Association *of* Academic Physiatrists

Support Climate Change Mitigation and Preparation for People with Disabilities

With its increasing heat, climate variability, natural disaster frequency and severity, and pollution due to wildfire smoke, **climate change is considered the greatest threat to global health of the 21st century.**

Physiatry, also known as physical medicine and rehabilitation, is a medical specialty focused on the care of people who live with chronic disability, a demographic that is rapidly increasing. People with disabling conditions often require complex clinical care due to devastating neurological injury or complicated medical or surgical problems.

People with disabilities, which includes approximately 26% of the United States population, are disproportionately affected by the health effects of climate change, and this disparity is expected to worsen without immediate action. They are especially vulnerable to the effects of heat injury, respiratory diseases, heart diseases, strokes, and infectious diseases such as Lyme disease due to climate change.

The health harms of climate change cost the US more than *$800 billion annually,* and these costs will continue to rise.

CLIMATE EFFECT	HEALTH CONSEQUENCE
Heat	Impaired mobility, communication, and ability to self-regulate temperature make it hard for people with disabilities to escape dangerous heat waves. This leads to **increased risk of heat stroke, which can be fatal.**
Wildfire smoke/pollutants	**Increases risk of lung disease, pneumonia, strokes, heart attacks, and COVID-19.**
Natural Disasters	People with disabilities face **significant obstacles to evacuation during disasters,** including power outages, flooding, debris, limited access to lifesaving medications and supplies, and psychological trauma.
Infectious Disease	Spread of Lyme disease, malaria, and dengue fever

The healthcare system as a whole is one of the largest contributors to emissions and waste in the United States. Healthcare contributes 10% of carbon emissions and 9% of harmful non-greenhouse air pollutants in the US.

The AAP supports legislation that:

1. Reduces carbon emissions, including from the healthcare sector.
2. Mitigates the health harms of climate change for people with disabilities.
3. Helps the healthcare system prepare for the rising health tolls of climate change through funding for climate change research and education for healthcare workers.
4. Includes people with disabilities in the development of climate policy.

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Support Increased Graduate Medical Education

In 2022, 14% of US adults were not able to get care when they needed it. That is more than 36 million people who could not get care they needed — in just one year.

There are not enough physicians to care for the American people, including the 26% of Americans that live with a chronic disability. Physiatrists are unique physician specialists. We diagnose and prescribe treatments for neurologic and musculoskeletal disease and work with persons with disabilities in a multidisciplinary team of health professionals to maximize the restoration of physical and cognitive function.

THERE IS A TOTAL PHYSICIAN
SHORTAGE OF 86-202K PHYSICIANS.
AN ADEQUATE NUMBER OF PHYSICIANS IS CRUCIAL TO THE HEALTH OF ALL AMERICANS.

Training a physician takes a college degree, 4 years of medical school, and 3-7 years of residency (graduate medical education): additional experience-based training providing patient care in a supervised setting. Subspecialists complete additional supervised fellowship training. There is a total physician shortage of 86-202K physicians, accounting for US healthcare demand, health equity, long COVID, cancer survivorship, the aging population and physician retirement and burnout. This need disproportionally affects urban and rural communities.

One of the greatest barriers to increasing the number of physicians in the United States is the cap on federally-funded post Graduate Medical Education (GME) residency positions. Despite a small increase in residency positions in 2020 (1000 positions nationwide over 5 years), after a quarter century freeze on Medicare support for GME, the national shortage remains profound. Enrollment in the nation's medical schools is increasing, but there are not enough residency programs for students to train to become licensed physicians. Training the next generation of physicians will require both expansion of existing programs and the creation of new teaching centers and new residency programs.

An adequate number of physicians is crucial to the health of all Americans.

SUPPORT GRADUATE MEDICAL EDUCATION

- ✓ The AAP supports legislation (S.1302/HR2389) that increases the number of residency slots nationally by 14,000 over seven years.
- ✓ Because residents train in a variety of health care settings, the AAP recommends that there is a balanced fiscal mechanism so residents and/or facilities can receive funding for training at all practice settings.

Residency Training Beyond the Hospital

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The Importance of Inpatient Rehabilitation Facilities

What are Inpatient Rehabilitation Facilities (IRFs)?

IRFs are a category of rehabilitation facilities designed to provide the care required by individuals with complex disabilities, a population that is steadily increasing. For patients with active complex medical and functional limitations, the IRF serves as a transition facility between the acute hospital and their ultimate living setting, most often in the community. The IRF focuses on returning individuals with significant disabilities to their highest possible levels of health and functioning.

What are the unique characteristics of IRFs?

- Physician rehabilitation specialists supervise their care at least 3 days per week.
- Treatment teams include a wide range of professional specialties: Rehabilitation Medicine, Rehabilitation Nursing, Physical Therapy, Occupational Therapy, Speech Language Pathology, Prosthetics/Orthotics, Case Management, Social Work, Nutrition, and Psychology.
- Patients receive more hours (at least 15hrs per week) of rehabilitation therapy than from other settings.
- Emphasis is on patient-centered, interdisciplinary team care including weekly patient care conferences.

What are the threats to IRFs?

1. The Medicare "60% Rule" requires at least 60% of each facility's patients to have one of 13 specific diagnoses. This rule is outdated and arbitrarily restrictive and leaves out many other individuals with similarly medically complex conditions such as those with cancer and organ transplants. CMS has not updated the list of diagnoses since 2004.
2. Burdensome IRF-specific documentation (such as the IPOC [Individualized Plan of Care] and the IRF-PAI [Inpatient Rehabilitation Facility Patient Assessment Instrument]) with arbitrary time deadlines that, if missed, can result in outright denials from CMS of the entirety of a patient's rehabilitation hospitalization. For example, the IRF-PAI is the assessment instrument IRF providers use to collect patient assessment data for quality measure calculations and payment determination in accordance with the IRF Quality Reporting Program (QRP). It has steadily increased from 7 pages requiring 55 minutes per patient to complete at its inception, to now being over 30 pages and requiring 1hour and 46 minutes per patient to complete!
3. Payers are increasing pressure to use alternative, less expensive inpatient facilities and reduce hospital lengths of stay to reduce cost without consideration of the added value and superior outcomes for IRF patients
4. Payers are also increasing pressure to remove marginal cases (either too complex or too simple) from IRFs. This threatens their ability to maintain the staff and programs needed to provide services to complex cases.
5. Administrative burdens to advocate for patients with Medicare Advantage plans that require time-consuming appeal of inappropriate denials and conducting peer to peers, all while continuing to adhere to overly stringent requirements to get into IRF leaves a significant gap for Americans with complex disabilities.

SUPPORT INPATIENT REHABILITATION FACILITIES

- ✓ Reform Medicare 60% rule to be more inclusive of complex medical conditions resulting in severe disability.
- ✓ Eliminate the Individualized Plan of Care (IPOC) documentation requirement for IRFs and reduce the IRF-PAI documentation burden back to its initial iteration.
- ✓ Support new CMS-requirement of having ONLY board-certified physical medicine and rehabilitation physicians to serve as medical directors of IRFs.

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Support Long-Covid Research

What is Long COVID?

Long COVID is a common term often used to describe symptoms affecting patients following the initial infection by the COVID virus, lasting for several months and affecting the patient's quality of life. It may also be referred to as Post-COVID Conditions or chronic COVID among other names. The National Academy of Medicine provides the following clinical definition of Long COVID:

- Long Covid is an infection associated chronic condition that occurs after SARS-CoV-2 infection and is present for at least 3 months as a continuous, relapsing and remitting, or progressive disease state that affects one or more organ systems.

Long-COVID Rehabilitation

Inpatient rehabilitation is effective in improving outcomes following severe SARS CoV-2 infection and guidelines recommend comprehensive rehabilitation for Long COVID recovery. A recent systematic review found that rehabilitation that included physical activity led to improvement in functional capacity, respiratory function, and quality of life (97, 72, 96% of studies respectively). Another systematic review found positive benefits of rehabilitation on post-COVID fatigue.

Physiatrists, with their focus on improving function, independence and quality of life, are uniquely qualified to treat patients dealing with the full range of Long COVID symptoms and are trained to work in a team environment to address the patient's symptoms. Current treatments for Long COVID remain mostly palliative and symptom-based due to the lack of understanding and evidence-based research targeting the underlying mechanisms. Physiatrists are well-positioned to lead large, randomized studies of specific rehabilitation protocols in order to develop evidence for the best methods of rehabilitation for Long COVID.

Funding for research into Long COVID rehabilitation benefits the further development of treatment for patients and effective rehabilitation that restores function and quality of life. Additional longitudinal studies focused on both adult and pediatric Long COVID patients are essential to future treatment and prevention of Long COVID.

SUPPORT LONG-COVID RESEARCH

- ✓ Support (S.801/HR 1616) Comprehensive Access to Resources and Education for Long Covid.
- ✓ Support (s. 2560) Long Covid Support Act.
- ✓ Support (S.4964) A comprehensive Federal response including, research, education and support for affected individuals.

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Support Rehabilitation Research

Federal Research Funding Facts

- Approximately 26% of Americans have a disabling condition, and the numbers are rising as the population ages, with enormous economic consequences. Rehabilitation research is needed to maximize the functional recovery and independence of those affected and lessen the economic toll of disability.
- Research funding supports state and local economies. For example, more than 80 percent of NIH funding flows back to the states through grants. This creates jobs at more than 3,000 universities, medical schools, teaching hospitals, and other research institutions in every state.
- Between 2003 and 2015, NIH funding fell by 22% due to budget cuts, sequestration, and inflation, as did the budgets of other federal research funding agencies. Since 2015, Congress has appropriated increased funds for the NIH, but funding remains behind 2003 levels in constant dollars, and other agencies lag farther behind.

IN 2019, RESEARCH CONDUCTED AT AAMC-MEMBER MEDICAL SCHOOLS AND TEACHING HEALTH SYSTEMS AND HOSPITALS GENERATED

$33 billion in gross domestic product

348,000 jobs

Medical rehabilitation seeks to maximize human functioning, independence, and quality of life in the face of temporary or long-term disabilities. Rehabilitation Research funding is provided by the following agencies:

- National Institutes of Health
- National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR, formerly NIDRR),
- The Department of Defense (through the Congressionally Directed Medical Research Program – CDMRP, and the Defense Advanced Research Projects Agency - DARPA),
- The Veterans Health Administration,
- The Patient Centered Outcomes Research Institute (PCORI), and
- other federal agencies.

SUPPORT MEDICAL RESEARCH

✓ Progress has been made and the AAP applauds Congressional action for improved funding. However, the progress must be sustained and expanded to other federal research funding agencies. AAP recommends at least $51.3 billion for NIH in FY 2025, and increased rehabilitation research funding across the federal government.

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Support Continued Funding for Expanding Telehealth Rehabilitation Services

Legislative efforts enacted in response to the COVID-19 pandemic greatly expanded reimbursement for all modes of telehealth, including telerehabilitation services. The Association of Academic Physiatrists (AAP) urges the Centers for Medicare and Medicaid Services to 1) continue to cover telehealth services at the same rate as for in-person services; and 2) invest in technology that ensures high quality digital care that replicates in-person encounters as much as possible.

Increased Telerehabilitation Services Promotes Health Equity

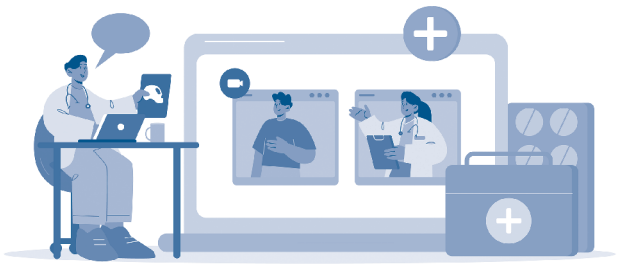
While the initial expansion of telehealth services occurred in response to a public health emergency, continued support of the expansion of these services is both a health equity and climate initiative. People with disabilities often have mobility, sensory, and cognitive impairments that make travel to health care facilities or offices challenging. Access to high quality telerehabilitation services minimizes the disparity in care this population often faces and has been shown to improve health outcomes in persons with spinal cord injuries and strokes.

Expanding Telerehabilitation Offers Unique Interagency and Private Entity Collaboration Opportunities

Ongoing patient and medical provider education and research (equivalency of services, infrastructure, implementation, etc.) are needed to continue providing high quality telehealth care. There are leaders in both the private and public sectors that provide education and research on telehealth technologies and processes. Focused collaboration and partnership between these entities—as well as leveraging work being done in the Veterans Health Administration setting—can enhance patient and medical provider education and research to both improve and continue providing high quality telehealth care.

SUPPORT CONTINUED REIMBURSEMENT FOR TELEHEALTH/REHABILITATION SERVICES

- ✓ The AAP supports legislation that continues coverage of telehealth services at the same rate as in-person services.
- ✓ Support legislation that increases research funding for cost effectiveness, implementation strategies, and innovative technology to improve access to telehealth services.



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What is Physical Medicine and Rehabilitation?

Physical Medicine and Rehabilitation (PM&R) is one of the forty medical specialties recognized by the American Board of Medical Specialties (ABMS). The American Board of PM&R was approved by the ABMS in 1947. The specialty of PM&R began in the 1930s to address musculoskeletal and neurological problems and expanded after World War II due to the substantial numbers of debilitating war injuries and the polio epidemic. The field of PM&R, also known as physiatry, is dedicated to the diagnosis, prevention, and treatment of all types of disabilities related to the brain, nerves, bones and muscles in people of all ages.

Physiatrist (fizz-ee-at'trist)

Physiatrists are physicians (MD or DO degrees) who have completed 4 years of medical school and 4 years of residency training. Additional sub-specialty training can be pursued in areas such as pain management, spinal cord injury medicine, brain injury medicine, sports medicine, pediatric rehabilitation medicine, cancer rehabilitation, and hospice and palliative care.

Physiatrists Focus on Function

Physiatrists are unique among medical specialists in that not only do they diagnose and treat neurologic and musculoskeletal conditions, they routinely work with persons with disabilities to maximize the restoration of physical and cognitive function. The restored ability to move, speak, comprehend and access the world around them allows individuals with disabilities to return to independent living or work. Physiatrists commonly treat and restore function to people with:

- Acute and Chronic Pain
- Back & Neck Pain
- Cancer Pain
- Nerve Pain
- Sprains, Strains
- Muscle Pain
- Amputation
- Arthritis
- Sports-related Injury
- Brain Injury (including Concussion)
- Burn Injury
- Cancer
- COVID-19 Related Injuries (including Long COVID)
- Geriatric Disorders
- Heart Disorders
- Human Movement
- Muscle Spasticity
- Nerve Injury & Disorders
- Pediatric Disorders
- Post-polio Syndrome
- Stroke
- Spinal cord Injury
- Tendons
- Transplant Recovery
- Work-related Injury

Where do Physiatrists Work?

- Rehabilitation Centers (i.e., inpatient rehabilitation facilities, long term acute care hospitals, skilled nursing facilities)
- Acute Care Hospitals
- Veteran's Affairs Hospitals
- Private Offices
- Outpatient Clinics

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