COMMENTARY

Using the Lessons of COVID-19 to Improve Access to Physical Therapists for People With Cancer

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THE PAST

The COVID-19 pandemic has disrupted life for people around the world, with particularly severe effects in the United States. In addition to the suffering of people with the virus, and strains placed upon health systems, there has been widespread disruption in health care, with near-total cessation of nonessential clinic and hospital services under COVID-19 quarantine protocols.1 In the oncology world, this has resulted in postponed treatments and widespread shifts from in-person to virtual clinic visits.2,3 In the United States, the reduction in diagnostic and treatment procedure volume during the pandemic is expected to result in more than 30,000 excess cancer deaths.4 These disruptions have also negatively impacted oncologic physical therapist and physical therapist assistant (PT/PTA) practice, reducing patient access to PTs/PTAs and disrupting the continuity of rehabilitation care. The effect of these disruptions on patient outcomes is unknown, though resulting increases in mortality and reductions in quality of life are likely. The challenges posed by the COVID-19 pandemic, and the reality that cancer will not wait, require PTs/PTAs to leverage new, integrated care models and telehealth interventions to provide accessible, continuous services during and after this crisis.

THE PRESENT

Care for people with cancer and cancer survivors is currently being delivered in a highly chaotic environment. Quarantine protocols vary by region and locality and shift unpredictably over time. In this environment, patients and PTs/PTAs must weigh the risk of COVID-19 against the risk of functional decline in the absence of rehabilitation services.5,6 Many people with functional impairments are going without PT/PTA care due to clinic closures and breakdowns in prepandemic patterns of referral and clinical follow-up. Consequently, it is incumbent upon PTs/PTAs to make every effort to facilitate patient access to rehabilitation care. In this Commentary, we summarize the clinically integrated physical therapist (CI-PT) model of cancer rehabilitation and discuss elements of its design that have allowed a CI-PT to maintain continuous, in-person care throughout the pandemic.7 We also discuss the widespread shift to telehealth in oncology and physical therapy and considerations for PTs/PTAs to most effectively use telehealth technologies to provide care for people with cancer and cancer survivors.

Overcoming Clinic Closures: The CI-PT Model

Clinic closures during the pandemic, due, in part, to rehabilitation services being deemed nonessential, have had a devastating effect on physical therapy and rehabilitation care.8 In this period, the CI-PT model of cancer rehabilitation adopted in thoracic surgical and bone marrow transplant (BMT) clinics at the Huntsman Cancer Institute (HCI) at University of Utah Health has empowered oncologic PTs to provide in-person care throughout the COVID-19 pandemic. The key feature of this model is pragmatism, with practice patterns defined by the unique needs of patients and the clinic setting. With necessity as

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its guide, PT practice is integrated into oncology clinic workflows, eliminating the need for a referral to an outside physical therapy clinic and providing nearly barrier-free, uninterrupted access to a PT for people with cancer and cancer survivors. Although the referral is eliminated, there is still the necessity for separate payment for PT/PTA services in the CI-PT model. In thoracic surgical clinics, the CI-PT is funded by the Precision Exercise Prescription study, a phase III clinical trial of pre- and postsurgical rehabilitation care under the CI-PT model (NCI R01 CA211705). In BMT clinics, however, the CI-PT bills for services just as any other outpatient PT/PTA would. We have found that there needs to be sufficient patient volume due to the relatively low number of codes billed per patient under the CI-PT model. With this volume in BMT clinics, a PT was found to be self-sustainable using standard billing procedures and codes.

Prior to the pandemic, this model had been demonstrated to greatly improve access to a PT for people with cancer and cancer survivors. Between 2016 and 2018, 646 patients were seen in these clinics by PTs, who performed more than 2900 functional mobility assessments and provided nearly 700 treatments. Prior to the adoption of the CI-PT model, no functional assessments or rehabilitation interventions were provided as part of standard care in these clinics, and very few patients received outpatient PT/PTA services. For example, in the year prior to CI-PT model adoption in thoracic surgical clinics, fewer than 10 patients were successfully referred to the outpatient PT clinic at the cancer center. The thoracic surgical provider attributed this lack to difficulties scheduling patients for PT evaluations quickly enough to be compatible with timelines for surgical care. It simply took too long for referred patients to be seen by a PT, both before and after surgery.

During the pandemic, the CI-PT model has enabled continuous patient access to cancer rehabilitation services. The PT integrated in thoracic surgical clinics at HCI has seen patients at regular follow-up appointments, keeping continuity despite the widespread shutdown of outpatient rehabilitation services. This was possible because the PT was part of the oncology clinic team. Simply put—when clinically integrated into the oncology provider’s clinic, the PT was deemed essential. Several elements of the CI-PT model design and adoption process contributed to its resilience, including changes in clinic culture led by oncology medical providers, modifications to clinic workflows to make space and time for a PT to practice, and development of protocols to streamline PT evaluation and intervention.

The first step of CI-PT development was to get buy-in from oncology providers to “champion” model development and adoption. Initially, approval was obtained to collect patient-reported functional mobility data in oncology clinics in order to better understand the level of physical function of the clinic population. These data showed a high prevalence of functional impairment, with more than 60% of patients having difficulty with either home or community mobility. Based upon these data, providers were eager to bring a PT into their clinic teams to address the high level of observed physical impairment. This required a change in clinic culture to create understanding of the role of the PT on the clinic team and awareness of the importance of tracking and intervention to support patient physical function from diagnosis through long-term survivorship. The leadership of the oncology provider was crucial to develop and maintain this cultural shift. During the pandemic, this culture was evidenced by the commitment of the entire clinic team to maintaining CI-PT care during the pandemic and by the insistence of the oncology provider that the CI-PT was an essential member of the team. This dedication to the CI-PT model was also made evident by the willingness of all clinic team members to support modifications to clinic workflows that created time and space for CI-PT practice. These modifications included changes to rooming procedure, collection of a new patient-reported measure of physical function, and carving out time in the clinic visit for a CI-PT to see the patient. This again demonstrated the strong culture of support that had been fostered by the oncology provider, which kept the team united through the inevitable bumps and hiccups that occurred as the model was adopted. Even with this cultural support, and engagement to modify clinic workflows, the addition of a CI-PT to the clinic team would not have been possible without changes to PT practice to make evaluation and intervention timelier and more meaningful for the clinic population and setting. A traditional PT evaluation was simply not pragmatic for this setting, due to time and space constraints. In the CI-PT model, patient-reported functional mobility data are used to give a patient a mobility “stage” that informs evaluation and treatment. Not only is this possible, in part, because of the predictable nature and timing of impairments for people being treated for cancer, but it also required the effort and willingness of PTs and rehabilitation managers to work to develop new practice patterns. Cultural change led by oncology providers, collaborative modifications to clinic workflows, and changes to PT practice that occurred during CI-PT development were intended to remove barriers that limited patient access to PTs. They also had the unintended benefit of creating a resilient model of PT care that was able to persist despite widespread clinic closures and discontinuity.

The successes of the CI-PT model before and during the COVID-19 pandemic suggest that PTs should consider it as a way to improve the resilience of rehabilitation services in the short term and facilitate greater patient access to PTs in the longer term.

**Embracing Telehealth/Virtual Oncologic PT Practice**

Disruption in cancer rehabilitation services during the COVID-19 pandemic exposed a lack of flexibility in oncologic PT/PTA practice patterns and an urgent need to better understand how we can fit into patients’ lives. In the 25th John H. P. Maley Lecture, Dr Nicole Stout identified fear of change and uncertainty as major limiters of PTs’ ability to “intersect and engage with a society that has tremendous
needs." Echoing Dr. Stout’s calls to action, PTs/PTAs must face uncertainty, embracing new care models to make physical therapy conveniently available in the constantly changing context of patients’ lives. As noted earlier, adoption of integrated PT/PTA models offers the promise of greatly improved patient access to cancer rehabilitation services. In addition, PTs/PTAs must fully embrace telehealth models to preserve patient access as oncology care shifts away from in-clinic visits during the pandemic.

The widespread shift to telehealth has been a hallmark of the COVID-19 pandemic in oncology care. For people with cancer and cancer survivors, this shift was jarring and sudden, with upheaval of treatment plans and delays in follow-up and surveillance. In this environment, it is reasonable to infer that there was also a loss of in-person access to oncologic PTs/PTAs during the pandemic. Among PTs/PTAs in general, there has been a profound shift toward telehealth due to the COVID-19 pandemic. Fifty percent of PTs/PTAs reported having provided video consults during the pandemic, a rise from only 2% prior to the crisis. Before the pandemic, physical therapy models of telehealth had not gained wide adoption, often due to uncertainty about state licensing, payment for services, and the inability to do hands-on interventions in telehealth visits. These issues, though significant, are surmountable with a flexible approach to telehealth that maintains a rigorous, patient-centered focus. The massive shifts to telehealth in oncology and physical therapy during the pandemic are likely to permanently transform the practice of oncologic physical therapy. With these changes, it is crucial that we do not allow the technology that facilitates telehealth interventions to also erect barriers to patient engagement. There is a danger that existing disparities in access to technologies, such as high-speed Internet, smartphones, and home computers, may be perpetuated in disparate telehealth access to PTs/PTAs. In addition, the level of comfort with the use of technologies can be a barrier to effective telehealth PT care, particularly among elderly populations. We need to develop and maintain awareness of how these disparities affect the communities that we serve and have the flexibility to engage with patients via their preferred communication method. The variety of available technology options can greatly increase our ability to maintain engagement with patients remotely but comes with the requirement to be vigilant that the technology is appropriate to the patient’s needs and capabilities.

The availability of telehealth has undergone a rapid increase during the COVID-19 pandemic and has been accompanied by temporary regulatory changes that have supported reimbursement for telehealth PT/PTA services by major payers and may loosen licensing restrictions on remote practice across state lines. While these are very positive advances to support telehealth in PT/PTA practice, we need to push to make these policy changes permanent. The APTA has called for PTs/PTAs to engage in grassroots advocacy at the state and federal levels in support of permanent policies to facilitate telehealth in physical therapy. We endorse these efforts and urge all PTs/PTAs to join with their voices and actions. We also urge PTs/PTAs to advocate for occupational therapists, speech-language pathologists, and other rehabilitation professionals to benefit from changes in regulation and compensation structures in order to ensure necessary patient access to interdisciplinary rehabilitation care delivered via telehealth.

**THE FUTURE**

In the Maley Lecture, Dr. Stout also called for retiring the idea that an episode of care ends at “discharge” in favor of models of care that allow us to have “prospective, proactive, and ongoing” engagement with patients. With this approach, the “episode” of oncologic physical therapy care is reimagined as a journey of relationship building that begins in the oncology clinic and continues along a continuum of communication and intervention based upon patient need. For people with cancer and cancer survivors, this journey typically includes a litany of office visits, diagnostic appointments, and filling prescriptions. It has long been unreasonable for oncologic PTs/PTAs to expect patients to make space in their lives to navigate the traditional path of referral and in-person visits to nonintegrated PT clinics. This was evident in very low pre-pandemic rates of PT utilization among people with cancer and is even clearer in the urgent light of pandemic-related disruptions. Both PTs and PTAs must push now for changes in the way we practice and modifications to clinic procedures and health systems, using the lessons of the COVID-19 pandemic to create a future of improved access to oncologic rehabilitation care.

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