

moving in the right direction

Mechanical Diagnosis And Therapy®
of the spine and extremities

►► The Proof is in the Outcomes

Jon Weinberg, PT, Dip. MDT

I have been a Physical Therapist for nearly 15 years, 11 of which have been spent in an orthopedic setting in the USA. Currently, I am in private practice in North Carolina.

Due to dissatisfaction with my outcomes using "Maitland", I took my first MDT course in 1999. I was subsequently completely bowled over with both the predictability and reliability of MDT. So much so that after completing the MII Diploma Program in 2005, I applied to become a McKenzie Certified Clinic, we sold off all of our modalities, and closed down most of our other sites.

This was great for the clinical spirit, but not for the financial soul of the practice. In fact, I noticed a very interesting phenomenon.

To digress a moment, being a business owner I have had the occasion to employ the service of attorneys from time to time. I have noticed that the more impressive the credentials and experience of the attorney the higher the fee. However, when I apply this to the physical therapist model the reverse occurs. If a generalist PT treats a back or neck, they employ many more techniques and modalities for longer periods of time generating substantial income. However, when a seasoned MDT clinician sees the same patient, he or she tends to get better in significantly less visits with much less intervention thus generating significantly less income.

So picture this, I had a very successful practice getting great outcomes but being paid a pittance. So we had a couple of options:

1. Buy an ultrasound, the machine that goes "Bing", a Swiss ball and start racking up the charges or,
2. Find a constructive way to tell the public and insurance companies what we do and prove that this method is more effective and economical than traditional PT.

Through a chance chat in Montréal with Mark Werneke, PT, Dip. MDT, we started to put our heads together to find out what would be the most effective way to initiate market-based research.

We found some likeminded clinicians (Dave Oliver, Troy McGill and Bill Cutrone) and with the help of the wonderful folks at

FOTO, started putting data together.

Mark and Dennis Hart of FOTO took the data collection group under their battle-scarred wings, giving us direction and suggestions and as a group we started along the path of outcomes collection.

After multiple meetings and phone calls to Blue Cross Blue Shield of NC (BCBSNC) over a three year period, suddenly an interesting

development occurred. We now had clinical outcome data. I was invited to present our findings to their medical board. We all felt very confident in our outcomes, but when Dennis Hart pulled together a joint report of our MDT group, our postulations were substantiated.

Using only the MDT system, we were able to get better functional outcomes in approximately 50% less time than the FOTO average (and about 70% greater than the national average).

Needless to say, BCBS was very excited with the data that we collected. In fact, they were so impressed with the data, that they have increased our reimbursement and are currently running a pilot study with my practice. As we anticipate continuing to show the same level of outcomes, BCBSNC may expand the study to those MDT practices also achieving the same level of outcomes next year.

So, I cannot emphasize enough the importance of collecting this data and I do recommend the use of FOTO for this purpose, as it is both patient and clinician-friendly. Additionally, it is a great marketing tool.

Finally, this means a practice is getting recognized rather than penalized for proven superior outcomes.

The days of the high dollar shake'n'bake practitioners are rapidly fading. If clinician's do not police themselves, the insurance companies will do it for us. I guarantee we will be much more satisfied if it is us who set the game plan. The most obvious way of starting that process is outcome collection. ■

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"Using only the MDT system, we were able to get better functional outcomes in approximately 50% less time than the FOTO average (and about 70% greater than the national average)."

►► Payers Don't Care What You Know Until They Know That You Care (About Them)

Ron Donelson, MD, MS, Dip. MDT

One way in which low back pain (LBP) causes suffering is the economic distress it brings to those who pay for its care. This is primarily employers who are either self-insured or who pay indirectly using contracts with a third party payer. Employers suffer not only the medical bills but the costs of losing employee productivity. So both employers and third party payers are motivated to cut costs while hopefully raising the quality of care for LBP.

Consequently, besides helping their patients, clinicians need to consider helping payers as well. MDT clinicians are uniquely qualified to do so. And the potential rewards are substantial.

Payers have tried various methods over the years for containing costs. Their latest strategy is called "pay-for-performance" (P4P) where providers are rewarded for delivering quality care, but the definition of "quality" varies. One definition is "guideline compliance". This model requires clinician profiling, or so-called "report cards", where clinicians' patterns of ordering diagnostic and therapeutic interventions are monitored using payers' claims data to determine guideline compliance. Higher compliance is then rewarded.

In the case of LBP, the National Committee for Quality Assurance (NCQA) and a group of spine care "experts" have created a highly regarded program to reward physicians and chiropractors who deliver so-called "high-quality, evidence-based care" -- again defined as guideline-compliant care -- that includes providing acute LBP patients with a clear understanding of their appropriate treatment options. Of course, this program assumes that LBP clinical guidelines represent the most recent and highest form of evidence, despite their focus on one-size-fits-all treatment, i.e. non-specific, advice and activity encouragement.**

But it is a second type of P4P that is especially attractive to MDT clinicians. It is based on practice-based outcomes by tracking individual clinics' cost and quality of care, independent of guideline compliance. For example, from their own claims data, payers can determine an MDT clinic's number of visits per patient, enabling a comparison with non-MDT care. Claims data can also identify the cost of any subsequent care, again being able to compare post-MDT with post-non-MDT care.

But payers can also benefit from data generated by clinicians who have direct access to the patients. This can produce both functional and patient satisfaction outcome measures, as well as any other outcomes a clinic wishes to measure. The data reported in Jon Weinberg's article in this Bulletin issue illustrates why MDT clinicians should pursue collecting their own outcomes, and doing so with confidence in gaining the attention of their payers. Most non-MDT clinicians, including academic centers, surgeons, and multi-disciplinary programs, are reluctant to even collect outcomes data, in large part due to their lack of confidence in what they'll show.

So, MDT clinicians are in a position to help both payers and themselves financially with this P4P model. This is done simply by collecting one's own MDT outcomes and sharing them with payers to corroborate with payers' own claims data.

Understand that producing superior functional outcomes with

"...producing superior functional outcomes with fewer visits is powerful in the LBP marketplace. In the eyes of payers and employers, this puts MDT programs in the driver's seat."

fewer visits is powerful in the LBP marketplace.

Again, most clinics have no outcomes and, if they do, they are very unlikely able to match MDT outcomes. In the eyes of payers and employers, this puts MDT programs in the driver's seat. MDT clinicians can then educate payers in what questions to ask non-MDT

practices in order to evaluate outcomes.

As Jon Weinberg reports with Blue Cross/Blue Shield of N.C., and as has also happened with an HMO in Tallahassee, FL (Capital Health Plan), MDT groups have been rewarded with increased reimbursement and much earlier and higher volumes of patient referrals, all driven by the payers.

After your hard work, time commitment, and substantial expense to become Credentialed or Diplomaed in MDT, the time has come to empower and position yourself to reap some financial reward for your investment. No one trained in MDT doubts that properly applying MDT methods of care across the full spectrum of low back, neck and also extremity disorders will generate superior outcomes, just as has happened in NC and FL. Very few MDT clinicians are currently collecting outcomes. But that will change rapidly with increased reimbursement at stake.

Many have been hearing about the FOTO outcomes system. It is not the only way to collect outcomes but it is a well-established, very friendly, and inexpensive way to do so. It offers many advantages over other methods, including the ability to 1) compare MDT and non-MDT outcomes, since many non-MDT clinics also utilize FOTO, and 2) risk adjust between your clinic and others (see Mark Werneke's article). At the very least, I would strongly suggest each MDT clinician contact and familiarize themselves with FOTO, if only to learn more about what's involved in outcome collection.

I am interested in hearing from anyone already collecting outcomes, whether with FOTO or with some other means, and also if you intend to implement an outcomes system. Please drop me a quick email: donelson@selfcarefirst.com. I'm happy to answer questions and be of assistance if I can. ■

***Discussed in "Rapidly Reversible Low Back Pain", available at www.optp.com and www.amazon.com.*



►► Multi-Clinic MDT Research Project: A Call for MDT Practitioners

Mark Werneke MPT, Dip. MDT

In order for health care practitioners, including certified MDT clinicians, to survive in a world of shrinking medical-service reimbursement and to remain competitive in today's increasingly critical scientific community, patient outcomes collected during routine clinical practice soon will become mandatory. Therefore, documenting clinical outcomes data using psychometrically sound measures and tools are important from professional/science and business/practical points of view. Professionally, MDT practitioners will continue to be challenged to publish high quality clinical research papers in respected peer-reviewed journals to demonstrate the efficacy and effectiveness of patient management using the McKenzie Method. In addition, from a business prospective, patient outcomes will be required to differentiate quality of care between rehabilitation providers to determine levels of medical-service reimbursement (i.e., value-based purchasing).

To improve our understanding of many aspects of the McKenzie management techniques and to address some of today's challenges, we developed a MDT clinical research group in the Fall of 2007. Our group is collaborative and presently consists of 5 MDT certified clinicians throughout the US (Diplomats: Mark Werneke, NJ, Jon Weinberg, NC, Dave Oliver, MI, Troy McGill, AK and Credentialed: Bill Cutrone, IN). The primary purpose of our group was to implement Practice Based Evidence (PBE) designed studies by MDT Credentialed or Diplomat therapists for managing patients with spinal impairments and to ultimately market and publish our treatment results, both for efficiency and effectiveness.

One purpose of PBE research is to determine which treatment techniques are associated with more efficient and effective outcomes. This requires documentation of patient outcomes using risk-adjusted effectiveness and efficiency data on as close to 100% of your patients as possible. Risk-adjustment is a statistical term that simply allows clinicians to compare outcomes between different clinics and practitioners in a meaningful way (i.e., statistical risk-adjustment allows an apples to apples comparison). As an example, a payer decides to compare outcomes between 2 competing rehabilitation clinics that both treat patients with spinal impairments. Clinic A treats a population who on average have more chronic symptoms and are older, and Clinic B treats a population who on average are younger and have more acute symptoms. A clinical comparison of treatment outcomes would not be fair or meaningful unless the payer uses a risk-adjusted approach to

take into account the different patient demographics between the 2 clinics.

Before our research group started data collection in 2008 we standardized our data collection process. We selected FOTO, Inc. for outcomes data collection and research endeavors because of FOTO's experience collecting outcomes data (i.e., FOTO has a large patient database of over 2.5 million patient episodes on which they have collected outcomes) and sophisticated risk-adjustment capability. FOTO is supported in the literature with over 40 peer review papers validating or using FOTO outcome measures and data. FOTO allows our group to investigate and objectively compare our MDT outcomes with other providers throughout the US. In addition, we have developed operational definitions for documenting physical examination test results, classification, and treatment processes, which we have added to the FOTO software to facilitate data collection. We anticipate that our data documentation and research approaches will allow us to develop multiple research projects examining the McKenzie approach as well as compare MDT with other classification systems and established clinical prediction rules for managing patients with spinal impairments.

"...patient outcomes will be required to differentiate quality of care between rehabilitation providers."

A large MDT clinical database will be required to develop high quality PBE designed research projects. Our group would like to extend an invitation for any other Credentialed or Diploma MDT trained clinician who would like to join our research efforts. The only research requirements would be to use the FOTO outcome tool, standardize the outcome documentation processes, collect data in a consistent manner, collect data on all your patients, assist the research team with your expertise, and contribute your data to the research data pool. No prior research experience is necessary; our group will provide in-house training to become familiar with our outcomes and data collection procedures. ■

We are looking forward to working with all MDT Credentialed and Diploma trained therapists who are interested in continuing our scientific journey to investigate the benefits of MDT. Please contact any member of our group for further information:

Mark: mwsurf75@verizon.net

Jon: jweinberg@nc.rr.com

Dave: daveoliver2003@yahoo.com

Troy: Troy.McGill@elmendorf.af.mil

Bill: bgcutron@stvincent.org



Getting Started on Outcomes Has Never Been Easier

Recently, FOTO® conducted two very well attended webinars for MDT practitioners. If you were unable to attend, FOTO is kindly extending an opportunity to view the recorded webinar: http://www.fotoinc.com/webinar_schedule.shtml.

SPECIAL DISCOUNT!! To help get MDT clinicians started, FOTO is also currently offering a special discount on the annual fee from \$495 to \$395 through the month of October. Following this special, further discounts will be measured on a sliding scale based on the volume of subscribers that continue or join - so now is an even better time to consider starting your outcomes collection!

Please contact Judy Holder, Manager of Provider Relations to obtain more information: judyholder@fotoinc.com or 800-482-3686 ext 38

► Remember Schlitz Beer? And Why Should A McKenzie Practitioner Care?

By Trent Wehrhahn, Senior Consultant - PTReferralMachine.com. September 2008. ©

I was reading about a Schlitz Beer ad campaign in Claude C. Hopkins' book *My Life In Advertising* when it hit me that marketing beer wasn't so different from marketing physical therapy. Claude C. Hopkins, a famous advertising guru, ran a marketing campaign for Schlitz Beer at a time when all the beer companies were doing pretty much the same thing – talking about their beer being “Pure”. No one was really telling the story of why their beer was pure or what they did to ensure the pureness of their product.

Claude Hopkins decided to simply tell that story. In the new marketing campaign he talked about how the machinery was cleaned twice a day to avoid contamination, and how they got their water from wells that were 4000 feet deep to ensure purity. He explained how the beer was cooled in a room with filtered air so the beer would not be contaminated by airborne pollutants. The interesting part of the story is that all brewers basically did the same thing! How did his strategy work? Schlitz Beer jumped from 5th place to “neck and neck” with the top brewery in just a couple of months.

Why was the Schlitz campaign so successful? Hopkins' explanation was that because Schlitz was the first to tell the story, everyone marveled at the process and assumed that they must be the purest because they were the only ones who actually explained how they ensured the purity of their product.

Being the first to tell the story is the key here. Because Schlitz was first in telling the story, they became the default in people's minds whenever “Pure Beer” was talked about. Being first also puts all of their competition in the position that if they try to tell the same story they are just a copycat.

So what does this have to do with health care? Before I relate directly to McKenzie Practitioners, let me share a real life story about this same type of scenario with dentistry.

We were working with a dentist client that did sedation dentistry. Sedation dentistry is becoming a pretty common service that is offered by most dentists but no one was talking about it in their advertising...that is except one. This dentist was on about 4 different radio stations, in the local newspapers and even on the local cable TV channel touting the benefits of sedation dentistry.

Was he saying they did anything different than all the other dentists in the city? No. He was just the first to tell people about it in his marketing.

Our client was located on the opposite side of Calgary, a city of about 1 million people, so we thought “Why don't we try to do the same thing on our end of town?” Well, it didn't matter how hard we

tried or how many ads we ran, or even that the “Sedation Guy” was not really a competitor, we couldn't get people to think about our client first when it came to getting sedation dentistry.

So what did we do? We decided to do the same thing with mini implants and became the “Mini Implant” place in about 6 months.

Now, how does this relate to you as a McKenzie Practitioner?

To begin with, most physical therapy clinics don't do any marketing to consumers, so being the first in your area to do so will get you a good chunk of business. But even if you are already marketing to consumers, most physical therapy materials talk about all the services they provide but never tell the story about what it is they really do. Typically you will see a list of services, a nice photo, and a phone number to call. Does that tell any kind of story that makes you unique, or does it position you as being exactly the same as every other physical therapy clinic out there? I am not saying you need to talk about being better than your competitors, but I am saying you need to tell a story about how using the McKenzie method helps treat back and neck pain.

You are probably thinking, “But we do more than just treat back and neck pain, what about all the other ailments we treat?” You can market those treatments too, but you should do that separately. Being specific is the key here, someone that has back and neck pain does not care about how you handle peripheral neuropathy (unless of course they suffer from that too) so you don't want to water down the message with other ailments. Choose an ailment you know you are really good at treating and have a track record of getting good outcomes (like using McKenzie to treat back and neck pain). Put together materials (website, patient guides, ads, letters, etc.) that explain how you use the McKenzie method to go about treating back and neck pain and give it a try. If it works, and I am sure it will, you will be busy treating people for an ailment you know you can get results for and have set yourself up to be “the place that treats back and neck pain”.

I can almost hear some of you saying, “we treat all kinds of stuff so what about those things?” What would you rather do, be busy treating people for one specific ailment or wondering how you are going to bring people in the door because your marketing isn't doing its job? You can always market your other services later, but do it one at a time, giving your prospects enough information to really understand what you do for their specific problem. All people want is enough information to know that they are making a good decision. By being specific you can give them exactly what they want. Isn't that what being a good provider is all about, find out what people want and give it to them? ■

For more information on how to create a marketing program that gets results visit www.PTReferralMachine.com and download our *Clinic Owners Guide To Marketing* or sign up for one of our introductory webinars.

New: Physical Therapy Mastermind



The PT Referral machine is now taking applications for our new Physical Therapy Mastermind groups. These groups will take you through the steps of building a winning marketing program over a 6 month period and consist of at least 6 non-competing clinic owners and a PTRM facilitator. Concepts will be presented by the facilitator, discussed by the peer group and then you will develop your own materials based on what was discussed that week. At the end of 6 months you will have a marketing program custom built for your clinic with the assistance of your peers and a professional marketing consultant.

To find out more go to <http://ptreferralmachine.com/mastermind>