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Managed Care and Social Work: Practice Implications in an Era of Change

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The purpose of this article is to explore the role of the clinical social worker in a time of unprecedented change. The events of the last decade have transformed health care delivery as well as professional performance expectations. To facilitate understanding, the environmental considerations that surround these changes are traced and discussed. A direct linkage is made to clinical social work practice and suggestions for the future survival of the profession is discussed. These suggestions include: (1) a greater focus on behaviorally-based outcomes that result in cost-beneficial service provision; (2) increased marketing of social work services to health care providers; (3) promotion of social work services as an integral part of the success of the interdisciplinary team, (4) incorporate a macro perspective into micro or clinical practice approaches; and, (5) explore non-traditional roles for social work professionals to expand their current practice arena.

Managed Care: The Beginning

In the later part of the 1980s it became clear that the cost of health care delivery had reached a national crisis. Although, there may have been multiple reasons for this major contributions included: (1) the results of better health care with many people living longer; (2) increased technological advances and the costs associated with it; (3) the use of heroic measures to maintain life beyond its traditional boundaries; (4) the lack of health care approaches formulated and implemented on a national level that

promote prevention, wellness and health education; (5) a desire to have "state-of-the-art" medical care complicated by the resistance to pay more for medical services through insurance programs or taxes; (6) a fragmentation of the insurance and/or health service reimbursement system; (7) fears by professionals of increasing malpractice claims and the cost related to negligent practice; and, (8) the cost of providing inpatient health care (Edinburg & Cottler, 1995; Epstein & Aldredge, 2000; Shortell & Kaluzny, 1994).

As difficult as these factors were to identify, change and control, plans to address them became paramount (Hernandez, Fottler, & Joiner, 1994; Shortell & Kaluzny, 1994; Skelton & Janosi, 1992). Additionally, what exemplified this concern was the population trend prediction that as the baby boomers aged health care spending would reach an astonishing peak of 16 trillion dollars or 30% of the gross domestic product (GDP) in 2030 (Burner, Waldo & McKuskie, 1992).

In the late 1970s into the middle 1980s it was estimated that the number of employed individuals without health insurance in the United States increased from 28.7 million to 35.1 million (U.S. Bureau of Census, 1984). This left an estimated 37 million Americans who might have experienced health problems with an inability to afford needed health care (Roland, Lyons, Salganicoff & Long, 1994). In addition, in 1988, the nations top 12 health insurers reported financial losses of 830 million dollars (Edinburg & Cottler, 1995). In review, the 1980's represent a time where environmentally the nation was in the midst of economic stagnation/recession (Mizrahi, 1995). At the time, health care reform strategies suggested to alleviate this unprecedented burden were considered successful only where cost containment and/or reduction ultimately resulted.

During the early 1990s politicians vigorously campaigned to be viewed as responsive to the American people's concern for health care reform. Election strategies included possible solutions designed to address health care reform. In fact, President Clinton in his 1992 election made health care reform his highest domestic priority (Mizrahi, 1995). Numerous proposals were considered for health care reform from a single payer system approach to limited policies for universal health care coverage.

Subsequent to the 1992 election President Clinton proceeded to address his campaign goal by establishing a task force to complete a plan for health care reform. The proposed model was different than the single payer approach that he had originally supported early in his campaign. Consequently, Clinton's intended health care reform proposal was not successful within his administration or the American public. Therefore, a modified plan was adapted that resulted in changes to health care that were designed to improve access and quality of care incrementally, rather than a more comprehensive plan to reorganize the health care system (Gilbert & Terrell, 1997). This later approach is exemplary of a managed health care competition where purchasing alliances were formed which would have the power to certify health plans and negotiate premiums for certain benefit packages (The Presidents Health Security Plan, 1993). In 1995, Edinburg and Cottler predicted that the future of most health care delivery (70% of all coverage) would be provided by managed care plans. Based on this method, managed care plans would require the following: pre-authorization for service by qualified consumers; pre-certification for a given amount of care with concurrent review of the treatment and services rendered; continued determination of the need for hospitalization through a process of utilization review; and, pre-discharge planning to ensure proper after care services are identified and made available (Hiratsuka, 1990). Examples of legislation that have improved access and quality of care include the Family and Medical Leave Act and the Health Insurance Portability and Accountability Act.

Despite these efforts, the number of American people without health insurance increased to an estimated 41.7 million people in 1996, a rise of 1.1 million from the previous year (Benfield, 1997). In the 2000 presidential campaign Al Gore continued to support health care reform efforts with a patient bill of rights. Specifically, he advocated for the inclusion of prescription drugs by Medicare, access and improved health care for rural areas and individuals with Alzheimer's, HIV/AIDS, breast cancer, and other chronic illnesses (Gore 2000). Furthermore, the Republican presidential candidate George W. Bush promoted the importance of patient choice in managed care and pushed for less governmental intervention in medical care (George W. Bush

for President, 2000). Groups such as the National Association of Social Workers (NASW) remain firm in their commitment for overall health care reform based on universal access to care (Social Work Speaks, 2000, Trattner, 1999). Clearly more broad-spectrum advocacy is a requisite to improved reform strategies. Ultimately, the 1990s have proved that the implementation of managed health care is here to stay. Incremental change strategies that highlight less liberal reforms can ameliorate managed care, and professional social workers must continue to encourage and represent innovative methods that advocate for change in the current system.

Understanding Managed Care

The complexity and diversity required to define the current concept of managed care cannot be underestimated. This very elastic term has been utilized to define a variety of health care service and delivery options that quickly change (Wernet, 1999). However, it is probably safe to say that a managed care plan is an integrated delivery system that manages health care services by approving services and following patients through the system rather than by simply financing or delivering without supervising the services (Epstein & Aldredge, 2000).

According to Dziegielewski (1996) in this high-pressure health care environment the following issues need to be considered. To begin with, the public demands quality for service and "state of the art care" (Shortell & Kaluzny, 1994). Politicians, researchers and consumers have advocated strongly for repair and reform (Comer, Mueller & Blanenau, 2000; McKinney, 1995; Mizrahi, 1995); however, America's insured are approaching health care reforms with hesitancy and trepidation in fear of ending up with "less for more." Although Americans want quality service, they do not want the increased costs especially from a health care system they believe is plagued by waste. Not surprisingly, Americans envision gaining access to state of the art technology that clearly links medical knowledge and technology to the provision of quality service. Health care delivery systems are expected to hire and retain the most qualified personnel, as well as, purchase

the most sophisticated equipment. The pressure from the public to secure these services is intense allowing intense competition for "covered" or "reimbursable" client resources.

Second, in this era of interdisciplinary service provision, it has become difficult to tell what specific skills each professional contributes to overall patient care (Dziegielewski, 1998; 1997). It is expected that knowledgeable and competent professionals working together as a team provide health care services. It is easy to see how the number of social workers has grown along with physician assistants, nurse practitioners, multi-skilled health workers, laboratory technicians, occupational therapists, physical therapists, etc. Unfortunately, this may cause the social worker to be viewed as just one of many "adjunct" professionals involved in health care delivery. Often the roles that social workers perform overlap with these other disciplines (Davidson, 1990, Holliman, 1998). For example, today nurses are being taught specifically how to run therapeutic support groups in health care settings (Arnold, 1996). Traditionally, however, most group leadership was considered the realm of the social work professional (Toseland & Rivas, 1984). Based on the sheer numbers of allied health care professionals and the overlapping of skills, tasks, and roles, one thing remains certain, all trained professionals will be forced to continue to compete and strive to locate a solid niche in this new and emerging managed care market (Dziegielewski, 1996; 1997).

Third, managed care has created a competition for survival among health care providers. In the past, health care organizations/providers facilitated expansion of their services by increasing marketability through the specific services they provided; however, managed care may prove this strategy futile if insurance reimbursement for each service is not ensured (Shortell & Kaluzny, 1994). To be considered viable each health care delivery organization must take the necessary steps to ensure its own survival, and be able to record progress in attaining both agency and societal missions (Shortell & Kaluzny, 1994). Competition to accomplish this task has created an arena for providing quality and competitive services for all. According to Hernandez, Fottler and Joiner (1994) this includes: (1) the provision of low cost traditional health services; (2) the provision of superior service

through technology or client service; (3) specialization into certain areas of practice (i.e., centers of excellence); (4) the diversification outside of the traditional bounds of health care delivery (i.e., wellness centers); and (5) creating new and ingenious ways to rework traditional service to be more reflective of current needs and trends. For example, under the influence of managed care many hospitals have opened health and wellness centers that reflect a full continuum of health care services (Dziegielewski, 1998).

As with all incremental societal change, numerous changes will occur at the most basic levels. For example, changes in terminology such as the term "patient" are being re-evaluated. Originally, the adoption of the term "patient" in the medical community caused many social workers to stop using the word "client" when referring to the individuals they served (Dziegielewski, 1998). Social workers, like other professionals, learned quickly that they needed to adopt the dominant label used in the medical environment. This use and acceptance of the term "patient" is obvious when reading articles in the social work health care literature (Alperin, 1994; Brown, 1994; Coursey, Farrell & Zahniser, 1991; Cowles & Lefcowitz, 1992). This term, however, has become somewhat outdated and remains in conflict with the concept of wholeness that is integral to marketing services in this competitive environment. Terms now being utilized include: "client" (a term familiar to social work), "consumers" (to represent those receiving a service) and "covered persons" (reflecting those who have some type of medical insurance coverage). Those in favor of the euphemism "covered persons" argue this term is indicative of the universal care perspective assuring that an individual has the security of medical coverage (Dziegielewski, 1996). Regardless, of what the individual who receives service is called, it makes sense for social workers to adapt this term and follow suit especially if they expect to compete as part of the system.

Finally, quality of care balanced with maintaining cost control is often hailed as the two most powerful driving forces in managed care (Shortell & Kaluzny, 1994; Ginter, Swayne & Duncan, 1998). Unfortunately, under most of the capitation models being proposed revenue schemes that increase quality of care cannot increase the cost of health care services (Flood, Shortell & Scott, 1994; Hernandez, Fottler & Joiner, 1994; Ross, 1993). This delicate

balancing act of quality of care and cost containment has resulted in cost containment as clearly tipping the scale (Ginter, Swayne & Duncan, 1998).

In terms of social work practice and managed health care, many social workers are feeling increased pressure to contain costs. This requires that social workers constantly and actively advocate for maintaining the provision of quality services. It is at this point that micro practice cannot be separated from macro practice in terms of identifying and supporting state and federal legislation that provide basic standards of quality care. Service provision needs to be endorsed that allows for universal accessibility, affordability, and service comprehensiveness (NASW, 1994). Social workers need to do more than simply ensure the provision of quality services. They need to recognize the macro aspects of practice that affect all Americans, and monitor policies and programs that will affect not only the clients they serve directly. For social work practitioners, it may help to think about working in the managed care system as similar to working with a client that has a different value system. Similar to practice, the social worker needs to start where the client is and treat the client as part of a system. It is critical to develop strategies that will improve overall care and access for those being served by the system. Viewing managed care from this perspective may take extra creativity and patience; however, it can enhance the awareness of the micro and macro level elements inherent in social work practice (Kirst-Ashman & Hull, 1997).

Social Work Practice and Managed Care

Traditionally, social workers have always worked closely with individuals, groups and families in regard to understanding situational and environmental concepts within their practice structure (Hepworth, Larsen, & Rooney, 1997). In order for social work practice and managed care to co-exist a marriage of sorts needs to occur. Unification is essential for professional social workers to remain a viable link in the health care environment. The current state of social work practice mirrors the turbulence found in the general health care environment (Dziegielewski, 1998). Social workers, similar to other health care professionals, are

being forced to deal with the numerous consequences of cost containment policies such as declining hospital admissions, reduced lengths of stay, reduced physician to patient contact, and numerous other restrictions and methods of cost containment. Struggling to work within these restrictions has become necessary based on the inception of prospective payment systems, managed care plans and other changes in the provision and funding of health care (Johnson & Berger, 1990; Ross, 1993; Simon, Showers, Blumenfield, Holden & Wu, 1995; Wernet, 1999). Not receiving services has been linked to increased rates of high-risk patient relapse where clients are more likely to be readmitted after discharge; and, although high-risk screening is typically in place, the pressure for quick dispositions remains problematic (Bywaters, 1991; Resnick & Dziegielewski, 1996; Holliman, 1998).

According to Ross (1993), employees who are at the greatest risk of losing their place in the delivery of health care services are those who: (1) do not create direct hospital revenues; (2) are not self-supporting parts of the health care delivery team; (3) hold jobs where productivity is not easily measured or questionable; (4) provide service where the long-term benefit for cost of service is not measured; and (5) engage in a service where the professionals role is often misunderstood, challenged and under-rated in the system. Therefore, emphasis needs to be placed on how social work professionals are an essential part of the health care delivery team providing both needed direct clinical services as well as fiscal support for the agency setting (Spitzer & Kuykendall, 1994).

Today, rapid change and flexibility is required as administrators are forced to try to cut costs by eliminating "expendable services" such as mental and preventive health, discharge planning and other supportive services. Social workers often assist clients in these areas, and because of this linkage often feel the brunt of initial dollar-line savings attempts. The sheer numbers of allied health care professionals who are moderately paid provide an excellent hunting ground for administrators pressured to cut costs (Dziegielewski, 1998). These administrators may see the role of the social worker as adjunct to the delivery of care, and may decide to cut back or replace them with poorly trained nonprofessionals simply to cut costs. Since substitute professionals often do not have either the depth or breadth of training when compared

to social work professionals, substandard care can result. For example, a trained paraprofessional in hospital discharge planning may simply facilitate a placement order, neglecting issues that respect the individual's culture, sense of personal wellbeing, ability to self-care or level of family and environmental support. Specifically, if a client is discharged home to a family that does not want to care for her, she is at higher risk for abuse and neglect. Social workers recognize that culture and environmental factors are paramount to efficient and effective practice, and the de-emphasis or denial of this consideration can result in the delivery of inefficient, ineffective, and potentially harmful sub-standard care (Dziegielewski, 1998). Although the employment of paraprofessionals can appear to be initially cost-effective, it may not result in quality care. When personal/social and environmental issues are ignored, clients are at risk of unequal, inequitable, and inadequate care or recovery.

Future Perspectives

The intention of this article is to help exemplify how managed care relates to social work practice. Most professionals agree that the last decade has truly transformed health care delivery. Work expectations for professional social workers; however, are not entirely new. The concepts of managed care clearly have its roots in the social programs that date back to the Great Society programs (Wernet, 1999). These incremental and "piecemeal" changes will indeed require constant flexibility and readjustment—if this marriage of sorts is ever to survive.

Dziegielewski (1996) summarized several steps for survival when presented with the numerous changes bequeathed with managed care. First, social workers are encouraged to address behaviorally based outcomes and clearly link these outcomes to cost effectiveness (Dziegielewski, 1997). Many times social workers are torn when they feel that their heritage of the "person in environment" stance is being discounted by a limited system that measures success by concrete outcomes alone. This is further complicated by the fact that many clients find little personal comfort in behaviorally based concrete outcomes determined for service provisions. Unfortunately, the result of pre-determined

impersonal provisions are a lack of listening, lack of rapport between service provider and client that may in turn be interpreted as disinterest. This may translate into dissatisfaction with all services and care. From a legal and financial standpoint, a case could be made to reintroduce the elements of listening, rapport building and availability as a means of diverting potential lawsuits.

Social workers who take the time with the client and family to answer questions and to deal with discomfort and loss help facilitate a viable discharge plan. A good rapport is essential in an environment where tolerance and flexibility is essential. In haste, it is easy to place blame on the client for blocking the completion of concrete goals required to show service effectiveness or to transfer feelings of powerless when stressed and limited within the managed care framework. The social worker must be vigilant in exploring the adequacy of the services provided and implemented. Although it is understandable to want to mourn the loss of "patient care" as it was before, the introduction of managed care and other cost containment strategies make direct social work practice critical.

It can be expected that the future rising of health care costs in conjunction with the need for cost containment will continue to be a practice reality (Alperin, 1994). Therefore, it is essential to link the provision of each service the social worker provides with the cost saving it invokes. For example, traditional services such as provision of hospital discharge planning should emphasize dollars saved in the overall prospective payment reimbursement system. The provision of counseling to assist a family to understand and manage illness limitations and reimbursement procedures could save a hospital countless dollars in potential lawsuits and legal proceedings. Dollar amounts should be calculated for justification of overall savings related to service provisions. For example saving costs through prevention can involve a home health care social worker that assists with psychosocial issues supporting the family to maintain their loved one at home. Social workers can assist clients and family members to acquire needed counseling, to defuse stressed situations, provide needed social support, as well as access to services to maintain community placement. The cost cutting feature of living in the community is phenomenal when compared to inpatient institutionalized care.

The provision of psychosocial services by a qualified professional can serve to create and maintain more options of this nature.

In general, a new mindset needs to be established with psychosocial service provision with each service being related to income generated and/or cost savings. In addition, services without direct income being generated can be valued based on the preventive costs they can save the organization.

Second, for social workers to compete successfully in the managed care market they need to present themselves as an essential ingredient to the success of the health care interdisciplinary team. Social workers need to negotiate for themselves and be equipped with the necessary skills of self-marketing (Gibelman, 1999). This requires professional self-marketing that emphasizes the myriad of services that social workers can provide. In managed care, it has been stated that social workers are viable and effective providers when compared to psychiatrists, psychologists and nurse practitioners (Consumer Reports, 1995). Now social workers need to "toot" their own horns about what they provide (Dziegielewski, 1996; 1998). To start this process the social worker needs to identify each service performed (e.g., discharge planning, referrals, direct clinical work) and to make the client aware that the service is being coordinated or completed by a social work professional. Laypersons may mistake social workers for nurses, teachers, or counselors. Many times social workers become so task oriented that they forget this simple but essential point. It is important for professional social workers to state that they are social workers.

When working within an interdisciplinary team, social workers need to ensure that all members are aware of their contributions toward the overall success of the intervention. This may be done by documenting the services provided and ensuring that other team members are aware of the psychosocial information about clients and families that can help them to complete their jobs assessing risk management and decreasing client dissatisfaction, complaints and lawsuits.

A third aspect for the survival of social work in managed care rests in the macro aspects of the larger environment. Essentially, social workers need to support and lobby for political and social recognition, acknowledging the value of social work services based on the principles of quality care and cost-effectiveness. In

this turbulent environment a clear representation of how social workers can contribute to improve outcomes must be made visible in order to ensure the continuation of current and future positions. Lobbyists are well aware of social works goals and missions and need to be strategically placed as these managed care decisions are being made. Managed care planners need to be made aware of and encouraged to include, the services that social workers can provide.

Lastly, social workers need to continue to grow beyond the traditional social work roles. Social workers need to continue to assume positions such as managers, owners of companies, employees, administrators, supervisors, clinical directors and case managers (Edinburg & Cottler, 1995). In these positions social workers will have increased power to influence specific agency policy and procedure.

In closing, the consistently changing cultural and political environment of modern health care delivery— is not necessarily the downfall of professional social work. Although crisis can be intimidating, it is also a catalyst to change (Roberts & Dziegielewski, 1995). In times of crisis, changes that could never have been made in the previous system may now become possible. Social workers need to acknowledge and accept this challenge swiftly and eagerly. New frontiers that can increase marketability need to be explored and pursued. Today, managed care has created a practice revolution in which social workers must face many challenges, opportunities, and subsequent risks. In spite of these changes, social work's perspective of "treating the total person" and "the person-environment stance" fits well with the current demand for a holistic medical practice with a focus on wellness and prevention. Now the task of health care social workers is not whether they can survive in managed care, it is how to best utilize their own talents while remaining ethical, active and assertive while providing outcomes driven services.

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