Managing Palliative Patients in IPR Through A Short Stay Family Training Program

Chris Wilson PT, DPT, DScPT
Suzette Smith PT, DPT, CLT
Christine Lipple OTR/L
Meghan Avromov LMSW

January 24, 2019 – Combined Sections Meeting
Washington D.C.

Beaumont

Disclosures

- The presenters have no conflict of interest
- Christine Lipple and Suzette Smith completed this project and presentation as a partial requirement for graduation from the Beaumont Health Oncology Residency

Objectives

1. Identify patients that are appropriate for a short stay family training program
2. Be able to verbalize methods to explore implementation of a short stay family training program for inpatient rehab
3. Adapt clinical documentation and goal writing for patients with degenerative, palliative or life-threatening conditions.
4. Improve coordination of care and transitions in care for patients with life threatening illness from hospital to rehabilitation to home

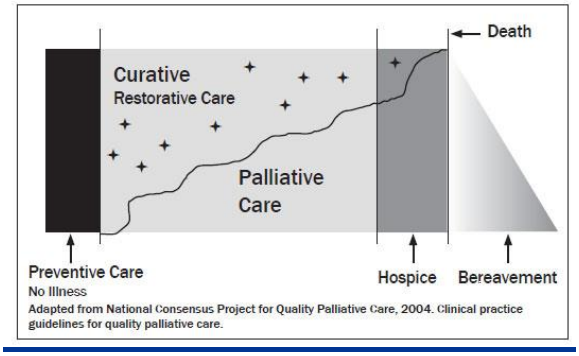
Operational Definitions

- Palliative Care:
  - An approach that improves Quality of Life (QoL) for patients (pts) and families facing life-threatening illness
  - Applicable **early in the course of illness**
  - In conjunction with other therapies that are intended to prolong life
  - Prevention/relief of suffering (i.e. pain, physical, psychosocial, spiritual)

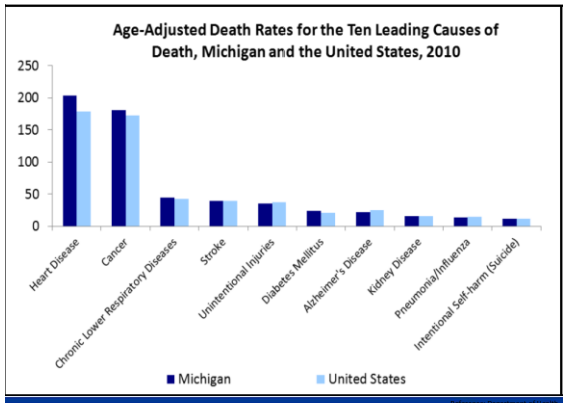
  (World Health Organization, 2018)
- Palliative care is often perceived as a transition from active care to hospice care
  - Includes patients with life-threatening illness not imminently dying but in physical decline that need support services similar to hospice

  (Lynn and Adamson, 2003)

Figure 1: Palliative Care Integration in the Disease Trajectory

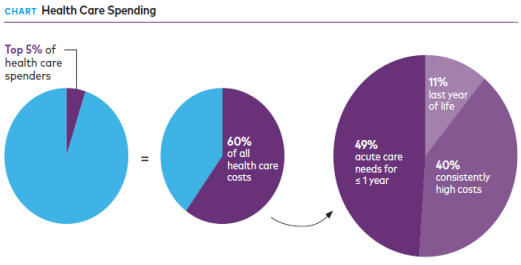


Adapted from National Consensus Project for Quality Palliative Care, 2004. Clinical practice guidelines for quality palliative care.



https://www.michigan.gov/documents/mdch/LeadingCauseDeath_380406_7.pdf

A System in Crisis (CAPC 2014)



Beaumont

Financial Implications

- "10 percent—of the sickest Medicare beneficiaries accounted for about 57 percent of total program spending, which was more than $44,220 per capita per year"
- Palliative Care (PC) documented net per-patient savings of $2,659
- (CAPC 2014)

Beaumont

Palliative Care vs Standard Care in Acute Care by DRG/ICD

- Average Cost per case of standard care: $13,650
- Cost Savings when Palliative Involved:
  - $2,076.00
- N=157
- Beaumont Sample

Beaumont

Palliative Care Team

- Referring Physicians
- Case Manager Nurse
- Social Worker
- Therapists
- Clergy
- Caregivers
- Family members and Patient

Beaumont

Preferred location for care in last months of life (n=606)

- Home = 74%
- Hospital = 16%
- Long term care = 10%
- Only 40% of people who preferred to die at home achieved this goal

- Burge F, Lawson B, Johnston G, Asada Y, McIntyre PF, Flowerdew G. Preferred and actual location of death: what factors enable a preferred home death?. Journal of palliative medicine. 2015 Dec 1;18(12):1054-9.

 Beaumont

Hospice vs. Palliative Care

Hospice

- Not covered under Home Care Benefit
- Covered under a separate Benefit
- Hospice receives ~$170 per day flat rate
- Pay nurses, drugs, therapy, equipment out of the same $170

Palliative Care

- Covered under traditional Medicare Part A or B
- Same FIM rules apply
- Reimbursement based on FIM scores

Beaumont

Who is the Palliative Care Patient?

- Chronic disease state
- Multiple hospital re-admissions
- Multiple co-morbidities
- Declining function
- Life limiting incurable disease
- Needing end of life planning

Beaumont

TABLE 1 Palliative Physical Therapy (PT) Practice Patterns

Palliative PT Model	Intervention	Goals	Clinical Patient Scenario	Therapist Intervention Examples
Rehab Light	Lower intensity and frequency with progressive rehabilitation	Short-term improved function and quality of life	• 63-y-old man with end-stage chronic obstructive pulmonary disorder limited in tolerance to PT due to dyspnea upon exertion • Is on 4-5 L of oxygen at home continuously via nasal cannula	• The therapist provides more frequent rest breaks during a progressive gait training program • Prescribes shorter bouts of activity throughout the day • Educates patient on rating of perceived exertion and dosing exercises via pulse oximetry feedback
Case Management	Evaluation and intermittent reassessment with program modification and instruction	Patient and caregiver safety with in-home management	• 79-y-old woman with advanced dementia who has a caregiver 24 h a day • She is ambulatory with a 4-wheeled rolling walker • Due to cognition, cannot meaningfully participate in formal PT	• Monthly consultative visits by the physical therapist to assess strength, safety and update a home exercise program • Caregiver education on safe patient handling and mobility techniques (ie, transfers, bed mobility with proper ergonomics for injury prevention)
Rehabilitation in Reverse	Patient training, equipment, and caregiver instruction at threshold levels of progressive decline	Maximize safe mobility throughout the course of disease	• 57-y-old man with amyotrophic lateral sclerosis • The patient is able to ambulate with forearm crutches but cannot walk in the community because of fatigue	• Therapy is administered weekly • The patient is instructed in wheelchair, bedside commode, and rolling walker use in anticipation of a future need for these pieces of equipment • Home exercises are provided to maintain strength and flexibility while avoiding overexertion
Skilled Maintenance	Skilled mobility assist beyond the ability of caregivers	Preserve function allowing caregivers to safely manage home care	• 45-y-old woman with stage IV breast cancer that has metastasized to her right femoral neck • Per orthopedist, she is 5% partial weight bearing on the right femur • She also has developed metastases to her brain that has impaired her judgement and safety awareness	• Therapist determines that ambulation is safe and feasible only with a professional who is able to monitor the 5% partial weight-bearing status • Therapist-administered exercises while seated or in bed without resistance to the right leg to avoid pathologic fracture • Prescription of a wheelchair and bedside commode for safe mobility when the therapist is not present
Supportive Care	Physical measures Psychosocial support around functional mobility changes	Comfort measures Adaptation and adjustment to progressive disability	• 86-y-old woman with stage IV lung cancer with widespread metastatic disease • The patient also has severe osteoarthritis • High risk of pressure ulcers • Lower-extremity swelling due to lymphedema	• Educating hospice team members on safe positioning and transfers to avoid injury • Teaching family members how to perform joint range of motion to reduce arthritis pain for less need for opioid pain medications • Performance of manual lymphatic drainage and wrapping to reduce pain and swelling

Wilson, Mueller, Briggs 2017

Beaumont

Communication Within Palliative Care

- Vital Talk – Delivering Serious News
- http://vitaltalk.org/topics/disclose-serious-news/

- GUIDE
  - Get Ready
  - Understand
  - Inform
  - Dignify
  - Equip

Beaumont

GUIDE Steps

Step	What you say or do
Get Ready – Info, People, Place	• "Let me take a minute to make sure I've got what I need." • Make sure you have all the information you need at hand • Make sure you have all the right people in the room • Find a place with some privacy
Understand what the patient knows	• "What thoughts have you had since the biopsy?" • "What have you taken away from other doctors so far?"

Beaumont

GUIDE Steps

Inform starting with a headline	• "The CT scan shows that the cancer has gotten worse" • Give the information clearly and to the point with a one-sentence headline of the most important piece of information you want them to take away • Avoid jargon • After the headline you will need to give more information, but after giving the headline, STOP! •
Dignify Emotion by responding directly	• "I can see this news is not what you were hoping for." • Expect the patients first response to be emotion • Acknowledge the emotion explicitly.
Equip the patient for the next step	• "Is there anything I could do to make this a little easier?" • "I want you to be prepared for the next step. Can I explain…" • Don't dismiss concerns or say that everything will be fine

Beaumont

Hospice and Palliative Care

- APTA HoD RC 17-11 – Unanimous and introduced by Michigan
- The APTA endorses the inclusion of the following concepts in hospice and palliative care:
  - Continuity of care and the active, compassionate role of PTs and PTAs
  - Rights of all individuals to have appropriate and adequate access to PT, regardless of medical prognosis or setting
  - An interdisciplinary approach, including timely and appropriate PT/PTA involvement, especially during transitions of care or during a physical or medical change in status
  - Education of PT/PTAs and students in the concepts related to treating an individual while in hospice and palliative care
  - Appropriate and comparable coverage and payment for physical therapy services
- Task force to develop a plan to achieve these goals

Beaumont

APTA HOD RC 8/9-15 Introduced by MI

- PRINCIPLE II. QUALITY OF PHYSICAL THERAPIST SERVICES
- A. MEDICALLY NECESSARY PHYSICAL THERAPIST SERVICES Physical therapist services are considered medically necessary as determined by a licensed physical therapist, based on the results of a physical therapist evaluation, and when provided to improve ***or maintain the current level of function or to prevent, minimize, maintain, slow the decline of, or eliminate impairments, activity limitations, or participation restrictions.***

Beaumont

Courses of Disease Processes

- Lynn and Adamson, 2003
- "Short period of evident decline"
  - Typical of cancer.
  - Longer term preservation of comfort and function until disease process becomes overwhelming to the systems, then a steady, rapid decline in function can occur.
- "Longer term limitations with intermittent exacerbations and sudden dying."
  - Common with organ system failure pathologies such as COPD and CHF
- "Prolonged dwindling"
  - typical of central nervous system failure
  - generally slow decline where institutional long-term care facilities are beneficial

Beaumont

The JAMA Network

From: Patterns of Functional Decline at the End of Life

JAMA. 2003;289(18):2387-2392. doi:10.1001/jama.289.18.2387

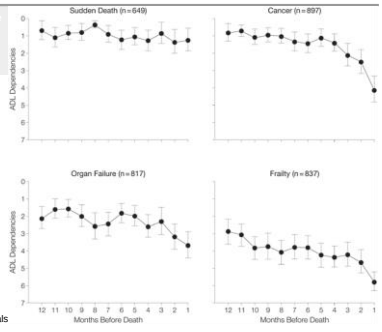


Figure Legend:
Error bars indicate 95% confidence intervals

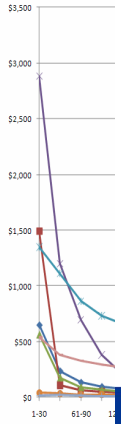
Beaumont

Chronic Diseases and Healthcare Reform

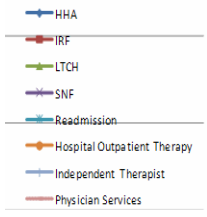
- Palliative care has potential to reduce readmissions
- Emphasis on continuum of care and continuity of services
- Ranganathan et al.
  - home palliative care patients had a reduced chance of 30 day readmission by ~10% as compared to standard care

- Ranganathan A, Dougherty M, Waite, Casarett D. Can Palliative Home Care Reduce 30-Day Readmissions? Results of a Propensity Score Matched Cohort Study. *J Palliat Med.* 2013; 16: 1290-1293.

Beaumont



Post Discharge Costs after Hospitalization



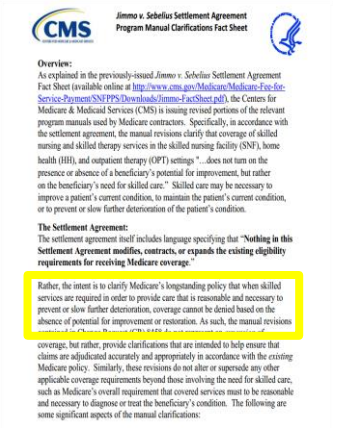
http://www.aspe.hhs.gov/health/reports/2011/PACexpanded/fig8.gif

Beaumont

Jimmo vs. Sebelius

- Longstanding practice whereby CMS, claims processors, and providers decide nursing care and therapy services are not available for beneficiaries whose condition is not "improving"
- Examples: "stable", "chronic", "plateaued"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf



CMS

Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet

Overview:

As explained in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet (available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf), the Centers for Medicare & Medicaid Services (CMS) is issuing revised portions of the relevant program manuals used by Medicare contractors. Specifically, in accordance with the settlement agreement, the manual revisions clarify that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The Settlement Agreement:

The settlement agreement itself includes language specifying that "**Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage.**"

Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, the manual revisions

coverage, but rather, provide clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the *existing* Medicare policy. Similarly, these revisions do not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare's overall requirement that covered services must to be reasonable and necessary to diagnose or treat the beneficiary's condition. The following are some significant aspects of the manual clarifications:

Clinical Documentation (Wilson, Boright 2017)

- Highly recommend clinical documentation justify why PT/OT was required to slow rate of decline, ensure safety, or maintenance required skill of a PT/OT
- Useful key phrases:
  - *Without PT, the patient's [body function/structure] would likely decline at a faster rate causing dysfunction to [Participation or Activity]…*
  - *Skilled therapy services are needed to ensure safety during [activity] due to the instability of the [health condition]*
  - *To optimize remaining quality of life, skilled PT is medically necessary to train the caregivers in X to avoid Y*
  - *Without preventative interventions by PT for [body function/structure], the risk of hospitalization is significantly heightened.*

Beaumont

Therapists' Role in Palliative Care

- Common misunderstandings about therapists' role in Palliative Care
- "Aggressive therapy" and "No therapy" are not the only options
- Focus to avoid interruption in rehabilitation care
- Strategic continuity and longitudinal management until end of life
- Even **more** sensitive to patient wishes/comfort
- Shift focus to:
  - Quality of life
  - Anticipatory future disability and equipment needs
  - "Bucket list" assistance
  - Prevention of pressure ulcers, contractures, immobility pain
  - Family/caregiver education and support/consultation

Beaumont

Differences between "Active" and "Palliative Care"

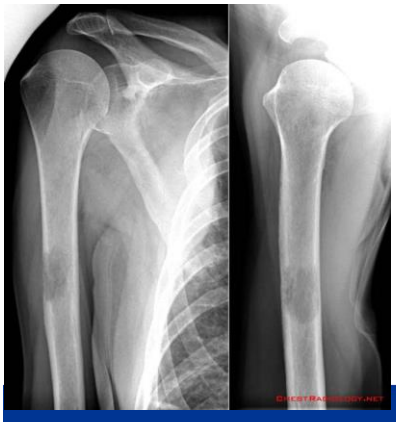
- Active Care
  1. Push patients closer to tolerance
  2. More aggressive with treatment compliance
  3. Focus on ADL function over temporary pain management
  4. Generally have clarity with care goals
  5. Little to no existential anxiety
  6. More fact-based interactions
  7. Procure DME with intent of improvement or long term stability
- Palliative Care
  1. Balance function and participation with comfort
  2. More willing to accept a "refusal" or physical variability
  3. Focus on pain control with modified ADLs
  4. Anticipate unclear care goals
  5. Patient and family distress
  6. Emotion-based interactions
  7. Procure DME for anticipatory decline or "bad days"

Beaumont

Bone Metastases/Tumors and Therapy (Mirels 1989, Coleman 2000)

- **In any cases of cancer, therapists should be vigilant for bone metastases**
- Conservative management of WB and resistive forces/manual therapy until risk of fracture of bone mets established
- Therapists can and should prompt for radiographs if concern for mets or unexplained pain
- **Risk Factors for Imminent Fracture:**
  - Pain
    - Especially with movement
  - Anatomical site
    - translational forces
    - WB bones
  - Size of metastasis
    - When 50% of cortex destroyed, fx rate ~80%
  - Cortical lesions >2.5–3.0 cm
  - Unresponsive to radiation

Beaumont



- "Bone metastases in the shaft of the humerus of a bronchial carcinoma with cortical destruction in both planes."
- Chestradiology.net

Beaumont

Bone Metastases/ Tumor Guidelines

DeVita VT, Hellman S, Rosenberg SA. *Cancer: Principles & Practice of Oncology*. 7th ed. Philadelphia, PA. Lippincott Williams and Wilkins. 2005.

- >50% cortex involved
  - No exercises
  - touch down or non-weight bearing
  - use crutches, walker
  - active ROM exercise (no twisting)
- 25–50% cortex involved
  - No stretching
  - partial weight bearing
  - light aerobic activity
  - avoid lifting/straining activity
- 0–25% cortex involved
  - Full weight bearing

Beaumont

Overarching Themes of Palliative Care Rehabilitation

- Expect and anticipate frequent and dramatic fluctuations in:
  - Functional capacity
  - Strength
  - Pain
  - Ability to perform their activities of daily living
  - Motivation
  - Emotional states
    - Getting good or bad news

Documenting progress and justifying future care

- An important part of therapy is using functional tools to document and validate progression or regression of care
- We use established, evidence-based, researched outcome measures called functional tools to document the patient's progress or current status

Suzette Smith PT, DPT, CLT

Beaumont

Case Example: The Inspiration

- Medically fragile patient admitted to IPR for "rehab"
- Patient goals do not match disease trajectory
- Patient feels IPR is last hope
- Patient unable to tolerate 3 hours of therapy per day and experiences physical decline
- Patient, family, therapists, nurses and doctors frustrated with unclear goals and unsure best course for patient
- Patient transferred off rehab to medical floor
- Patient feeling like a failure that was unable to tolerate IPR
- Staff feeling unsure how to help this patient succeed and discharge home
- Now what?

Short Stay Family Training (SSFT) Program on IPR

Program Goal: Empower caregivers and family members by giving them the tools to be independent in caring for a patient with a life limiting condition. The program focus is to improve caregiver skills; not to achieve patient independence in all physical, functional and participation activities at DC.

Program Outcome: To transition home and reduce hospital readmission.

Methods:

- Deliver education to assist in discharge with optimal safety and comfort.
- Early involvement of the Palliative care team to transition from hospital to home with or without home care rehabilitation services.

Quality Improvement Committee

- Voiced concerns from care team/therapists on how to manage palliative patients
- Convened a task force of content experts
- Root cause analysis
  - Acute Care tracking of patients
  - IPR tracking of patients

- Team members:
  - Dr. Maltese, Chief PMR
  - Steven Efthyvoulidis, IPR Nurse Manager
  - Jim Paolucci, IPR Admissions
  - Ruth Kechnie, 5 West Nurse Manager
  - Jerryl Birchmeirer, 5 West Care Manager
  - Meagan Hahn, 5 West Social Worker
  - Norma Spryszak 5 West Nurse Specialist
  - Janet Seidell, PT/OT Supervisor Acute
  - Eli Siwa, PT/OT Supervisor IPR
  - Sherine Awad, PA IPR
  - Nada Kinaya, NP Palliative Care
  - IPR Midlevels
  - Chris Wilson, PT
  - Meg Avromov, 7 West Social Worker
  - Suzette Smith, PT Resident
  - Christine Lipple, OT Resident

Post-Acute rehabilitation options

Subacute Rehab (SAR)

- Slower paced
- Longer length of stay
- Sometimes perceived negatively as "Nursing Home"
- Decreased medical staffing for pain/symptom control

Traditional IPR

- High intensity pace
- 3 hours per day, 5 days a week
- Medical staff available 24/7
- Short length of stay
- Equipment available

When traditional rehab isn't the best option

- Low physiologic reserve and poor tolerance for conventional rehab
- Progressive weakness due to disease process
- Unmanaged symptoms (pain, breathlessness, nausea/vomiting)
- Increased risk of readmission
- Patient and family goals don't match medical trajectory

Medically Fragile Patients in IPR

- ~70% of oncology patients can complete traditional rehab with an average length of stay of 10 days and discharge to the community (Guo et al 2008)
- 30% transfer off to medical floor
- The patients that transfer off rehab have:
  - Increased chance of dying in hospital
  - Decreased chance of discharge home directly from hospital

Transfer Off IPR to Medical Floor

- Guo et al, 2008
  - 38% of cancer patients transferred off of rehab
    - 88% due to worsening medical condition
  - 52% of patient transferred off were eventually discharged home vs 90% that do not transfer off dc home
- Alam et al, 2008
  - 15% pass away in the hospital vs 2% that do not
  - 21% of cancers with neoplasm transfer off rehab vs 9.7% that have non-cancer diagnosis

Discharge Locations after Transfer

- Fu et al, 2014
- 38% of patients with lymphoma transferred off rehab
- Of these patients that transferred off, after acute they went:
  - 34% directly home
  - 26% died in the hospital
  - 18% SAR
  - 11% back to IPR

Survival After Transfer Off Rehab

- Fu et al, 2017
  - 38% of multiple myeloma patients transferred off rehab
  - Median survival time of those that transferred off = 180 days
  - Median survival time of those that did not transfer off = 550 days

Gap in Patient Care

- If these patients have worsening medical issues with traditional rehab programs, then how do we help them get home?
  - What is the best option
- Existing research is focused on predicting which patients may transfer off rehab in order to prevent patients from experiencing worsening medical conditions from the intense rehab
- Started off on that track and then realized that there is a GAP in the care
- If not IPR or SAR, then what? How do we give patients and family members the confidence to succeed at home
- We propose instead that there is a gap in care and we should instead focus our research in ways to fill this gap

How do We Fill this Gap in Care?

- Our solution is the Short Stay Family Training program
- Shifting focus from getting better and stronger to function, safety and comfort and family independence
- Meet the patients #1 goal
  - To get home! and be more mobile

What is the Short Stay Family Training Program? (SSFT Program)

- On Inpatient rehab unit
- Skilled therapy 3 hours a day, for 5 days.
- The effort in therapy is shared between caregiver/family and patient, as appropriate.
- A caregiver/family member is expected to be present during therapy sessions to participate in hands-on-training.
- The main goal is to provide education to patients and family members to ensure a safe transition home with assistance.
- Traditional therapeutic exercises and activities are still included as appropriate

Importance of Caregivers

- The focus of the SSFT approach is to improve caregiver skills.
- A study of caregiver needs over the course of the cancer trajectory found for caregiver to be successful they need(Given et al 2012):
  - Support, coordination and communication with the health care team.
  - Caregivers should be considered an integral part of the health care team.
- Another study reported that next of kin should be considered an extension of the healthcare team and that their involvement improves cancer patient outcomes. (Bergerod et al 2018)

Quality of life

- Evidence suggests quality of life (QOL) is the main concern for patients with a terminal disease (McCaffrey et al 2016)
- Advanced cancer patients report decrease in mobility as one of the biggest factors affecting QOL, including basic tasks such as getting out of bed. (Wilson et al 2017)

Possible candidates for SSFT include:

- Advanced cancer or an advanced/end stage life limiting condition (ie. CHF, COPD, CRF, etc)
- Medically cleared for discharge from acute care, however home safety concerns that require substantial family training that cannot be completed during the acute care stay (anticipated to take > 4 days)
- Unable to tolerate traditional post-acute rehabilitation

Possible candidates for SSFT include:

- Must have key caregiver(s) available to be trained - this person must be the primary caregiver after discharge.
- Family training requires the skill of rehabilitation professionals in areas such as safe patient handling/mobility, activities of daily living, durable medical equipment, safety or precautions

Exclusion criteria for SSFT

- Clearly demonstrates rehabilitation potential and can tolerate three hours of traditional therapy
- Does not have a defined caregiver for training or caregiver not available at discharge
- Actively dying or preferring hospice to inpatient rehabilitation

Inpatient Rehabilitation Facilities (IRF) Reimbursement

- Based on IRF-patient assessment instrument
  - IRF- PAI
- Takes into account clinical information and expected needs of a patient
  - Based on this information places patient into payment categories for payment
- First categorized by Primary dx for admission
  - Further categorized in to Case mix groups (CMGs) by age and initial functional index measure scores (FIM)

Inpatient Rehabilitation Facilities (IRF) Payment

- Initial FIM scores assess burden of care in areas of function (ADLs), motor (gross motor) and cognitive performance
- Four tiers within CMGs based on comorbidities, with increased secondary diagnosis for stay leading to increased payment
- Higher payment for more complex patients with higher burden of care to IRF

Admission criteria 60/40 rule

60% of admissions must have one of the following 13 qualifying diagnoses

1. Stroke
2. SCI
3. Congenital conformity
4. Amputation
5. Major multiple trauma
6. Femur fracture
7. Brain injury
8. Neurological disorder
9. Burns
10. Rheumatoid or psoriatic arthritis with significant decline in ADL function
11. Systemic vasculitides with joint inflammation with significant decline in function
12. Severe or advanced osteoarthritis affecting 2 or more weight bearing joints
13. Joint replacements: bilateral hip or knee, or with significant obesity or over age 85

Admission criteria: Reasonable necessity for IRF stay

- Require interventions from multiple rehabilitation disciplines
- Require the intensity of rehab unique to inpatient rehab facilities
- Deemed medically stable to participate
- Requires close medical supervision by a physician and 24 hour nursing
- Requires an interdisciplinary approach to care

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatRehabPaymtfctsht09-508.pdf (11/28/18)

How to switch from intense traditional IPR to a Short Stay Family Training Program?

Education is Key

- Physical Therapy
  - Methods for maintaining safe out of bed mobility for as long as possible
  - In an expert consensus document by Stout et al, (2016) suggested that physical therapy is underutilized in end of life care as they are trained to increase functional status and rehabilitative procedures.
- Occupation Therapy
  - Energy conservation with ADLs and adaptive methods for decreased caregiver burden and increased patient independence
- Social Work
  - Staying focused on realistic goals, coping strategies, palliative concepts,
  - Key cog in communication between Acute, Palliative and IPR care team
- Speech
  - Tactics for prolonged ability to eat and communicate with loved ones
- Nursing
  - Wound care, tube feeding education, ostomy care
  - Weaning ADL assistance off progressively during stay

What do we say to these patients?

- Care team still needs to give them information and prepare them for functional regression due to disease progression without guaranteeing that they are going to have future issues
  - "It's a good idea to plan for good days and bad days"
  - "We want to address your goals while focusing on how to get you home safely"
  - "There is a tool for everything, you might not need it now, but at least you know its out there"
  - "All of your goals do not need to be accomplished in IPR, lets get you home to keep working on those goals"
  - "It is important to have a plan A for when you are feeling strong and a Plan B for harder days"
- Continue to work towards patient goals ex. Stronger for chemo, stair management

Functional Outcome Measures

- For ambulatory patients
  - 10 meter walk test
  - Minimal walking to save energy
  - Meets frequent patient goals for short distance walking while allowing outcome measure assessment
    - Walking Speed: the Functional Vital Sign, self-selected walking speed is a versatile assessment measure that is appropriate and valid among a variety of diagnoses. (Middleton et al 2015)
  - It has the ability to predict discharge situation and the scores correlate to fall risk.
  - **Most importantly improvements in walking speed are linked to improved quality of life (Fritz 2009)**

Rate of Perceived Exertion

Rating of Perceived Exertion	
6	No exertion at all
7	Extremely light
8	
9	Very light
10	
11	Light
12	
13	Somewhat hard
14	
15	Hard (Heavy)
16	
17	Very hard
18	
19	Extremely hard
20	Maximal exertion

(Gresham 2018)

Fatigue Scale

Pain Scale

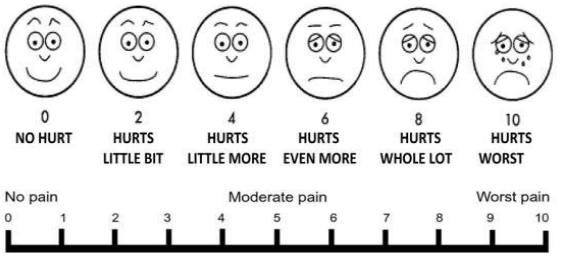


TABLE 1 Palliative Physical Therapy (PT) Practice Patterns

Palliative PT Model	Intervention	Goals	Clinical Patient Scenario	Therapist Intervention Examples
Rehab Light	Lower intensity and frequency with progressive rehabilitation	Short-term improved function and quality of life	• 63-y-old man with end-stage chronic obstructive pulmonary disorder limited in tolerance to PT due to dyspnea upon exertion • Is on 4-5 L of oxygen at home continuously via nasal cannula	• The therapist provides more frequent rest breaks during a progressive gait training program • Prescribes shorter bouts of activity throughout the day • Educates patient on rating of perceived exertion and dosing exercises via pulse oximetry feedback
Case Management	Evaluation and intermittent reassessment with program modification and instruction	Patient and caregiver safety with in-home management	• 79-y-old woman with advanced dementia who has a caregiver 24 h a day • She is ambulatory with a 4-wheeled walker (rolling) • Due to cognition, cannot meaningfully participate in formal PT	• Monthly consultative visits by the physical therapist to assess strength, safety and update a home exercise program • Caregiver education on safe patient handling and mobility techniques (ie, transfers, bed mobility, gait) and ergonomics for injury prevention
Rehabilitation in Reverse	Patient training, equipment, and caregiver instruction at threshold levels of progressive decline	Maximize safe mobility throughout the course of disease	• 57-y-old man with amyotrophic lateral sclerosis • The patient is able to ambulate with forearm crutches but cannot walk in the community because of fatigue	• Therapy is administered weekly • The patient is instructed in wheelchair, bedside commode, and rolling walker use in anticipation of a future need for these pieces of equipment • Home exercises are provided to maintain strength and flexibility while avoiding overexertion
Skilled Maintenance	Skilled mobility assist beyond the ability of caregivers	Preserve function allowing caregivers to safely manage home care	• 45-y-old woman with stage IV breast cancer that has metastasized to her right femoral neck • Per orthopedist, she is 5% partial weight-bearing on the right femur • She also has developed metastases to her brain that has impaired her judgement and safety awareness	• Therapist determines that ambulation is safe and feasible only with a professional who is able to monitor the 5% partial weight-bearing status • Therapist-administered exercises while seated or in-bed without resistance to the right leg to avoid pathologic fracture • Prescription of a wheelchair and bedside commode for safe mobility when the therapist is not present
Supportive Care	Physical measures Psychosocial support around functional mobility changes	Comfort measures Adaptation and adjustment to progressive disability	• 86-y-old woman with stage IV lung cancer with widespread metastatic disease • The patient also has severe osteoarthritis • High risk of pressure ulcers • Lower-extremity swelling due to lymphedema	• Educating hospice team members on safe positioning and transfers to avoid injury • Teaching family members how to perform joint range of motion to reduce arthritis pain for less need for opioid pain medications • Performance of manual lymphatic drainage and wrapping to reduce pain and swelling

Rehab Light and Rehab in Reverse (Briggs 2000)

- Rehabilitation Light
  - Slower progression
  - Decreased intensity, frequency, duration
    - More family participation vs patient
    - Education/demonstrating interventions vs physical interventions (exercise, transfers, etc)
  - Deference to pain control and comfort
    - Base intensity on vitals (including Borg RPE) and fatigue/pain scales
- Rehabilitation in Reverse
  - Trains patient and family
  - Anticipate functional decline (plan for good days and bad days)
  - Procures needed equipment beforehand
  - Teaches family positioning and safe patient handling

Rehab in Reverse (Briggs 2000)

Christine Lipple OTR/L

Beaumont

How to Apply this in the Hospital

- Where does therapy fit in this palliative spectrum?
- Identifying patients appropriate and initiating conversation about goals of care
- Changing frame of mind from traditional rehab to meet patient / family to achieve goals
- Discussion of complex patients with palliative team to provide insight into current functional mobility/ ADL abilities, barriers to returning home, and discussion on goals of care post-acute.

Physical Therapy Screening Acute

- Aggressive screening and early identification of palliative care and chronic disease patient during hospitalizations
- Essentially direct access for referral to PT/OT services
- Avoids traditional model of a patient not often getting a PT/OT treatment till day 3-4
- Direct communication between nurse and PT/OT for any possible patient needs with *immediate assessment and treatment*
- *Therapist participates in daily huddles*

Palliative Care Rounds

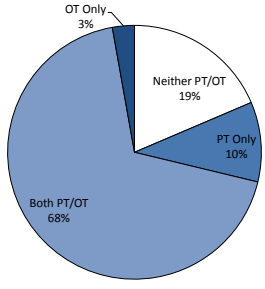
- Palliative Nurse Practitioners
- Hospice Nurses
- Social Work
- Care Manager
- Skilled Physical / Occupational Therapy
- Spiritual Care
- Service Excellence
- Review each patient in acute with palliative consultations
- Review palliative patients referred to IPR to keep in touch and guide care
- Other acute patients that team needs to have palliative consult (IPR candidate or not)

OT's Role in Hospice & Palliative Care

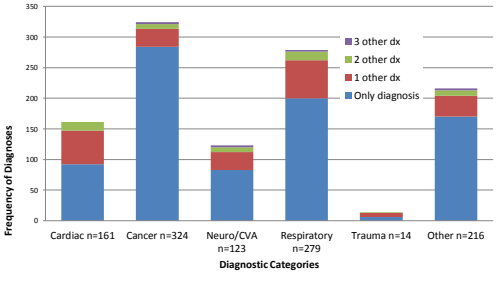
Shift focus from traditional rehab to:

- Quality of life
- Anticipatory future disability and equipment needs
- "Bucket List" assistance
- Prevention of pressure ulcers, contractures/ consultation
- Quality of life may mean being in bed in the comfort of home vs a nursing home trying to "rehabilitate" to walk again.
- Patient and family distress
- Emotional-based interactions
- Procure DME for anticipatory decline or "bad days"

Frequency of PT/OT orders in Patients with Palliative Care Consultations in Acute Care (Wilson, Roy 2017) n = 963



Diagnosis Distribution 1 Year Palliative Care (Wilson Roy 2017)



How the Program Works

Short Stay Family Training (SSFT) Program on IPR

Program Goal:

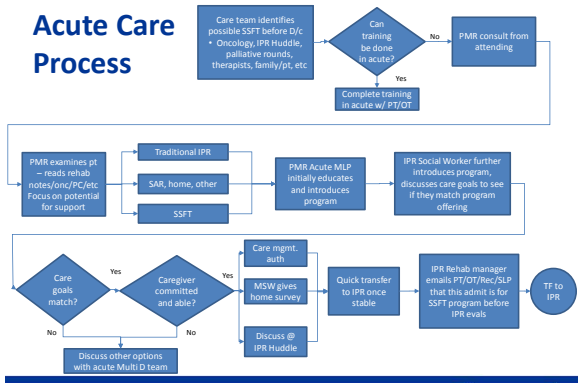
- **Empower** caregivers and family members
- Provide **training** and **education**
- Improve caregiver skills

Program Outcome:

Improve quality of life by:

- Transitioning to home safely
- Reduce hospital readmission

Acute Care Process



Acute Care Process

Patient identified as SSFT candidate:

- Therapist to initiate and schedule family training for next session
- Documentation – see next slide
- Case discussed in IPR huddle in Acute
- If appropriate per PM&R- SSFT brochure provided
- Social work consulted to meet pt/family in Acute Care
  - Discuss specifics of program and identify MSW as liaison

Documentation: Justification

Justification for Short Stay Family Training Program in Inpatient Rehab (IPR):

I have identified this patient to require additional rehabilitation for patient/ family/ caregiver training. Patient assessed and rehab needs identified. Patient would continue to benefit from skilled occupational/physical therapy for education and family training prior to safely returning home. Patient presents to be a candidate for Short Stay Family Training Program in inpatient rehab secondary to:

☐ Patient has a designated caregiver/ family who will be caring for the patient upon returning home
☐ Patient caregiver/ family available to participate in 3 hours of therapy per day
☐ Patient requires skilled therapy in at least two disciplines (i.e. Physical Therapy, Occupational Therapy, and Speech and Language Pathology)
☐ Patient's current functional status is below baseline requiring family training that cannot be completed during the acute care stay (anticipated to take > 4 days)
☐ Patient unable to tolerate traditional rehabilitation

Patient's current barriers to returning home include:

Please refer to assessment portion of note and specific goal section for patient specific needs. Therapist paged attending.

Next scheduled patient/family/caregiver training with _____at _____on _____.

Documentation: Home Evaluation

- Critical this Home Evaluation is done or started in acute to help identify a candidate for IPR SSFT

HOME ASSESSMENT AND RECOMMENDATIONS

Layout/Entrance:
1. Parking facilities: ☐ Garage ☐ Attached ☐ Detached ☐ Carport ☐ Driveway
2. Is there sufficient room for loading and unloading? ☐ Yes ☐ No
3. Terrain of driveway/walkway ☐ Level ☐ Sloping ☐ Cement/asphalt ☐ Grave ☐ Grassy
4. Distance to parking space:
5. Can patient manage the sidewalk independently?

Front Entrance:
1. Number of steps:
2. Steps: Height: Width: Depth:
3. Porch dimensions: inches wide by inches deep
4. Handrail present: Handrail Height:
5. Storm door:
6. Doorway width:

Bathroom: Layout- Location
1. Measurements
   A. Doorway width: inches without door: inches
   B. Front edge of toilet to wall: inches
   C. Right side of toilet to obstruction: inches
   D. Left side of toilet to obstruction: inches
2. Sink Height- ☐ Closed ☐ Open Style Cabinet
3. Toilet Seat Height: inches
4. Accessible from wheelchair level
   ☐ Bathroom door ☐ Toilet ☐ Sink ☐ Outlets ☐ Mirror ☐ Cabinets/Drawers
5. Bathing Facilities
   ☐ Tub/shower ☐ Stall shower
   A. Height of tub/shower ledge: inches
   B. ☐ Doors ☐ Curtain

Documentation: Home Evaluation

Bathroom: Layout- Location
1. Measurements
   A. Doorway width: inches without door: inches
   B. Front edge of toilet to wall: inches
   C. Right side of toilet to obstruction: inches
   D. Left side of toilet to obstruction: inches
2. Sink Height ☐ Closed ☐ Open Style Cabinet
3. Toilet Seat Height: inches
4. Accessible from wheelchair level:
   ☐ Bathroom door ☐ Toilet ☐ Sink ☐ Outlets ☐ Mirror ☐ Cabinets/Drawers
   ☐ Light switch ☐ Tub/shower
5. Bathing Facilities
   ☐ Tub/shower ☐ Stall shower
   A. Height of tub/shower ledge: inches
   B. ☐ Doors ☐ Curtains

Bedroom:
1. Door width: inches without door: inches
2. Floor covering:
3. Bed Type: Bed height: inches
4. Dresser type: Height: inches
5. Accessible from wheelchair level:
   ☐ Doorway ☐ Bed ☐ Dresser ☐ Closet ☐ Light switches

Living/ Family / Kitchen Room:
1. Entrance width: inches
2. Flooring type: inches
3. Furniture- ☐ Couch: inches ☐ Recliner: inches ☐ Coffee table
4. Accessible from wheelchair level:
   ☐ Doorway ☐ Furniture ☐ Carpet ☐ Layout for access ☐ Curtains

Documentation: Family Training on Acute – completed or still has needs

Family training completed on the following date:

☐ Observation ☐ Hands on

The following areas were reviewed:

☐ Tub transfer
☐ Shower stall transfer
☐ Toilet transfer
☐ Bed transfer
☐ Rolling walker safety
☐ Transfer safety
☐ Energy conservation
☐ Home safety
☐ Diagnosis-specific precautions
☐ Review of dressing and adaptive equipment
☐ Visual perceptive deficits/compensation
☐ Recommended amount of supervision
☐ other:

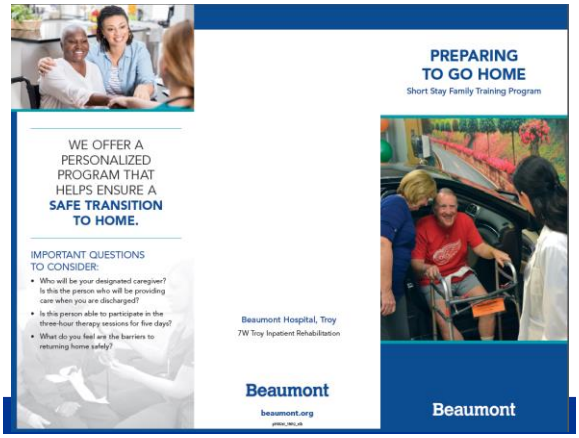
Family confirmed the following equipment and DME at home prior to admission:

Discharge equipment and DME recommendations concluded from this session:

Handouts provided this session:

Assessment: The patient's family ☐ safely provided required assistance ☐ Requires further training

Plan: ☐ No further family training required ☐ Family to return on: ☐ Areas to cover with next family training session:



Patient Case

- Indicated candidate for IPR SSFT
- Completed Family training in Acute Care and discharged home

Patient Case

- Indicated candidate for IPR SSFT
- Completed Family training in Acute Care and patient / family chose SAR

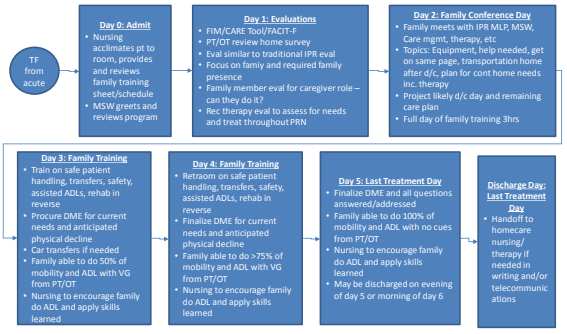
Patient Case - MZ

- Indicate candidate for IPR SSFT
- Initiate training in Acute Care however continued family training needed therefore d/c to IPR for SSFT

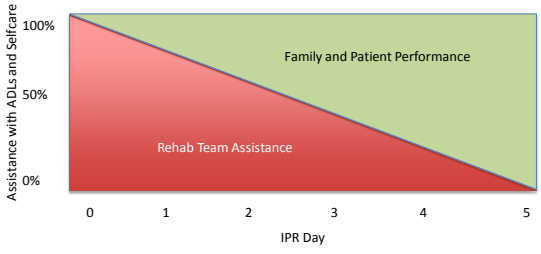
Meghan Avromov, LMSW

Beaumont

IPR Short stay Family training Program



Beaumont



Patient Case through 5 day SSFT

- Patient: MZ - 74 year old female
- Diagnosed with pancreatic cancer with metastatic disease to the liver
- Undergoing chemotherapy with medical complications requiring admissions into the hospital
- Poor prognosis with patient wishing to focus on quality of life
- Plan for home with hospice
  - Including equipment coverage

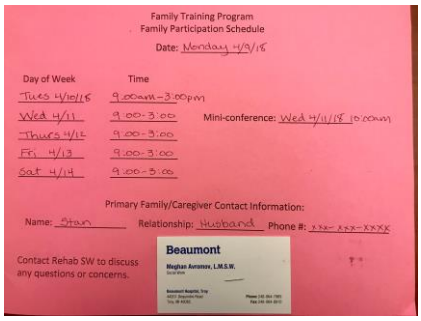
Prior to Admission

- Rehab Social worker to see patient on Acute Care.
  - Discuss patient and family goals of care
  - Discuss goals of Short Stay Family Training Program
  - Discuss case with Acute Care therapy team and during IPR admission meeting
  - If possible, multiple meetings to ensure goals align

Day 0 – Admission Day

- Prior to transfer
  - If not completed prior to approval, meet with patient and family on acute to discuss aspects of SSFT program.
  - Develop schedule for family training – complete “Pink sheet” and provide copy to family. Discuss anticipated discharge date.
- Upon transfer
  - Discharge date provided to patient/family (5 days) on whiteboard
  - Communicate 5 day training times to therapy scheduler.

Pink Sheet


Family Training Program
Family Participation Schedule
Date: Monday 4/9/18

Day of Week	Time
Tues 4/10/18	9:00am-3:00pm
Wed 4/11	9:00-3:00
Thurs 4/12	9:00-3:00
Fri. 4/13	9:00-3:00
Sat 4/14	9:00-3:00

Mini-conference: Wed 4/11/18 10:00am

Primary Family/Caregiver Contact Information:
Name: Stan Relationship: Husband Phone #: xxx-xxx-xxxx

Contact Rehab SW to discuss any questions or concerns.

Beaumont
Meghan Avramov, LMSW

MZ – Day O

- Patient receiving Occupational and Physical Therapy in Acute Care setting with therapy recommending SSFT program (See Acute Flow)
- Social Worker spoke with MZ, spouse SZ, and daughter on Acute Care

Day 1

- Patient / Family Schedule from 9am-3pm
  - Social Work Meeting
  - Occupational therapy Evaluation
  - Speech Therapy Evaluation
  - Physical Therapy Evaluation
  - Care Manager(CM) will meet with patient/family (pending day of admission)
  - If ramp is indicated, address with patient/caregiver and notify Care Manager

*Important to schedule rest breaks between each rehab therapy session

MZ – Day 1

- 9am-10am Occupational Therapy Evaluation
  - FIM Scoring for self care: toilet transfer, dressing, shower (Max assist for seated activities), Home Evaluation completed
- 10am-11am Rest break
- 11am-12pm Speech Therapy Evaluation
  - FIM Scoring: Eating, auditory comprehension, verbal expression, problem-solving, memory.
  - Other considerations for Speech: what is patient's priority (sometimes would rather focus on PT/OT; other times it is pt's priority to include SLP. Is the pt tolerating diet safely? Option to re-start SLP service once pt is home
- 12pm-1pm Lunch
- 1pm-2pm Physical Therapy Evaluation
  - FIM Scoring on mobility: Bed, Bed to chair transfers, ambulation, and stairs (Mod-Max for bed mobility, 2 person for transfer, ambulating 25 feet with w/c follow, 10MWT = .13 m/s)
- 2pm-3pm Social Work meeting/ Recreational Therapy Evaluation/ Care Manager

Day 2

- Mini – Conference in morning
  - Including family/caregiver, patient, social work, PA/NP, care manager, speech therapy if indicated, PT or OT.
  - Discuss discharge recommendations and amount of assist/equipment anticipated
- Patient and Caregiver/Family to participate in 3 hours of training with therapies
  - Family/ patient able to do **25%** of mobility and ADL with VG from PT/OT
- Social Work session
- Care Manager continuously involved (may be behind the scenes)
  - Therapy to complete DC Recommendations Tab, let CM know if ramp and /or wheelchair needed (provide measurements / script)

MZ – Day 2

- Mini-Conference
  - Discussed discharge plan for home with hospice
  - Equipment recommendations: wheelchair/transport chair, ramp, hospital bed, over the bed tray table, commode, handybar, walker
- Occupational Therapy
  - Hands on training with spouse
  - Spouse assisting with toileting
- Physical Therapy
  - Patient not feeling well, new diagnosis of pneumonia
  - Demonstration of car transfer observed by patient and spouse
  - Increased hands on assist provided for bed to chair transfer
- Speech Therapy
  - Completed Evaluation and Swallow Evaluation

Day 3

- Family/ patient able to do **50%** of mobility and ADL with VG from PT/OT
- Possible Palliative Care Meeting
- Possible Social Work meeting

MZ – Day 3

- Occupational Therapy
  - Spouse practice bed to/from commode transfer
  - Activity pacing and gait belt education
  - Pressure relief techniques
- Physical Therapy
  - Spouse and daughter hands on wheelchair bumping up curb (home entrance)
  - Practiced managing ramp
  - Education on transport chair
- Speech Therapy
  - Maximizing communication strategies at home
- Social Work
  - Daughter expressed concern for her father to have support and respite at home
  - Follow up meeting with Hospice to help family understand and prepare

Day 4

- Family able to do **>75%** of mobility and ADL with VG from PT/OT
- Possible Social Work Meeting

MZ – Day 4

- Occupational Therapy
  - Spouse completed bed to transfer with use of walker and stand/pivot
- Physical Therapy
  - Spouse practiced proper guarding and gait belt use for stair training
  - Educated on different transfer techniques: modified pivot when pt feeling fatigued
- Social Work
  - Patient stating feeling relieved and at peace with her decision not to have more chemotherapy
  - Patient wanted to hire help, so that spouse would be able to play golf and have respite time
- Speech Therapy
  - Comprehension and communication strategies

Day 5

- Family able to do **100%** of mobility and ADL with VG from PT/OT
- Independence Day Sign posted after therapies, Patient/Caregiver able to complete care in room (with assist from staff PRN)
- Care Management meeting with patient/family if warranted
- Possible Social Work Meeting

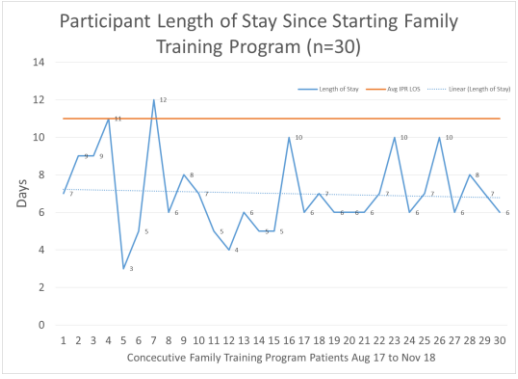
MZ – Day 5

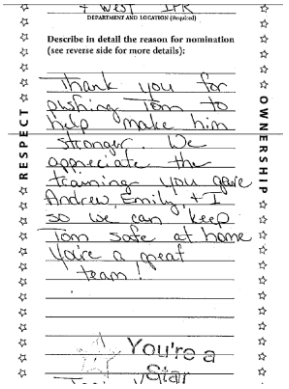
- Occupational Therapy
  - D/C FIM
  - Patient/Spouse independent with shower and dressing
- Physical Therapy
  - D/C FIM
  - TMWT .5MPS (improved from .13MPS)
  - Patient/Family completed bed mobility, w/c management, stairs, and car transfer
- Speech Therapy
  - Breath support and memory strategies
- Social Work
  - Patient expressing normal range of emotions
  - Discussed coping strategies
  - Provided resources (Wilson Cancer Center, Hired Help, Hospice)

Maybe stories are data with a soul
- Brene Brown

Main Trends from August 2017-November 2018

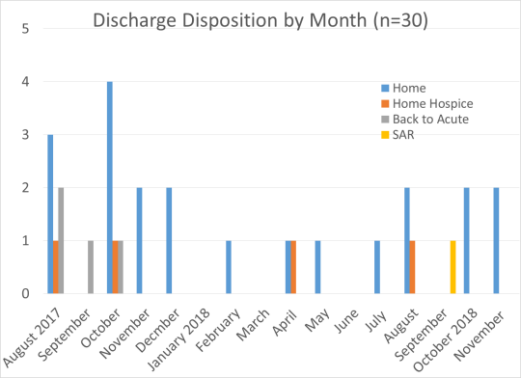
- Length of stay
- Family presence and patient satisfaction
- Discharge location
- Barriers/challenges





Patient Satisfaction Recognition

- Close monitoring of patient satisfaction
- Satisfaction scores remained stable despite challenging conversations and shorter family-focused Length of Stay
- Small sample size of SSFT in big picture of all IPR patients
- 2018, received National Press Ganey award showing that all IPR survey returns were above 95%



Transtheoretical Model of Behavior Change

- Need to be sensitive to where they are emotionally and mentally
- Meet them where they are at
- Transtheoretical model of behavior change
- Precontemplators may benefit from further palliative care/social work discussions before IPR SSFT program

https://en.wikipedia.org/wiki/Transtheoretical_model#/media/File:Stages.jpg

Pre-contemplation

Characteristics
- Not currently considering change
- Does not recognize need to change
- "Ignorance is bliss"
- Reluctance, resistance

Techniques
- Validate
- Clarify
- Opportunity for discussion that might lead to slight increase in readiness
- Positive re-framing (encourage pt to: see it in a different light, try to see it from a positive perspective, try to look for something good that is happening)

Contemplation

Characteristics
- Still Ambivalent
- Still not considering change
- Still resistant but will discuss sometimes
- May say "all the right things" but still refuse to act

Techniques
- Validate lack of readiness
- Risk-reward analysis
- Opportunity for discussion that might lead to slight increase in readiness
- Planning for change: thinking about/trying to come up with strategy about what to do; thinking hard about what steps to take

Preparation

Characteristics
- Still ambivalent but considering small steps toward change
- Somewhat more open to discuss change

Techniques
- Identify and assist in problem solving re: obstacles to change
- Verify underlying skills for making the change
- Encourage small initial steps
- Acceptance: trying to accept the reality of the situation, accept that this has happened; "learning to live with it"

Action

Characteristics
- More openness for the new behavior
- Working through feelings of loss

Techniques
- Practicing the new behavior
- Focus on goal of quality of life
- Pt may be concentrating efforts on doing something about the situation; taking action to assimilate the situation; planning strategies and steps to take; looking for what is good in the situation

There is always HOPE… But hope is not a PLAN

Training for "now" or "the bad days"

Can run parallel with their hopes and plan for the future

Hope

Aligning with Patient Family Centered Care (PFCC)

OUR MISSION
Compassionate, extraordinary care every day

OUR VISION
To be the leading high-value health care network focused on extraordinary outcomes through education, innovation and compassion

How does the SSFT Program improve patient/ family centered care?

- Providing alternative option to return home safely if traditional rehab is not appropriate
- Cohesive discharge goals between patient , caregivers/family, therapy, and medical team
- Provide protocol/ process to improve communication for interdisciplinary team to help guide transition of care
- Provide Framework for patient, family/ caregiver expectations for rehab stay

PFCC in ACTION!

- Patient and family understand/ choose/ agree to this program
- Leads to less stress / confusion/ misunderstanding / inefficiency
- Allows for consistent resource person/ navigator for patient and family when they have questions and/or concerns

Ongoing Process Improvement

- Ongoing data collection:
  - Length of stay
  - Monitoring insurance billing – No denials yet
  - Discharge disposition
  - Readmissions
  - Family involvement
  - FIM/Caretool
  - Quality of Life Outcome Measures
  - Patient and care team satisfaction
- SSFT program has guided framework, however continue to utilize case by case approach
- We learn something new from each patient case with the program continuing to evolve

Conclusion

- Healthcare has changed toward prospective management of palliative and declining patients
- Emphasis on the family training is a skilled rehab service
- Very satisfying to help a terminally ill patient get home safely and comfortably
- Reduces stress on families, patients and care team

Acknowledgements

- All images accessed via Wikimedia images or Creative Commons unless otherwise cited
  - https://commons.wikimedia.org/wiki/Commons:Reusing_content_outside_Wikimedia
  - http://creativecommons.org/licenses/
- Thank you to all members of the SSFT for collaboration on development of content
- Special thanks to John Maltese MD, Reyna Colombo PT, MA; Janet Seidell PT MPT; Eli Siwa PT and Matthew Trunsky MD

References

- Alam E, Wilson RD, Vargo MM. Inpatient cancer rehabilitation: a retrospective comparison of transfer back to acute care between patients with neoplasm and other rehabilitation patients. Archives of physical medicine and rehabilitation. 2008 Jul 1;89(7):1284-9.
- APTA position Paper on Hospice and Palliative Care, THE ROLE OF PHYSICAL THERAPY IN HOSPICE AND PALLIATIVE CARE HOD P06-11-14-11
- Burge F, Lawson B, Johnston G, Asada Y, McIntyre PF, Flowerdew G. Preferred and actual location of death: what factors enable a preferred home death?. Journal of palliative medicine. 2015 Dec 1;18(12):1054-9.
- Briggs R. Models for physical therapy practice in palliative medicine. *Rehabil Onc.* 2000;18(2):18-19.

References

- Center to Advance Palliative Care. Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships, 2014 A Palliative Care Toolkit and Reference guide, National Business Group on Health. https://www.capc.org/payers/palliative-care-payer-provider-toolkit/
- Coleman RE. Management of Bone Metastases. The Oncologist. 2000; 5:463-470.
- DeVita VT, Hellman S, Rosenberg SA. *Cancer: Principles & Practice of Oncology*. 7th ed. Philadelphia, PA. Lippincott Williams and Wilkins. 2005.
- Fu JB, Lee J, Smith DW, Shin K, Guo Y, Bruera E. Frequency and reasons for return to the primary acute care service among patients with lymphoma undergoing inpatient rehabilitation. PM&R. 2014 Jul 1;6(7):629-34.

References

- Fu JB, Lee J, Shin BC, Silver JK, Smith DW, Shah JJ, Bruera E. Return to the primary acute care service among patients with multiple myeloma on an acute inpatient rehabilitation unit. *PM&R.* 2017 Jun 1; 9(6): 571-8.
- Given BA, Given CW, Sherwood PR. Family and caregiver needs over the course of the cancer trajectory. *The Journal of Supportive Oncology*. 2012; 10(2): 57-64..
- Gresham G, Dy SM, Zipunnikov V, Browner IS, Studenski SA, Simonsick EM, Ferrucci L, Schrack JA. Fatigability and endurance performance in cancer survivors: Analyses from the Baltimore Longitudinal Study of Aging. Cancer. 2018 Mar 15;124(6):1279-87.
- Guo Y, Persyn L, Palmer JL, Bruera E. Incidence of and risk factors for transferring cancer patients from rehabilitation to acute care units. American journal of physical medicine & rehabilitation. 2008 Aug 1;87(8):647-53.

References

- Lynn J, Adamson DM. Living Well at the End of Life. White Paper. Santa Monica, CA; Rand Corporation: 2003.
- McCaffrey N, Bradley S, Ratcliffe J, Currow DC. What aspects of quality of life are important from palliative care patients' perspectives? A systematic review of qualitative research. Journal of pain and symptom management. 2016 Aug 1;52(2):318-28.
- Middleton A, Fritz SL, Lusardi M. Walking speed: the functional vital sign. Journal of aging and physical activity. 2015 Apr;23(2):314-22.
- Mirels H. Metastatic disease in long bones: A proposed scoring system for diagnosing impending pathologic fractures. Clin Orthop. 1989; 249: 256-264.

References

- Ranganathan A, Dougherty M, Waite, Casarett D. Can Palliative Home Care Reduce 30-Day Readmissions? Results of a Propensity Score Matched Cohort Study. *J Palliat Med.* 2013; 16: 1290-1293.
- Stout NL, Silver JK, Raj VS, Rowland J, Gerber L, Cheville A, Ness KK, Radomski M, Nitkin R, Stubblefield MD, Morris GS. Toward a national initiative in cancer rehabilitation: recommendations from a subject matter expert group. Archives of physical medicine and rehabilitation. 2016 Nov 1;97(11):2006-15.

References

- Wilson CM, Roy DM. Relationship Between Physical Therapy, Occupational Therapy, Palliative Care Consultations, and Hospital Length of Stay. J Acute Care Phys Ther. 2017; 8(3): 106-112. DOI: 10.1097/JAT.0000000000000059
- Wilson CM, Mueller K, Briggs R. Physical Therapists' Contribution to the Hospice and Palliative Care Interdisciplinary Team: A Clinical Summary. J Hospice Palliat Care Nurs. 2017; 19 (6): 588-596.
- Wilson CM, Boright L. Documenting Medical Necessity for Palliative Care and Degenerative or Chronic Conditions. Rehabil Onc. 2017; 35: 153-156.
- World Health Organization. (2018) WHO Definition of Palliative Care. Accessed December 1, 2018. https://www.who.int/cancer/palliative/definition/en/