THE ISSUE IS

Now That We Have Managed Care, Shall We Inspire It?

We knew it, but Mary Foto said it: "Managed care is here to stay" (as quoted by Hettinger, 1995, p. 19). It seems apt, then, that we come to terms with managed care—literally. And coming to terms is a process with which occupational therapists are familiar. Parham (1987) said that reflective practitioners name and frame their realities, using language and logic to first explain what they see (name) and then to spell out a course of action (frame). Although Parham discussed this process in the context of treatment, therapists might benefit from a reflection that names and frames managed care. This article aims to prompt such reflection while making this point: We have managed care, but we must continue to inspire it—to keep caring for the health of others central to our practice.

Before turning to this discussion, I will speak of my intent. Some readers may argue that an educator who is removed from clinical realities has no grounds for commenting on managed care. The argument has logic, but it does not consider that people can sup­pon one another from different vantage points. What therapists offer patients is an empathic but divergent perspective on their realities; we sometimes name it hope. This reflection has a similar aim. My purpose is to salute those who grapple with managed care and to offer suggestions that make sense from where I practice.

The Language and Logic of Managed Care

Some may argue that managed care is the ultimate oxymoron because it names an incongruence larger than grateful dead. More typically, descriptors of a different kind associate with the term care. Some descriptors name those who will receive care—child, elder, patient—and others name the type of care that will be given—critical, intensive, quality. The odd juxtaposition of managed care causes one to ask how management applies to care. Usually, a person is said to manage a budget or a household. Does care warrant such management?

Interestingly, the first dictionary definitions for management associate with the training and handling of horses. From these earlier meanings came the more familiar one of skillful handling, direction, or control (Merriam-Webster's Collegiate Dictionary, 1993). Given this understanding, one can better grasp the thinking of those who named managed care. A delivery system gone wild needed taming. Those who named the problem framed a congruent action. Unbridled excesses, runaway costs, and a galloping use of procedures invited management.

Syndicated columnist Dave Barry (1994) saw humor in the health care system's extravagance before managed care. He told the story of 8-year-old Natalie who modified a childrens' board game by putting the gamepieces in her nose. When one gamepiece accidentally went in the wrong direction during an intake breath, Natalie's parents took her to the hospital. Although the gamepiece was already in her digestive tract, the total bill was $3,200. Barry suggested that stool searches done at home are far cheaper.

Certainly, the cost of health care delivery needs to be managed, and a logical approach to managing cost is to control both access and use. Management extends beyond cost, however. As a business, health care delivery warrants accountability; as a human service, it needs ethical responsibility. Productivity, measurability of outcome, reasonableness of cost, efficiency of effort, quality of service, and justification of effectiveness are concepts fundamental to the practice of good business and ethical service. It is unfair to assume that the managed care industry has pressed practitioners toward functions that oppose good care.

Early in our profession's history, when a reconstruction aide named Ora Ruggles (Carlova & Ruggles, 1946) took leave from practice, Eleanor Clarke Slagle asked her to return, saying, "Get behind the effort and push!" (p. 113) Ruggles did so, starting occupational
therapy departments in many places. More currently, Frito argued this need relative to managed care (Hettinger, 1995). Good management is an effort therapists can push. If over the years, occupational therapists failed to tend to good business, thus adding to the extravagance of health care delivery, they invited the redirection inherent in managed care. Therapists will always need to be good managers who are accountable for business and responsible for service, and in this context, managed care makes sense.

Managed Care: Naming the Incongruence

Boisaubin (1994) took a more serious look at runaway costs than Barry (1994) did, noting the larger implications of cost-containment:

The Kaiser Permanente System found that it would save $3.5 million if it stopped using an expensive nonionic x-ray agent, even though the cheapest alternative caused more patient reactions. Most reactions have been mild and nonfatal; is it worth $3.5 million to avoid those reactions? However, in this tradeoff an occasional patient will encounter discomfort, morbidity, or even mortality. Ideally, the $3.5 million would be better spent on health screening to prevent 35 breast cancer deaths, 100 cervical cancer deaths, or 105 heart attacks. The once rhetorical debate focusing on the worth of a human life becomes all too realistic in this new calculus. (p. 1)

The management of extravagance is a powerful function; it can change the ways in which helpers offer care and patients receive it.

Occupational therapists have described the effects of managed care on their therapies. Noting the restrictions on access that have followed capitation, Kornblau (1995) asked:

Is this legal? Yes. Health care is not a right. It is something agreed to in a contract between a coverage provider company and a policy purchaser.... Although the behavior is legal, I cannot help asking myself whether it is ethical. Is it right to give physicians monetary incentives to sacrifice care which would improve the quality of one’s life? (p. 4).

Occupational therapists have described far-reaching outcomes of managed care, including shorter lengths of stay, cross training, augmentation of revenues by raising patient volume, interdisciplinary treatment, fewer and shorter outpatient and home health services, and “one stop shopping” where patients can access many services in one place (Joe & Hettinger, 1995). Some therapists note that the managed care system has compromised care by turning it into a bureaucracy that forces poor treatment, misunderstanding of patient needs, disregard for therapists’ opinions, delays in authorization, increased paperwork, and compromised reimbursement (Hettinger, 1995). Years before the introduction of the term managed care, many therapists cautioned against a growing press for productivity, efficiency, and profit that threatened humane practices (Baum, 1980; Boyle, 1990; Burke & Cassidy, 1991; Dickerson, 1990; Grady, 1992; Howard, 1991; Kari & Michels, 1991; Peloquin, 1993; Yerxa, 1980). The far-reaching controls of managed care, aimed first at excess, have limited care. How should therapists frame a response?

We might recall the appeals for reform of the health care system that invited a greater change than management. Many persons proposed a broader action with several aims, including universal access to adequate health care (Council on Ethical and Judicial Affairs, American Medical Association, 1995), comprehensive and affordable (quality) care by competent providers (Boisaubin, 1994), and a hope to focus on prevention and to personalize delivery (Boisaubin, 1994; Peloquin, 1993). This call to action transcends any response named management. Ron Anderson, a physician and administrator, said it well in his interview with PBS personality Bill Moyers (1993):

You try to bring healing to a person and help them [sic] heal themselves. Many times, if they have information, and if they’re empowered through a caring milieu, they will be better able to function. The doctors and nurses won’t be going home with them, so it’s very important that we get them to the highest plane of function that we can. We have a saying in our geriatric ward that we’ve never met a patient we couldn’t care for. We’ve met many we couldn’t care. (p. 26)

Management—skillful handling, direction, and control—is a function of good care but only a part of good care. Even in the realm of horse training where the term management originated, trainers have suggested other actions:

We shall have to give up our inclination to control our horse by force. Instead we shall have to try to learn to respect the way he wants to do things.... And, instead of trying to impose on our particular animal our idea of what he should be able to achieve, we must first seek to learn what his capabilities really are.... We shall have to add to our analytical capability an equal capacity for intuitive thought.... Without this, our relationship with our horse will be one of spiritual warfare instead of harmony and beauty. (Hassler, 1994, p. 16)

In health care, when management issues preempt all other concerns, the ethos of caring and the art of practice are at risk. There is much logic to the language of managed care, but that language seems inadequate to the task of caring. As Hayakawa (1969) noted, any one instrument has its limitations. A thermometer, made to read temperature, will not read color, weight, or odor. “Every language,” said Hayakawa, “like the language of the thermometer, leaves work undone for other languages to do” (p. 8). Attention to sound management principles, one valid approach to reforming health care delivery, leaves work undone; it needs to be part of a larger vision and responsibility.

Naming and Framing Another Response

In his reflections about education, Davies (1991) said much that may help this discussion. From his position on a state governing board, Davies concluded that the regulatory function of those on state boards is mere background; their essential function is to inspire education. A question that he thought board members must ask is this: “Are we helping to create an environment in which teaching and learning are honored and can flourish?” (p. 58). He said that the making of that environment is a call to (a) engender a restlessness throughout the system, (b) disturb complacency, and (c) insist that rules be broken when there is good
and sufficient reason.

The health care system invites a similar effort. Occupational therapists must see their business functions as a vital background to good practice. Because they have high stakes in health care delivery, therapists must manage themselves well. They must get behind the management effort. But they must also ask whether they are making an environment that nourishes care for the health of others. They might then name and frame a more essential action: inspire care.

Why should occupational therapists inspire health care delivery? To inspire is to exert a living influence, to animate or hearten the spirit (Merriam-Webster’s Collegiate Dictionary, 1993). To inspire is to make something happen—to build something—from the inside out. Inspiration is a form of edification. The various systems within which therapists practice need inspiration if they will emerge reformed. And occupational therapists are immersed in the kind of making that inspires.

Since its origins, occupational therapy has made inspiration a basic function. The strong link between occupation and care delivery, therapists manage responsibly while also inspire care.

There is a shouting SPIRIT deep inside me:
TAKE CLAY, it cries.
TAKE PEN AND INK,
TAKE FLOUR AND WATER,
TAKE A SCRUB BRUSH,
TAKE A YELLOW CRAYON,
TAKE ANOTHER’S HAND—
AND WITH ALL THESE SAY YOU,
SAY LOVING.
So much of who I am
is subtly spoken
in my making. (p. 61)

Meaningful occupation, the core of our therapy, animates and extends the human spirit.

The founders of the profession often spoke of its spiritual aims. Barton (1920) named occupational therapy a making—not of a product, but of a person stronger physically, mentally, and spiritually than before. The inspiring action of occupational therapy is well-described by Ruggles (Carlova & Ruggles, 1946): “It is not enough to give a patient something to do with his hands. You must reach for the heart as well as the hands. It’s the heart that really does the healing” (p. 69).

On a systemic level, occupational therapists are also animators. Whether they practice in hospitals or schools, prisons or community programs, therapists hear comments that note their singularity in livening the settings within which they work. Occupational therapy clinics are alive; therapists make life worlds that inspire and empower.

Inspiration is a function of occupational therapy; it is familiar and basic. It seems fitting that we stand among those who manage responsibly while also inspiring care for the health of others.

Inspiring Care: Moving Past the Rhetoric

The features of managed care—efficiency, accountability, and cost containment—have become familiar, and we recognize in them the actions of good business. But how shall we recognize the actions that inspire care? As long as they shape an environment in which caring for the health of others is central, these actions may take many forms. And whether this shaping occurs on a large or small scale, its function might, as Davies (1991) suggested, engender a restlessness throughout the system, disturb complacency, and cause any rules that compromise health care to be broken with good reason.

Therapists might consider the following example: a large action aimed at the rules of managed care. OT Week ran part of an article from The Washington Post about the bills spearheaded by physicians and passed by five legislatures (Doctors Take on Managed Care, 1995). These bills restricted managed care business practices “in the name of patient protection” (p. 12). The Arkansas law, for example, requires that every health maintenance organization (HMO) allow patients to see any physician who will accept the HMO rate, thereby increasing access. Occupational therapists can launch efforts. At the very least, they can lend support to those who inspire the system politically.

Therapists might consider the following to be an action that challenges the rules but on a smaller scale. Many persons spend time writing letters to justify treatment or advocate therapy; the letters propose a broader view of health. Whenever caring for a person’s health becomes more central to payers as a result of these letters, the therapists who wrote them can claim to have inspired health care.

As I considered the smaller actions that inspire, I saw a woman walking briskly down my street. Although walkers are common in my neighborhood, she caught my attention because she carried a brown bag and moved from one side of the road to the other, grabbing curbside litter. I was inspired. Nested within her personal routine (exercise) was an action that launched a larger effort (neighborhood cleanup).

Persons can inspire most of the systems within which they function. In 2 to 3 minutes, sales cashiers can liven someone’s day. If a form of inspiration can occur within such short time frames, there is cause to believe that therapists can, over longer periods, make caring for health a more central concern among patients, coworkers, administrators, and third-party payers.

One of our founders named the inspiration that can edify our practice as he spoke to a group of graduating students:

May you realize in increasing measure the value of certain spiritual things which are the real making of life, but which we call by many common names. Kindness, humanity, decency, honor, good faith—to give these up under any circumstances whatever would be a loss greater than any defeat, or even death itself. (Kidner, 1929, p. 385)

The call to manage and inspire care is a plea to bring to life forms of health care delivery that manage the system and animate the act of caring about health.
Actions That Inspire: A Sampling

The following are general suggestions for inspiring the health care delivery system. Each has a background managerial function within which nests a more essential and inspiring function (B. C. Abreu, personal communication, October 15, 1995). These suggestions make sense within the context of this reflection, and they seem sound to clinicians with whom I have shared them. Admittedly, they lack the particularity of application that persons who enact them might provide. I offer them to those who seek possibilities.

1. Infuse competent treatment with kindness, decency, honor, and good faith.
   Managerial function. This action makes a good “package deal” for patients, payers, and referral sources.
   Inspirational function. We do the right thing for our clients.

2. Introduce, research, and publicize clinical improvements, flexible approaches, and creative managing techniques.
   Managerial function. This action establishes our efficacy as practitioners, our artistry as practitioners, and our skill as managers.
   Inspirational function. We promote practice by showing what we do and telling how it works.

3. Include in clinical pathways and practice guidelines the protocols and critical outcomes that address physical and mental health in the broad sense.
   Managerial function. This measure is cost-effective in the long run.
   Inspirational function. We retain our holistic heritage.

4. Speak with logic and passion for patients whose health depends on longer stays and more therapy.
   Managerial function. This action reclaims consumers at risk and offers good service.
   Inspirational function. We temper limited access with strong advocacy.

5. Educate clients with a knowledge that leads them to prevent dysfunction and manage themselves.
   Managerial function. This action taps a new market and supports a goal of managed care.
   Inspirational function. We enact our ethos of helping others to help themselves.

6. Declare boldly and widely (at local, state, and national levels) the links between human occupation and health.
   Managerial function. This action reclaims our unique position in health care systems.
   Inspirational function. We promote the professions’ core function, values, and standards.

7. Open channels that foster dialogue with managed care personnel.
   Managerial function. This action affirms our worth as players in the system.
   Inspirational function. We declare aims for reform broader than cost containment.

8. Assume leadership roles (e.g., members of quality improvement councils, case managers, case reviewers) in the systems within which we practice.
   Managerial function. This action shows systems personnel that we are savvy leaders.
   Inspirational function. We take positions from which to argue a vision of health that includes occupation.

9. Monitor and support larger political actions (e.g., legislation, coalitions).
   Managerial function. This action helps us shape policy.
   Inspirational function. We press for health care delivery that is managed, caring, and ethical.

10. Apply sound problem-solving approaches to paperwork and business tasks.
    Inspirational function. This action jostles the sluggishness of reimbursement.
    Inspirational function. We make more time for caring.

11. Cultivate among practitioners a respect for business principles.
    Managerial function. This action supports quality-process models (i.e., total quality management, continuous quality improvement).
    Inspirational function. We include in process monitoring the actions that meet high standards.

12. Collaborate with those whose vision (i.e., caring for the health of others) supports our own.
    Managerial function. This action gains us strength in numbers and conveys our faith in teams.
    Inspirational function. We cause deeper and better reform.

When Hall (1922) spoke about the task faced by the Society for the Promotion of Occupational Therapy, he could have been noting the challenge we face today: “It seems reasonable to assert that here is a work of national importance, a human reclamation service touching vitally on matters of vast social and economic consequence” (p. 164). We have begun to manage health care delivery, and there is logic in our getting behind that effort. But we can reclaim more.

Health care reform is a building from the inside that calls for a greater responsibility than any form of management that shapes from the outside in. Health care reform, in its truest sense, is an edification through actions large and small—it is the making of an environment in which caring for the health of others is central. When it comes to health care delivery, the issue goes past the logic that we must manage care to this question: Shall we inspire it? 

References

Barton, G. E. (1920). What occupa-
tional therapy may mean ro nursing. Trained Nurse and Hospital Review, 64, 304–310.


