

FAST FACTS AND CONCEPTS #364
THE ROLE OF PALLIATIVE REHABILITATION IN SERIOUS ILLNESS
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Introduction: With various serious illnesses, patients experience high levels of functional loss, deconditioning and dependency for activities of daily living (ADLs). This can lead to social isolation, depression, caregiver breakdown, and institutionalization (1,2). This *Fast Fact* will review the benefits and challenges of palliative rehabilitation.

What is Palliative Rehabilitation? Palliative rehabilitation is defined as the process of helping a person with a progressive, often terminal illness reach their physical, psychological, and social potential consistent with physiological and environmental limitations and life preferences (3,4). While the aim of conventional rehabilitation is to restore function closer to or better than baseline, palliative rehabilitation primarily aims to promote independence in self-care activities, improvement in symptom control, stabilization of functional decline, and/or provision of emotional support. Subset definitions of palliative rehabilitation have been described based on the patient's anticipated recovery (5-6):

- **Preventative Rehabilitation:** attempts to preclude or mitigate anticipated functional morbidity from the underlying illness or its treatment for patients who often have no functional impairments yet.
- **Restorative Rehabilitation:** refers to the effort to return patients to their premorbid functional status when little long-term impairment is anticipated (e.g. short-term functional impairments anticipated from a neutropenic fever, but there is a high chance of return to previous baseline functional level).
- **Supportive Rehabilitation:** attempts to maximize function after permanent impairments caused by an underlying illness and/or its treatment for which morbidity is anticipated to progress over time.
- **Subacute Rehabilitation (SAR):** pertains to the more conventional rehabilitation. SAR requires at least an hour per day of physical therapy and is delivered five days a week or more in a subacute care facility. In most circumstances SAR cannot be co-administered while on the Medicare Hospice Benefit (MHB). Therefore, the decision to pursue a trial of palliative rehabilitation versus SAR should be individualized on prognosis, potential to regain function, and overall goals of care.

Benefits of Palliative Rehabilitation: Research suggests that cancer and non-cancer patients with progressive illness and pain, dysphagia, skin breakdown, muscle weakness, diminished endurance, and/or orthostatic hypotension can all benefit from palliative rehabilitation (2,3):

- In a study of over 300 hospice patients with cancer, those who received near daily palliative rehabilitation until their death, reported improved quality of life along with a reduction in pain, leg edema, dyspnea, and immobility. Modalities included range-of-motion exercises, chest physiotherapy, swallowing exercises, acupuncture, and bed repositioning using pillows (7).
- A retrospective study of patients admitted to a VA palliative care unit suggested that 56% of patients had improved ADL scores within 2 weeks of completion of the rehabilitation program (4).
- Other studies have supported that a comprehensive inpatient or outpatient rehabilitation program for cancer patients led to improvement of pain, mood, mobility, cognition, and quality of life (8-12).
- For COPD, CHF, and neurologic illnesses, customized rehabilitation strategies have been associated with improvements in quality of life, exercise capacity, fatigue, dyspnea, and mood (13-17).

Who performs palliative rehabilitation? Physical Therapists (PT), Occupational Therapists (OT), and Speech and Language Pathologists (SLP) are board-certified and licensed clinicians who can focus on different aspects of palliative rehabilitation (18). To prevent miscommunication, clinicians should clearly inform rehabilitation specialists when the goals of rehabilitative care are not for complete restoration of function, but rather symptom management, safety, or prevention of immobility or skin breakdown.

- PT: manages common functional issues such as muscle weakness, deconditioning, motor deficits, and pain. Specific interventions offered include stretching, muscle strengthening, provision of adaptive equipment, environmental modification, education on energy conservation, and therapeutic exercise. They can play an active role in caregiver education and on the use of equipment, body mechanics, and fall prevention (18-21).

- OT: assesses and provides treatment programs to improve or maintain performance with ADLs, work tasks, recreation, use of adaptive equipment, and discharge planning. OTs focus more on fine motor deficits than PTs. Specific OT interventions include home assessments, prescription of adaptive equipment, coaching in domestic tasks, stress management, and caregiver support (19,22,23).
- SLP: addresses oral-pharyngeal-laryngeal function and the cognitive components in communication. They assist with feeding and communication via evidence-based modalities including vocal training, visual comprehension, tongue coordination techniques, and food management strategies (19,24).

Insurance Coverage and Reimbursement Challenges: Often insurances will only cover the cost of rehabilitation in an inpatient setting (acute or subacute) if the patient is demonstrating objective progress in restoring function. The MHB allows for rehabilitation resources (albeit often limited in duration) for safety training, symptom management, and ADL assistance (18). Many palliative care programs lack rehabilitation partners with specialized education and training in end-of-life care. Hence, many patients who would benefit from palliative rehabilitation struggle to gain access to it. To mitigate access issues, clinicians and rehabilitation specialists might consider one-time evaluations during inpatient stays, whereby the patient gets evaluated and both the patient and the caregiver are educated on helpful rehabilitation strategies to be continued at home or in an outpatient setting.

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