How Does Access to Inpatient Rehabilitation Services Affect Veterans' Outcomes?

The authors of "How Veterans Use Stroke Services in the VA and Beyond," which begins on page 21 of the June 2006 issue, report that rehabilitation after stroke is more common in patients who have received care through both the VA and Medicare than in patients who have received care only through the VA. They also report that such rehabilitation is even more common in triple users—patients who have received care through the VA, Medicare, and Medicaid.

It should be noted, however, that for many VA patients who've had a stroke, their Medicaid coverage likely was initiated at an acute inpatient rehabilitation facility—where many patients prefer to receive poststroke care. These facilities are known for their thorough attention to all aspects of a patient's life and function, including vocational and social support.

The authors do not address this important question: Are acute inpatient rehabilitation VA resources available for the Florida-residing veterans in their study population? The answer may more fully explain their finding that 60% of their veteran study participants dually used stroke-related health care both from the VA and Medicare while only 30% used stroke-related health care from the VA exclusively.

In 1999, the VA mandated the availability of the care for stroke survivors recommended nationally by the HHS Agency for Healthcare Policy and Research (AHPR) to veterans through inpatient stroke rehabilitation facilities accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). But another change soon obviated the intent of the 1999 mandate.

Since 1966, CARF had been accrediting inpatient rehabilitation facilities only as defined by the Centers for Medicare and Medicaid Services (CMS). But after CARF acquired the Continuing Care Accreditation Commission in 2003, it began accrediting all levels of intensity of rehabilitation services, including subacute skilled nursing home facilities.

Many VA medical centers reacted to this change by moving their acute inpatient rehabilitation services into their nursing home units. (One reason for their doing so was that the 1999 Veterans' Millennium Health Care Act forbade facilities to reduce the number of beds designated for extended care services, while stretched VA budgets necessitated a systemwide reduction of bed capacity.)

As a result, the number of VA inpatient rehabilitation units shrank from over 80 in 1996 to just 50 in 2001. This occurred in the face of an aging veteran population that (as the authors correctly point out) is the group with the highest incidence of stroke. The resulting decline in the intensity and quality of patient care services available to veterans likely explains why those with other resources choose to seek poststroke care outside the VA, at CMS-defined inpatient rehabilitation facilities that are recommended nationally by the AHPR and represent the current standard of care.

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In the rehabilitation division at my institution, we have found that, over time, the functional improvement efficiency for patients in our nursing home unit is only a third of that achieved when the same patients are sent to an affiliate that has an inpatient rehabilitation facility. Even though it may be more beneficial to the patients to receive care in inpatient rehabilitation facilities, their placement in an outside facility takes money away from

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the VA system, while internal nursing home placement brings in additional fiscal support to the local VA medical center.

I hope that policy makers will consider the authors' work, as well as the concerns I have expressed over quality stroke care, when deciding how best to provide state-of-the-art care for our veterans.

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The corresponding author and his colleagues respond:

We agree with the reader that the shift away from inpatient rehabilitation bed units may have had an effect on VA patients' outcomes in terms of functional and cognitive recovery. We have had numerous anecdotes relayed to us by our clinical colleagues regarding this very point. It makes sense to hypothesize that when inpatient rehabilitation bed units are closed, VHA patients with multiple eligibility look elsewhere for intensive rehabilitation treatment. These issues offer providers and researchers with the opportunity to form a natural partnership.

We, as a community with veterans' best interests in mind, need to assess the impact of multiple system use and organizational restructuring on veterans' outcomes. In the closing paragraph of our article, we tried to provide direction on the next steps of evidence-based research. For example, if and when veterans are forced to seek alternative treatment settings, are their outcomes the same? How do factors such as access, comprehensiveness of services provided by alternative systems, plan benefits, and patient satisfaction affect patients' preferences and choices for their care? And, as the reader asked, how do patients fare after a rehabilitation unit is closed or the care setting is shifted to the nursing home?

Our study has laid the descriptive groundwork, but additional research is needed to target patient outcomes specifically. Outcomes such as mortality, recurrent stroke, myocardial infarction, and hospital readmission are all potential indicators of the quality of rehabilitation services provided at a specific institution. Investigators at the Rehabilitation Outcomes Research Center and the Stroke Quality Enhancement Research Initiative, located at the North Florida/South Georgia Veterans Health System in Gainesville, FL, in conjunction with the Kansas City VA Medical Center, Kansas City, MO; the Physical Medicine and Rehabilitation Program Office of the VA Central Office, Washington, DC; clinical providers at the Durham VA Medical Center, Durham, NC; and other interested groups, are beginning to explore these very issues.

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