disease or its treatment. This is also referred to as prehabilitation

-”Joint Camp”

-Exercise prescription prior to Chemo/Radiation

-Education of disease risk factors.

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Restorative rehabilitation

Attempts to return patients to their premorbid functional status when little or no long-term impairment is anticipated and patients have remaining functional activity.

-Post ACL tear

-Post fracture

-Acute Sprain

Supportive rehabilitation

Attempts to maximize function by augmenting self-care ability and mobility for patients whose disease has been progressing and whose functional impairments are increasing and may not be reversible. This is where most rehab actually starts

- Balance training for patients with Diabetic Neuropathy
- Endurance training for patients with Cardiovascular Disease
- BIG/LOUD program for Parkinson's Disease
- Rehab after CVA

Palliative rehabilitation

Attempts to maintain as high a level of QOL as is feasible in terminally ill patients by relieving symptoms. Aims to reduce dependence in mobility and self-care activities in association with the provision of comfort and emotional support.

- Ordering of Wheelchair and adaptive equipment for ALS
- Focus on Mobility for a cancer patient with no further treatment options
- Lymphedema management to help prevent wounds

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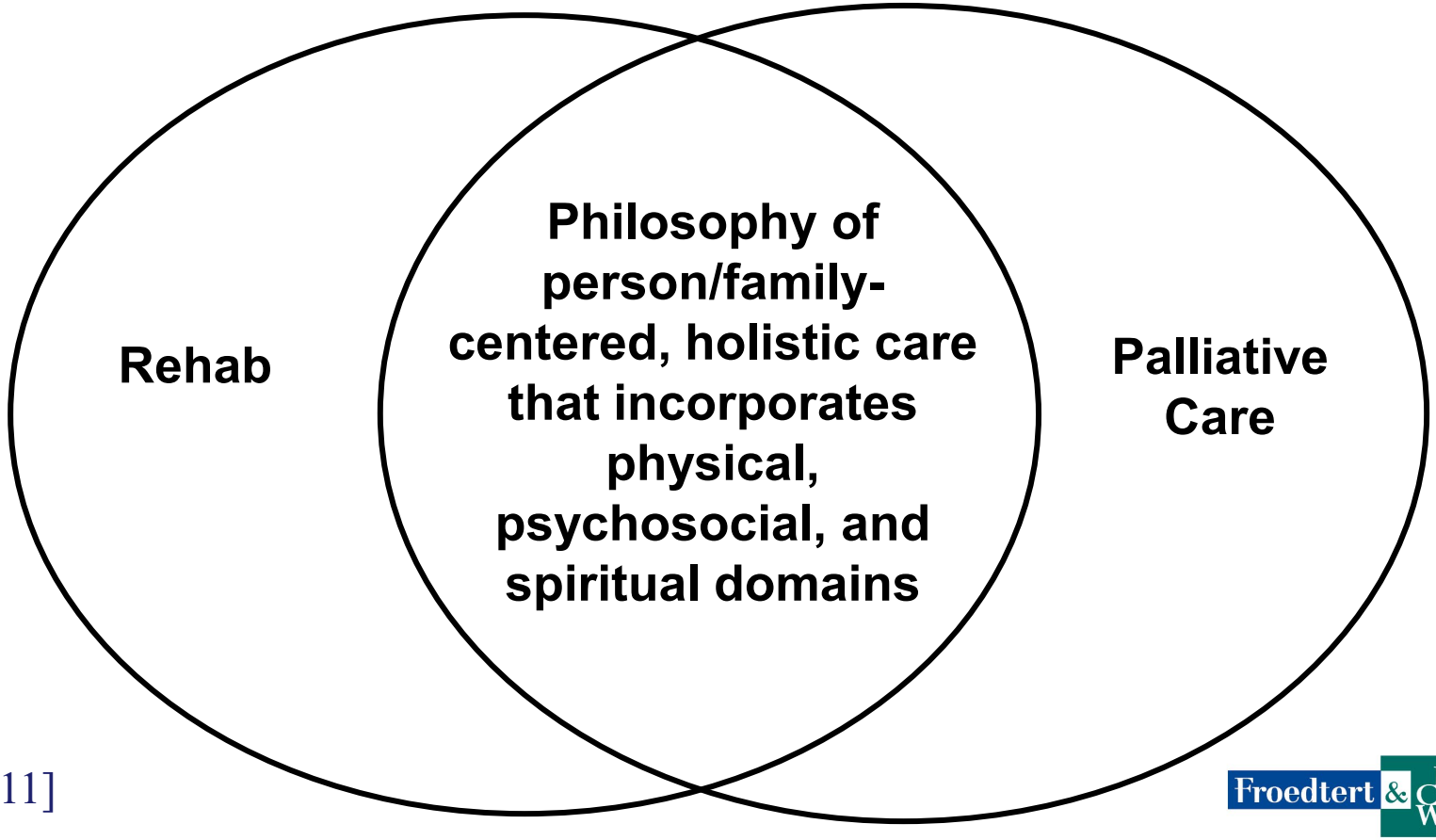
What Rehab can look like across a Disease Process [1]

Phases of disease	Issues for rehabilitation professionals to address
I. From diagnosis to treatment planning	What to expect regarding the impact of cancer treatment on function Understanding function and how to preserve it Comprehensive rehabilitation pretreatment (eg, ROM, ADL, strength)
II. Treatment	Evaluating the effects of treatments on function (surgery, chemotherapy, radiation, biologic agents) Preserving and restoring function through exercise, edema management, and increased activity Controlling pain using heat, cold, and TENS
III. Posttreatment	Developing and supporting a program to help restore daily routines and promote a healthy lifestyle Educating the patient about what to self-monitor (strength, ROM, edema, pain, etc) Supervising a maintenance program of exercise, edema management, and mobility
IV. Recurrence	Educating the patient about the impact of recurrence and its effect on function Educating the patient about what to monitor in the context of the new clinical status Supervising the patient in an appropriate program to restore function or prevent its decline Assisting the patient in maintaining activity and quality of life
V. End of life	Educating patient/family regarding mobility training, good body mechanics, and assistive devices Pain management (nonpharmacologic treatment) and symptom control Maintaining independence and quality of life

Palliative Care and Rehabilitation



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Rehabilitation's Role in Symptom Management

Pain Management

- Exercise targeting core muscles
  - Stabilizing neck, trunk, back
- Postural education
  - Stabilizing at rest positions
  - Body mechanics with ADL
- ROM
- DME and AE
- Psychosocial
  - Guided imagery, deep breathing

[15,16, 17, 20, 21, 22, 23]

Fatigue Management

- Exercise
  - Fatigue levels found to be about 50% lower in exercising cancer patients, even in studies with small sample sizes. [18]
  - Evidence of relief in depression, anxiety, pain and improvement in muscle strength, muscle mass, and bone density [19]
- Energy conservation strategies
  - Activity prioritization
  - Modification and adaptations to reduce energy expenditure (DME, AE, positioning)
- Mindfulness [19]

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Rehabilitation's Role in Decreasing Caregiver Burden

- Modifying the environment for ease of care
  - Durable medical equipment, altering home set up
- Maximizing functional performance with ADLs and basic functional mobility to decrease level of assist
- Education
  - Family training
    - Body mechanics, transfers, providing cares with ADLs, and prevention of pressure injuries at bed based or chair evel.
    - Energy conservation, clustering cares, communication between caregiver and patient.

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Rehabilitation's Role in Optimizing Quality of Life

- Time spent with Patient
- Enabling participation in valued activities
  - Family milestones (weddings, babies, graduations)
  - Valued roles (parent, spouse, grandparent, work, volunteering)
- Maximizing comfort through symptom control
- Providing a sense of control and preserving a sense of dignity

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Rehabilitation's Role in Optimizing Quality of Life

- Even in individuals with cancer cachexia, skeletal muscles have the capacity to respond to exercise training [12]
- Objective outcome measures of rehabilitation in palliative care patients may involve patient-reported parameters, such as improvement in mobility, pain scores, anxiety levels, and satisfaction with care as well as caregiver-related outcomes, such as caregiver burden and QOL.
- Both control and intervention group indicated decline in function, however group that received therapy reports improved mental health, improved ability to participate in social roles, and improved activity expectations and self-efficacy [7]

Underutilization of Rehab Services

- Less than 10% of patients receiving cancer treatment were referred to therapy within 12 months of a noted deficit [1, 8, 12]
- Rehab as interdisciplinary team member helps avoid financial burden by reducing hospital admissions, proactively assessing patient needs, and have been shown to improve patients physically and psychologically [8]

Timing of Referrals

There is no consensus as to when to consider a referral to physical medicine and rehabilitation in palliative care patients. Some general suggestions include:

- Frequent falls at home
- Neurocognitive changes affecting daily life
- Multifactorial pain that limits activity and function
- Interest in pursuing a long-term guided exercise program
- Caregivers or family members reporting an increased burden of care
- Fatigue that limits activity and QOL, with a desire to be more active
- Recent illness exacerbation requiring hospitalization and accompanied by a decline in functional status

[1]

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Impact of Rehabilitation on Treatment Trajectory

- Discharge Planning
  - Knowledge to anticipate potential future needs based on disease, rehab potential, future treatments planned
  - Discussions on short and long term planning
  - Barriers to post acute rehab
    - TPN, radiation schedule, expensive medications, transfusion dependency

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Typical Discharge Recommendations

- Home
  - Independently
  - Home with family supervision/assist
  - Home with home health services
    - PT/OT/SLP, home safety evaluation
  - Home with outpatient services
    - Patients cannot receive Outpatient therapy when they are receiving any home care services
- Post Acute Rehab
  - Inpatient Rehab
    - Must tolerate 3 hours of therapy per day
    - Requires medical needs in addition to rehab needs
  - SubAcute Rehab
    - 100 days of coverage per year from Medicare, patient must have rehab goals for reimbursement
- Long Term Placement
  - LTAC
  - Assisted Living
  - SNF
  - Group Home
  - Memory Care
- Hospice*
  - Residential
  - Virtual
  - Home Hospice

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“Rehabbed to Death”

Ms. P. was an 87-year-old woman with moderate dementia who lived alone in an apartment before, admitted to the hospital with pneumonia.

- During her hospitalization, she became deconditioned and could no longer walk without assistance. Friends and family were unable to provide help at home. She transitioned to a nursing home for post-acute care, paid for by Medicare.
- At post acute care, she developed diarrhea and was readmitted to the hospital with a *Clostridium difficile* infection.
- She transferred back to the nursing home for more rehabilitation, developed delirium, which led to a fall.
- Re-admission.
- Transfer back to the nursing home. 100 days post-acute care covered by Medicare ended, but continued to need help with activities of daily living. Returning home was not an option, since her financial and social supports were limited.
- Ms. P. paid out of pocket for long-term care in the same facility until she exhausted her small savings and qualified for Medicaid.
- She was hospitalized repeatedly until she died, a year after her initial hospitalization, never having returned home.

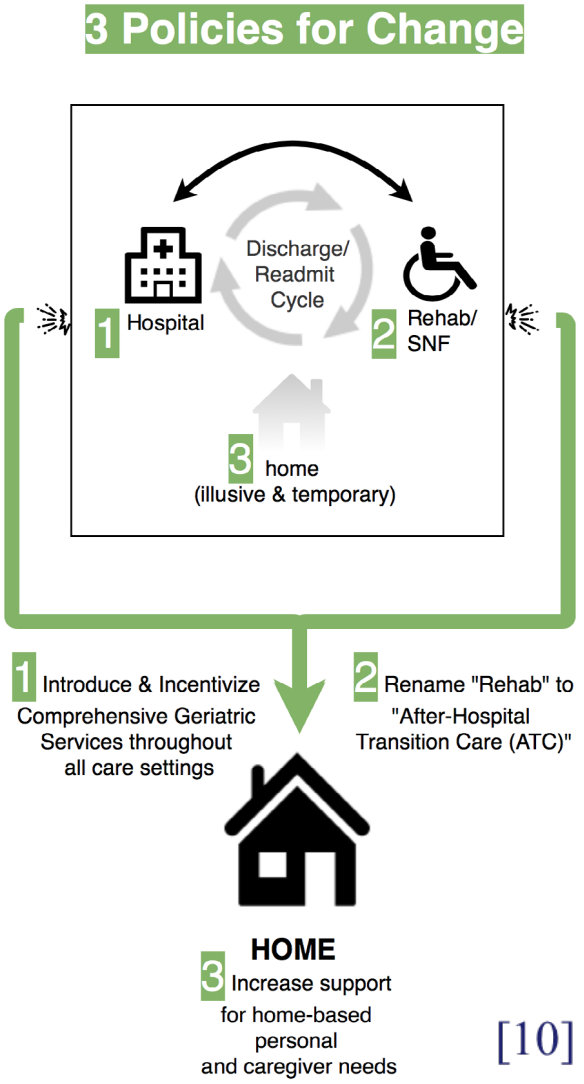
[9]

Coordination of care

- These patients are often told they have to go to “rehab” (as post-acute care facilities are called on the wards) to “get stronger before going home.”
- Inpatient providers think, “I know this person is declining. But if she can’t go home, where will we send her besides a post-acute care facility?”
- The post-acute care providers think, “This person is clearly declining. Why did they send her here without talking about goals of care?”
- Patients and families think, “How did we end up in a nursing home? Aren’t there any other options?”
- Often, no one mentions the possibility of death or discusses the goals of care.

How to break the cycle

- Policy Change
- Consider change of verbiage from calling it Rehab
  - Post Acute Care or Transitional Care
- Honest discussion with patients regarding medical prognosis and rehab prognosis



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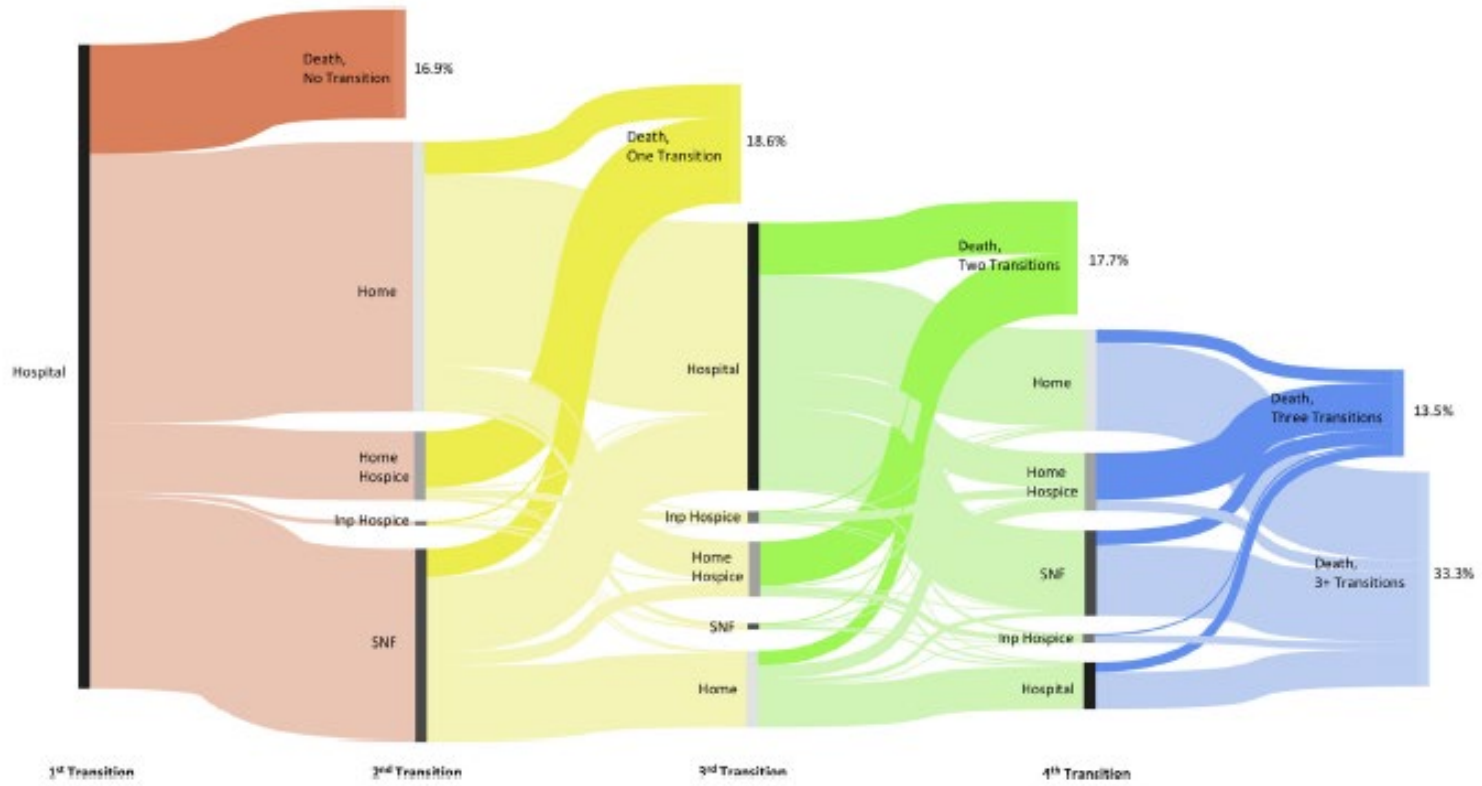

Figure 1. Sequence of care transitions after first hospitalization in the last 6 months of life as seen in Medicare claims in the United States. This figure does not include 19.5% of Medicare decedents who do not have a hospitalization in their last 6 months of life. Inp, inpatient; SNF, skilled nursing facility.

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Barriers to optimizing care plan approaching end of life.

- Ineffective communication
- Providers unaware of scope of Rehab services, locations of rehab, and referral process
- Rehab providers not trained in palliative care
- Timing of referrals
  - Can we capture referrals on the OP side before hospitalizations begin
- Perceived value of Rehab services by patients and other team members

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Key Take Aways

- All Rehab disciplines can have a role from diagnosis to death
- Early referrals to Rehab can help with long term planning prior to hospital admission
- Appropriate discharge planning requires appropriate education regarding medical and Rehab prognosis

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Questions?

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