Managing the Occupational Environment of Managed Care

Sara J. Brayman

Key Words: environmental design • institutional practice

The emergence of managed care has resulted in a practice environment buffeted by rapid and sweeping changes. Shifts in philosophy and approach to payment for health care affect the nature of the service and the method of its delivery. The occupational adaptation frame of reference is used to illustrate the challenges imposed by the physical, social, and cultural components of the changing occupational environment. Perceptions, observations, and concerns of middle level occupational therapy, physical therapy, social work, and nursing managers illustrate the impact of this new environment. Therapists are challenged to understand their own changing work setting and to apply the same effort to mastering its challenges as they would to examining the context of their patient's occupational performance and to designing and implementing an appropriate clinical intervention.

Persons who work in today's health care industry must interact within an occupational environment that is rapidly changing. Many of these changes have been initiated since the movement toward a system of managed care. Provider roles have been redefined, priorities modified, and reimbursement patterns rewritten; all these actions have resulted in modifications to the nature of practice and the context in which we work. This article describes the perceptions of health care supervisors who practice within one rapidly changing university health care facility to provide insight into the changing demand present in this emerging occupational environment.

The Changing Occupational Environment

The health care revolution in the United States has been shaped by societal and economic changes. Among them are an aging population and a decline of family support systems, which have contributed to an increased use of health care services. Consumers are now more educated and assertive and demand quality and efficiency in health care delivery. The exciting opportunity for positive outcomes through new, costly, and once thought to be impossible technology has further increased the cost of diagnosis and treatment. Perhaps the most influential force in this revolution, however, has been the national effort to control burgeoning health care costs (Barber, 1992; Brooten, Hayman, & Naylor, 1988). In response to the demand for cost control, a shift from indemnity insurance to a contractual relationship among the care provider, payer, and consumer has occurred—managed care—and its emergence was inevitable.

The introduction of this systematic approach to managing the scope and the cost of health care has created turmoil in the health care environment. Managed care payer systems are setting the trend for insurers by seeking the lowest cost service providers and channeling plan members to them. These arrangements represent important shifts in both the philosophy and approach to traditional health care delivery and has changed who is seen and by whom, where one is seen, what intervention is provided, and when it is provided. Shifts are also evident in how the value of the service is defined and how the quality of that service is evaluated. The scope and appropriateness of care allowed and the payment for that care are set prospectively. Plan members are confronted with many financial incentives to use only those providers and services outlined in their plan (Ritch, 1995). Services may be managed by preferred providers, health maintenance organizations, or other managed indemnity programs.
The Impact of a Changing Occupational Environment

Regardless of the model, the emergence of managed care has had a major impact on the care provider’s practice environment. Hospitals and other health care organizations have responded by reorganizing their operations. Reengineering is often initiated to streamline services, increase consumer satisfaction, and reduce costs. Reengineering typically means reducing the workforce, tightening the scope of service, shrinking overhead, modifying processes, and redefining service delivery. Any of these changes can be stressful to workers, concomitantly resulting in painful upheavals in the work setting (Hamel & Prahalad, 1994). These changes, although designed to improve health care delivery, have resulted in rigorous and stressful environments of continuous disruption, which has been described as permanent white water (Triolo, Allgeier, & Schwartz, 1995).

With reengineering, programs and products are reviewed in terms of the bottom line. Reductions within hospitals, for example, are achieved by drastically reducing cash reserves to meet operating obligations, laying off employees, delaying equipment purchase and maintenance, and tightening their market or even limiting or abandoning financially troubled but clinically needed services. Making do with less seems to be a common theme in environments focused on the bottom line. Reengineering seems to translate primarily into downsizing and unfortunately has not changed the way employees work or what is expected of them. The great risk of just downsizing and restructuring is that nothing is done to change the work itself. Instead, the work is done by fewer people who simply have to work harder. One executive told Business Week that he finds it difficult to go to work each day “because I’m going to have to push people to do more, and I look at their eyes and they’re sinking into the back of their heads...but they are not complaining, because they don’t want to be a part of the next reduction in force” (Hammonds, Kelly, & Thurston, 1994, p. 84).

In addition to reducing staff and redesigning programs, health care organizations are banding together into multihospital systems that offer broad arrays of integrated health and social services. These new organizations require the employee to make still more adjustments in his or her work setting, such as moving into a different work setting, working with a different population, acquiring new skills, adapting to new technology, or working a different shift. The change may also include redefining the organization’s mission, policies and procedures, human resource guidelines, schedules, and type of work to be accomplished. The real issue is whether change will happen with planned foresight or within a crisis atmosphere and whether it will be continuous and peaceful or spasmodic and brutal (Hamel & Prahalad, 1994).

During these adjustment periods, employees and supervisors will have to examine their traditional roles and relationships. As organizational structures flatten, clinical administrators and supervisors return to patient care. In the process of implementing change, some individuals or groups will be affected more than others. “Some will lose power, influence or status, others will have to acquire additional skills, work in different environments, associate with different people, change titles, supervise fewer people, make do with fewer resources or change behaviors” (Johnson & Boss, 1993, p. 8).

Change is difficult for everyone. When an organization is experiencing major change, signs of personal distress become evident. Physical and psychological distress affect workers’ performance and result in decreased energy for work. Staff may become immobile and disoriented or may withdraw and be unable to attend well to their environment (Scott & Jaffe, 1991). In a study of factors affecting nurses’ adjustment to change, Stolte (1994) reported that conflict among nurses and between other health care professionals hindered all changes except those involving technology. McKibbin (1995), writing about upheavals in the health care industry, described the paradox present in the change process: “Too much change too soon, ungrounded and with no direction, leads to chaos and its backlash—resistance—which threatens survival. On the other hand, too little change too late leads to stagnation, which also threatens survival” (p. 40). When major change occurs, the climate in the work setting is open to conflict, confusion, frustration, and chaos.

Personal Perspectives

A series of small focus groups at one university teaching hospital was facilitated to understand the demands that the occupational environment places on persons during a period of rapid change. Participants were occupational therapists, physical therapists, social workers, nurses, and counselors, all of whom were middle level managers. Each focus group lasted 1 hour. After the topic was introduced, the groups were asked to discuss the kinds of broad changes (not particularly related to the microculture of that hospital) that they had observed and believed had affected their practice. The discussion was lively, and participants required no prodding or further direction from the facilitator. The focus group discussions were
recorded and the tapes transcribed. A coarse sift of the discussion follows.

The business of health care was seen as a major theme in the discussions, as noted by the following comments:

- There is a business reason to care how customers are. We used to worry about that from a human level.
- As long as health care is dependent on third-party payers, there isn’t enough money.
- There is a lot more emphasis on management than there is on care.
- The patient is not the focus of the value when you have a value system that is geared to the bottom line.
- Because everyone has downsized, the resources once available to the patients no longer exist.
- More work is needed for each patient, and it needs to be accomplished in less time by fewer workers.

Considerable discussion also centered around human resources, employer and employee loyalty, and the relationship between the organization and its employees. Some of the participant concerns are summarized as follows:

- Human resources have become the most expendable of all the things within the organization.
- If this worker will not do it, we will get ourselves a new worker who will.
- As livelihoods become more tenuous, employees will put up with more.
- Because of all of the layoffs, a lot of people are quite happy to have a job.
- There is no sense of real commitment from either the organization or from the employee.
- Employees must be able to accept responsibility for themselves.
- Loyalty has switched from paternalism of the old system to partnership in the new.

Another area of concern was the changing nature of the work itself and its effect on practice:

- The acuity of patients has changed; the patients have tremendous medical problems.
- More patients are seen but with fewer supporting resources.
- The emphasis is now on day programs.
- Hospitals are becoming the smallest component of the health care industry.
- We used to focus on the individual patient; now we focus on group treatment.

All disciplines participating in the groups expressed concern that professional educational programs did not address the nature of day-to-day practice, resulting in a general frustration with entering practitioners who are ill-prepared for the changing nature of the work:

- New supervisors feel betrayed because education does not suit their needs.
- Students are introduced to every theory, yet they do not know any well enough to apply it in the clinical setting.
- Students are not prepared for the real world.
- New graduates have been educated to practice in an environment that no longer exists, so the workforce is ill-prepared in terms of skills, adaptability, or emotions to do the job that is currently needed.

Conflict between individual and organizational value systems also was expressed by each discipline present. This conflict was reflected in terms of professional issues, including cross training, deprofessionalization, and changing professional values:

- We base our purpose and identity on conditions that are no longer present in the workforce; now we are asked to change our basic identity as a specific professional to that of a general health care worker.
- We entered the profession for altruistic reasons and find that we have to give up those values of serving others fairly rapidly to remain employed.
- We wonder what values the health care system is going to have and if those values are going to be in synchrony or in constant conflict with those that were current when we were trained in a particular mode at a particular time.
- Other people are going after pieces of different jobs.
- Who can provide this service cheaper?
- As a profession, we are going to have to prove efficacy or that our services are effective.
- Boards of nursing are being attacked in many states that regulate practice so that nurses without licenses can do the same job as nurses with licenses.

Emerging technology was discussed briefly. It was interesting to note that the groups did not mention advances in clinical technology. But they did mention the increase in information and financial management technology. More information on demographics, resource utilization, and outcome measurements was stressed.

Frustration with the pace of change and the response of all levels of staff members to those changes in the work environment were described in the following comments:

- Things are moving so quickly that we are afraid we are going to miss something; often we don’t know
The Importance of the Occupational Environment in Adaptation

An appreciation of the relationship between a changing occupational environment and work performance is helpful in facilitating adaptation. Rogers (1983) described the relationship as reciprocal—the environment enables human performance, and occupational performance is always influenced by the characteristics of the environment in which it occurs. This relationship is central to many of the theories, models, and frames of reference used in the profession (Kielhofner, 1992; Mosey, 1981; Reed, 1984; Schkade & Schultz, 1992).

One practice model that explains the interaction between the person and the environment is occupational adaptation (Schkade & Schultz, 1992). The desired outcome from this interaction is an effective, efficient, and satisfying response to the challenges posed by the environment (Garrett & Schkade, 1995). Occupational adaptation is considered to be both the normative process of a person mastering a challenge imposed by his or her occupational environment and the outcome resulting from that process. The occupational environment is the context in which occupational performance occurs and is distinguished from other contexts because of its demand that the person generate an occupational response (Schkade & Schultz, 1992). The demands posed by an occupational environment consist of physical, social, and cultural subsystems and a multitude of factors or components that shape each subsystem.

This model illustrates the effects of the physical, social, and cultural components of the occupational environment on the practitioner who is attempting to adjust to a changing health care system. For example, because of a declining number of admissions and shorter lengths of stay on a psychiatric unit, a therapist with many years of practice experience in that setting may be reassigned to a physical medicine and rehabilitation center. Even though this therapist remains employed in the same facility, he or she will be confronted with a combination of new or different demands and expectations imposed by the physical or nonhuman factors of the new occupational environment. The goals of therapeutic intervention may remain the same, and the tasks of practice may change. For example, the therapist’s skills in facilitating a client’s return to functional living, which may include long-forgotten or new activities such as manipulating splinting material and prescribing adaptive equipment, are challenged. The physical demands of the job itself also change. Perhaps longer periods of standing, lifting, and bending are now necessary. This therapist’s changing occupational environment may also include the challenge of adjusting to a large multidisciplinary workroom. The rate of imposed changes and the overall turbulence within the organization where every department and function are also changing.

The social subsystem of the new occupational environment also imposes new demands on this practitioner. The therapist must enter into new workgroups where he or she must establish new relationships with different colleagues, which can be a source of increased discomfort, further exacerbating the challenges imposed by the new physical environment. Supervisory relationships may change, and familiar social patterns and rituals may be lost. Formal and informal relationships must be defined and restated and new social networks developed, which may create more discomfort than the more tangible challenge of relearning specific practice skills or adjusting to a new office.

The cultural subsystem in the occupational environment under managed care may present the most difficult challenges to the practitioner. In some ways, the changes are similar to those experienced when one changes employers or rotates to a new team. The difference lies in the pace of the imposed changes and the overall turbulence within the organization where every department and function are also changing. Hospital units are closing or being redefined, and staff members are reassigned. Standard operating procedures are replaced by new policies and procedures that are unfamiliar and may be uncomfortable to implement. Demands for increased productivity emerge, and time-keeping procedures change. Nothing seems to be the same. Perhaps the most difficult challenge imposed by managed care is reflected by the movement of health care away from its focus on altruism to one that seems to provoke conflict between the organization’s values and the practitioner’s personal and professional values. These changes often are reflected in referral patterns and critical pathways that challenge familiar and accepted standards of intervention, revised performance expectations, and the demand for increased productivity, which may limit the therapist’s opportunity to perform adequate evaluations, family teaching, or individual treatment. Collectively, these changes can be said to create an uneasy culture.

When rapid major changes occur that result in uncertainty, little opportunity exists to maintain equilibri-
um. Survival in this white-water environment will depend on anticipating the changes and mastering them. Understanding the demands of the occupational environment may hasten mastery and improve the outcome for the patient and practitioner alike. Other skills needed to hasten mastery include not only accomplishing the specific tasks of the job, but also adapting efficiently and effectively to the changes in the work settings.

Summary
This article explored the impact of managed care on the occupational environment to which practitioners must respond with some degree of mastery. King (1978) posited that the essential purpose of occupational therapy is to stimulate and guide the adaptive processes, which she described as a person’s active response evoked by specific demands from the environment. Just as patients with disabilities are challenged by their environment, we clinicians face the challenge of managing our occupational environment. It is just as important for the practitioner to gain an understanding of the changing environment of the work setting and to make preparations to meet its demands as it is for that same therapist to examine the context of a patient’s occupational performance when designing and implementing a clinical intervention. The challenge of managing our occupational environment is to understand the environment itself and prepare for change. ▲

References