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# Impact of Managed Care on Employment and Training: A Primer for Survival

*Managed care has become the dominant economic force in health care delivery and has challenged many of professional psychology's training concepts and cherished attitudes. Organized psychology has not kept pace with the rapid industrialization of health care during the past decade and has been overlooked as a participant in health economic decisions. A number of changes need to be made in professional education and training if psychology is to be a major player in the new health systems. Additionally, professional psychologists must reexamine some of their most generally accepted attitudes and beliefs if they are to survive. These are described with a number of recommendations for the survival of an embattled profession.*

> *The illiterate of the future are not those who cannot read or write, but those who cannot learn, unlearn and relearn.*
>
> *—Alvin Toffler*

Psychotherapists have long been conditioned to believe that more is better, "self actualization" is the real goal of psychotherapy, and, consequently, the most prestigious practitioners are those who see a limited number of clients over a long period of time (Bloom, 1991). Managed

care, with its emphasis on brief therapy, is changing all of this. A growing body of outcomes research demonstrates that efficient therapy can also be effective therapy (Bennett, 1994). For the past several years, it has been argued that most psychotherapists must receive retraining to become skillful in the efficient-effective therapies (Budman & Gurman, 1983a, 1988). Over the past decade I have retrained literally hundreds of psychiatrists, psychologists, social workers, and counselors in a 130-hour module over a 2-week period and observed that for retraining to be successful, there must be significant changes in the practitioners' attitudes and belief systems. This "enabling attitude" has now only begun to receive the attention of those who are engaged in retraining practitioners (Bennett, 1994; Friedman & Fanger, 1991). Yet this point of view is not new.

Balint (1957), in his monumental work, said.

> A further reason for the failure of traditional courses is that they have not taken into consideration the fact that the acquisition of psychotherapeutic skill does not consist only of learning something new: It inevitably also entails . . . a change in the doctor's personality. (p. 23)

Although Balint was speaking of training the general medical practitioner in psychotherapeutic skills, three and a half decades later Bennett (1994), in addressing the personality changes needed to retrain psychotherapists in efficient-effective interventions, stated that "ironically, much of this involves teaching psychotherapists to become more like general practitioners."

When Cummings and VandenBos (1979) described their "general practice of psychology" and argued that the psychologist should function as a primary care physician not subject to a gatekeeper, they had not anticipated how important these concepts would be in this era of managed care. Their formulations are more appropriate than ever:

> By combining dynamic and behavioral therapies into interventions designed to ameliorate the presenting life problem, using a multimodal group practice, professional psychology can define its own house in which to practice. This general practice of psychology postulates throughout the life span the client has available brief, effective intervention designed to meet specific conditions as these may or may not arise. (p. 438)



And in further describing "brief, intermittent psychotherapy throughout the life cycle," they concluded:

> There is a great need in our society for that now extinct person known as the family doctor, a caring human being who heard and responded to all of a family's therapeutic needs. Who is better equipped to be the family doctor in this age of alienation than the psychologist? (p. 439)

## THE RESOCIALIZATION OF PSYCHOLOGY

Currently underway is the greatest resocialization of psychologists to occur since the explosion of clinical psychology in the post-World War II era. It is being stimulated by the unprecedented growth of managed care, and it is occurring without (until very recently) the help and guidance of the American Psychological Association (APA). Professional psychology is rapidly changing itself to meet the demands of survival in spite of the shortsighted assurances of many of professional psychology's leaders during the past several years that managed care was paradoxically both a gimmick that would go away and a threat that would be defeated. This seemingly overnight resocialization of professional psychology has five aspects.

### 1. The Stampede Into Group Practices

Recognizing that solo practice is rapidly becoming an endangered species (Cummings, 1986; Dörken & Cummings, 1986, 1991), psychologists are forming multimodal group practices all over the nation, and at an astounding rate. In many instances managed care companies have helped psychologists in their networks to identify exceptionally skilled colleagues and have encouraged their banding together and facilitated their transition from solo to group practices. The principles of the general practice of psychology (Cummings & VandenBos, 1979) are receiving new and intensive interest, and the lines of demarcation among the various schools of psychology are blurring in favor of psychotherapy integration (Cummings, 1992c). Among those practitioners so engaged, there is a new vitality, whereas for those who desperately cling to solo practice or who have waited too long and find the networks closed to new applicants, there is a growing fear and depression.

**2. Acquiring the Growing Arsenal of Time-Effective Treatment Techniques and Strategies**

Psychology's long-standing resistance to brief psychotherapy is being swept away in the rush to acquire new skills in time-effective interventions. Those who have long been associated with intensive, problem-solving approaches (Bennett, 1994; Budman & Gurman, 1988: Cummings, 1992) are suddenly in demand, and new national companies have been formed in response to the clamor for retraining. One need only peruse the scores of brochures that are coming to practitioners through the mails to see that for every seminar in long-term therapy there are literally dozens of offerings in time-effective or brief therapy. The APA, which would be expected to lead the way in this conceptual revolution, was, under Bryant Welch, curiously aloof. Both the stampede into group practices and the rush to acquire new therapy skills are grass-roots phenomena by psychologists who are in the trenches.

**3. A Shift in Values and a Fundamental Redefinition of the Role of a Helper**

Practitioners who have long enjoyed a steady, limited stream of fee-for-service clients coming through their comfortable offices will understandably lament the passing of this golden era of psychotherapy. Yet new payment methods such as capitation and prospective reimbursement free the practitioner to perform services needed by the client but previously not covered by fee-for-service insurance. Ultimately, they make possible offices-without-walls, a prospect that is frightening for many and eagerly welcomed by others. Because the shift in attitudes and values is difficult but fundamental to the practitioner who survives, the changes required will be more fully described here later.

**4. The Ability to Demonstrate Efficiency and Effectiveness Through Outcomes Research in One's Group Practice**

Both practitioner and client are struggling with the new intrusions called *utilization review* and *case management*. Gone are the days when the third-party payor, mystified by what goes on in the inner sanctum of psychotherapy, accepted the word of the practitioner. Gone also are the days when practitioners justified their treatment by quoting gurus, originally those such as Freud, Jung, and Adler, and more recently, to name only a few, Haley, Erickson, Goulding, Masterson, and occasionally (to my dismay) even Cummings. Organized settings make possible sophisticated outcomes research, and soon third-party payors (now the managed care companies) will know more about what goes on in the treatment setting than does the practitioner. Psychotherapists will have to demonstrate their effectiveness as well as their efficiency.



Confidentiality is for the protection of the client and must be zealously guarded. It was never intended to protect the practitioner from inefficiency or ineptitude, but many psychotherapists rationalize confidentiality as a refuge for themselves. As harsh as it may sound, not all practitioners are created equal. Fifty percent are below average by definition! As time-effective techniques continue to reduce the number of psychotherapists needed, managed care companies will want to draw from the upper half of the normal curve of providers. Practitioners will have to justify what they do in outcomes research. This will require a reformulation of confidentiality so that it continues to protect the client yet yields aggregate data that permit research.

Psychologists, with their knowledge and training in research, will have the advantage over other professions that provide psychotherapy and who are not so highly trained. However, psychotherapy outcomes research is a difficult and highly specialized endeavor, and just as retraining in time-effective therapy is needed for most practitioners, the sharpening of research skills will be a must.

**5. Regaining Autonomy by Qualifying as Prime (Retrained) Provider**

Most psychotherapists who provide treatment services for managed care companies do so in networks of preferred providers. The industry is beginning to identify practitioners whom they call *prime providers* or *retained providers*. These are practitioners who have formed multimodal group practices through which a total array of treatment and diagnostic services can be delivered on a capitated or prospective reimbursement basis. Thus the group named as a prime provider is responsible for a defined population in a geographic area. Prime providers or retained groups have demonstrated exceptional skills in time-effective therapies, and they further demonstrate their continued and growing effectiveness by conducting their own outcomes research. Internally, outcomes research is used to sharpen the focus and effectiveness of their own delivery system.

The innovative vitality of many psychologists has propelled them be-

yond the prime provider groups to *regional group practices* (RGPs), which are multidisciplinary, involve scores and sometimes even hundreds of practitioners, and serve a wide geographical area and diverse populations. The RGP is undoubtedly the wave of the future and will require purchasing the legal, business, and management skills needed to succeed. Herein lies real autonomy: Contracting with managed care organizations (MCOs), these RGPs possess considerable clout. An MCO can readily replace an individual practitioner and even a small group. A delivery system using a large regional group is not easily replaced, resulting in an increase in bargaining strength for the practitioners.

The advantage of prime provider groups to the managed care companies is in significant savings in utilization review and case management inasmuch as the retained provider group is case managing itself, individually and collectively. The advantage to the practitioner is the regaining of autonomy, for now no one is looking over one's shoulder.

## ESSENTIAL PARADIGM SHIFTS

These emerging extended group practices (RGPs) have a special attractiveness to managed care companies other than just the ability to serve large segments of the market—their ability to predict costs—which enables the RGP to enter into capitation agreements and assume risk. It will not be long before group practices that cannot predict costs will be replaced by those that can.

To succeed as a prime provider will require a fundamental and even pervasive shift in values from the traditional approach, which is referred to as the *dyadic model*, to the time-effective approaches, which are referred to here as the *catalyst model*. Drawing on my experiences in retraining literally hundreds of psychotherapists during this past decade. I have chosen to describe this imperative change in values as a series of paradigm shifts. I also acknowledge liberally incorporating the fertile ideas of Bennett (1994) and Budman and Gurman (1988), which in turn are based on their own extensive experiences in retraining.

The need for a fundamental shift in values is no more pronounced than in the expressed attitudes of Cantor (1993), who justified 11 years of semiweekly sessions by the nonsequitur that she had accorded the client a reduced fee, or by Kovacs (in a presentation at the 101st Annual Convention of the APA as cited by Rosofsky, 1993), who acknowledged that he would accept a Woody Allen in 24 years of psychotherapy as the price to be paid for therapist autonomy. Society simply will no longer accept such blatant rationalizations, and because we have lost control over the delivery of our own services, such statements resemble "grandstanding" to our own constituency.



The extreme positions of Cantor and of Kovacs are not reflective of those of most psychologists who nonetheless understandably dislike managed care. Working within it is seen as akin to (borrowing words from the popular motion picture) sleeping with the enemy (Zimet, 1994), not exactly a winning attitude, but one that was nurtured by the unnecessarily strident stance of the APA during the latter part of the 1980s. The APA Practice Directorate has taken a more responsible stance under Russ Newman, developing materials to help psychologists better interact with managed mental health care systems. It has not been easy for psychology, which struggled many years to attain autonomy only to see the rules of the game change just as it became the preeminent psychotherapy profession. All this underscores the importance of the following paradigm shifts.

### Paradigm Shift 1

Dyadic model: Few clients are seen, but for lengthy courses of treatment, usually individually.

Catalyst model: Many clients are seen, for brief episodes of treatment, very often in nontraditional modes.

Outcomes research has already begun to demonstrate that many psychological conditions do better in brief episodes of problem-solving therapy (Cummings, 1993). Other examples are group programs designed to teach and facilitate independent living among the chronically mentally ill that maximize effectiveness, whereas continuous individual psychotherapy for these clients is only minimally impactful. Many therapists have found that it is much harder work to see a large volume of patients in brief episodes than to treat a few patients several times a week continuously for several years.

### Paradigm Shift 2

Dyadic model: Treatment is continuous, often weekly or even more frequently.

Catalyst model: Treatment is brief and intermittent throughout the life cycle.

Brief, intermittent therapy throughout the life cycle has now been empirically studied for more than 30 years of follow-up (Cummings, 1992c) and has been shown to be more efficient and effective than keeping the patient in treatment beyond the resolution of the life problem presented.

**Paradigm Shift 3**

Dyadic model: The therapist is the vehicle for change, and emphasis is on treating psychopathology. The aim is a "cure" in some form.

Catalyst model: The therapist is merely a catalyst for the client to change, and the emphasis is on restoring the inevitable drive to growth that has gone awry.

This is decidedly a developmental model that regards growth as the striving of every living organism. The therapist acts as a catalyst so that the client resumes the growth cycle that was temporarily derailed. It broadens the client's repertoire of responses to conflict, stress, or anxiety beyond the typical mode acquired in childhood. The client may, in future years and under exceptional stress, temporarily resort to the old mode, but it is surprising how little intervention is needed to resume growth in these intermittent contacts.

**Paradigm Shift 4**

Dyadic model: The therapy is the most important event in the client's life, and it is within the treatment span that the client changes.

Catalyst model: The therapy is an artificial situation like an operating room, and significant changes occur and keep occurring long after therapy has been interrupted.

This is especially difficult for therapists who need the narcissistic supplies accorded by grateful clients. It is long-term clients whose dependency has been fostered who are grateful. In the newer model, clients recall the experience as something that was accomplished by themselves.

**Paradigm Shift 5**

Dyadic model: Therapy continues until healing occurs, and the client is terminated as "cured" to some degree.

Catalyst model: Therapy is yeast for growth outside therapy, and formal treatment is only interrupted. The client has recourse to therapy as needed throughout the life cycle.



The client does not remain in treatment, as many do, for insurance against the fear the problem or symptom will recur. Termination anxiety is diminished or eliminated inasmuch as treatment is only interrupted, and the client is encouraged to return as needed.

**Paradigm Shift 6**

Dyadic model: Individual and group psychotherapy in the office are the main modalities by which healing takes place.

Catalyst model: Every healing resource in the community is mobilized, often as a better approach than office practice.

Rather than disdaining support groups or self-help programs, the practitioner cooperates with and offers consultation to these resources.

**Paradigm Shift 7**

Dyadic model: Fee-for-service is the economic base for practice, and the therapist must constantly fight against limitations on benefits.

Catalyst model: Prospective reimbursement or capitation frees the therapist to provide whatever psychological services are needed by the client.

House calls, imperative with house-bound agoraphobics and desirable with the chronic mentally ill, as two examples, become standard. Prevention programs that include such things as stress management, assertiveness groups, healthy lifestyle programs, parenting groups, and vocational and marital counseling, can be provided, whereas they would not be covered in fee-for-service insurance reimbursement.

## PSYCHOLOGY AND HEALTH ECONOMICS

Having surmounted the psychological (attitudinal) barriers to a successful future practice, the psychotherapist must now acquire business and management skills. For those psychologists who are like me, this is the most formidable barrier of all. It is as if we gravitated to psychology because we espouse statistics but eschew anything that smacks of business or economics. We no longer have the luxury of our splendid isolation. What follows is our own "reality check."

### 1. How Did Managed Care Happen?

All goods and services follow the laws of supply and demand: Increased demand over the available supply causes prices to escalate, whereas a glut of supply over demand results in prices falling. The glaring exception has been health care. An overproduction of practitioners should cause fees to drop; instead, the greater the number of health care practitioners, the higher have been the fees. This is because the practitioner controls both the supply and the demand sides. It is the doctor who decides what is to be done, and how and when it will be done, and in the case of psychotherapy, how long it will take. All this is rapidly changing, because those who pay the bills (principally the employers) are taking the economic supply-demand control away from the doctor. As intrusive and arbitrary as managed care can be, when we had the control there was no incentive within our ranks to reduce costs by increasing our efficiency and effectiveness. Health care escalated to 2½ times the inflation rate of the general economy, with mental health and chemical dependency treatment driving the costs disproportionate to their perceived importance by society.

### 2. The Industrialization of Health Care

After 200 years as a cottage industry, health care is industrializing. The supply-demand control of health care's goods and services has shifted from the practitioner to industrial interests. As in all the industrial revolutions that preceded this one, there are six characteristics that constitute insights as to what lies ahead. (a) Those who make the goods and provide the services (in our case, psychotherapy) lose control of the production of their own goods and services. The control passes to business interests. (b) Because industrialization thrives on cheap labor, the master's-level issue that psychology failed to resolve may well be our demise. In addition, many practitioners have already experienced a reduction in income resulting from the lower fees "negotiated" as part of belonging to an MCO network. (c) Efficiency and effectiveness increase under industrialization, with a consequent reduction in the numbers of practitioners required. For example, 38 HMOs the size and efficiency of Kaiser Permanente can treat 250 million Americans with only 290,000 physicians, half the present number, and with only 5% of the gross national product (GNP) instead of the current 14%. (d) Quality at first suffers, then reaches a new higher level as the industry grows out of its infancy. Practitioners are seeing this wide disparity in quality and will also soon begin to see a stabilization. (e) The increased efficiency of industrialization makes possible distribution to the masses. As an illustration, no one would insist that Levitz furniture is of the quality of Chippendale, but the general population would not have adequate furniture without industrialization. Hence, "managed competition" is the centerpiece of every major health reform proposal under current study. To put it simply, everyone will have shoes, but there will be no more Gucci loafers. (f) Finally, there is a consolidation where the successful companies are buying the unsuccessful ones. This prediction, made years ago (Cummings, 1986), is exceeding all expectations in both intensity and timing. As predicted, the majority of health care in America may be in the hands of 12 to 18 "mega-meds" by the year 2000.



### 3. The Less Expensive Practitioner

Psychology's failure to find a place for the master's-level practitioner has resulted in the formation of a subdoctoral psychotherapy profession that now has statutory recognition in almost all of the 50 states. The APA has continued to recognize, through the annual publication of a directory (*Graduate Study in Psychology*), over 500 terminal master's programs in psychology, which are producing 6,000 master's-level counselors per year. There are now approximately 130,000 licensed or certified counselors, more than all the licensed or certified counselors, more than the licensed psychologists and psychiatrists combined!

This historical shutting-out of the master's-level counselors while encouraging their training, coupled with our failure to demonstrate that doctoral-level psychotherapists are more effective, are leading the managed care companies to look at the master's-level counselor as a less expensive alternative. The public and the media have already adopted the generic word *therapist*, which cuts across the various professions, whether these be doctoral psychologists, clinical social workers, or master's-level counselors. The generic word is applied even to psychiatrists doing psychotherapy but usually not to those performing medication therapy inasmuch as this is the one activity that excludes nonmedical therapists. Inevitably, most of the psychotherapy of the future will be conducted by master's-level "techni-

cians," and this will further reduce the demand for doctoral-level psychotherapists and redefine the role of the successful doctoral psychologist, as will be described here later.

## THE PSYCHOTHERAPY OF THE FUTURE

The most powerful economic arguments for mental health benefits is the evidence that they reduce inappropriate medical care utilization (Cummings, 1991: Goldman & Feldman. 1993). In the 130 million Americans now covered by managed behavioral health care, most of the economic "fat" has been effectively wrung from the mental health system. There remains the far greater economic drain in the medical-surgical sectors resulting from the use of services by the millions of physician visits by somaticizing patients (Cummings, 1993). Thirty years of research have demonstrated the medical-cost offset effect in organized settings: the reduction of inappropriate medical-surgical care by the use of psychological interventions. The current rediscovery of the medical-cost offset phenomenon indicates that the future of the doctoral-level psychologist will be found in health psychology.

The doctorally trained psychologist is in a unique position to plan, research, and implement intervention programs for both the somaticizers and the noncompliant chronically physically ill (Cummings, Dörken, Pallak, & Henke, 1993; Pallak, Cummings, Dörken, & Henke, 1993), as well as behavioral programs for the millions who demonstrate faulty living habits. But in the fact that the interventions of the future will be derived from empirical outcomes research, resulting in treatment protocols, there is an even broader role for the doctoral-level psychologist.

As previously stated, most of the hands-on behavioral treatment will be conducted by master's-level therapists working with empirically derived treatment protocols of targeted, focused interventions. Research, experience, and the nature of human diversity have shown that protocols serve only about 30% to 35% of the persons suffering from each condition being addressed. The master's-level therapists will need the clinical acumen of the doctorally trained therapist for the remaining 65% to 70% of patients.

Outcomes research is beginning to demonstrate that many psychological conditions respond more effectively to group therapy than individual therapy. In addition, there is a growing body of evidence that



indicates preventive services in the form of psychoeducational groups reduce the demand for both psychotherapy and inappropriate medical-surgical utilization. These psychoeducational groups range from stress management, parenting programs, and smoking cessation, to programs designed to improve compliance with medical regimens in hypertensives, diabetics, and other chronic diseases where noncompliance is rampant. Outcomes research has identified well over 100 potentially useful psychoeducational approaches.

It is very likely, as a result of empirical findings, that only 25% of the psychotherapy of the future will be individual. It is anticipated that another 25% will be group therapy, whereas half of the psychological interventions will be preventive services in the form of structured psychoeducational programs involving small group participation. The doctoral psychologist will be conducting the empirical research on which the eventual design and implementation of these therapies will rest. It must be reiterated that the 25:25:50 ratio, or something resembling it, will be the result of tested effectiveness and not primarily a drive for further cost-containment.

The most important single characteristic that will define the successful psychologist of the future will be the ability to predict one's costs. This makes the psychologist (i.e., group of psychologists) eligible for capitation and able to assume risk. Without the ability to predict costs, there can be no determination of the capitation rate for which the practitioners will assume the risk to perform all of the services. It also follows that the ability to control (reduce) one's costs makes possible a capitation rate that will be more attractive than that of one's competitors. Only the predictability of costs, therefore, will make the practitioner a participant in the future health care system.

Finally, the successful psychologist will have to market the group's products and services once these have been developed. Unfortunately, space does not permit an extensive discussion of marketing skills. Suffice it to say that most practitioner groups will need to purchase this imperative service.

It would follow from the foregoing that our doctoral programs in professional psychology, including the professional schools, are training excellent practitioners for the 1980s. The skills that future challenges require are not taught in the present curricula. In 1994 the California School of Professional Psychology's Los Angeles campus launched the first managed care track, a historic event that is a har-

binger to the doctoral programs that are lagging behind society's demands for the new professional psychologist.

## SUMMARY AND CONCLUSION

The prediction that by the year 2000 more than 50% of current psychotherapists will be out of business (Cummings, 1988) is rapidly moving to fulfillment. The losers will be those psychologists who do not or cannot master the foregoing attitudes and skills.

The future professional psychologist will be primarily a health psychologist who will require retraining to acquire an enabling attitude for success and a knowledge of the growing body of efficient-effective therapies. The most likely role will be that of a supervisor to master's-level therapists who are performing from empirically derived protocols of focused, targeted interventions, from which there will be as many as 70% of patients not covered by the intended protocol who will require the benefit of doctoral-level skills.

Furthermore, the future doctoral-level psychologist is in an excellent position to conduct outcomes research and to plan and implement effective and efficient delivery systems in an expanded clinical management role. In summary, the future doctoral practitioner will be an innovative clinician, a creative researcher, an inspired supervisor, a knowledgeable health psychologist, a caring skilled manager, and an astute businessperson.