Emerging physical therapy trends.

Perspectives on value-based care from industry leaders

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The time is now.

A decade and counting after passage of the Affordable Care Act, and more than four years after Medicare launched its Quality Payment Program, over 80% of healthcare providers are participating in reimbursement models linking payment to care quality. And now, it's time for outpatient rehab practices to join the shift as well.

While physical therapists have been eligible to participate in value-based programs like the Merit-based Incentive Payment System (MIPS) for a few years now, relatively few have chosen to do so. Their primary reason for remaining on the sidelines? For most, it's hard to do alongside the realities of running a practice. As long as fee-for-service continues to pay the bills—and as long as they continue to provide great patient care—the majority see no reason for anyone to change anything.

With that in mind, we reached out to leaders across the outpatient-rehab arena, from practice owners and clinicians to technology vendors and industry consultants. We asked them for their thoughts on value-based care, and we asked them to provide insight on the emerging trends they believe could influence such care in the future.

What they told us can be described as a wake-up call for the profession.

Here are a few points our industry leaders presented as evidence:

- Bundled payment models have now been implemented by 6 out of 10 private payers, and more than 9 out of 10 major hospitals and health systems plan to participate in these models over the next two years.
- More than 60 percent of U.S workers with employer-sponsored health coverage are now enrolled in self-insured plans, in which the employer is financially liable for the cost of covered benefits.[1]
- Musculoskeletal disorders alone cost U.S. employers more than $800 billion per year in medical expenses and lost productivity.[2]

Furthermore, our experts pointed out that the MACRA legislation requires Medicare to reimburse all providers through value-based payment models. With the full implementation of the Quality Payment Program and MIPS in 2022 it is expected that >95% of all Medicare providers will participate—but success in the program (or in any value initiative) is by no means guaranteed. Their overwhelming recommendation? Start preparing now while there's less at stake so you can master the competencies value-based care requires.

Musculoskeletal disorders alone cost U.S. employers more than $800 billion per year in medical expenses and lost productivity.[2]

1 HEALTHAFFAIRS.ORG
2 BONEANDJOINTBURDEN.ORG

Turn data into action.

CHRIS HOEKSTRA, PT, DPT, PHD

Director of Knowledge Management,
Therapeutic Associates Physical Therapy

Assistant Professor,
Oregon Health & Science University,
School of Medicine Department of Medical
Informatics and Clinical Epidemiology

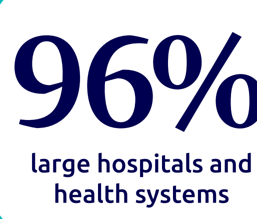
For his doctoral degree in biomedical informatics, Hoekstra studied how clinical information systems can be used in the physical therapy decision-making process. His job at Therapeutic Associates, an outpatient practice with clinics in four Western states, involves helping the organization glean useful information from its clinical and business-operations data. One area where having such information helps? In their management of risk-based contracts that reward providers for care value.

"I'm going to bang this drum as loud as I can," Hoekstra says. "To succeed in value-based care, you have to know your risk strata. If you're negotiating a contract with a company to treat and reduce incidence of low-back pain among employees, you need to have data that says you can get them this much better for this amount of money in this amount of time... You should also have a way to understand any other risks you have as an organization. What are your costs? What's your staffing like? Do you have what you need to manage this contract?"

> "You need technology that can deliver data in a way that you can use it, and you need processes in place that allow you to consume that data and put it into action."

Finally, Hoekstra says, "know what your purchaser wants from the value proposition." Is the employer trying to decrease their musculoskeletal spend? Are they trying to increase employee satisfaction? You need to understand their definition of success. Because at the end of the day, that's what drives their definition of value—and it should drive your definition of value as well.

Percentage of healthcare organizations participating in at least one risk-based contract in 2020.[3]



96% large hospitals and health systems

83% mid-sized organizations

69% smaller institutions

3 NUMEROF & ASSOCIATES

Add value with virtual care.

JEME CIOPPA-MOSCA, PT, MBA

Senior Vice President of Rehabilitation,
Hospital for Special Surgery, New York City

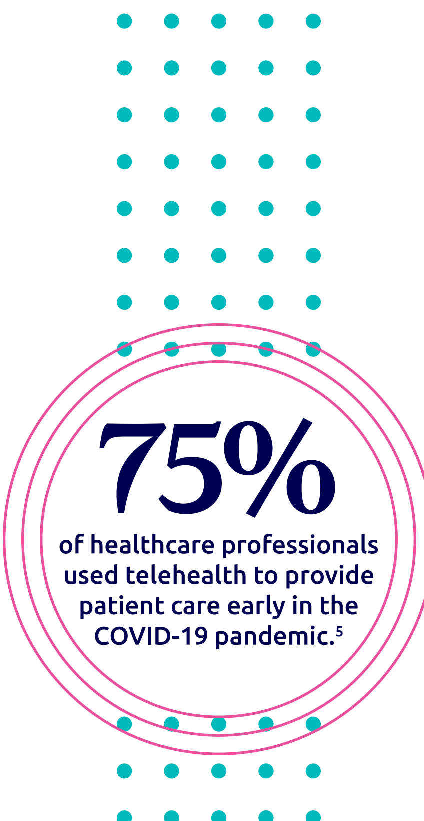
As a leader within the world's largest academic medical center specializing in MSK health, Cioppa-Mosca is a physical therapist who is truly on the cutting edge of the profession. Her latest experience on the front lines—practicing in a pandemic—has her optimistic about the future of telehealth and its role in value-based care.

"I think we're going to see a lot more telehealth regularly embedded in the episode of care," Cioppa-Mosca says. Telehealth isn't a replacement for in-person care, she notes, but "an additional tool in the toolbox" requiring a different skill set and care guidelines. At HSS, they pivoted to telehealth as COVID-19 swept through New York City.[4]

As HSS moves forward with telehealth, Cioppa-Mosca says, they're continuing to collect outcomes data along the way. Moving forward, outcomes will become even more critical as therapists across the country must prove that what they do within the healthcare ecosystem is truly effective.

At HSS, the goal is to align outcomes data with their own clinical guidelines. They do this for two reasons, Cioppa-Mosca says. "One, to ensure that our care guidelines and models are correct. And two, so that we can ask ourselves, does the care provided actually get people better? By what standardized metrics are we going to look at, through multiple clinicians at multiple locations

> "How will employers know which therapist is top notch? Their reported outcomes data."



4 SPRINGER
5 AMERICAN TELEMEDICINE ASSOCIATION

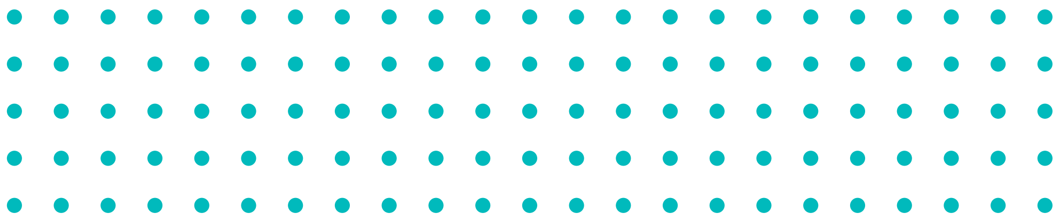
> As a profession, we need to know that our outcomes are aligned with our guidelines, and to prove to ourselves—and to payers—that we're actually helping people get better."

53%

of large U.S. companies expect to offer more access to telehealth services on their health plans in 2021.[6]

throughout our ecosystem, to know the answer? With this data in hand, only then do you have the ability to actually go to a payer or influence legislation, like telehealth laws—because you have the data necessary."

Another shift happening in healthcare? Employers, says Cioppa-Mosca. "Employers are pushing to reduce healthcare. I think for physical therapy in particular, direct access has just barely started to tip the iceberg of how big and what an impact it could have, especially on MSK. Now in the UK, physical therapists have been reclassified as frontline providers and I think that's where we are potentially moving, especially for musculoskeletal disease for employers because all the places where we provide therapy for an employer on site, it's 40 to 50% direct access. And again, that's where the skills of the therapist must be top notch. And how will employers know which therapist is top notch? Their reported outcomes data."



6 BUSINESS GROUP ON HEALTH

Lose the fee-for-service mindset.

JERRY HENDERSON, PT

Co-founder and Vice President of Clinical Strategy, Clinicient

When you're leading a company that makes EMR and billing software designed specifically for physical therapy practices, you can't help but develop a deep understanding of the connections between clinical care and reimbursement.

Value-based care was born of necessity, Henderson says. "People have recognized that the fee-for-service system is broken beyond repair. When it's all about volume for the provider, that leads payers to try to ration or control utilization." When insurance companies are in the position of making healthcare decisions, he says, "that's a no-win game."

Value-based programs like MIPS, Henderson continues, "incent clinicians to provide the right care to the right person at the right time." He sympathizes with the majority of PT practices "that are still very much in a fee-for-service world," because he knows that's how they're able to keep their lights on. For now, they really have no other choice.

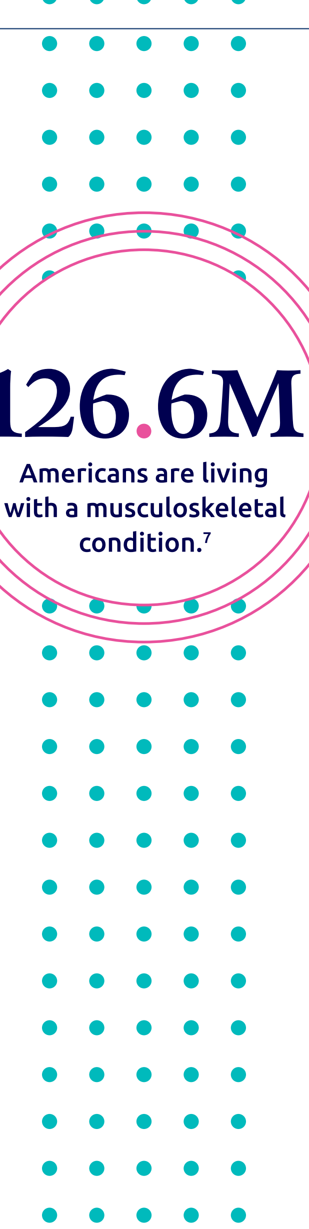
> "The more you can engage with people outside of the four walls of your clinic, the better prepared you're going to be for value-based care."

Still, Henderson says, value-based care has been written into law. CMS has a mandate to create these Quality Payment Program models, and MIPS is just the beginning. Fee-for-service will fade away, he predicts, and value-based care will become the new norm.

His recommendation: "Start with a shift in mindset. You can do things now that will prepare you for the future that are also important in fee-for-service."

Focus on patient engagement, for example, not only because it can bring patients in the door, but because communication with patients when they're not in your clinic will be critical to success in value-based care.

Similarly, to prepare for potentially lucrative population health management programs (contracts with employers, for example), therapists should take responsibility for their active patient caseloads. "Know exactly how many patients you have, and know who's new and who's dropping out," Henderson says.



> "Start with a shift in mindset. You can do things now that will prepare you for the future that are also important in fee-for-service."

Practices that put processes in place that facilitate communication and effective caseload management will add to their bottom line in the short term as they build for success down the road, Henderson says.

"There's a very bright future ahead for people who make small changes today."

7 AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Move to MIPS.

KELLY SANDERS, PT, DPT, OCS, ATC

President,
Team Movement for Life,
San Luis Obispo, CA

With 26 physical therapy clinics in California, Arizona and North Carolina, Movement for Life has always strived to be on the leading edge. In keeping with that ethos, the organization chose early on to participate in MIPS and act as an early adopter in the quality payment program.

"We already had outcomes and patient-satisfaction measures in place, but we liked that MIPS would force us to be more disciplined about using them," Sanders explains. The fact that it was voluntary was also a good thing. "We saw it as a chance for us to work out the kinks before we faced penalties or they started to go up."

One significant change the organization had to make as a consequence of this decision involved bringing in additional technology, Sanders says. They purchased tablets, for example, so patients could check in and fill out intake forms electronically. Fortunately, their patient-engagement platform could process patient-reported outcomes—and it helped them with MIPS reporting compliance.

> "I think PTs have a real opportunity to work with large employers to help them control their healthcare costs."

"For us, it's been about getting our processes dialed in—making sure we're doing everything consistently," Sanders says. Outcomes had previously only concerned their therapists, who'd use them to help guide patient care. "But now they're more of a shared responsibility between our clinicians and our front-office teams."

+5.3%

projected increase in health plan costs for large employers in 2021.[8]

8 BUSINESS GROUP HEALTH

As the team at Movement for Life pushes for progress in MIPS, they're focused on exceeding national outcomes benchmarks and on maintaining high NPS scores. Since almost half of the organization's business comes through Medicare, it's important they do well in the program now to position themselves for success in the future.

"The financial piece of this is a big one," she says. "As of now, this is our only opportunity to improve payment through CMS."

Why MIPS?

Some PT practices must participate in MIPS, while others can voluntarily opt-in to the program. Either way, participation now is a good idea: It makes a practice eligible for incentive payments, and prepares providers for future participation in risk-based alternative payment models when they become more common.

Practices must participate in MIPS[9] if during the year they have:

$90K+
in Medicare charges
+

200+
unique Medicare patients
+

200+
services billed to Medicare

9 CMS QUALITY PAYMENT PROGRAM

Differentiate with data.

MAGGIE HENJUM, PT, DPT, OCS, FAAOMPT

Founder and Owner,
Motion, LLC,
Minnesota and Utah

Owner and CEO,
Therapy Partners Inc.

Value-based care should be part of practice culture and not just “metric-driven,” says Maggie Henjum.

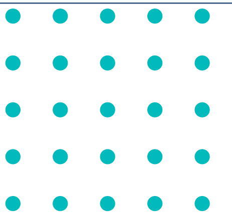
The owner of three physical therapy clinics—two in the Twin Cities and one in Park City, Utah—Henjum says the key to providing quality care at a lower cost has everything to do with education.

For clinicians, that involves continuing education and following the latest research in the field, while for patients it’s about engagement in and out of the clinic.

> “We’re doing this for the betterment of our outcomes. We’re doing this for the betterment of our patients.”

“The literature really supports early access to physical therapy,” Henjum says. “In most realms of musculoskeletal care, the earlier you get in, the better the outcome, and that comes down to encouraging engagement and nurturing the relationships you have with your patients.”

To make visits easier for patients, Henjum says, they’ve turned to online scheduling. They bolster patient outreach through emails and social media, and they occasionally sponsor local community events. “As a ‘mom and pop’ clinic we’re always saying, ‘You twist an ankle, we want to know about it; you tweak your back, we want to know about it.’ I think that’s where we have an advantage in private practice. Hopefully, when something happens, people are going to think of us.”



> “It’s the culture of your clinic that facilitates value-based care.”

Motion is participating in MIPS, so metrics and data collection are an important part of each clinic’s day-to-day work. Henjum’s goal, however, is to not let that distract from clinical care or negatively impact the patient experience.

Toward that end, they’ve honed their clinical workflows to streamline data gathering and reporting. And their therapists understand the data collection is for them even more than it is for insurance or as a means for driving revenue.

“I really believe in data because bias can be huge,” Henjum explains. “You think, ‘Oh, I’m getting everyone better,’ but you look at the data and it might not coincide with your beliefs.” At Motion, she adds, value-based care goes well beyond any program designed by CMS. “We’re doing this for the betterment of our outcomes. We’re doing this for the betterment of our patients.”

$4700

Average one-year cost savings when patients with uncomplicated low-back pain receive physical therapy instead of advanced imaging following initial consultation with a primary care physician.[10]

10 HEALTH SERVICES RESEARCH

Stand by your product.

MICHELLE COLLIE, PT, DPT, MS

Chief Executive Officer,
Performance Physical Therapy,
Rhode Island and Massachusetts

Unlike many others in the profession, Collie saw no reason to wait when it came to signing on with Medicare's Quality Payment Program.

"The way I see it," says Collie, who is president of the Rhode Island American Physical Therapy Association, "if we're not measuring quality, then we're not standing by our product."

Performance Physical Therapy includes more than a dozen clinics across two states. The practice has reported through MIPS since 2019, the first year physical therapists were permitted to join the program.

Collie says that one commercial payer will be giving them a 2-4% bonus based on their MIPS reporting, and they're about to start a pilot program with another major insurer to provide ongoing care of patients with hip and knee osteoarthritis for a (capitated) monthly fee.

"If we see a patient at one of our sites, we'll just charge them for that service," Collie explains. "But then we're also going to manage them outside of our clinics, and for that we'll be on a monthly subscription."

For each patient, she says, the insurance company will be paying them approximately $80 per month for this off-site care. They reached a deal with the payer by leveraging the outcomes data reported for MIPS, and by nurturing a long-term business relationship and the trust the two organizations had in each other.

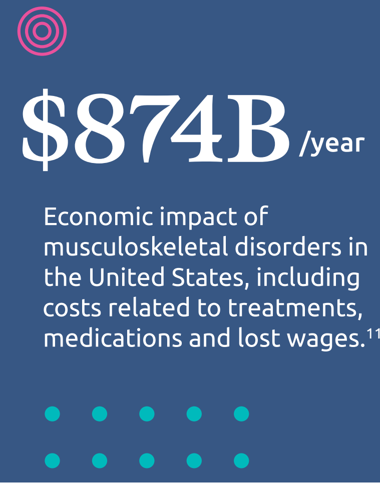
> "It helps when the PT knows they're getting compensated for all the stuff they're doing outside of the clinic."

> "If we're not measuring quality, then we're not standing by our product."

They also pointed to research that shows extended physical therapy significantly reduces the need for hip- or knee-replacement surgery.

The program will allow them to "not just focus on getting a patient's quads a little stronger, but to work on behavioral changes like getting them to exercise every day," Collie says. They might see that individual in the clinic Monday and Thursday, "and then we're going to follow up with a five-minute phone call on Tuesday, and check in again on Friday."

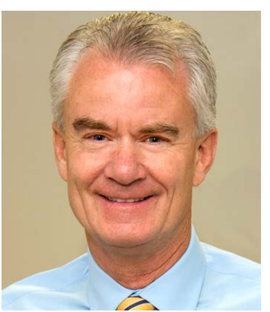
Those calls might only take a few minutes each, but they should pay off for both the practice and the patient, "and it saves money for the insurance company too," Collie says.



$874B /year

Economic impact of musculoskeletal disorders in the United States, including costs related to treatments, medications and lost wages.[11]

11 BONE AND JOINT INITIATIVE



Measure, measure, measure.

STEPHEN HUNTER, PT, DPT, OCS

Rehab Services Director,
Intermountain Healthcare,
Salt Lake City, Utah

Value-based care is nothing new for the rehab team at Intermountain Healthcare. It's been over two decades since Intermountain developed its ROMS (Rehab Outcomes Management System) quality tracking and analytics tool, and today about 50% of the organization's income derives from risk-based contracts.

Such contracts reward providers for care quality and efficiency—and may reduce or eliminate payments when value-based metrics aren't met. To succeed, "you need to focus on reducing utilization," Hunter explains, "and providing the best possible care at the lowest reasonable cost."

A fixture at Intermountain since the mid-1980s, Hunter says he's thrilled to finally see growing interest in alternative payment models. "I've been waiting for this for 20-plus years. I think the challenge now is the implementation, because you can't just flip a switch and go from fee-for-service to value-based. You're changing the way providers treat patients, and that takes time."

> "One thing we learned from COVID is that telehealth is a value-based product. It's an efficient way to deliver healthcare."

Hunter's advice to practices that are ready for the transition? First, he says, "you have to be willing to adapt as new evidence comes out. The way you treated this patient a year ago may not be the way you should be treating them now." Practice leaders should prioritize continuing education and training, and provide their clinicians with all the resources they need to follow the evidence wherever it goes. "It's not easy," Hunter notes. "To do it effectively, it has to be part of your culture."

His other bit of advice, Hunter says, is to “measure, measure, measure.” At Intermountain, they use ROMS for this purpose, but other organizations might deploy other tools. “It doesn’t matter what you use, but you need to have something that can tell you whether or not what you’re doing is making a difference.”

> “It doesn’t matter what you use, but you need to have something that can tell you whether or not what you’re doing is making a difference.”

Healthcare costs per person in the United States in 2019 were

$11,100

That’s more than twice the average cost ($5,496) in other wealthy countries like Switzerland, Canada & the U.K.[12]

Country	Spending
United Kingdom	
Japan	
Australia	
France	
Canada	
Belgium	
Average	$5,496
Netherlands	
Sweden	
Germany	
Switzerland	
United States	$11,072

U.S. per capita healthcare spending is almost twice the average of other wealthy countries.[12]

12 PETER G. PETERSON FOUNDATION

Push for population health.

MIKE FOX, PT, SCS
Chief Clinical Director,
MOTION PT Group

Mike Fox doesn't hesitate when asked what the Quality Payment Program has meant for his practice. "I think people can see the writing on the wall. Measuring performance and demonstrating the value of our service relative to other providers is critical," he says.

With clinics in four states, MOTION is focused on quality and controlling care costs and has tools in place for measuring outcomes. The practice isn't participating in MIPS at the moment, but it is interested in signing value-based contracts with physician groups and other organizations. "One of our goals as a company," Fox says, "is to be at the forefront of population health. How can we help minimize readmissions? How can we help a large health system manage its patient community?"

> "Patient engagement is a two-way street. It's both sides—patient and provider—working together for better outcomes."

The answer will involve a combination of strategies, from efficient and effective fee-for-service work in the clinic to the use of technologies like fitness apps that can track a patient's progress with their home exercise program. And it will involve getting the message to PCPs and referral sources about the importance of sending patients to physical therapy early. "That's where we can really show our value and really make a difference in patients' lives," Fox says.

83% of healthcare executives say population health is critically important.[13]

99% say their organization will participate in risk-based population health management.[13]

13 NUMEROF & ASSOCIATES

Make quality business decisions.

JANIE TAYLOR, PT, DPT, OCS

Chief Executive Officer,
Physical Therapy Central,
Davis, Oklahoma

A MIPS participant since 2019, Physical Therapy Central also contracts with several large health systems through the Comprehensive Care for Joint Replacement (CJR) program. The practice includes 45 clinics across Oklahoma and is the largest outpatient therapy organization in the state.

When it comes to the Quality Payment Program, Taylor notes, she's occasionally asked why the practice voluntarily opted in. Her answer: "This was a quality decision, but it was really a business decision as well." Cuts to Medicare's fee schedules factored into that thinking, as did the bonuses they could earn through the program. "We're very mindful of the payment incentives tied to MIPS," she says.

Her opinion is that fee-for-service payment models unintentionally result in physical therapy operating in a practice silo. "When we go to value-based payment, it drives us to work with other providers and it's much more interdisciplinary. I'm trying to lower costs and improve outcomes. How can I do that with my patient if I'm not communicating with their physician?"

> "It's no longer about volume, it's about accountability. You have to be able to accept accountability for your patients and their outcomes."

For Physical Therapy Central, Taylor says that communication includes an annual "scorecard" the practice sends to its referring providers. The report features data pulled from patient engagement surveys, and it shows each clinic's performance in several key areas, including number of visits to discharge and average cost-per-episode.

For their therapists, Taylor adds, streamlining workflows has been important to success. Clinicians use tablets to gather data, for example, and they rely on a patient-engagement platform to improve communication with patients when they're not in the clinic. "Now our patients can just use an app to see their home exercise program or to watch videos that show them what they need to do," she says.

Can technology solve all the potential hurdles a practice might face in a value-based world? Certainly not, Taylor says, "but having the right tools can be a big help."

The Comprehensive Care for Joint Replacement (CJR) Model

Physical therapists can take part in bundled care programs like the CJR by contracting with participant hospitals, which are financially accountable for the quality and cost of healthcare services provided during qualifying episodes of care. The CJR model was created to test the efficacy of bundled payments for care associated with hip and knee replacements. The model encourages care coordination across disciplines, including physical therapy.

77%

of CJR hospitals earned reconciliation payments (totaling $128.9 million)—rewards for providing care at a cost below a set target price.

89%

of CJR hospitals implemented same day post-surgery ambulation and physical therapy.

$17.4M

CJR's estimated net savings to Medicare over two years.[14]

14 CENTERS FOR MEDICARE AND MEDICAID SERVICES

Show value with data.

MARCO CIAIZZA, MHA, PT, MTC

Director of Rehab Services,
Carolinas Rehabilitation,
Atrium Health

Carolinas Rehabilitation has always been a forward-thinking organization when it comes to demonstrating value. Historically, they've done so through external benchmarking and analyzing their performance compared to that of other practices, but they also like to benchmark internally, Ciaizza explains. "We look at that data quarterly, and we use it to create a kind of continuous-improvement environment."

While Carolinas Rehabilitation is not currently participating in Medicare's alternative payment models, the practice has embraced value-based reimbursement in the contracts it has with private payers. "For us, value-based care means providing quality care over a period of time, and at a lower cost compared to our competitors," Ciaizza explains. "And one important part of that is backing it up with data. We're able to demonstrate with our outcomes data and our patient satisfaction scores that we're not only helping people get better, but our patients are happy with the care they're receiving."

Any practice "can assume their care is good," Ciaizza notes, "maybe because they're following evidence-based practice guidelines and they're committed to continuing education, but unless you're measuring that care, there's no way to really know."

"You have to be progressive, always forward-thinking. If you're standing still, then you're moving backward."

58%

of private payers were participating in bundled payment models in 2020.[15]

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Exceed expectations.

TERRY GEBHART, PT, DPT

Owner,
Colorado in Motion,
Larimer County, Colorado

For Gebhart and the team at Colorado in Motion, an orthopedic and neurologic practice with seven offices, value-based care begins with the patient. “A big part of the treatment plan for all of our patients is asking them what their expectations are, what they hope to get out of physical therapy,” he explains. They use that conversation to tailor treatment programs customized to fit each patient’s needs.

“That leads to more satisfied customers, but it also helps our practice in a program like MIPS through increased reimbursement for better performance,” Gebhart says.

Colorado is a direct access state, and that plays a part in their value strategy as well. “Our approach has always been to educate the consumer, one at a time, with, ‘Hey, if you hurt your back or your knee, you can come see us directly.’ We’re really trying to shift the consumer mindset to see physical therapy as their first point of care.”

> “I think we’re going to see more therapy clinics working directly with employers and with consumers to help lower healthcare costs.”

When patients knock on their door, Gebhart notes, “they’re not going to get unnecessary drugs. And we don’t own an imaging facility, so we’re not going to be biased to order an MRI.”

If there’s an overarching trend in healthcare at the moment, it’s that companies and individuals are “fed up with paying higher premiums and getting less,” Gebhart says. His practice views this as an opportunity to make inroads with self-insured employers who might see physical therapy as a way to drive improvements to their bottom line.

As of 2020, twenty U.S. states allow unrestricted or direct patient access to physical therapy.[17]

"I think we're seeing more and more companies becoming smarter about healthcare," he says. "They're tired of going the traditional route, with primary care and orthopedic surgeons" and procedures that may or may not prove effective. "They know that they can't keep this up. The costs are out of control."

> "Our approach has always been to educate the consumer, one at a time."

Maximize MIPS

Payment bonuses earned through the Merit-based Incentive Payment System hinge on a practice's scores in two performance categories—Quality Measures and Improvement Activities. These scores are weighted and combined to arrive at a total MIPS score.[16]

Quality measures

(85% of final score)

Best practices are to use a Qualified Clinical Data Registry (QCDR) to submit Patient Reported Outcome.

Improvement activities

(15% of final score)

Qualifying activities include collection and follow-up on patient experience and satisfaction data, implementation of processes for developing individual care plans, and others.

16 AMERICAN PHYSICAL THERAPY ASSOCIATION
17 CMS QUALITY PAYMENT PROGRAM

Lead by example.

LARRY BENZ, PT, DPT, OCS, MBA, MAPP

Chief Executive Officer and President, Confluent Health

Known by many in the outpatient therapy community, Confluent Health is a "house of brands," as Benz describes it, and a true authority on high-quality, low-cost care in the industry. The company partners with independent physical therapy practices, providing them support—and economies of scale—as their PT owners continue to run their day-to-day businesses.

"PTs know what's best for their local practices," Benz notes, but many lack the resources they need to compete in an industry undergoing swift and significant change. One way Confluent can help, he says, is by working with practice owners to develop "pathway models" of care.

> "Outpatient PT is a low-cost, high-value-add business, and during a time of great change and economic headwinds, that's the right place to be."

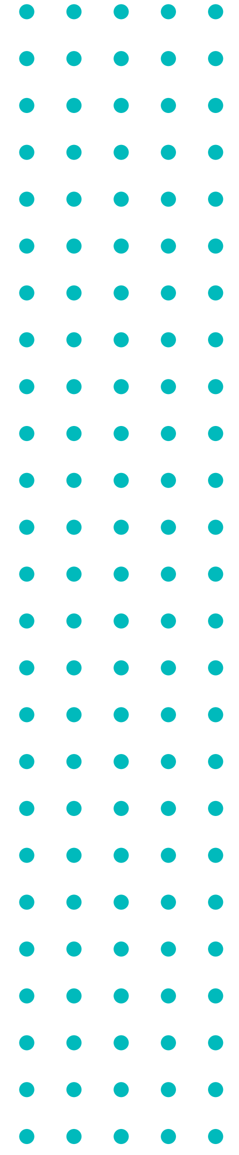
"The research shows that as a patient, where you start in the healthcare system is where you end," Benz explains. When a patient with a musculoskeletal condition starts their care path with a relatively low-cost treatment like physical therapy, that usually leads to long-term cost savings.[18] "The old traditional approach is, you have an initial meeting with either your primary care provider, a nurse practitioner, or a PA, and they refer you to a physician, a neurosurgeon, and/or an orthopedic surgeon. Then, if you're fortunate enough to get involved in PT, that happens much later downstream."

The cost of this approach? Statistically between $2100 and $2300. The cost of seeing a physical therapist first? Typically no more than $1000, an over 50% savings.

In Confluent Health's own case, he notes, the company has embraced the PT first pathway model for its nearly 4,000 employees. Truly putting their money where their mouth is, Confluent has been putting a heavy focus on PT first for a few years now. "If an employee of ours is experiencing an MSK issue, they will have zero copays for their first five PT visits. Compare that to if they were to see any other provider or visit urgent care or an emergency room, they would be paying a lot of money out of pocket. We start this pathway model, not with an MSK eval by a PT, but with an MSK assessment that provides instant results that go beyond MSK pain. This allows us to really understand the right treatment for the person."

$1,543

is the average cost savings for patients with neck or back pain who see a physical therapist via direct access rather than through a physician's referral.[19]



The assessment tool used at Confluent, known as the Orebro MSK Pain Questionnaire, parses the patient into low risk, moderate risk, or high risk. The tool also helps determine treatment and protocol, whether it's primarily focused education and self-management, a biopsychosocial approach, pain neuroscience education, conservative PT, or, if you're at a high risk and you need additional diagnostics, a physician. With this tool, the patient gets affirmed that they're going to the right provider. In Confluent's experience, nearly 90% of the time, the right provider is a PT.

> "I do believe that our best days are ahead of us as a profession."

For practices looking to break into the self-insured market, Benz' best advice is all about data. "Quality programs like MIPS are helping our industry demonstrate the value we offer. Use the competencies you develop by participating in these quality programs to demonstrate the value you offer. When you do, you're going to be noticed, and success will almost certainly follow."

"I do believe that our best days are ahead of us as a profession," Benz says. As practices continue to show value in the healthcare ecosystem, "more patients are going to demand us—they're going to demand to see us first."

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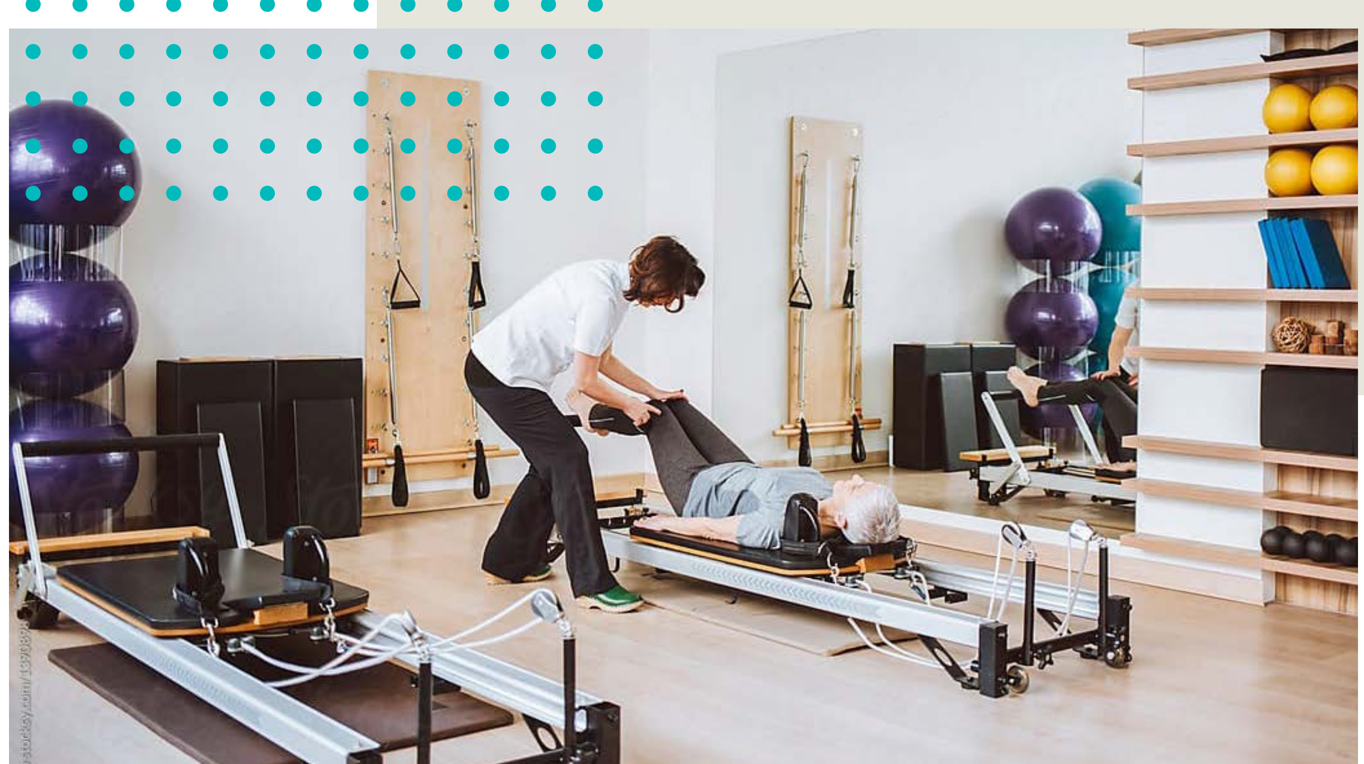

A clear way forward.

The good news for all in this exciting and challenging time is there is a clear way forward—a path that physical therapy practices of all shapes and sizes can follow to survive and thrive in a value-based world. That road is long, and it's certainly not easy, but for most in the industry, it starts in the same place.

It begins with an understanding of what's at stake—what you stand to gain by participating now, and what you might lose if you don't. It also requires a knowledge of current healthcare trends and how those trends will shape healthcare in the future.

As a profession, outpatient rehab therapists are perfectly positioned to deliver the high-quality, low-cost care that is recognized and rewarded in value-based programs. In order to be successful, however, their practices must be ready to take that first step.

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