A New Tool for Negotiating Contracts

Podiatrists need to document our patients' walking levels.

BY JON A. HULTMAN, DPM, MBA

Determination of physician reimbursement should include recognition of the entire value that practitioners deliver both to patients and to society in general. While third-party payers reimburse DPMs for the hands-on covered services delivered to patients when treating specific conditions, they have placed little to no value on their "intangible" contributions which reduce the total healthcare costs to society in general. So many DPMs complain that they can no longer negotiate contracts with third-party payers, and yet, they could use these unrecognized contributions as incentives for third-party payers when negotiating contracts.

How might we establish this pathway? Our specialty can, and should, develop studies that demonstrate the "overall" value DPMs deliver to society in general—which is the reduction of the total costs of healthcare as well as an increase in the quality of patients' lives. Studies that we can generate that quantify the magnitude of this cost savings would go a long way towards rectifying the challenge of negotiating contracts with third parties.

A ballpark estimate of the annual costs generated by chronic disease is approximately $1.72 trillion. Included in these costs are the following: (1) obesity: $260 billion, (2) Type II diabetes: $237 billion, (3) cardiac disease: $219 billion, (4) strokes: $57 billion, (5) osteoporosis: $25.3 billion, (6) depression: $210 billion, and (7) a decline in functional capacity with aging: $139.3 billion (The number used for this is the estimated cost of the 1.29 million people living in nursing homes. This figure, however, does not include the 810 thousand people in assisted living who generate additional costs). The total costs of these seven conditions account for *two thirds* of the $1.72 trillion associated with treating all chronic diseases.

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One common denominator of these seven conditions is that they can all be improved significantly by walking. The decline in functional capacity associated with aging is almost entirely eliminated when patients walk more—with a target of at least 30 minutes a day. DPMs are in a unique position to make it possible for the numerous patients who want to walk more but cannot because of a foot, ankle, or leg problem to achieve this goal. Every payer should take notice that by encouraging walking and making it possible for many who thought they would never have this option, DPMs are in a position to reduce the total cost of chronic disease. This extends the value of visits to podiatry practices well beyond that of the "covered" services they deliver. The problem is that, to date, we have no studies showing that a visit to a DPM leads to an increase in the amount a patient walks; however, DPMs in various practice settings could collect this data which could then be used to negotiate contracts with third-party payers to show greater value when seeking employment by medical groups or HMOs.

One way to develop this much-needed data would be to document the amount that a patient walks

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as part of each initial H&P. This would then be used as a baseline for measuring progress towards the goal of "walking more." If the patient is relatively inactive or is already reducing the amount s/he walks as s/he ages, a responsibility of his/her physician is to provide education regarding the health benefits of walking. Similar to the role of physicians educating patients regarding the health benefits associated with the cessation of smoking, DPMs should be educating their patients regarding the benefits of walking.

Providing this education will take time, but the additional time invested raises the quality of the patient's visit as well as its value to the healthcare system in general. Given all the various attempts made by third party payers to "pay for quality," this is one preventative measure they could support to actually increase quality while at the same time reducing the total costs of healthcare.

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Although many elderly patients who make appointments with DPMs are not doing so with the intent of increasing the amount they walk, they would be accepting of advice that might help to keep them out of nursing homes. Information provided regarding the interconnection between activity and functional capacity should serve as the primary motivation for these patients to want to "get up and walk" more.

We are in a particularly unique position to articulate this value to third-party payers as well as to patients. If treating a podiatric condition enables a patient to walk more, or return to their sport activity, the value of that care goes well beyond simply treating the condition. Studies providing supportive statistics would be of immeasurable support in presenting this case. As a specialty, DPMs need to "own" walking before any other specialty claims it. **PM**

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