



**Interfacing with Managed Behavior Health Care Organizations: An Emerging Scale of Private Practitioner's Self-Perceived Competence**

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<b>Author(s):</b>	<i>Robert A. Keefe, and Michael L. Hall</i>
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# Interfacing with Managed Behavior Health Care Organizations: An Emerging Scale of Private Practitioner's Self-Perceived Competence

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*Robert H. Keefe, PhD, and Michael L. Hall, PhD*

During the last 20 years, mental health care has entered the cost-saving service environment known as managed care. Managed behavioral health care organizations utilize panels of providers comprised of social workers, psychologists, and psychiatrists to render care to their beneficiaries. Managed care organizations use a number of "tools" to assure that the care their panel of providers renders is cost-effective. These "tools" range from credentialing service providers to capitating insurance benefits (Jellinek & Nurcombe, 1993). In order to maximize their cost savings, managed care organizations use a frugal approach whereby social workers' services are used rather than psychologists', whose services are used rather than psychiatrists' (Stone, 1995).

The new service environment has had a number of effects on service providers and service recipients. Instead of formal education in the new service environments, service providers have had to seek specialized training to equip them to manage their practices under managed care guidelines (Feldman, 1997). Because much of today's mental health care is managed by managed care organizations, private practitioners are faced with learning how to interface with for-profit enterprises looking to cut costs for services.

As the managed care industry continues to grow, the type and intensity of pressures on providers and academic training centers in regards to the managed care industry are likely to increase. Historically, training in managed care has been largely ignored by academic training centers which have lagged behind the fields of mental health

practice in providing training in the most current trends affecting the professions (Feldman, 1997; Shore, Hoge, & England, 1997; Van Dyke, Schlesinger, Meyer, & Resnick, 1997). Melnick and Lyster (1997) add that managed care companies are not structured to assist providers in handling new requirements, new regulations or new limits. Likewise, Shueman, Shore, Lancaster, and Altman (1997) stress that practitioners who contract with managed care organizations are not learning the basic skills that will enable them to work effectively with managed care organizations. Moreover, managed care organizations have provided little opportunity for trainers to learn what their trainees should know about rendering psychiatric care under managed care guidelines (Shueman et al., 1997). Shueman et al. stress that fewer than one-half of the practitioners they surveyed considered themselves competent in specified skill areas, which include problem-oriented, goal-focused treatment. Providers must, therefore, better position their practices by improving their skill in coping with the expected turbulence in the future. With these facts in mind, Troy, Jackson, and Frances (1997) argue that a restructuring of the training paradigm across the disciplines is necessary to meet the accountability imperatives associated with managed care. These non-clinical demands are not treatment driven, but rather cost and market driven. Consequently, they are put in place by managed care companies to generate information for the purposes of saving benefit dollars and making other financially-based decisions better to position the company without necessarily better positioning the client or the provider. These financially-based

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*Robert H. Keefe is Assistant Professor, School of Social Work, Syracuse University, 404 Sims Hall, Syracuse, NY 13244. Michael L. Hall is Associate Professor, Public Administration Program, Sage Graduate School, New Scotland Avenue, Albany, NY 12208*

motives are issues which require further consideration by national organizations such as the National Association of Social Workers, and the American Psychological and Psychiatric Associations as to how the helping professions should respond to these non-consumer-driven motives.

### Managed Care Management Skills

Patterson (1990) asserts that a partnership between management and clinicians represents the best mental health delivery system. Given the market forces present in today's delivery of behavioral health care, the truth of this assertion is likely to be found in the future for managed care organizations and their provider panels. According to Patterson (1990), fiscal responsibility covers a number of skills which will be required in order to create management and clinical partnerships. Additional skills in strategic management will be needed to equip the provider with the ability to handle the uncertain future of private practice under managed care. Frequent changes within managed care companies will continue to cause a struggle between the managed care organization and service providers. Schreter (1997) emphasizes that there are six core skills for successful practice: clinical care (e.g., problem-oriented treatment), clinical management (e.g., coordination among health care providers) clinical knowledge (e.g., use of preventive strategies), skills with special populations (e.g., innovative treatment programs), administrative competence (e.g., understanding benefit plans), and ethical case management (e.g., patient advocacy).

Because managed care companies' documentation requirements continue to increase, providers with strategic management skills will be more apt to choose the necessary technology and software for maintaining a low overhead operation. Additionally, providers must improve their communication and negotiation skills to open continuous dialogue with managed care organizations in order to work through the maze of managed care contract, treatment and quality assurance issues.

### Management Competence

A plethora of research has been published on defining, exploring the applications of, and positioning ways of teaching the very skills that Patterson (1990) suggests need to be developed and linked to clinical principles for the rationed delivery of behavioral health care in the managed care context. The lack of these skills has been called a crisis in managing hospitals (Benson, 1991), as well as in private practice settings.

An emerging issue in the management literature is a point of view indicating that to determine skill alone is not complex enough to understand the sophistication of competence (Wagner & Morse, 1975). Competence is a human characteristic which must be understood first in the context in which it occurs. Jacobs (1989) writes: "We operate in complex social settings and so understanding an individual's behavior requires that we first study their [sic] situation from their [sic] own perspective" (page 37). Jacobs goes on to state that this idea of competence is not new. What has happened, she states, is during the rapid growth of management assessment and development, we have lost sight of this perspective. Given this state of affairs, a different type of management competence scale is better suited to addressing self-perceived competence before a specific management skill measurement which addresses behavioral management competence can be developed.

Although the concept of competence is multidimensional, it is composed of skills applied in a given context listed above (Mirabile, Caldwell, & O'Reilly, 1987). It has long been known that such skills can be assessed, evaluated, and measured. By measuring competence, a baseline measure can be applied to improve the management skills necessary to function effectively within the managed care environment.

### Measuring Competence

A competence analysis can be used for private practitioners' management improvement. Skill building can be accomplished by measuring man-

agement competence which allows for improved management. Thus, seeking to know, through measurement, providers' self-perceived competence at present has enormous implications for how well they will fair under managed care guidelines.

The logistics of measuring provider competence are challenging. Most competence scales aimed at management skills assume managers are working in an organizational setting. Conceptually, skill scales assume a different management dynamic than a private practitioner would experience. Although there are similarities between what organizational managers do and what private practitioners do when they manage, private practitioners are also performing clinical tasks which are different than tasks performed by managers in other industries. Such a dynamic would make straightforward application of management skills scales difficult for private practitioners. Thus, the application of these scales will invariably have shortcomings which could endanger the adequacy of a benchmark measure when used with private practitioners (Schoon, 1985).

### **Nature of Competence and Measurement**

Understanding management competence can be traced to White's research of the early 1960s (Wagner & Morse, 1975). White posited that all individuals have a drive to influence and master their environments. Building on White's work, Wagner and Morse (1975) noted that competence results from a person's life history, including his/her work. They report that "a sense of competence" is a subjective evaluation of one's actual competence, which leads to competent behavior from the psychological rewards brought forth by feeling competent about particular skills. In other words, if one "feels" one is competent, one will most likely "manage" competently. The competence construct then is both psychological as well as behavioral, whereby one dimension of the construct reinforces the other.

Competence in a management and/or a managed care context is a combination of psychomotor and

psychological constructs. Competence in how one conceives of a problem and its solution is complete only when combined with action. Yet, the very competence which creates the solution begins with believing one is capable of generating a solution. The management, treatment and managed care situations all present complex and changing problems. One must believe that, no matter what the presenting problem is, one is capable of solving it. It is this major psychological ingredient that forms a major portion of overall competence.

Wagner and Morse (1975) translate White's sense of competence into an "individual's feelings and confidence about his abilities in mastering an organizational and work setting" (p. 451). This translation is particularly germane to work environments and problem solving work situations. Using the competence feelings approach, Wagner and Morse developed a 23-item instrument to measure how competent a person feels himself/herself to be. They applied the instrument to work settings in which they found relationships among measures of organizational effectiveness, task performance, and perceived competence (Wagner & Morse, 1975). They tested their instrument on a sample of 310 individuals (internal consistency  $r = .96$ ) and later administered the instrument to 35 managers (test-retest  $r = .84$ ) (Lorsch & Morse, 1974). The test with the 35 managers was performed to determine the efficacy of the scale. Wagner and Morse report that the results indicate the practical utility of the scale, and thus, the construct of psychological competence.

There are a number of advantages resulting from the Wagner and Morse approach to self-perceived competence measurement which seem particularly valuable for private practitioners in the managed care environment. First, their instrument allows for self-reporting. It is a "pencil and paper" instrument which does not rely on additional raters. Moreover, because many practitioners in behavioral health do not work in organizational settings, using traditional ratings from superiors and/or subordinates are not suitable. Second, a relationship

between their self-perceived competence scale and task performance was noted. A measurement of this kind works better from a practitioner's perspective in managed care and points to construct validity of the scale. Third, because behavioral health practitioners come from various disciplines, including social work, psychology, and psychiatry, a competence scale in managed care cannot be "context specific" and still be useful across disciplines. Such a scale must focus instead on the functions rather than the context in which those functions occur. Thus, the Wagner and Morse scale holds promise for understanding how providers are performing under managed care. Naturally, because Wagner and Morse developed their instrument for measuring competence in organizational work environments, adaptations and additions were made to the scale. These changes are noted in the next section.

The primary purpose of this study is to provide an initial assessment of this scale's usefulness in assessing private practitioners' self-perceived competence in interfacing with managed care organizations. A secondary purpose is to provide continuing education programs with information concerning where current private practitioners perceive themselves to be on the continuum of interfacing competently with managed care organizations.

### Method

#### *Sample*

Because managed care has affected a large proportion of practitioners nationwide, a survey approach was used. This approach has been widely regarded as being particularly useful in obtaining information of a large population (Grinnell, 1997).

To obtain the sample, the authors used a table of random numbers to draw the names of private practitioners from the rosters of the Register of Clinical Social and Workers, The American Psychological and Psychiatric Associations. The sample was limited to social workers, psychologists, and psychiatrists because these three professional disciplines are the most widely reimbursed by managed behav-

ioral health care organizations. A total of 3,910 names were drawn, which amounted to approximately 10% of the listed private practitioners. Of those sampled, 620 (15.9%) were social workers, 1,688 (43.1%) were psychologists, and 1,602 (41%) were psychiatrists. Within these rosters, the total number of social workers employed solely in private practice is 6,198. The total number of psychologists reported to be in private practice is 16,871. The total number of psychiatrists reported to be in private practice is 16,031.

Key informants from two large managed care organizations and four universities offered input on the questionnaire's content including questions concerning continuing education. After incorporating their input, the authors pilot tested the questionnaire on 75 private practicing social workers, psychologists and psychiatrists who also offered additional input on the design of the questionnaire. Their input was also incorporated. Following the design phase, questionnaires were mailed to respondents with pre-addressed envelopes and return postage included. A cover letter describing the purpose of the research and assuring the respondents' confidentiality was enclosed.

Once the questionnaires were returned, the respondents were coded by discipline to form a stratified random sample. A total of 130 social workers, psychologists, and psychiatrists who were listed in these rosters but were either retired or no longer in private practice and did not have clients insured by managed care organizations were excluded from the analysis. Consequently, while reviewing the rosters from the Register of Clinical Social Workers, and the American Psychological and Psychiatric Associations, those practitioners who were not in private practice were excluded, thus lowering the total number of practitioners who met the study's criteria. The final sample consisted of 3,780 private practitioners.

After securing copyright permission, the Wagner and Morse instrument was adapted to the managed care context. Adaptations in the wording of the

instrument were limited to changing terms which are organization-specific to include instead the term "managed care." Figure 1 displays the 19 questions from the adapted Wagner and Morse instrument used for the managed care context. The adapted instrument was then mailed to the selected practitioners. A likert-type scale was used for questions which dealt specifically with interfacing with managed behavioral health care organizations.

**Figure 1 - Items from the Wagner and Morse Instrument**

1.) Coordinating care under managed care conditions is easy once you understand the various managed care company requirements (e.g., record keeping, precertifying treatment).

- strongly agree                       agree  
 neither agree nor disagree    disagree  
 strongly disagree

2.) Even though my work is rewarding, I am frustrated by managed care company requirements and find my paycheck to be the one reason I continue to treat clients.

- never                                       rarely  
 frequently                                 nearly always  
 always

3.) I do not know why, but when I am supposed to be in control of my clients' care I feel more like the one being manipulated as I try to satisfy managed care requirements.

- never                                       rarely  
 frequently                                 nearly always  
 always

4.) I feel like I am getting nothing done due to managed care requirements.

- never                                       always  
 frequently                                 nearly always  
 always

5.) Working under managed care gives me a chance to test myself and my abilities.

- never                                       rarely  
 frequently                                 nearly always  
 always

6.) Working with managed care makes me tense and anxious.

- strongly agree                       agree  
 neither agree nor disagree    disagree  
 strongly disagree

7.) Managed care organizations recognize good care performance.

- strongly agree                       agree  
 neither agree nor disagree    disagree  
 strongly disagree

8.) When it comes to details of a clients care, my managed care insurer:

- always provides the right amount of control.  
 nearly always provides the right amount of control.  
 frequently provides the right amount of control.  
 rarely provides the right amount of control.  
 never provides the right amount of control.

9.) My managed care organization facilitates my treatment with my clients.

- always                                       nearly always  
 frequently                                 rarely  
 never

10.) Communication with my managed care organization is open and productive.

- always                                       nearly always  
 frequently                                 rarely  
 never

**Figure 1 (cont.) - Items from the Wagner and Morse Instrument**

11.) My managed care organization sees my care plans and treatment as judicious and cost-effective.

- always                       nearly always
- frequently                       rarely
- never

12.) Managed care conditions allow me to formulate meaningful and effective treatment plans.

- always                       nearly always
- frequently                       rarely
- never

13.) My managed care organization listens to my treatment plans openly.

- always                       nearly always
- frequently                       rarely
- never

14.) Managed care does not affect my ability to manage treatment time.

- strongly agree                       agree
- neither agree nor disagree                       disagree
- strongly disagree

15.) Managed care requirements do not affect my ability to manage my personal time.

- strongly agree                       agree
- neither agree nor disagree                       disagree
- strongly disagree

16.) Managed care allows me enough discretion to be effective in treating clients.

- strongly agree                       agree
- neither agree nor disagree                       disagree
- strongly disagree

17.) I have found that the clinicians employed by managed care companies to be a good resource on difficult-to-treat clients.

- strongly agree                       agree
- neither agree nor disagree                       disagree
- strongly disagree

18.) I have found managed care company clinicians to be knowledgeable of the treatment modalities I use.

- strongly agree                       agree
- neither agree nor disagree                       disagree
- strongly disagree

19.) Treatment plans managed care companies use do not capture the essence of how I treat my clients.

- strongly agree                       agree
- neither agree nor disagree                       disagree
- strongly disagree

One factor referred to as "competence" by Wagner and Morse (1975) was chosen because the eigenvalue was well above one (1). The 19 items loaded onto this factor. This factor seems to be capturing the underlying core of competence in the managed care context that the authors of the original scale tapped into. Wagner and Morse argued that the concept of competence began with how competent one thought himself/herself to be. This being true, the adapted scale for this study captures a similar dimension among practitioners working under managed care guidelines. Factor analysis using varimax rotation led to the selection of the 19 items. The factors were not forced in the analysis.

A number of items had low factor loadings and were consequently omitted from the scale. The items omitted were: 1) "No managed care company

employee knows this job better than I do.” 2) Considering the time I spend on the job, I feel thoroughly familiar with the managed care requirements.” 3) “Managed care interferes with orderly care planning.” 4) “The managed care requirements I work under are manageable.” 5) “My talents, or where I can concentrate my attention best, are found in areas not related to managed care.” 6) “I go home the same way I arrive in the morning, feeling as though I have not accomplished a whole lot.” 7) “Performing my managed care tasks well is reward in itself.” 8) “Managed care shifts my time emphasis from care to regulations and record keeping.” 9) “Maintaining and organizing records has become more difficult under managed care.” 10) I feel that managed care companies dictate how I am to render care.” Items on that factor were then selected. Cronbach’s Alpha coefficient of .8417 was calculated for the 19 items.

## Results

A total of 582 (15%) practitioners returned the questionnaire. Of those practitioners who responded, 168 (28.9%) were social workers, 158 (27.1%) were psychologists and 256 (44%) were psychiatrists. Two-hundred and fourteen respondents were located in the northeastern United States (67 social workers, 56 psychologists and 91 psychiatrists), 155 were located in the southeastern United States (37 social workers, 38 psychologists and 80 psychiatrists), 94 were located in the midwestern United States (23 social workers, 30 psychologists and 41 psychiatrists), 26 were located in the northwestern United States (12 social workers, 2 psychologists and 12 psychiatrists), 25 were located in the southwestern United States (8 social workers, 8 psychologists and 9 psychiatrists) and 68 were located in the western United States (21 social workers, 24 psychologists and 23 psychiatrists).

After reviewing the geographic distribution of the providers, the second procedure completed was frequency distributions of the variables. With respect to the practitioner demographic variables: 417 (71%) are between the ages of 40 and 60, 224

(39%) have greater than 25 years of professional practice experience, 217 (47%) receive more than 30% of their referrals from managed care organizations, 281 (48%) have more than one-half of their client caseloads comprised of clients insured by managed care organizations, 261 (57%) belong to five or more managed care organization panels, 149 (26%) have had more than 20 hours of training learning about the managed care industry, 377 (64%) spend more than 80% of their professional time in private practice, 541 (93%) self-identify as Caucasian and 292 (50%) are male.

The data indicate that the study group consists of an experienced group of practitioners of comparable age and demographic backgrounds and from every region of the country. The data do not differ based on provider discipline. For most of the variables, the mean, median, and mode are the same.

Chi-square analysis on the differences in gender by profession is statistically significant (chi-square = 71.37,  $df = 4$ ,  $p < .0000$ ). There is a gender difference across these professions which reflects the current trends of the professions in which there are more females practicing social work than males, and more males practicing psychology and psychiatry than females. Although the disparity between the numbers of males and female physicians entering psychiatry is diminishing, the practitioners surveyed had been in practice for over 20 years thus reflecting the gender differences in psychiatry at the time these psychiatrists were being trained. The differences between the practitioner groups based on racial self-identification is also noteworthy. The overwhelming majority of the respondents self-identify as Caucasian ( $n = 473$ ). The group with the next highest number of self-identified as African American ( $n = 7$ ).

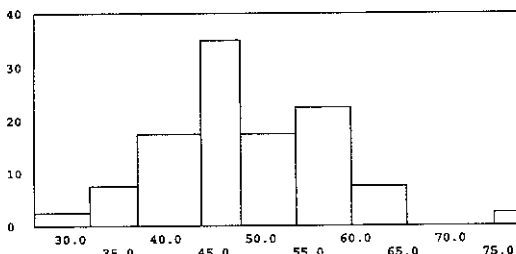
The next analysis conducted was analysis of variance on each of the variables used in this study. Differences based on profession were noted in three of the variables: age, number of managed care organization panels to which the practitioner belongs, and percentage of time spend in private practice. Social workers are older than psycholo-



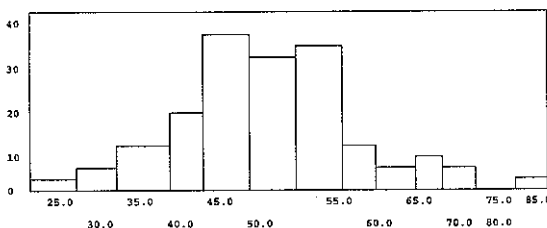
gists and psychiatrists (means = 54.23, 53.60 and 51.44,  $F = 5.73$   $p < .003$ ), psychologists belong to more managed care organization panels than social workers and psychiatrists (means = 7.33, 6.62 and 4.72  $F = 4.94$   $p < .007$ ) and social workers spent a greater percentage of their time in private practice than psychologists and psychiatrists (means = 85.77, 77.60 and 63.37,  $F = 23.34$   $p < .000$ ).

Figure 2 displays histograms of the self-perceived competence formed from 19 of the 23 items in the self-reported adapted competency scale and for each discipline separately. The histograms show a data distribution approximating a normal curve.

Psychologists

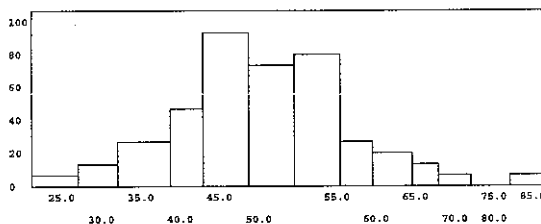


Psychiatrists

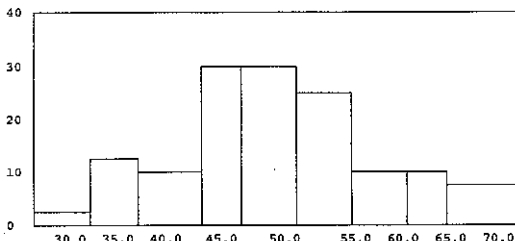


**Figure 2 - Histograms and Factor Analysis of Practitioners' Competence**

All practitioners



Social Workers



The scale of competence has a range of scores from 19 to 95 with a midpoint of 57. The competence average for those responding to the instrument is 49.4 ( $n = 322$ ) indicating that the sample as a whole feels below the midpoint about their management competency under managed care conditions. Considering their years of practice, one might reasonably expect higher than midpoint reported competency. Because greater time in practice would logically yield a better understanding of practice contexts plus concomitant constraints and because the practitioners studied have been in practice for more than two decades, professional experience, it could be reasoned, would push the group average closer to the midpoint on the scale than is apparent here.

Analysis was performed on the competency scale using analysis of variance procedures. There is no statistically significant difference on the competency measure among the treating professionals. Although social workers display a higher mean value on the competency instrument (50.4) than psychologists (48.1) and psychiatrists (49.5), the differences in means among the professions cannot be considered anything other than an artifact of chance.

### Discussion

The respondents are very experienced (mean years of post academic degree experience = 23) and can be presumed to feel competent in the managed care arena. However, their feelings of competence as measured here might be due to the past number of years in which they have been in private practice. They may have felt more competent in the past because their training (both academic and on-the-job) prepared them adequately to interface with third party payers. Today, however, their environment has radically changed. Perhaps the most experienced practitioners are now those feeling the most profound impact of this change whereas the less experienced practitioners, who do not expect themselves to feel competent yet, are actually feeling somewhat better about their ability to weather the changes in behavioral health care because the changes had already taken place while these practitioners were still in their training. Moreover, many seasoned practitioners who have not had to accommodate changes in their practice are perhaps less likely to adapt to changes in service delivery requirements.

There are limitations to this study which need to be addressed. First, the random selection procedure did not yield a large percentage of returned questionnaires. However, the number of respondents is larger than similar studies of private practitioners working under managed care guidelines. It is also uncertain why the respondents in this study are overwhelmingly Caucasian. Because the rosters from the Register of Clinical Social Workers and

the American Psychological and Psychiatric Associations do not identify their members by racial and ethnic groups, we do not know if professionals from various oppressed groups elected not to respond to the questionnaire.

It is also interesting to note that social workers were the largest practitioner group which spent the greatest percentage of time in private practice. Given the criterion that practitioners had to be in private practice to participate in this study, those social workers listed in the Register of Clinical Social Workers whose practice was split between various practice settings were excluded. Consequently, although social workers far outnumber psychologists and psychiatrists in the population of mental health professionals, their practice tends to be in agency and hospital settings, which thus lowered the number of social workers eligible for participation in this study. The reason for making this exclusion was in order to assure that the sample consisted of practitioners who were most likely to interface with managed care companies. Because social workers are very likely to work in various agency settings, it is likely that their time working in private practice as a group is less than psychiatrists and psychologists. It was assumed that social workers practicing in other venues would be less likely to interface with managed care organizations and therefore would not be able to self-evaluate their experiences interfacing with managed care organizations as thoroughly those social workers who identified themselves as practicing solely in private practice. To compensate for this potential problem in sample distribution, future researchers studying private practitioners and managed behavioral health care may wish to weight the samples so that the total sample sizes would be more even.

Although self-reported data have drawbacks, the usefulness of the approach has support from the literature cited earlier in measuring competence. The scale shows promise for advancing both the understanding of where private practitioners stand in ref-

erence to managed care at present and for creating continuing education training seminars and communication linkages for all the key players in managed care.

Because a cross-sectional approach was used, issues relating to the scale's stability at this point are legitimate. The fact that the scale has a very high alpha value, however, suggests that the findings at this point are reliable. Ongoing longitudinal analysis of the scale consisting of the same practitioners would be beneficial in assessing its continued applicability to private practitioners working under managed care guidelines.

Given the configuration of the data from the 569 respondents, there seems to be some pressure on these practitioners in their efforts to provide treatment and to interface effectively with their managed care companies. The presence of a mean on the scale of competence below the midpoint raises this issue. At present, there may be a management competence gap among some of these providers. Troy, Jackson, and Frances (1997) suggest that schools of social work, and other mental health professions, take the lead in involving practitioners when practice has been affected by managed care. By taking such a leadership role, schools of social work and psychology and psychiatry residency programs can take the lead in developing practice standards as well as field education training experiences in facilities which have been impacted by managed care. Academic training centers would be wise to explore how they could develop small clinical networks to contract with managed care organizations to provide treatment to their patients. These networks would be wise to focus on hiring practitioners who have the highest level of licensure in the state's in which they practice. The practitioners would also be wise to obtain additional certifications in short-term oriented treatment such as certificates in cognitive/behavioral therapy, drug and alcohol abuse counseling, and marital and family therapy. By fostering this type of relationship to various managed behavioral health care organizations, these clinical networks would be provided

with the opportunity to perform outcomes research on their practice while having an already established relationship with the managed care organizations with which they contract.

The National Association of Social Workers and the American Psychological and Psychiatric Associations may wish to consider further continuing education programs which focus on the managed care organization and private practitioner interface. Goldman (1997) argues for changes in licensure to reinforce skills and knowledge essential for practitioners to work in the managed care environment.

Continuing education programs would be wise to target seasoned practitioners who appear more likely to feel less competent in their interactions with managed behavioral health care organizations. By targeting this population of practitioners, continuing education programs could develop cross-discipline workshops which deal with the specific nuances of client care reporting. These workshops should focus on private practitioners' ability to discuss clearly defined client goals and objectives and the estimated termination date for treatment. Although clients' self-reporting is a legitimate measure, it must be reinforced by additional goals and objectives which are behavioral-oriented and specific.

Other workshops could focus on the contributions each discipline provides to mental health care. Workshops led by psychiatrists who provide training to social workers and psychologists in the most current research on psychiatric medications would provide social workers and psychologists with a further knowledge base on the effects of these medications on the rate of client improvement. Likewise, workshops led by psychologists who provide training on the use of psychological testing, particularly as a guide to client assessment, would provide social workers and psychiatrists with additional data in negotiating for additional certified sessions by the managed care organization for ongoing client care. Workshops led by social workers on the nuances of short-term, solution-

focused treatment in the areas of specific client presenting issues (such as grief counseling, trauma survivor counseling), combined with the recommended workshops listed above, would provide psychologists and psychiatrists with additional knowledge on brief therapy models and build upon psychologists' knowledge base of psychological testing and psychiatrists' knowledge base of medication management.

Finally, although managed care organizations require practitioners to disclose client-sensitive information, workshops must continue to reinforce clients' rights to self-determination and confidentiality. Managed care organizations state that they only require practitioners to disclose specific client information to determine whether or not treatment is medically necessary. Workshops should empower practitioners to require that managed care organizations legitimize their request for any additional information which goes beyond information required to determine the medical necessity of ongoing client care.

These workshops would also build upon the competencies which Shueman et al. (1997) stress are needed. By developing workshops which are problem-oriented and goal-focused, continuing education workshops will enable practitioners to articulate client needs more adequately to managed behavioral health care organization reviewers. The outcome will likely be a stronger partnership between managed behavioral health care organizations, private practitioners, and their clients.

### Conclusion

Because the practitioners in the sample are in private practice, their management competence is an important element in the context of managed care in which they must function. The adapted management competence scale is a self-reporting mechanism with which to tap into this important dimension of their practice. In this regard, the scale may be indicating that the effectiveness of the practitioners' past approaches to managing their practices are in question. Because there is no before-and-after measurement on the scale to gauge

the practitioners' perceived competence under non-managed care conditions versus what they face today, more testing on the instrument can address both the scale's stability and its long-term usefulness for measuring private practitioners' competence in interfacing with managed care companies.

Using a stratified sample of practitioners from various oppressed groups which may have been underrepresented in this study, would add to the research on this topic. Such testing would give a clearer picture of the practitioners' perceived competence as well as provide an additional tool for schools of social work and psychology and psychiatry resident training programs in how to interface effectively with managed care organizations. The additional testing would also benefit managed care organizations in selecting new providers as well as helping their current panel of providers in negotiating for ongoing treatment for their beneficiaries.

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