

# Integrating Prehabilitation, Rehabilitation, and Prospective Surveillance into Cancer Interdisciplinary Teams





### In Brief

A growing body of evidence finds that prehabilitation, rehabilitation, and prospective surveillance can improve clinical outcomes, quality of life, and functional performance. To achieve these gains, rehabilitation services must first be purposefully and strategically integrated into the cancer program or practice. Individuals with cancer can experience a variety of impairments and functional limitations from the disease and its treatments; these may include fatigue, pain, loss of range of motion, weakness, balance impairments, cognitive issues, urinary or fecal continence issues, or lymphedema. A structured approach to periodic assessments, termed *prospective surveillance*, can proactively address these issues, identifying and treating emerging impairments. Purposeful integration of rehabilitation services into a cancer program should include strategic planning meetings, a fiscally responsible pro forma, clinical pathways for efficient referrals, and a process for monitoring patient outcomes. In addition, a means to train rehabilitation professionals on the basics of cancer care and anticipated side effects is needed. After the cancer rehabilitation program is up and running, ongoing data collection is necessary to monitor clinical and financial outcomes, as well as a marketing and communication plan to sustain and grow the program.

Innovations in cancer care have resulted in more people surviving the disease, more people living longer with the disease being treated as a chronic condition, fewer side effects, and improved tolerance to cancer treatments. At the same time, more individuals diagnosed with cancer aspire to have a better quality of life in addition to a longer life. Strategically leveraging the unique skills of the entire interdisciplinary team, including rehabilitation professionals, can help improve quality of life (QoL) before, during, and after cancer treatment. Specifically, licensed healthcare providers, such as physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs), can help mitigate the side effects of cancer or its treatments.<sup>1</sup> There is emerging evidence that rehabilitation professionals' involvement in cancer care across the entire care continuum helps improve health outcomes and treatment compliance, reduce

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healthcare costs, and facilitate reintegration into the workforce and community.<sup>2,3</sup> To achieve these outcomes, prehabilitation and prospective surveillance must become part of routine cancer care.

### Defining Prehabilitation

Silver and Baima define *prehabilitation* (or prehab) as “a process on the continuum of care that occurs between the time of cancer diagnosis and the beginning of acute treatment. It includes physical and psychological assessments that establish a baseline functional level, identifies impairments, and provides targeted interventions that improve a patient’s health to reduce the incidence and the severity of current and future impairments.”<sup>4</sup> Although prehab is a relatively novel concept to oncology, one of the initial clinical applications of prehab was within sports medicine and orthopedic surgery.<sup>5,6</sup> This early use involved the foundational supposition that if a surgical limb (and the rest of the body) had better strength and endurance going into surgery, these gains would be appreciated postoperatively. To achieve these gains, the patient is prescribed a series of exercises or activities to complete before surgery, including muscular strengthening as well as cardiovascular, balance, and flexibility activities.<sup>7,8</sup> A holistic prehab program includes adoption of healthy behaviors such as smoking cessation and nutritional modifications.<sup>9</sup> As cancer and its treatments often result in similar physiologic insults to the system, prehab can be used help optimize patients’ functional status during cancer treatment.

### Defining Prospective Surveillance

Stout et al. describes the concept of *prospective surveillance* as a “proactive approach to periodically examining patients and providing ongoing assessment during and after disease treatment, often in the absence of impairment, in an effort to enable early detection of and intervention for physical impairments known to be associated with cancer treatment.”<sup>10</sup> Specific to breast cancer, a physical therapist or other healthcare provider would periodically screen a patient to monitor for subtle changes in strength, range of motion, fatigue, lymphedema, pain, or difficulties performing activities of daily living (ADLs). Instead of waiting until these issues worsen and result in substantial dysfunctions for the patient with breast cancer, these issues are identified early and appropriate referrals are initiated; conditions are addressed proactively, resulting in shorter, more cost-effective care. Because physical issues can increase the risk of delaying or disrupting cancer treatment, prospective surveillance also has the potential to improve cancer clinical outcomes, shorten hospital length of stay (LOS), and contain healthcare costs.

### Making the Case for Prehab and Rehabilitation

Poor preoperative fitness and physical status are risk factors for serious postoperative complications and prolonged disability in individuals with cancer.<sup>9</sup> Recognizing the physical benefits that exercise has for individuals with cancer, the American Cancer Society (ACS) recommends: 150 minutes of moderate and 75 minutes of vigorous intensity exercise per week and 2 to 3 sessions or weeks of resistance training of major muscle groups.<sup>9</sup>

Despite this recommendation, too few patients with cancer are prescribed prehab services. One reason may be that healthcare providers are reluctant to “pile on” and add another appointment or task for patients already experiencing a multitude of treatment appointments, life changes, and stressors. While this decision may be well intentioned, the benefits of prehab often outweigh the risk of additional stressors. In fact, in our experience, many individuals newly diagnosed with cancer are eager to adopt exercise and healthy behaviors. Many patients express that at a time in their lives when many things are beyond their control, exercise and healthy behaviors are life choices that they can make to have some semblance of control.

As noted above, the reluctance to overwhelm patients with cancer may prompt some providers to suggest only one or two health behavior changes; however, multimodal, structured prehab protocols have proven more beneficial than using a single approach.<sup>9</sup> In 2017 Chen et al. assessed whether a four-week prehab program would improve functional capacity of older adults scheduled for colorectal cancer surgery.<sup>11</sup> Participants demonstrated an increased amount of physical activity and improvement in distance ambulated on the six-minute walk test; an increased number of patients also met current ACS physical activity guidelines. In a study by Mayo et al., 33 percent of participants diagnosed with colorectal cancer who participated in a prehab program demonstrated improvements in their physical function with a significant increase seen in their mental health, vitality, self-perceived health, and peak exercise capacity.<sup>12</sup> Minnella et al. reported that the distance walked over six minutes in a prehab group was higher compared to those who participated in an exercise program only after colorectal cancer surgery.<sup>13</sup> Finally, as it relates to time to return to ADL performance, Carli, Gillis, and Scheede-Bergdahl demonstrated that participation in prehab programs before cancer surgery enhanced postoperative functional capacity and patients’ ability to return to ADLs more quickly than those who did not participate in a prehab program.<sup>9</sup>

In 2016 the National Institutes of Health (NIH) convened a group of subject matter experts in cancer rehabilitation to outline a variety of recommendations to improve integration of rehabilitation services within cancer care.<sup>1</sup> A key recommendation is: rehabilitation screening and assessment should be performed as a part of a comprehensive cancer care plan. The consensus group also recommends that functional status be evaluated objectively at regular intervals, including prior to commencement of active cancer treatment, periodically during cancer treatment, and throughout survivorship. These assessments are aimed at preserving and optimizing function, as well as monitoring for late effects of treatment. In addition, the consensus group recommends a thorough assessment of the content and psychometric properties of existing clinical measurement tools to establish validity with key cancer diagnoses, as well as to establish reliability, minimally clinically important difference, and sensitivity to change. The consensus group found that integration of rehabilitation services within the cancer care continuum helps address and proactively mitigates common side effects of cancer and its treatment, includ-

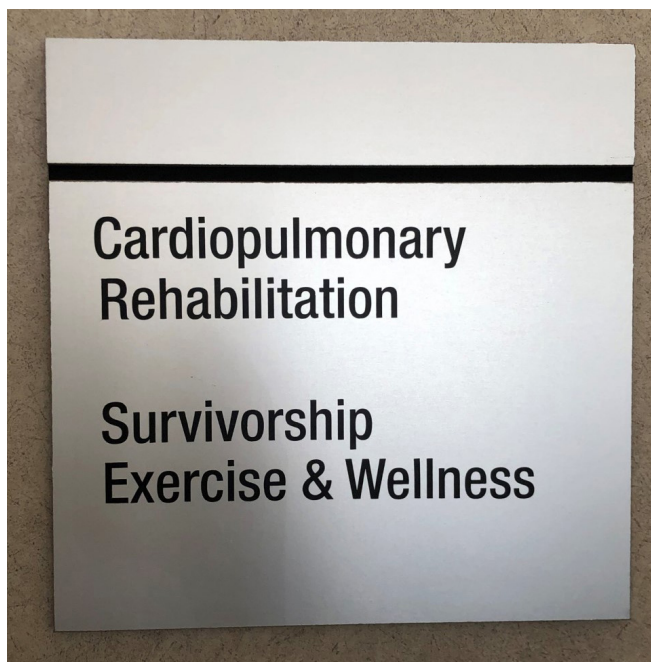
ing pain, fatigue, distress, balance impairments, and limitations to ADLs and functional activities.

### Ensuring Sustainability and Growth

It is estimated that between 60 to 90 percent of people surviving cancer have impairments and meet criteria for participating in rehabilitation services.<sup>2</sup> Thorsen et al. reported that 43 percent of patients with cancer require physical therapy.<sup>3</sup> Despite growing evidence, many cancer programs experience challenges integrating rehabilitation services within routine cancer care. One challenge is reimbursement. Because rehabilitation services are traditionally episodic, reimbursement of these services is optimized for patients already with impairments severe enough to require a referral. This reimbursement model often limits routine preventative or early intervention rehabilitation, as well as community- or population-health activities (e.g., community health fairs). In addition, because most oncologists experience extensive time demands with multiple highly technical and critical healthcare decisions during patient care, providers may focus on addressing chief complaints as opposed to employing a holistic, population health approach, which includes prehab or rehabilitation. Other challenges are technology related; specifically, how well the electronic health record (EHR) is integrated within the healthcare system so that providers can quickly refer patients for these services based on evidence-based measures.<sup>14</sup> In addition, there may be a poorly integrated patient registry for managing patient care plans or the patient's plan of care (POC) is not consistently integrated in the continuum of care.

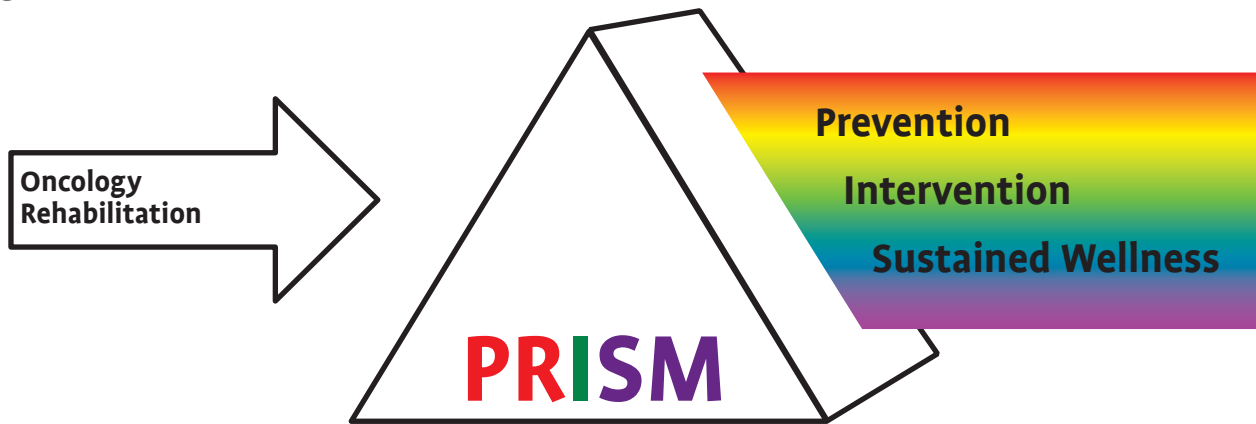
Cancer rehabilitation is not a novel concept. In 1969 Dietz introduced classifications for cancer rehabilitation, which include preventative, restorative, supportive, and palliative approaches.<sup>15</sup> In 2015 Colombo and Wilson introduced the **PREvention, Intervention, Sustainable wellness Model (PRISM)** concept as a means to educate healthcare providers, rehabilitation therapists, and patients about the expanding role of rehabilitation within cancer care, including with patients with advanced cancers.<sup>16</sup> PRISM is a visual depiction of the preventative and wellness roles that rehabilitation therapists can provide across the cancer care continuum in addition to their traditional role as rehabilitative interventionists (Figure 1, page 50). Prevention includes activities related to health promotion and wellness such as early detection and health screening for at-risk populations. Care activities focus on managing comorbidities and their complications, as well as initiating prehab to strengthen the body before cancer treatment.

Within the acute hospital setting, preventative care activities can be safely and effectively employed to shorten LOS and reduce the risk and extent of complications (e.g., venous thromboembolism, debility, falls). An important component to this approach is the employment of clinical pathways to facilitate and expedite referrals. For example, at Beaumont Cancer Institute in Royal Oak, Mich., when a medical oncologist initiates chemotherapy orders during a hospitalization, physical therapy and occupational therapy are automatically included within that order set to begin hospital-based prehab activities (e.g., walking programs, energy



(Top): Beaumont's Rehabilitation and Dialysis Center building is a key location for oncology rehabilitation services in coordination with the the Beaumont Cancer Center. (Bottom): Beaumont's Survivorship Exercise and Wellness Program shares space with the cardiopulmonary rehabilitation gym.

Figure 1. PRISM Model of Care



conservation techniques, fall prevention). In addition, Beaumont Cancer Institute implemented medical executive protocols to facilitate initiation of a PT/OT order with clear inclusion and exclusion criteria. The protocol allows nurses, discharge planners, and even therapists to begin PT/OT services once needs are identified and if there are no exclusion criteria. This practice is most effectively applied when rehabilitation therapists participate in tumor boards, daily huddles, and rounds where physical and/or occupational therapy needs are identified. Because regulations vary by institution and locale, some medical executive protocols may require physician co-signature; this can be accomplished by routing the order to the attending physician's EHR inbox. A similar process can be implemented in the ambulatory or outpatient setting where a rehabilitation therapist attends a tumor board or multidisciplinary clinic and identifies prehab or rehabilitation needs. The rehabilitation therapist sends referrals to the physician for authorization and then schedules outpatient therapy.

On the other end of the PRISM spectrum is *sustained wellness*, which is often aligned with the survivorship phase of cancer care (after cancer treatment has concluded or stabilized). Rehabilitation professionals can initiate sustainable and individualized exercise programs for patients with cancer to help them achieve and maintain a healthy lifestyle.<sup>17</sup> Exercise may be carried out independently by the patient at home or in a community fitness center. Because some patients with cancer may not feel comfortable performing these activities independently or in a community setting, hospitals and cancer programs should consider development of a medical fitness center (e.g., an exercise gym supervised by medical professionals). At Beaumont Cancer Institute, the rehabilitation department established a Cancer Survivorship Exercise and Wellness program to fill this need. Provided as an out-of-pocket service, every patient with cancer receives an individualized exercise session and these exercises are performed under the supervision of a licensed physical therapist assistant

(with specialty cancer training) in a group setting. This allows individuals to begin their exercise program in a controlled setting under the guidance of a trained health professional to minimize the risk of injury, incorrect performance, or other health risks.

A cancer survivorship care plan (as required by the Commission on Cancer [CoC]) offers another opportunity to systematically establish ongoing rehabilitation involvement within the survivorship phase of care. This might include activities, such as an annual visit with a physical therapist (as endorsed by the American Physical Therapy Association), to employ prospective surveillance to identify and proactively address emerging issues before they result in extensive debility.<sup>18</sup> Surveillance can be carried out at survivorship clinics, patient education classes, or support groups. Finally, staff who coordinate cancer survivorship programs are an optimal resource for identifying needed referrals to rehabilitation.

### Integrating Rehabilitation into Cancer Care

In addition to the traditional interventionist approach to rehabilitation, cancer programs screen patients for common physical, cognitive, or psychosocial impairments. Specifically, during cancer treatment, patients should be screened and observed on a periodic basis for pain, difficulty with ADLs, cognitive impairments, balance issues, weakness, limited range of motion (ROM), and fatigue. If no formal interventions are required, patients should be prompted to start or continue an exercise routine.

Below are examples of how Beaumont Cancer Institute has integrated rehabilitation within the cancer care continuum. At Beaumont, physical therapists travel to the cancer center to attend tumor boards and perform screenings on patients who participate in the breast multidisciplinary clinic. In general, the screenings last about 15 minutes and, because these individuals are newly diagnosed, some do not present with substantial impairments or functional limitations; however, many initially present with fatigue. This screening provides an opportunity to prescribe exercise or

offer referrals to other services, such as occupational therapy or speech-language pathology. Some patients participate in the breast multidisciplinary clinic after surgical excision. These patients may present with mobility restrictions, increased girth, pain, fatigue, or lymphatic cording, which often require more immediate referral. Attendance at the multidisciplinary breast clinic allows the physical therapist to screen patients for their ability to achieve and maintain a set position for completing radiation therapy. If patients are not able to achieve this positioning, physical therapy is initiated to restore appropriate shoulder range of motion or body positioning to successfully complete their radiation therapy regimen. In collaboration with the surgeons who attend clinic, the physical therapist can discuss postoperative weight-lifting restrictions and how to slowly institute a weight-lifting program after surgical intervention. These proactive discussions help minimize the risks of lymphedema, especially for patients who increase their activity levels too quickly following surgery or radiation.<sup>19</sup>

An underutilized role for physical therapists is integration within the care processes for gastrointestinal, gynecological, and genitourinary cancers. In addition to prescribing exercise and addressing movement disorders, pelvic floor physical therapy may be beneficial to treat pelvic and abdominal pain, constipation, sexual dysfunction, or urinary and fecal incontinence.<sup>20</sup> Because this specialty service requires advanced certification and training, the first step is to establish a relationship between oncology team members and pelvic health physical therapists.

Beaumont Cancer Institute stations a PT in the hospital's radiation oncology department to provide consults to patients. Once the radiation oncologist or nurse navigator identifies a patient who needs a consult, the individual is screened and monitored by the physical therapist each week while undergoing radiation treatment and then again at 3-, 6-, and 12-month follow-up visits. Key diagnoses that have benefited from screenings in radiation oncology include individuals with breast, head/neck, lung, prostate, glioblastoma, sarcoma, and cervical cancers.

Finally, Beaumont Cancer Institute has integrated rehabilitation within the survivorship care team, and rehabilitation is a key consideration when a patient's survivorship care plan is developed. Within the Beaumont Health System, rehabilitation services are offered in a variety of



Members of the Beaumont Oncology Rehabilitation Leadership Team. Left to right: Cindy Marsili, PT, Board Certified Oncology Specialist; Chris Wilson, PT, DPT, DScPT, Residency Program Director; Jannifer Stromberg, MD, Radiation Oncology and Medical Director of the Wilson Cancer Center; and Janet Seidell, PT, MPT, CLT, Senior Manager Rehabilitation Services.



Left to right: Stromberg, Marsili, Wilson, and Seidel.

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settings, including dedicated multidisciplinary survivorship clinics and support groups. In these settings, in addition to receiving consultations from nurse navigators, social workers, and dietitians, patients are screened by the physical therapist. Common findings include fatigue, weakness, deficits in range of motion, increased limb girth, and difficulty performing some ADLs. Regardless of the setting or screening method, integrating rehabilitation therapists into the interdisciplinary cancer care team provides another set of skilled eyes to identify, treat, and cross-refer to optimize patients' clinical outcomes and quality of life.

### **Ensuring Program Sustainability**

Integrating prehab, rehabilitation, and prospective surveillance into a cancer program requires an interdisciplinary commitment and ongoing dedicated support from administration, oncology providers and staff, inpatient providers and staff, and the rehabilitation team. At Beaumont Cancer Institute, key stakeholders work as a team to educate oncology leadership and administration on the value that rehabilitation services provide to patients and providers alike. Education is also provided on the changing landscape of cancer survivorship and the desires of patients and their families to move forward into survivorship in the healthiest way possible. In our experience, it helped to first identify the oncology providers at our institution who were already referring patients to rehabilitation services, as well as the oncology providers most interested in rehabilitation and survivorship resources. We also looked at the rehabilitation services that were most frequently requested for patients with cancer. This information was behind our decision to start first with a proactive lymphedema prevention program and our breast multidisciplinary clinic discussed previously. These were both high volume areas and the surgeons, radiation oncologists, and medical oncologists were interested in becoming more proactive in preventing lymphedema in their patients.

Our pilot program, integrating rehabilitation services into a breast multidisciplinary clinic, was previously published<sup>21</sup> and involved a physical therapist being present at the clinic visit to complete limb girth measurements and discuss healthy exercise behaviors with patients. Patients were then automatically referred to physical therapy after completing their oncologic treatments

or at the 12-month mark to repeat measurements. In addition to this systematic evaluation process, providers monitored patients on an ongoing basis to screen for early signs of lymphedema so that appropriate patients could receive a prompt referral to a lymphedema certified physical therapist. Based on the success of this pilot program and the ensuing enthusiasm from oncology providers, rehabilitation team members, and patients and families, we developed additional workflows and processes throughout the oncology program for referring patients to appropriate rehabilitation services.

During implementation of the oncology rehabilitation program, our oncology team noted that patient enthusiasm for these early interventions was reflected in improved patient satisfaction scores. This included comments that showed the appreciation our patients had for gaining knowledge on how to proceed effectively through their cancer care. For example, once the physical therapist in the breast multidisciplinary clinic met with patients, they could cross-refer or direct patients to other supportive care services.

In addition to the patient benefits of prehab and rehabilitation, our oncology providers also recognized the role these services play in CoC and other accreditations. In 2020 the CoC updated its standards to include compliance guidelines for cancer rehabilitation services: "1. The cancer committee develops policies and procedures to guide referral to appropriate rehabilitation care services on-site or by referral. 2. The process for referring or providing rehabilitation care services to cancer patients is monitored and reviewed by the cancer committee and documented in the cancer committee minutes."<sup>22</sup>

Our rehabilitation team members and oncology providers brainstormed other ways to further integrate these services to provide a seamless experience for our patients with cancer and empower them to regain control of their wellness. We developed workflows and referral processes to make it easier for staff, nurses, physicians, and patients to access resources and appointments. We leveraged the strengths of many teams, both inpatient and outpatient, and built enthusiasm among team members to share brochures and information regarding prehab and rehabilitation services. In this way, our pilot program grew to become a comprehensive program with seamless integration of prehab, rehabilitation, and prospective surveillance services into the oncology program.

### **Internal and External Environmental Factors**

Those looking to implement a similar comprehensive oncology rehabilitation program must consider many internal and external factors. Buy-in from oncology and administrative leadership is necessary early in the process to ensure that resources are in place, including staffing, physical space, equipment, and educational resources for staff and patients alike. The oncology rehabilitation program's mission and goals must be closely assessed (and updated as needed) to align with the mission of the oncology program.

Identify key stakeholders and champions to advance the concept and initial program development. Education and meetings with staff and providers help build enthusiasm and commitment prior to embarking on oncology rehabilitation program devel-

opment and integration. Development of a comprehensive, realistic financial pro forma and patient volume estimates are critical. Consider piloting a smaller program at first to demonstrate value and success before implementing a more comprehensive, permanent program.

In our experience, it was important to identify strengths and related programs already available at Beaumont Cancer Institute; existing programs and referral relationships helped raise awareness and build additional referral relationships and subsequent workflows.

Concurrent with the development of our cancer rehabilitation program, Beaumont Cancer Institute was also developing and growing oncology nurse navigation services and a cancer survivorship program. This meant that workflows were evolving and fluid, as opposed to attempting to integrate a new service within a long-established and deeply rooted workflow.

Every institution has its own organizational and administrative structure, and we tried to align our ideas and vision to build our interdisciplinary oncology rehabilitation program within these existing structures. For example, the rehabilitation department expressed a desire to build an oncology rehabilitation residency program, and we realized that our oncology rehabilitation program would grow patient volumes by leveraging resources available as a teaching institution.

When developing a comprehensive oncology rehabilitation program, there are many external factors to consider. For example, in Beaumont Cancer Institute's geographic region, value-based purchasing programs are underway for many conditions, and we anticipate these will continue to evolve for oncology services as well. We want to be well positioned as these bundled payments are developed and have services in place to help improve patient outcomes and lower costs and unwarranted readmissions across the cancer care continuum.

Beaumont Cancer Institute engaged community and philanthropic support as it developed its cancer supportive care resources, including the oncology rehabilitation program.

We collaborated with our hospital-employed and private practitioner physicians and advanced care providers, as well as our cancer survivorship program staff members, to keep rehabilitation referral patterns steady. In addition, efforts are ongoing to ensure that new providers in the Beaumont Health System are aware of the breadth of our services and engage these providers in our workflows and referral patterns.

### **Oncology Rehabilitation Program Components**

To establish an oncology rehabilitation program, several core components need to be in place, including financial accountability and sustainability, administrative accountability, ongoing education, and effective communication.

#### **Financial Accountability**

Financial components include creating the aforementioned pro forma, which forecasts a neutral budget (when the program is expected to break even) and a return on investment (when the program is expected to bring in revenue). Administrators use the

pro forma to evaluate added costs or expenses and whether these can be absorbed in the operational budget during initial implementation. Pro formas are also important when scheduling time for therapists to be available for patient screenings, which often are not billable procedures. Although patient screenings are not revenue producing, downstream revenue is realized from new referrals for subsequent episodes of care. Tracking these metrics is crucial to first establish a neutral budget and then demonstrate resulting downstream revenue. Key measures to track are the number of new referrals produced from rehabilitation screening and revenue produced in relation to costs (mainly the salary cost of the therapist provider).

As it relates to billing insurance companies for cancer rehabilitation, the rehabilitation department will follow conventional billing methods and guidelines for individual payers to obtain reimbursement for exercise prescription or traditional rehabilitation services. A key consideration in billing is clear documentation linking impairments or functional limitations to the cancer diagnosis to establish medical necessity for these services.

To help ensure adequate reimbursement and return on investment, monitor all charges, charge capture (payments), and charge reconciliation for all administered rehabilitation interventions. Doing so will allow for a collaborative relationship with the cancer program or health system's financial team to establish processes for tracking these financial metrics. Include these financial analysts early in program development to avoid having to re-engineer any processes that do not ultimately result in financial sustainability.

#### **Administrative Accountability and Ongoing Education**

Oncology rehabilitation program logistics include issues, such as identifying staff that will perform screenings, establishing clinical assessment procedures (direct interventions) and documentation, and developing referral mechanisms to prehab and rehabilitation services (inclusive of PT, OT, or SLP).

Staff providing prehab and rehabilitation services must be educated and receive specialty certifications or advanced training in oncology. Beaumont Cancer Institute has found that while oncology training for rehabilitation staff is important, it may not be the best use of their time to do patient screenings. Instead, their skills may be better employed treating patients referred for services. For example, although a pelvic floor specialist may be qualified to provide screenings at a colorectal multidisciplinary clinic, these screenings can be performed just as proficiently by a general oncology therapist. This frees up the pelvic floor specialist to provide direct treatments for those with pelvic pain or dysfunctions. Regardless of which staff members perform screenings, administrators need to establish a tracking mechanism to capture results from prospective surveillance screenings, including referrals for exercise prescription, for traditional rehabilitation, and for those patients who might need medical clearance before exercising, such as individuals with chemotherapy-induced cardiotoxicity. In addition to ensuring appropriate training for screening and referrals, administrators must ensure that all members of their rehabilitation team have a foundational education and clinical



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When prehab, rehabilitation, and prospective surveillance models are integrated within the cancer care continuum, patients will experience an improvement in cancer-related health outcomes and a better quality of life, as well as reducing overall healthcare costs.<sup>23-25</sup>

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skill set to provide prehab and rehabilitation services to this patient population. This includes assessment of staff competency, initial and continuing education, and integration of prehab and rehabilitation services, so all patients diagnosed with cancer have access to basic rehabilitative care. In our experience, individuals diagnosed with cancer may require prehab or rehabilitation at any point in their disease trajectory and in many different settings. Accordingly, staff may need to provide “generalist” level of cancer rehabilitation at acute care or intensive care units, inpatient units, skilled nursing facilities, home care settings, and outpatient ambulatory clinics. Our advice is to designate one person as the “cancer therapist” at each location or setting. Administrators must also develop a clear mechanism for referral from the generalist cancer therapist to a specialist cancer therapist, if needed.

Administrators should perform a gap analysis to identify the oncology rehabilitation program’s strengths and where additional opportunities exist. This should include an action plan to address identified care gaps. In Beaumont’s initial gap analysis, we identified a knowledge gap among staff as it relates to the basics of cancer care. The administrative team developed an action plan for training and education, developed platforms to provide ongoing education, created a cancer program website, and hosted symposiums and conferences for staff as well as outside clinicians to generate revenue to reinvest back into staff education. Opportunities for staff to gain oncology education include participation in tumor boards and multidisciplinary clinics; attendance at continuing education events; specialty certifications in cancer rehabilitation, lymphedema, and pelvic health; and board certification as an oncology specialist physical therapist. To meet staff education and training needs, Beaumont Cancer Institute developed a comprehensive, robust educational curriculum on cancer rehabilitation. As a result of this curriculum development, Beaumont established a clinical residency for physical therapists in cancer rehabilitation and was the first program in the United States to achieve accreditation by the American Board of Physical Therapy Residency and Fellowship Education ([abptrfe.org](http://abptrfe.org)).


### **Marketing and Communication Efforts**

All providers should be able to speak to the value of prehab and rehabilitation, including front office staff who answer the phones, therapists at all levels of care, and all members of the multidisciplinary cancer care team, including but not limited to physicians, nurse navigators, and social workers.

Marketing starts with developing a plan for internal and external communication. At Beaumont Cancer Institute, marketing efforts included brochures, emails, newsletters, flyers, and show-cases, as well as rounding in physician offices and presenting at leadership meetings within the organization. Social media is an important part of the marketing plan, but it can be challenging for large healthcare organizations with tighter controls on posting to the organization’s social media accounts. The administrator needs to work closely with the marketing and communications department on key messaging and delivery mechanisms, including website development, media kits and press releases, community calendars, and community-facing events and classes. A key component to marketing oncology rehabilitation services is the collection of patient testimonials (with appropriate consent) to share with key stakeholders and use in communications. In addition to traditional marketing, cancer rehabilitation staff should be supported and encouraged to attend and be active at community service events.

### **A Look to the Future**

When prehab, rehabilitation, and prospective surveillance models are integrated within the cancer care continuum, patients will experience an improvement in cancer-related health outcomes and a better quality of life, as well as reducing overall healthcare costs.<sup>23-25</sup> As many healthcare institutions shift focus to population health management, cancer rehabilitation administrators should connect with institutional leaders to be part of a comprehensive population health management plan. Know the community that the healthcare system serves and establish processes and mechanisms to keep these community members engaged in the wellness trajectory. This will help the institution and its providers partner with patients, families, and caregivers in shared decision making and the development of patient-centered care plans. Involve patients and families in planning for the oncology rehabilitation program to gather valuable feedback and input from these healthcare stakeholders.

Creating a plan for sustainability is key for ongoing success and growth of any oncology program and must be constantly updated and modified based on the fluctuating healthcare climate.<sup>12</sup> Sustainability requires ongoing communication between team members, including the establishment of professional relationships across the acute to postacute continuum of care. Establish clinical pathways, guidelines, and protocols as well as standards and quality metrics, monitor performance, and implement continuous process improvement. Communicate metrics and outcomes regularly to leadership teams, physicians, and providers, and to patients, families, and caregivers. Embrace flexibility and adaptability to adjust the oncology rehabilitation program as the needs of physician providers and patients change. 

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