Cancer Rehabilitation: An Important Opportunity to Improve

Many hospitals and cancer centers are working towards implementing the Commission on Cancer’s (CoC) new standards that focus on patient-centered care. Three of these new standards (Figure 1) significantly impact cancer rehabilitation, which is an eligibility requirement for accredited programs. In fact, navigating patients with treatment-related impairments to cancer rehabilitation services is a critical part of quality oncology care. Understanding the link between distress and impaired physical function in survivors is also important. And finally, the documentation of cancer rehabilitation referrals and follow up recommendations should be part of all survivorship care plans.

What is the gap in care?
The documented need for rehabilitation services varies from approximately 65-90%, and studies have shown that there is a significant unmet need. The first step in understanding if your institution is meeting the needs of its cancer patients is to put a tracking mechanism in place that will allow you to know how many of those undergoing cancer treatments are being referred for rehabilitation services. You can assess whether there is a gap in care by comparing the number of new cancer cases with the number of oncology patients referred for rehabilitation services. In many hospitals, this data is easily available through the cancer registrar and rehabilitation director, respectively.

A Major Problem with Distress Screening
Although one of the new CoC standards is distress screening, implementing this without understanding the recent research on distress in cancer survivors is problematic and may lead to increased healthcare costs with less than ideal outcomes. Here’s why: New research is demonstrating that a leading cause of distress in cancer survivors is reduced physical functioning and/or disability. Research also shows that physical problems are outpacing emotional ones when it comes to reduced health related quality of life.

If we know that many, if not most, cancer survivors experience emotional distress, at least in part due to physical impairments that may be amenable to rehabilitation interventions, and we also know there is a significant gap in cancer rehabilitation care, it makes sense to screen for physical impairments as well as for emotional distress. Survivors who

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Oncology Under the Microscope

Dear Colleagues,
I was at a recent meeting in Washington, DC, of cancer center leaders from across the country and heard two very interesting presentations by a couple of thought leaders in the economics and delivery of health care. Ezekiel Emanuel, an oncologist/political philosopher and director of the Biomedical Ethics Center at Penn and Lee Newcomer, another oncologist and the SVP for Oncology, Genetics and Women’s Health and United Healthcare.

There were two take-aways from their presentations that really struck me and affirmed the general theme we have chosen for our ACE 20th Anniversary Annual Meeting to be held in San Francisco this coming January. Dr. Emanuel put our health care system in a global perspective that I had not quite previ-

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Cancer Rehabilitation: An Important Opportunity to Improve Outcomes
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are not screened for physical impairments will end up living with more pain, fatigue, disability — and distress — than they need to. Moreover, this will likely result in not only survivors functioning below the level that they are capable of but also utilizing unnecessary healthcare resources.

Understanding the Difference between General Exercise and Wellness and Rehabilitation

New reports raise concerns about safety issues in cancer rehabilitation.4 It’s important to avoid referring survivors with unaddressed physical impairments to general exercise or wellness programs. When evaluating cancer rehab services, it’s helpful to look at the two rehabilitation models that have developed in the United States. The first is a conventional model in which physicians and allied health professionals trained in rehabilitation medicine (e.g., physical, occupational and speech therapists) work together to treat patients’ impairments. An alternate model is the cardiac rehabilitation model in which the cardiologist manages the impairment(s) and works with a fitness professional. One of the critical things to understand is that someone who is qualified to treat impairments must “own” this care. In the cardiac rehab model it is the cardiologist, and he or she manages the impairment(s) in the cardiovascular system. With oncology patients there are many impairments that occur in different organ systems typically making these patients more medically complex to treat from a rehabilitation perspective. The oncologist (or another physician such as the primary care physician) may not be trained to deal with all of the impairments and/or may not have sufficient time to address them—this is why in cancer rehabilitation the conventional model works best. The oncologist needs the support of a trained rehabilitation team, healthcare professionals that are board certified and/or licensed in rehabilitation medicine and therefore qualified to assess and treat impairments. It is important to note that fitness professionals are generally not qualified to diagnose or treat impairments, but they are important members of a rehabilitation team and can oversee general exercise interventions.

Improving Care and Outcomes

In order to improve oncology patient outcomes and satisfaction, the first step is to implement tracking of rehabilitation referrals and understand if there is a gap in care at your institution. Next, implement dual screening and identify both emotional and physical impairments. This will lead to appropriate referrals (navigation) to rehabilitation and/or mental health professionals. Survivors without impairments or whose impairments have been appropriately addressed should be referred to general exercise and wellness programs. Finally, document this in the survivorship care plan. A commitment to quality oncology care means that cancer rehabilitation becomes the standard of care for all survivors. ■

Julie Silver, MD is an associate professor at Harvard Medical School in the Department of Physical Medicine and Rehabilitation. She has published extensively on cancer rehabilitation and developed the STAR Program® (Survivorship Training and Rehabilitation) Certification which is a best practices cancer rehabilitation service line model that has been adopted by more than 100 hospitals and cancer centers in the U.S.

www.OncologyRehabPartners.com

References


Closing the Cancer Rehab Gap in Care: Lessons Learned from the STAR Program

As the focus shifts to high quality cancer care with objective measures of success, it seems obvious that improving the physical health outcomes of survivors would be a priority. In fact, there is a significant effort at many institutions to implement cancer rehabilitation as an integral part of the oncology care continuum.

The STAR Program® (Survivorship Training and Rehabilitation) certification has been granted to more than 100 hospitals and cancer centers throughout the United States. The STAR Program is a best practices model for delivering cancer rehabilitation care and includes three steps: providing training in evidence-based cancer rehabilitation care to a multidisciplinary team of oncology and rehabilitation professionals; implementing protocols; and tracking and demonstrating improved outcomes. STAR Program certified facilities focus on improving outcomes in four specific categories: 1. Clinician education; 2. Patient function; 3. Patient satisfaction; and 4. Referrals and revenue. Because cancer rehabilitation care provided by licensed and/or board certified healthcare professionals is generally reimbursable by third party payors (Figure 1), implementing this care has many benefits to patients and institutions. It improves survivor outcomes and satisfaction and financially supports not only a cancer rehab service line, but also the overall survivorship care program.

Launch of a National Campaign to Decrease the Gap in Care
One of the first challenges that STAR Programs face in an effort to deliver high quality cancer care, is the ability to identify and document the rehabilitation gap in care. Although the need for cancer rehabilitation among survivors varies depending on many factors, including the cancer diagnosis, according to published studies, the majority of cancer survivors (approximately 65–90% in numerous populations) will develop physical impairments that are at least partially amenable to rehabilitation interventions.

In 2013, we launched the STAR Program Connection to help STAR Programs work together and learn from each other. The STAR Program Connection includes an annual conference, webinar based focus groups, and an online forum – all of which facilitate the sharing of ideas and best practices in cancer rehabilitation care. Strength in Numbers (SIN), also part of the STAR Program Connection, is a national campaign designed to close the gap between the need for evidence-based cancer rehabilitation and the delivery of these services. The first SIN campaign (version 1 or v1) began in January 2013 and the second one (v2) will be launched in January 2014. We invited all STAR Programs, whether they were still in training or had already launched, to participate. Those that had launched were encouraged to implement six specific

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Figure 1. Cancer Rehabilitation Interventions. This chart shows cancer rehabilitation interventions. Of note is that the general exercise/wellness category is usually the only one that is not reimbursable by third party payors, including Medicare. Nutrition, mental health and other services are important and often delivered together with conventional rehabilitation interventions.
strategies to decrease the gap in care at their institutions (Table 1). Some strategies focused on clinical protocols, while others were geared toward educating oncology and other healthcare professionals, as well as survivors, about the benefits of cancer rehab and the availability of the services. Each strategy was worth 10 points total, and programs could earn from 0–10 points per strategy, depending on specific implementation criteria for each one. STAR Program Coordinators were given all of the tools and templates they needed to implement each strategy efficiently and effectively.

Table 1. Strength in Numbers Strategies
All strategies were optional and had a total of 10 points that were based on specific criteria related to reach and impact.

1. An Invitation to Refer (education/marketing)
2. No Survivor Left Behind (clinical/screening)
3. Broadcast Recovery (education/marketing)
4. Making Rehab Click (online education/marketing)
5. Get a Head Start (clinical/prehabilitation)
6. Show Your Stars (event education/marketing)

Preliminary Results from Strength in Numbers
Experience has taught us that prior to receiving the STAR Program Certification, many facilities, though not all, refer fewer than 10 percent of new cancer patients for rehabilitation services at some point in the oncology care continuum. A difficult task for newly launched STAR Programs is to begin to accurately track rehabilitation referrals. Because it takes time and expertise to develop a reliable tracking system, at the time SIN v1 was launched there were only 22 STAR Programs accurately tracking rehabilitation referrals.

Participation in SIN was optional, and many programs opted to participate partially or be observers, either because they were still in training or they had other critical priorities (e.g., several hospitals were undergoing EPIC implementation). Of the 22 STAR Programs that were able to track referrals from January-March 2013, the penetration rate was 16 percent. SIN v1 strategies began in April 2013, and referrals began to improve.

The preliminary results in September 2013 demonstrated that of the initial 22 facilities, the penetration rate went from 16 percent to 20 percent with an overall 4 percent increase in referrals. It is anticipated that these results will further improve over time as the strategies are more fully implemented and expanded. This is a significant early improvement in the healthcare delivery of oncology services (can-
Cancer rehabilitation is part of the oncology care continuum across hospitals and hospital systems in the U.S. In evaluating the STAR Programs that had the highest increases in referrals (some of which were not part of the initial 22 facilities), seven achieved greater than 100 percent year over year growth, and another group of 15 programs grew more than 40 percent.

Lessons Learned from Strength in Numbers

As expected, there was significant variation between STAR Programs in terms of their ability to increase referrals, and this was affected by many factors. However, two key factors stood out. The first may seem obvious — how many total points they accumulated overall in the campaign affected their success. The second was whether they were operating a small boutique program or a well-developed, appropriately sized service line. Right sizing involves a sophisticated calculation. Put simply, it involves having enough healthcare professionals and administrators on the team to make it successful. To determine how many staff are needed, the calculation involves evaluating the number of annual new cancer patients; how many hospitals/outpatient sites are in the system; the number of oncologists/other physicians, nurse navigators, mental health professionals, etc. who can refer patients; and so on.

Programs that participated in SIN v1 and received a high number of points significantly increased their referrals, whether they were the right size or not. Programs that were appropriately sized increased their referrals, regardless of whether they participated in SIN. And programs that were both the right size and scored well during SIN seemed to stand out as having much more success than if they only had one of these factors in their favor (refer to Table 2).

In summary, high quality oncology care cannot be achieved without implementing an evidence-based cancer rehabilitation service line with a multidisciplinary team comprising both oncology and rehabilitation healthcare professionals. Also crucial to an effective cancer rehabilitation program are protocolled screening procedures to identify physical and psychological impairments (dual screening), streamlined referral procedures to refer recovering survivors for appropriate rehabilitation services, and documentation of improved patient outcomes.

Table 2. This table illustrates that either active participation in SIN or being the “right size” helped to improve referrals; however, the combination of both factors was quite dramatic.

<table>
<thead>
<tr>
<th>STAR Program examples</th>
<th>Approximate number of annual new cancer cases</th>
<th>Number of participants on the STAR Program team</th>
<th>Total SIN v1 points (max=60)</th>
<th>Ratio of referrals to cancer rehabilitation</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2000</td>
<td>25</td>
<td>30</td>
<td>11.5%</td>
<td>Good SIN participation but too small of a service line = STEADY GROWTH</td>
</tr>
<tr>
<td>B</td>
<td>2700</td>
<td>50</td>
<td>9</td>
<td>9.4%</td>
<td>Service line is bigger, although probably still not quite the right size and low SIN participation = STEADY GROWTH</td>
</tr>
<tr>
<td>C</td>
<td>2600</td>
<td>130</td>
<td>43</td>
<td>118%*</td>
<td>Excellent SIN participation and service line is close to being the right size = DRAMATIC GROWTH</td>
</tr>
</tbody>
</table>

*Because there are many survivors who never received rehabilitation and are now being referred for services, the number of referrals may exceed 100%.

Julie Silver, MD is an associate professor at Harvard Medical School in the Department of Physical Medicine and Rehabilitation. She has published extensively on cancer rehabilitation and developed the STAR Program® (Survivorship Training and Rehabilitation) Certification which is a best practices cancer rehabilitation service line model that has been adopted by more than 100 hospitals and cancer centers in the U.S. (www.OncologyRehabPartners.com).

References

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ously fathomed. Health care spending in the United States in 2012 was $2.87 trillion – that figure would rank it as the 5th largest economy in the world, behind Germany at $3.37 trillion GDP and ahead of the whole GDP of France at $2.43 trillion. U.S. healthcare is just huge. Newcomer pointed out that average family healthcare insurance premium costs and out of pocket expenditures are projected to exceed 50% of average household income by 2018 and equal average household income by about 2033. While we all see incremental increases at our own organizations, this portrayal illustrates how the rate of growth in health care spending is not sustainable, yet we all know that demand for services will continue to grow. We face an interesting challenge – we are part of a very large problem and must also create the solution.

Those of us in the cancer care and research segment of the industry understand that oncology care and services delivered to our patients ultimately accounts for a large percentage of the total health care spend and is typically the largest or second largest service line in most health systems. We therefore will have a high degree of accountability for attempting to improve the efficiency and value of the care we deliver. We need to continue to innovate and lead in these changes or less thoughtful solutions will be imposed on us either by policy or market forces which tend to discount the personal relationships we as care givers have with our patients.

For these reasons, the ACE Education Committee and I are very excited about the program and the presenters we have assembled for the 20th Annual Meeting. Featured speakers include Dr. Derek Raghavan, who is developing new approaches to system-wide delivery of oncology care at the Levine Cancer Center of the Carolinas’ Health Care system, as well as Dr. Patricia Ganz of UCLA, who chaired the Institute of Medicine Committee that recently published a seminal report “Delivering High Quality Cancer Care – Charting a New Course for a System in Crisis.”

We are also pleased to have the fabulous Palace Hotel in the heart of San Francisco as our meeting location. If you have not signed up already, I invite you to take another look at the meeting brochure. (www.cancerexecutives.org/annual-meeting-101). We know that this comprehensive program will provide you with information and awareness that will make you a better leader in your own organization as we all work to create the future oncology care system in this country.

We also want to take the opportunity during the Annual Meeting to celebrate our accomplishments and acknowledge our past leaders with the ACE 20th Anniversary Ball, a special event that will be held at the Palace Hotel Ballroom. Stay in, dress up and spend a wonderful evening with your colleagues!

See you in San Francisco.

Ted Yank, M.H.A., is President-elect of ACE and Chair of the ACE Education Committee. Ted is Associate Director for Administration at Dan L. Duncan Cancer Center in Houston, TX

CHAMPS Oncology recently released its latest oncology brief,

How Health Reform is Transforming U.S. Healthcare: Implications for Cancer Care Providers,

an educational piece on how healthcare reform is transforming healthcare and how it will impact cancer care providers.

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Season’s Greetings and Best Wishes for a Happy New Year!

From our ACE family to yours!