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INSIDE

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Rehab providers using telemedicine to overcome distance barriers

While not cheap to implement, telerehab can result in cost savings

It's a standard topic of grumbling among administrators and physicians alike: Too often, consumers pick convenience over quality when choosing a doctor or hospital. Patients rarely are willing to drive more than 15 minutes for a visit — an important factor when you consider the multiple visits many rehab patients require for outpatient therapy.

But lack of proximity can be overcome with technology, as many rehab managers are finding out. Increasingly, managers are turning to telemedicine as a way to reach patients in rural communities who otherwise would not have the time, means, or inclination to travel for therapy sessions.

Consider the benefits telemedicine can offer:

- improved relationships with referral sources in rural communities;
- an opportunity to reach patients in rural communities who don't have ready access to rehabilitation expertise;
- increased access to patients from nearby communities for outpatient treatment after their discharge from the hospital, or for ongoing educational needs for patients with chronic conditions like arthritis;
- improved communication between therapists and other providers at satellite facilities or those employed by affiliate institutions;
- in some cases, improved patient satisfaction.

Two trends regarding telemedicine in rehab are clear. First, the

Executive Summary

❑ Many hospital rehabilitation departments are turning to telemedicine as a way to reach patients and providers in rural communities without sacrificing staff travel time.
❑ Government grants can defray start-up costs for many providers.
❑ Spend time researching your needs before investing in equipment.

industry leaders are instituting telemedicine programs. The Rehab Institute of Chicago, the National Research Hospital in Washington, DC, Shepherd Spinal Center in Atlanta, and others that are highly regarded in the field all have telemedicine programs in place or are in the process of starting them.

Second, although rural telemedicine is in its infancy, it is expanding quickly. Based on the latest data available — a February 1997 study conducted by the U.S. Department of Health and Human Service's Office of Rural Health Policy, *Exploratory Evaluation of Rural Applications of Telemedicine*:

• Nearly 30% of rural hospitals were using some sort of telemedicine technology to deliver patient care by the end of 1996.

• Orthopedics is the third most common clinical application of telemedicine, finishing behind radiology and cardiology.

• The cost of telemedicine remains high. Average equipment purchases for hospitals surveyed ranged from $134,378 for spoke sites (affiliate institutions) and $287,503 for hub sites (the main institutions providing the centralized transmission, hardware, and software) — and that's not including costs for switches and telephone lines. Reported annual transmission costs ranged from an average of $18,573 for spokes and $80,068 for hubs.

But don't let the costs stop you from investigating the possibilities of telemedicine, says **Logan Ludwig**, PhD, director of the health sciences library, media services, and telehealthcare for Loyola University in Chicago. Lots of grants are available to assist institutions with start-up costs, he points out **(see related story on p. 55 for more information on grant opportunities)**. Although costs vary widely depending on an institution's needs, Ludwig recommends that medical facilities use a system with a minimum of 384 kilobytes in order to get a sufficiently sharp image resolution.

In addition, telemedicine can be looked at in terms of its ability to defray costs and even as a revenue generator, Ludwig and others tell *Rehab Continuum Report*. Often, a patient is more likely to come back for a follow-up visit with a therapist, for example, if he or she can drive 10 minutes to a local hospital with a telemedicine link to your institution instead of spending one hour driving to your facility. If your institution conducts interdepartmental meetings between satellite facilities, telemedicine can save staff members the travel time commuting between institutions.

Ludwig says the costs of instituting a telemedicine program don't necessarily outweigh the costs of staff travel, if your utilization is high enough. Loyola has instituted telemedicine programs through multiple affiliations with other providers for this reason, he says. The more the system is used, the more per-unit costs go down.

In addition, the costs associated with staff travel lie not just in transportation fees, but in the lost revenue physicians or therapists could be generating if they were seeing patients at the hospital instead of traveling.

Educational institutions are big users

Loyola is one of several educational institutions interviewed by *Rehab Continuum Report* that are participating in tele-rehab. Although the facility has previously used its telemedicine capabilities for communication between physicians and specialists or videoconference training of students, Loyola recently entered an alliance with the Rehab Institute of Chicago and Southern Illinois Healthcare, located 400 miles south of Chicago.

The telemedicine project — which should be up and running by June — will allow the Rehab Institute of Chicago and Loyola to provide community education seminars to patients in rural Chicago on topics such as preventing lower back pain and other job-related injuries, says **Joanne Smith**, MD, senior vice president and chief operating officer of the corporate partnership division of Rehab Institute of Chicago. In addition, the project will allow physicians in Chicago to share

COMING IN FUTURE MONTHS

- Global health financing in rehab
- Physiatrists becoming more popular among rehab providers
- More on the per-diem vs. per-episode prospective pay debate
- Maximizing clinical training with students
- How wound management can help a rehab department

Thinking of linking but concerned about costs?

Grant programs, Web sites offer help

Scared to even propose a telemedicine program to your hospital administrator for fear of being subjected to a discussion about budget cuts? Concerned that your therapists and patients would recoil at the idea of video linkage as a proper substitute for one-on-one, in-person patient care? Help exists from a number of Internet and government sources.

Resources you may want to check out include the following:

Office for the Advancement of Telehealth. Address: 979 Rollins Ave., Rockville, MD, 20852. Telephone: (301) 443-0447. Fax: (301) 443-1330. Web site: HYPERLINK http://telehealth.hrsa. gov/services.htm. In 1998, the office administrated 41 telehealth and telemedicine grants in 29 states totaling more than $13.6 million. The institution plans to distribute information this fall on how to respond to a request for proposals that would distribute between $5 million and $8 million in funds in 2000. The organization's Web site offers a number of links to other telemedicine sites as well as databases, journal articles, legal information, and news updates.

Other helpful Web sites include:

HYPERLINK http://www.tmgateway.org

A federal telemedicine gateway Web site; a telemedicine information exchange site.

HYPERLINK http://tie.telemed.org

Offers resources, classified ads, and other information exchange vehicles.

HYPERLINK http://www.atmeda.org

The American Telemedicine Association Web site.

A listserve used by many telemedicine project officials can be accessed via the University of Missouri. To sign up, contact Joe Tracy at the University of Missouri by e-mail at HYPERLINK mailto:rtgp@proteus.mig.missouri.edu or HYPERLINK mailto: TracyJ@ health.missouri.edu. ■

leading-edge technology with nurses and other clinicians employed in the inpatient rehab unit of Southern Illinois Healthcare.

Provider education also is an important component of the Mid-Nebraska Telemedicine Network, funded through a $1.4 million grant from the U.S. Office of Rural Health. In one case, an occupational therapist at Good Samaritan Hospital (the hub institution) in Kearney, NE, did a telehealth consultation with a patient who was about to be discharged and therapists at a hospital in nearby Cambridge, where the patient was to receive outpatient care following discharge from Good Samaritan.

"The occupational therapist demonstrated to the Cambridge folks the exercises she was asking the patient to do, and also asked the patient to actually perform the exercises on-camera," says **Wanda Kjar**, RN, interim director of the Mid-Nebraska Telemedicine Network. By seeing the patient perform the exercises, the rural health care team was able to get a more accurate assessment of the patient's condition and areas she specifically needed to work on, Kjar says.

At the University of Texas Medical Branch at Galveston (UTMB), the rehab department uses a team approach in its telemedicine project, which allows caregivers to treat hundreds of youngsters in rural and medically underserved areas in east Texas. The program — a collaborative venture between UTMB, Lamar University, and Stephen F. Austin State University — was recently awarded a $1 million grant from the Texas Telecommunications Infrastructure Fund Board.

Getting the team in the same place

The entire provider team — including UTMB physicians, nurses, dieticians, occupational therapists, physical therapists, social workers, and speech pathologists — is present for every exam, says **Kim Conner**, a pediatric occupational therapist at UTMB. "This allows us to be sure that we're all on the same page, reducing the chance for miscommunication by the patient, the parents or the caregivers," she says.

UTMB's pediatric project, established five years ago, allows pediatricians and other providers to work with chronically ill patients. "We work with children who are technologically

dependent or have other chronic physical and mental conditions," says **Sally Robinson**, MD, professor of pediatrics and chief of the special services division of UTMB. "We see kids who need ventilators or respirators to breathe; kids with spina bifida and cerebral palsy and other neuromuscular disorders; kids with traumatic brain injuries, metabolic disorders or feeding problems. It's really difficult for parents to travel back and forth with these kids who are hooked up to all kinds of equipment."

Patient status not ideal after travel

Because children and elderly patients often are so tired from long trips to providers for rehab that they cannot perform exercises effectively, using a telemedicine program can provide an added benefit in a rehab setting, says **Cathy Wasem**, MN, RN, director of the telemedicine and telehealth programs at the Rockville, MD-based Office for the Advancement of Telehealth. "Are you really getting your best evaluation when the child has had to travel two or three hours to see a specialist?" she says. "The trip can be taxing. Once the patient gets there, he or she may not be at their best or able to react in the normal way."

Patient satisfaction with the telemedicine process is high at Good Samaritan, Kjar says. "We've had something like 19% to 27% [of patients] tell us that they actually like this encounter better than seeing the doc in person," she says. "We decided that's because in telemedicine, you often have all your caregivers in the room at the same time. And after a while, the TV goes away. You're talking to the person, and it's just like being there with them."

More than 3,000 patients have been treated through telemedicine since it was implemented in December 1995, Kjar says. One such offering is the arthritis program, which includes a monthly support group for patients and individual patient and provider consultations, says **Janet Reise**, RN, Good Samaritan's arthritis coordinator. "Our primary and secondary market is over

Rutgers research aims to bring telerehab home

Patients will perform 'virtual' exercises

Although much telemedicine rehab is being done between hospitals, at least one researcher believes that home-based rehabilitation is where the field is headed.

Grigore C. Burdea, PhD, the principal investigator and director of the Center for Computer Aids for Industrial Productivity at Rutgers University in New Brunswick, NJ, has developed a concept called the Rutgers Master. The product — a sensory glove that enables doctors and therapists to measure and control the amount of force a patient exerts from each finger when using the glove — is currently undergoing pilot tests at Stanford Medical School, where Burdea is working with Vincent Hentz, MD, head of Stanford's division of hand surgery. Although the program is linked between Rutgers and Stanford, Burdea sees its eventual use in the home because it is PC-based. Patients ultimately will be able to borrow the system and connect it to their home computers, Burdea says.

Patients will be able to access exercises stored on the computer. The "virtual" exercises were developed through consultations with therapists and searches of clinical literature.

Objective measures possible

The product also hooks into a database, which will transmit information such as strength levels and number of repetitions achieved. Therapists can monitor this information so that adjustments can be made to the program. "This gives objective measures — scores, times, velocities. And numbers don't lie," Burdea says.

Burdea, who is developing modifications of the product for use with elbow and knee injuries, believes the Rutgers Glove can save therapists time and money. "Today, medical cost pressures are such that people have less time with therapists," he says. "If you can reduce the time therapists spend with patients, this will have a medical and cost impact." ■

Need More Information?

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- **Kim Conner**, Occupational Therapist, University of Texas Medical Branch at Galveston. E-mail: kdconner@utmb.edu.

200 miles," Reise explains. "My patients really like it because they don't have to travel. And because it's done under a grant, there is no charge to them [for visits]."

Kjar says she believes the telemedicine efforts also have brought in additional revenue through increased referrals from clinicians and other clinicians. "[Referring] physicians are sometimes fearful that once they refer a patient, the patient never comes back. By telemedicine, you can keep the patient in their hometown facility, and even allow the physician to take part," Kjar says. "And it builds confidence in our clinicians once physicians and nurses see them in action. They feel more comfortable with us." ■

Rehab groups still protesting outpatient cap

Legislation introduced to mitigate cuts

The fight isn't over yet for elimination of — or at least revisions to — a new Health Care Financing Administration (HCFA) policy that limits Medicare Part B annual expenditures on nonhospital rehab services to $1,500.

Both the Alexandria, VA-based American Physical Therapy Association (APTA) and the Bethesda, MD-based American Occupational Therapy Association (AOTA) are lobbying hard for legislation that allows exceptions to the $1,500 annual cap on outpatient rehab services, and are urging their members to do the same. Meanwhile, providers affected by the cap are making substantial changes in their practices.

The new HCFA policy, which took effect Jan. 1, was passed as part of the Balanced Budget Act of 1997. It establishes a $1,500 annual limit per patient for occupational therapy and a combined cap of $1,500 for physical therapy and speech-language-hearing-services. It affects private practitioners, clinics, rehab agencies, skilled nursing facilities, and home health agencies (for services for non-homebound individuals).

Legislation introduced by Sen. Charles Grassley (R-IA) and Sen. Harry Reid (D-NV) in late February proposes exclusions for certain classes of patients from the therapy cap. It was pending at press time in the Senate Finance Committee, of which Grassley is a member. Specifically, the bill creates exemptions for:

- individuals who have more than one incident or diagnosis of need for therapy during a calendar year;
- individuals who have one or more diagnoses of illness, injury or disability which intensify their need for therapy in a calendar year;
- individuals who would be hospitalized if they did not receive therapy beyond the limit;
- other individuals whom the Department of Health and Human Services designates.

This category could include patients who have suffered a severe stroke or those with Parkinson's disease, multiple sclerosis or compound or multiple fractures, according to a position paper released by AOTA.

Executive Summary

- ❑ Sen. Charles Grassley (R-IA) and Sen. Harry Reid (D-NV) introduced legislation in late February that creates exemptions for certain classes of patients affected by the Jan. 1 $1,500 annual patient cap on outpatient rehab services.
- ❑ The American Physical Therapy Association and the American Occupational Therapy Association are encouraging administrators and therapists to write their members of Congress urging them to support this change.
- ❑ Some outpatient rehab groups are seeing fewer Medicare patients and are educating patients about the impact of the cap.

"We think it's a good prospect that we'll see some action on it [the $1,500 cap] this year. Because there will be budget legislation this year, there will be something for us to attach these provisions to," says **Fred Summers**, associate executive director for professional affairs at AOTA.

But because the current rules took effect Jan. 1, rehab managers will have to live with the cap for now. What's an administrator or therapist to do? Both AOTA and APTA are urging their members to write letters to congressional officials protesting the cap.

"We have evidence that 1% of Medicare beneficiaries had already exceeded the cap by early March. This [$1,500 cap] will backfire on Congress because it will ultimately end up costing them more money. These patients [who exceed the cap] will take up space in nursing homes and hospitals if they don't get the therapy they need to become functionally independent," says **Jerry Connelly**, senior vice president of APTA.

Providers interviewed by *Rehab Continuum Report* say that although it is too soon to assess the impact of the $1,500 cap, they have already taken actions to mitigate the future effects.

Riverside Rehabilitation Center in Plains, PA, for example, is now treating 40% fewer Medicare patients, says **Frank Pugliese Jr.**, CEO at Riverside. In addition, Pugliese has met with every clinician at Riverside and has sent several supervisors to seminars about dealing with the $1,500 cap.

In addition, Riverside has stressed patient education and communication, Pugliese says. The clinic has drafted a letter explaining the $1,500 limitation that is given to every Medicare patient. When a patient is approaching the $1,500 limit, a therapist will sit down and discuss the patient's medical and payment options. "We're staying very proactive and keeping abreast of everything we possibly can. We're doing everything we should be doing to practice good medicine," he says.

At Warm Springs Rehabilitation System in San Antonio, the hospital has brought two of its three free-standing clinics into the hospital because of the anticipated impact of the $1,500 cap, says **James Ashbaugh**, CHE, regional director of operations for the hospital. Because these two clinics are now physically located at the hospital, they are no longer subject to the $1500 cap. That strategy is not feasible to try for the third center, which is located in Del Rio, TX, a rural community. The hospital has installed a computer system to help track spending on Medicare patients so they can warn patients if they are approaching the $1,500 cap.

In addition, the system has talked with a nearby physical therapy practice about the possibility of referring patients to the practice once the cap is reached. The $1,500 limit is a per-facility limit, not a per-patient limit, Ashbaugh points out.

If you're a free-standing facility considering linking with a hospital as a way around the $1,500 cap, Connelly of APTA says he advises against it. "HCFA hasn't yet defined what exactly is a satellite facility for a hospital. It's not as easy as it sounds, and it would alert the [Office of the] Inspector General and trigger compliance concerns." ■

Prospective pay formula debate continues

Per-diem vs. per-episode still a bone of contention

The construction of a prospective payment system for the rehab industry continues to draw the ire of industry groups as officials debate the use of a per-episode vs. a per-diem reimbursement for Medicare patients.

Although a spokesperson for the Health Care Financing Administration (HCFA) tells *Rehab Continuum Report* that no decision has been made on reimbursement design, some industry observers say HCFA is pushing for a per-diem payment scale.

Kenneth Aitchison, president of West Orange, NJ-based Kessler Rehabilitation Corp. and chair of the American Medical Rehabilitation Providers Association (AMPRA) prospective pay task force, says he left a March 3 Technical Experts Panel meeting with the impression that HCFA "absolutely believes per-diem is the way to go. It's clear that what they're doing with the staff time measurement studies . . . is being done in such a way that they are not getting information on what to put in place other than per-diem."

The Technical Experts Panel provides input on the work plan, sampling frame, and data

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collection procedures for the research study by an Aspen Systems / Muse & Associates team, which has the contract from HCFA to develop the patient classification system. Aspen Systems is located in Rockville, MD. Muse & Associates is in Washington, DC.

Aitchison says he is sending HCFA a letter on behalf of AMPRA objecting to the per-diem approach. AMPRA previously has written to HCFA and published information on its Web site advocating the advantages of a per-episode payment system. The organization contends that a per-diem system will generate higher costs because providers will have an incentive to keep patients in the hospital longer.

The HCFA spokesperson says there still is an opportunity to modify the per-diem approach stated in the contract awarded to Muse and Aspen, but the modifications would need to be done before the contractors go into the field to conduct the staff time measurement studies. "Once we go into the field, we'll have to commit to one way of doing the data," the HCFA spokesperson says.

The HCFA spokesperson stresses that even if a per-diem system is adopted, HCFA will not use the Resource Utilization Groups system currently being used in skilled nursing facilities as a resource allocation tool for a rehab PPS. "We will develop our own system [for rehab facilities]," he says.

The scheduled timeline for the project is as follows, according to HCFA:

Field studies for the staff time measurement studies will begin by June. HCFA plans to send information out to hospitals informing them of how they can volunteer to serve as a test site.

Field work for the staff time measurement project should be completed by the end of the summer, with a draft instrument ready for review by late 1999.

Another Technical Experts Panel meeting will be held in January or February 2000 to review the staff time measurement information. ■

OT pay strong . . . but they're working harder

AOTA finds change is impacting staff therapists

Changes in the rehab industry are definitely affecting the productivity demands on and work habits of many occupational therapists, but to a large extent many are receiving pay increases, according to a November 1998 survey conducted by the Bethesda, MD-based American Occupational Therapy Association. The results of the survey weren't released until recently.

Of the nearly 1,000 practitioners who responded to a surveyed conducted by the association, close to 50% have enjoyed pay increases during the last 12 months, reports the association in its *OT Week* publication. However, 22% reported no pay change at all while 18% reported pay decreases. In addition, 14% had their status changed from salary to hourly, a move AOTA says "may be the beginning of a trend." The percentages add up to more than 100 because some respondents had more than one job.

Work environments are changing more than pay structure, the survey reports. "As increased travel, weekend work schedules and occasional overtime become commonplace, many OT practitioners noted the importance of being able to adapt to their employers' changing needs," AOTA states in its report.

AOTA officials stress, however, that the survey is not a scientific measurement of salary levels because of the informal way it was conducted and the fact that only 1,000 respondents were involved.

At least one consultant says she has seen salary and staffing adjustments at rehab departments at many hospitals with which she works.

"One way or another, people must reduce

American Occupational Therapy Association Survey

Respondents who changed employers:	
Layoff	8%
Better opportunity	6%
Other	8%
Dissatisfaction with employer	19%
***Respondents who did not change:**	**72%**

*Percentages total more than 100 because some respondents had more than one job.

costs. You can't pay staff more than you're getting reimbursed. In most cases, people are not getting reimbursed at last year's salary levels, unless you're not seeing much managed care in your market," says **Nancy Bleckley**, president of Bloomingdale Consulting Group in Valrico, FL.

Many hospitals may still be awarding raises due to Equal Employment Opportunity Commission standards, but they probably are making other adjustments that affect overall personnel expenses, Bleckley says. "One client I have went to the staff and said 'We need to cut X% in salaries, and we've got to figure out a way to do that. They did it by eliminating one full-time employee — the last person hired — and put the other people on hourly rates plus bonuses. Or hospitals may begin to redline salary ranges." ■

Cardiac rehab hit with stricter supervisory rules

Proposal prompts letters to HCFA

A cardiac rehab industry group has initiated a letter-writing campaign in response to proposed rules from HCFA that would increase the physician supervisory requirements of cardiac rehab programs.

Under a proposed new policy by HCFA, continuous telemetry monitoring by a physician would be required for any cardiac rehab program. In addition, physicians would be required to read and interpret each EKG rhythm strip generated by a cardiac rehab program, as well as review and revise exercise prescriptions generated by cardiac rehab staff members.

Because most centers are staffed by nurses or exercise physiologists, the additional physician supervision would be cost-prohibitive for many programs, as well as unnecessary, says a representative for the American Association of Cardiovascular and Pulmonary Rehabilitation (AACPR) based in Madison, WI. If the proposed requirements were passed, a center would have to pay physicians for their time spent supervising these activities, even though these physician activities would not be reimbursable under current Medicare regulations, says **Pat Comoss**, chairperson of AACPR's health policy and reimbursement committee and owner of Nursing Enrichment Consulting in Harrisburg, PA.

The AACPR has scheduled a meeting with HCFA to discuss its concerns about the policies, Comoss says. The group's main concern is that discussions take place before the regulations are passed without an opportunity for public comment. The group favors either a public comment period or at least the chance for cardiac rehab providers to discuss the issue with HCFA before a new policy is passed.

"One of the reasons that we're concerned . . . is that cardiac rehab programs are staffed with well-trained professionals including cardiac nurses and exercise specialists who are there to do the job of watching patients and adjusting the exercises they're performing. One group of physicians said in a letter to HCFA, 'Are you asking me to do my nurses' job?'" Comoss says.

Comoss points out that the increased physician supervisory proposals are part of an overall review HCFA is doing of how cardiac rehab is reimbursed. Because the current reimbursement rules for this patient population were written in 1989, the AACPR agrees it is time for revised guidelines, Comoss says. The group previously has tried to convince HCFA to expand the patient diagnoses that are eligible for Medicare reimbursement for cardiac rehab, Comoss says. Currently, only three groups of patients can be reimbursed: post-myocardial infarctions (heart attack patients), post-coronary artery bypass surgery patients, and patients with stable angina. ■

Cut out the middleman through direct contracting

On-site PT pays off for two practices

Looking for a new source of revenue to make up for the recent reimbursement squeezes by Medicare and private-pay insurers? You may want to consider a technique that is working for some physical therapists: direct contracting with employers.

Providing on-site physical therapy to several key large employers has boosted the patient base for two practitioners interviewed by *Rehab Continuum Report*: **Joseph Mancuso**, PT, owner of

Executive Summary

- ❏ Direct contracting with employers can provide an additional patient base and enhanced revenues to rehab practices or departments.
- ❏ Remember that putting these contracts in place can take time and patience.
- ❏ Numbers talk. Show anticipated cost savings as part of your sales presentation, and give regular reports on costs saved to show how your presence is benefiting the employer.

Twinboro Physical Therapy in Central, NJ, and **Marilyn Roofner**, PT, director of outpatient rehabilitation at Orlando (FL) Regional Health Care System.

"It's an obvious connection," Roofner says. "Employers are paying the bill for their employees to have health services. This is a way to not so much cut out the insurance company but go directly to the employer by providing on-site services as well as services in your rehab setting."

In an average year, Orlando Regional Health Care has 21,000 patient visits from direct contracts with employers, Roofner says. Clients include The Walt Disney Co., Frito-Lay, *The Orlando Sentinel* (a local newspaper), Sea World, and Lockheed-Martin.

Services are based on the company's needs, both Roofner and Mancuso say. In several cases — including Roofner's work with Disney and Mancuso's work with Bristol-Myers Squibb, General Motors, and Rutgers University — therapists have set hours each week that they see patients at an on-site facility at the workplace. Visits are billed directly to the employer as if a patient had visited the practice independently. In other cases, Roofner says she contracts at a one-time fee for educational sessions — for example, a "healthy back" session for new pressroom employees at *The Orlando Sentinel*, or a stretching workshop for dancers at Walt Disney World.

Both practitioners note the on-site therapy is very beneficial to the companies involved. At Bristol-Meyers Squibb, for example, where the physical therapy facility is open two days a week from 7:30 to 9:30 a.m., the company has recognized significant savings, says **Joseph Ferro**, MD, senior medical director of Bristol-Meyers Squibb. "Our most impressive was in carpal tunnel [injuries]," he says. "According to the Department of Labor, each injury costs $3,000 — $30,000 if surgery is required. Three years prior to instituting our program, we had 12 cases, all of which required surgery. Since 1992 [when the on-site PT program started], we have had a total of three surgical cases [of 22 patients with carpal tunnel injuries]."

A client of Roofner's completed a two-year study after instituting on-site PT services and a certified personal trainer. "They had a 50% decrease in the reported number of sprains and strains and a 66% decrease in workers' comp costs," she says.

While these success stories make great testimonials when pitching to potential new clients, how can an outpatient rehab department or hospital start from scratch? The key lies in your own accounts receivable and patient records, Mancuso and Roofner say **(for other tips on working with direct contract clients, see story on p. 66)**.

Review your records to see which employers you are frequently drawing patients from. The larger the size of the employer, the better the chance they would be amenable to on-site services or a direct contract relationship in which employees come to your facility.

Do your research before approaching the company, Mancuso says. Find out who its insurance carrier is, or whether the company is self-insured. If it is self-insured, the money is coming out of its own pocket anyway. Include information on the number of specific types of treatment your practice is providing for its employee population, and ways those costs can be lowered by seeing employees on-site soon after an injury has occurred, not to mention preventing future injuries. Prepare a presentation that shows how a direct contracting relationship can reduce its health care costs.

Build on relationships you may already have in place. Mancuso was able to parlay a strong referral base from one local physician into a direct employer contract when the physician — Ferro — went to work for Bristol-Meyers Squibb.

Roofner got support from one patient who was a corporate vice president at a target client. "She kept working it from the inside and saying 'we need to have this.' Even though it took about five years, we got the business because I was knowledgeable about the company and their needs, based on good relationships and rapport with some of their employees who had been patients." ■

Know how to play the direct contracting game

Use these tips to land clients

They didn't teach you this in physical therapy or occupational therapy school. You're trained to take care of patients, not to wine and dine them. But a growing trend in the rehab industry — and many other areas of health care — is to increase referrals by bypassing insurance companies and contracting directly with employers **(see related story on p. 64)**.

So where do you get started after you've identified a few key corporations that could benefit from such a relationship with your outpatient rehab department or practice? Here are tips from two therapists who have been there: **Joe Mancuso**, PT, owner of Twinboro Physical Therapy in Central, NJ, and **Marilyn Roofner**, PT, director of outpatient rehabilitation at Orlando (FL) Regional Health Care System.

Know your costs. In order to put together a proposal for a potential client, you need to know how much it's going to cost your department or practice to provide the service. How many hours will you or your therapist spend with clients and on related projects, such as preparing a presentation or drive time to the facility? Will you need to provide equipment? In most cases, costs involve staff time, Roofner says.

Does the facility have a site that is suitable? Mancuso advises practitioners do what they can to provide services on-site, even if there is not a designated wellness center or medical facility. The reason: Reducing lost work time is a major selling point in favor of an exclusive relationship with a physical therapy unit. One company Mancuso had approached for three years finally accepted a proposal when Mancuso offered to get started at no out-of-pocket costs to the employer. "I said, 'Just give me a room.' I brought the exercise mats and worked with patients. Right now, we do hands-on treatment and teaching. Anything that requires the use of exercise equipment, they come here." The insurance company is billed directly.

Whenever possible, bill the employer directly rather than billing the insurance company. "We [rehab providers] can provide the service at a less expensive rate if we don't have to bill the insurance company," says Roofner. Roofner says 99% of her direct contracting business does not involve billing the insurance company — despite being located in a fairly mature managed care market.

Include the insurer in the communication loop. Roofner says she meets with each employer's insurance company as she is pitching the account. "You're better off explaining the program to anyone that may prevent you from doing it," she says. "It's very hard for an insurance company to argue with a way to lower costs. Once they see that physical therapy is such a small part of costs, it's less threatening. And if you're offering a way they can help reduce premiums, that's a benefit. At first, some insurers I've talked with were concerned. But the longer we talked, the more they realized we were on the same team."

Pick your on-site therapists carefully. Mancuso himself often sees patients at the employer sites, while Roofner selects her staff therapists who see these patients with care. You need someone who is as comfortable talking with a blue-collar employee as with the chief executive officer of the company, both Roofner and Mancuso say. "You need someone who can think on their feet, who's always got their eyes and ears open, and can communicate well in a politically tricky environment," Mancuso says. "It's important to know when to step in and say, 'I notice your employees are having problems with this particular doctor.'

Good relationships = good marketing

As always, provide excellent customer service. Provide employees with better service than they or their employers expect, and be flexible, Mancuso says. "If you show up and there are three patients away, figure out a way to make it work. There's a different attitude you have to adopt when you're a staff therapist."

Provide results-oriented information. Roofner gives clients scheduled reports detailing how much her services have saved the company. She compares average costs for specific types of injuries — usually pulled from worker's compensation filings or national journals — compared with the costs and average number of visits Orlando Regional Healthcare has achieved for the company's employees. Numbers can also help in a sales presentation. "I might tell an employer that the average cost of back surgery is between $60,000 and $70,000, including time away from the job. That compares with a $500 or

$1,000 expenditure for a back education program for employees."

Realize that word of mouth and good relationships are the best marketing tools for this type of business. Approach benefit managers or other executives with companies with which you have an existing relationship. And be patient! Roofner says the average amount of time it takes her to land an account is two years. ■

Y2K work moving slowly for health industry

Government queries getting slow response

With slightly more than six months left before the year 2000, many hospitals are still figuring out how to prepare, two government agencies say.

Of 200 skilled nursing facilities surveyed by Minneapolis-based Rx2000 in a project for the Health Care Financing Administration (HCFA), only 33 responded, says **Peter Ashkanz**, a spokesman for HCFA. Out of 420 home health agencies contacted, only 57 responded. Rx2000 was not available for comment.

The data are so low, however, that they did not generate statistics meaningful enough for a significant confidence rating. "Our sense is that based on the low response rate, no one is thinking about it," Ashkanz says.

A spokeswoman for the Office of Health and Human Services (HHS) in Washington, DC, says her overall assessment is that two categories of hospitals do not seem to be doing well in their year 2000 planning: hospitals in rural markets or hospitals in urban facilities that operate on a shoestring budget. The HHS spokeswoman suggests that rehab facilities assess their computer equipment to see if any of the equipment contains an embedded microchip. This equipment, as well as any billing systems, should be a first priority.

"You've got to do this, or your claims won't get processed," she says. "Medicare is saying that if they [hospitals] can't bill, we can't pay. And malpractice insurance won't cover Y2K problems."

The HHS spokeswoman suggests that providers with Y2K concerns visit the government Y2K Web site at http://www.gsa.gov. *Rehab Continuum Report* readers can also see the December 1998 and January 1999 issues for more information.

Rehab administrators in a hospital setting should look to their information services department to take the lead on Y2K issues, says **Nancy Bleckley**, president of Bloomingdale Consulting Group in Valrico, FL. "If your hospital IS department has not contacted you, contact them and ask for a review," she says. "Be prepared to give them information regarding all your equipment and everything that might be at risk."

Private practices and other freestanding facilities should turn to a consultant to identify and coordinate Y2K issues, she says. "There are other more pressing issues facing the industry now that rehab administrators need to be concerned with."

Bleckley says the most critical Y2K issue for

New manual can steer you through Y2K

With the year 2000 deadline fast approaching, hospitals, other health care providers and the medical device industry are scrambling to complete a process that in many cases was started too late. What may have once been a logistical issue is burgeoning into an overwhelming problem, compounded by the scarcity of time, rising costs, and a lack of programming resources and expertise.

As the Y2K issue moves far beyond a mere "technological" issue, American Health Consultants has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for non-technical hospital managers. This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, the potential fixes, and the possible consequences, including:

- Will your computers and software work in 2000?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K compliant?
- Are you at legal risk due to Y2K?

The Hospital Manager's Y2K Crisis Manual is available now for $149. For more information on the *Hospital Manager's Y2K Crisis Manual*, contact American Health Consultants customer service at (800) 688-2421 or www.ahcpub.com. ■

nonhospital facilities concerns their medical management software program, which often includes the facility's billing system. Some medical management software vendors are passing along fairly high Y2K compliance costs to their customers, she says. Facilities that do not have computer service contracts may wish to invest in these, however, as a way to ensure Y2K compliance. ■

Combined CARF-JCAHO survey now a reality

Effort intended to save administrators time

Two major accreditation bodies for rehab hospitals have taken their efforts to coordinate surveying activities one step further with the implementation of an enhanced combined survey process.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and CARF . . . The Rehabilitation Accreditation Commission are conducting joint surveys for freestanding rehabilitation hospitals. The effort is expected to reduce staff time spent preparing for and conducting these accreditation activities by hospitals being evaluated.

"When we were surveyed by JCAHO in 1996 and CARF in 1997, the time spent preparing for both of these on different occasions was pretty substantial," says **Michael Caputo**, assistant administrator of Mediplex Rehabilitation Hospital in Bowling Green, KY. The facility served as a beta test site for moderate integration of the enhanced JCAHO/CARF initiative. "We've probably reduced the time spent preparing for our joint survey [which is planned for fall 1999] by 30% to 40%."

Each accrediting body will continue to award its own accreditation decision, issue its own survey report, and charge its customer survey fee, according to a joint statement released by the two organizations.

Since the enhancement was implemented in late February, CARF has received positive feedback from participating institutions, says Sally Saadeh, director of special projects for the medical rehabilitation division at CARF. To date, four surveys have been completed using the combined interview method. ■

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