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Testimony of

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DOD/VA Collaboration and Cooperation to Meet the Health Care Needs of Returning Servicemembers

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Good morning, Senator Akaka and Members of the Committee. Thank you for inviting me today to share my experience and recommendations regarding cooperation among the DOD, the VA, and the civilian rehabilitation hospitals to provide for the medical rehabilitation needs of retuning servicemembers.

I am Dr. Bruce Gans, a physician who specializes in Physical Medicine and Rehabilitation (PM&R). I currently am the Executive Vice President and Chief Medical Officer of the Kessler Institute for Rehabilitation in New Jersey. I have been president of the Association of Academic Physiatrists (the society that serves medical school faculty members and departments), and the American Academy of PM&R, which represents approximately 8,000 physicians who specialize in PM&R. I currently serve as a Board member and officer of the American Medical Rehabilitation Providers Association (AMRPA), the national association that represents our nation's rehabilitation hospitals and units. In the past, I have chaired medical school departments at Tufts University School of Medicine in Boston, and Wayne State University School of Medicine, in Detroit. I also served as President and CEO of the Rehabilitation Institute of Michigan in Detroit for ten years.

Kessler Institute for Rehabilitation is the largest medical rehabilitation hospital in the nation. We operate specialized Centers of Excellence to treat patients with amputations, traumatic brain injuries, spinal cord injuries, strokes, and many other neurological and musculoskeletal diseases and injuries. We also offer more than fifty sites for outpatient rehabilitation services in New

Jersey that provide services such as medical care, physical therapy, prosthetic fabrication and fitting, cognitive rehabilitation treatment, high technology wheelchairs and electronic assistive device fittings, and many other services.

We are also a major medical rehabilitation education and research facility. We train physicians, therapists, psychologists, and others as to how to provide rehabilitation programs and services. We also host many research programs and projects to advance the knowledge and science of medical rehabilitation. Much of this research is funded by federal grants from the National Institutes of Health (NIH), the National Institute for Disability and Rehabilitation Research (NIDRR), other federal and state organizations, and private foundations.

The reason I am speaking with you today is to share my experience regarding how in the past we tried, without success, to offer our medical rehabilitation services to returning military personnel, both active military and veterans. I will also share my views as to how the civilian medical rehabilitation provider community can help the DOD and VA health systems to provide the highest quality immediate and long-term rehabilitation care to our wounded warriors at facilities that are close to their homes, while still being cost effective for our nation.

Rehabilitation Capacity in the Civilian Health Care System

Over the past 60 to 70 years, our nation's civilian health care system has developed a rich capacity to provide sophisticated medical rehabilitation care through an array of several hundred free-standing rehabilitation hospitals, more than a thousand rehabilitation units of acute care hospitals, and thousands of outpatient therapy centers. Many of these facilities are capable of providing technically advanced care for patients with traumatic brain injuries, amputations, and all the other injuries being experienced by our service members. This rehabilitation care is provided by multidisciplinary teams of physicians, nurses, therapists, neuropsychologists, and many other professionals in well organized and goal directed programs.

Highly specialized expertise exists in some of these facilities to deal with the exact problems our service members have. For example, there currently is a network of 14 Spinal Cord Injury Model Systems in a grant supported program funded by NIDRR that provides state-of-the-art clinical care, as well as conducts cutting edge research to advance the effectiveness of medical rehabilitation. Similarly, there is a network of 16 Traumatic Brain Injury Model Systems, and a smaller network of Burn Rehabilitation Model Systems also funded by NIDRR. Each of these centers has been able to demonstrate objectively how they provide exceptional clinical care, as well as community outreach, education, and research.

In addition to the centers that have received these grant designations, there are many other equally well-qualified rehabilitation programs in operation today that are serving patients with the same injuries. Consider that when the SCI Model System grant program was recently competed, more than 30 qualified organizations applied for the 14 awards that were eventually made.

My point is that there is a rich care-giving capacity that already exists in our country that could be tapped to assist our servicemembers and their families. There is also an established basis for judging program quality, to determine which ones can meet rigorous standards of excellence.

The Private, DOD and VA Sectors Have Not Worked or Planned Together Well

About four years ago, when it became apparent that serious injuries were being incurred by growing numbers of our troops, we at Kessler tried to reach out to offer our services to the DOD and VA. We called, wrote, emailed, and in other ways tried to engage medical and administrative leaders in the Departments and individual facilities to offer our assistance. Unfortunately, at that time we were unable to find a receptive ear.

One of the reasons we reached out to the VA in particular, is because we knew that over the last few years, much of the VA's clinical ability to deliver rehabilitation care in organized units had been taken out of service, presumably as a response to budget pressures and a belief that the demand for services was in decline as our veterans were aging and expiring.

Sadly, in retrospect we can see that dismantling the VA rehabilitation capacity was an unfortunate choice. The need for physical medicine and rehabilitation has now grown dramatically. While I applaud the efforts of the DOD and the VA to create high quality treatment facilities such as the VA Polytrauma Centers, the current efforts fall far short of the immediate need for technically excellent, compassionate rehabilitation care that can be provided to all in need, in a timely manner, and close to home in the patient's local community.

Having a limited number of centers that can only be accessed by people if they uproot themselves and their families to live in temporary housing of variable conditions, only adds insult to injury. Further, it still leaves patients and families at risk to eventually return to a home community with no accessible life-long care capacity that they can utilize. It seems to me that this is unwise, unnecessary, and a breach of our moral responsibility to our service members as a grateful nation.

In the era following World War II, when there were very few local rehabilitation care delivery options, it made sense to create a national network of veteran specific settings to provide care not otherwise available for our returning GIs. In fact, that early work of the VA is largely responsible for having trained physicians, supported important research, and allowed the civilian sector to build upon their experience to create our rehabilitation capacity today.

Now, however, the situation is reversed. A large and qualified network of services does exist in the civilian sector, and a limited distribution of VA and DOD facilities exists. There is no need to recreate a "separate but equal" VA-housed network that will have to be available for the next 80 years to provide solely for the life-long specialized needs of our injured service members.

A Recommended Course of Action

The solution is obvious: establish a mechanism for qualified civilian rehabilitation hospitals to contract with the VA and DOD to provide high quality services to our injured, both now and for the long term. Services should include medical, pharmaceutical, therapy, psychological, social,

Durable Medical Equipment, and especially case management support. Certainly, we should continue to utilize the capacity of the VA and DOD where it now exists. But we should not force people to leave their homes and support systems for many months. And we should not just drop them back into distant home communities without access to appropriate ongoing services that they will need indefinitely (for repairs and replacements for prostheses, ongoing cognitive rehabilitation therapies, continuing counseling for Post Traumatic Stress Disorder, or the treatment of other related conditions).

Last week, I had the privilege to meet with Secretary Nicholson and several members of his senior staff, to discuss these matters. At that meeting, I recommended to them that a standing Coordinating Council between the DOD, the VA, and the private medical rehabilitation hospital community be established. This Council could work together to Develop standards to qualify appropriate provider organizations to serve service members;
1) Target case management resources to oversee these servicemembers' unique needs;
2) Establish appropriate contracting and payment mechanisms; and
3) Provide ongoing monitoring of the programs it would create.

In addition, there should be funds targeted to create a focused research program to understand how effective this collaboration will be, and how to improve upon it, based on outcomes of care and satisfaction of patients and their families.

Another Problem Exists

There is another current problem of enormous importance in the civilian rehabilitation community that is threatening the ongoing existence of the care delivery capacity I have just described. It centers on drastic cutbacks being imposed on the field by the Centers for Medicare and Medicaid Services (CMS) that are trying to balance budgets and constrain expenditures by denying access to needed rehabilitation services. Due to the regulation we know as the "75% Rule," more than 8% of the nation's rehabilitation beds have been closed in just the last year. Those beds closed because of these pressures, and thousands more are expected to be forced to close as the regulatory pressures continue.

We desperately need a rational plan for maintaining and nurturing an appropriate care giving capacity for medical rehabilitation. By stopping the further escalation of the pressures forcing bed and facility closures now, we will preserve the availability of services that can be of enormous help to our soldiers today, and sustain the availability of those services for their lifetimes. Senators Ben Nelson, Jim Bunning, Debbie Stabenow, Olympia Snowe, and colleagues have recently introduced S.543, the "Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007" to address this critical problem.

I urge that in addition to creating effective mechanisms to allow the cooperation of the DOD, the VA, and the private rehabilitation hospital community, you also support S.543 to preserve the private-public rehabilitation hospital resource so that our service members may readily access it now and in the future.

Thank you very much for giving me the opportunity to address the Committee. I would be happy to respond to any questions you might have.