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Author(s):	*Michael L. Hall and Robert H. Keefe*
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Exploring "The Managed Behavioral Health Care Provider Self-Perceived Competence Scale": A Tool for Continuing Professional Education

Michael L. Hall, PhD; Robert H. Keefe, PhD, CSW, ACSW

Since the late 1980s, the reimbursement for behavioral health care services has been governed largely by managed behavioral health care organizations. The rapid changes in reimbursement — from the retrospectively reimbursed fee-for-service system to the prospectively reimbursed managed behavioral health care system — have required private practicing social workers, psychologists, and psychiatrists to be trained in practicing within a new financial reimbursement and treatment certification system (Keefe & Hall, 1998). For many private practitioners, managed behavioral health care organizations' certification of behavioral health care services has led to a significant departure from the way practitioners provided care at the beginning of their careers (Keefe & Hall, 2000).

A major problem for continuing social work education is that private practicing social workers report that they have not been adequately trained to interface effectively with managed behavioral health care organizations in order to assure that their clients are certified for continued treatment (Keefe & Hall, 1998). Because of this problem, private practitioners have had to learn on the job how to work within managed behavioral health care's cost-containment system (Keefe & Hall, 1998; Schreter, 1997; Shueman & Shore, 1997), while continuing social work education programs have tried to catch up with the demand to train practitioners to interface with managed behavioral health care organizations. In the former fee-for-service system, the provider would bill and be reimbursed for services already rendered. However, under managed behavioral health care, service providers have had to adjust their practices to the managed behavioral health care organizations' certification protocols and reimbursement rates established before the care is rendered. The care is prospectively reviewed before the managed behavioral health care organization reimburses the provider for services to be rendered. This scrutiny has caused many social workers, psychologists, and psychiatrists to report feeling stress and anxiety concerning their ability to work with managed care organizations (Bartlett, 1997; Bell, Kravitz, Siefkin, & Foulke, 1997; Keefe & Hall, 1998; Strom-Gottfried, 1996).

The purpose of this study is to report on a scale used to measure private practitioners' self-perceived competence in interfacing with managed behavioral health care organizations and the scale's utility for continuing professional education programs.

Literature Review

Williams (1989) argues that changes in practice environments tend to disturb relationships between professionals. The once familiar environment is replaced with new demands and expectations from external sources with which providers must cope. This state of flux often changes a provider's capacity to maximize his/her career goals (Brooke, Hudak, Finstein, & Trouson, 1998) and business-operating procedures. Experienced practitioners report that they are doubtful about whether their accumulated professional knowledge, skills, and attitudes related to clinical and managerial issues are sufficient to work under managed care guidelines (Parry, 1998). Nonetheless, it is up to the treating practitioner to ensure continued competence, while the external pressures imposed by managed behavioral health care will force practitioners to adjust to new standards of practice (Grossman, 1998).

The measure of competence, however, as it

Michael L. Hall, PhD, is an Associate Professor and Director of Graduate Programs in Management at The Sage Colleges Public Administration Program.

Robert H. Keefe, PhD, CSW, ACSW, is an Assistant Professor at Syracuse University School of Social Work.

Correspondence should be addressed to Robert H. Keefe, School of Social Work, College of Human Services and Health Professions, Sims Hall, Syracuse University, Syracuse, NY 13244-1230.
Telephone: 315/443-1443; fax: 315/443-5576; Email: rhkeefe@social.syr.edu

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relates to the private practitioner and managed behavioral health care organization interface, has received little attention. Keefe and Hall (1998) conclude that private practicing social workers, psychologists, and psychiatrists do not perceive themselves as being competent to interface effectively with managed behavioral health care organizations. However, they did not address all indicators of competence as they relate to this interface. Consequently, there is very little information available for continuing social work educators, who, as they developed programs, focused on the interface between private practitioners and managed behavioral health care organizations.

Indicators of Competence

The constructs of competence and self-efficacy derive from Bandura's (1977) work on Social Cognitive Theory. Competence has been defined as "a cluster of related knowledge, attitudes, and skills that affect a major part of one's job" (Parry, 1998, p. 60). Wagner and Morse (1975) conclude that a primary component of how a professional functions is based on his/her belief that he/she is competent to decide independently upon important issues within the context of his/her work. Competence, or self-efficacy, attached to treatment skills, is based on the ability to make clinical decisions independently and then act on those decisions in the context of one's work.

The competencies that practitioners developed to work with fee-for-service payers are different than those required to function under managed behavioral health care organizations' guidelines. Under managed behavioral health care, the provider would necessarily require skills to negotiate contracts, advocate for clients, and act as an entrepreneur resulting from market conditions brought about by managed behavioral health care organizations. Braveman and Fisher (1997) and Fried, Topping, Morrissey, Ellis, Stroup, and Blank (2000) report that practitioners are uncomfortable with at least some of the new roles managed behavioral health care organizations require.

White (cited in Wagner & Morse, 1975) proposed that there is a basic drive in all humans to influence and master their environments. It is this basic drive in all humans, combined with their satisfaction with their jobs, work environments, and colleagues, that leads to competence. According to Wagner and Morse (1975), competence is the end result of one's life history of interactions with the external world, including work. Thus, competence is the result of factors such as how one has worked, endured, and learned under a number of conditions, including career tasks. Therefore, competence is the attitudinal aspect of one's actual work skills and knowledge. In fact, Bandura (1995) has defined this portion of one's attitudes as "the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations" (p. 2).

Wagner and Morse (1975) assert that their refinement of White's thinking led to the notion that a "sense of competence" is not just a component of one's personality, but of one's "feelings and confidence about his abilities in mastering an organizational and work setting" (p. 451). Bandura (1995) stresses that competence is "an individual's perceived confidence in their [*sic*] ability to successfully perform a specific behaviour" (p. 451). One's sense of competence can be viewed as a mindset about how capable one feels one is by means of "engaging in a work environment and solving (the) problems in it" (Bandura, 1995, p. 451). Wu and Short (1996) note a similar definition for self-efficacy, based on their work with teachers, stating that "...self efficacy involves one's beliefs about one's competence and ability to act" (p. 3). Thus, it stands to reason that if one were trained as a practitioner in one environment and later practiced in that environment, one's sense of competence would naturally develop along the contour of that environment. If that environment were to change radically, as in the change from the fee-for-service system to the managed behavioral health care system, one's knowledge, skills, and attitudes would likely have to change as well. The many changes in services and

payment conditions that happened to providers throughout the 1990s could reasonably seem to precipitate changes in their sense of competence.

Instrumentation for Measuring a Sense of Competence

Wagner and Morse (1975) argue that every form of psychological assessment has strengths and weaknesses, "whether the approach is psychodynamic, psychometric, clinical, phenomenological, or behavioral" (p. 452). Morse (1969) reports on a number of approaches to measuring work-related competence and the flaws those approaches are likely to have. They provide a paper-and-pencil, self-report instrument that offers a reasonable facsimile of competence with the added benefits of ease and efficiency of administration.

The instrument is a 23-item stem questionnaire. The 23 items were culled from a larger set of items and were then tested for efficacy. Wagner and Morse (1975) performed a number of analyses on the instrument seeking to determine its efficacy, including Kuder-Richardson reliability reported to be .96 and test-retest reliability reported to be .84 over a two-month period. Wagner and Morse's (1975) instrument was thought the best base for the present research inasmuch as it addresses the issues of working within a management context. Their instrument, more than the teacher- or addictions-based self-efficacy scales found in the literature, more closely resembles the managed behavioral health care environment in which providers must work.

Method

Following Wagner and Morse (1975), Keefe and Hall (1998) developed an instrument that adapted the 23-item stems for managed behavioral health care conditions and added a number of related items thought to be useful in formulating the sense of competence in the managed behavioral health care

Figure 1. The Adapted 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).

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.

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.

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

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

6.) Manage care organizations recognize good care performance.

7.) When it comes to details of a client's care, my managed care insurer:

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

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

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

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

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

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

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

15.) Managed care allows me enough direction to be effective in treating clients.

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

Questions 1, 3, 5, 12, 13, 14, 15, and 16 have the following response options: Strongly agree, Agree, Neither agree nor disagree, Disagree, and Strongly disagree.

Questions 2, 3, 4, 6, 8, 9, 10, and 11 have the following response options: Never, Rarely, Frequently, Nearly Always, and Always.

Question 7 has the following response options: 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, and Never provides the right amount of control.

environment. After reviewing the literature and interviewing managed care administrators, Keefe and Hall (1998) revised and clarified the additional items. Because the research was exploratory, and the original scale was a global measure of competence, the additional items were thought to be necessary for a full examination of the perceptual components of managed behavioral health care competence. Following the design phase, the 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. The final set of items is shown in **Figure 1** (see page 29.)

Table 1: Frequency Distributions

Age	N	Percent
30-49	214	36.6
50-69	34	58.9
70-79	26	4.5
Missing	6	
Total	**584**	**100.0**

Years Experience	N	Percent
1-14	104	17.9
15-29	354	61.2
30-up	120	20.7
Missing	12	
Total	**578**	**99.8**

Race	N	Percent
White	541	92.7
African American	10	1.7
Hispanic	9	1.5
Native American	2	.3
Asian/Pacific Islander	22	3.8
Missing	12	
Total	**578**	**100.0**

Hours Communicating with Managed Care Organizations	N	Percent
0-1.0	61	11.6
1.01-2.00	245	46.5
2.01-5.00	146	27.5
5.01->20.00	74	14.0
Missing	64	
Total	**526**	**99.6**

Hours of Training Learning about the Managed Care Industry	N	Percent
0	170	29.6
1-5	105	18.3
6-9	43	7.5
10-19	106	18.5
20-29	65	11.3
30-59	57	9.9
60-up	27	4.7
Missing	17	
Total	**573**	**99.8**

Percent Clients Referred by Managed Care Organizations	N	Percent
1-29	241	52.5
30-59	103	22.4
60-100	114	24.9
Missing	132	
Total	**590**	**99.8**

Percent Clients Insured by Managed Care Organizations	N	Percent
0-29	134	35.1
30-69	220	37.2
70-100	162	27.4
Missing	0	
Total	**590**	**99.7**

Number of Managed Care Organization Panels Joined	N	Percent
1-5	256	52.2
6-10	125	27.5
11-64	75	16.4
Missing	134	
Total	**456**	**99.9**

Percent Time in Private Practice	N	Percent
0-19	73	12.4
20-39	45	7.7
40-59	48	8.2
60-79	45	7.6
80-99	96	16.3
100	281	47.8
Missing	2	
Total	**588**	**100.0**

Self-perceived Competence	N	Percent
24-29	4	0.9
30-39	55	14.0
40-49	148	36.8
50-59	143	35.5
60-69	42	10.0
70-79	8	1.9
80-84	1	0.2
Missing	189	
Total	**396**	**99.3**

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 Workers and 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 for services by managed behavioral health care organizations. A total of 3,910 names were drawn, which amounted to approximately 10% of the listed private practitioners in each of the rosters. Of those sampled, 620 (15.9%) were social workers, 1,688 (43.1%) were psychologists, and 1,602 (41%) were psychiatrists.

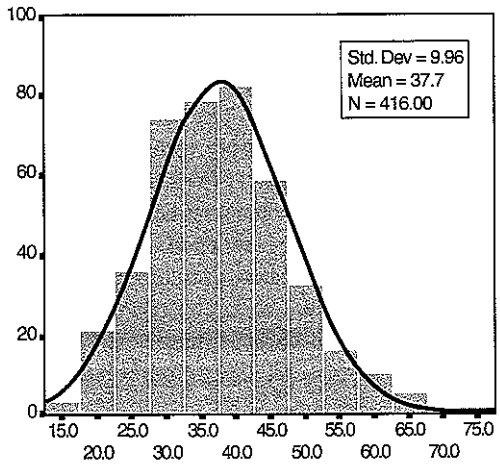
Table 2: Analysis of Variance of Practitioners' Self-Perceived Competence

Practitioners' Self-Perceived Competence

N	Mean	Std.	Dev.
Entire Sample	411	37.66	9.95
Social workers	118	38.96	9.73
Psychologists	108	36.62	8.79
Psychiatrists	185	37.47	10.77

Kurtosis = .239
Skewness = .120

Providers' Self-perceived Competence



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 behavioral health care organizations, were excluded from the analysis. The final sample consisted of 3,780 private practitioners. A total of 582 (15%) practitioners returned the questionnaires. The response rate was 28.3% (n=168) social workers, 9.7% (n=158) psychologists, and 16.4% (n=256) psychiatrists. Of those practitioners who responded, 28.9% (n=168) were social workers, 27.1% (n=158) were psychologists, and 44% (n=256) were psychiatrists. Two-hundred 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).

Results

Because of the low response rate, confidence intervals were run to obtain the sample and estimated population means. On each variable, the sample mean fell within the accepted 95% confidence interval range. Descriptive statistics were generated for selected demographic variables on the 582 cases. The data indicate that the respondents have an average of 22 years of professional, post-academic degree experience and average 53 years of age. They spend an average of three hours per week communicating with managed behavioral health care organizations. They have had nearly 15 hours of training on learning how to work with managed behavioral health care organizations. Forty-four per-

Table 3: Reliability and Factor Analyses

	Scale mean if deleted	Scale variance if deleted	Inter-total correlation	Corrected alpha if deleted
Question 1	35.5962	86.5449	.5805	.8985
Question 2	35.1683	86.0969	.6275	.8968
Question 3	34.2548	89.6072	.4864	.9015
Question 4	34.6947	87.5668	.4199	.8998
Question 5	35.7500	87.4024	.4228	.8975
Question 6	35.5721	89.0261	.6913	.8963
Question 7	35.7019	89.0049	.4485	.8977
Question 8	35.4375	88.9021	.6615	.8967
Question 9	34.8269	90.0856	.4874	.9014
Question 10	35.4688	87.3484	.6856	.8954
Question 11	35.1274	86.1018	.7056	.8944
Question 12	35.7163	87.8904	.4876	.9021
Question 13	35.3486	88.6083	.3901	.9071
Question 14	35.3846	84.3818	.6874	.8945
Question 15	35.7404	87.7782	.5871	.8982
Question 16	35.1635	86.3588	.5907	.8981

Alpha = .9043 Standardized item alpha = .9098

Factor Loadings for Competence

	Factor		Factor		Factor
Question 1	.61468	Question 7	.66257	Question 13	.41533
Question 2	.69049	Question 8	.71077	Question 14	.76190
Question 3	.56535	Question 9	.53633	Question 15	.61483
Question 4	.60922	Question 10	.73693	Question 16	.63819
Question 5	.65328	Question 11	.75658		
Question 6	.76413	Question 12	.52719		

Eigenvalue for Competence Factor = 9.96024

cent of their clients are insured by, and 28 percent of their clients are referred by, managed behavioral health care organizations. They belong to an average of six managed behavioral health care organization panels and spend nearly 74 percent of their time in private practice. Sixty percent are male.

Results of the questionnaire are shown on **Table 1** (see page 30).

The self-perceived competence items were treated as a summated rating scale. The scores on the scale range from 16 to 80, with a midpoint of 48. The practitioners' mean score is 37.66, indicating that they do not feel competent interfacing with managed behavioral health care organizations. The Kurtosis = .239 and the skewness = .120, indicating that the scale closely resembles the true population distribution. The managed behavioral health care variables selected for inclusion in the analysis are shown in **Table 2** (see page 31).

Scale Extraction

Factor analysis was then conducted on the adapted competence scale items and their managed behavioral health care companion additions. Factor analysis was chosen because the data set contains more than 300 cases, which is considered the acceptable number for factor analysis (Comrey, 1988). A majority of the items (79%) had skewness values of less than 1. The varimax factor rotation was chosen and examined for factors with eigenvalues of 1 and above.

The factor analysis revealed five factors using principal components analysis. One of the factors had the strongest eigenvalue (9.96) and the variables with the highest factor loadings onto it. This factor also explained the largest amount of variance (34.3%). The other factors added cumulatively to less than 20% to the explained variance. The principal components analysis explains the most variance and succeeds at yielding the most theoretical efficiency (Comrey, 1988; Tinsley & Tinsley, 1987). The strongest factor emerged as the "managed behavioral health care competence" factor. Not all of the adapted Wagner and Morse items showed up on the factor, nor did all of the additions find their way onto the factor. A total of 16 items emerged as being salient in factor analysis terms and are shown with the accompanying histogram in **Table 3**.

Table 4 displays the inter-item correlation coefficients for the 16 scale items. The values in the table for the items compare favorably with those reported for the Wagner and Morse (1975) 23-item scale.

Once the "managed behavioral health care competence" factor emerged, a series of additional analyses were performed. Because a factor emerged, it was pursued as a scale. Cronbach's Alpha of .9043 was calculated for the 16-scale items. The Standardized Alpha, or an Alpha Coefficient for all

Table 4: Correlation Analysis of Individual Items with Their Summed Total*

	Competence		Competence		Competence
Question 1	.6489 n=416	Question 7	.6685 n=416	Question 13	.4920 n=416
Question 2	.6880 n=416	Question 8	.7039 n=416	Question 14	.7423 n=416
Question 3	.5566 n=416	Question 9	.5541 n=416	Question 15	.6478 n=416
Question 4	.6135 n=416	Question 10	.7301 n=416	Question 16	.6578 n=416
Question 5	.6667 n=416	Question 11	.7508 n=416		
Question 6	.7288 n=416	Question 12	.5693 n=416		

*$p = .000$

16 items accounting for missing data, was determined to be .9098. Split-half reliability analysis was subsequently performed on the 16 items. The correlation between forms value was .8213, and the equal length Spearman-Brown coefficient was .9019. The alpha for part 1 with 8 items was .8372, and the alpha for part 2 with 8 items was .8166.

Convergent Validity

A correlation analysis was performed in order to establish convergent validity for the "Managed Behavioral Health Care Provider Self-Perceived Competence Scale." The items of the scale were again summed as per any Likert-type summated scale. Once the items were summed, a correlation analysis was performed with all 16 items correlated against the summed item competence. The results appear in **Table 4**. The lowest correlation coefficients in the analysis are .5541 and .4920.

Discussion

The purpose of this article was to expand upon Keefe and Hall's (1998) findings on the implications of the competence construct not previously reported on in the literature. Another purpose was to provide continuing social work educators with a scale they could use to evaluate their workshops for private practitioners, who must learn how to interface effectively with managed behavioral health care organizations. The "Managed Behavioral Health Care Provider Self-Perceived Competence Scale" holds some of the same dimensions of the original scale from which it has been adapted. The alpha coefficient points to a psychological element at the center of the respondents' perception about the manner in which they go about their professional work. The original scale tapped a construct that most likely lies at the heart of one's competence in a work context. The new scale appears to maintain this construct with no drop in acuity.

Wagner and Morse's (1975) original premise is that work competence is built on the self-perception of how competent one feels himself/herself to be. Building on the research of the original scale, the present research lends some support to Wagner and Morse's assertion that self-perception is efficacious for, and transferable to, the managed behavioral health care context in which private practitioners must function. The research also provides a tangible instrument for continuing social work educators to develop workshops for private practitioners who have to interface with managed behavioral health care organizations.

Although self-reported data have drawbacks, the usefulness of the approach has support from the literature cited earlier in measuring competence or self-efficacy. The scale shows promise for advancing both the understanding of where private practitioners stand in reference to managed behavioral health care at present and for creating continuing education training seminars that are geared toward practitioners involved in managed behavioral health care. For example, continuing social work educators may apply the instrument before and after training to obtain an indication of how competent the practitioner felt about proceeding in practice under managed behavioral health care organization guidelines. Likewise, the scale could be useful for NASW and CSWE as they evaluate the effectiveness of continuing education programs devoted to social work practice in managed behavioral health care environments.

Policy makers could also benefit from use of the scale. As the federal government continues to move toward managed behavioral health care to curtail Medicare and Medicaid costs, it is likely that the private practitioners who have to meet these new mandates may not be entirely comfortable with the new regulations. Continuing education programs could then provide the training that the practitioners need to become more skilled at working with managed behavioral health care organizations, while using the scale to asses the programs' effectiveness in accordance with guidelines put forth by NASW and CSWE.

Other than the drawbacks associated with self-reported data, there are additional limitations to this study. First, although the total number of respondents is larger than similar studies of service providers working under managed behavioral health care guidelines, the percentage of returned questionnaires is small. Due to resource constraints, there were no attempts to conduct follow-up mailings with nonrespondents. This problem is most noteworthy with respect to psychologists, who were the least likely to respond, despite the finding that they belonged to more managed behavioral health care organization panels than social workers and psychiatrists. Although the results of the confidence interval analysis minimizes this concern somewhat, further research that has a larger response rate from private practitioners would give further insight into the rigors practitioners face.

With respect to the sample, it should be mentioned that the rosters used for this study reflect a limited pool of the population of private practitioners. Inclusion in the rosters of the Register of Clinical Social Workers and the American Psychological and Psychiatric Associations is voluntary and comprised largely of highly experienced practitioners. Consequently, the sampling frame may reflect a more experienced population. Because the sample was drawn nationwide, it is possible that the subjects who did not respond to the questionnaire may live in areas that had yet to be impacted by managed care. Likewise, it is possible that the practitioners who did respond may have a strong bias against managed behavioral health care organizations. Moreover, because many of the practitioners' demographic characteristics are not published in these registers, it is not possible to assess the representativeness of the sample to that of the population. This limitation likewise restricts the power of the confidence interval analysis. Comparing this research with other studies to identify possible selection bias would likely be unsuccessful due to the incompatibilities with the definitions of key terms, the lapsed time between studies, and the difference in research parameters.

Because a cross-sectional approach was used, concerns related to the stability of the results are legitimate. Ongoing longitudinal analysis consisting of the same practitioners using the scale would be beneficial in assessing the scale's reliability and continued utility for private practitioners working under managed behavioral health care guidelines and the subsequent continuing education programs training them. The fact that the scale has a strong alpha value, however, suggests that the findings at this point are reliable and stable.

It is worthwhile to note that social workers spent the greatest percentage of time in private practice. This outcome is possibly a result of the sampling frame used. Although there are other rosters of social workers, such as the NASW Academy of Certified Social Workers, they are more likely to include social workers employed in areas other than in private practice. Given the criterion that practitioners had to be in private practice to participate in this study, it was decided that the Register of Clinical Social Workers would be the best roster to identify private practicing social workers.

According to Wagner and Morse (1975), "A sense of competence from effective organizational behavior provides a psychological construct linking the individual and the organization in a manner that allows the goals of both to be met simultaneously and even to reinforce one another" (p. 458). If true, one of the important implications for providers and

managed behavioral health care organizations is that common goals could be attained, rather than having both parties at potential odds with one another over treatment modalities, treatment protocols, pay structures, and expenses associated with treatment. Such an approach is more likely to be productive, less expensive, and result in improved treatment for the client, and should be incorporated into continuing education programs.

Moreover, the "Managed Behavioral Health Care Provider Self-Perceived Competence Scale" could be used as a screening device for managed behavioral health care organizations wishing to train their panel providers, and as a self-assessment device to prepare practitioners for interfacing with managed behavioral health care organizations. The scale can also be used for model building. With emerging scales of specific practice skills, the new competence scale could be included in the constellation of variables explaining how treatment practice variables interact within the managed behavioral health care context. Information from model building can be used in professional degree education of health and human service professionals. Additionally, more appropriate organizational arrangements, which better serve both the service provider and the payer, can be designed.

Conclusion

Because social workers continue to enter private practice in large numbers (Gibelman & Shervish, 1996) and nearly all insured mental health care has fallen under the purview of managed care (Sabin, 1995), the onus of training practitioners already in private practice to interface with managed behavioral health care organizations will fall to continuing education programs. Inasmuch as social workers outnumber other professionals in private practice, administrators of continuing social work education programs will likely feel the responsibility for this training, more than continuing educators in other fields. The time is ripe for continuing social work educators to be at the vanguard of these efforts for building a strong foundation on which private practitioners can thrive in the new service reimbursement system.

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