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Social workers' perspectives on managed care : an exploratory study

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on Managed Care: An
Exploratory Study

ABSTRACT

The purpose of this study is to explore social workers' perceptions of the impact

of managed care on their work with clients. The thesis question is "What are clinical

social workers perceptions of the impact of managed care on practice?" Included in this

question are social workers' perceptions of the impact of managed care on their

therapeutic relationships with clients, their effectiveness and autonomy, helpful support

systems when interacting with managed care organizations, ethical issues including

confidentiality and issues of social justice, assessment, implementation of the treatment

plan - including the time frame of treatment and choice of treatment modality, and

assignment of the mental health care provider.

There were 12 participants in this qualitative study. Five of the participants

worked in agency settings, and seven of the participants worked in private practice

settings.

All of the participants expressed the feeling that managed care negatively impacts

their work with clients, specifically the therapeutic relationship. Participants discussed

several factors that influenced the therapeutic relationship, but control over the treatment

process emerged as the overarching factor. Participants related grappling with the issue

of how one maintains control when a third party is involved in the treatment. The answer

for many participants was to be proactive in finding constructive ways to positively

impact treatment decisions through interactions with clients, other workers, and managed

care representatives.

SOCIAL WORKERS' PERSPECTIVES ON MANAGED CARE:

AN EXPLORATORY STUDY

A project based on an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

I spent my first internship at a residential treatment program. Over the course of my year at the agency, I witnessed changes in the types of decisions made by managed care organizations regarding the authorization of treatment. I saw the experiences of clinical social workers change during this time of alteration. I was curious about these social workers' perceptions of managed care, how they handled the changes, and how the management aspect of insurance companies affected social workers' professional work with their clients. I was interested in learning more about any differences that might exist in social workers' perceptions and experiences based on treatment setting, years in the field, and age of the social worker. This curiosity, and the subsequent completion of a literature review, provided the basis for the formulation of the study purpose and research question.

The purpose of this study is to explore social workers' perceptions of the impact of managed care on their work with clients. The thesis question is "What are clinical social workers perceptions of the impact of managed care on practice?" Included in this question are social workers' perceptions of the impact of managed care on their therapeutic relationships with clients, their effectiveness and autonomy, helpful support systems when interacting with managed care organizations, ethical issues including confidentiality and issues of social justice, assessment, implementation of the treatment plan - including the time frame of treatment and choice of treatment modality, and assignment of the mental health care provider.

I began the exploration of the thesis question by first gaining a better understanding of the role of managed care in mental health care. Managed care organizations are organized systems of care that implement ways to control or manage costs of care or "fiscal intermediaries" (Gibelman & Mason, 2002). The implementation of managed care in mental health care is achieved through such methods as controlling the length of time of treatment, placing restrictions on the types of treatment a client can receive based on cost considerations, and limiting the type(s) of practitioner(s) the client can see (Segal, 1999).

A review of previous studies and articles revealed findings indicating managed care as a pervasive mode of service delivery in the United States mental health care system (Kane, 2004). The literature over the past two decades since the inception of managed care is replete with discussion of its impact on practice. Noted areas of impact of managed care on practice include: ethical issues - such as compromise of client confidentiality accompanying managed care and disparity between care and access based on social class (Gilberman & Mason, 2002; Jean-Francois, 2008; Segal, 1999) and limitations imposed on contact with clients and number of authorized sessions and treatment goals (Gilberman & Mason, 2002). The potential disparity in access to, and quality of care, between those whose treatment must be approved by managed care organizations and those who are free from such restrictions, raises ethical issues related to social justice (Aviram, 2002).

As the social work profession has historically played an important role as providers of care to the poor, the impact of managed care on service delivery with populations in need is likely to be keenly felt by social workers practicing in a range of mental health settings (Jean-Francois, 2008). I became interested in learning how social workers in different settings handle this dilemma. Do they feel they are still adequately able to serve the poor? Do social workers

who have the opportunity to work with a range of clients elect to work with those who do not have managed care involvement and therefore represent a different social class? Are social workers finding ways to serve the poor outside of the restrictions imposed by managed care organizations? In other words, are social workers finding ways to take, or maintain, control over central aspects of their practice in the age of managed mental health care?

There has been much research on the ways managed care removes control from social workers and threatens the therapeutic relationship (Acker & Lawrence, 2009; Strom-Gottfried, 1998). However, there remains a gap in the empirical research on social workers' perceptions of a sense of efficacy and control in their work with clients with managed care coverage (Acker & Lawrence, 2009). This study intends to add to the knowledge in this area by further exploring and updating the experiences and perceptions of social workers whose practice involves following guidelines for treatment as provided by managed care organizations.

This thesis is organized in five chapters. The literature review follows this introduction with relevant literature on social workers' perspectives on managed care. The review also examines gaps in the research in this area. The methodology chapter describes the study design and implementation, including methods of recruitment, data collection, and analysis. The findings chapter presents the sample characteristics and the themes that emerged in an analysis of the data. The discussion chapter utilizes relational theory as a lens through which to view and contrast study findings with the extant research on this topic. This final chapter draws implications for practice; policy and future research and notes study strengths and limitations.

It is my hope that the findings from this study will provide a window into social workers' first hand experiences and perceptions of managed care in 2011, and the impact of managed care on the therapeutic relationship, in particular. It is hoped that findings will contribute to a better

understanding of how social workers may adapt their practice to maintain a sense of control in treatment decisions when working with managed care. This could, for example, include making decisions in the best interest of their clients and the therapeutic relationship.

Finally, it is hoped that the findings from this study will provide helpful information for social workers that work in managed care settings. Social workers may disagree with some of the voices in this study, but they will have an opportunity to view managed care in a different light. For those who agree with some of the perspectives found in this study, they may feel united and less isolated. Clinicians may be more motivated to work with other social workers to change policy in managed care on an issue they disagree with. Clinicians may learn about helpful resources that support clients in obtaining appropriate and affordable treatment.

CHAPTER II

Literature Review

The purpose of this study is to explore clinical social workers' perceptions and experiences with managed care in a number of areas including: the impact of managed care on the therapeutic relationship, treatment effectiveness, professional autonomy, assessment and implementation of treatment plans; support systems for workers in their interaction with managed care; and ethical issues in practice, including in the areas of confidentiality and social justice.

This chapter will describe the work that has been done in this field. It will first introduce the reader to the history of managed care in the United States and the implications that its establishment as a method of cost containment in mental health care has held for the profession. It will then review the extant literature on social workers' perceptions of and experiences with managed care in the delivery of services. Gaps in the existing research as related to the study purpose will be noted throughout the review. The review ends with a summary description of relational theory, including its basic tenets, relevance to the study, and use as a theoretical lens through which to view study findings.

The History of Managed Care

Managed care had its origins in the development of Health Maintenance Organizations (HMOs) first introduced in 1971 under the Nixon administration as a way to "build a true 'health system' and not a 'sickness' system alone... to maintain health and not merely to restore it" (Nixon, 1971, quoted in Deleon, Vandenbos & Bulatao, 1991 as cited in Segal, 1999, p. 47).

The concept underlying the development of HMOs was fully realized in the passage by Congress of the HMO Act of 1973. HMOs served mainly those who had access to such plans through their employment; those who lacked such access through employment were left uncovered by the provisions of this act (Segal, 1999; Cohen, 2003).

In the late 1980s it became evident that the HMO system was not adequately meeting the health care needs of a large portion of the population, and "the cost of health care delivery had reached a national crisis" (Dziegielewski & Holliman, 2001, p. 125). By the early 1990s it had become clear that the nation could benefit from a new health care plan. Health care reform had become a major political issue, serving as a forefront issue in Clinton's 1992 presidential campaign (Dziegielewski & Holliman, 2001, p. 127).

As a centerpiece of Clinton's 1992 campaign, health care reform included overhauling the system that had been put into place under previous administrations. Following his election, however, the passage of real health care reform became difficult and controversial. In response to pressures exerted by the public and his own administration, Clinton's comprehensive approach to health care reform, articulated during his campaign, was modified as one that would "improve access and quality of care incrementally, rather than a more comprehensive plan to reorganize the health care system" (Dziegielewski & Holliman, 2001, p. 127).

The shift in national and political debates on health care policy at this time included issues related to the delivery of mental health care. A greater emphasis was placed on comprehensive services and the integration of private and public sectors. A major outcome of this policy shift was the implementation of the managed care model in public sector programs, including Medicaid and Medicare (Iglehart, 1996). According to Segal (1999) "Competition for new health and mental health patients in the early 1990's, led to the advent of 'managed care

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organizations' seeking new markets, to become rapidly involved with the provision of services to the poor covered by Medicaid" (p. 47). The function of managed care organizations was to "gate keep" insurance company costs by providing authorization for the most cost efficient treatment for patients covered under the plan, and paying only a percentage of the actual costs (Dziegielewski & Holliman, 2001; Segal, 1999).

Social workers were active throughout the 1990s in advocating for health care reform that met the needs of clients, particularly the poor (Miller, 1994). According to Rose (1997) who wrote about the profession's role in advocating for reform during this period, "Health care reform has been a major issue for social workers. NASW [National Association of Social Workers] became an active player in the reform debates during the early years of the Clinton administration…" (p. 57).

The Impact of Managed Care on Social Workers and Social Work Practice

Managed care has had a direct impact on social workers and their clients in a number of areas. This section will address these issues in succession, beginning with a discussion of the ethical issues involved in practice under a managed care system.

Ethical issues. The NASW Code of Ethics "specifically requires that [social workers] strive to attain social justice in all areas of practice" (NASW, 2008). In a study on social workers perceptions of ethical dilemmas, Bransford (2005) found that social workers encounter ethical dilemmas in the context of experiencing conflict between professional values and the expectations for social work practice in managed care settings. For example, social workers may experience pressure from managed care organizations to discharge clients earlier than they think appropriate (Bransford, 2005).

Egan (2005) surveyed 117 social workers that worked in home health agencies in

managed care settings. Her findings indicate that social workers felt that "…patients were discharged from care with unmet psychosocial needs" (p. 1). Social workers in Egan's study reported that patients with continuing needs were no longer receiving formal and "deemed appropriate" care; instead, they were receiving care from informal caregivers and community services (Egan, 2005).

Community Health Centers have historically been settings in which those who have lost coverage or are uninsured can receive treatment (Shi, Politzer, Regan, Lewis-Edema and Falik, 2001). Findings from a study by Shi et al (2001) suggest that Community Health Centers serving Medicaid recipients have experienced reduced ability to serve the uninsured population. The authors posit a few possible reasons for this. One possible reason is that communities with a larger number of Medicaid recipients as residents are likely to have "a reduced level of charity care in that community" (p. 64); the consequent reduction in charity funds results in less ability to cover the cost of treatment for the uninsured. Another is that Community Health Centers have limited patient care capacity, and Medicaid clients squeeze out available slots for the uninsured. Yet another possibility, according to these authors, is that Community Health Centers may need to use all available federal monies to offset the uncovered costs for Medicaid recipients, thus reducing the funds available to cover the cost of treatment for the uninsured (Shi et al, 2001).

In addition to meeting the needs of their clients, clinicians are increasingly expected to meet the demands of managed care cost containment objectives. An area of practice in which the impact of these conditions is particularly likely to be felt is behavioral health care (Adams, 2007). Adams (2007) reviews the literature on stress, burnout, and ethical and moral conflict experienced by social workers placed in this position. Her review found little in the way of evaluation and measurement of the effect of moral and ethical conflicts on clinicians, including

clinicians' reactions to the competing demands and expectations of practice in a managed care environment.

Adams (2007) looked at the "relationship of the amount of managed care participation to clinician burnout, stressors, career decision-making and diagnosis practices…" with a sample of 118 social workers (p. 4972). Adams used qualitative interviews to better understand how managed care influences social worker stress and burnout. Study findings pointed to a potential ethical dilemma: Many of the private practice clinicians in Adams' (2007) study did not see clients with managed care involvement and many clinicians in public settings admitted trying to avoid contact with managed care clients. According to Adams (2007), a possible explanation for clinicians' resistance to involvement with managed care clients is the stress that such involvement creates for the worker. Adams (2007) found that "increased managed care participation is related to increased burnout and increased job unrest" for the social worker (p. 4972). Based on her findings, Adams raises the following question, having ethical implications: Are clients with economic needs – those more likely to have managed care health coverage (Munson, 1996) – being punished by social workers who perceive the stress associated with managed care as a disincentive to their involvement in the treatment of this population? How does the conflict between clinician and managed care affect both client and clinician?

Cohen, Marecek and Gillham (2006) describe the conflict for workers between professional values and the managed care system as "a cultural clash" (p. 251). Their study included interviews with therapists about their experiences working with managed care. Study findings indicate that the majority of the participants felt that "Working for managed care organizations demanded several practices that violated the therapist's standard of care and professional ethics" (Cohen et al., 2006, p. 251).

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Additional research has found that clinicians do not believe managed care has the client's best interest in mind - a core value of the social work profession. In Kane's (2004) study of clinicians' beliefs about managed care, findings suggest that clinicians believe that managed care organizations control the type of treatment a client receives. In Kane's study, 69% of the social workers agreed with the statement that managed care companies "are more interested in profits than clients" (p. 399).

In another study supporting this finding, Keefe, Hall and Corvo (2002) studied 582 social workers in private practice and found that approximately 39% of study participants' caseloads involved clients with managed care involvement. The practitioners reported that they were not reimbursed for care provided to one third of these clients. Tragically, 42% of the group for whom payment was not made later entered therapy with more acute symptoms (Keefe et al., 2002).

Findings from several studies have confirmed that low-income and vulnerable populations are at greatest risk of experiencing restrictions in services as a result of managed care involvement (Gilberman & Mason, 2002; Hudson, 2001; Strom-Gottfried, 1998). Especially disturbing are study findings indicating that clients from low economic backgrounds are more likely to be affected by the restrictions placed on mental health care by managed care organizations than those with higher incomes – the latter being less likely to have coverage through managed care organizations (Segal, 1999). As discussed previously, the managed care system was implemented to contain soaring health care costs (Cohen, 2003; Segal, 1999) including costs associated with "the provision of services to the poor covered by Medicaid" (Segal, 1999. p. 47).

Another potential ethical dilemma facing clinicians involves "compromise to client confidentiality when the managed care organization demands access to client records and/or

detailed information about the client's presenting problem, course of treatment, and documented outcomes as a condition of authorizing care or service" (Gilberman & Mason, 2002, p. 201). Strom-Gottfried (1998) expands on the issue, discussing the "threats to worker-client privacy under aggressive care-management systems" (p. 299). She explains that workers are expected to verify to managed care organizations that the client needs treatment; in doing so, workers are placed in the position of jeopardizing patients' privacy (Strom-Gottfried, 1998).

Implementation of treatment plan. The implementation of the treatment plan can frequently create conflict for social workers in their interactions with managed care organizations. Findings from a study by Ginsberg (2009) "showed that over half of the respondents reported a conflict in providing diagnoses for reimbursement, maintaining confidentiality, terminating treatment, and complying with adverse decisions; and the majority reported that it is a common part of social work practice" (p. 689).

Research has suggested that managed care involvement has influenced the treatment planning and assessment. In a study by Gilberman and Mason (2002) looking at clinicians' perceptions about the impact that managed care has on treatment, mental health professionals were given two case vignettes; one included involvement with a managed care organization, the other did not. In their discussion of study findings, the authors report that, "Managed care has a significant influence on case assessment and treatment planning across the mental health disciplines. Although respondents did not favor adjusting treatment approaches to meet managed care expectations, they nevertheless did so" (p. 201). Study participants thought that managed care involvement resulted in "fewer client contacts, limited treatment goals, or limited number of sessions" (Gilberman & Mason, 2002, p. 205).

Others have found that "the practice of altering diagnoses is widespread" among those practicing in a managed care environment (Kane, Hamlin & Hawkins 2003, p. 112). It must be noted that deliberately misdiagnosing a patient would, in most circumstances, be considered unethical. How does this conflict affect the clinician? Kane et al. (2003) found that clinicians who felt they needed to misdiagnose a client in order for the agency to be reimbursed were more likely to have negative attitudes towards managed care than those who did not feel pressured to misdiagnose. This study also found more negative attitudes towards managed care among clinicians who thought that the way treatment was administered had changed significantly for the worse since the implementation of managed care in the mid-1990s (Kane et al., 2003).

Other studies have looked at clinicians' perceptions regarding the value and understanding exhibited by managed care organizations toward their treatment framework and ideology. Several studies have looked at psychoanalytically oriented practice and managed care (Alperin, 1994; Cohen, Marecek & Gillham, 2006; Urdang, 1999). Cohen et al. (2006) found that social workers felt that managed care misinformed clients regarding the nature of psychotherapy, and that this misinformation negatively affected the therapy and therapeutic relationship between client and clinician. One possible reason for clinicians' perceptions of misrepresentation of psychoanalytically oriented therapy by managed care organizations may be clinicians' perception of negative views on the part of managed care organizations towards this type of treatment. Alperin (1994) found that psychoanalytically oriented practitioners believed their work to be less valued by managed care organizations than other forms of therapies.

> Psychoanalytically oriented practitioners feel that most managed care companies are biased against psychoanalytic psychotherapy. Because of managed care's disregard for the treatment relationship, narrow focus only on the behavioral manifestations of symptoms and on character pathology, preference for short-term approaches, and

utilization review procedures, its basic principles are incompatible with those of psychoanalytic psychotherapy (p. 137).

The findings of research on treatment with managed care involvement consistently point to therapists' perceptions that managed care is excessively involved in treatment decisions and that this has an impact on the therapeutic relationship. The effect of managed care involvement at this level on the therapist's sense of autonomy and control in the work with a client constitutes an important question for further study.

Sense of autonomy. For the purposes of this study, the researcher is interested in learning about similarities and differences in present day social work practitioners' understanding and perceptions of their role vis-à-vis managed care organizations, compared with those found in studies carried out between 1990 and 2000, the years directly before and following the advent of managed care. For example, Strom-Gottfried (1998) described the threat that managed care organizations presented to the provider's sense of autonomy, where autonomy, "reflects the principle that the caregiver is free to determine the client's needs and how best to meet them" (p. 299). At the time of her writing, according to the author, "The emergence of managed care [has] diverted some of that power to third-party reviewers" (p. 299).

Munson (1996) further explored the managed care emphasis on cost-saving as a diversion of power, or sense of autonomy, away from the therapist as well as the client. Munson asserted that [these trends are] "reflected in the emergence of managed care as an efficiency movement that has not been monitored" (p. 241). Munson went on to say that clients and clinicians lose control when cost containment and savings is achieved through government and private industry downsizing and reorganizing (p. 241).

While previous research points to possible reasons for social workers' feelings of loss

regarding a sense of autonomy, it stops short of describing this experience from the viewpoint of the worker. According to Acker and Lawrence (2009), previous literature described the stressors for social workers, but not how the social worker was affected and/or how they perceived these stressors. While a great deal of attention has been given to managed care over the years since its inception, there remains a gap in the literature regarding the impact of managed care organizations' influence in treatment decisions on social workers' sense of efficacy and autonomy in treating a client (Acker & Lawrence, 2009).

Therapeutic relationships. This research study is interested in exploring social workers' perspectives on the nature and extent of the effect of managed care organizations' influence in treatment decisions on practitioners' therapeutic relationships with clients. Previous studies looking at this issue have yielded findings indicating that social workers perceive the requirement that both the clinician and the client obtain prior authorization for treatment from managed care organizations as significantly detracting from the development of the therapeutic relationship (Munson, 1996; Strom-Gottfried, 1998). Munson (1996) writes that the regulations of managed care organizations affect the therapeutic relationship, essentially taking control away from both the client and the therapist.

Another aspect of managed care's influence on the therapeutic relationship is the restriction placed on clients' choice of therapist (Munson, 1996). In line with the overarching goal of decreasing services, managed care organizations usually authorize reimbursements for approved providers only. Many managed care organizations require that clients seek therapists through their managed care provider rather than pursuing a therapist on their own, frequently dictating to the client which therapist they can see and for how long (Iglehart, 1999). This requirement has the effect of discouraging "therapist shopping" - historically a way for clients to

exercise some control over the process of finding a therapist with whom they feel most comfortable. Since Munson (1996) and Iglehart (1999) wrote on these issues over a decade ago, it will be of interest to explore present day workers' perceptions regarding whether and in what ways these issues are still prevalent, and the impact these restrictions may have on the therapeutic relationship. Finally, given the disparity between low- and higher-income clients, in terms of their likelihood of having managed care involvement, the issue of ethics is raised once again in relation to inequality in access to client choice of therapist. Whether and in what ways this reality is perceived by the therapist as affecting the therapeutic relationship is also an area requiring further study.

Support systems for social workers. This researcher is interested in exploring social workers' perceptions of the nature and availability of possible sources of support that are helpful in their interaction with managed care organizations. Findings from previous research suggest that social workers benefit from competence in managed care (Acker, 2010; Acker & Lawrence, 2009; Berger & Ai, 2000; Daniels & Rowland, 2004; Kane, 2001, 2003, 2004; Kane, Houston-Vega, Tan, & Hawkins, 2002; Neuman & Ptak, 2003). Recommendations based on findings include the development of additional courses in schools of social work aimed at preparing students for work in managed care environments. Further recommendations include the provision of continued training for social work graduates in workplace settings regarding best practices in work with managed care (Daniels & Rowland, 2004; Kane, 2001, 2003, 2004; Kane, Houston-Vega).

Acker (2009) discusses findings from her study of social worker competence and experience of burnout in interactions with managed care. Using a sample of 591 social work clinicians, the author found that participants who felt more competent in working in a managed

care environment were less likely to experience burnout and role stress. Study participants' feelings of competence were also positively associated with lower levels of emotional exhaustion and somatic- flu-like symptoms (Acker, 2009). In another study on social workers' sense of competence in working with managed care organizations, Acker (2010) found that clinicians who feel competent and well-trained to work with managed care organizations report having access to more tools with which to negotiate on behalf of their clients.

Kane (2001) also studied social workers' feelings of competence to work with managed care. His findings detail social work students' perceptions of competence in specific areas, including documentation and lawsuits.

> Students learned documentation skills in the field component of social work education (68.7%) and not in the classroom (29.3%)… Finally, only 33.3% of students believed they had the necessary documentation knowledge and skills to protect themselves from a lawsuit; and fewer believed the classroom (15.2%) or the field component (18.2%) of social work education prepared them to avoid liability or a lawsuit. (p. 55).

Neuman and Ptak (2003) note the benefits for social workers of being informed about accreditation standards in managed care. According to these authors, social workers are more likely to experience success in obtaining approval and appealing denials for treatment if they are knowledgeable on the standards and rules of managed care. These authors discuss the importance of social workers having the ability to appeal denial of treatment and protect themselves and their clients from decisions made by managed care organizations that they believe are unethical or not clinically appropriate (Neuman & Ptak, 2003).

Sources of support in the workplace. Acker (2009) found that workplace social support and effective and satisfying communication between social workers and administrators are helpful in assisting workers to manage a stressful work environment.   In Acker's (2009) study of social workers' perspectives regarding what is helpful when working with managed care organizations,

participants who reported feeling more supported were less likely to report feeling emotionally

exhausted and more likely to report feelings of higher self-esteem, competence, and self

confidence in their work. In this study, social workers with larger caseloads felt less able to work

adequately with their clients (Acker, 2009).

Supervision has been noted to be an important component of support for clinicians

working in managed care environments (Munson, 1996). Munson (1996) points out that the

managed care environment de-emphasizes the role of supervision: "The role of supervision has

changed as the locus of control has shifted from practitioners to managed care companies" (p.

249). According to Munson, the decreasing role of face-to-face supervision is a direct reflection

of the emphases inherent in a managed care system.

> Managed care companies do not require supervision because their model of
> accountability is not based on [professional] supervisory oversight. Face-to-face
> individual and group supervision provided by a seasoned clinician has been replaced by
> telephone and written contacts with managed care case managers, many of whom have no
> clinical background. In this process, clinicians not only lose control of the treatment
> process, but also, in many instances, of reasonable access to case managers who make
> crucial decisions regarding the availability, outcome, and duration of care. (pp. 249-250)

Another potential support system and source of empowerment for social workers working

with managed care organizations is afforded workers through group support or peer supervision.

Bransford's (2005) research suggests that social workers use their authority to influence

managed care policies and practices more effectively in a group than when working

independently. Working in a group is a way for social workers to exercise control by identifying

and challenging the ethical issues present in managed care environments. Bransford (2005)

notes that there is a need for more research on "the ways that social workers are currently and

actually exercising and using their authority in organizations and groups" (p. 418).

In earlier research predating the advent of managed care, Maslach (1982) found that [their own] families provide an important source of support for social work clinicians. This study also found that social workers who did not have children were more likely to report higher levels of exhaustion than those who had children. More recent research conducted in managed care environments support this finding (Acker, 2009). Acker (2009) attributes this finding to the association of age and life experience – itself supportive – with likelihood of having children. She states, "…workers who are older with more life experience including having family and kids are at a lower risk to become burned out compared to those who have less life experience and do not have children" (p. 278).

Relational Theory

This study uses relational theory to inform the research question and as a lens through which to view study findings. Goldstein, Miehls and Ringel (2009) describe relational theory as a combination of theories that inform our understanding of relationship, including intersubjectivity, object relations, and attachment theories. The authors describe the importance of both therapist and client and explain the impact of each on the therapeutic relationship. "Relational treatment emphasizes openness and collaboration between client and therapist, mutual impact, the client's subjectivity, and the therapist's empathy, genuineness, and use of the self in therapeutic interaction" (Goldstein, Miehls & Ringel, 2009, p. 238). The authors go on to explain that the relationship is vital in the treatment and can "…be used to help clients and therapist bridge differences, examine similarities, overcome impasses, and manage enactments" (p. 238).

The tenets of relational theory, underscoring the importance of the relationship between client and the therapist in treatment, are used as a lens through which to view these study

findings. Using relational theory as a foundation for the study, the researcher examined how a "third party," or managed care, affects the relationship between the therapist and the client. Using the framework that holds that the relationship impacts the treatment, the question is also raised: how does managed care's influence on the relationship affect the treatment?

Summary

The foregoing review reveals significant previous research on the topic of social workers and managed care, also noted by Acker and Lawrence (2009). The topical areas addressed most extensively are stressors inherent in the managed care environment, and ethical issues arising in practice with managed care (Acker & Lawrence, 2009). The literature supports the notion that training in managed care, in school and workplace, increases workers' sense of competence in their interactions with managed care organizations (Neuman & Ptak, 2003). The research suggests that clinicians who feel more competent will be more likely to work effectively with managed care organizations, to have appropriate treatment approved, and to ensure that client needs are met. Clinicians who feel competent working with managed care organizations are also more likely to avoid a lawsuit or risk liability with clients and managed care organizations (Kane, 2001).

There is less literature on clinician perceptions of their relative influence on and/or ability to change managed care policies with which they disagree (Munson, 1996). This study asks clinicians how they believe they can make a difference in managed care settings. It is hoped that study findings will shed light on social workers' thoughts and feelings regarding how they may be empowered to express ideas regarding managed care in a manner that could bring about change. Findings may serve to provide others with new tools for improving services to clients and relieving stress for workers in managed care settings.

CHAPTER III

Methodology

Study Design and Sampling

The purpose of this study is to explore social workers' perceptions of the impact of managed care on their work with clients in mental health settings. The question this researcher seeks to answer is "What are the perceptions of clinical social workers regarding the impact of managed care on their work with clients?"

To answer this question, an exploratory qualitative research design was employed. The researcher conducted 12 in-person semi-structured interviews with social work clinicians who have regular interactions with managed care organizations. The inclusion criteria for study participation were: a master's degree in social work, and current practice in a mental health setting - including private or public agencies, and/ or independent (private) practice - with clients having managed care involvement.

This research strove to capture clinicians' individual stories and experiences of interacting with managed care organizations. A qualitative approach allowed for more in-depth and open-ended feedback from participants. The use of this approach, versus a more structured methodology such as employed in quantitative research, permitted participants greater freedom to share their individual stories. Interviews were recorded and transcribed verbatim by the researcher.

Since this study was exploratory in design, participants were recruited using a non-probability sampling approach. It is important to note that this sampling approach reduces the

representativeness of the sample and, therefore, the generalizability of the findings to the entire population of social workers working in managed mental health environments.

The researcher accrued the sample through a snowball approach. Given the constraints imposed by the brief time period available for recruitment, this approach was felt to be the most feasible for accruing a sample. Also, given the exploratory nature of the research, a small sample of 12 participants recruited through this approach was felt to be sufficient to gain new knowledge in this area.

The researcher contacted staff members individually at the agency at which she interned the previous year, and emailed her former supervisor and co-workers. The researcher also emailed Smith alumni in the Washington DC area with whom she had had previous contact, and social workers from her hometown. She contacted her former Smith School for Social Work Field Advisor who provided contact information for an individual with a Smith College affiliation who had access to on-line databases of social work organizations; this individual offered to post the recruitment flyer on-line. Participants responded by emailing the researcher at her Smith email account or calling her on the telephone number provided on the recruitment material (See Appendix B).

Participants could choose between a phone, and an in-person interview. Those who lived more than fifty miles away from the researcher were only given the option of a telephone interview. Participants who were interviewed in person were provided two copies of an informed consent form at the time of the interview. The participants were asked to read the informed consent page, ask any questions they may have had about informed consent, and complete the attached informed consent form (See Appendix C) before participating in the study. The participants signed one copy for the researcher, and were given the option to sign one copy

and take it home for their records. Participants were encouraged to keep their copy of the informed consent.

Participants who were interviewed by telephone were given the option of receiving the consent form via email or regular mail. If the consent forms were mailed, they were provided two copies of the form that they were to sign and return to the researcher in a self-addressed, stamped envelope. After the researcher had received the completed consent form, the potential participant was contacted through email or telephone (depending on the participant's preference) and a telephone interview was scheduled at a time that was convenient for the participant and researcher.

Data Collection

The interviews were conducted in person and by telephone, depending on where the person was geographically to Washington, DC and Baltimore, MD. The participants who met in person with the researcher chose the site they preferred to meet, that the researcher agreed upon. Many participants chose to meet in their private offices. The interviews that were conducted on the telephone were recorded placing the researcher's phone on "speaker phone" and recording the phone conversation with a separate recording device and/or a back up recording program on the researcher's computer. The interviews conducted in person were recorded with a recording device and/or back up recording program on the computer.

Interviews varied in length depending on the individual. The majority of interviews ranged from half an hour to an hour. The instrument included demographic questions regarding age, gender and ethnicity (See Appendix D). The remaining interview questions were open-ended and asked about participants' experiences and perceptions about the impact of managed care on social work practice and their work with clients in the following areas: the therapeutic

relationship; their ability to make independent decisions regarding treatment based on their own professional or theoretical training; the resources clinicians found helpful when interacting with managed care; and their thoughts about what social workers could do individually or with others to bring about change in areas of managed care practice that they felt were problematic.

Sample Characteristics

The sample included 12 clinical social workers with their master's degrees, practicing in the United States. Eight of these individuals were women and four were male. Seven participants worked in private practice and five worked in agency settings. Of the seven social workers that worked in private practice, two social workers reported that they were not on any managed care panels, and five said they were. The sample ranged in age from twenty-eight years old to eighty-five years old. The mean number of years people had been working in the field was 21, with a range of six months to 52 years. Participants reported having worked with managed care from a range of six months to when managed care was incepted. Eleven people identified as White or Caucasian and one person identified as African American.

Data Analysis

The researcher transcribed collected data. Data was collapsed into themed categories for analysis. The demographic data was measured for statistical/descriptive presentation. The qualitative data analysis began with a review of the transcriptions, and involved notation of repetitive themes and ideas. When the same theme was identified in a different interview, this assisted the process of theme development. During this process, four overall thematic categories were identified, including: practices of social workers in managed care; assessment and treatment; the therapeutic relationship; and social workers' perspectives and experiences with managed care. Within these categories, subcategories emerged, including: sharing client

information; billing; authorization for treatment; paperwork; resources; and four themes representing the range of participant perspectives and experiences with managed care: "The 'business' of managed care"; **"**managed care: a 'medical model'"; "Different rules for different insurance companies" and "What can we do?".

Quotes were selected from the data to clarify and illustrate each category and theme. Meaningful quotes in each interview were highlighted and placed in a chart with three columns: theme, quote, and participant characteristics. Each selected quote was then placed in another chart according to its category or theme. At one point there were 10 charts of categories and themes. These were collapsed into the four categories, as listed above.

CHAPTER IV

Findings

The purpose of this study was to explore social workers' perceptions of managed care. One of the researcher's interests was in learning about possible differences between current perceptions and experiences of managed care and those reported in the extant research dating from the 1990's or earlier, after the advent of managed mental health care.

Several themes emerged in the analysis related to how social workers adapt their practice to managed care, as well as their thoughts on managed care as a system of health care. Some differences were found between those in private practice and those who worked in agency settings, and between those who had been in the field for a longer time and those who had graduated more recently. Following a description of the sample characteristics, this chapter will present findings on participant experience of social work practice in managed care in the following areas: sharing client information; billing practices; authorization for treatment; paperwork; supportive resources for social workers working with managed care; the impact of managed care on assessment; decisions regarding treatment modality, the therapeutic relationship; and general perspectives and experiences with managed care. Direct quotes are used throughout to illustrate the views of the participants and the themes that emerged from qualitative analysis.

Sample characteristics

The sample included 12 masters-prepared social workers practicing in the United States. Eight of these individuals are women and four are male. Seven participants work in private

practice and five work in agencies. Participant age ranged from 28 to 85. Since some

participants gave their age in decade of life, rather than actual age, the median age was calculated

as in the 50's, with only three participants being under age 47. The length of time that

participants had been working in the field with a master's degree ranged from 6 months to 52

years, with a mean of 21 years in the field. The length of time participants reported working

with managed care ranged from 6 months to about sixteen years, when managed care was

incepted. Eleven participants identified as white or Caucasian and one participant identified as

African American.

Practices of social workers in managed care

      Sharing client information. Managed care procedures generally require clinicians to

share information – including treatment notes – about clients' diagnosis, history and progress

with a managed care representative. Participants related their experience of these requirements

as varying by insurer, treatment setting, and client diagnosis. All participants indicated that they

had had the experience of being asked to share information about a client and/or their work with

the client, at some point. The responses of participants in private practice differed from those

who practiced in agency settings. Of note, the responses of participants in private practice were

more similar as a group, than were the responses of those in agency settings.

      Participants in private practice. All participants in private practice indicated that they

were vague or spoke in "general terms" about the information they shared regarding their clients.

Most of these participants indicated that they did so in order to protect the client's confidentiality

– even if providing less specific information might jeopardize authorization for continued

treatment. One participant said, "I think confidentiality is much more important than getting

more sessions you know. Sometimes I air on caution. I talk in very general terms."

These participants indicated that they generalized regarding patient information because they could not be sure how the information would be used or where it was going, and did not want the information they shared with managed care to be used against the client. One participant expressed his thoughts about the sharing of client information in this way:

> [Don't] give more information than is necessary, but yet be responsible about the notes. You want to have notes, clear notes so you can tell what is going on, but not so detailed information that it could be used against the client.

These participants discussed what they felt to be the ethical issues involved in sharing client information. A male participant, who had been working in the field for over five decades, and had worked with managed care since its inception, said,

> I never liked the idea of reporting to the insurance companies. Very quickly I saw, very early on that it was really a question of ethics. That I was sharing information with the office people and having absolutely no idea what was happening to the information.

This quote echoes the concern expressed by many of the participants about their responsibility to protect clients' confidentiality, particularly when they were not sure who would have access to the shared information.

Participants in private practice, as well as agency-based settings, expressed feeling pulled in different directions by the requirements of managed care and adherence to social work ethics. They shared the feeling of being placed in a position of having to decide how to protect client confidentiality while also obtaining session approval and work cooperatively with managed care. This feeling was particularly apparent in participants' discussion of the sharing of treatment notes.

One participant who has chosen not to sign up with a managed care provider panel or sign a contract requiring adherence to managed care requirements said, "I don't send them my notes. I do a quickie summary." When asked if managed care companies requested that she

provide notes, she said, "yes," but "No, I'm not about to. Give me a court order." She went on to say, "I draw the line. If insurance companies are going to get in the way of the treatment, so much so that they're keeping the treatment that needs to happen from happening, then I'll stop. I'll stop the treatment."

It is important to note that the only other clinician interviewed who is not on any panels also spoke about refusing to provide case notes to managed care companies.

Participants in agency-based settings. Participants who worked in agency settings had varied approaches to sharing client information with managed care. One participant, in her 20's, who had worked in an agency setting for five years shared feeling pressured by the agency to uphold HIPPA (The Health Insurance Portability and Accountability Act of 1996), while feeling pressured by the managed care provider to violate patient confidentiality – in other words, "squeezed" between these two competing demands:

> I guess the forms I get every once in a while, Aetna I guess it is, that I have to fill out, like whether or not the person came and what we did in treatment, I don't know if I feel comfortable filling those out.

She said that there had recently been a person in her agency who had violated HIPPA and she described her agency as having become "HIPPA Nazis."

One participant who has been in the field eight years said he usually only shares client information during the authorization process. "Sometimes [woman's name] who works at Value Options, [a managed care organization] she'll say, 'I need a little more information on the background,' so I'll put in that information."

One participant who works with seriously mentally ill adult clients indicated that the skilled sharing of client information could be a powerful tool in developing relationships with managed care providers that would ultimately benefit the client.

Um, you mean in terms of protecting their confidentiality..? I don't worry so much about that at this point because what I have learned is actually the more detailed the story of my patient that I share with the case manager of the insurance company the more understanding they are and it actually helps me get more authorization… And I am actually talking about a person with a story, so that I can tell the UR person about a person with sexual [abuse] history for example. I'm not going to tell the details, but I am going to tell them there was server abuse or something like that. Um, so it actually, it helped get the authorization. The other thing it does, I don't know how relevant it is to your study, it helps me develop a relationship with the reviewer of the insurance company, because I have to work with them."

This was the only participant who indicated that she did not worry about confidentiality when obtaining authorization for clients. It is important to note that this clinician was working in a setting with chronically mentally ill adults. However, for all participants, whether they were in private practice or agency settings, sharing client information involved an assessment of the ethical issues involved. This was true for those who had been practicing for several decades, as well as for practitioners who were new to the field.

Billing. Although the researcher did not ask clinicians about billing, this issue was raised by most participants in their responses to the interview question: "Please tell me about your experience interacting with managed care organizations in the following areas: treatment planning, assessment, sharing client information, termination and required paperwork." The majority of private practitioners said they brought up the topic of managed care and laid the ground rules for the billing process in the first session. These rules varied among participants, but all indicated that they were clear about their rules and that they felt it was vital to address them in the first session. Three of the seven private practice participants said they discussed what the process would be when managed care stopped covering the therapy for the year, and set a price with the client for what they would pay when this occurred. Some participants felt that issues of coverage and billing closely affected – and in some cases, were a determining factor in

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– decisions made by client or therapist about their work together and how it would proceed. One participant said,

> That insurance will cover work done in the session, but work done out of the session they will have to pay for, which is not reimbursable. Case manageable work, or children work or with other providers, I'll bill you for that at a private rate. I will tell people up front… They have a choice to go to another person, which is fine because I don't want to be in a situation where either I resent not doing work that I think is important. Just before you came I was on the phone with a psychologist collaborating on a new referral. That 15-minute phone call is just important as 15 minutes in a session.

No other clinician talked about using this exact approach. One participant indicated that she charges the regular fee for clients with managed care who cancel or do not show up. She voiced the belief that the managed care company's policy of not charging for missed appointments is detrimental to the therapeutic relationship.

> Because I have a cancelation policy where I tell people I have to have 24 hours notice or they're responsible for the session. And no matter, I say they are responsible for paying for the whole session, whatever the managed care would pay me, they still hand me the $10 co-pay… Technically managed care says if the client cancels I am not suppose to charge the patient, but that actually gets in the way of the therapy because then people can cancel willy-nilly and not take responsibility for the work they are doing and then it doesn't get discussed the same as someone else. So there's a whole complexity to that, because technically I am not suppose to be charging them. I do charge people, [laughs] and I am probably not supposed to. But my feeling is that it is important for the therapy, unless it's like someone died or something. But it does muddy the waters if you can hear what I am saying… It's a lot cleaner when the person is just paying me, and I don't have to feel like I am doing something that is against the rules, which I am when I am charging them, but I do it anyway.

As illustrated in the example above, participants' strongly-held beliefs about and orientations to therapeutic treatment clearly influence them to implement certain rules. Participants also seem to have given a great deal of thought to the issues for which they had developed a set of rules to follow, in their interactions with managed care.

Many of the participants in private practice did their own billing. One participant who has been in practice and working with managed care companies for 14 years said,

Most of my colleagues do hire someone to their billing with the insurance company, but when I hear them talk, even though they do some of the work, there's a fair amount of preparation that has to be done in order for them [the billing person] to do their work. By the time I do all of that, my practice is so small, I feel like I should just do it myself. Even though I hate it, it's not deadly. It's not what I went to school for.

Although there was some variation in the degree to which these participants placed responsibility for billing issues on their clients, no participant in private practice indicated that they place the full responsibility on the client. Some placed no responsibility on the client and others had clients make various phone calls to the managed care provider. But all participants in private practice, or their billing specialist(s), were the ones to submit the bills for reimbursement from the managed care provider. Many of these participants required their patients to pay in advance of being reimbursed from their insurance company. A few social workers allowed clients to pay after having been reimbursed. For some clinicians it depended on the specific case.

In general, participants who worked in agencies did not raise the issue of billing in the research's interview; rather, the issue of "authorizations" for treatment, based on diagnosis and the client's history was raised more often. When this subset of the sample did mention billing it was to state that their agency had a billing specialist and that they were not personally involved in that aspect of the agency/clinician interaction with managed care.

Authorization for Treatment. Although the researcher did not ask participants specifically about authorization, it was often raised by participants in response to the same question that elicited discussion of billing and in the context of discussion regarding the impact of managed care on the therapeutic relationship. No matter the treatment setting, many participants who initiated discussion on this topic felt that the process of authorizing treatment (on the part of a managed care company) has a negative impact on practice, in general.

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Participants practicing in agency settings spent more time during the interview discussing the negative aspect of authorization than did those in private practice. However, among all participants, regardless of setting, there was a common theme that emerged in connection with authorizations that related to issues of "control." Clinicians talked about the "control" that accompanied insurance companies' power to authorize treatment. One participant discussed the control she felt insurance companies have:

> Well what I tell people is that I am not on any insurance company panels, but they can get out of network coverage. And I submit. But even when that is the case some insurance companies like to maintain control… even though I'm not part of their system. But they get in the way, to be honest with you.

Participants also discussed how they attempted to exert some control with the insurance companies concerning authorizations, as well as in the assessment process. The assessment was brought up in relation to authorizations because they are so closely connected; the clinicians' assessment is often provided to the managed care provider during the authorization process. The participant's effort to exert control in this process was evidenced in their choice of wording in documents and phone conversations with managed care. One participant described this experience.

> You know the assessment, it's like you can do one assessment for yourself and then another one for managed care, you can't always tell managed care everything. So you can still be honest and ethical and at the same time not divulge too much about certain patients and certain symptomotology, and certain problems.

Although a common theme, the experiences, approaches and perspectives of participants regarding the issue of control ranged widely. The longer the participant had been in the field the more developed was their approach often was and their perspectives around inserting their influence with managed care regarding authorization for treatment. One participant in her 50s, who had been in the field 30 years, said she incorporated into her practice the time frame

insurance companies usually authorize for patients in the partial hospitalization program in which she works. This participant said she learned that it was not helpful for clients to be encouraged by clinicians to blame the insurance company for the amount of time treatment would be covered, and realized instead that it was helpful to prepare clients for the next step of less intensive treatment. She said it was important to adopt a treatment modality that incorporated a timeline similar to the one used by insurance companies in order to help clients not feel rejected. She spoke of past experiences that affected her current approach of handling authorizations. "I used to say the insurance hasn't approved anymore so we have to step you down. I stopped doing that, and now I just say the time has come to step you down to fewer days."

Although this participant has learned to incorporate the time frame that managed care authorizes into her treatment, she wonders about this approach. She says,

> So anyway, so our program is set up to be a short term, get them stabilized and get them out kind of program, now the interesting question, and I don't have the answer to this, if the whole program is set up like this because of managed care because that's what insurance companies will approve… The same way that in the olden days, years ago when people would go to inpatient rehab, because my first job at alcohol and drug rehab and it was one of those 28 day rehabs and you know people thought, and they were probably right, is that why they were 28 days is because that's what the insurance companies authorized… Because that's what they paid for, they would pay for 30 days.

A participant in his 20's, who had been in the field eight years and works in an agency, shared his frustration and concern regarding managed care's practice of changing the length of time teenagers are authorized to stay in the program:

> It used to be the normal stay was a year. But in the year I have been here they have chopped it down to six months. So basically you have to do the same work people were doing in six months. So basically [clients] are returning to families or group homes or foster homes. And so like I said, before they would have been here a year and they go to their families or whatever and they have a break down and end up back here. So I don't

know how you're really saving money. So instead of looking at people getting better, they're looking at money. So is money more important than people?

Most participants expressed strong feelings about this authorization process, including those who indicated that they had never experienced clients being denied authorization for continued treatment.

Participants in both private practice and agency settings talked about consciously changing the wording they used in their documentation in order to comply with what they felt the managed care company wanted to see.   The participant quoted above who worked in an agency setting with adolescents and had been in the field eight years expressed the difficulties he faced trying to be truthful while also ensuring that his clients obtain the treatment they need as adolescents in residential care.

> Well sometimes I have to tweak my wording, not to say I'm lying. Because I'm not lying. But I may need to tweak my wording on certain documents whether he [the client] is staying here or going somewhere else. Because if I say he's completely healed he won't get to stay here or go to a group home or whatever. So I like have to tweak my wording. If they're doing really well I try to make them believe something's [not right], but that's about it.

Paperwork. Four out of the seven participants in private practice who have been in the field and working with managed care for over a decade noted a decrease in the amount of paperwork and greater ease working with the system, in general, than in years past. One participant in her 60's and in the field for 14 years attributed the change to Obama's Health Care initiative and the conversations that have surrounded it.

> Anyway, so it seems as if, when Obama said we were going to have a [health care reform] insurance got a little friendlier, little more accessible. You can actually speak to a person, versus a computer generated menu. That's been great. It's so much nicer to speak to someone.

Although some noted there was less paperwork than in previous years, almost all participants expressed a desire to use a method of paperwork of their own choice, rather than that imposed by the managed care company. A participant in her 50s in private practice and working with managed care for 20 of her 30 years in the field said, "It's bothersome to me, and it takes a long time, I like to do my own paperwork…I don't mind taking notes for myself, but I really despise doing it for managed care."

In some agencies, phone calls were often used in lieu of paperwork. Other agency-based participants shared that there was an overwhelming amount of paperwork associated with managed care.

Resources. Participants were asked, "What resources do you find helpful when interacting with managed care?" There was a range of responses that will be explored in this section. Four participants, in both private practice and agency settings, responded to this question by pausing and saying, "nothing" or "not much." With further probes from the interviewer three of these participants shared something they found helpful, while one participant continued to say nothing was helpful. One person noted electronic billing as being helpful, another person noted his billing specialist.

Some participants working in both private practice settings and agency setting said they found the DSM IV to be a helpful resource in their efforts to make the necessary case for authorizations. These participants found it essential to carefully match symptoms to diagnoses, using DSM IV wording in order to get the treatment authorized. They also spoke specifically about using the symptoms the DSM IV assigned to certain diagnosis in order to have treatment authorized. One person said,

The only thing [that is helpful] is how important the DSM is, using the DSM for a diagnosis. That's what is important, letting them know you are complying with the DSM for diagnosis. And that you are treating certain symptoms, it's symptom based and you're treating the symptoms.

In general, supervision was not identified as a resource for working with managed care. Two out of three of the participants who did not have their license and was required by law to have supervision, noted supervision helpful when working with managed care. The rest of the participants who had their licenses did not note having supervision at their work place. A participant in his 60's who has been in the field for 41 years, and working with managed care for 11 years called two weeks after the interview and explained to the researcher that there was something he hadn't mentioned during the interview; he stated that he was not offered supervision at his agency as a licensed clinician and thought that was a problem, although he did not specifically relate this to managed care. To supplement the lack of supervision he attends a monthly group with other clinicians and uses that as supervision. But, he added, he still feels he could benefit from supervision at his agency. Four out of the nine participants who were licensed noted being in a peer or supervision group. These participants talked about peer/group supervision being an important support in all forms of their work, but particularly helpful as a way of learning about other people's approaches to working with managed care. A participant in her 60's in private practice, working with managed care for 14 years explained that she attends a monthly peer supervision group:

> I do think another part of peer supervision can be sort of learning how to negotiate with the insurance companies. Because we do talk about our fees and to work to get the best payment we can from the insurance companies.

Participants also said that informal conversation with colleagues was helpful. A participant in private practice in her 60s who has worked with managed care for 10 of the 20 years she has been in the field said,

> Whenever I get together with my peers we bellyache about [managed care] [laughs]. We should all wear signs, 'we hate managed care.' So yeah, that's my resource, other colleagues we get together, it's not something we're thrilled about. No, there's no resources that help me. I think a lot of it is that I have grown up with it… But because I was in it so much, from the beginning, I just learned the little buzz words. I hear other people, 'I sent it in, and they wanted more information.' I just know what they're looking for, and I play the game.

Regardless of their practice setting, participants perceived the relationships they formed with managed care staff as a vital resource for authorizing treatment for their clients. One participant stated that the managed care agency with which he dealt had a staff person assigned to the clinicians at his agency. But the majority of participants said they got to know managed care staff members informally, while talking on the phone, and requested to work with them in the future.

The Impact of Managed Care on Assessment and Treatment

Participants' perceptions about the impact of managed care on assessment and treatment modality was shared in response to a direct question on the issue, as well as in the context of response to the question asking participants' about their background and training. A majority of participants indicated that they had attended social work schools that taught from a psychodynamic framework; however, all participants indicated that they used wording purposefully, matching a "behavioral" approach, which they felt was more in keeping with the expectations of managed care. A participant whose practice spanned 20 years and included several years in the public sector prior to his current work as a private practitioner, indicated having been trained in a psychodynamically oriented school. He said,

I learned early on that it is certainly helpful not to communicate with these people [managed care] in psychoanalytical terms. You know in the public sector, you always have to do these behavior goals. Well you can always come up with some sort of behavior that would be appropriate. My approach is never overestimate the intelligence of anyone in the treatment reviews.

Another participant in her 20s who was trained psychodynamically, and has been in agency-based practice working with managed care for 5 years, stated,

And [the psychodynamic graduate school she attended] doesn't train, they sort of teach you how to do assessments, and about therapeutic relationships but they don't really teach you. So by the way, this dialectal therapy, this is cognitive behavior therapy, I actually went to school for a while to learn applied behavior analysis [afterwards]. Um and, and yeah so I don't feel like I was really, like if I didn't have the experience I had in undergrad I would be screwed. You can't write psychodynamically and have it accepted by Medicaid. Medicaid will not be happy with you, they do not consider it evidence-based practice so therefore do not write it on your treatment plan and that kinda sucks. Because there are times what a person needs, is just to be with you, but you can't write that on the treatment plan… So you have to like finagle it so it sounds like you did something evidence based during the session and I really hate that. Um I feel like that just makes my job harder…. It becomes a real pain because Medicaid comes in and does an audit and we are suppose to do a treatment plan exactly every six months and so it's really hard to make measurable goals and for it to look like you are making progress when you've only seen someone, maybe five times in six months.

Many participants expressed strong emotions regarding the requirement that they must use managed care treatment plan formats. Overall, participants felt that their training and orientation was devalued by the managed care provider. Most participants shared that they would prefer to determine the format for treatment plans and not be required to follow managed care guidelines. One participant in private practice described managed care involvement in this area as "intrusive", raising ethical issues particularly in the area of client confidentiality. Here she shares her thoughts about writing treatment plans and assessments for managed care.

You know the assessment, it's like you can do one assessment for yourself, and then another one for managed care. You can't always tell managed care everything. So you can still be honest and ethical, and at the same time not divulge too much about certain

patients and certain symptomatology and certain problems… Well I really don't like contacting them, and doing treatment plans, I really feel it's intrusive… I just translate what I do in their language.

All but one participant raised the issue of the length of (authorized) treatment as a problem. A male clinician who has been in the field over fifty years and working with managed care since its inception, is currently on no managed care panels, meaning he has signed no contracts with managed care. He spoke at length about the changes he has seen over the course of his career. He made reference to the length of the DSM as a way to represent the change he has experienced, remembering when it was only one page. Here he discusses his views on the current state of managed care and social work practice as a whole.

> I think, I think, (pause) I think the age of good casework is over.
> [Interviewer] How come?
> Ahh, (pause). The whole culture doesn't seem to ah, to be favorable, the drugs that are available… People usually want quick action. The insurance, the whole business. Psychotherapy is devalued by any kind of managed care I know of.
> That's not how I was trained. That's not, that not, I don't believe that that kind of ah I don't think that ahh good casework can generally be done like that… So, as I say I am very pessimistic any kind of favorable accord with managed care or insurance companies. And I think it probably will grow tighter and tighter.

As noted previously, length of treatment and managed care authorization for continuation of treatment emerged as another theme for participants in the context of discussing their experiences with managed care. It was apparent that most participants spent a lot of time thinking about this issue in their daily practice. A participant in her 40s who is also on no panels and has been in the field over 20 years said,

> So I'm not going to see people for five times, six times, and then have them [managed care] say, oh we [are] not going to pay for anymore. And I don't want to be dictated that I have to see this family, as a family if that's not what's what warranted. Then if you [managed care] don't want to cover them and you're going to get in the way of their treatment, then maybe [inaudible] I'll do my therapy, and if you want to pay for it, cool. But if not, the family's got to decide. But I won't do it based on what they say.

All but one participant who discussed the issue of length of treatment shared negative feelings about the managed care approach to authorization for continued treatment. The exception was a participant who has been in the field 20 years and was trained in a psychodynamic school. He is currently working in private practice, having worked previously in a public agency setting. While he shared more positive perceptions than the other people interviewed, and too spoke at length about this issue, clearly having devoted much thought to the subject.

> I think why maybe I've had less trouble than other people is ah, for the most part, you know the private, except for people with severe illnesses I don't see people more than once a week. So I'm not trying to ah, do intensive therapy. And I also understand a lot of managed care referrals [are] short term, short treatments, you know? …At least what I learned over time, is seeing people more, is not more. Ah, it ah, for some people it increases resistance… There's nothing original about this, but perhaps you'd like to hear a psychoanalyst say, 'Psychoanalyst are likely to get bogged down in long treatments in course of an adverse external factor' [Quote by Donald Winnicott].

The Impact of Managed Care on the Therapeutic Relationship

In response to the question regarding their perspective on the effect of managed care on therapeutic relationships, 10 participants discussed the negative impact of having a third party involved in what they optimally believed should be a relationship between the client and therapist. One participant who has chosen not to be on any insurance panels shared a story that illustrated her views on the impact that insurance companies have on the therapeutic relationship and the work carried out by the client and therapist.

> But they [insurance companies] get in the way, to be honest with you. This one insurance company, every single time this mom calls to ah you know either about the coverage, or to get it extended. They encourage her to either quit and go to someone in the plan; it doesn't cost them as much. And they tell her what sort of treatment she should be getting [for her child] and what sort of therapy she should be looking for. And they have never even met the child, and [they're saying] what should be done. We've been working with the child for a year. So you know they think they've got the answers [laughs]. It's just

really frustrating because they're continuing putting into this mother's mind that maybe the therapy isn't the right one, because they're got this idea of what the therapy should be.

A participant in her 50s who has practiced with managed care for 20 of her 26 years in the field, talked about her feeling about managed care as "intrusive":

My experience, it's a real problem, it's not the best relationship to have with patients. It's like a third party, and they can be intrusive, managed care. And it got into the treatment, the managed care, the fact that they wanted to end it, and the patient was thinking of ending it, and I think it was an easy way out for the patient to leave. Managed care does affect people, you know terminating in the relationship with the therapist… It's used as an excuse. They just switch therapists frequently. 'And now I have this insurance, so I will go to this therapist…' Maybe they don't have to form a certain amount of attachment that they may have formed.

The discussion of fees in clinical practice emerged as a theme in participants' discussion about the impact of managed care on the therapeutic relationship. Most participants indicated that the issue of fees is ever present in clinical practice, regardless of managed care involvement. However, several participants noted some differences in the way in which this issue enters the room in the context of working with managed care. The overall feeling of participants was that there was less consistency in the decision-making process (between the therapist and client) regarding fees when managed care was involved. Managed care would discontinue coverage and a new set of decisions would have to be made. In the face of a decision by managed care to discontinue coverage, a client might choose to end treatment, or the therapist and client would negotiate a price. In view of the problems that participants felt this created in the relationship, three out of seven of the private practice clinicians related that they chose to pre-negotiate the cost of treatment after managed care coverage was discontinued. Some of the private practice participants expressed concern that the strain for the therapist of continually having to renegotiate and/or lower fees can enter the treatment and therapeutic relationship.

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Participants also talked about the strain caused by the payments provided by managed care being lower than their regular fee. One participant discussed her experience with clients who expressed feeling guilty about the fact that managed care did not pay the therapist at the same level as her regular fee. This participant discussed how money enters the relationship for the therapist as well as for the client.

> Interestingly, one of the ways I believe it has impact on the relationship, for some of the patients they are very aware that their managed care is paying me less than what I normally charge… It's come up for them almost a feeling of guilt. You know they are getting something from me, and somehow cheating me because of managed care… Some of them know I am getting rid of their particular insurance company because the fee is going down, and they are very aware of that, of when the managed care isn't going to be paying, so that's going to be affecting things. That's affecting their relationship and something we're going to be talking about more. In terms of the care I give people, I don't think impacts on the kind of care I give people. However, having said that, when someone is coming in and paying me a check for a $140, which is my full fee, I can't help but be aware of the fact that this is a person who is paying me my full fee. I don't think it can't not be in the relationship.

Social Workers Perspectives and Experiences with Managed Care: Emerging Themes

Certain themes emerged in the course of analysis of the interview material. These themes include: the 'business' of managed care"; managed care as a "medical model"; different rules for different insurance companies; and "what can we do?" This section will discuss each theme, providing illustrative quotes from transcribed material.

"**The 'business' of managed care".** Five participants spoke at some point during the interview about what they felt "drives" the managed care system. These participants indicated that while they found it difficult to work within the confines of this system, they understood that the reason the system operated the way it did, was due to the reality of the high cost of health care and insurance companies needing to contain costs. For usually a small amount of time during the interview, these participants would leave their past experiences and emotions about

managed care out of the conversation, and their tone would slightly change and they would say,

"but I know why they do that..." It was always about money, the reality of health care costs, and

managed care being necessary as a way to pay for services.

However the same participants and others would adopt a tone of defeat when discussing

the nature of managed care as a business. This tone is evident in the following quote from a

male participant who has been working in the field for eight years: "

> Well, it's frustrating, like I said you feel defeated. You try to serve the client but it's also
> a business. Even though I have nothing to with it. I know they [have to make money] in
> order for me to get paid. So it's a balance.

Another example is provided by this statement from a participant in her 60s who works in

private practice and has been in the field for 14 years,

> I don't have a high opinion of insurance companies of any type [half laugh]. I think it's
> unnecessary evil. I don't think all of them are terrible. But I think there's been instances
> where they have really not had the patience's interest at heart; many instances. And um
> and so the big business kind of thing worries me, and I don't know how to fix that…

Another participant, also in her 60's and in the field for 20 years, 10 of which involved

work with managed care companies, said,

> But the health care system is just so distorted in priorities. So the only thing that I would
> like to see is that people with biologically based illnesses, you know there are a ton of
> people out there with adjustment disorders who kind of just want to figure things [out],
> and that's fine. But I understand the insurance company saying, you know we don't want
> to pay for everything. But there are certain illnesses, like eating disorders. Like I know
> people with very serious eating disorders and the insurance company won't pay for
> hospitalizations, and that's horrible, you know serious depression, people who really need
> longer therapy, panic disorder, schizophrenia, those things absolutely. I would think. But
> I think the problem is that not everyone is on the same page. Some people think
> everything should be paid forever, and there are just limited resources. I do believe the
> biological based problems should be paid for as long as possible. But then I know what
> people say, [when] the insurance company says 'we'll pay for the biological based
> disorders.' I do believe there are people who put down more biological disorders,
> because they're subjective and they're like maybe it's depression. I am one who sort of
> wavers. I know where the insurance companies come from and I understand their need to
> limit what they pay out.

"Managed care as 'medical model'". Several participants referred to managed care as employing a "medical model". Participants used this term to describe their perceptions that the model for managed care in mental health mirrored the model used in medical care. Participants discussed co-pays as one of the ways managed care uses a medical model. "In-network" was also discussed within the framework of discussing the "medical model". (In- network refers to a mental health or medical health provider who has signed a contract with an insurance company to operate services for their clients at a fee negotiated by the insurance company --often lower than the clinician's customary fee.) Participants reported that, in their experience, managed care companies and/or insurance providers often prefer that clients to seek treatment with in-network providers with an established rate.

Four out of seven private practitioners recounted experiences of being paid more as "out-of network" providers than as in-network providers, or as part of a managed care "panel". One participant thought clients have also begun to follow the managed care company's "lead", in pursuing only in-network treatment providers, rather than exploring options for treatment out-of-network. A participant who has decided not to participate on any panels said,

> It's interesting, I have had people who have come, paid out of pocket, and then submitted, so technically they didn't pay out of pocket, they paid me and then submitted. And then they get so much back, that they are getting less than their co-pay, than if they went to someone in their plan. But most people would never figure that out, because their first question is, 'do you take insurance? They won't even go to the next [question], 'How much is out of network, what can I pay?' And because the system is set up the way it is right now, it's become such a medical model… But, ah so in that way because it's such a medical model in every one's mind, it is helpful when people do get coverage because people will say, at least it's something, at least it cuts down. You know so it's kind of catch 22, because I think if the whole system, like we were talking, where it wasn't covered at all, and then everyone would be in the same boat. But you get some people who you know who go in network, they don't want to go out of network. You get some people who can't pay ah can't pay full fee. But they'll do 50%, 20%. You're all on a different playing field.

Many participants said they did not think the medical model was an appropriate approach for the mental health profession and that it got in the way of the relationship and treatment. But some of these same individuals said they liked the idea of fee-for- service – commonly employed in the "medical model" of care. These participants were referring to their preference for a system in which the therapist would be paid directly and managed care would not be involved.

"Different rules for different insurance companies". Many participants said they found the wide ranging differences and inconsistencies in the expectations and guidelines of different managed care companies extremely difficult. Some social workers shared that it was difficult to learn all the different rules. Some said it was particularly difficult to be on many panels, each with their own guidelines to follow. Many participants had elected to be on a few panels; these tended to be panels that paid better, had fewer guidelines to follow, and were connected to insurance providers that were more likely to provide coverage for their cliental population.

"What can we do?" This theme emerged when participants were asked what they felt social workers could do to bring about change in the system of managed care. There were two sides to this theme: some participants felt resigned and that there was nothing they could do to impact the system; others were involved in changing the system.

A woman who has been working in the field of social work over 25 years said she felt that fighting on behalf of individual cases could have larger implications. She also discussed using information from other similar cases helpful.

> Sometimes on individual cases I have asked [The American Board of Examiners] to intervene because it was a larger issue, it wasn't just an individual case, it had larger implications… But I did take it to larger organizations because of implications of excluding social workers. Insurance, an issue around one patient could you know have

larger implications. I wrote letters. I wrote letters to the insurance company. I gave the legislation in New York state. I gave them statute that showed parity between psychologists and social workers, you know I quoted a case that the statute in NY changed, I mean proved them wrong…

The clinicians who talked about being in groups involved in changing the system, often talked about being part of organizations for social workers, such as NASW and other advocacy groups. They stated that they viewed this as a way to change managed care policy. Some participants were members of NASW; others were members of organizations in their specific area of practice. Some were part of multiple groups, and others were members of several organizations. Participants described writing letters with the support of these organizations on behalf of causes regarding managed care and its impact on clients and on social work practice. A few participants who were part of NASW said they were not sure how effective NASW was in bringing about a change in policy in the area of managed care. Many people shared that they felt they could do more; even though this was the group who were already actively involved in changing the system, they still had a tone of doubt about the ultimate benefits of their actions.

A man who has been in the field over 50 years and working with managed care since its inception, was one of a group of participants who felt nothing could be done to change the way managed care operates. He responded to the question of what social workers could do to impact managed care as follows:

> Well, ah, I think it's a lost cause. I've, I've almost always encouraged young people, that if they have any interest in social work, or psychology or any type of human behavior. Encouraged them often to go into social work or psychology or some field like that. But recently I ah haven't been so eager to do that… I have spent twenty-five years in training. Twenty-five years and I don't make as much as a good plumber.

CHAPTER V

Discussion

The purpose of this study was to explore social workers' perceptions of the impact of managed care on their work with clients in mental health settings. A major theme represented in the findings is the loss of control experienced by participants whose practice includes involvement with managed care. Participant experience in this area will be summarized at the outset of this discussion. Participants' efforts to gain or maintain a sense of control in their practice and in the treatment relationship constitute the salient findings discussed in this final chapter. These include: competence and preparation for work in managed care environments; interactions with managed care providers, including relationship-building and information sharing with and on behalf of clients; decision-making regarding participation on managed care panels; and the use of supportive resources in and outside of the workplace.

Throughout the discussion, study findings will be compared and contrasted with findings from previous research. The researcher uses relational theory as a lens through which to view the findings. Following the discussion, implications of findings for social work education, practice, policy, and research will be addressed. Finally, the strengths and limitations of the study will be noted, followed by the conclusion.

Loss of control and preparation for work in managed care

The majority of participants perceived managed care to have a negative impact on the therapeutic relationship. Similar to findings reported in previous studies, a major reason given by participants in this study for this negative impact was a lessening sense of control; the feeling

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on the part of participants was that managed care took control away from the therapist and the clients. As early as 1996 Munson wrote about the loss of control on the part of clients and therapist that accompanied the implementation of managed care regulations (Munson, 1996).

The managed care practice of authorization for treatment figured prominently among the factors that contributed to this feeling. This study found that social workers perceive authorizations for treatment as a negative influence on the therapeutic relationship. This was similar to the findings in the literature. Authorizations were noted in the literature review as a distraction from the treatment in the late 1990's (Munson, 1996; Strom-Gottfried, 1998).

Feelings of competence and preparation for work in managed care environments

The benefits derived by social workers from feelings of competence as they work with managed care as been widely reported in the literature. The literature supports an association between social workers' feelings of competence, comfort, and support in their work with managed care, and the nature of the relationship between the client and the therapist (Neuman & Ptak, 2003, Acker 2009). For social workers, that feeling of competence can be developed through formal education in school and through training in their work place (Acker, 2008; Acker, 2009; Berger & Ai, 2000; Daniels & Rowland, 2004; Kane, 2001, 2003, 2004; Kane, Houston-Vega, Tan, & Hawkins, 2002; Neuman & Ptak, 2003). Findings in previous research indicate that therapists who felt competent in working with managed care were better able to handle the necessary documentation, authorizations, and were more capable of getting managed care to cover treatment for their client (Kane 2001).

This study also found that therapists valued competence in work in a managed care environment. The three study participants who had been in the field less than 10 years indicated that they now wished that they had had more training in school on how to work with managed

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care. Study participants who had been in the field for periods longer than 10 years tended to indicate the use of social work groups and colleagues, versus formal education, to better understand how to work with managed care.

The difference in participant views on whether managed care content should be taught in schools or obtained on-the-job may be due to several factors. First, recent graduates may be less likely to accept the idea that they have much more to learn, and that this learning will continue throughout their career. On the other hand, those who have been in the field longer may be more likely to see themselves as life-long learners, who must continue to find ways to educate themselves.

Another possible factor underlying the difference in views may have to do with attitudes regarding the relevancy of the psychodynamic framework in which participant education was rooted, relative to preparation for work with managed care. For example, those who had been in the field for less time tended to have more negative perceptions as to how their psychodynamic training had prepared - or not prepared - them to handle interactions with managed care; whereas, those who had been in the field longer seemed to value their psychodynamic training and looked elsewhere for training in work with managed care.

Finally, the expectation of newer graduates that their training would include managed care may reflect the reality of the workplace today compared with that of those who graduated years ago, prior to the inception of managed care. Studies on the relationship between length of time in the field and social workers' perspectives about how they should be educated with regard to managed care did not appear in the literature reviewed and represents an area for future study.

Interactions with managed care providers: information-sharing and relationship-building on behalf of clients

Neuman and Ptak (2003) discuss the importance of social workers having the ability and knowledge to appeal denials of treatment and to protect their clients from decisions made by managed-care organizations that they believe are unethical or not clinically appropriate. This study found that participants had difficulty discussing how to handle or change a decision regarding treatment made by a managed care company or provider they felt was wrong. Interestingly, however, several participants did offer information regarding how a practitioner might be proactive and take control of the situation before managed care issued a decision with which the social worker might potentially disagree. This was revealed in participants' discussion about maintaining control while sharing client information; billing; authorization for treatment; paperwork; and resources. Regardless of the length of time they had been practicing in the field or their treatment setting, participants had all developed ways to maintain control over as many areas of decision-making regarding treatment as possible, while interacting with managed care. Much of what participants shared in the interview was how to discuss with the client the process of working with managed care. Several participants indicated the importance of being "up-front" with the client in the first session about how they handle certain aspects of their practice with managed care.

Using the lens of relational theory, one can examine how therapists have adopted and refined techniques to ensure that clients are apprised in advance regarding issues that may arise in treatment, and in the therapeutic relationship, with managed care involvement. The principal goal for the therapist or clinician in the initial sessions is to begin forming a relationship with the client. However, at the same time, a different set of goals may also be present for the therapist

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who must follow specific guidelines and expectations of the managed care company. The findings in this study revealed that therapists were expected to gather a great deal of information in the first interview with a client who has insurance coverage through a managed care company. Participants reported that in the initial sessions with the client covered by managed care, in addition to gathering the client's history and information about the presenting problem, the therapist had to develop a diagnosis and treatment plan as well as address the issue of payment and the expectations for the client in the context of certain limitations that may be imposed by managed care. For example, some participants indicated that they also have discussions in the initial session about what will happen when managed care no longer covers the treatment. These added requirements may undermine the goal of developing a therapeutic relationship for both the client and therapist.

One managed care requirement was noted by some participants to be decreasing in intensity. Four out of the nine social workers who had been in the field over ten years noted there was less required paperwork in recent years. This was not noted in previous studies. This may due to the fact that many of the studies included in the literature review are over ten years old and pre-date the large-scale introduction of electronic record keeping. One participant offered that the reduction in paper work might be due to the Obama administration's discussion of health care reform. Despite the perception of reduced paper work, however, most participants still expressed the feeling that managed care negatively affected the therapeutic relationship.

Decision-making regarding participation on managed care panels

Four out of seven of the participants working in private practice noted improved remunerative benefits as out-of-network providers compared to what was possible as an approved ("panel") provider with certain managed care organizations. While not supported in

the literature, this finding is important; it reflects a high level of frustration on the part of participants who shared feeling degraded by the payment rates for their services through managed care. It also reflects a certain level of knowledge on the part of therapists regarding "loopholes" in the system and how to use them. Importantly, participants noted that clients are often not aware that therapists can be reimbursed at higher rates as "out-of-network" providers, or that the client themselves can be reimbursed directly for payments to an out-of-network provider. Since this information may be neither readily available nor apparent to the client, the responsibility to inform clients about such arrangements, so that they might make informed choices about their treatment, also falls to the therapist.

Study Implications

Study findings have implications in the area of education and training, policy and practice. This section will also explore future research topics that could be helpful in better understanding social workers' perceptions on the impact of managed care on their work with clients in mental health settings.

Implications for social work education and training. Study findings suggest that recent graduates have differing perceptions from those with significant post-masters practice experience regarding the responsibility of schools in the preparation of students for work with managed care. Since most of the participants in this study attended programs with a psychodynamic orientation, this raises the question as to whether student perceptions have changed regarding what is considered essential curricular content in such programs. Are recent graduates expecting more technical training in matters such as writing the treatment plans necessary to receive reimbursement from managed care providers? If so, questions are raised as to how to fit this content into programs in which more traditional components of psychodynamic

theoretical content already compete for space in the curriculum. Do students want one or the other, or do they want both? Is it realistic for a two-year program to offer training in both areas?

Conversely, or in addition, should post-masters training opportunities be made more accessible to recent graduates and practitioners alike, through continuing education courses in schools or in the workplace? The findings point to the importance of further training in this area for workers' feelings of competence and preparation for practice in mental health settings. Consideration should be given by schools of social work and clinical societies to the ways in which practice and policy content on the system of managed care can be integrated into school and/or agency-based education and training settings going forward.

Implications for policy and research. Participants' perceptions of the benefits to social workers and clients of increased worker competence in managed care argues for policy development in the area of requirements for social worker training and education in managed care, possibly linked to licensing or other forms of professional certification.

Findings indicative of low reimbursement rates for social workers, and the resulting decision on the part of clinicians to practice out-of-network, points to issues of inequity for social workers as well as for those who would benefit from access to their services. If clinicians do not feel they are paid adequately, according to this study's findings, they are more likely to abandon contracts with managed care organizations, including those that cover recipients of Medicaid. This means that poor and low-income populations who may be more likely to have coverage through managed care organizations may have fewer, or different, options for mental health services. Future research could focus in this area, looking at outcomes for the poor related to reimbursement rates for social workers. For example, such inquiry could include the effect of clinician reimbursement rates in a number of areas, including patterns of social work practice,

client access to services and/or treatment, and client mental health outcomes. Implications for policy, based on the findings from future study, could include enacting higher mandatory reimbursement rates for social workers in order to ensure their participation in managed care panels that serve the poor.

Implications for practice. Findings indicative of participant practices that enhance practitioner ability to maintain a sense of control in work with managed care provide several implications for social work practice. Discussion with clients early in the treatment relationship regarding expectations and planning around managed care requirements, reimbursement practices, and authorization for treatment may benefit clients by helping them become more knowledgeable about all aspects of their care and make best use of the treatment relationship.

In their communications with managed care representatives, participants' deliberate choice of wording, in description both of the client's presenting problem, as well as recommended treatment, represents another set of implications for practice. Participants reported this as an important tool in maintaining control over their treatment with clients. While also related to the need for increased education and training for social workers, the opportunity to talk with and learn about such practice tools from other practitioners in the field, through supervision or other forms of peer support, may benefit social workers in managed care environments in their efforts to provide the best possible treatment for clients. In so doing, social workers may be motivated to unite with others to bring about changes in managed care policy aimed at maximizing the quality of treatment and access to services for clients; such efforts might result in lessening the emphasis on strategic communication as a method of asserting control, and advocating, instead, for the acceptance ("approval") of valued best practices through managed care.

Strengths and limitations of this study

There were several limitations in this study. The use of the snowball method of recruitment resulted in a sample with a similar orientation (i.e., psychodynamic) in their training and educational background to that of the researcher. This method of recruitment also posed limitations for achieving diversity among participants in terms of race and ethnicity, thus restricting the degree to which findings reflect the potentially differing perspectives of a diverse group of clinicians. The fact that both the research and the large majority of the participants identified as white limits the extent to which potentially discriminatory aspects of the managed-care system were explored. Finally, while representing the method of choice for exploratory study, the use of qualitative research methods, including open-ended questions and semi-structured interviews, poses limitations in terms of objective measurement of participant experiences. Finally, it is possible that the researcher's biases regarding the impact of managed care on practice, based on the previous year's experience as an intern, may have entered into the interview process and affected the nature of the data collected.

Strengths of this study include the diversity of the sample in terms of geographic representation. Participants resided and practiced on both coasts, as well as the mid-western part of the United States. The snowball method also allowed for a sample of participants with particular interest in this topic, providing an opportunity for the collection of rich data based on their knowledge, experience, and interest in the topic.

Conclusion

The purpose of this research study was to explore social workers' perceptions of the impact of managed care on their work with clients in mental health settings. The findings of this study suggest that many social workers feel that managed care negatively impacts their work

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with clients, specifically the therapeutic relationship. Participants discussed many factors that influenced the therapeutic relationship, but control over the treatment process emerged as the overarching factor. Participants related grappling with the issue of how one maintains control when a third party is involved in the treatment. The answer for many participants was to be proactive in finding constructive ways to positively impact treatment decisions through interactions with clients, other workers, and managed care representatives.

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Appendix A

HSR Approval Letter

SMITH COLLEGE
School for
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Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

January 23, 2011

Julia Coles

Dear Fraley,

Your revised materials have been reviewed and they are fine. One little thing: You inadvertently repeat a phrase in the last paragraph under **Precautions** in your Application. You probably want to delete one of them. We are happy to approve your study.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your interesting and very useful project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Beth Lewis, Research Advisor

Appendix B

Recruitment Letter

I am a Social Work student at Smith College School for Social Work in Northampton, Massachusetts. I am conducting research for my Masters of Social Work thesis, exploring social workers' perceptions of the impact of managed care in their work with clients. The criteria to participate in this study are that you are a social worker currently practicing in a mental health setting with managed care involvement. Please let me know if you or others you know would be interested in participating in this study. The study would include a one hour interview with me in a location of your choosing or via phone if you live more than fifty miles from Washington DC or Baltimore, MD.

Interested people may contact me via email or by phone.

Thank you for your time in considering participating and/or passing this information on to others who meet the criteria for inclusion in the study.

Sincerely,

J. Fraley Coles

Appendix C

Informed Consent Form

Dear Participant,

I am a social work student at Smith College School for Social Work. The data collected will be used in completing my MSW thesis. The findings may be used for presentations and publication.

You are being asked to participate in a semi-structured, open-ended interview. The criteria to participate in this study are that you are a master's prepared social worker currently practicing in settings and/or with clients having managed care involvement.

The interview will last approximately an hour depending on your responses. The interview will include demographic information and open-ended questions asking about your perceptions of the impact of managed care on your work with clients.

The interview will take place in a mutually agreed-upon private space. If you live further than fifty miles from Baltimore, MD or Washington, DC the interview will be conducted over the phone. I will be using an audio recorder to record our conversations. These recordings will be kept in a secure and locked compartment and separate from your consent form and other identifying information. I will be the only one transcribing the recordings.

There is minimal risk associated with your participation in this study. By participating in this study you will have an opportunity to reflect on an aspect of your practice. Through your participation you will also be contributing to the profession's understanding of managed care and its impact on practice. Such increased understanding may contribute to the profession's capacity to enhance service provision to a large segment of consumers. There is no monetary compensation for participating.

The data collected for this research will be confidential. -My thesis advisor will have access to the data only after all identifying information has been removed.

In presenting the data all vignette or quotes used will be carefully disguised.   All notes, transcripts, and electronically recorded data will be kept in a locked, secure location for a period of three years as required by Federal guidelines. At three years time, this data will be destroyed. Should the data be needed beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Participation in this study is voluntary. You may withdraw from the study during or after the interview and you may refuse to answer any or all of the questions without penalty. You may decide to withdraw your interview from the research study up until April 1, 2011. Should you withdraw from the study all data will be withdrawn and immediately destroyed. After that, I will have written up the data as part of my thesis.

You may contact me at any time via email or by telephone to withdraw before April 1, 2011 or with any questions or concerns about this study, before or after the interview. Should you have any concerns about your rights or about any aspect of the study, you are encouraged to call me, or the Chair of the Smith College School for Social Work Human Subjects Review Committee.

Thank you for your time and for taking interest in my study.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

Please keep a copy of this form for your own records. Thank you for your participation.

Appendix D

Data Collection Instrument

1. First I would like to ask some demographic questions. Please tell me which age you fall into:

   Twenty to thirty, thirty-one to forty, forty-one to fifty, fifty-one to sixty and over sixty.

   Please share how many years have you been practicing with a master's degree. Of those

   years, how many have been with clients with managed care involvement? How would you

   describe your race and or ethnicity? How would you identify your gender?

2. Please tell me about your experience interacting with managed care organizations in the

   following areas:

   - Treatment planning

   - Assessment

   - Sharing client information

   - Termination

   - Required paperwork

   2. I'm interested in learning about your perceptions of the impact of managed care

   involvement on the therapeutic relationship with clients.

   (Probe) For example, has involvement with managed care affected the pace of

   treatment, the timing of making a diagnosis, or other areas of your work with clients?

   What, if any, has been the impact on your relationship with the client?

   3. Please tell me about your perceptions of the impact of managed care on your feeling of

   being effective in your work with clients.

(Probe) For example, have you felt that managed care involvement has made a difference in terms of feeling that you were able to help the client address the problem they came for help with, or provide the type of help that you feel is recommended for particular problem? Or, in feeling that you were able to help the client make the best possible use of services/treatment?

4. Please tell me about your experience of managed care in terms of its impact on your ability as a clinician to make independent decision(s) based on your own professional or theoretical understanding, or training.

(Probe) For example, have there been times when your thoughts about treatment planning differed from recommendations made by the managed care organization? Tell me how you experienced this.

5. What resources have you found helpful when interacting with a managed care organization?

(Probe) For example, are there resources or information you gained from your education, training sessions, literature, colleagues or supervision that you have found useful when interacting with managed care organizations? Tell me more about how you used (any of) these resources.

6. What actions, if any, do you think social workers should take, independently or with others? (Probe) with regard to addressing any of the issues that you have discussed related to managed care involvement?

7. Are there any areas that we have not covered regarding your perspectives or experiences regarding managed care?