Several things we do now hamper us from achieving a place in a new managed care, consumer-driven system. The following recommendations are based on my having performed Medicare and private Blue Cross occupational therapy review for the past 17 years.

Sharpening Our Professional Image and Business Acumen

Developing clarity of thought and written expression. We must develop skills in putting information on paper that allow someone who is not an occupational therapist to understand why we are treating a patient. This is important because our services will continue to be reviewed by the system. It also helps us in the long run because it enables us to review our clinical decision making on whether a patient needs or continues to need skilled occupational therapy treatment intervention or something else. As we move into a prospective payment system, we must be able to make appropriate decisions, or we will lose first money and then our patients' satisfaction. Triage must be performed at appropriate points.

Defining our level of services. Does a patient need services that require the skills, knowledge, and judgment of an occupational therapist? What clinical reasoning is expressed in the documentation? What criteria are used in the decision-making process? We must not confuse skilled occupational therapy with positive change. Skilled treatment is not always required to bring about positive change, and we should recognize that. But by clearly differentiating care from treatment we do not mean to abandon care.

A therapist might be instrumental in designing different care systems, might work as an administrator in or consultant to those systems, but would not, in fact, try to pass the care off to the insurance industry as skilled occupational therapy treatment.

We must learn to define stimulation as distinguished from rehabilitation. Patients often have problems with social isolation and lack of initiative. They live in nondemanding environments. We must be able to determine which patients need continuing stimulation (for which the services of an occupational therapist are not required) and which need skilled occupational therapy treatment. The demand for occupational therapy does not legitimize the service. Our error has been in thinking that because people will pay, they need our services. We must make it clear that we offer treatment for specific deficits that have developed in conjunction with medical problems that have resulted in the patient's inability to carry out daily life tasks and that rehabilitation will occur only if a skilled occupational therapist intervenes. We have to stop treating patients to enhance revenue. As a consultant to hospitals, I read medical records by occupational therapists that suggest they are providing only stimulation. We hurt ourselves by doing this.

Becoming good business managers. In addition to focusing on meeting patients' needs, we must now consider payers' needs and expectations as well. We must prove our cost-effectiveness. Payers want good data, data that explain what therapists do. We have to meet with benefits managers to discuss expanding occupational therapy benefits to the patient. We have to learn about our payers, about capitation, fee for service, and at-risk contracts, about the impact of occupational therapy on premiums. And after we have a contract, we have to work with benefits managers to resolve any patients' complaints.

At a recent presentation before a department director's forum of occupational therapists, I found that not one of the 35 attendees, probably all or most of them department heads, had seen his or her last Medicare cost report. How can a department head not know the cost that one of his or her major payers has settled for the previous year? How do they know if administration is telling the truth about the number of treatments they need to produce to justify another part-time aide or perhaps another staff occupational therapist if they have not seen their cost report? We

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have to manage our departments as
businesses.

When we at Blue Cross call therapy
departments regarding either billing
errors or problems with records
submissions, therapists often tell us
that it is not their problem and direct
us to the billing office or the medical
records office. In fact, Blue Cross
considers the therapy department re-
sponsible for providing information
about its services. The bottom line is
that unless the therapy department
can clarify a problem, the bill does
not get paid.

We must address all issues that
affect efficiency and cost-effectiveness
for the payer. We must bill correctly,
understand billing systems, and pro-
duce documentation on request as to
the appropriateness and the effective-
ness of our services.

Defining what we do. The insur-
ance industry views occupational
therapists as doing all things for all
people. When occupational therapists
speak to someone in the industry,
usually somebody other than a thera-
pist, they must clearly define the fac-
tors or pathology that they address as
the result of illness or injury. Again,
skilled treatment needs to be distin-
guished from care.

Controversial issues in the pro-
fession, such as the use of modalities,
should be discussed in a way that an
insurer can understand, for example,
therapists should talk about the use of
a modality for reducing pain to in-
crease the functional use of the in-
volved hand.

Recently, a program review by
the government brought to Blue
Cross of California's attention that
Medicare is reviewing the medici-
-cal record for evidence of the unique
skills, knowledge, and judgment of
the occupational therapist. If such
unique skills are not documented, the
services are considered routine ones
that could be offered by nursing staff
or other personnel.

We must stop giving away what
is ours. Retraining in work perfor-
ance, self-care, play, and leisure ac-
tivities; retraining in cognitive skills;
work evaluation and work hardening;
hand rehabilitation—these are the es-
sential services of occupational the-
rapy. We can share our skills if we
must, but we should define them as
occupational therapy.

Moreover, we must find new
ways to look at and discuss daily life
tasks, pointing out the importance of
functional independence and how it
restores the patient's dignity. We have
to stop apologizing for what we do.
Robotics has shown the complexity of
putting on a sweater or tying a shoe-
lace. Such tasks cannot be as easy as
we have made them appear, and we
must make it clear that not everyone
can do them as successfully as we.

Improving efficiency. We must
focus on ease of administration of our
services, stripping away redundan-
dy, and duplication. I am always sur-
prised when hospital administrators
are willing to pay me a healthy con-
sultant's fee to tell them that they are
duplicating paperwork. I assume that
everyone else in the facility has not-
ticed this.

Finally, we must use our collec-
tive and individual influence to make
certain that the delivery system is ef-
effective, responsive, and patient or-
iented, not product oriented. We can
do that by supporting and marketing
our value with data that show out-
comes, by monitoring patient's satis-
faction, and by rewarding staff for
being responsive to patients' needs.
We have to be flexible enough to
change and adjust our occupational
therapy departments and programs to
meet patients' needs. And we must
continue to provide consumer
education.

Organizing for Survival

What AOTA can do. In organiz-
ing for entry into the managed care
system, the American Occupational
Therapy Association (AOTA) can play
a major role by offering continuing
education courses that help us deal
with managing the system. These
might include topics on interfacing
with insurers, understanding the cost
of doing business, and on negotiati-
ing—an important skill for individual
therapists.

AOTA can also represent us col-
lectively in national forums by mak-
ing presentations to group disability
managers, such as risk insurers, and
to people in organizations like the In-
stitute for Rehabilitation and Disabil-
ity Management. They can develop
and distribute educational and mar-
keting packets about occupational
therapy services. They can mount a
national campaign for therapists to
perform insurance review for therapy
services.

This last strategy is especially
important. Almost 20 years ago, the
first therapist entered Blue Cross of
California, and now there are 18. We
have a larger therapy department than
any other insurance company in the
nation. We try to set the example for
others to follow; yet very few insur-
ance companies have been under
pressure from occupational therapists
to offer occupational therapists' peer
review. If the companies do not feel
pressure, they are not going to offer
peer review.

The role of state associations.
Our state association can also play an
important role in these managed care
systems. They can offer services in all
the same areas as AOTA, but tailor
them to each state's idiosyncratic pol-
icies and practices. State associations
need to develop leadership within
the state. They should present ex-
hibits at state conferences, develop
and distribute marketing packets, sup-
port all AOTA continuing education
activities, and provide continuing ed-
ucation for state-specific programs.

Most important, each state asso-
ciation must decide whether to foster
a preferred provider organization of
occupational therapists. Physical ther-
apists have one in California and one
in Illinois, and both are doing well
for organizations not much more than
a year old. We will have to decide
whether we want to enter as a state
association into a preferred provider
arrangement or whether each one of us should develop an individual contract. It would be more constructive if each state association carefully thought the decision through, following the example of the Wisconsin Occupational Therapy Association (WOTA).

The Wisconsin example. In 1985, health maintenance organizations (HMOs) became a dynamic force in Wisconsin health care. The state government offered its employees an option to switch to an HMO for their personal coverage. In Madison alone, a 40% rapid increase occurred in the number of people insured by an HMO. When Wisconsin’s occupational therapists became aware that occupational therapy was not a benefit of the health maintenance system, they challenged the state association to do something.

WOTA first hired a consultant in regulatory and government health, who drew up a plan of action. That plan was subsequently revised and modified (and is probably undergoing further modification today). A telephone survey of the health maintenance organizations was conducted to determine patterns of coverage for all rehabilitation and therapy services. WOTA formed a committee with subgroups in the Milwaukee and the Madison areas to deal with this issue, and the committees were given introductory courses in health maintenance organizations. Committee members then investigated each health maintenance organization in the state, drawing a profile of number of enrollees, board members, and the profit margins. When the profiles were examined by the entire committee, it became clear that all health maintenance organizations had one element in common: Occupational therapy was perceived as a service needed by the elderly and chronically disabled. However, because these populations were costly enrollees, occupational therapy was viewed as antithetical to the health maintenance organization’s promotion of itself as a cost-effective system.

The committee members then searched for materials on the breadth and depth of occupational therapy services that could be presented to the health maintenance organizations. Finding none targeted for insurers, they developed a packet that markets occupational therapy in their state to health maintenance organizations. They learned that they had to compete with other professions for a share of the shrinking health dollar and that the health maintenance organizations—still a young industry—are a very volatile system. They merge, they shut down, they change in many ways; however, two features seem to prevail: a strong commitment to a capitation or managed care system and a great effort to make sure that no one in the system is unhappy. Therefore, they have a tight communication network. If an occupational therapist makes inroads into one system, that gives occupational therapists entree into another.

Individual efforts. Individual occupational therapists also can organize for managed care systems. We can undertake professional development that will give us the business, political, and marketing skills to negotiate and participate in a managed care system. We can continue to establish ourselves as primary access providers with a focus on health prevention and health promotion. With like groups we can develop a powerful negotiating stance, offering innovative strategies for quality treatment at lower prices to meet the competition.

The image we project to this system must reflect our growth as managers. If it does not, outsiders will continue to be brought in to manage us. We must be able to negotiate and have a clear understanding of the negotiation process. Without these skills, we face problems, for there may be misunderstandings about what we do and why we do it, the cost/benefit ratio of our services and quality-of-life issues.

We must support recruitment for our schools, and we must make their well-being and other staffing issues our top priorities. If the schools do not produce new occupational therapists for this system, we are not going to be part of it.

We must continue to voice support and lobby for a better understanding of rehabilitation issues; equipment issues, which are very poorly understood by the insurance industry; return-to-work issues, which are only now beginning to be understood by the industry as significant; children’s issues, which the industry tends to ignore; and aging issues, some of which (particularly care) it also tends to ignore.

A new development as seen by Blue Cross of California is that consumers want immediate attention from their health care providers. They want personal services. These demands will increase, not decrease. The successful department will be one that provides quality service as well as quality care. The pressure for cost-efficiency will not let up, but the demand for health care is insatiable, and the population will continue to age. Our knowledge and skills to meet the needs of an aging population gives us an edge.

Methods to measure quality will continue to be developed. However, quality will still be defined by patients in terms of satisfaction with the service, the treatment, and the cost. That is the challenge we must be able to meet. Change will remain the one constant in health care. Managing that change will allow us to continue to provide high-quality treatment at an affordable price.

Editor’s Note. Part 1 of this article appeared in the September 1988 issue of the journal.