Minnesota Cancer Plan Update: Survivorship Work Group

Issue Analysis

**Issue #3: Cancer Rehabilitation and Physical Impairment from cancer treatment**

**ISSUE STATEMENT & RATIONALE/EVIDENCE BASED RESEARCH:** Physical impairments after cancer treatment increase distress, morbidity and mortality. Targeted, cancer-specific physical rehabilitation and cancer-specific exercise has been shown to reduce physical frailty, reduce disability, lengthen survival and improve quality of life in cancer survivors. Part of required distress screening is the imperative to utilize qualified professionals to address the distress caused by physical impairments imposed by cancer. Research has shown that cancer survivors are not being referred for existing services and that there are not enough qualified professionals to meet the needs of the increasing numbers of cancer survivors, particularly with increasing elderly and frail survivors. Additionally, minority populations and populations who do not access traditional medical services are excluded from this care.

- “Cancer Rehabilitation is medical care that should be integrated throughout the oncology care continuum and delivered by trained rehabilitation professionals who have it within their scope of practice to diagnose and treat patients’ physical, psychological, cognitive and functional impairments in an effort to maintain or restore function, reduce symptom burden, maximize independence and improve quality of life in this medically complex population.” Silver JK, Raj VS, Fu JB, Wisotzky EM, Smith SR, Kirch RA. Cancer rehabilitation and palliative care: critical components in the delivery of high-quality oncology services. Support Care Cancer. 2015 Dec;23(12):3633-43.


- 25% of cancer survivors have poor physical health and 10% have poor mental health compared with 10% and 6% of adults without a history of cancer respectively. Weaver, K. Mental and Physical Health-Related Quality of Life among US Cancer Survivors: Population Estimates from the 2010 National Health Interview Survey. Cancer Epidemiol Biomarkers Prev; 2012. 21(11);2108-1.


What factors & barriers contribute to this issue?
Oncology departments/programs lack integration with rehabilitation, especially Physiatry
Inadequate medical training in medical schools and oncology residency programs regarding the types and effectiveness of rehabilitation interventions
PM&R residency training programs not devoting adequate time/resources to training in cancer rehabilitation
PT, OT, SLP training programs not devoting adequate time to/resources to training in cancer rehabilitation
Payment systems that have silos versus ACO models
Poor understanding of medical professionals regarding the specifics of medical exercise prescriptions and how they must be administered to have beneficial/safe effects on cancer survivors (generally have been relegated to sports medicine professionals)
Lack of understanding of rehabilitation care as covered medical care as opposed to community exercise/wellness
Lack of screening for physical impairments since Commission on Cancer implemented Distress Screening Guideline but no physical impairment screening guideline
Health care systems that do not interface with racial and ethnic communities on cultural differences with diet and exercise as well as survivorship care in general
Lack of partnerships with qualified community cancer exercise professionals in affordable, accessible settings
| Lack of training for Cancer Exercise specialists  
Survivors uneducated on cancer exercise specialists versus community fitness trainers  

| What are the gaps in policy, systems and services that give rise to this issue?  
Lack of leadership/innovation in Minnesota medical training programs relative to developing effective collaborative models of PMR/Oncology interface  
Lack of research into effective collaborative models of oncology-rehabilitation care  
Silo-driven payment models  
Lack of understanding of rehabilitation as covered medical care leading to unfair, erroneous denial of treatment  
Regulatory agencies enforcing only distress screening and referral systems, and not physical impairment screening and referral systems for cancer survivors  
Lack of requirement for certification of cancer exercise specialists providing cancer exercise community classes  

| What are the POLICY opportunities to address the identified factors, and racial, economic, geographic, and other barriers that contribute to this issue? What are the POLICY opportunities to address the identified gaps?  
Require physical impairment screening for cancer survivors with referral to qualified rehabilitation and exercise professionals  
Require medical schools, PMR residencies and Oncology residences in MN to have training in evidence based cancer rehabilitation  
Develop telemedicine opportunities and payment mechanisms for cancer rehabilitation  
Pilot/grant projects to develop models of care in Minnesota medical training institutions |
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<th>Requirement/Strategy</th>
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<td>Require oncology survivorship programs to track percentage of minorities under their care receiving screening for physical impairment and referrals to services.</td>
<td>Work with insurance companies in Minnesota to evaluate compliance with standards of care coverage for physical impairments as medical care. Require community programs stating that they are a “Cancer Exercise Program” to disclose qualifications of class instructors, certify instructors as cancer exercise trained if offering “cancer exercise classes.”</td>
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<td>What are the STRATEGY opportunities to address both the barriers and the gaps relating to this issue?</td>
<td>Reach out to Medical training program leaders in Oncology and PMR in MN. Reach out to PT, OT, SLP training program leaders in MN. Seek grant funding for pilot models.</td>
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1. Who are the existing partners/organizations already working on this issue?  
Unknown
2. Which partners/organizations should work together to address this issue?

Which strategies promote health equity?