

Capitalizing in Times of Difficulty

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Anthony Delitto

I would first like to thank the organizers for inviting me to deliver this keynote address. I am both honored and humbled. Our strong physiology backgrounds cause us to realize that there are a number of stimuli that cause one's heart to race. Receiving the call asking me to consider delivering a WCPT keynote address, which remains one of the greatest thrills in my professional career, certainly caused my heart to race. Of course I agreed without hesitation. I often wonder if the heart really ever realizes the difference between the excitement associated with such an honor and the resultant panic that strikes when I realized I would be in this position today!

Among the many gifts I have received, one of my favorites sits on my desk. It's a rock with a quote that was given to me by the Editor Emeritus of Physical Therapy, the late Jules M. Rothstein. He gave it to me shortly after I became Chair of Physical Therapy at the University of Pittsburgh. On this rock is a quote from Albert Einstein: "In difficult times lies opportunity." I do not think for one minute that Jules was trying to scare me away from the job of Chair. Nor was he warning me to watch for the difficult times that almost assuredly awaited me as a Chair! I prefer to believe that he was reminding me to look for the opportunity that oftentimes lurked somewhere behind challenges and appropriately and decisively react to these opportunities. By appropriately, I had to thoughtfully and without bias consider the situation, preferably with the benefit of data (as opposed to emotions). Once the situation was accurately surmised, decisiveness was never a problem.

I would like to center my talk today on this quote and how I believe it relates to the future of our profession. I would first like to discuss “difficult times” and then follow up with what I believe are “opportunities.”

By difficult times, I am referring to the health of all of our respective health care systems. I will make the safe assumption that there is not a single person sitting in this audience who comes from a health care system that would describe itself as “healthy.” This unfortunate fact is also a convenient one when considering that I am delivering a keynote to a world-wide audience. Whether we are in a socialized medicine or a private-pay environment, our health care systems are riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, inappropriate care, waste and fraud. These problems significantly increase the cost of medical care and health insurance for employers and workers.

The \$1 trillion U.S. health-care system is in particularly great peril. In fact, the overly cynical description of “the modern-day equivalent of a medieval patchwork of fiefdoms, with doctors, hospitals, and insurance companies allied to form local power structures” may not be too cynical in some people’s minds. In any regard, disparities and inequities continue to exist despite their longstanding recognition, outcomes vary and treatments are not received equally. It is an industry that has become a high-volume, low-margin business that is riddled with inefficiencies, outrageous costs, and outmoded technology. In the USA, health care now accounts for a record 16% of the nation’s gross domestic product. Medical spending continues to increase at prodigious rates. This figure is expected to reach 20% of the gross domestic product in the next 5 years.

There is not a single person in this audience that has not been directly affected by the dwindling health of our respective health care systems. As physical therapists, we are especially affected, particularly in the area of reimbursement for our services. We have always acknowledged that we are low on the food chain when it comes to health care expenditures. We have all seen the pyramid charts that illustrate the disproportionate amount of expenditures that hospitals and physicians receive (up to 80% of the health care dollar) while physical therapy is listed with all other “ancillary” services for a

combined total of less than 5% of expenditures. To make matters worse, we have seen this very small proportion of the health care dollar shrink further over the past few years in what we all know as reimbursement rate declines.

I have listened to practitioners complain about reimbursement rate declines for years. In the past, these conversations typically take place in very nice restaurants over very expensive meals where these same individuals pick up the tab. After watching these individuals drive away in cars that are worth a small fortune, I have typically chalked such talk up to a group that is never satisfied. We know the story of the “Boy Who Cried Wolf.” Nowadays, however, it is becoming increasingly clear to me, a physical therapist in academia who has spent most of his time in research, that there really is a wolf out there this time. Reimbursement is at critically low levels.

Most physical therapy practices have continued to come to grips with decreased collections. But as a profession, we are now beginning to recognize the profound rippling effect of decreased reimbursement rates. In the past 10 years, salaries for physical therapists have stagnated. When compared to the increasing price of physical therapy education, the disparity between the cost for education and entry-level salary has increased to a point where it has clearly infringed on the applicant pool. Coupled with the attractiveness of programs where students need to make similar academic investment but receive much higher entry-level salary (e.g., PharmD) along with those programs that require much less academic investment and greater salary (e.g., PA programs), it does not bode well for the health or our applicant pool.

The strong applicant pool has been the lifeblood to our educational institutions. For years we have taken for granted the popularity of our profession, which in the USA has flourished in spite of very little in the way of effort on our part to grow and sustain such enthusiasm. I believe that we will see continued competition for high-quality applicants as we make education more and more expensive while entry-level salaries remain stagnant.

Considering the latter, what is the cause of stagnant entry-level salaries? Though our profession has never been dominated by

independent practitioners, the delivery of physical therapy services was always profitable to someone. Even when profit was distributed to hospitals, rehabilitation companies or private practitioner entrepreneurs, there still remained enough resources to adequately respond to increased salaries as the market dictated. Now, I am told by those in whom I have trust that present reimbursement rates do not allow for such modifications.

There are not many solutions to these problems if we cannot solve declining reimbursement rates. I have heard of success stories in alternative practice environments, but I am not sure that we are ready as a profession for widespread conversion to cash-only businesses. I am not ready to give up on strategies to address the falling reimbursement rates, and it is in this area that I would like to address my remaining comments and focus on opportunities.

I would like to go back to the food-chain. While I agree that our profession is commonly an afterthought when it comes to calculating reimbursement rates, I wonder if we should be reconsidering our strategies to counter this movement. In the past, we have been reactionary to reimbursement cuts that have been more or less arbitrarily imposed on our profession. Consider the \$1500 Medicare cap. Where did \$1500 arise? More recently in the US, one of our largest private insurers has decreed that a physical therapy visit is worth \$40. I am certain that these decisions are not based on the potential need for care or possible effectiveness of the physical therapy services. In truth, these arbitrary decisions are not based on any data. They are simply put in place.

Our response is not only reactionary, but we typically take our argument to the level of the food chain where the person at the other end is only interested in how much less they can offer for our services. Even if we made the argument of positive impact and cost-effectiveness with the benefit of data, I doubt our demand for greater reimbursement would be received favorably. We are taking our case to the level of the food chain that has a boundary. No matter how artificially based, we are unlikely to see a substantive move past that boundary and into the direction of increased reimbursement.

There are two important steps to take in order to have a better chance at improving our ability to seek a more fair reimbursement. First, we need to identify those areas where we have substantive proof that we can have a positive impact on the cost-effectiveness of care. By substantive proof, we should be prepared to document the cost-savings of using physical therapists as providers of service in certain areas. The bigger the cost savings coupled with effectiveness to the patient, the better case we can make for our services. Second, we need to take our argument to the level of the food chain where we can have an influence on reimbursement. Our credibility in this endeavor is greatly enhanced with the benefit of data.

To take on the first task, I would like you to imagine me throwing a basket of 100 dollar bills on the floor and a basket of 1 dollar bills on the floor. If I gave you 30 seconds to pick up as much money as you could, which bill would you target? Now, I would like us to consider physical therapy's impact to the health care system in certain areas of care. Impact is defined as cost-effectiveness. We should compare our cost to our overall effectiveness. We need to think broadly here. Include in the cost not only the cost of physical therapy services, but also cost savings that using physical therapy services might entail. What are the areas of care that correspond to the \$100 dollar bills for physical therapy?

For example, consider managing low back pain. There was a recent publication from the Wall Street Journal that documented the cost savings of early utilization of physical therapy in the management of low back pain. Early PT utilization was compared to a previously used method where the initial contact was with physicians. In the physician as first contact case, patients waited long periods of time for appointments, unnecessary ancillary tests were ordered (including expensive imaging) and prescription drugs were administered. The average cost of care with a physician driven approach was over \$2000. When compared to an approach where physical therapists were used initially, the cost savings per episode of care was around 50%. Physical therapists in the USA were ecstatic with such data and the fact that it was published in such a reputable news source as the Wall Street Journal. Certainly rational people will see our positive

impact and consider reimbursing us appropriately for the cost-savings that can directly be attributable to our intervention.

Next, let's consider to whom we take this argument. Shall we take the argument to the insurer? How are we to be certain that an insurer will not respond by simply take the cost savings as part of the profit? In the above scenario, Aetna was the insurer. Aetna is a for-profit company with a responsibility to its shareholders. I won't elaborate on the obscene profits of third party insurers in the USA. Suffice to say that many of us in the US strongly believe that we do not have a trusted partner in many of our third-party payers when it comes to dialogue related to cost-effectiveness.

Now, consider another payer of health care costs, namely the employer. In the previously mentioned scenario, employers included Boeing and Starbucks. When compared to commercial insurers, I would argue that the employer is the most important payer of health care services and whose interests are more aligned with ours in providing high quality cost effective care. Employers pay the bill for the exorbitant costs of managing low back pain, whether it be in their worker's compensation business or in their commercially insured employee and family plans. I have no doubt that providing information about our cost effectiveness to this particular consumer would not only be favorably received, but would more likely lead to demands for better reimbursement for our services. The take home message that is missed in the Wall Street Journal publication is the fact that the employers (Starbucks, Boeing) demanded that the insurer (Aetna) provide greater reimbursement to the provider of health care in the form of higher reimbursement for physical therapy services. This is a precedent that deserves repeating.

Data from our provider led insurer in Western Pennsylvania, the UPMC Health Plan, not only mimic that which occurred in the state of Washington, but our preliminary evidence suggests that the cost savings of early utilization of physical therapy services might have been underestimated in the original Wall Street Journal publication. First, the magnitude of the problem: \$6.2 million on 937 cases in the first 6 months of 2006. Managing low back pain is the third costliest condition behind neoplasms and cardiovascular conditions. We implemented a plan of early utilization of physical therapy with

evidence-based approaches. Early utilization has led to a higher percentage of patients being improved at the 4-6 week point after onset, which in turn has led to a lower utilization of imaging, epidural steroids and prescription drugs, the three highest cost buckets. Cost savings were maximized when physical therapists followed evidence-based practice principles. Our health insurer now wishes to market this approach to other employers in the area. This type of partnership only bodes well for our profession's future.

What are the other examples in physical therapy that mimic managing low back pain? In a rapidly aging society, musculoskeletal costs are increasing rapidly. In some environments, musculoskeletal costs exceed other conditions, including cardiovascular costs. Are there other musculoskeletal examples that would provide similar cost-effectiveness data if physical therapy were appropriately used during the episode of care? By appropriately, I am referring to using an evidence-based approach.

Just to demonstrate that I can move out of the musculoskeletal arena, consider for a moment the complaint of dizziness, which is one of the leading causes of a visit to a primary care physician in the aged population. The parallels to low back pain are apparent. In general, non-specific drugs are all that a primary care physician can offer along with expensive workup, including imaging and other special tests. A physical therapists' role in the management of dizziness is an emerging area with a wealth of evidence to support the role of physical therapy in sub-classifying and treating patients with this disorder. I was recently visited by one of our leading otolaryngologists who asked how he could become more involved with the physical therapy community in the Western PA area. Pennsylvania recently passed a direct access law and in the span of two years this otolaryngologist has seen the majority of his consults come from physical therapists. In fact, he was trying to figure out a way that he could bill these visits as consults rather than new patient visits partly because he was paid more for consults and partly because he was performing a consultation as opposed to a new patient visit. He was impressed with the workup of the physical therapist, which he offered was far superior to the primary care physician's workups he had received in the past.

This is usually the time where we as physical therapists can stand up and cheer for ourselves. I had a very different reaction, however. My reaction was one of missed opportunity. Had we the foresight to document the cost-savings in this shift from primary care to physical therapy as a first contact, would we have the makings of another Wall Street Journal-like article? As a profession, did we miss an opportunity to demonstrate our cost-effectiveness? Does managing dizziness represent another example of the \$100 bill on the floor?

I am certain that we have many other examples of \$100 bills in our profession. I believe we need to place a high priority on obtaining the actual cost-effectiveness in these examples.

What do we do with the \$1 dollar bills? In the words of Mark Twain, we should be careful of what we ask for...because we may not like the answer that we get. Before we consider eliminating our presence in certain areas, we should at least think about our efficiency in delivering care. I have no doubt that we can increase the efficiency at which we administer physical therapy services in order to improve the overall cost-effectiveness. For example, in managing people after stroke, we need to ask, "Are we administering intensive therapy to those most likely to benefit the greatest at the time period when they can benefit the greatest?" I am told by my compatriots who work in this area that there is much room for improved efficiency in delivering physical therapy services after stroke. I am certain those who manage people with stroke will attend sessions like the one occurring today by Dr. Wolf, Weinstein and colleagues. Look at what they are presenting. Consider their conclusions in relation to published guidelines. Now ask yourself the hard question: how well are we adhering to those practice standards in our everyday clinical environments? Is there room for improvement? I think you will agree that the answer is an emphatic YES.

What do we have to do?

1. We need to expand our definition of the consumer of our services to include not only the patient, but the ultimate payer of our services. In this case, I would suggest we focus our efforts on the government (the largest employer in the world) and other



large employers. Both of these consumers are presumably interested in cost-effectiveness.



2. We need to identify those areas where we have substantive proof that we can have a positive impact on the cost-effectiveness of care. By substantive proof, we should be prepared to document the cost-savings of using physical therapists as providers of service in certain areas. This will take some re-directing of our research and policy-making resources, but the benefit can be dramatic. The partnering of our own provider network, including private practitioners, through an established funder such as the Foundation for Physical therapy, would be the perfect marriage for this goal.

3. We need to identify in what situations we are NOT cost-effective and consider changing our approach or eliminating ourselves. I say this fully realizing the consequences of even considering removing ourselves from areas of care that take on the characterization of scared cows. I realize that we need to be careful about exactly how we go about this very critical and potentially contentious exercise.

4. We need to close the chasm that presently exists between evidence and practice behavior. Studies show that fewer than 50% of the time we practice using evidence-based practice principles. This is unacceptable for a profession that calls itself evidence-based. It matters little to me that other health care practitioners operate at this same embarrassing level, including physicians. There is an emerging body of evidence that demonstrates that practicing in an evidence based mode results in more cost-effective care. In our situation in Western PA, outcomes were improved by over 60% when physical therapists practice with evidence-based principles. If we attempt to make our case that we can deliver cost-effective care, evidence based practice is a very good partner in this goal.

So, where is our opportunity? Like all problems, they first must be recognized as such before appropriate and definitive action can take place. Reimbursement is a problem not only for the entrepreneurs in our profession, but for all of us. Second, we must realize that data is of critical importance in documenting our cost-effectiveness, and we must be prepared to dedicate resources to obtain such data. I consider myself in the mainstream of the research community. I



believe cost-effectiveness research is an area of research that is underappreciated by those in the research community. We must change this attitude. Third, we must create venues whereby we are presenting this data to the right constituents, namely, an expanded list of consumers that includes employers and government agencies. Forth, we must identify barriers to practice using evidence-based practice principles and develop strategies to improve adherence to such standards so that we can better deliver on our promise of enabling cost-effective care.

Thomas Edison said that, "Opportunity is missed by most people because it is dressed in overalls and looks like work." I have little doubt that the actions I propose are doable, but they will take work. But, as we have heard over and over, physical therapists are never afraid of work. I look forward to working with everyone here in achieving these steps to demonstrate to all that our field can deliver cost-effective care and, in fact, we are essential for any health care system that is truly interested in cost-effectiveness and improving the health of our health care systems.

Thank you again.