

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

A

Social Work Practice and Industrialized Managed Care:
A Case Study

by

Donald Stanwood Cornelius

A dissertation submitted to the Graduate Faculty in Social
Welfare in partial fulfillment of the requirements for the
degree of Doctor of Social Welfare, the City University of
New York

1997

UMI Number: 9720080

**Copyright 1997 by
Cornelius, Donald Stanwood**

All rights reserved.

**UMI Microform 9720080
Copyright 1997, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI
300 North Zeeb Road
Ann Arbor, MI 48103


© 1997

Donald Stanwood Cornelius

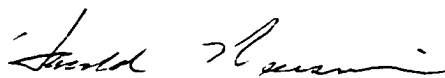
All Rights Reserved

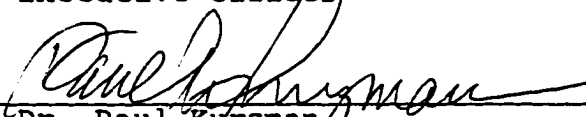
This Manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare

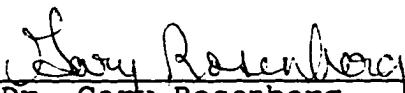
12/13/86
Date


Dr. Irwin Epstein
Chair of Examining Committee

12/13/76
Date


Dr. Harold Weissman
Executive Officer


Dr. Paul Kurzman
Supervisory Committee


Dr. Gary Rosenberg
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

Social Work Practice and Industrialized Managed Care:

A Case Study

by

Donald S. Cornelius

Adviser: Professor Irwin Epstein

Presented in this study are the findings from an examination of the practice experiences of a group of social workers to adapt the structures of their for-profit outpatient mental health services to the policy and economic requirements of industrialized managed care. Using the stage theory of social program development and evaluation, developed by Tripodi, Fellin and Epstein (1978) in Differential Program Evaluation and Bielawski and Epstein (1984), the study describes and evaluates the evolution of the practice through the four stages of program initiation, contact, implementation and stabilization. Discussion of the initiation stage explores the impact of the privatization and industrialization of social welfare, and the application of entrepreneurial business values and practices on service design. The contact stage is examined through the application of marketing theory and practice as a method to engage clients. Program implementation, stabilization and outcomes are discovered to be determined more by business skill and market forces than by the nature or quality of

social work intervention with primary clients. The study discusses the difficulties of securing program success in a market environment unrelated to the traditional roles, skills and experiences of social work practice.

Implications from the case study's findings are used to suggest ways the field of social work might influence the ongoing developments of industrialized social welfare.

This study is unusual in that it describes a program that failed to achieve its intended mission of social service while attempting to maintain the professional autonomy and economic stability of its social worker principals.

Acknowledgements

With joy and thanksgiving I acknowledge all the many people who through their support and encouragement have been significant contributors to the successful completion of this dissertation and of my doctoral education.

Irwin Epstein, who served as my mentor and guide, contributed, without reservation, his extraordinary breadth of knowledge and experience. His regard for social work and his standard of excellence for the field and its practitioners is evident both in his scholarship and personal dedication. I am grateful for our walk together and for the inspiration of his example. Gary Rosenberg is the one person most responsible for encouraging me to accept the challenge of doctoral study. He calls forth the best in other as he does in himself; for this, I will always be indebted. Paul Kurzman has been a sure and solid supporter throughout my time in the doctoral program. His open availability to his students and the precision of this counsel is admirable and deeply appreciated. I am also grateful to the other members of the doctoral faculty, and in particular to Harold Weissman, who through their efforts have led and acknowledged by participation in the university.

The journey represented in this study was joined by my friends and colleagues Mark Dworkin and E. John Levinson. They have permitted me to share our story so that others might learn from our experiences. Their work, insights and perspective have formed a invaluable contribution to its content. I thankfully acknowledge this gift to myself and to the field of social work.

Friendships are had won and therefore deeply treasured. Richard Joelson has become a friend indeed as we struggled together through six years in the doctoral program. He has counseled, encouraged and, through his facility with language, contributed to the shape of the dissertation.

This work is dedicated to honor my life partner Leonard Rothschild. His confidence in my goal, loving reassurance and sacrifice of time and attention have been written on every page. No expression of gratitude will completely tell how much I appreciate the freedom and respect he brings to our lives. Together we have accomplished a mighty deed.

Table of Contents

Introduction	1
Chapter	
1. Perspective From the Literature: Industrialized Social Welfare and Social Work Practice	5
Industrialization	5
Privatization	9
Behavioral Health Care: The Expanding Scope of Mental Health Treatment	14
Managed Care and Mental Health	21
Current Issues in Mental Health: A Summary	26
The Social Worker: A Role in Managed Mental Health Care?	28
A Plan - Reflection in Action	36
An Evaluation - Reflection on Action	39
2. Study Design and Methodology	43
The Design	44
Data Sources	47
Data Integrity	54
Organizing the Data	56
3. Program Initiation: An Environment for Opportunity	60
Responding to Opportunity	61
Corporate Sponsorship	65

Finding the Principals	68
Professional Corporation	77
Responding to the Managed Care Market	80
Strategic Misunderstandings and Miscalculations	83
The Licensure Miscalculation: An Expensive Sidetrack	98
Reviewing the Role of XM	101
Analysis and Conclusion	104
4. Program Initiation: Building the Organizational Structure of CCA	107
Entrepreneurship	108
Personal Investment: Decisions and Behaviors .	109
Capital Risk: Time and Money	113
Capital Risk: Intellectual and Emotional	117
Building the Organization	124
The Business Plan	125
Management	131
Capitalization	137
Advise and Counsel	146
Summary and Analysis: Building the Organization	152
5. Program Contact: Locating and Engaging Customers	157
Planning: Market Research and Product Development	161
Sales: Marketing the Continuum of Care	166
Analysis: What went wrong?	173

Market Research and Development: A Second Effort	180
Marketing for Capital Acquisition	188
Analysis	198
6. Program Implementation: An Action Stage of Program Development	205
The Staff	207
The Clients	212
Services and Interventions	217
Implementation Outcomes	221
Clinical Outcomes	223
Business Outcomes	228
Program Stabilization: An Unstable Outcome	234
De-stabilization of the Partnership: The End of Business	237
7. Discussion	245
Viability of Managed Care Oriented Group Practice	249
Professional Autonomy	260
Issues of Ownership	268
Perspectives of Influence	269
References and Bibliography	277

List of Tables

Figure 1. Client Population by Age	213
Figure 2. Client Population by Primary Diagnosis	215
Figure 3. Length of Treatment	216
Figure 4. Satisfaction Survey Results	226
Figure 5. Client Contact Sessions - September 1994 to April 1995	229
Figure 6. Income and Expenses	231

Introduction

Social workers have been involved in the delivery of mental health services since the closing days of World War I. This involvement has consisted of a broad range of activities including direct treatment services to clients, developing and disseminating knowledge about mental illness and treatments, building and administering mental health service delivery systems, and in the last several decades, achieving recognition along with psychiatry and psychology as independent professional practitioners of mental health diagnosis and treatment.

Primarily these activities have been conducted within two venues. Social workers have staffed and administered the public and private agencies established to provide treatment to the mentally ill. And secondly, either as individuals or in small groups, social workers have established stand alone private practices catering to the mental and emotional health needs of their communities.

In both instances, social workers have achieved relative autonomy in determining the structure, the process and the intended outcomes of the care they provide. This autonomy has been radically challenged in the last decade by several fundamental changes in the health care delivery system.

Privatization and industrialization have been the dominate forces in this change. Privatization has moved the provision of health care services from public and voluntary auspices to private entrepreneurial ones. At the same time health care delivery has become an important profit center for business corporations. In a rapidly escalating process over the last ten years, large for-profit corporations have introduced the goals, techniques and values of the industrial economy into the provision of health care. Health care professionals in turn have had a diminishing role in determining the character of health care delivery.

Social workers, along with other health care givers, have had little choice but to accommodate these changes. Through a gradual accumulation of financial control and with governmental sanction, the insurance industry has become the conduit through which most private and public health care dollars are distributed. With the power of the purse, insurance companies have been increasingly determining the structure and process of care. Those providers who choose not to accommodate to these changes find themselves outside the reimbursement stream.

The social worker who may wish to remain active in reimbursed health care is challenged by the opportunities and difficulties inherent in providing service in this environment. Much has been written about the history and development of this market. There are materials and forums

available that suggest strategies of accommodation to it. However, there are few instances in the literature where social workers have chronicled the professional and personal consequences of making these accommodations. It is the purpose of this dissertation project to begin to address this lack of information.

Utilizing a single case study methodology, the investigator will describe and analyze the development, practice experience and dissolution of Counseling Care Associates, P.C. (CCA). Note: the name CCA has been created to mask the identity of the agency and to protect the confidentiality of its principals, Board of Directors and the data sources for this study. CCA was founded in October of 1992 as a professional corporation with the intention of providing mental health services (behavioral health care) to the individuals who were covered by the industrialized managed care organizations active in a major metropolitan region of the northeast. For reasons that will be discussed, the principals of CCA abandoned the attempt to implement this mission in September of 1995. The report of CCA's experiences entails: a) a discussion of the economic and social policy environment behind the development of CCA; b) the design of services which conform to the contextual assumptions; c) the implementation of the design; d) an evaluation of the professional corporation's experience from inception to dissolution; and e) an exploration of the

implications for social work practice as the behavioral health care industry dominates the provision of mental health services.

CHAPTER 1

Perspective from the Literature:

Industrialized Social Welfare and Social Work Practice

CCA, as a social work practice providing behavioral health care services, has a social and an economic context. Understanding this framework is central to grasping the motivation and structure of the practice. There are five elements to the context which will be explored in detail: 1) the industrialization of health care; 2) the privatization of public welfare services; 3) the reframing of mental health services, from psychiatry to behavioral health care; 4) social work as a mental health profession; and given this context, 5) a desire of social workers to maintain some measure of control over their professional activities and economic security.

Industrialization

The industrialization of health care, in the last several decades, has a well documented history. For example, Paul Starr (1982), Victor Fuchs (1986) and David Lindorff (1992) offer comprehensive social and economic examinations of the development of health and welfare corporations.

Federal policy, through the Health Maintenance Act of 1973, encouraged private proprietary firms to develop and market health care for a profit. As these corporations matured, they made loans and stock offerings with the understanding that profits were to be made for investors. Discovering the potential for financial gain by providing welfare services, corporations built hospitals, nursing homes, home care firms, and health maintenance organizations as profit making opportunities.

As privately held businesses, these corporations have been somewhat free of regulation. They have been able to exercise a relatively unencumbered hand in establishing practices in the delivery of health care which promote business profitability as a priority. With these incentives, the private sector has been steadily assuming control of human services that were traditionally in the hands of voluntary and public agencies. David Stoesz (1986) refers to this development as "corporate welfare."

Starr, Fuchs, Lindorff and Stoesz all agree that the most critical aspect of corporate welfare has been the introduction of market place value concerns into the delivery of services. Fuchs (1986) highlights three specific factors key to corporate success which have been introduced. Each interjects values that were not essential to health care delivery prior to industrialization but can not be avoided now that corporate health care is well established.

The primacy of capital is the first of these factors. It is expensive to build and maintain the infrastructure of corporate health care delivery systems. Capitalization of this magnitude can not be derived from within the health care community alone. Outside investors are essential. However, the motivation for investor involvement in these systems is the expectation of profits, not providing care. To protect investor's risks, business management and accountability standards are introduced. As a result, concerns for capital risk and profitability are built into the basic infrastructure of contemporary health care (Coke, 1993; Gould, 1993; Lindorff, 1992).

The requirement of business expertise is the second factor brought to health care by corporate interests. Personnel trained in the knowledge and principles of business are needed to operate the capital protecting management and accountability systems. Such training and expertise are not typically part of the academic or clinical culture of health care professionals. Consequently, health care corporations have looked outside the care giving professions to find the acumen needed to run their health care business operations. Involvement of these business trained managers introduces their particular values and concerns into the operational fabric of health care delivery (Sherrill, 1995).

Thirdly, the requirements of sound business operations has resulted in the development of corporate bureaucratic structures within health care. To insure success, health care corporations are required to interact with each other, with the customers and consumers of their services, with health professionals and the regulations and regulators of federal, state and local governments. Policies and procedures are the lubricant which orders this interaction. As Fuchs observes, it is the corporate bureaucrats who know how to formulate, implement, administer and take advantage of these policies and procedures for the success of their investors (Cornelius; 1994; Leyerle, 1984; Lindorff, 1992, p.217-242).

Perhaps managed care is the best expression of how all of these factors have become operational in the delivery of health care. Managed care is a corporate invention. It brings the standards and values of business management and accountability to health care. Men and women expert in the running of large corporations have been charged with the creation of new bureaucracies which exercise control over pricing, access to health care, the structure and process of care, the utilization of care and the care giving professions. Under managed care, at each point on the care giving continuum preset regulations determine what health care service may be provided, to whom, by whom, where and precisely at what cost. It is only through such strict business oriented controls that investor

capital and profits can be protected (Coopers & Lybrand, 1991; Cornelius, 1994; Gary, 1991; Lindorff, 1992; Lynn, 1991; Sherrill, 1995).

The industrialization of health care is now a well established movement. Any individuals or groups wishing to participate in the delivery of health care services will be required to see this as an essential part of the context in which their services will be offered and practiced. Participating in this industry requires adaptation to the core functional and value concerns of for-profit corporations (Gould, 1993; Oss & Sipkoff, 1995). As the experience of CCA is explored, we will seek out how these general principles of industrialization find a particular expression.

Privatization

The industrialization of health care is dependent on a public policy of privatization. It is a position that is essentially ideological, that is, a belief that the private sector is more effective and efficient at attending to the public good than government (Donahue, 1989; Salamon, 1989; Smith & Stone, 1988; Starr 1989). The history and incremental development of this ideology within the current social fabric has been widely discussed (Brown, 1990; Fabricant & Burghardt, 1992; Kamerman & Kahn, 1989; LeGrand & Robinson, 1984; Rainwater & Rein 1986; Salamon, 1989; Savas, 1987).

The policy has two key attributes. Functions meant to improve and support the public welfare (common good) are transferred from the public to the private sector. However, the transfer is not a total abdication of a public role; it is more a division of responsibility. While government establishes welfare priorities, determines what services should be delivered, and contributes public funds, private sector parties are given the responsibility of generating the programs and delivering welfare services (Donahue, 1989; Salamon, 1989; Starr, 1989). These attributes are the public policy foundation which made corporate welfare possible, and they continue to encourage it (Fuchs, 1986; Starr, 1989). Steven Smith and Deborah Stone (1988) discuss two important consequences of privatization that have bearing on the current developments in health care. The first has to do with the development of two new constituencies in the consumption and provision of welfare services. In incremental steps beginning in 1967, the federal government began reimbursing states for social welfare services offered through multiple sources including private agencies. State and local governments and private interests saw in the Federal policy an opportunity to increase the flow of federal tax money into their pockets.

New agencies multiplied with these dollars to provide such services as community health centers, child care, home care, substance abuse treatment, adult homes and nursing

homes among others. Legislation enabling this development also changed the criteria for access to these services. Need for care, rather than the means to pay for care, became the key to admission. Public sponsored welfare services were no longer confined to the poor, the elderly and disabled, but extended into the general population. A whole new consumer constituency for welfare services was created. Entitlement was extended to all regardless of economic means.

Privatization built another powerful constituency - the providers. The multiplication of both public and private service centers multiplied the numbers of professionals involved in service delivery. Staff, managers, board members, and investors have been strong advocates for maintaining and increasing welfare services to conserve their jobs and profitability. According to Smith and Stone, privatization has created a new, large and politically involved constituency of consumers and providers which has the ability to put demands on public and private treasuries to support their interests and to determine welfare policy.

In the political discussion surrounding privatization, there is the implication that the private sector welfare services are composed of small groups directly responsive to the needs of the local consumer community (Donahue, 1989; Lohmann, 1987). This is a rhetorical myth. A second consequence of privatization, according to Smith and Stone,

has been the creation of large organizational structure. One of the consequences of federal funding was the imposition of national accountability standards in spending and service quality. To insure compliance, centralized authority and regulations were established to coordinate and monitor the delivery of services throughout regions. Government sponsored privatization actually supplanted local funding and control with a system of increasingly large agencies administered by professional bureaucratic managers. This has made it easier for the control of both public and private welfare services to fall into fewer hands (Smith & Stone, 1988).

Privatization has had a major affect on the roles performed by the care giving professions as well. Social workers, physicians, psychologists and other care professionals traditionally work under a value orientation of healing and service to their clientele. Within privatized welfare systems, the focus may shift away from service, the essence of professionalism, toward meeting the service goals of organizations, the essence of bureaucratization (Cornelius, 1994; Fuchs, 1986; Leyerle, 1984; Lindorff, 1992; Lurie, 1987; Starr, 1982).

Professional care givers also become active in performing indirect care roles as corporate executives, managers, product developers, sales people, where the focus is on business maintenance (Bickerton, 1990; Pauly, et.al.,

1990; Schneller, 1991; Wagman & Schiff, 1989). Work tends to be defined less by professional domain and more by the role functions determined by corporate policy. The job description of a case manager may not tell you whether the work is to be performed by a physician, nurse, social worker or para-professional (Fabricant & Burghardt, 1992).

The ideology of privatization and the policies sown by it has had a profound effect on the contemporary welfare service environment. The consequences of implementing the ideology have provided justification for moving welfare services from the public to the private sector and the acceptance of the profit motive in providing care. It has created new welfare constituencies who demand levels of service which the national economy probably can not afford. Privatization has given incentive to the creation of increasingly large structures of service to facilitate control and profitability through economies of scale. Private welfare systems, particularly focused on health care, have become some of the biggest corporate entities in the United States. Professional care givers in these systems may be less directed by their professional domain and value stance and more by their role in the corporate structure. And finally, an enormous constituency of consumers and providers with the power to influence welfare policy has been created.

CCA's existence and character are a reflection of these forces. Privatization has given welfare service providers an opportunity to participate in the entrepreneurial ventures of service for profit. CCA was such a venture. What are the opportunities and risks involved when social workers become owners of social welfare organizations? Can social workers acting in accordance with their personal and professional interests succeed in this increasingly complex private market? What are the costs, what the benefits? This report on CCA's practice experience provides some insight into these issues.

Behavioral Health Care:

The Expanding Scope of Mental Health and Treatment

Gerald Grob (1992), in his introduction to a special issue of Health Affairs devoted to mental health policy, asserts that policy decisions and priorities are not necessarily based on what works or is needed but upon the social and political assumptions held about the policy question. Having some awareness of the current assumptions about mental health, illness and treatment become indispensable to an understanding of the present care giving environment to which CCA was responding.

Mental illness and mental health have been considerably transformed during the last ninety years. Psychotic

disorders and mental retardation were the sum of mental illness when the century began. The non-psychotic disorders: anxiety, phobias, and depression, were added in subsequent decades. Many of these primary disorders, we now recognize, have an organic etiology (Grob, 1991; Klerman, et. al, 1992).

In the last half of the century substance abuse, personality disorders, domestic violence, sexual dysfunction and other problems in living have come to be defined as mental illnesses. There are now over two hundred and fifty syndromes defined as representing mental dysfunction in DSM-IV, the diagnostic manual of psychiatry in the United States (American Psychiatric Association, 1994). Additionally, the focus of mental illness diagnosis and treatment has moved substantially beyond symptom recognition and relief to include concerns such as: functional impairment, vocation, life role performance, self care skills, capacity for independent living and economic self-sufficiency (Klerman, 1990; Klerman, et. al. 1992; Koyanagi & Goldman, 1991; Liberman & Corrigan, 1993; Olsson, 1990). As in other areas of medicine, mental health and treatment has an ever expanding domain of interest (Sharfstein and Stoline, 1992).

Concurrent with these developments were shifts in the setting of mental health treatment. Until the 1950's treatment of the mentally ill was centered around the state hospital systems. It was structured for those with the most

serious psychopathology (Grob, 1991; Grob, 1992). In the 1960's there was a significant restructuring of care settings. Facilitated by the advances in antipsychotic and antidepressant medications, treatment of mental illness began to be provided in local communities. Episodic care in general hospitals rather than specialized psychiatric facilities became the centers of primary treatment. Outpatient facilities, located in community mental health centers, were structured to provide the secondary supportive services between hospitalizations or to prevent the need for inpatient custodial treatment of the most seriously and chronically ill (Grob, 1991; Koyanagi & Goldman, 1991; Liberman & Corrigan, 1993; Mechanic & Surles, 1992).

There was a secondary but significant consequence of this shift from hospital to outpatient community based treatments. Rather than focus on the most seriously ill, the community mental health movement created and funded by the federal government began focusing its treatment concerns on the non chronic and episodic disorders (Mechanic & Surles, 1992). Community residents were encouraged to see the mental health centers as places to seek care for the emotional and psychological pains they experienced in daily living.

Simultaneously, general medicine recognized that mental illness and emotional distress may be masked as physical illness and/or contribute to it. These developments

increased care seeking by the general public for mental health treatment (Grob, 1992; Leaf, et. al., 1988).

As the settings and scope of mental health service evolved so did the care giving professions and the treatment technology they employ. The first treatments were essentially custodial and physician directed. However, with the advent of psychotropic medications in the 1950's, the more bizarre and debilitating symptoms of mental illness were controlled or contained. Patients gradually moved back to the communities and families from which their illness had previously isolated them. Psychotherapeutic counseling and case management were utilized to help patients cope with the secondary symptoms of their illness. Talk therapies addressed the internal and interpersonal psychological sequelae of mental illness; case management the social and functional impairments. Case managers extended patient care beyond direct treatment to the brokering of services provided by a variety of community agencies and resources (Mechanic and Surles, 1992; Olfson, 1990; Surles, et. al., 1992).

These newer treatment technologies did not require medical expertise for their application. While physicians continued to diagnosis and treat much of the primary symptomatology with medication, social workers, psychologists, nurses and a wide variety of other professional and para-professional counselors have become

expert at treating the mentally ill (Grob, 1992; Huxley, et. al., 1989). Social workers, for example, now provide about 60% of the non-physician treatment for mental illness in the United States (Gibelman, 1995).

The diversification and strengthening of the mental health professions served to stimulate the demand for mental health treatment. Practitioners encouraged the utilization of their services by the general population. Social workers and psychologists marketed their availability and expertise in treating the emotional or psychological consequences of daily living. The non-medical professions also moved aggressively to be included in the medical insurance reimbursement stream as primary care providers. The cost and utilization of mental health treatment escalated proportionately.

In the 1980's the demands by consumers, mental health professionals and the for-profit treatment centers made mental health the fastest growing portion of medical costs. All the stakeholders successfully lobbied the payers of health insurance to include the treatment of alcohol/substance abuse and the sub-acute mental disorders into their medical benefits. Over the last several decades, the inclusion of a mental health benefit has become a standard item in medical insurance policies (Sharfstein & Stoline, 1992). These inclusions further stimulated and encouraged the public to take advantage of their medical insurance for

the treatment of their mental and emotional distress (Frank, Salkever, & Sharfstein, 1991; Klerman, et. al. 1992). In 1990, fifty four billion dollars of private and public funds were spent on mental health and substance abuse treatment services (Sipkoff, 1994).

The current configuration of mental illness and treatment provided CCA a legitimate place in the market. Social workers have achieved legal recognition as mental health professionals. They have achieved expertise in many of the diversified treatment technologies associated with psychiatric care, especially in diagnostic assessment, the psychotherapies and case management. Contemporary psychiatry has provided a host of diagnostic conditions to which these technologies are applicable. The consumer publics have been successfully educated and marketed to believe that emotional distress and problems in living can be remedied by psychiatric intervention. And there are large sums of money available through third party reimbursement to pay for their broad application.

All of these developments suggest that providing mental health treatment could be a potentially lucrative business opportunity for mental health professionals. While there may be opportunities in providing mental health care, there are several countervailing forces working against this assumption. Mental health treatment, especially for the chronically ill, is long term, multifaceted and expensive.

It may be difficult for a profit seeking single specialty practice, such as CCA, to find a relevant place in this complicated service delivery system. A second hazard to the assumption is the likely setting for treatment in the near future. Mental health service is slated to be incorporated into the large and comprehensive medical systems of care now being built (Perez, 1995; Rosenberg & Weissman, 1995). Where will the smaller single specialty practice fit into this developing dynamic?

There are also policy decisions being made that may curtail or limit the financial resources which could support mental health business opportunities in the near future. Richard C. Surels, a former Commissioner of Mental Health for the State of New York, observes that the marketing and utilization of mental illness and treatment to the general population has, in his opinion, diverted energy and financial resources away from the care of the 2-5% of the population with chronic debilitating mental illness. He believes state governments will have to decrease their commitment to the treatment of sub-acute illness so as to protect funds for essential services to the very ill (Mechanic & Surels, 1992). The corporate payers of health insurance may be coming to the same conclusion. Mental health treatment costs are growing too quickly. Business leaders are especially worried about their liability for mental health care as currently defined and maintaining

resources for the seriously ill (Sharfstein & Stoline, 1992).

Public and private health care planners have been faced with the substantial challenge of how to structure and deliver mental health services to best meet the needs of all the stakeholders. A policy consensus has emerged. The strategy is managed care (Frank, Goldman & McGuire, 1992; Frank, Salkever, & Sharfstein 1991; Goldman, et. al. 1992; Sharfstein & Stoline, 1992). CCA and its principals were active in planning and implementing a service design dominated by this policy agenda. Describing and evaluating the experience of CCA in this endeavor with managed care is an essential component of the study.

Managed Care and Mental Health

Managed care was conceived by the insurance industry in the mid-1980's as a strategy to help the business community contain the yearly escalation of its corporate resources devoted to health insurance premiums for their employees (Borenstein, 1990; Coopers & Lybrand, 1991; Gary, 1991; Hoy, Curtis, & Rice, 1991; Lynn, 1991; Moran & Wolfe, 1991). In recent years, the three levels of government have also been shifting their employee and public assistance health care dollars towards a managed care benefit design (Grobman, 1994). By 1995, 58% of the insured population, about 107

million Americans excluding Medicare, are covered by some form of managed care program. This represents a 16.3% increase over 1994 (Psychotherapy Finances, May 1995b). Expectations are that the yearly growth will continue until 90% of medical care is administered through some type of managed care.

Traditional indemnity insurance allows access to care by demand. Under managed care, costs are contained by restricting demand through the control of access to care and limiting utilization of services. Patients and providers must show predetermined standards of medical necessity to access the care giving system and, once inside, demonstrate that the utilization of care giving strategies are appropriate to the illness. While the rhetoric of the managed care industry says that these measures are being used to insure the quality and efficiency of effective care, the primary goals of managed care until now has been to save money (Geraty, et. al. 1994).

Managed care has flourished because it promises to reduce costs. But in addition, it appeals to and supports the goals of an industrialized health care system. For example, to fulfill its promise of cost reduction, managed care requires efficiency through economies of scale. The health care industry has responded by building large systems of care that intend to provide for the broadest health care concerns of its constituency. In turn, these giant systems

increase the control and standardization of medical treatment; reinforcing the cost saving strategies of managed care. Over the last five years, private health corporations have rapidly consolidated and nationalized to expand their scope and control of market share (Edlin, 1994a; Edlin, 1994b; Edlin, 1995; Major, 1995; Psychotherapy Finances, December, 1994). As of May 1995, 83% of all mental health managed care is being provided through the 12 largest managed care organizations (Psychotherapy Finances, May, 1995b).

The broad acceptance of privatization has added ideological legitimacy to the tenets of managed care. Although President Clinton's health care reform did not succeed, the reliance on private sector managed care has been accepted by government planners as a way to control the escalation of costs and to avoid building the bureaucracy of a government operated managed care system (Finley, 1995; Scallet, 1995; The White House Domestic Policy Council, 1993; Wechsler, 1995). Many states are experimenting with managed care by turning to private health maintenance organizations to provide health care to their employees and for Medicaid and public assistance recipients (Coleman, 1994; Defino, 1995; Helf, 1995; Grobman, 1994).

Consequently, there is a large pool of public money which private sector health care organizations are seeking to capture. In 1990 state and local governments spent \$15.9

billion dollars on mental health and substance abuse care, Medicaid \$9.5 billion (Sipkoff, 1994). Governments believe that by allowing profits to be made off the public treasury, there will be a net gain by inspiring efficiency through competition (Finley, 1995; Grobman, 1994).

Although managed care has had wide acceptance by the payers, it faces some serious challenges in mental health if it is to accomplish more than reducing the cost of care. A critical challenge will be to find profits in the care of the chronically ill. Chronic care is expensive, long term and involves a host of non-medical supportive services. Currently, much of the money spent by the private insurance companies for mental health services is for counseling psychotherapy and acute hospitalizations (Sharfstein & Stoline, 1992). Private insurance has limited its exposure to demands for mental health care by reducing benefits and access. This strategy does not work for those who need constant and expensive care without exposing them to inadequate treatment. A managed care solution to this problem has not yet been crafted (Budman, 1995; Frank, et. al. 1992; Flynn, Panzetta, & Shumway, 1994; Mechanic, & Rochefort, 1992).

A second design challenge for managed care in mental health is its narrow focus on the medical model in treating mental illness. We observed earlier that medications and hospital stays are only a small part of adequate care. Safe

housing, vocational and social rehabilitation, and social welfare services are crucial to success. Only with this broad range of psychiatric and psychosocial interventions can the improvement or stabilization of the chronically ill be maintained (Goldman, et. al. 1992). Limiting the discussion of mental health as a medical treatment inside a medical benefit presents a significant conundrum. The medical model is not the best paradigm for a comprehensive care strategy (Goldman et. al., 1992; Hogan, 1992; Mechanic & Surels, 1992). There is no mechanism inside the current structure of managed care to access or pay for these non-medical services (Budman, 1995; Flynn, Panzetta, & Shumway, 1994; Sharfstein & Stoline, 1992).

Corporate managed care, as we currently know it, may have a third challenge. The managed care strategy was designed and implemented by the health care industry as a profit center and to serve the needs of the payers. Consumers and providers of health care have had little or no input into its creation or current form (Cornelius, 1994). Until now providers have met with little success at restraining the implementation of managed care, its impact on their autonomy in care giving or the downward pressure on their fees. It remains to be seen how, when or if the consumers of health care will challenge the limits on access and intensity of care that managed care implies. At the moment, challenges to corporate directed managed care are

only beginning to be made (Lindsey, 1992; Petersen, 1994; Psychotherapy Finances, June 1995a; Wechsler, 1994). It is not possible at this time to assess their impact on modifying the character of managed care. However, in some respects, the CCA experience may be a source of data about the providers' encounter with managed care and offer information about designing a more pro-active response.

Two realities, therefore, exist about managed care as it relates to mental health. First, managed care is a powerful presence in the psychiatric care system. But in the second instance, it is not at all clear that managed care can successfully cope with the complex and non-medical aspects of appropriate psychiatric intervention. How this tension finds expression in service delivery and program design is explored in the CCA experience.

Current Issues in Mental Health: A Summary

Providing mental health services must be designed in a way consistent with the current political, social and economic environment. There are a number of broad categories which define some of the contemporary boundaries of this milieu. One is the evolution of what is considered a mental health problem. Four or five decades ago, concern was focused on the obviously disturbed. Today a continually expanding range of life problems are considered psychiatric

conditions. New care giving technologies have been developed to treat these disorder. They involve psychotropic medication, psychosocial rehabilitation and diverse forms of talk therapies which are applied to individuals, groups and families. Care is provided in a variety of settings including: psychiatric and general hospitals, outpatient mental health and substance abuse treatment centers, and the private offices of practitioners. These developments have added to the increased demand for mental health treatment in the general population. Concurrently, professions such as social work, psychology and nursing have grown to meet this perceived need. These non-physician professionals have successfully promoted their expertise as mental health practitioners. They have received licensure from state governments as qualified providers and have gained the right to third party reimbursement. They have marketed their services to the public. A synergy of expanding notions of mental health, of mental health practitioners and consumer demand, has formed to make mental health treatment a fast growing and expensive part of health care.

To balance this growing demand with the resources available to meet them, the large corporate payers of health care have developed managed care as a restraining force. Consumers and providers have been required to temper demands for care with a demonstrated need for care. Managed care

has been somewhat successful at restraining cost by limiting access to care and the utilization of mental health benefits. It remains to be seen if managed care can balance the interests of the profit seeking health care industry with those of the consumer public and the provider professions.

Designing and providing mental health services in this environment will be difficult. While the problems may be apparent, the possible strategies to solve them are not. Today the crucial policy issues are not about the science and art of mental health treatment, the process of care. They are about the structure of care.

The Social Worker:

A Role in Managed Mental Health Care?

One of the primary assumptions behind the implementation of CCA rests on the belief that social workers should have a role in the current restructuring of mental health care. This conviction derives from a perspective rooted in the history, practice experience and value principles of social work.

Harry Specht and Mark Courtney (1994) in their book, How Social Work has Abandoned its Mission: Unfaithful Angels, present a comprehensive discussion of the historical, social, and professional determinants which has

led social workers to play a significant role in the field of mental health. Social work and modern psychiatry developed simultaneously in the United States. Their professional association began during WW I when social workers were used by psychiatrists as treatment adjuncts with emotionally disabled military personnel. While Specht and Courtney are critical, on ideological grounds of many aspects of the affiliation of psychiatry and social work, their historical panorama demonstrates a long, fruitful and respected involvement by social workers with the mental health care giving system (Barker, 1987; Courtney, 1992; Field, 1980; Goldstein, 1996; Wakefield, 1988a).

The greater part of this association has occurred, and still remains rooted, in the public sector. Social workers fill many public agency mental health staff positions as: direct service workers, administrators, public officials and policy planners. Historically, social workers have been actively involved in founding these agencies. This experience in the public sector has given the field recognized expertise and professional standing within the mental health establishment. In recognition of this achievement, all states now license social workers along with physicians and psychologists as mental health professionals (NASW, 1995). As licensed care givers, social workers have a large stake in all structural modifications to the current system.

This claim is strengthened by the growing involvement of social work in the private sector. Private corporate executives have looked to social workers to fill a number of important positions in their organizations. One most akin to traditional practice has been as counselors in employee assistance programs (EAP) and in human resources (Bickerton, 1990; Gustavsson & Balgopal, 1991; Popple, 1981; Teare, 1987; Wagman & Schiff, 1989). However, with the growth of managed care, social workers have begun to fill roles which, while incorporating traditional aspects of practice, are structured primarily to meet corporate goals. For example, the managed care industry has employed social workers as: case managers, administrators, researchers, product design specialists and sales people. Even CEO positions of large behavioral managed care firms have been occupied by social workers (Strom & Gingrich, 1993; Wagman & Schiff, 1990).

One of the most vibrant developments of social work in the private sector has been in private self directed practice. Especially during the last twenty years, social workers have transferred the mental health practice skills they acquired in the public sector to their own private enterprise (Barker, 1987; Fizdale, 1974; Goldmeier, 1990; Jayaratne, Siefert & Chess, 1988). The characteristics and motivation for the social worker involving themselves in private practice are well researched and described (Alexander, 1987; Brown, 1990; Cohen, 1966; Frisman, 1990;

Goldmeier, 1990; Goldmeier & Wells, 1986; Grosser & Block, 1983; Jayaratne, Siefert & Chess 1988; Matorin, et. al., 1987; Peek & Plotkin, 1951; Wagner, 1989). Senior workers' desire for practice autonomy, professional advancement, a broader client mix and greater financial rewards has been largely frustrated by the organizational and budgetary constraints of work in public agencies. Consequently, social workers have looked beyond public service to meet these personal and professional needs (Wagner, 1989). Private practice until now has been the primary strategy for achieving these ends.

Some debate exists concerning the appropriateness of private practice as a outlet for these professional frustrations. Specht and Courtney (1994) believe private practice represents a turning away from the social work profession's essential mission of public service and advocacy. They believe that the development of private practice has diverted energy away from justice seeking to personal self interest and financial gain (Courtney, 1992; Specht, 1990). Jerome Wakefield (1988 a&b) on the other hand sees mental health private practice as a derived task given to social workers because of their historical involvement in the field of mental health. While certainly not a primary mission of social work, mental health private practice meets a social need that social workers have the expertise and social sanction to perform (Carlton, 1977; Kurzman, 1976; Strom & Gingrich, 1993).

Fabricant and Burghardt (1992) suggest that the development of private practice is one of the consequences of the deterioration of public sponsored social welfare. Service conditions for public clients and personnel have been steadily declining in the last two decades. Caseloads have expanded beyond a worker's ability to provide appropriate care. Decreasing salaries and poor working conditions have not supported professional self respect and have undermined altruistic commitment. The public welfare mission of many agencies has been displaced by struggles to survive. Funding cuts have not supported basic services. Public service workers are not leaving agency based practice for private practice because they are turning their back on the needy, but because public service no longer adequately supports their efforts.

However the debate is resolved, it seems appropriate to conclude that all of these conditions have contributed to the development of social work private practice. Social welfare, health care and the helping professions have been profoundly affected by the current political and economic climate. Social work private practice is both a result of and an expression of the ideological and public policy shift toward privatization and the industrialization of social welfare functions (Wood & Middleman, 1989). In their desire to participate in the benefits of these trends, social workers have sought licensure as mental health practitioners

and the right to receive third party reimbursement for their services (Shatkin, Frisman, & McGuire, 1986). By engaging in private practice, social workers participate in all of the consequences as well (Bakalinsky, 1980; Kurzman, 1973; Strom, 1993; Wagner, 1989). They have no choice but to be involved in the structural changes now taking place (Fabricant, 1985; Wood & Middleman 1989).

However, taking up with the trends of privatization leaves social workers open to several threats to their professional mission. Social workers along with physicians, psychologists, nurses and other health care providers risk losing their professional identity. Industrial titles such as CEO, president, vice president, product sales coordinator or even case manager hide professional affiliations with an organizational role or title. What do these titles suggest about the expected direction of primary loyalty by the executives who confer them? Perhaps a greater danger in this identity confusion is separation from the value principles which direct the practice of the helping professions (Bakalinsky, 1980; Blumenthal, 1994; Gordon, 1984; Land, 1988; Ortiz, 1987; Wagner, 1989).

Charles Levy (1984) notes that one of the essential cultural functions of social work is the provision of human services from the value perspective embodied in the NASW Code of Ethics. Social work, as a socially constructed institution, is meant to use these standards to define its practice conduct. This ethical constant remains as social

workers are involved in contemporary roles and structures not necessarily associated with the original tasks of the field (Wakefield, 1988 a&b). The primacy of the client and the maintenance of a just and equitable social structure are the foundation of these ethical principles. Clients with physical and mental disorders within the health care system are particularly vulnerable. As social, political and economic forces actively reframe the structures of service to these individuals, it is essential for the social worker to remain active in the reframing. Social work from its value perspective has much to say about how this care is structured (Carlton, 1977; Gordon; 1984; Kurzman; 1984; Lurie, 1987).

CCA's principals' concern with the structural modifications in mental health care is firmly rooted in their value principles. Structure is the container for the care giving process. Social workers' value orientation requires them to create and build structures of care which give priority to client's interests. Fabricant and Burghardt's (1992) research demonstrates how difficult a task this can be in the privatized social service marketplace. As the structures of care industrialize, the concerns with production and efficiency for the sake of profitability tend to dominate the actions of the organizations. Work is organized and conducted to insure that organizational financial goals are met (Fabricant,

1985; Lurie, 1987). Client care is a byproduct of industrialized structure.

The characterization Fabricant presents is not necessarily an accusation, but it is a notation of serious concern. Recalling the description of managed care from the previous section, managed care, as currently constructed, is a product sold by managed care companies to the payers of care to control their costs. At present, managed care is the active structural model of the privatized and industrialized health care system with which all providers and consumers must contend. Because social workers are now very much an integral part of the managed care system, they are required by their history, practice experience and value orientation to find structure within managed care which protects their professional mission and the clients for whom they practice. Anxiety about how this might be accomplished is not unique to social work. Many of the commentators on the current process of health care restructuring sound similar themes of apprehension. The concern is well documented (Bogdanich, 1991; Fuchs, 1975; Fuchs, 1986; Leyerle, 1984; Lindorff, 1992; Sherrill, 1995; Starr, 1982). How this concern might take structural form is not well researched. As a private agency of social workers engaged in private practice, describing and evaluating CCA is a means of gathering information about one attempt in meeting this challenge.

A Plan - Reflection in Action

Articulating a design to meet the enumerated variables is a difficult conceptual leap. Structural modifications in health care create a dynamic process involving incalculable political, economic, social, and personal/professional variables. There are few stable points of reference around which a plan can be drawn. In the years between 1992 and 1995, when CCA was initiated and the venture terminated, there have been major shifts in emphasis which have a consequential impact on service delivery design. For example, in 1992 managed care organizations (MCOs) were suggesting their providers form local single specialty mental health group practices. By 1995, when CCA closed its doors, the notion was becoming passe. The same MCOs promoted the formation of regionalized multi-disciplinary practices. However, even this service design was offered as a short lived transitional phase. Fully integrated and comprehensive health care delivery systems are the eventual goal.

With hindsight, on this issue alone, CCA as a local single specialty practice would have a difficult time surviving. But this is not the place for analysis or conclusions. In October of 1992, a group of social work practitioners began meeting to consider the implications to the growing impact of managed care on their practice. As a

consequence of these discussions, there was a decision by some of the participants to take action. CCA was the result. Reflection upon that decision, its background and the ensuing consequences form the substance of this project.

Donald Schon in his book The Reflective Practitioner (1983) provides a possible frame to order and analyze the action taken:

In real world practice, problems do not present themselves to the practitioner as givens. They must be constructed from the materials of problematic situations which are puzzling, troubling, and uncertain. In order to convert a problematic situation into a problem, a practitioner must do certain kinds of work. He must make sense of an uncertain situation that initially makes no sense....It is this sort of situation that professionals are coming increasingly to see as essential to their practice. They are coming to recognize that although problem setting is a necessary condition for technical problem solving, it is not itself a technical problem. When we set the problem, we select what we will treat as the "things" of the situation, we set the boundaries of our attention to it, and we impose upon it a coherence which allows us to say what is wrong and in what direction the situation needs to be changed. Problem setting is a process in which, interactively, we name the things to which we will attend and frame the context in which we will attend to them (Schon 1983, p.40).

The salient points of Schon's conceptualization of reflection in action can be summarized in these few principles: 1) The practitioner is called upon to make sense of situations which are puzzling, troubling and uncertain; 2) Making sense is the attempt to bring coherence or logic to the experienced confusion; 3) Coherence imposes boundaries, identified as the problem or problems around

which thought, planning and action can be ordered; 4) The order is named and becomes the context (frame) for reflection in action. [Schon suggests that reflection on these named actions could be referred to as "frame experiments." Schon 1983, p.63]; and 5). Within this frame, the practitioner has an opportunity to thoughtfully evaluate the adequacy of his response to the original situation which is puzzling, troubling and uncertain.

Using Schon's schema, the CCA experience can be understood as a social work practice response, reflection in action, to the confusion imposed by the privatization and industrialization of health care. Planning and designing a response gave the social work participants an opportunity to hypothesize they were making sense of these impinging forces. Building an organization gave coherence and presented the organizers with a series of concrete problems to be solved. In working the solutions the participants believed they were finding ways to structure and provide service within this confusing environment. Formalizing the organizational design with the incorporation of CCA set the frame or context for practice action and provided a set of boundaries around which to evaluate the adequacy of a particular response to industrialized managed care.

An Evaluation - Reflection on Action

A natural consequence of reflective action is the development of knowledge which occurs as the practitioner evaluates past and current behaviors. Schon writes:

Practitioners do reflect on their knowing-in-practice. Sometimes, in the relative tranquility of a postmortem, they think back on a project they have undertaken, a situation they have lived through, and they explore the understanding they have brought to their handling of the case. They may do this in a mood of idle speculation, or in a deliberate effort to prepare themselves for future cases (Schon 1983, p.61).

The case study evaluation of CCA's practice experience, from this perspective, becomes a deliberate effort at reflection. Although not the initial intention, retrospectively the CCA experience can be conceptualized as a Schon type frame experiment. Evaluating the experience holds within it the potential to broaden our understanding and develop theoretical propositions about how social workers might practice within the health care market place.

Farbricant and Burghardt's (1992) research has demonstrated that the industrialization of social services has had profound affect on the structure and provision of social welfare services in the public sector. Their findings suggest that traditional forms of practice and the orientation of the social service professions do not possess the knowledge or experience to make an adequate response to these new conditions. Much of the accumulated practice

wisdom may no longer be relevant. In their concluding recommendations, Fabricant and Burghardt call for an effort to counter this dearth of information by experimentation. Attempts to adapt to the new social service paradigm should be seen as a series of trials and errors from which new knowledge will emerge. Collecting and interpreting data from these trails will provide opportunities for creating more appropriate forms of practice. It is important that the process and outcomes of such experiments be shared (Fabricant and Burghardt 1992, p.215).

Although CCA was not a public agency, from an initial position of idle speculation, many of the responses of public sector social service workers and agencies outlined by Fabricant and Burghardt suggest elements of commonality between public and private agencies such as CCA. Evaluating the CCA practice provides useful information to a social service environment in which the distinctions between the private and public sector are quickly disappearing. Therefore, a deliberate evaluation of CCA provides a unique opportunity. While commentators on contemporary social work practice such as Fabricant and Burghardt (1992), and Specht and Courtney (1994) recommend experimentation with new configurations of practice, such self-conscious efforts are difficult to find or create. Specht and Courtney (1994), for example, suggest a wholesale reconfiguration of the social work effort toward "a community-based system of

social care" (Specht & Courtney 1992, p.152). Yet in this political and economic environment it is difficult to see such broad and complicated suggestions actualized.

Fabricant and Burghardt, on the other hand, are more inclined to anticipate small incremental accumulations of data and insight to inform practice development.

There are few examples in the social work literature that document the design and outcome of such experimentation. The one which most closely parallels the CCA project was directed and reported by Ruth Fizdale (1974), Social Agency Structure and Accountability. Fizdale presents a single case study of the Arthur Lehman Counseling Service (ALCS), an agency deliberately created as an experiment. The founders were attempting to discover how social work skills and practice structures learned in the public sector for public welfare clients might be translated to a private agency with self pay middle class clients. This work chronicles and evaluates one of the first private for-profit group practices at a time when the private practice of social work was about to burgeon.

The CCA project and this case study have much in common with the experience of ALCS and Fizdale's report: 1) It is a single case study; 2) The investigator/reporter was an active participant in the project and thus involved with the analysis of his own work; 3) Both projects were seeking information about social work practice in a time of

transition. Forty years after ALCS's founding in 1954, the private practice of social work has become a significant part of routine social work practice. Yet under industrialized managed care in 1996, this well established practice pattern is under extreme pressure for major modification; 4). ALCS and CCA were both working agencies where actions taken were concerned with real-life events; and, 5). The experiences of senior professionals in the field are offered as potentially instructive to others as social workers test different models of adaptation to new and challenging conditions.

CHAPTER 2

Study Design and Methodology

A single case study was the research methodology selected for this project. Robert Yin (1989) suggests the case study as an appropriate methodology..."when the investigator has little control over events, and when the focus is on contemporary phenomena within some real-life context (p.13)." The CCA experience clearly fits these criteria. As Schon (1983) defines a frame experiment, the investigator is within a context where few variables are under his direct control. The actions taken and the knowledge gained result from a continual flow of "surprises" to which the practitioner responds in largely unanticipated ways to the real-life circumstance he confronts (Schon 1983, p.56). For these reasons, the case study was determined to be a valid empirical methodology to chronicle and analyze the real-life practice based surprises of CCA and the social worker practitioners' responses.

Yin outlines three potential goals for a case study. The investigator might hope to describe, explore and/or explain the phenomena in which he is interested. All three goals are addressed. The design, implementation and outcomes of the CCA experience are described in this report. There is also an effort to explore and explain the impact

of the industrialization of health care in a particular instance of social work practice and, in a more general way, to anticipate a professional response to the phenomena of industrialized social welfare.

The Design

Five structural components to case study research design are described by Yin:

1. the study question:
 2. its propositions, components of the question to be examined;
 3. its units of analysis, discovery of relevant data:
 4. the logic linking the data to the propositions; and
 5. the criteria for interpreting the findings.
- (Yin 1989, p.29)

Interestingly there are suggestive parallels between Yin's structure for a case study and the reflective process of Schon's practitioner as discussed in the previous chapter. To review: 1). In Schon, the practitioner is called upon to make sense of the situation which is puzzling, troubling and uncertain - in Yin, it becomes the study question; 2). Making sense is the attempt to bring coherence or logic to the experienced confusion - the proposition; 3). Coherence imposes boundaries, identified as the problem around which thought, planning and action can be ordered - units of analysis; 4). The order is named and becomes the context for reflective action - the link between data and the proposition; and 5). Within the frame the

practitioner has the opportunity to thoughtfully evaluate the adequacy of the response - the interpretation of the findings. Application of Schon's schema to the CCA experience would appear to fulfill the design requirements of a case study as described by Yin.

This case study incorporates all five of Yin's and Schon's design components. First, the study question is framed by a desire of the investigator to reflect on the adequacy of group practice within a continuum of care, the mission of CCA, as an appropriate response to the inroads of industrialized managed care on the private practice of social work. There are, secondly, a number of salient propositions contained in this question which are explored: 1). To be an adequate response, group practice needs to address the social workers' desire for perceived autonomy in rendering care and in structuring the organization of their practice. 2). The practice group must be economically viable, that is, providing sufficient financial resources to meet the personal needs of the social workers for economic security and to cover the costs of providing care. 3). The adequacy of the social workers' practice skills and experience are also tested in the group practice structure as they are required to be simultaneously clinicians and business entrepreneurs. 4). Reflection on the study question includes an awareness of the social work value dimension to group practice development as a response to industrialized managed care.

CCA is the primary unit of analysis for the study. However, within this broad category, sub-units received particular scrutiny. Two of CCA's principal partners were interviewed for the case study as data sources. Additionally, they read the manuscript reports and provided commentary on the interpretation of the data compiled by the principal investigator and author of the case study, who was the third social worker involved in the development of CCA. The fourth partner was not available to participate in the research. XM Corporation and managed care organizations were additional units of analysis as their policies and actions were instrumental in the development and unfolding of CCA. Finally, to provide a validating perspective on data analysis from the CCA experience, the investigator interviewed three principal partners from three private for-profit group practices operating contemporaneously in the CCA region.

The fourth component of the case study design is the logic linking the data, the study question and propositions. This linkage was made by using the model for social program evaluation developed by Tripodi, Fellin and Epstein (1978). The investigator selected this methodology to sequence the presentation of the data and to provide a framework for coherent analysis. More specific information about the Tripodi model will be provided later in this chapter.

Criteria for interpreting the findings, the fifth

component of the study design, are established by the propositions. At the end of the study a discussion evaluates the appropriateness of group practice for CCA, its shareholders and for the field of social work. The terms of the evaluation are: economic viability, perceived professional autonomy, adequacy of social work skills and experience in pursuit of group practice objectives and adherence to social work value principles.

Data Sources

Data and information related to the case study were assembled through the following methods and activities:

Documents -

Many primary source materials were available to inform the case study. These consist of minutes from all the directors' meetings from October 1992 to October 1995, notes from contacts with consultants, attorneys, accountants, managed care organizations and other groups and individuals during the operation of CCA. Business plans, budgets, financial reports to the directors, tax returns and computerized financial records were accessed to supply business and financial information about the corporation. Copies of applications, contracts and provider manuals with managed care organizations and with the state for licensure

as an outpatient alcohol treatment facility were examined. Correspondence and internal memos, program planning documents, marketing materials, and network management records were in the possession of the investigator for review. Data for interpretation was also collected from informal logs of telephone conversation, random notes and jottings by the investigator.

CCA's administrative operations were assisted by a computerized practice management system. The data base supplied quantitative information about practice patterns and trends.

A computerized literature search of topics germane to the study was made. Much of the pertinent contemporary discussion about managed care does not appear in the professional peer reviewed literature. Consequently, attention was directed to trade periodicals, professional newsletters, position papers, policy directives from MCOs, and the proceedings from professional meetings. The business literature, especially related to the theory and practice of small business operations, contributed to a fuller understanding and analysis of the dynamics of business practices and entrepreneurship.

Interviews -

Conversations with key informants played a role in the case study. Many individuals, other than the principal partners, were involved in the development and operation of

CCA. These persons included: contacts within managed care organizations, consultants, administrative staff and friends or colleagues who were asked for advice and counsel. A structured interview was not an instrument used in this study since most individuals were concerned with only specific aspects of CCA. The interview process was informal and frequently involved more than one contact with the investigator. Notes from these interviews, however, are part of the formal data set for the study.

Direct Observation and the Participant Observer -

Direct observation and participation were primary sources of information for this study. The investigator was present and/or a party to all of the circumstance to be described in the case. Such an inside position is quite different though from the role of the observer/investigator imagined by Yin. From his perspective, the observer comes to the study from the outside with a particular research objective. The study takes form as the investigator familiarizes himself with the context and content of the situation. He may even become a participant observer, that is, as the study proceeds his presence may begin to affect the character or outcomes of the case. In the CCA study the investigator is more than observer, and more than participant observer. He is a central subject in the case as well, a subject/researcher. Yin does not address the

issues involved when the investigator is a principal actor in the phenomena under review.

Such an all inclusive role for the investigator may not be typical, but it is not unrepresented in phenomenological social work research. The Fizdale (1974) case study of the Arthur Lehman Counseling Services is a good example of the subject/researcher. Ruth Fizdale was a founding principal of the practice as well as the primary investigator and author of the study. Harold Weissman's (1966 a,b,c,d) study of Mobilization for Youth would be another. While not explicitly discussed in Schon's (1983) work, the perspective of the subject/researcher is implicit in his conceptualization of the reflective practitioner. In the context of practice, the practitioner's knowledge and action are critical variables in the results of professional behaviors. Analysis of that process involves therefore a review of the practitioner's use of self. The reflective practitioner is both subject and observer in the evaluation of the outcomes.

In such cases, the investigator's experience becomes data for the study. Nancy Drew (1989) suggests several examples of how this might occur. First, the investigator's personal interest in the phenomena might be considered critical information. What the researcher attends to in the collection and analysis of data often originates out of the personal concerns the investigator brings to a project.

According to Drew, in phenomenological research the categories of analysis are largely determined and enriched by these personal interests and should be acknowledged as part of the essential data set.

An example from the CCA project might serve as an illustration of Drew's principle. A motivating factor in the creation of CCA was a desire of the principals to maintain personal and professional autonomy in a managed care environment. During the course of the experience, the principals discovered that working with managed care actually subverted these personal goals. The gradual realization of this subversion may have been a factor in the decision to close down the practice. There were many economic and organizational issues in CCA's failure, but the awareness and inclusion of the principals' personal goals and objectives regarding autonomy are critical data in creating the fullest rendering of the CCA case study.

There is a second dimension to using the investigator's experience as data in phenomenologically oriented studies. Drew believes that as the investigator proceeds, subjective responses to the subjects and content emerge. These personal responses are also essential data elements. Guba and Lincoln (1981) concur. They suggest that in any qualitative research project the investigator ought to be recognized as a data collecting instrument. As the investigator is immersed in a study, all the perceptive

capacities of the human brain are operating. These personal and subjective perceptions are of critical importance and form a separate category of data about the project.

Speaking with a more existential voice about the same concept, Irving Zola writes:

As part of the research situation, the researcher herself or himself is worth studying. To comprehend fully the texture of everyday life, it is not sufficient to relegate to a methodological appendix ...what this experience meant to the investigator. Rather we must look at that experience - the anxiety, fear, delight, repulsion - as part of the situation we are trying to understand (Zola 1991, p.9).

In the CCA case study, data about the personal concerns and experiences of the subject/investigator were seen as a potential advantage to fulfilling the project's goals. Again an example might illustrate the point. Over time, a sense of frustration and disillusionment became the investigator's dominant emotional response to CCA's inability to achieve organizational integrity. As a consequence, he found it increasingly difficult to maintain his enthusiasm for and financial commitment to fulfilling the original CCA mission. This experience parallels a finding by Fabricant and Burghardt (1992). They found that many social service workers were frustrated and demoralized by their experiences providing services in an industrialized social service environment where their freedom to exercise personal use of self was significantly curtailed. Once again the experiential involvement of the investigator provided useful

data for the study.

It is the investigator's expectation that an awareness of the many possible dimensions of his personal involvement in the CCA project may be seen as an advantage. There is the role of subject, observer, investigator and instrument to be explored and utilized in the collecting and analysis of the data. No other investigator could have been more closely associated with CCA from its development to its dissolution.

Hazards attend to this methodology. Questions of bias and reliability are fundamental to such an intensity of personal involvement (Drew, 1989; Goering & Strauss, 1994; Guba & Lincoln, 1981; Kleinman, 1991; Krieger, 1985; Schon, 1983; Zola, 1991). For Donald Schon (1983), the practitioner always runs the risk of being drawn into a fundamental error when involved in the reflective process. More often than not reflection in action is a solitary experience, errors in knowledge, judgement or action can be compounded by isolation. Incorporating some of the following checks and balances reduced the danger of confounding the results in the CCA case study.

Susan Kreiger (1985) suggests the investigator make a self conscious inventory of personal thoughts and feelings of reactions to data and events as the study unfolds. This allows the subjective experiences to be open to scrutiny and review. A diary is the suggested tool for recording and

monitoring these personal data elements. Sherryl Kleinman (1991) also sees this as a means to counter unconscious or unintended bias ... "examine (and note) your emotional reactions...If you do not, your feelings will still shape the research process, but you will not know how (p.184-85)." The investigator journaled to follow this advise in limiting unrecognized bias.

Secondly, Yin (1989), Guba and Lincoln (1981) recommend that, when possible, having multiple observers is one of the best methods of limiting bias and insuring the reliability of a case study or qualitative research. In the CCA study a type of multiple observation was possible. Two of the four social worker partners participated in discussions with the investigator on key data summaries and reviews of the findings before and after conclusions were drawn. Irving Zola (1991) comments: "We need to share more systematically what we write with those we study before we publish (p.10)." While all of the parties were subjects in the investigation, they were concurrently intimate observers and commentators on the CCA experience as well.

Data Integrity

The valid and reliable collection of data is key to the integrity of the research endeavor. Yin (1989) suggests several principles for case studies which have been

incorporated into the research design to insure a measure of construct validity and reliability to the finished project.

The first principle is the use of multiple data sources. The document list as outlined above is extensive. Notes from interviews, CCA meetings, professional conferences, logs and the computerized data base fulfill the requirement for multiple data sets. Review of these sources permitted the investigator to cross check references over time and among various subjects in the study.

Building a case study data base is the second of Yin's principles. The study has a large data base consisting of hard copies and/or microcomputer files of all relevant documents. Interested parties might consult the data base to authenticate the validity of the investigator's analysis and conclusions.

The data base also facilitates Yin's final principle of data integrity, maintenance of a chain of evidence. Data collection is cumulative. It documents events and impressions. The final report includes specific references to documents, interviews and observations. These references reveal the actual evidence and circumstances from which data was gathered and conclusions drawn. The data base corroborates the methodological procedure and establishes the links between the collection of information, the design of the study and the final report.

Organizing the Data

Yin suggests that one of the most difficult technical aspects of case study research design and reporting is the discovery of the logic and criteria for organizing and presenting the data. The effort requires both a prospective guess and a retrospective adjustment as the investigation unfolds.

Prospectively, the investigator chose to use the evaluation tool for program development suggested by Tripodi, Fellin and Epstein (1978) in their book Differential Social Program Evaluation. There was some risk in this choice, since there are no examples in the literature where the Tripodi design model has been used in its entirety (Goldberg, 1995). However, in reviewing the possibility of alternative evaluation designs that might have been considered to organize data analysis and presentation for this case study, none were as comprehensive as the model proposed by Tripodi, et. al. (Goldberg, 1995; Leithwood & Montgomery, 1980; Mayntz, 1983; Patti, 1978; Westhues, 1980).

Retrospectively, the differential program evaluation design worked well as a data organizing instrument. In addition, the CCA case study provides both an example of a comprehensive application of the Tripodi methodology, and validates its usefulness as a tool to order a complicated program evaluation.

There were two modifications to the original Tripodi blueprint incorporated into the study. Bielawski and Epstein (1984) add an additional fourth stage, program stabilization, to Tripodi's three stages of program development: program initiation, program contact and program implementation. The second modification was developed by the investigator. The first stage, program initiation, was found to be better described by dividing the developmental tasks by referencing them separately to external and internal environments.

While the characteristics of the stages will be highlighted at the beginning of each chapter, it might be helpful to look at a brief summary of the specific agenda for the four developmental stages. Tripodi, Fellin and Epstein (1978), and Bielawski and Epstein (1984) describe these attributes:

"Program initiation refers to that stage in which the ideas for a program are translated into a plan of action and in which necessary resources are secured. It involves all of the planning and preparation required before the content of the program can be delivered to its recipients...this stage (is) primarily concerned with procurement or selection of material resources, staff, technology and clientele."

"Program contact is that stage in which a program has achieved its objectives of initiation and is devoting its efforts to the active engagement of a target population with the program staff...In this stage (the concern is) with locating physical, social, and psychological obstacles to the effective delivery of services; locating other community resources that will aid, or impede, or substitute for the program's own activities..."

"*Program implementation* is that stage in which a program, having achieved the necessary conditions of initiation and program contact, applies its technology, services, and so on toward attainment of ultimate program goals...concern (is) with the extent to which major organizational goals are achieved...criteria for follow-up activities and possible program termination are specifies...(Tripodi, et. al. 1978, p.7)."

"*Program stabilization* is the point at which the program achieves a degree of autonomy from its external environment...Autonomy means the extent to which a program possesses a distinctive area of competence, a clearly demarcated clientele or membership, and an undisputed jurisdiction over a function, service, goal, issue or cause...Autonomy gives an organization a reasonably stable claim to resources and thus places it in a more favorable position to compete for resources...In the stabilization stage, the program's continued existence is not in question and it has successfully accomplished the tasks embodied in each of the prior stages (Bielawski and Epstein 1984, p.17-18)."

In differential program evaluation, the quality of the analysis can be strengthened by the inclusion of three additional dimensions. As each stage is reviewed questions about program effort, program effectiveness and program efficiency can be addressed. "...*Program effort* refers to the description of the type and quantity of program activities ...*Program effectiveness* is concerned with whether intended outcomes, and beneficial unintended consequences, have been attained as a result of program efforts;...and *program efficiency* is devoted to determining the relative cost of achieving these outcomes (Tripodi, et. al. 1978, p.9). The case study looks at the organizational development of CCA through each of the four stages as well

as the effort, effectiveness and efficiency of the actions taken.

Each of the subsequent chapters will focus on an explication of CCA's four stages of development as a social program. Chapter 3 looks at the external characteristics of the initiation stage, Chapter 4 at the internal. In Chapter 5, the program contact stage is described and evaluated, and in Chapter 6, program implementation and stabilization are depicted. Chapter 7 is a discussion of the findings from the case study for the field of social work.

CHAPTER 3

Program Initiation:
An Environment for Opportunity

The initiation stage is the first of the four phases of program development. Beginning with the planning process, the program's mission and objectives are identified, and the ideas behind the program are translated into a plan of action. During this stage, the appropriate means and technologies for reaching the objectives are selected, as potential program clientele are identified and targeted. The developers build the program's infrastructure by procuring and cultivating the necessary financial and physical resources, a competent staff and social legitimacy (Tripodi, Fellin & Epstein 1978, 7, 26-28, 46-50).

This chapter will focus on the external conditions which shaped the mission and organizational characteristics of CCA. In Chapter 4, the internal conditions related to CCA's initiation will be investigated. The dual focus, looking out and looking in, refines and expands on the differential evaluation techniques suggested by Tripodi, Fellin & Epstein (1978), where the external and internal conditions of program initiation are not distinguished.

Responding to Opportunity

The precise moment when the accumulated perceptions of an individual become a distinct idea is difficult to identify. Perhaps less difficult is recognizing the occasion when the thought is shared. Toward the closing hours of the 1992 Behavioral Healthcare Tomorrow Conference in Chicago, two social workers from a major northeast coast metropolitan area began to explore with each other their mutual interest in forming a behavioral health care group practice. There were, of course, antecedents to the discussion.

The most immediate one derived from the spirit and tenor of the conference itself. The Behavioral Healthcare Tomorrow Conferences are yearly events sponsored by the Institute for Behavioral Healthcare, a trade association of the behavioral health care industry. Representatives of large purchasers of services, insurance companies, managed care organizations, provider institutions and individual mental health practitioners gather to share ideas and check the pulse of new developments. During the subset of meetings devoted to the provider community, representatives from managed care organizations were expressing interest in speeding up the consolidation of solo practitioners into groups. Established practitioner groups described their successful experiences working with managed care companies.

Such consolidations were well underway in 1992 on the west coast and in select areas of the mid-west such as Minnesota. The managed care organizations (MCOs) expressed their intention to expand this trend across the country and predicted that such practice configurations would sweep the nation in the next two to three years as their market share increased. Grouping providers would aid their goals of reducing costs through the management of access, more efficient utilization review of care, discounting fees and the consolidation of administrative tasks among fewer players. Provider groups would also set the stage for the next phases of managed care restructuring, regionalizing care and providing services within a continuum of care.

Networking is an important component of such gatherings. One attendee, from here on known as Principal #1, building on contacts made at prior conferences and as chair person of a state Society of Clinical Social Workers task force on managed care, was well acquainted with social workers from the west coast who were actively engaged in group practice development. He had also, at prior national meetings, established informal working relationships with managed care organization personnel including operating: executives, marketers, and network development specialists many of whom were social workers. Most saw practice groups as the next phase in mental health care delivery.

The mood established by the conference was positive and upbeat. On the rostrum, in workshops and in the corridors, MCOs and providers assured each other they could and would find ways of working together to support their mutual needs. The slogan "win/win" was frequently touted; implied in the sloganering was the suggestion that by working together, the survival interest of the managed care companies and the providers would be upheld and respected. Providers, when speaking among themselves, saw the trend toward managed care practice groups as an opportunity to continue their clinical work, continue control over the process of care, and further their entrepreneurial goals. There was little or no suggestion of any down side to this trend.

Few dissenting voices were heard at the conference regarding group practice development. One memorable dissenter was a former vice president of California Blue Cross/Blue Shield. He was of the opinion that small stand alone group practices could not be trusted by the industry to provide care that was of high quality and cost effective. "Negative experiences with such groups by the California Blues is well known in the industry," he said. Some groups in California had had a hard time providing a uniformly high quality of care. They were not particularly well managed and some were taking disproportionately high percentages of the reimbursements off the top as management fees. Clinicians who were providing the services for the groups

were being short changed and the Blues' customers were complaining.

The impact of the conference served to heighten anxiety among provider participants since the proposed changes in the structures of care had few antecedents; the two social workers shared their concern about the future viability of their successful individual practices as industrialized managed care increased market penetration in their region. Both had been in full time social work private practice since the mid-1980's and both had benefited from the fee-for-service reimbursement of their clients' health insurance. Their interest in managed care policy had alerted them to the quickly changing service environment, making them aware that the northeast would soon be dominated by the health care industry's managed care products. As in the west, it was anticipated that managed care would largely bring an end to fee-for-service reimbursement and undercut the principal pillar of financial support to the cottage industry of social work private practice.

Both social workers from the metro-area left the conference believing that they had gained an important perspective about what was about to happen to the structure of behavioral health care in their area. There were few providers at the conference from the northeast, and no social workers in private practice from their immediate region crossed their paths.

This knowledge and experience with the larger world of the behavioral health care industry opened Principal #1 to another level of interest and opportunity in developing a group practice. During the conference, he was approached by a national psychiatric health care corporation to possibly partner with them in developing an outpatient service in his region. The XM Company (for reasons of confidentiality the actual name of the corporation will not be identified) had a fifteen year history of providing private inpatient psychiatric and substance abuse treatment services in the metropolitan region.

Corporate Sponsorship

Private mental health practitioners were not the only people becoming anxious by the changing patterns of service delivery and reimbursement brought on by the new managed care strategies. In the description of the context for this case study (Chapter 1) it was noted that during the decade of the 1980's both inpatient and outpatient mental health utilization increased. Private inpatient psychiatric facilities were the larger beneficiaries of this increase. They were exceptionally successful at recruiting patients to use the newly designed psychiatric benefits of the typical health insurance plan. Public policy supported this growth, many state governments developed regulations mandating that

inpatient psychiatric and substance abuse treatment be considered part of the basic health insurance benefit.

Typically these plans allowed for thirty or more days of inpatient care. Psychiatric hospitalizations were designed around maximum utilization of these benefits. For example, an inpatient substance abuse detoxification and course of treatment were usually twenty eight days; a length of stay determined with little or no regard for the degree of patient symptomatology. Long, multiple hospitalizations were not unusual, and, as a consequence, inpatient mental health treatment costs became the fastest growing portion of health insurance premiums during the 1980's. One of the first priorities of managed care was to reduce this indiscriminate utilization of the inpatient benefit.

Under managed care, psychiatric facilities began to see a rapid decline in the average days of inpatient care. In 1991 the typical length of stay in the XM facilities was between twenty four and twenty eight day, by 1994 it had decreased to between seven and ten with an expectation of even further reduction.

As a result, many inpatient psychiatric and substance abuse services went out of business, and those that did not fail had to design new services to guarantee their profitability. One design strategy was to build a continuum of care that did not depend on inpatient billings alone. Patients could enter the continuum at any one of several

levels depending on the severity of their illness; within the same system of care, services could be increased or decreased as the patient's condition improved or deteriorated. A continuum might include, acute inpatient hospitalization, twenty three hour inpatient emergency observation and stabilization, partial hospitalization, in home stabilization, intensive outpatient or periodic outpatient care. XM stated its intention to build such a continuum of care around its metropolitan facility to insure its continuing place in the regional health care market. In pursuit of this goal, a senior XM executive approached Principal #1 at the Chicago conference. She had know him in the professional community, was familiar with his clinical work and his interest in managed care driven practice. Their initial conversation indicated that both might benefit by working together; XM, by developing an outpatient component to its inpatient services and, Principal #1, by having the backing and support of a national health care corporation in building his practice group. Principal #1 agreed to look within the professional community for other practitioners who might partner with him in exploring the feasibility of forming a outpatient service to be formally affiliated with XM in a regionalized continuum of care.

This association was grounded on some common assumptions. Both acknowledged that future survival would depend on working with managed care organizations and

designing services based on the clinical and business models being put forward by the major MCOs. As Principal #1 said, "We will need to be managed care friendly." A second assumption suggested that providers from different levels of care could and should work together with mutual benefit. Linked together they would be in a position to provide a comprehensive continuum of services to the MCOs. Thirdly, the association would provide a timing advantage to the participants. In September of 1992, managed care penetration of the regional market had just begun. There were few private outpatient service groups operating in the region and it was believed that having a continuum of care in place would provide a marketing advantage in the near future. The fourth assumption was entrepreneurial. XM and the private practitioners Principal #1 would contact were expecting to find profit in providing care. It was this enticement that sparked interest and motivated the tremendous effort and commitment involved in developing the continuum of care.

Finding the Principals

During the year prior to the 1992 Chicago conference, Principal #1 had instituted a local monthly meeting of the state Society of Clinical Social Work's managed care task force. The meetings were open to members of the Society who were concerned about the impact of managed care on their

practices. Participants were asked to monitor the growth of managed care in the region and communicate their findings to the membership at large. The Society was also interested in developing a collective policy and position about managed care. Most Society members were only beginning to have a sense of the impact managed care would have on their private practices.

Two perspectives on managed care characterized local task force participants. One group, representing about three quarters of the participants, saw health care industry sponsored managed care as a threat to their clinical autonomy and economic livelihood that needed to be thwarted. They believed that the intrusion of managed care ought to be resisted and that working with MCOs was collaboration with the enemy. The other faction took the opposite position, they believed that managed care organizations were too powerful to be thwarted and that accommodating them would be necessary to survival. Furthermore, they identified with the stated goals of managed care: the need to control costs, monitoring utilization for appropriateness, the development of care strategies based on outcomes, and the belief that managed care would ultimately lead to increased access to mental health services for more people.

It was from this latter group of social workers and from other mental health practitioner contacts of Principal #1 that potential partners were recruited. Sixteen mental

health professionals agreed to attend the first meeting on October 15, 1992 to discuss building a continuum of care. The group consisted of thirteen social workers, two psychologists and a psychiatric nurse. The first cut in this number came quickly when it was realized that local state law did not permit members from different professions to form a professional corporation. Since Principal #1 was a social worker and the group's organizer, all but the social work participants dropped out. An attorney, himself a mental health professional, knew no legal way around the state statutes governing professional corporations. According to his reading of the regulations, health care practitioners could not operate as co-owners in any private corporate structure which involved the mixing of health care disciplines. These regulations did not apply to public and private health care corporations and facilities licensed by the state government.

This proved a critical perturbation since practice groups in other areas of the country routinely involved a multi-disciplinary profile. Unlike the local jurisdiction, most states do not have laws which limit corporate affiliation among health care providers. MCOs are interested in having access to all the mental health disciplines, psychiatric physician involvement being particularly essential. Questions were raised about the ability of a group without psychiatric leadership to

succeed, but the organizing group of social workers choose not to see this as a major road block.

Strategies to minimize this obstacle were suggested by XM. Psychiatrists from their inpatient facility would be encouraged to supply psychiatric coverage for the outpatient service. Cut backs in inpatient days had already been occurring and several senior staff physicians indicated they would be interested in working for the new practice in order to diversify their sources of income. Negotiations began immediately to identify a strong candidate as the medical director. Physician interest and conversations with several of the psychiatrists gave the fledgling group confidence that a multi-disciplinary staff could be assembled. Psychiatrists would be neither partners or employees of the corporation, but would work as independent consultants to the group and their clients.

XM, at this point, also began to encourage the founding group to consider becoming a state licensed facility. Licensure would circumvent the regulations pertaining to professional corporations and allow the practice a legal means to assemble a multi-disciplinary group of providers. The XM corporate guides assured Principal #1 that their contacts with state regulators and experience with their licensed facilities would make obtaining a license a genuine possibility. Since there was a moratorium on licensure of for-profit outpatient mental health programs by the Department of Mental Health, XM suggested the group consider

licensure as an outpatient alcohol and/or drug treatment facility. While substance abuse licensure was not a comprehensive solution to the problems of multi-disciplinary participation, it could be an incremental step in securing the involvement of all the mental health disciplines as well as gaining legitimacy for the organization through state sanction.

Seeing several possible ways to circumvent the regulatory obstacles, the social work group continued weekly gatherings. A second cut in numbers occurred in the second month of meetings. Group participants became increasingly aware that success in initiating the practice would require a considerable investment of time and money. Principal #1 suggested the participants begin investing with a verbal commitment. They were asked to accept accountability to each other to work on committees and assignments to push the practice formation forward. Operating capital for payment of attorneys, consultants and clerical support would also be required in the near future. Group members were made aware by Principal #1 that a significant capital investment would be required to fully participate in the practice.

Pressures to begin actualizing the plan forced everyone to re-consider their personal commitment. One additional person withdrew which left a core group of seven: two women and a man from a contiguous county who had been in a group practice together for about ten years and four men from the

immediate area who had just begun to know each other. At this time, a day long meeting was planned with a goal of establishing a more personal and less formal connection among participants. The group also had its first formal meetings with the administrative representatives from XM.

These meetings were critical in beginning to formalize the association between the social workers and XM. All parties were assessing their willingness and comfort in partnering with each other. XM wanted to ascertain the professional maturity and competence of the individuals involved, and the social workers wanted to sense the place and value of the practice in the XM business plan for the region. Notes from these meetings suggested a high level of anxiety among the founding partners. They believed their close association with XM would increase their opportunities for success; however, they were also deeply concerned that the size of XM would dominate the affiliation and might cause them to become overly dependent on one strategic partner.

Two questions coming out of these concerns were raised at the first meeting. Why did XM choose to work with an unformed group; and second, how would an a new outpatient service be affiliated with XM to insure success for both? The chief XM spokesperson addressed the first concern in the following way:

" XM wants to affiliate with a new entity because you come with no baggage. You get business because you are new and attract attention. We want to put our mark on the practice as it develops. Established providers have egos and fixed identities that we would have to work around. If we need each other it is a win/win for both."

Providing an answer to the second was more complicated, but again the XM executive gave a description of the XM business plan which recognized the needs for a continuum of services in a market dominated by managed care. XM's success had been in the inpatient market, the social workers were experienced outpatient providers. Working together XM and the social workers would be offering a strong, comprehensive, integrated continuum of care that was intended to capture managed care contracts. The group of social workers believed that their interests and those of XM were mutually dependent and the group agreed to begin the formal work of building an affiliation with XM.

XM personnel and the social workers recognized that affiliation with XM would have a second critical benefit. Care giving in the industrialized managed care market was quickly becoming big business. In the west, many large group practices had sophisticated business leadership. The speakers on the subject of group practice development at the Behavioral Healthcare Tomorrow conferences were often the MBAs and accountants who managed these practices. There was an honest recognition by the social work clinicians that

they were out of their area of expertise in establishing a business. Affiliation with XM, it was believed, would compensate for this basic weakness in knowledge and experience. At the end of the first meeting and the agreement to work together, XM assigned a senior corporate business manager to work closely with the social workers offering them a constant flow of business advice, consultation and support.

Another important reassurance was given by the XM representatives during the initial contacts. They provided figures from their inpatient discharges, from both their psychiatric and substance abuse facilities, which promised twenty or more referrals a month to the outpatient programs the social worker group would be operating. XM had two full time marketers in the region who would promote the practice as a XM affiliated facility with the same quality standards as the XM inpatient programs. Also the inpatient facilities received many inquires for care that were not appropriate for inpatient service. These consumers, too, would be potential clients for outpatient services.

Shortly after this meeting there was a third and final culling of principal participants. Several factors were involved in the process of reducing the number of partners. The contiguous county group was a strong functioning unit with a ten year history of working together. Their reluctance to fully participate in committing to a new

entity became apparent as more time was required in building the organization. Group dynamics also came into play, questions of leadership and doubts about the ability of the two groups, represented by the two counties, to integrate led the two sub-groups to go their separate ways. XM also encouraged the split, the lead XM executive felt that seven decision makers would prove unwieldy for them and they strongly suggested a cut in the number of partners. Consequently, with XM's urging, the three members from the contiguous county were asked to withdraw by the other participants. The final association consisted of four social workers, who would become a professional corporation, and XM.

Each of the four social workers brought different interests and experience to the venture. There was little competition for status and role since everyone had an important niche to fill in the fledgling organization. Principal #1 was interested in assuming the responsibility of executive director. His position of convener and his close association with the XM staff solidified his place as the group leader. Principal #2 began his work as the recording secretary and attended to many of the organizational details. He had also been a principal partner in another social work group practice and was able to contribute this perspective. Principal #3 had twenty years of experience as chief social worker in a public

mental health clinic. He filled the role of clinical director and clinical program developer. Principal #4 had successfully developed a large practice in the two counties of the region. His experience in marketing led to his interest in directing the marketing effort.

Professional Corporation

Incorporation was a defining moment. It solidified the organization as a legal entity registered with the proper authorities, there were laws and regulations to which it must adhere, the corporation was given a name, directors were appointed and charged with acting in the best interest of the corporation, shares were distributed to the owners, and by-laws formalizing the terms of association and disassociation were written.

For the principal partners, incorporation was also a defining moment of commitment to each other and to their vision of building a continuum of care with XM. A first capital call for \$10,000 from each partner was a concrete representation of this commitment. Money was needed to pay legal fees, corporate registration fees with the state and to open the bank accounts which would give the corporation financial standing in building the infrastructure. The partners were beginning the long road of putting themselves and their financial resources at risk. The capitalization

and business operation of the practice will be discussed in more detail in the following chapter.

The first order of business was finding an appropriate name. Professional corporation names are governed by three rules. The profession must be named in the title, it must accurately represent the type of business conducted and it may not infringe on the name of another corporation presently registered. Social Work Counseling Care Associates, P.C. (CCA) was the name selected. (Note: CCA is not the actual name of the corporation, but a designation selected by the investigator to mask the identities of the subjects related to the study).

Writing the corporate by-laws, or shareholders agreement, was the next step in the process. The principals were advised that the typical by-laws of a simple corporation were all that were required. Additional clauses, based on the practice experience of the participants, were added. Documents were prepared, personal attorneys reviewed them and the shareholders agreement was signed by the four principals. One year later this assumption about the "simplicity" of the corporate affiliation proved to be an error when XM withdrew from their agreements with CCA and when one of the principals decided to leave the practice.

As a legal entity, CCA was a simple corporation. However, the professional association required complicated definitions of roles, functions, agreements on

reimbursements, rules of engagement and disengagement for all the principal parties. An adequate rendering of these processes was not written into the by-laws, nor were the details of XM's affiliation with CCA part of these foundation documents. It was learned subsequently by the partners that medical practices do typically have such sophisticated contractual relationships between participating members.

There was a naivete on the part of the partnership and their attorneys about the complexity of the venture being undertaken. There are a number of possible reasons for this shortcoming: 1) it was difficult for the social workers to find business and legal professionals in their area who were familiar with the new models of practice and the contractual arrangements which bind them; 2) XM's experience was in inpatient care and in the management of large organizations, not in start-up entrepreneurial endeavors. Additionally, XM, in its counsel, was motivated by its self-interest and could not be relied upon to protect the interests of the social workers in framing the affiliation; and, 3) a loose arrangement between CCA and XM seemed to be the most comfortable for both parties at the inception of the affiliation. As a result, the legal contracts were also loose and therefore inadequate in defining the responsibilities of the participants to CCA and to each other.

This is one of the first in what will become a series of occurrences in the process of evaluating CCA where we find that the partners did not have an adequate perspective on the intricate nature of what they were taking on in establishing CCA. Their advisors and counselors fell short in giving the social workers an adequate understanding of the personal, legal, and business ramifications of implementing their vision.

Responding to the Managed Care Market

The time period between the first conversations about a group practice to the incorporation of CCA was six months. There was a feeling and perception of urgency in the process and when asked about the time frame for becoming operational, the representative of XM said, "We should be up and running now. There is not much time to find a place in this market." While time constraints were real, the intensity of the effort to move forward inhibited a careful consideration of all the ramifications of CCA's strategic thinking; and, in the end, it deflected away from a more incremental implementation of the initiation stage of the practice.

Pressure was coming from several sources. The parties were aware that MCOs were making rapid inroads in the west. For example, an affiliate of XM in Colorado reported that

the dominant shift to managed care had happened in the span of one year in his community. The MCO representatives were saying that their timetable for penetrating the east coast was speeding up, as they were aggressively marketing their managed care products to corporate purchasers in the CCA region.

In the first months of 1993, contracts for managed care designed insurance benefits were being negotiated for 1994. It was implied that providers savvy about managed care would be first in line to receive contracts to service these product lines. At forums such as the Behavioral Healthcare Tomorrow conferences, executives from managed care organizations were telling providers that they would have an advantage in this process if they could demonstrate competence in practicing these basic principles of managed care: 1) treatment goals and approaches geared to improving functioning, 2) utilization and case management, and 3) having the business and information systems needed by the health care industry. CCA's practice design met all these criteria.

The XM representative was also aware that the MCO holding the mental health benefit contract for state employees was going to be affiliating with local group practices. These groups were to be scattered throughout the state and would provide initial assessment and treatment for all employees seeking care through their 800 number referral

lines. Three such group affiliations were planned in the CCA region. Again it was implied that a group practice with a managed care accommodating attitude and appropriate infrastructure would be in an excellent position to secure this special group designation. Time was a factor. It was known that such group contracts would be issued early in 1994, and CCA/XM believed an effective organization had to be developed within twelve months.

Such knowledge, or corporate intelligence, was an important contribution of partnership with XM. The corporation had local and national marketers who were in constant contact with MCO provider network managers and marketers. Knowing and staying with the trends had helped make them a proven success, but knowledge from such a powerful source also produced pressure of its own. There was a sense that XM, as a large national corporation, was on the inside of what was occurring in the market. The information was assumed to be accurate and timely, later it will be shown that such confidence was misplaced. Yet in fairness to all the parties concerned, the trends and predictions were cross referenced by what was being said in the trade literature, by provider contacts in the west, by representatives of MCOs and in the many national meetings focused on managed care. The need for the CCA principals to know their market, at the time, was a topic well explored, however the analysis of the market proved faulty and the conclusions too hastily drawn.

Responding to the pressure of time, the principals were very effective at establishing the core of CCA. Partners were selected, a mission was agreed upon, the affiliation with XM was established, capital was raised, the practice was incorporated and the infrastructure was built. However, responding to the pressure of time led to miscalculating the complexity of the undertaking and misunderstanding the strategic plans and goals of managed care.

Strategic Misunderstanding and Miscalculations

Strategic planning has become a fundamental management tool of the modern corporation and has been widely accepted by social welfare organization planners as well. It provides techniques for managers on many levels ... "to respond to changes in their environment: they must be aware of what changes are occurring, interpreting the meaning these changes have for their organization, and develop appropriate responses to these changes (Gummer, 1992, p.90)." Strategic planning may be defined "...as a disciplined effort to procure fundamental decisions and actions that shape and guide what an organization...is, what it does, and why it does it (Bryson, 1990, p.5). Burton Gummer commenting on the work of A. Langley (1989), observes that for the most part strategic planning is not only a

method of improving corporate decision making, but "...it also serves other functions, including social and political ones (Gummer, 1992, p.90)."

The decision to incorporate CCA was the result of a strategic plan by the principals of the organization and the corporate sponsors of XM. CCA was an organizational response to the changes resulting from the strategic planning of the MCOs and their corporate sponsors. The founding partners believed that group practice within a continuum of care would be an effective response to the strategic designs of industrialized health care; a belief that proved to be both a misunderstanding and a miscalculation of the actual intentions of MCOs and provides us with a perspective on the external conditions which made it difficult for CCA to implement its services.

Managed care was planned with at least two important goals in mind. The manifest purpose was to control the cost and utilization of health care services. However, as we discussed earlier, managed care is also part of the strategic plan of the health care industry to gain the upper hand in making health care an important profit center for its shareholders. In order for this to occur, MCOs had to become the primary conduit through which health care money and service were either directed or offered. At the same time MCOs sought to control the providers of care. This was progressively accomplished by making health care providers

employees of health care systems or by forcing care givers to offer their services through MCOs. Insurance companies have gradually convinced the payers of care to offer their health benefits through managed care operations with the promise to reduce health care premiums. Providers in turn have had to offer their service through MCO operations or lose their patients. Participation by providers in these plans requires them to offer care within the corporate guidelines of the MCOs.

A part of the industrialized managed care strategic plan has been to convince providers of the wisdom of accepting the structures imposed by managed care organizations. In behavioral health care this has been done through the medium of such trade groups as the Institute for Behavioral Healthcare. MCOs have largely underwritten the cost of these trade organizations, sponsoring their conferences and publications.

The MCOs have used these forums to support the implementation of their strategic plans. Providers have been told that by working with MCOs, they and the MCOs would "win", that is, succeed as a profitable business. By partnering with the MCOs, providers were also promised that through the discounting of their fees and by subjecting themselves to the utilization mechanisms of managed care, their practices would benefit through a higher volume of client referrals. Multi-disciplinary group practice was

promoted as the best organizational structure to facilitate this association. MCOs promised long term partnerships based on mutual benefit to those providers who fell into line.

The Council of Behavioral Group Practices was organized in 1992 by the Institute for Behavioral Healthcare as a support organization for provider groups who were willing to accommodate to this strategic plan. The Council was to act as liaison between the MCOs and the provider community while supporting the efforts of the providers in developing and coordinating their strategic plans. CCA joined the Council in 1993 trusting that membership would add credibility to their organization as it sought business with MCOs.

A primary underpinning of the strategic plan for CCA rested therefore on the belief in these implied promises from MCOs articulated through the Council. CCA principals were presenters at Institute workshops, served on Council committees and developed personal relationships with senior executives from several of the largest MCOs. In designing the structure of CCA, the principals used the practice models developed by other Council members.

Doubt in the wisdom of these core beliefs began to emerge by June of 1994. CCA had pushed its organizational timetable in the hope of becoming one of the three regional care groups for JJJ (the actual name of the MCO is masked to protect the confidentiality of data sources and by legal

contract between providers and the MCO). JJJ held the mental health benefit contract for state and local government employees. The principals and an XM executive marketed JJJ, and personal conversations between CCA's executive director and JJJ's medical director were used to promote the affiliation. Despite compliance with all essential organizational and programmatic requirements of the application, the contract was awarded to another practice. As far as the principals were able to ascertain, CCA was the most "managed care ready" practice in the region. Why this readiness did not win the JJJ contract was never discovered.

In a subsequent interview with a principal from the group who won the contract the following information was obtained:

We had already been operating as an outpatient mental health group practice for almost twenty years. How we got involved with managed care was through JJJ. They called us and asked whether we would be interested in working with them. We agreed and they asked us to develop an outpatient program for them. That is how it began...Many of our providers had been involved with managed care in their practices and through working with insurance...Interviewer: So you gained most of your experience about the inner workings of managed care after you were awarded the contract and through your previous clinical experiences.
P: Yes...

Organizational alliance with the tenets of managed care learned through participation with the Council was of no net gain to CCA in this instance. JJJ awarded its regional care

contract to a practice with little contact or familiarity with the larger world of managed care.

CCA developed its strategic plan believing it paralleled the strategic planning of managed care. It was assumed that by doing so CCA would be in an advantageous position to secure managed care business in its region. Experiences such as the failure to achieve the JJJ contract demonstrated that the founding assumptions were not wholly accurate. MCOs were not necessarily fulfilling their stated aims, nor could an individual managed care organization be depended upon to follow the strategic planning statements of the managed care industry as represented by their trade organizations.

There are several possible explanations for this fundamental miscalculation. Gummer (1992) explains that strategic planning can have goals that relate to issues other than managerial operations. They can have social, political or symbolic meaning as well. A. Langley writes: "(Strategic planning)...may therefore also be used to convey a message that is purely symbolic-to impress others within or outside the organization or to hide another less laudable motive (Langley, 1989, p.607)." In her research, Langley discovered that symbolic strategic planning is frequently seen as manipulative or underhanded. "...Symbols lose much of their value as soon as people suspect that it is a symbol, and not the real thing (Langley, 1989, p.608)."

Over time it became apparent that much of what MCOs were saying about their strategic plans in public forums, in their promotional literature and in personal contacts with providers was more symbolic than real. The experience with JJJ gives credence to this conclusion. CCA began to sense that MCOs were primarily seeking opportunities to further their business aims, rather than working with the provider community to offer a mutually beneficial affiliation and to render quality care.

CCA's encounter with JJJ was representative of the experiences of other providers in similar circumstances with other MCOs. In an effort to discover whether or not the conditions faced by CCA were anomalous or typical in the field, the investigator interviewed three principals from three other group practices operating in the same regional territory. From time to time in the course of this evaluation, we will look to these interviews to more broadly substantiate the conclusions drawn.

All three interviewees quickly lost trust in the statements and promises of the MCOs. Frustration and anger emerged as the providers sensed that they were being manipulated by managed care personnel. Business advantage rather than the quality of care or respectful partnership have come to characterize the operations of the MCOs. The following comments by a principal from the comparison group are rather typical:

We might get a huge amount of referrals in a short period of time, but it is very volatile. You never know from week to week where you stand with them (the MCO)...You know truthfully, they are all liars...they come in and say we are going to do a collaboration and we are going to work primarily with your group. But they are talking to every other group, it's as if we (providers) don't talk to each other. They make promises about the number of referrals which they never come up with. And if you ask them about it, they will tell you it's because they are disorganized or some bullshit, but they lie...They try to get you dependent on them, then they threaten to pull the rug out and they control you. They throw you lots of referrals then they withdraw and ask you to be an exclusive with them... They promise tremendous volume. They all talk the same talk. "If we don't have you we can't provide a quality service." I haven't seen one of them I can trust, that's honest ...there is an appearance that they are letting you in on things, but they are very selective on the information they are giving you...I don't have any sense what is really going on inside these organizations. They just don't tell the truth about their intentions.

Other experiences support the conclusion that the manifest strategic plans of MCOs were framed to take advantage of the providers rather than to work with them. In the two years that CCA was in operation none of the four largest managed care organizations responded to CCA's efforts to develop a group contract or affiliation. This did not mean however that the MCOs were indifferent to the ability of the principals to service their clients. Each of the principal partners was in the preferred provider networks of the majors MCOs as individual clinicians. Over the time of the operation of the practice all the principals received regular referrals from the MCOs. In December 1993, about 50% of their clients were from managed care referrals,

by June of 1995 about 90% came through managed care. Nevertheless, MCOs refused or ignored offering CCA a group contract. This refusal ran counter to the stated strategic aims of managed care and made it impossible for the principals to maintain the expensive infrastructure they created to service the needs of managed care. MCOs have been able to capitalize on the discounting of fees and the clinical control of providers through their networks without bearing any of the cost of organizing or maintaining these systems.

CCA was able to secure group contracts with three of the smaller MCOs. However, in spite of heavily discounted fees, CCA never received referrals in volume. On reflection, it seems fair to conclude that some of the strategic planning statements of organized managed care were more symbolic than real and were stated to manipulate the provider community. It became a serious miscalculation for the principals of CCA when they took the MCO's stated strategic goals as necessarily representative of their intentions.

A second explanation for the failure of MCOs to live up to their well publicized strategic plans with the providers has been the unprecedented volatility of the managed care organizations themselves. Mergers and acquisitions have become a major preoccupation with managed care entities, especially in the last three years, 1993 through 1995 (Troy,

1995a). This phenomenon had serious consequences for CCA. First, as companies merged, personnel changed, many of the personal connections established between the principals of CCA and managed care executives were broken in the process. There appeared to be a preoccupation on the part of those who remained with maintaining their own orientation within the transitions. Managers became reluctant to make new commitments and organizational relationships; no one knew how such affiliations would fit into the strategic thinking of the new entities.

In mid-1994, CCA was actively negotiating with two managed care oriented home health care companies to provide social work services to their patients in their homes. There was active and regular communication as the programing and terms of affiliation were being developed. Suddenly telephone calls to the best prospect were not returned. A few weeks later CCA discovered that the two companies had merged and when contact was finally reestablished CCA was told: "Things are a mess around here, there is no time or money to make any new deals."

When mergers were not the issue, the constant internal reconfiguration of MCOs presented problems in maintaining contacts within the organizations themselves. CCA's marketing director had spent a year developing a relationship with a senior executive case manager at the local office of a major MCO. Several weeks after making

a marketing presentation at their offices and receiving positive interest in CCA's services, the director discovered that the executive was leaving the MCO and that the local case management offices were moving to another state in the region. New personnel would staff the new location.

Other providers in the area were also constantly thrown off balance by the volatility inside managed care organizations caused by mergers and acquisitions. These comments from a comparison group executive are representative of this experience:

There are a lot of mergers going on and existing organizations change their mission and a lot of disorganization comes. The people (MCO personnel) we often deal with don't have time for us. They just want to come in, set something up fast and move on to the next thing. So many of the organizations (MCOs) are dysfunctional. You will have a contract with a MCO with several divisions and they don't talk to each other. They will have an agreement to do business with you, but people in other divisions won't know anything about you. Even the computers don't talk to each other. So they seem crazed...They move up in an organization, move to another company, but then we are dealing with someone else that doesn't know us from a hole in the wall. Then we are back at square one...

The constant need to begin again and the discovery that CCA could not build on established relationships had not been part of the strategic thinking. No one in the planning of CCA anticipated or was fully aware of the volatility of the managed care market or the instability within managed care organizations themselves. The failure to anticipate or plan for this possibility became another significant strategic miscalculation for CCA.

Between 1990 and 1992, when the CCA principals were becoming familiar with behavioral managed care, many of the larger managed care firms were still headed by mental health professionals. Human Affairs International was founded by a social worker, Preferred HealthCare's CEO was a doctor of social work. The founder and CEO of American Psych Management was a psychiatrist. This quickly changed during the ensuing three years. Independent MCOs were consolidated to form larger entities and then purchased by major insurance companies such as, Prudential, AETNA and CIGNA to solidify their control over the management of care. As the MCOs grew, corporate culture rather than health care culture began to pervade the relationships between providers and MCOs. Bottom line financial pressure forced fees and utilization to levels lower than CCA had foreseen.

When CCA began clinical operation in late 1993, a major managed care referral source was paying social workers \$75 for a psychotherapy visit. In March of 1994, the company informed its social work providers that beginning May 1, 1994 their reimbursement rate would fall to \$59. Network social workers were given a choice: if they did not wish to accept this new fee schedule, the MCO would simply remove their name from the provider referral list. At the time, about 16% of CCA's business was coming from this particular MCO. This was a blow to CCA's ability to meet expenses. At a subsequent regional providers meeting called by the

company, the provider relations representative (a social worker) made the following comment about the reduction:

"I tried very hard to maintain the reimbursement level at the higher figure, but our competitive edge in negotiating new contracts was being threatened by our high levels of reimbursement. Upper management has continued to put pressure on me to lower the rate even more, but I have told them, we would not be able to keep you, our quality professionals, in our network if we went much lower. I am hoping to hold the line for the next year at least."

While this was an empathic response, what was of most interest to CCA was the realization that fees might be reduced even more in subsequent years for the company to remain competitive. Two factors combined to threaten CCA's ability to survive financially: the unwillingness of the MCOs to establish group affiliations which might have provided volume business and the reduction in reimbursements. Together these pressures made it almost impossible for the four principals to generate enough income from their own labor as individual network members to pay overhead expenses for the new organization.

Mergers and consolidations of the number and quality seen in 1993 and 1994 put the kind of pressure on CCA that was not anticipated in the strategic planning of the principals. Stress increased with another new and unanticipated merger that was closer to home. XM, the CCA corporate affiliate, was purchased by a very large national medical health care system. XM's assets were to provide

them with a behavioral health care division. This happened in November of 1993, at about the same time CCA and XM began their formal working affiliation, CCA began clinical operations in December of 1993. Almost immediately, XM lost interest in CCA as the XM executive who had initiated and shepherded the affiliation left the XM division and became regional director of marketing for the new purchaser.

CCA lost a great deal in this merger. It lost the personal interest of the XM personnel who had been a driving force behind the inception of CCA. While the formal affiliation continued for another ten months, there was no comparable enthusiasm from any other XM executives. Lost, too, was the information, business and program planning expertise upon which CCA was dependent. Additionally, XM never used the alternative to hospitalization programs that CCA developed with XM, the foundation of the CCA/XM continuum of care.

This development threatened CCA's survival by depriving the organization of a client base and the essential structural supports necessary for success. XM's withdrawal undermined the whole strategic premise upon which CCA was founded. The principals of CCA had not gone into business to establish a stand alone group practice, but to be an essential part of a regional care system. CCA had not understood nor foreseen how easily XM could withdraw its interest and support.

One other miscalculation found CCA on the fringes of what was fast becoming the dominant structural configuration for managed care operations, namely large integrated delivery systems (Shortell, Gillies, & Anderson, 1994; Troy, 1995b). Integrated systems implies comprehensive medical services, primary outpatient care, acute inpatient hospitalization, diagnostic and surgical centers, rehabilitation, mental health, and custodial care from cradle to grave. Large regional hospitals saw the development of these comprehensive care centers as the only means to keep their place in their local markets and counterbalance the power of the national MCOs.

Integrated systems of the size being developed in the metropolitan region where CCA operated essentially leave the small provider outside the system (Troy, 1995b). While small local provider groups may have been viable in the late 1980's and even briefly in 1992 when CCA was in the initiation stage of its development, in less than two short years the market environment was becoming inhospitable to a group the size of CCA. No one advising CCA and none of the principal planners anticipated the rapidity of this change.

CCA's strategic plan envisioned the group as part of an integrated system of care. At its inception, the organization had expected to have time to establish itself and thus be in a position to join a larger network in the future. The CCA plan anticipated this occurring after five

years. More will be said about this miscalculation when we discuss the client contact stage of program development in Chapter 6.

The Licensure Miscalculation: An expensive sidetrack

Inpatient substance abuse detoxification and rehabilitation were a substantial part of XM's regional market share. However, MCOs have been cutting into this business by requiring their enrollees to complete a course of outpatient treatment prior to approval for the more expensive inpatient stay. The XM strategic plan called for CCA to provide these outpatient services and to direct clients who needed a more intensive level of care to their inpatient facilities. After hospitalization, patients would return to CCA for aftercare and stay within the CCA/XM continuum of care. Fulfilling this part of the XM strategic plan required CCA to be licensed by the state office of alcohol and substance abuse services.

XM led CCA to anticipate other advantages to licensure. As a social work professional corporation, CCA could not exist as a truly multi-disciplinary practice employing psychologists and psychiatrists. Licensure would allow the agency to operate under the regulations of the substance abuse authority, permitting the clinic to employ the other mental health disciplines. In addition, CCA would gain

legitimacy as a substance abuse treatment center. MCOs generally prefer to use licenced facilities to provide intensive treatment for their drug and alcohol abuse referrals. Licensed facilities typically have a broader array of resources, drug testing, group treatment and the multi-faceted services required for recovery.

A state license would also allow for the possibility of developing a wider array of treatment services for revenue enhancement, including intensive day programs and a partial hospital. A license appeared to increase the potential client pool for CCA as well as giving access to the Medicaid and Medicare reimbursement stream. XM convinced the CCA principals that the license would make the organization more attractive to the MCOs as a comprehensive care center.

The CCA principals had their doubts about the wisdom of seeking the license since it required a major expenditure of scarce capital resources. An initial review of the licensing process showed it to be an expensive and time consuming endeavor. CCA would have to locate in a site where a certificate of need (CON) could be granted, space sufficient for the operation would have to be rented and maintained for the year it would take for the application to be approved, and a consultant would be needed to shepherd the licence through the state bureaucracy. It was estimated it would cost about \$100,000 to acquire the license, CCA staff time in executing the application was not part of this anticipated cost.

In June of 1993, XM increased the pressure on the principals regarding the licensure application by suggesting that an affiliation would be less attractive to XM without the prospect of a license. The principals acquiesced and the application process began. This proved to be a critical strategic miscalculation. The most serious consequence was the drain on precious capital, rent and utilities for the clinic space cost \$3,000 a month for twenty two months, the consultant was paid \$36,000, and there were administrative expenses and legal fees as well. XM shared none of the financial risk, though the principals made the investment believing XM would honor its stated intention to use CCA as its outpatient service. The principals finally accepted the risk believing that possessing the license would help insure the value of their investment in the CCA/XM affiliation.

None of these strategic assumptions proved correct. After its purchase, XM staff never honored their contractual commitment to provide supportive services, referrals and marketing for the clinic; they broke the affiliation agreement before the license was approved, but after the application process had begun. MCOs continued to cut chemical dependency treatment throughout 1994, well established substance abuse treatment programs were having a difficult time finding clients, managed care case managers limited service intensity as much as possible until patient

relapse precipitated more intensive levels of care. By April of 1995, when the operating certificate was issued, CCA had no capital left to employ a director, market the program or implement treatment services. Furthermore, in spite of critical need verified by state and local officials, chemical dependency service were generally being under utilized due to MCOs' lack of support in an effort to protect their bottom line.

Pursuit of the substance abuse license became an expensive miscalculation; in fact, it may have been one of the more critical strategic error depriving CCA of precious personal and financial capital. Analysis of the interview data suggests that the three comparison group practices competing in the region were able to marginally maintain themselves by the careful husbanding of capital and limiting their overhead. CCA overreached its resources in the licensing process, and by failing to insist that the XM Corporation share the financial risks involved, CCA lost flexibility in utilizing its capital funds.

Reviewing the Role of XM

Of all the external forces operating to influence the character of CCA, none played a more critical role than XM. All four principals agreed that without the participation of XM during the initiation stage, they would not have engaged in the entrepreneurial risks CCA's development

entailed. In the planning phase, XM's involvement was personally reassuring to the social workers unschooled in the principles and practices of business.

Their confidence in XM was based on a number of factors: 1) XM was a national corporation listed on the New York Stock Exchange with fifteen years of successful and profitable operation; 2) XM's strategic thinking behind the outpatient service as part of a continuum of care seemed a reasonable reading of the service environment and represented congruence with the planning statements of the managed care industry; 3) the stated desire of XM to maintain and increase market share in their region by establishing an outpatient service to complement their inpatient facilities was a credible reason for forming a partnership with social workers experienced in outpatient mental health care; 4) the XM executive who had initially approached Principal #1 appeared sincere in her interest and commitment to the CCA/XM affiliation. She and her staff devoted large blocks of time to getting the venture off the ground; and, 5) early in 1993, XM suggested that they could lend \$100,000 to supplement capital development for the practice. The offer was taken as a sign of trust in the success of the venture and in the partnership with CCA's shareholders.

While partnership with XM was reassuring, it was also a source of anxiety for the principals. This was not, after

all, an association between equals, in the planning phase the partners realized they would be dependent upon XM for both the business expertise necessary to insure the successful operation of CCA and for referrals to provide adequate cash flow as the business matured. XM's size and the critical nature of their contribution raised fears that XM would "own" the operation and infringe on the autonomy of the partners to determine the direction of their business.

Consequently, in response to these fears, the partners engaged in contradictory strategies in their dealings with XM. For example, they frequently sought reassurance from XM that the corporation would honor their verbal commitments of support for the partnership, emphasizing the tie of dependency. Yet, at the same time CCA attempted to keep XM at a safe distance. The principals decided not to accept the offer of a loan believing this would allow XM too much access and potential control. CCA, for similar reasons, did not require of XM a stake in the financial risks of acquiring the substance abuse license.

The inability of the partners to resolve this conflict was a critical flaw in the affiliation with XM. By not giving or insisting that XM have a financial stake in the success of CCA, the partners weakened the bond between themselves and their corporate sponsor. The social workers did not fully appreciate that it is financial ties and legal contracts which bind businesses to each other and not

personal relationships and verbal agreements between executives and managers.

At the inception of the CCA/XM affiliation, both sides were eager to use the assets of the other for mutual benefit in dealing with the inroads of managed care. The social workers provided the opportunity for XM to branch out into the provision of outpatient services in an important metropolitan region. XM offered the opportunity for the social workers to enter the world of industrialized health care.

Analysis and Conclusion

Four social workers began their association in 1992 believing they had found a means to survive and prosper as care givers in the industrialized health care market place. By establishing CCA as a behavioral group practice, they hypothesized that they were making an accommodation to the strategic plans of managed care organizations. Affiliation with XM appeared to offer an extra measure of insurance to the strategic plans crafted by CCA. Partnership with the larger corporation, they believed, would give the social workers needed expertise in business management and reserve a place for them in a comprehensive psychiatric continuum of care.

Christine Oliver (1991) identifies five ways in which

organizations typically respond to the pressures and expectations of other organizational entities in pursuit of their shared or competing interests: they might acquiesce, compromise, avoid, defy or manipulate. Most often, organizations will utilize all of these tactics to one degree or another to maintain their viability. CCA's weakness and inability to sustain itself were grounded in too close an acquiescence to the manifest strategic plans of MCOs and XM which in the end deprived the principals of CCA the flexibility to employ the other tactical options of compromise, avoidance, defiance and manipulation.

Acquiescence might be permissible as a dominant tactic in organizational relationships when there is stability and a measure of equality in power and control among the associated entities. But neither of these conditions are descriptive of the industrialized health care market place of 1995 or between CCA, XM or the MCOs. The volatility of the market place made it impossible to form reliable relationships between CCA, XM and the managed care organizations that could endure mergers and acquisitions. Fees and reimbursements have not been based on the real costs of providing a service, but in competition between MCOs in their struggle for market share. Furthermore, providers have been surprised to discover how little control they have within managed care organizations which use their services but need not be concerned about their survival. At

this writing, MCOs are the dominate force and appear to be acting with impunity in their competition with each other.

Manipulation is an organizational tactic which Oliver (1991) observes in her research. We have seen how MCOs have used their strategic plans to manipulate providers to achieve their corporate ends. CCA fell prey to this process as did the comparison practices interviewed.

CCA was caught in a practice environment in which the tactics and the profit value structure of business were the dominant forces in play. The principals of CCA were in unfamiliar territory. Their training and social work value orientation did not adequately prepare them for their encounter with the business of industrialized managed care or their affiliation with a business organization with the size and sophistication of XM. More will be said of these encounters in the next chapter as the internal conditions of CCA's development are described and evaluated.

CHAPTER 4

Program Initiation: Building the Organizational
Structure of CCA

In the previous chapter, we determined that CCA was an expression of the strategic plans of industrialized managed care, of the XM Corporation and the principal partners of the practice. Much of the analysis focused on external factors which shaped the character of CCA and its organizational environment. This chapter will look more closely at the internal process of program initiation. Keeping this dual focus, looking out and looking in, is essential to the fullest understanding of the threats and opportunities in the life cycle of an organization regardless of its stage of development (Boyle & Desai, 1991; Nelton, 1992).

The literature which informs the analysis of this internal process is drawn primarily from the small business community. Social work scholarship provides little original information about the management and operation of entrepreneurial organizations like CCA (Keyes, 1988; Reichert, 1977; Tropman, 1989). Entrepreneurship and the business principles which enable it have not been a part of the traditional professional education and culture of the field of social work. This may put social workers at a

significant disadvantage as social welfare services are privatized and industrialized (Lurie, 1987; Reichert, 1977). As we shall see, this lack of fundamental business knowledge in the education and professional experience of the social work principals of CCA worked against the success of their endeavor.

Entrepreneurship

"The entrepreneurial impulse is the innovative impulse, the desire on the part of a person or an organization to do or try something new or different (Tropman, 1989, 221)."

Tropman's definition of entrepreneurship as it might relate to social service professionals broadens the significance of the entrepreneurial impulse much beyond the marketing of a better widget or engaging in high risk business for profit. It draws our attention away from the entrepreneur and toward the process; the development and implementation of new solutions for old or new problems. This orientation is particularly important to the field of social work where entrepreneurship may be associated with or confused with greed (Specht, 1990; Specht & Courtney, 1994). Viewed dispassionately, the concept of entrepreneurship can become a means to analyze and articulate the personal and business experiences of CCA.

Shapero (1984) suggests that as we examine the entrepreneurial process; it is important to focus on what he calls the entrepreneurial event, the act of innovation. His research suggests that most such events have common elements. The process, regardless of the character or personality of the entrepreneur, follows a typical pattern. It emerges as the result of two decisions: the personal decision to change from a given path in life, to become an innovator, and the decision to start a business. Two broad categories of behaviors are represented in these choices: the first has to do with the personal behaviors of the principals in actualizing the innovation; and the second is in creating the organization, the business, which contains and acts out the innovative design. We will look at these two categories in detail as they relate to the initiation phase of CCA.

Personal Investment: Decisions and Behaviors

Risk is a word frequently attached to the personal aspect of entrepreneurial innovation (Anonymous, 1989; Beam & Carey, 1989; Land & Jarman, 1993; Main, 1990; Shapero, 1984; Tropman, 1989). Entrepreneurship requires capital risk, the expenditure of time and money to bring the innovation into fruition. Intellectual risk, the testing of personal ideas and solutions to the problems

which the innovator seeks to challenge and the exposure of his innovative thinking to public review is also required. Closely associated with intellectual risk, is emotional risk, "...one's self-esteem and sense of competence is associated with one's offerings and products. A faulty product or service can cause embarrassment, shame and guilt (Tropman, 1989, 222)." Finally, there is interpersonal risk. Entrepreneurship requires enormous expenditures of time and energy. Family and personal relationships often suffer in the wake of these expenditures. Personal dealings with partners and associates are put under tremendous pressure and often fray (Anonymous, 1989; Main, 1990).

Understanding the depth of risk reveals why most established organizations hesitate to be entrepreneurial. They can not afford to lose. It is difficult to maintain and operate an existing business and explore new options (Sage, 1993; Shapero, 1984; Tropman, 1989). Perhaps this insight explains more fully the rationale behind XM's willingness to affiliate with the social worker principals of CCA. Outpatient mental health was a new venture for XM and to establish a new infrastructure would have entailed all the risks mentioned above. XM was able to test the regional market with no substantial corporate or personal hazard to their staff or capital. The social workers took on the innovative or entrepreneurial risk.

Motivation to take such a challenge must be substantial. Shapero (1984) suggests that the thought of engaging in entrepreneurial events occurs to groups and individuals constantly, but more often than not they never progress beyond thought or conversation. He finds that the motivation which tips the scale toward action is usually due to negative forces in the personal lives of the participants. "...Company formations occur among refugees, people who have been fired, women experiencing the 'empty nest syndrome', and people who are insulted or frustrated on their jobs (Shapero, 1984, 25-26)." Entrepreneurship is first a very personal decision to change one's life course.

The decision to initiate CCA validates Shapero's findings. All four principals were moved to action by the awareness that their means to livelihood was being threatened by industrialized managed care. Three of the partners were in full time private practice, the fourth had been a senior social worker at a public mental health clinic for twenty four years. He too was aware that managed care was changing the character of the public sector and the security of his long held position; his professional development was at a standstill and he was looking for a challenge outside of public service. While the negative force is instrumental, the entrepreneur also has to have faith in the innovation he proposes (Sage, 1993; Shapero, 1984). As we saw in the previous chapter, all four partners

believed that in initiating CCA they had come upon a way to survive and prosper as social work clinicians in a privatized environment increasingly dominated by industrialized health care.

Shapero's impressions validated by the CCA experience are further corroborated in the interviews with the other clinicians who had begun group practices in the region. Negative stimuli were fundamental to their motivation. All believed that managed care was undermining their ability to make a living doing the work they loved. Initiating an entrepreneurial event was their response to the threats represented by managed care. A founding partner of one of the comparison organizations explained his motivation for moving out of solo practice:

"The area here where I have my practice is blue collar and with many middle management type people. For years, my practice was thriving. I would have never thought I would go into the therapy business. When managed care came along, I said I was not going to join in any of the panels. I could survive without getting involved in managed care. I would go for the carriage trade. But as it turned out 50% of my patients were soon covered by managed care contracts. This frightened me and I said: well let me join the networks, then I can decide if I want to accept their patients. At first I would not accept their business, but that was not working out. I was losing referrals. So I slowly had to get involved in more and more panels...I tried at first to keep managed care to half my caseload, but my finances were affected greatly by it. At the same time DD (an MBA friend) started talking with me. We had long talks about mental health being industrialized. He was working for a Fortune 500 company at the time. He said: look I'll leave my job, this is where the action is going to be. I saw everything I had worked for falling apart. I felt that he was accurate about what he was predicting. I heard what other therapists were saying about their

experiences and that led to forming (the name of his outpatient business)."

Negative forces coupled with a strong belief in the innovative solution are requisite to taking entrepreneurial risks. A high degree of confidence in the innovation often takes on the quality of missionary zeal which serves to spur entrepreneurial motivation (Beam & Carey, 1989). Zeal and intellectual certainty for developing managed care accommodating practice was evident in two of the CCA principals and particularly in the convener of the group. Principal #1 had made over thirty speeches and presentations about managed care, he taught and supervised other social workers in learning about managed care; Principal #2 spoke before professional groups, consulted, and taught courses on group practice development at a local university. Both contributed to the professional literature on managed care related topics. Total commitment to the innovation precedes the investment of time and capital in initiating the entrepreneurial enterprise (Anonymous, 1989; Main, 1990).

Capital Risk: Time and Money

The extent of personal risk in building CCA was considerable. Appreciating the depth of the risk explains why the principals were frequently asking XM for reassurance of their backing and interest. During the first months of

organizational development, the primary investment was one of time. The principals agreed to devote twenty hours a week to developmental tasks, in addition to their clinical responsibilities. However, it quickly became evident that time commitment could not be so easily structured. Getting the job done became the only time limiting criteria. In the typical entrepreneurial endeavor, time, or "sweat equity", is a key capital investment (Shapiro, 1984).

The first tension among the CCA principals emerged around issues of time, the interpersonal risks of entrepreneurship. Everyone felt stretched to the limit, and wondered if perhaps they were contributing more to the effort than others. For example, one principal was more relaxed in his personality style than another, and, as a consequence, qualitative perceptions of tension and frenzy were confused at times with quality of commitment. These feelings were managed by holding frequent meetings in which the partners reported on their activities as a way to be accountable to each other. Discussions about emotion based perceptions were encouraged and close contact was maintained. These meetings continued weekly until the practice suspended operation. Periodically, all day retreats were held for the same purpose.

Maintaining close personal contact among the principals was important in dissipating the tensions inherent in developing CCA. The attempt, however, was not without

limits. CCA had decided to have offices in two counties; a decision that required one of the principals to have his primary clinical practice location in another community away from the other partners. This structure prevented the daily contact and involvement the other three principals enjoyed and, as a result, good working cohesion was at times difficult to maintain. Perhaps this physical and interpersonal distance partially explains why the more isolated partner was the first to resign from the practice.

Time pressure intruded in other ways. There was no time for exercise, relaxation, or even eating properly. Family members, mates and children, felt abandoned. Principals found they had to give up cherished activities; there was no time for tennis, reading and teaching. Fourteen hour days were not uncommon. Clearly, entrepreneurship can be an intrusive life changing phenomenon which carries considerable personal and emotional risk (Main, 1990).

Financial investment is the second capital risk involved in entrepreneurship. The social workers who founded CCA had only their personal financial resources to rely upon. They used savings or equity from their homes to supply the initial capital investment. Each contributed a total of \$38,000 over the three years of operation. An additional \$50,000 loan, secured by the personal assets of the partners, created the capital fund. These funds,

approximately \$200,000, were used to build the infrastructure of the practice and to cover the monthly short fall between income and expenses as the business unfolded.

Personal income was also reduced and invested in operations. The partners agreed to salaries that were thirty to forty percent lower than their pre-CCA income levels. The difference became an additional financial investment. Depending on prior income levels, each principal indirectly contributed between \$80,000 and \$150,000 of income over the three years of operation. Shapero (1984) notes that, within entrepreneurial events, taking extreme levels of financial risk is not uncommon. Checks will be written with no money to cover them; entrepreneurs will take risks up to and including bankruptcy, putting their own and their investor's assets in jeopardy to achieve their goals.

High levels of risk in time and money were also evident among the comparison groups. All three had been unable to maintain their personal income once the initiation of their practice group began. Money had to be diverted from personal salaries to pay for infrastructure and operations. After three years, none of the principals in the comparison groups had been able to achieve parity with their former income nor did they expect to do so in the foreseeable future. However, unlike the CCA principals, none of the

principals from the comparison group made as large a financial capital investment at the initiation stage of their business, all three depended on current income to finance the structure and operations of their groups. Time investment was noted as a major commitment by each interviewee. All three saw the diversion of effort away from clinical practice to administrative duties as a major investment. Six day work weeks and ten to fourteen hour days were commonly mentioned.

As the investigator discussed practice development with the CCA principals and the comparison group, it became apparent that, while time and money were important investments, the intellectual and emotional risks were perceived and experienced as of greater personal significance.

Capital Risks:

Intellectual and Emotional

Capital risk, time and money, can be measured and accounted for arithmetically. The intellectual, emotional and interpersonal aspects of entrepreneurial risks, on the other hand, are not so easily quantified (Tropman, 1989). They are more open to qualitative review and analysis. While these less tangible qualities are often mentioned in the discussions about entrepreneurship, there were few

substantial accounts found in the professional literature about their expression in particular circumstances.

Providing information and understanding about the experiences of the CCA principals in entrepreneurial risk taking is one of the results of this case study.

Strong belief in the venture is critical to successful entrepreneurship. The substance of this belief is the intellectual capital risked in the entrepreneurial event. If we look at the writings, and public comments of the CCA principals, the outlines of the intellectual capital expended in the development of CCA are apparent. CCA is a reflection of how the social workers who founded the organization understood their venture as an expression of a privatized ideology and the professional opportunity in the private provision of social welfare services. Their professional careers were a reflection of their commitment to privatization.

Private full-time social work mental health counseling was the primary practice modality and practice setting for three of the four CCA principals. The fourth principal was in part-time independent practice. To bolster their private practice opportunities, all the CCA principals were state licensed social workers at the highest level, a designation that permitted them to practice independently, to qualify for insurance reimbursement, and to gain entry to managed care provider networks. Appropriate state licensure is an

essential element to the regulatory and professional legitimacy of a private practitioner. Additionally, all the principals had honed their social work direct practice skills in mental health settings. Each had been employed in the public sector as mental health workers and had enriched their experience through post graduate training in various methods of psychotherapeutic intervention. They identified themselves to the public as clinical social workers in private practice, experts in mental health treatment.

CCA's principals also closely identified with that sub-set of clinical social workers who are interested in promoting private entrepreneurial practice by membership in their state Society of Clinical Social Work, with two of the partners having been state and local office holders in the Society. Membership in the organization has no private practice requirement. However, social workers in private practice gravitate to Society membership because of its emphasis on clinical practice methods and its explicit support of policies and positions which serve the interests of private practitioners.

Professional legitimacy was also supported by membership in the National Association of Social Workers (NASW). One principal was a member of the Academy of Certified Social Workers and an NASW diplomate, a designation of achievement in direct practice. All the principals were diplomates of the American Board of

Examiners in Clinical Social Work. The Board is an independent agency which certifies clinical social work expertise through experience and examination. It is the professional equivalent to board certification of physicians and psychologists in areas of clinical specialization.

The CCA principals took advantage of every public and professionally sanctioned opportunity to engage in private entrepreneurial practice and to build their professional careers in this practice setting. Their careers, therefore, are both a product of and a reflection of the privatization of social welfare services. Furthermore, it was their experience and comfort at functioning in this realm that made them intellectually ready to participate in another phase of the industrialization process; moving beyond their respective one person endeavors to developing a managed care accommodating outpatient mental health business: CCA.

Feeling intellectually prepared to make this transition is part of the private personal decision to engage in an entrepreneurial event and starting a business to implement the innovation becomes a public declaration of these private decisions (Shapiro, 1984). It is in the public exposure of entrepreneurial intention that the emotional risks of entrepreneurship are underscored. In 1992 and 1993, all the principals were convinced that they were reading the health care market correctly, their confidence extended to public talks about the developing policy agenda of the managed health care industry. During this period, many other

professionals sought out the principals' advice and counsel about their own practice development ideas.

In November of 1993, Principal #2 presented a paper on group practice development using CCA as a case study. During the questions a participant asked: "I don't see most of us able to do what you guys are doing. How do you know this project will work in the long run, aren't you all taking big risks?" His answer reflects an awareness of entrepreneurship's intellectual risks:

You are right, we are taking big risks. I believe I have outlined most of them in what I told you this morning. I must admit that I am not absolutely sure we are on the right track. Managed care may be unmanageable. I may have to come here in a few years and tell you how we failed. This is my best guess at the moment about what is happening and how we might respond to the changes. Continuing in your solo practice might be the better way to go in the end, but I am prepared to take the risks involved in a group.

Of course, should Principal #2 be invited back, he would have to report that the intellectual and financial capital invested did not bring about a successful implementation of the CCA mission. Again to quote Tropman: "...one's self-esteem and sense of competence are associated with one's offerings and products (Tropman, 1989, 222)." The public exposure of entrepreneurship is not just to the professional community. Family members and friends are also largely aware of the qualitative intellectual, emotional and interpersonal risks.

There was then an internal emotional response or price to the CCA experience for the principals. It was often sensed as an emotional roller coaster. There could be joy and elation at accomplishing a particular goal and then, in a few hours or days, the realization that the achievement of that goal had not significantly furthered the cause. For example, in April of 1995, CCA was granted a license to operate the outpatient substance abuse program. There was genuine pride in the achievement, but shortly after came the realization that financial constraints would not allow the clinic to become operational. Disappointment became a familiar feeling and, when compounded by developments in 1994 and 1995, despair followed.

Managing the emotional risks is as important as managing the dispersement of capital and the operation of the business in entrepreneurship. Emotions effect judgment. These comments from one of the CCA principals are illustrative:

Looking back on the early stage, emotions had a big impact on our development. The euphoria of being the chosen one for an affiliation with XM; the sense of power gained from inside information through XM and the conferences; the urgency and pressure to act decisively and quickly during a window of opportunity: its now or never, wait and be left behind; the excitement, thrill and sense of empowerment in being ahead of the wave; the sense of arousal, promise and smell of success that drove us all to work hard and diligently to achieve the American dream. All of these feelings interfered with our ability to assess and evaluate accurately what was going on around us.

On reflection, this principal was evaluating the level of risk, the emotional engagement with the potential of CCA, and the way in which the emotional charge may have energized but also led to an inattention to detail and recognition of potential hazards. In the next section of this chapter, we will see how these emotions and lack of business experience may have kept the principals from fully appreciating the complexity of initiating an entrepreneurial innovation on the level of CCA. As Langley's (1989) research suggests, the analysis of entrepreneurial opportunity involves the complex evaluation of quantitative and qualitative data. Often, in her experience, strategic planning is not propelled by the careful analysis of information but by the preconceived intentions and the emotions of the planners.

In the examination of an entrepreneurial event, Shapero (1984) suggests that the analysis focus on the personal behavior of the innovators and upon the organizational tasks of starting a business. Time, money, intellectual and emotional capital were expended. Through their investment, the partners were able to form an alliance strong enough to create the professional corporation: CCA. They were able to develop a shared vision of a managed care accommodating practice which inspired them and others to take similar risks. XM, while clearly in pursuit of their own agenda, expressed confidence in its affiliation with the social work entrepreneurs. The national corporation made a public identification with the goals and mission of CCA.

Recognition of the effectiveness of this effort is important. As indicated earlier, most innovative ideas do not move beyond thought and conversation. CCA became a functioning business, an outpatient mental health practice with a two year life span. In the next section of this chapter, we will describe and evaluate the development of CCA's business infrastructure.

Building the Organization

Building the business organization to implement the innovative design is an essential part of the entrepreneurial endeavor. There is a substantial literature coming from the business community which describes this process (Barren, 1989; Barsley & Kleiner, 1990; Beam & Carey 1989; Brazell, 1991; Bates, 1990; Field, 1991; Gaskill, Van Auken & Manning, 1993; Lussier, 1995a; Lussier, 1995b; Nelton, 1992; O'Neil & Duker, 1986; Otterbourg, 1989; Sage, 1993; Scarborough & Zimmerer 1987; Smith, 1981; Upton, 1992; Venkataraman, et.al. 1990). Each writer orders the planning elements in slightly different sequence, including or excluding factors which reflects their personal experience. Some note five or six categories to be attended to (Lussier 1995 a&b), others twenty or more (Smith, 1981). In this study, five issues have been selected as most pertinent to the initiation of CCA as a business organization, four are:

the business plan, management, capitalization, and advice and counsel. The fifth area, marketing, will be discussed separately in Chapter 5. Examination of each of these issues will provide a description and evaluation of CCA as a small business enterprise.

The Business Plan

Business plans are the blueprints for business development. Anne Field (1991) suggests that without a business plan, a new business is likely to flounder. The ideal document should be twenty to fifty pages long, which Field believes reflects an objective indicator of thoroughness. Conceptualization of the business, its product, goals and objectives ought to be explicitly rendered. Clear financial projections and a detailed budget are essential parts of the plan. These fiscal projections need to be based on realistic, not optimistic assumptions, and anticipate likely problems in meeting financial goals (Knight & Knight, 1993). A solid marketing strategy describes the product or service, who the customers will be, why they will want the service, how it will be delivered, what it will cost, and how potential customers will be contacted (Brokaw, 1991; Field, 1991; Maher, 1993; Otterbourg, 1989; Upton, 1992).

An adequate business plan becomes an analytic tool for the entrepreneur (Field, 1991). The plan is a focus from which to solicit advice and counsel from experienced people in the field so that a critical analysis of the entrepreneurial innovation can be made and expert opinions can be gathered. Unfortunately, many small businesses do not begin with such a detailed blueprint. Often, the entrepreneur, feeling pressed for time and anticipating opportunity knocking, moves forward without a critical analysis of the venture (Field, 1991, Lussier, 1995a). CCA made this error, the group moved into its initiation phase without an adequately detailed business plan and therefore without a thorough analysis of its potential.

CCA's business plan was developed by the principal partners, through conversations with consultants, other professional contacts and the XM staff. They based their plan on seven working assumptions: 1) Individual solo practitioners will not be able to provide MCOs with the business and operational structures needed for the complete implementation of managed care strategies; 2) Practice groups will become the preferred providers of MCOs in the region; 3) MCOs will be looking to contract with a continuum of care, seeing this as "one stop shopping" in providing services to their clients; 4) A CCA/XM affiliation will provide such a continuum; 5) Revenues will be generated from a mix of group contracts with MCOs, from outpatient

continuation of care referrals from XM facilities and from existing insurance and self pay fee for service business; 6) XM will provide CCA with the business, marketing and program planning management consultation necessary for successful operation; and, 7) CCA will locate its practice and build an organizational structure which meets the regulatory requirements as needed to become a state licensed outpatient alcohol and substance abuse treatment program.

Unfortunately, these working assumptions were never given the detailed rendering suggested by Field. This is not to say the partners did not have a blueprint for developing the practice. All the working assumptions were eventually incorporated into the organization, but the plan existed in the minds of the organizers rather than in a document that could be critically evaluated. There was no detailed written business plan until February, 1994. This proved to be a serious error.

First, as the working assumptions demonstrate, the health and vitality of CCA as an organization was very much intertwined with the XM affiliation. The CCA principals were depending on XM for expert management advice, marketing and program development, and for its place on the managed care continuum of care. Working from the unwritten business plan allowed both CCA and XM to believe they were on a convergent path. As a result, the affiliation rested on broadly stated assumptions that were never fully

articulated, which caused serious difficulty the moment the two organizations began doing business together. There was no way for CCA or XM to clearly hold each other accountable for their part in the CCA endeavor. CCA partners believed they had a firm commitment from XM to follow the working assumptions. XM, on the other hand, seemed more casually tied to the plan. Their corporate integrity and financial health were not tied to the ultimate success or failure of the CCA innovation. The letter of affiliation between CCA and XM reflected this more casual connection to the business plan. It was a two page document stating the essentials of the affiliation, however, there were few details in the formal agreement about how the affiliation would be implemented and nothing about what would occur if the working assumptions proved faulty.

During early 1994, after XM marketed the MCOs, it became clear that MCOs were not going to contract with the CCA/XM continuum of care. The service represented an intensity of care the MCOs were not willing to support, more will be said about this discovery in the next chapter. At this point, XM withdrew interest in CCA. The basic assumptions behind the venture had been based on the strategic statements of the MCOs. Both CCA and XM had believed that groups offering a continuum of care would gain major business from the MCOs. When this proved not to be true, the reason behind the affiliation dissipated. XM

shifted its attention to shoring up its inpatient facility by developing a day hospital on its grounds. This demonstrated that CCA was only one of several contingency plans that XM had for dealing with managed care.

In October of 1994, CCA put pressure on XM to abide by the articles of the affiliation agreement. XM responded by informing the partners of its intention to move the regional marketing office out of the CCA site and withdrew from sending referrals to CCA. When CCA sought legal advice, the attorney was surprised by the brevity of the affiliation agreement. His commentary: "Whoever told you to sign this agreement gave you bad advice. This should have been a forty or fifty page document." (CCA's attorney at the time advised that the affiliation agreement was adequate and approved its signing). These details ought to have been part of the business plan. A more comprehensive plan would have allowed both CCA and XM to clearly understand the expectations and requirements of their affiliation.

A second significant error in the business plan had to do with the capital assumptions. The original CCA budget was crafted by the XM staff. All of the projections were based on the strength of the CCA/XM affiliation and a belief in the validity of the continuum of care. The size of the infrastructure built by CCA was based on these projections and budget as well. Square feet of office space, quantity of furniture, office equipment, computers and software, even

the size of the office staff were determined by the XM financial plan. CCA never developed separate budget assumptions nor a budget which anticipated the possible failure of the CCA/XM affiliation.

There were discussions in the CCA partnership about the wisdom of such a full commitment to the XM budget plan. But without a real alternative to consider, the partners allowed the XM projections to stand. As a result, when the affiliation did not work as planned, the CCA financial situation became critical. The real income and expenses of CCA bore no similarity to what was projected in the XM crafted budget and there were no contingency plans to call upon.

The lack of a detailed business plan led to a third error. There was never a comprehensive analysis of the CCA entrepreneurial innovation as a possible accommodation to managed care. This resulted in a piecemeal evaluation of the practice mission and design. As the initiation process unfolded, there were many discussions with other social work colleagues and MCO personnel, but the discussions were always based on a verbal presentation of the CCA plan. No one was ever presented with a comprehensive business plan to analyze and evaluate. The advice and counsel given by outside observers could never be fully attended to because there was no formal structure into which it could be incorporated and discussed.

The fundamental inadequacy of the CCA business plan is an indication that the social workers who founded CCA were not familiar with the basic knowledge needed to operate a successful business. They were well aware of their deficiency. To their thinking, the XM affiliation would compensate for their lack of knowledge and experience in business operations. Unfortunately, this assumption compounded the CCA management error. XM's business staff proved equally unfamiliar with the requirements of small business operations associated with entrepreneurial innovation. The specialized management skills need to operate a small business are basic to entrepreneurial success (Haswell & Holmes 1989). The weakness of the business plan is only one example of how the CCA principals neglected to provide their new business with an appropriate management structure and advice.

Management

The involvement of social workers in management functions is not unusual and there is considerable information in the social work literature about management science. Journals such as Administration in Social Work are reflective of this extensive and specialized body of knowledge. Senior social workers often find themselves called upon to administer departments and agencies in the

public sector. Social workers are being employed by the health care industry to fill management positions. Prior to their involvement in private practice, all four CCA's principals had held management positions in public agencies. Three of the principals had ten or more years of experience managing the business operations associated with their individual private practices. However, while there are generic management skills common to all business operations, there are specialized business skills associated with entrepreneurship and the small businesses which bring their products and services to the market place (Upton, 1992). Successful management of entrepreneurial business requires familiarity with a broad body of knowledge related to business practice and operation (Haswell & Holmes, 1989; Nelton, 1992; Sage, 1993).

Business management expertise has been shown to be a key factor in the ultimate success or failure of small business operations (Haswell & Holmes, 1989; Gaskill, Van Auken & Manning, 1993). Gaskill (1993) finds that management error in business planning and operation is the variable most closely associated with small business failure. During the initiation phase of an entrepreneurial event there are high levels of organizational stress as the business learns to operate in the real world of the marketplace. A knowledgeable and experienced management is particularly important to this initial phase. A knowledge of accounting, financial planning, management theory and

marketing is a prerequisite to entrepreneurial success (Barsley & Kleiner, 1990; Upton, 1992).

Management skills learned in positions unrelated to small business operations, therefore, may not translate well into entrepreneurial situations (Otterbourg, 1989; Upton, 1992). CCA's management team is illustrative of the difficulty of translating management skills and experience from one type of organization to another. By training, the CCA principals were clinicians. Although all four had held social welfare management positions, this experience was closely associated with not-for-profit service delivery or clinical administration. Nothing in their professional education and little in their work experience gave them the broad range of basic business skills noted by Barsley, Kleiner (1990) and Upton (1992). This limited their effectiveness as managers for CCA in several important ways.

First, they did not fully appreciate the precarious nature of their beginning as a small business. They were not sufficiently conservative in their use of capital resources. For example, during the first four months of operation it became immediately clear that the financial projections made by the XM staff were not realistic. XM was not able to bring in the level of referrals from their facilities necessary to meet anticipated revenue assumed by the budget. In addition, XM was unable to secure any MCO contracts that provided for use of the initial product

developed by CCA and XM, the Transition Program. Consequently, referrals from MCOs arrived at a slower pace than the budget anticipated and treatment services provided by the four partners could not generate sufficient income to compensate for the shortfall. There was a monthly deficit of between \$5,000 and \$6,000, which should have been an immediate signal to change the level of expenditure. Expenses needed to be cut and a new budget drafted. Neither was done in a timely fashion.

Additionally, support staff was a particularly costly item to the budget. Nevertheless, eight months passed before the hours of the support staff were cut to conserve money. The financial situation called for immediate and decisive action. Lack of accounting and fiscal management experience contributed to this error.

Lack of management experience may have made it difficult for the management team to see the significance of events as they related to the basic health of their business. The business consultants XM assigned to CCA were managers of large inpatient mental health facilities. They were familiar with the ways in which such institutions maximized income from inpatient benefits, insurance, Medicare and Medicaid. After a few initial consultations it was clear the XM managers did not have the information nor the incentive necessary to support the survival needs of CCA. Nevertheless, the CCA management team continued to

look to XM for advice and counsel about the operation of their small outpatient business. The initial business plan called for XM to supply business expertise, but XM was unable to fulfill this promise in two ways; they did not provide consistent assistance as promised and the assistance they did provide was not relevant to CCA's needs. The management team was not able to move much beyond this assumption and quickly find an appropriate alternative source of expert advice. An immediate search for a new partner or consultant with appropriate small business management experience would have been an appropriate managerial response by the CCA team.

Neither of these possibilities was considered in a timely fashion. It was nine months into 1994, ten months after operations began, before a business consultant, active in group practice formation and operation, was engaged. A similar error was made in the search for an additional partner. Rather than look for a business person to supplement their partnership, the CCA managers searched for an individual similar to their own background and training, a fellow clinician. None of the partners considered had the needed business skills.

There was also a marked inattention to detail, again, especially in the expenditure of funds. No one in the management team paid close daily attention to this basic aspect of business operation. Partners were engaged in

activities which diverted their attention from these important details but which also subverted their success. They were either busy seeing patients, increasing their caseload in an attempt to close the budget gap, or marketing the large MCOs; the only two fiscal solutions seriously considered by the partners.

CCA managers continued to believe that volume referrals from MCOs was the only means to achieve financial stability. Consequently, big blocks of time were spent marketing the MCOs. None of these marketing efforts paid off in bringing a volume of referrals sufficient to cover expenses. In the meantime the daily financial drain was not aggressively addressed nor were workable alternative strategies considered.

Focus on the original vision in the management team was difficult to dispel. Entrepreneurs are inclined to remain loyal to their innovative ideas and in doing so may lack the flexibility to make appropriate shifts in their plans and thinking (Scarborough & Zimmerer, 1987). Continued pursuit of the state license after the loss of XM's involvement in the practice is an example. Application for the substance abuse clinic license was in direct response to participation in the XM continuum of care. XM felt they needed CCA to have a licensed substance abuse operation to legitimize their outpatient services. Such a service, however, was not vital to CCA as an operation without the XM affiliation.

The CCA managers continued to believe that a state license would make them more attractive as a treatment center for MCOs and would add to their worth as a business. What they failed to see was that the expenses in pursuit of the license were so draining to their capital resources that the life of their business was being seriously jeopardized by the process. Money was being expended for a goal with no potential to have an immediate positive effect on CCA's bottom line.

From one perspective it seems that CCA was undercapitalized, that insufficient financial backing was a root cause of CCA's lack of success. Entrepreneurial endeavors often run out of money. But as Haswell and Holmes (1989) observe, it is also frequently not how much money is required as it is how monies are managed that makes the difference between success and failure in small business longevity. CCA had substantial capital resources, about \$200,000, however, these funds were not always used to maximize the basic survival of CCA through its process of initiation.

Capitalization

The success or failure of small business ventures are often linked to the amount of available capital, however, as demonstrated, of equal importance to the amount of capital

is the way in which capital resources are managed (Anonymous, 1989; Haswell & Holmes, 1989; Otterbourg, 1989; Thompson, 1988). Under the previous evaluation of management expertise, we discovered the problems the CCA management team had in using its capital funds to best advantage. Several difficulties were noted. Daily monitoring of expenses was inadequate, as was the challenge of reframing the financial plan to conform to the realities of the market CCA encountered when operations actually began. Capital funds, their availability and management, became a constant preoccupation of the CCA principals.

During the first phase of CCA's formation in January 1993, the principal shareholders each agreed to contribute \$35,000 to the CCA capital fund. This was to be paid to the corporation in installments over the first year of operation. By December 1993 when the offices opened, CCA had \$140,000 in its bank accounts. In addition, the partners agreed that all professional services rendered by them would be billed through the corporation and the proceeds used for the general operation expenses of CCA. In 1994 this amounted to approximately \$300,000. The four principals also signed personal guarantees for loans taken by CCA to purchase furniture, telephones, computer hardware and software. These loans totaled \$50,000 and were to be paid back by the corporation over a period of five years.

XM also made a capital contribution, in the affiliation contract XM agreed to contribute \$30,000 to CCA and to supply supportive services. During the first three years of operation XM was to advance \$10,000 each year to the CCA marketing effort, to provide sixty five hours a month of consultation time with an XM business administrator and to offer the opportunity to use the resources of the marketing, program planning and research staff of the XM organization. In years two and three, CCA would incrementally pay XM for these services and to pay back the advances of money and administrative support from year one.

Perhaps the most significant part of XM's projected capital contribution was its promise to use CCA as the outpatient extension of its inpatient services. Much of the expensive infrastructure leases and purchases, including the advanced information system, were made to service the programs designed to support the outpatient component of the continuum of care. CCA's principals considered the XM promise as part of their capital fund when crafting their budgets. XM had presented CCA with a financial plan which projected that during the first year of operation XM referrals and referrals from MCO contracts would more than cover the expenditures which the CCA principals and the XM executives had planned and approved.

Unfortunately, the XM promise was an unsecured one and when XM was unable to present CCA with the projected referrals and MCO business, there was no contractual

obligation in the affiliation agreement for XM to cover the resulting deficits. The XM default left CCA with a major capital crisis.

If CCA was to survive, the capital fund created by the shareholders had to be supplemented; to accomplish this goal, three strategies were tried. Conserving capital by decreasing expenses was an obvious first step. However, this proved difficult since the largest budget items were fixed expenses, the cost of rent and utilities for the substance abuse clinic site and salaries of the principals. Salary reduction was not acceptable because the principals were already at the limit of absorbing personal debt. If salaries were cut enough to salvage the capital account, CCA would be forced to close its door immediately. On the other hand, reducing space by renegotiating the leases with the landlord would have closed down the licensing process. At the time, the management team believed that the conservation of capital by reducing expense would not provide much relief. Therefore, the principals concentrated on two capital augmentation strategies: securing new business and looking for potential partners with available funds for investment.

The first, searching for new business, will be explored in more detail in Chapter 5, but in sum, it involved a local marketing effort, the continued attempt to make contractual agreements with MCOs, and/or affiliation with other regional

health care systems. The second strategy involved the search for additional shareholders.

During the early spring of 1994, shortly after it became clear that XM was not going to live up to its commitments, the principals began to make contact with other social workers in their region to explore the possibility of selling them shares in CCA. It was hoped that additional partners would add to the capital account and bring more business to the enterprise. The search produced only two suitable candidates who expressed interest and met the principal's criteria for joining the practice: professional maturity, entrepreneurial interests and available investment capital. However, none of the discussions with potential social work investors resulted in a decision to buy shares in CCA. Although they were seriously concerned about the long term affect of managed care on their private practices, they chose to remain independent. They were unwilling to take on the entrepreneurial risks of CCA.

When the effort to find a partner in the local social work community failed, the principals turned to a consultant from California who acted as a liaison between mental health professionals who were looking for business opportunities through affiliation with other like-minded people. In December of 1994, her efforts led to discussions between CCA and a psychiatrist who had an outpatient service in a neighboring county. He wanted to become more oriented to

managed care business and saw connection with CCA as a means to achieve this goal. The potential of partnering with a psychiatrist was made possible by changes in the laws governing corporations. A new corporate entity called a *limited liability corporation* was created by the state legislature in October of 1994, it allowed for multi-disciplinary professional business affiliations, a partnership configuration unavailable to CCA in 1992.

Partnership between the psychiatrist and the CCA social workers offered important opportunity to both. The psychiatrist would be able to join an organization with a strong managed care accommodating infrastructure, and the social workers might gain a contributor to the CCA capital fund and the multi-disciplinary profile which had been missing from their original partnership. It was agreed that the psychiatrist would join CCA through the creation of a new limited liability corporation to be called CCA Practice Management Systems, but this affiliation never materialized. Stresses in the partnership brought on by the capital crisis subverted the potential benefits of a new investor.

During January and February 1995, one of the four principal partners signaled his desire to resign from CCA. He believed he could no longer afford the personal financial risk and burden of supporting CCA, he had lost faith in the ability of CCA to fulfill its intended mission. His potential resignation from the practice would shift the

financial and administrative burden to the remaining three partners. With the absence of one of the four principals, the addition of a new shareholder became moot as a net gain to CCA's capital resources. Operating capital accounts were nearing depletion and the principals, with no new business opportunities on the horizon, began to doubt their ability to sustain the financial obligations of the CCA through 1995 even with the infusion of capital from a new partner. Negotiations with the psychiatrist were suspended as the partners began to wonder how long they might be able to sustain their personal commitment to CCA's entrepreneurial goals.

Concurrent with the search for a new professional shareholder, CCA's principals also began looking for a new corporate partner or buyer as a possible source of capital. When MCOs began contracting with provider groups in the west, a new business opportunity was spawned. Corporations were formed which bought group practices from their professional owners and joined them into regional or national care networks, Group Practice Affiliates (GPA) was such a corporation. CCA began discussions with GPA in January of 1995 after they expressed interest in finding a place in the CCA regional market. GPA would provide expansion capital, administrative support, marketing and strategic planning assistance to the professional practices which joined their network. The price of affiliation was usually 100% ownership or some portion of shares over 51%.

Original owners were usually required to stay on as GPA employees to sustain the practice through a transition phase of three to five years. The prospect of sale to such an entity as GPA began to raise other concerns for the principals which touched on the core of their entrepreneurship. Since CCA was so new and its total revenues relatively small, its value at sale would be very low. (Typically health care practices are valued at some percentage of gross receipts over a period of several years prior to the point of sale). If CCA were sold, GPA would become a controlling power while offering the principals no substantial return on their original financial investment. More onerous, the principals would forfeit autonomy and control of their clinical practice and become employees of GPA thus subverting their original entrepreneurial goals. Consequently, the possibility of sale to GPA as a source of capital went no further than several preliminary fact finding discussions.

Each of the three strategies to augment the CCA capital fund presented an economic dead-end or unacceptable compromises to the partners. As they discussed their choices, they became aware of a personal value conflict inherent in their search for funding. There were risks and some opportunities in the sale of shares to the psychiatrist or to GPA; but the question began to emerge: was survival of CCA at any price the goal of the principals? During the

search for additional capital, they discovered that in CCA's struggle for survival, the partners had diverted all their time and energy away from the clinical concerns that led to CCA's inception. Every meeting, including those scheduled for clinical purpose, was devoted to survival management rather than to client treatment. Business interests, represented by the quest for additional capital, had surpassed clinical interests as a dominant concern.

The significance of this diversion of personal energy was compounded by the ineffectiveness of the management team effort to locate an adequate survival strategies. There was no positive reinforcement from their efforts. As time passed, they were well aware of their lack of perspicacity in leading the business and the possible inattention to their clients. In spite of considerable effort, the partners were not able to find the additional capital needed to carry their business forward.

Successful implementation of an entrepreneurial endeavor must include equal attention to both the managerial aspects of the enterprise and to the products or services being offered. The volatile and complicated business arrangements associated with industrialized managed care made it difficult for the same individuals to accomplish both tasks simultaneously. This awareness was not limited to the experience of CCA's partners, as principals from the comparison organizations reported similar concerns. In all

three instances, the lines between business and clinical functions became more distinct over time. Two of the groups reassigned clinical partners to positions of business leadership; in the third instance, there were two principal owners, one a business man and the other a clinician; but even in the third group, the clinical partner was primarily concerned with administrative duties.

CCA was not able to make this adaptation. Unlike the comparison organizations, CCA never found a stable and reliable source of funds adequate to meet the financial challenges of building the organization they had envisioned.

Advice and Counsel

Complicated issues of business planning, management, marketing and capital formation were evident in every phase of CCA's life as a professional corporation. The partners came to understand that they did not have the knowledge and experience necessary to address these issues on their own. This is not an unusual predicament among entrepreneurs. Failure to recognize the inadequacy of knowledge and experience and to seek the appropriate advice and counsel is one of the four most common errors behind the failure of small entrepreneurial businesses (Lussier, 1995a; Orlando, 1995). Sharon Nelton (1986) discovered that entrepreneurs do not easily seek or accept advice about their ventures, or

fail to see the differences between previously acquired skills and those needed for success in a new endeavor (Otterbourg, 1989). For the founders of CCA, however, taking advice was less difficult than finding knowledgeable advisors and counselors.

One of the attractions for the CCA/XM affiliation was that it appeared to address this need. CCA's principals believed that XM could provide the business and marketing expertise necessary for the successful operation. However, reliance on XM could not be complete. CCA needed to locate an attorney and an accountant to represent its interest as the affiliation with XM was negotiated.

The difficulty in locating good advice and counsel was highlighted in the very first months of 1993, even before CCA was incorporated. A committee of the partnership sought referrals from other health care providers to identify attorneys and accountants with experience advising health care businesses. The committee interviewed candidates and then selected both an attorney and an accountant to build the legal and financial framework for the partnership and affiliation with XM. Neither of these individuals, however, adequately protected the interests of CCA. When XM failed to honor the affiliation agreement with CCA in February of 1994, the partners discovered that both the legal contracts and the financial plans were inadequate to protect CCA's interests. It became increasingly evident, from such

experiences, that the professionals who were advising the health care community in the CCA region were themselves unprepared for the complicated legal and financial arrangements industrialized managed care required.

This was an observation corroborated in the interviews with the principals from the comparison organizations as well. All of them had difficulty in locating the legal and financial advice needed to deal effectively with managed care organizations and their business operations.

The advice and counsel sought by the partnership more often than not missed the mark. There were a number of reasons for this problem. First among them was the nature of the business environment created by managed care. As discussed earlier, the rapid growth of managed care made for a volatile marketplace; mergers, acquisitions and the adaptations in the structures of health care were and are unstable and evolving. Few persons consulted, including those who were marketing their managed care expertise, had a sufficient grasp of the volatile managed care process to be helpful. CCA's principals and individuals from the comparison groups were frustrated to find that managed care consultants often knew little more than themselves. To their chagrin, they discovered that they were the experts in managed care practice formation.

Another problem in getting advice and counsel was one of regional translation. When CCA consulted with

colleagues on the west coast, they discovered that conditions in a mature market were very different than those in their region where the penetration of managed care had just begun. MCOs had also changed and evolved in their strategic relationships with east coast providers. They seemed less accommodating and more competitive. Managed care personnel themselves were limited in their ability to be helpful since they too were disoriented by the rapid changes, were new to the field or were unwilling to be supportive to those whom they saw as potential competitors.

Advice and counsel that was available also came at a high price. When CCA finally found a competent attorney in 1995, his fee was \$200 an hour after an up front retainer of \$1,500. One accountant required a \$1,000 monthly retainer, another charged \$100 per hour. Managed care knowledgeable consultants and marketers charged between \$75 and \$150 an hour for their services. These fees are not exorbitant and represent typical costs for legal and accounting expertise. Nevertheless, with other demands on CCA's budget, it became difficult to pay for more than the basic necessities of the cost of doing business: reading contracts, auditing, preparing reports and tax returns for the practice. As the sophistication of the operations with MCOs increases so too does the level and expense of legal and financial services. It becomes very difficult for a relatively small organization, the size of CCA, to afford these necessities.

Cost was an additional limitation to the principals in keeping up with developments in the field of managed care. Many of the conferences and workshops sponsored by and for industrialized health care were expensive to attend. Tuition for most three day conferences is between \$500 and \$1000, room and board at first class hotels, airfare and missed work added to the cost of keeping current. It is particularly difficult for practices in the developmental stage or of the size of CCA to afford such educational expenses. On many levels it became apparent to the CCA managers that, because of their size and limited capital resources, it was difficult to remain knowledgeable and competitive in their field.

Through a process of trial and error, those who could be trusted to advise were located. It took most of the life time of CCA and thousands of scarce dollars to find competent advisors. The three comparison organizations in the region were experiencing a similar predicament and began tentatively to share information with each other. During the fall of 1994, the executive director of CCA called a meeting with two of its competitors. The group met and discussed forming a provider coalition which would meet regularly to share information, addressing common problems. These were difficult first sessions since the three were in competition for business, but the reluctance to share information was overcome in time by the knowledge that the

managed care organizations were intentionally working to inspire a competitive environment among the practice groups. Working together had its advantages as the market became regionalized and the number of the practice groups was growing to meet the demand. It was discovered that the large MCOs both competed with and talked with each other to achieve strategic advantage over the providers; and, the providers determined they had to do the same to meet the challenges. As trust within the group of competitors developed they began to counsel and advise each other.

The Council on Behavioral Groups Practices (CBGP) was an additional source of expert advice and counsel to CCA. Membership in the Council requires participants to help one another, without fee, in the promotion and development of group practice. In the CCA region, there was only one other member located in a different part of the state. Contact with this group resulted in a significant contribution to CCA during the last year of the operation. The principal shareholder was a social worker/business man who had developed the largest private behavioral health care group in his region. His expertise was utilized in designing and implementing many of the survival strategies attempted by the CCA partners.

Research into the factors which contribute to the success of small business operations notes the critical role knowledgeable advice and counsel can play. Entrepreneurial

business people need to be aware of the limits of their perspective and to engage others with expertise to supplement their experience and knowledge. As the industrialization of health care increases, the complexity of successful management grows with it.

Summary and Analysis:
Building the Organization

Four areas of organization building have been selected to represent the critical issues the CCA principals addressed in building the corporation which was to contain and implement their innovation. These issues include: the business plan, management of the practice, capitalization, and advice and counsel. In turn, each of these areas was influenced by the external conditions of the industrialized marketplace in which CCA tried to conduct its business as well as the internal process, the personal strengths and weakness the principals brought to their endeavor.

A fully articulated business plan is essential as a guide to practice development; it becomes the standard to judge the adequacy of the planning effort and frames the criteria against which the initial operation of the business is evaluated. We discovered in our description of the CCA planning documents that they were not sufficiently developed to accomplish this design and evaluative task. Rather than

a set of documents that could be thoroughly reviewed, the business plan remained primarily in the minds of CCA's principals and the XM executives. This was a critical weakness since it allowed for assumptions of expectation between XM and CCA personnel that may or may not have been intended. Furthermore, the inadequate business plan did not allow for a thorough evaluation of the design by an outside party who might have provided a different perspective on the CCA/XM continuum of care's opportunities for success.

Effective management is always part of a successful business operation; it is particularly critical in the early stages of organizational development. The uncertainties of the managed care marketplace called for a management team that was adept at start up business operations and which had the knowledge, experience and flexibility to respond quickly to a dynamically changing business environment created by the industrialization of health care. The founders of CCA, both XM and the principal shareholders, were not prepared to manage the problems of implementation they confronted when operations began. XM did not have the experience, incentive or motivation to work with CCA after the initial product line failed to attract managed care business. Without XM, CCA's principals lacked the business expertise to manage on their own.

The failure of XM to continue to honor its affiliation agreement after February 1994 precipitated an administrative

crisis for the CCA management team. They were confronted with the problems of daily operation, the need to develop and market a new product line, and the search for additional capital resources. Their lack of knowledge and experience related to small business development made it difficult for them to appropriately address these complex issues.

Time became an additional confounding factor; the principals were subject to a dual responsibility that overwhelmed their ability to manage. Shortage of funds required them to maximize their clinical hours and at the same time devote efforts towards stabilizing the business. The shortage of time and experience worked against the successful management of CCA in a difficult business environment.

Under capitalization and the quality of financial management can be threats to small business success. Both these issues were critical for CCA during its organizational life. CCA/XM had built a very expensive infrastructure to service its continuum of care. This included the diversion of substantial capital resources to seek licensure to operate an outpatient substance abuse program. Income and the capital funds were unable to support this level of expenditure. When XM was unsuccessful at selling the continuum of care and withdrew from the affiliation with CCA, the principals were left with no alternative plans to increase revenues. The CCA management team also failed to

take immediate steps to reduce expenses as they sought different marketing options and partnership with other entities to supplement their capital fund.

The CCA management team was well aware they were working beyond their level of competence and experience. Accounting for this deficiency was part of the strategic thinking behind partnership with XM and the search for advice and counsel in the early planning stages of program initiation. However, the partners did not fully appreciate how difficult it would be to find professional competence in the areas of legal and financial counseling. Only through a lengthy process of trial and error were they able to find lawyers and accountants who could be helpful. The purchase of these services was an additional drain on the budget.

The rapid developments in industrialized managed care left a knowledge vacuum that was difficult to anticipate. Managed care consultants and personnel, it was discovered, had little more experience than the CCA principals themselves. The partners had to rely on their own ability to rapidly educate themselves through their contacts in the behavioral health care trade organizations and with a support group they created with their regional competitors. Unfortunately, CCA had lost financial viability before the partners were able to fully capitalize on their hard won experience.

Entrepreneurship requires a high degree of risk. The CCA principals engaged in risking substantial amounts of their time and money. Intellectual and emotional risks were taken as the principals exposed their entrepreneurial innovations to public scrutiny. On an interpersonal level, the partners risked their relationship with each other, their association with other social work colleagues and the XM personnel as they sought to create an organization which would allow them to continue to practice their profession in an industrialized health care system.

Despite the problems of building and managing the CCA organization, there were some important accomplishments. CCA was able to build a business structure that rented and operated 3,500 square feet of office space for two years, successfully obtained a license to run an outpatient substance abuse clinic, purchased and managed \$50,000 worth of infrastructure to support the CCA/XM continuum of care, employed one full time and two part time administrative employees and an office manager. Most significantly, CCA did engage in clinical operation for almost two years. Over 10,000 hours of outpatient counseling and psychotherapy were provided to clients, generating an income of approximately \$600,000 to CCA.

CHAPTER 5

Program Contact: Locating and
Engaging Customers

Chapters 3 and 4 focused on the description and analysis of the initiation stage of the practice group in which CCA built the organizational structures necessary to provide outpatient mental health services to managed care organizations. We move next to the second stage of program development and differential program evaluation: the program contact stage. The central task of this stage is engaging the target populations (the customers or clients) for whom the program was initiated. Tripodi, Fellin and Epstein (1978) note that the effort, the expenditure of resources, shifts to a different emphasis in this stage. Program personnel seek the attention of potential consumers and they look to insure that the services offered are relevant to client's needs. Directors are concerned with locating and attending to the physical, social or psychological obstacles to the effective delivery of program services; and, directors look for and manage other community resources that might aid, impede or substitute for the program's activities (Tripodi & Epstein 1978, 28-32, 51-55, 121-132).

Engaging target populations in the following description and analysis is going to be used as synonymous

with or interchangeable with the theory and practice of marketing. This is a different orientation to many of the concepts Tripodi, Fellin and Epstein (1978) bring to this stage of differential program evaluation. Nevertheless, the analysis of the contact stage of CCA remains essentially faithful to the evaluative method Tripodi, Fellin and Epstein suggest. Viewing client contact from the perspective of marketing seems more contemporary with the language and attitude of social service delivery in a service environment dominated by privatization and industrialized health care.

Just as private sector involvement in service provision has changed the administration and management of caregiving, by introducing business practices to social service management, so too has it altered the ways providers engage their clients. In the last ten to twenty years there has been a gradual shift away from the traditional approaches to engagement. Until recently, clients received services by being assigned to an agency, living or working in a particular catchment area, or personally locating the services or providers they needed (DiGiulio, 1984; Stoner, 1986). There are several reasons why these older engagement methods have become obsolete.

First, privatization has caused a proliferation of services. A small section of an urban region can have many hundreds of providers offering essentially the same type of

care. For example, in a two county area in the CCA region there are 7,000 licensed social workers and psychologists, many in private practice (results from an unpublished survey by the local Psychological Association). Such proliferation has required providers to compete with each other for clients. Employing marketing techniques in the quest for business has become an acceptable form of engaging clients for the organizations and professions who provide social welfare services (Belser, 1987; DiGiulio 1984; Royse, 1988; Seelig, 1987; Stoner, 1986; Tryon, 1983).

A second factor leading to the introduction of marketing to service delivery has been the reduction of public funding for social welfare care. Social policies in support of privatization continue to cut state and federal dollars from service delivery systems, thus requiring established public service centers to compete with each other and private sector providers for a limited and diminishing pool of clients and money. In order to garner support for their programs and businesses, social welfare providers have been drawn to employ techniques borrowed from the business community to engage consumers, to attract financial resources and to draw public attention to their organizations. These efforts are best defined under the rubric of marketing (DiGiulio, 1984; Holmes & Riecken, 1980; Stoner, 1986).

There has been growing recognition and acceptance for using marketing theory and techniques as a necessary part of engaging clients and consumers in a service environment dominated by the ideology of privatization and the business orientation of an industrialized health care system (Caroff, 1988; DiGiulio, 1984; Fine & Fine, 1986; Genkins, 1985; Holmes & Riecken, 1980; Hutchinson & Lewis, 1987; Lauffer, 1986; Ray & Knight, 1991; Rosenberg and Weissman, 1981; Schnall, 1989; Seeling, 1987; Segal, 1991; Steele & Hazelton, 1991; Stoner 1986; Veeder, 1991; Yankey, Lutz & Koury, 1986). Therefore, as we describe and analyze the program contact stage of CCA's development we will be doing so through the marketing paradigm.

Marketing may be divided into three core activities. These include: *planning* - research and development of products or services; *advertising and sales* - engaging consumers to buy a particular product or service; and, *public relations* - providing publicity and visibility for the organization and its services (Stoner, 1986). It is important to note that these tasks are not usually distinct and progressive but occur simultaneously and recursively. In this chapter, CCA's experience with these three marketing activities will be described and analyzed in detail. We will also explore CCA's attempts to develop and promote new programs and services when its first product line, the continuum of care, faltered.

Planning: Market Research and Product Development

Marketing prowess is an essential component of success in a privatized economy. Consumer purchase of goods and services is the source of profits. CCA's success as a business, therefore, was dependent upon finding a satisfactory approach to the managed mental health care marketplace. The research and development stage began in 1992 as part of the strategic planning for the group. In the third chapter, we saw how outpatient services within a comprehensive continuum of care were the product MCOs said they wanted and needed.

Discussions with colleagues from areas with high managed care penetration and with managed care personnel corroborated these notions about the needs of industrialized managed care. Attending to these discussions, reading in the trade literature, and participation in numerous managed care oriented conferences were the core activities of CCA and XM's market research. As a result, both CCA and XM personnel concluded that building the mental health substance abuse continuum of care was a product the market needed and would represent the primary product offered by the CCA/XM affiliation.

Services were broken down into five outpatient components within the CCA product line: the transition program, outpatient psychotherapy, social work home care,

behavioral medicine, and the licensed outpatient substance abuse treatment program. XM was to supply acute inpatient hospitalization for psychiatric and substance abusing patients, a twenty three hour holding facility for symptom stabilization, and a day hospital.

Each component of the continuum of care was based on the research of developing and well established trends in mental health treatment. Services were structured so that patients could enter the care system at any point. Intensity of service was to be stepped up or stepped down based on the level of intervention needed to stabilize symptoms and improve functioning. The transition program was to support patients who were returning to their community or family after an acute hospitalization. Monitoring the implementation of the patient's after care plan, symptoms and psychiatric medications was the primary goal of the service. Patients who were becoming symptomatic but were not in need of acute inpatient care could also be placed in the transition program until their symptoms stabilized and the need for acute care could be avoided.

Development of the transition program received a great deal of staff attention in its design and implementation. It was to be the signature service of CCA and demonstrate to the MCOs the commitment of the CCA/XM affiliation to the stated desire of the MCOs to provide the most effective level of intervention for the least expenditure of health

care resources. Theoretically, transitional service would minimize the use of acute care, enable patients to continue the stabilization process outside the inpatient setting and provide a continuity of service throughout their rehabilitation.

Outpatient psychotherapy was structured to represent a less intensive level of care. Individual, group and family counseling using a short term focal treatment model was to help patients maintain health and solve problems in living. Case management and psychiatric medication monitoring were part of this service.

Social work home care was intended to augment the continuum of care in two ways. Patients who were unwilling or unable to be part of an organized program could be monitored at home. Secondly, home care was structured to support the treatment of medically ill psychiatric patients or of patients developing psychiatric symptoms as a result of physical illness. The behavioral medicine service was designed to support social work home care and as an independent product. Behavioral medicine techniques, hypnosis, biofeedback, psycho-education, and counseling have all been shown to moderate psychiatric and medical symptoms.

Substance abuse treatment was the final piece of the outpatient continuum. This was of particular importance to XM since they had a strong presence in the regional substance abuse treatment community. Many of their

inpatient referrals from the CCA region were to this service and until CCA was licensed and operational all discharged patients went to other licensed outpatient facilities.

XM's responsibility was for the inpatient side of the continuum. Their facilities included an acute care psychiatric hospital and two inpatient substance abuse treatment centers. They were able to treat adolescents, adults and geriatric patients in these facilities. In development was a twenty three hour stabilization program, which allowed for close supervision of acutely ill individuals but where admission to inpatient care was not necessary. The day hospital was for patients who needed a highly structured program outside an inpatient setting to continue their rehabilitation.

The CCA/XM continuum of care represented a well developed product line responding to the stated strategic needs of the managed care market. Assessing and meeting the wants and needs of the MCO consumer was the first but not the only target of the CCA market strategy. The CCA principals had a decade of providing outpatient psychotherapy in their region. Each principal brought a slightly different treatment emphasis and referral network into the practice. This included association with national and local employee assistance programs, physicians, attorneys, school systems, social work colleagues and hundreds of present and former clients. Marketing plans

were made to reinforce these contacts and to acquaint them with the expanded services of CCA.

The local network, however, could never support the expanded CCA/XM continuum of care, only supplement it. There were several reasons for this. Well established referral sources were no longer able to make referrals to the practice without consulting the managed care organizations who controlled the referred client's benefits. Although the CCA principals were on most of the major MCO networks, they were listed as individual providers not as CCA. Each partner, not the practice, therefore received the referrals. This made it difficult to spread the work to other CCA staff or even fairly distribute referrals among the principals. The second problem which inhibited reliance on the local network had to do with the limits of professional collegiality. Referral contacts are most often made through close personal or professional association. As the administrative responsibility of the principals increased it became more difficult to personally provide all of the care coming through this older well established network. It was precisely these changes in referral patterns which led the principals to rely heavily on their managed care market strategy. While important, the old referral networks were not sufficient to maintain a business operation the size of CCA.

Sales: Marketing the Continuum of Care

Having researched and developed the CCA/XM product line, the next phase of the marketing strategy involved sale of the product. XM led the way in designing the sales strategy. The marketing staff of XM was a well organized department of the XM corporation. Four full time XM sales people operated in the CCA region. The head of the local marketing team was an active participant in all the important discussions which led to the CCA/XM affiliation. As a large successful business, XM filtered every corporate decision through its current and future marketing plans. The CCA/XM affiliation was no exception.

The sales strategy had a national and a local focus. On the national level XM took complete responsibility for representing the CCA/XM continuum of care to the MCOs. XM had been active in the managed care market with facilities in the west where managed care penetration was high. XM expected to build on these contacts in the east, where in 1992, managed care penetration was low and just beginning to take over mental health substance abuse services. CCA principals and XM were expecting these well established national contacts to give the CCA/XM continuum a strategic advantage in their regional market. In November of 1993, one month before CCA began operation, the local XM marketing director promised that within the next two months the CCA/XM continuum would have at least fourteen MCO contracts.

According to the XM sales plan, the CCA staff would have no role in the implementation of the national sales strategy. XM would be using its time tested and effective methods of large corporate deal making, an approach unfamiliar to the CCA staff. The local strategy, on the other hand, involved the CCA staff more significantly, but it too was dependent upon direction from XM. Plans called for XM's regional sales people to market the continuum of care to local contacts as they marketed the other XM product line and for the CCA principals to continue networking efforts with their traditional constituencies. Weekly meetings between the CCA principals and the XM marketing staff were held to coordinate local arrangements and to insure mutual accountability. The importance of the CCA/XM affiliation and joint sales strategy was reinforced by having the local XM marketing offices move into the CCA site.

The local sales effort was not particularly rich in plan or execution. Most of the effort was appropriately directed toward the national strategy since it was from this sector that much of the volume business was expected to flow. Both CCA and XM understood that referrals from the local market would not be able to sustain the level of business necessary to make the CCA/XM continuum of care profitable.

This understanding proved absolutely correct. In late February 1994, three months after the CCA/XM affiliation began operation, the XM marketing director informed CCA principals that XM was not able to include the CCA/XM continuum on any of the 1994 contracts just negotiated with managed care companies. Not one of the fourteen MCOs XM expected to participate bought participation in the CCA/XM continuum of care.

This was a disorienting discovery to the CCA principals, as it was a surprise to the XM marketing staff. All the marketing efforts, research and development, advertizing, and public relations had been based on the assumption that an outpatient group practice within a comprehensive mental health continuum of care was the correct product line to appeal to the managed care market. The viability of the continuum of care as a needed service was further called into question when the CCA staff began interacting with the direct service workers, the physicians, social workers and psychologists of XM's inpatient facilities.

During the early months of the CCA/XM affiliation, the CCA partners realized they would need to market the continuum of care to XM's line staff. Contacts between XM and CCA had been on the executive level, but after operations were initiated, program contact had to occur between CCA and the professional staff who made referrals

from the XM inpatient units. CCA staff visited the sites, met with social workers, attended XM facility marketing meeting, staff development and training sessions and did much to increase their visibility at the XM psychiatric hospital. When referrals were slow in coming, the CCA Clinical Director began attending the twice weekly discharge planning meetings of the hospital's four treatment units.

Despite these efforts, referrals were sparse. Only two or three client referrals a month came to CCA from XM psychiatric and substance abuse rehab discharges, far from the twelve to fifteen projected in the CCA/XM business plan. The CCA Clinical Director discovered that most XM discharges were not appropriate for CCA. As the discrepancy became an issue between CCA and XM, the Clinical Director was told by XM executives that the patient profile of the psychiatric hospital had changed during the year CCA was under development. Most patients were now coming from the urban areas of the region; CCA was located on the suburban side of the hospitals catchment zone and its facilities were inaccessible to these urban patients. Also, a growing number of XM's patients, about fifty percent, were now insured by Medicaid rather than from private health plans, as a social work professional corporation CCA was not eligible to receive Medicaid reimbursement.

Referrals from the XM substance abuse treatment facilities were also in short supply. The few clients who

did enter treatment could not be adequately served by CCA, since there were not enough participants to run groups and/or the MCOs would not reimburse for substance abuse treatment in an unlicensed clinic. CCA's license to treat substance abuse patient was a year away.

It became apparent, too, that XM did not have the flow of inquiries for outpatient care that had been represented by the XM marketing team when negotiating the CCA affiliation. During the first six months of the operation, about two referrals a month came directly from the local XM marketing team and not all of these became treatment cases.

Consequently, the CCA/XM sales effort never produced a sufficient number of referrals from MCOs, the XM inpatient facilities nor from the outpatient contacts of XM and CCA to populate the programs developed for the continuum of care. Within the first four months of operation, January to April 1994, it became clear there was no demand either from the MCOs, the XM facilities or the local professional community for the continuum of care product line.

In a terse meeting with the principals, the XM marketing director suggested that CCA's immediate survival would be dependent upon developing its own aggressive local marketing effort. To the CCA principals this suggestion was as absurd as it sounded, every effort from the first conversation between CCA and XM to this meeting had been

premise of a national need with a national strategy. Local efforts could not and would not carry the business forward as it had been planned. All programing and the infrastructure of the practice had been built to service the national industrialized managed care market.

This was a turning point in the CCA/XM affiliation. Prior to the February meeting, XM had participated with CCA principals as partners in their regional business strategy for the future. After February 1994, XM lost interest in the CCA/XM affiliation. When XM discovered that MCOs would not buy participation in the continuum, XM backed off from promoting the CCA/XM product line. The goal of the affiliation had been to capture managed care business for the CCA/XM continuum of care, not develop a local market, when this proved impossible XM quickly moved on to other ventures. Unlike the principals of CCA, XM had alternatives in their strategic marketing plans. XM continued to rent space in the CCA office until November of 1994 and contributed \$10,000 to advertisements in the local market. But XM did little to help CCA develop an alternative approach to securing business that might sustain the practice through a major transition. From this point the CCA principals were on their own in the development of a new business plan and marketing strategy.

The scramble for marketing alternatives began. Immediately the CCA principals contacted their national

managed care connections, they were able to schedule marketing meetings with five major companies active in their region and many small operations visited the facility. While CCA got an attentive hearing and secured a contract with one of the five major players in their market, they never received a volume of business from these MCOs. Referrals to the individual principals increased as a result of these efforts and their names were added to several significant provider network lists, but none of the product line on the continuum of care, except the outpatient psychotherapy product, received enough referrals to become operational.

Ironically, success with psychotherapy referrals produced problems on another front. As their treatment hours increased, it became harder for the principals to devote enough time to the management of CCA and to engage in marketing the practice. These problems increased tension among the principals. They had not started out to become a large psychotherapy group practice, and not all the principals were on an equal footing with their clinical hours. It was difficult to maintain a sense of equity as money flowed into the business but was insufficient to sustain the cost of overhead and meet the salaries of the four principals. Frustration increased as it became apparent after each passing month that referrals to the continuum of care were not materializing.

When the contact stage began, the advertizing and sales of the continuum of care provided experiential and quantitative data which CCA and XM did not expect to find. Their product line could not be sold, the demand for it did not exist in the market.

Analysis: What went wrong?

Understanding what went wrong in the marketing strategy of CCA and XM is fundamental to understanding why CCA faltered in the contact stage of its development. The conclusions and assumptions of the CCA market research were probably correct as a theoretical representation of the stated aims of managed care, but were untimely and certainly not in tune with the immediate condition of the market CCA/XM was trying to reach. By 1994, if behavioral managed care was moving toward participation in a continuum of care, it was a continuum different from that envisioned in the CCA/XM marketing strategy developed in 1992. An economically effective continuum could not be expressed strictly within a psychiatric frame, it would need to include a comprehensive representation of all medical services. However, the health care market place was not prepared to take this step in 1994. As of this writing, comprehensive systems of care in the CCA region are just now beginning to form. CCA had built a business that managed

care was not yet ready to accept. There are a number of economic and strategic reasons why this was true.

CCA/XM product line was to be viewed as a cost saving strategy. Patients would receive the level of care appropriate to treat their symptoms and functional impairment. The patient would not be over treated by being hospitalized unnecessarily, a high cost to MCOs, or under treated by inadequate services, leading to costly recidivism. It was suggested that such a system would save money in the long run. There is little empirical evidence, however, that a continuum of care represented by the CCA model saves money. It may in fact be more costly in the short run. The CCA transition program, for example, would have added the potential for daily contact between the patient and CCA, thus increasing utilization and cost. MCOs need not experiment with this level of care when a master level clinician seeing the patient several times a week might well provide the same benefit. There was no immediate clinical or economic reason for an MCO to risk more expensive care by supporting the CCA programs, especially when cost savings was and continues to be the primary marketing strategy of managed care.

Industrialized managed care was and is very focused on business strategy not service. MCOs during the initiation phase of CCA's operation were primarily interested in the capture of market share by promising cost savings.

Increased market share in turn positions the MCOs for the competitive edge in mergers and acquisitions. CCA/XM's continuum of care was not related to these strategic needs of MCOs and had the potential to subvert them by providing a potentially more expensive service.

The CCA/XM affiliation represented another problem for MCOs. Nicholas Cummings, founder of American Biodyne, a major behavioral managed care company, and now a managed care consultant, in an interview with *Psychotherapy Finances* (1996), notes that MCOs are fearful of practice configurations like the CCA/XM affiliation. The MCOs see such operations as potential competitors in the local market. Regional practice groups can provide the same service as the MCOs without the management overhead and profit needs of a large national corporation. Therefore, MCOs are buying regional practice groups or are trying to control them through managed competition. From this perspective CCA/XM's marketing strategy represented a competitive threat to the market strategy of the MCOs.

If Cummings is correct, the CCA/XM affiliation made another significant error in the implementation of its sales plan. The plan called for a very public presentation of the continuum. Principals were encouraged to speak and show the colors in local and national venues. CCA was designed and presented to all as a very savvy managed care operation. It was believed by XM that public exposure would bring positive

attention to the developing business, however, the high profile exposure may have actually worked against the success of CCA. In Cummings' view, CCA/XM as a successful regional continuum would have been a competitive threat to national managed care operations in the region. It is quite possible that the MCOs decided not to support the success of the CCA/XM affiliation and run the risk of supporting a potential competitor. While there is certainly no confirmation from any MCO personnel that they actively undermined CCA's success, there are at least three situations that give it circumstantial credibility.

First, in 1994, the MCO holding the managed care contract for state governmental employees and all the local school districts was establishing a regional care center. CCA/XM actively marketed the MCO for the contract and worked hard at establishing all the programs and infrastructure such an operation would require. CCA/XM staff had personal access to the highest levels of management in the MCO for its marketing effort, yet CCA was not awarded the contract. A small group with no organizational managed care experience or any of the infrastructure for operating such a practice was recruited by the MCO to be their regional care center. The awarded practice had made no effort on its own to secure the business prior to its being recruited.

The second piece of evidence is the way in which CCA/XM was shut out of the market. CCA never received one contract

from a major MCO which produced volume business. This was most unusual given that the three control practices in this study were all awarded contracts and received high levels of referrals from these agreements. CCA was at the gate first and had all the infrastructure requirements that MCOs said they wanted. Only one of the comparison practices groups had a business operation infrastructure comparable with that of CCA. Yet, in spite of, or as we maintain because of this level of sophistication, CCA was never allowed to participate in the regional market by being sent referrals.

A third experience with a managed care regional provider relations executive may have tipped the hand of the MCO in not sending any business to CCA/XM. The executive, during a site visit and marketing meeting with the CCA principals, aggressively confronted the CCA staff with her belief that CCA's product line was just a front to fill the beds of XM's inpatient facilities and to establish XM as a regional player. Following this meeting CCA did receive a facility contract with the MCO, but the MCO never sent one referral to CCA through its regional referral lines. This MCO was one of the five largest MCOs with contracts in the CCA/XM region and had a high volume of local business. These series of circumstances suggest a pattern of diverting business away from CCA in order to keep the CCA/XM affiliation from become a regional competitor for managed care business.

Marketing prowess is necessary for entrepreneurial success. It involves market research, product development and a sales plan. As we evaluate the CCA market strategy, we have demonstrated that it was flawed in each of these three areas. The market research suggested that the consumers of CCA's services, the MCOs, were interested in purchasing a continuum of care. In reality, the MCOs did not need or want so comprehensive a product line. It was potentially more costly to the MCOs because it added levels of care that were not essential to servicing their corporate contracts. The large number of mental health care providers and other groups operating in the area were more than adequate to meet the basic service needs of managed care. Furthermore, the MCOs were engaged in strong competition with each other to increase their national market share by reducing costs. The CCA/XM marketing strategy, therefore, was not in tune with the realities of its market; at best, it was perhaps ahead of the market but certainly not with the market.

The ambitious marketing plan also set CCA/XM to appear as a potential competitive threat to MCOs. If CCA had gained significant business it could have become a strong regional competitor to managed care. CCA/XM may have shown too much of its hand, too much of its own strategic design, MCOs could not risk supporting their own competition, and so did not direct business to CCA.

These apparent weaknesses in the CCA/XM marketing plan, also point to flaws in the strategic planning assumptions of the CCA principals. The affiliation with XM may have subverted the success of the principals' original intent in forming their group. Their innovation was intended to insure the continuation of their income and autonomy in the world of managed care, to secure a more dependable place in the health care market. XM had the same intention. CCA and XM believed that by joining forces each would protect the other. The reverse happened, CCA principals lost their place in the market. XM continued because the CCA/XM affiliation was only one of its marketing efforts. CCA on the other hand had invested all its capital resources in making the affiliation a viable product. When the product line proved unacceptable, XM moved on. CCA, by this time however, was spent and had no resources left to develop alternative forms of business.

Small business failure is frequently related to a flawed understanding of the market place. Entrepreneurs often misread the market and/or have unrealistic expectations of the potential for their innovative design (Otterbourg, 1989). CCA's marketing strategy was not based on a realistic or accurate appraisal of its managed care consumers. This misreading was magnified by the narrowness of the potential customer base in CCA's strategic plan. Small businesses can fail when they focus on one customer or

set of customers (Scarborough & Zimmerer, 1987). CCA risked all its resources on one plan, the affiliation with XM. When the plan failed to produce viable business, CCA was in a less flexible position to look for other opportunities; its capital resources were close to exhaustion.

Market Research and Development: A Second Effort

Building the continuum of care had framed the entire developmental process of CCA. When it became clear the continuum was not marketable, XM moved on to other interests and CCA was left without a product to sell. CCA tried to engage XM in a new effort at product research and development, but at the last meeting with the XM's regional marketing staff, the director placed the problem in CCA's hands. The XM executive suggested CCA focus on a local marketing effort while alternative strategies to engage managed care were investigated. This suggestion placed CCA in a conundrum: a business designed to contract with the national managed care market had to discover a way to turn its focus 180 degrees and engage a local market that was already saturated with mental health services.

CCA's management team worked hard at confronting the dilemma and within the next twelve months a number of alternative marketing strategies were investigated or tried. These involved appeals to potential consumer publics both

lay and professional, seeking new investors and affiliation with other health care facilities.

The principals immediately fell back to what they knew best, clinical social work, as the basis for a new and local marketing orientation. A quick survey of possible counseling programs suggested that psychotherapy treatment groups might be a viable market niche for CCA to fill. Many mental health practitioners in private practice are unable to establish treatment groups because they do not have the number of clients required for group formation. A group therapy program was hypothesized as a way for CCA to augment rather than compete with the treatment of other mental health professionals. It was also thought that groups might be a way for CCA to maintain contact with its own clients when their individual counseling ended or when their yearly mental health benefit was depleted. Groups held the potential to add value to client's treatment and to be priced so they could afford to self-pay for extending their care.

A group therapy program might be an enticement to MCOs as well. Managed care case managers frequently enquired about placing patients in therapy groups as a treatment of choice. Group therapy has the advantage of appearing cost effective since reimbursement rates to providers for group sessions are usually twenty to fifty percent less than for an individual session.

A market survey of clients and professional colleagues suggested that groups focused on such topics as substance abuse relapse prevention, eating disorders, women in transition, children with ADHD, gay men, and work stress might be attractive to the consumer public. Consequently, CCA's management team made the decision to develop and test market a group treatment program as a potential new product line to attract the attention of both the local consumers and the MCOs. Twelve psychotherapy groups were planned, the program was advertized to the professional psychotherapy community, to current and former CCA clients, to the MCO case managers and through the local XM marketing staff.

Initial reception of the program was positive, seven of the twelve planned groups began weekly meetings. However, problems arose almost immediately which raised questions about the viability of the program. Referrals from other than CCA professional counselors were few in number. It became evident that new clients were only coming from individual social workers who knew the group leaders personally; the counseling professions were not entrusting their clients to their competitors even when it might benefit their care. Furthermore, the expectation that CCA's present and former clients might be willing to self-pay to extend their care proved false. When their insurance benefit ended, most clients would not remain in treatment even at a significantly reduced fee. More than 95% of those

CCA clients approached about group participation were unwilling to consider it.

Marketing the group program to managed care organizations offered no improvement in the number of client contacts. MCOs considered group treatment as an option to individual counseling and not as a complement to it. Managed care case managers were typically only willing to certify one intervention per week per client whether an individual, group or family session. Consequently, groups were not a way to increase revenues from MCOs. Many of the assumptions behind the group program were not found to be true in practice.

Testing the market for the group program produced mixed results. Groups were operating, but they were difficult to sustain as a means to engage and enrich CCA's client base. There was an important lesson learned from the experience that became representative of the issues involved in finding a new marketing focus for CCA. None of the alternative market approaches produced enough improvement in service volume to offset the cost of CCA's overhead. Again, the principals were looking to discover a new marketing strategy as the immediate solution to the financial crises brought on by the failure of the continuum of care. It is impossible for any marketing effort to be immediately successful, since it takes time to develop, fine tune and establish consumer loyalty. CCA's principals appeared to be confusing two

ends: the need to establish new markets and the need to find a survival strategy for their business.

Madeleine Stoner (1986) finds that such confusion is not unusual in service organizations trying to engage clients in a shrinking market. Allocation of time, money and expertise become defused among too many competing interests. CCA's management team was stretching its capital resources tightly in pursuit of a new marketing focus while, with the same assets, attempting to maintain the infrastructure of the practice. A good example of how these competing interests played against each other came to light when CCA tried to direct money to an advertizing campaign intended to establish a more visible presence in the local community.

Two of CCA's principals had used advertisements in their weekly community newspapers as a means of contacting consumers. The approach had worked well for them in creating visibility in their local market. Following their example, CCA designed an ad campaign to appear in the three community newspapers contiguous to its primary practice site. A biweekly advertisement was placed at a cost of \$500 per month. Each run on average produced two referrals. While the advertisement was successful at finding new business, the net revenue gain was not equal to the expense; the additional cost to the budget therefore was not sustainable and after three months the ad campaign was

terminated. Limited capital resources made it difficult to fund and maintain a consistent and effective marketing effort while meeting CCA's operating expenses.

The confusion between a new marketing strategy and a survival strategy was further evidenced when CCA began researching the development of a practice management billing system as a potential new service. CCA learned that some practice groups in other areas of the country were diversifying their income by providing administrative support to providers based on the administrative capacity they had built into their systems; such diversification had the added potential of making their businesses less dependent on managed care. A consultant advised CCA that it might make use of its computerized practice management software to do insurance billings for other counselors or medical practices in its region.

Researching the idea showed that it would be a costly business to initiate, it required planning time and thousands of dollars invested with the support staff to develop business procedures as well as money for an advertising campaign. A billing service was determined to be neither an efficient use of CCA's resources and expertise nor a way to quickly improve cash flow. As the new marketing research and development effort progressed, it became apparent to the principals that the creation of an entirely new service or product line was not a way to insure

CCA's survival. Capital resources of time and money were not available for a major change in direction and held little prospect of engaging a whole new consumer base.

Consequently, the most effective marketing effort was the promotion of the psychotherapy counseling service. It built firmly on the principals' expertise and traditional sources of referral. Program development, advertising and sales were not expensive since they relied on well established methods of client service and engagement. The principals called on professional colleagues and sought to reestablish the flow of clients they had depended upon in their individual psychotherapy practices. CCA's collective identity was minimized and the clinical expertise of the partners was brought into sharper focus. Former clients were contacted through a mailing, and professional affiliations were reinforced by renewing contact through participation in professional meetings. The partners renewed contacts with the employee assistance program (EAP) community in their region; EAPs had been a rich source of referrals to their individual practices.

Contacts with the managed care organizations were not neglected in this new marketing plan. Each principal was a preferred provider on ten to twelve MCO networks. Individually they had well established relationships with these organizations which pre-dated their involvement with CCA. These contacts were renewed and reinforced. However,

the principals were no longer marketing the CCA continuum of care but their well established reputation as social workers and counseling psychotherapists.

The success of these efforts was immediate and positive. Within a few months all the social worker clinicians had a full caseload and the number of referrals sources had grown and diversified. Promoting the counseling services proved the most effective of CCA's marketing efforts and it was also the most efficient. The expenditure of time and money was minimal and it marketed a service the MCOs were willing to support with referrals and reimbursement.

Data from interviews with the comparison organizations corroborated the validity of psychotherapy counseling as the product CCA could offer that met market need and demand. All three of comparison groups engaged their clients by marketing their counseling programs. The advantages of this strategy were identical to those experienced by CCA: the product was a reflection of what the principals knew best, and it was a product that met market demand and could be provided at a cost the purchasers was willing to pay. Development of a counseling program was not capital intensive, it relied on well established treatment expertise and required no expensive infrastructure.

The search for a marketable product line, the outpatient counseling program, was successful. One

effective way to engage the consumer public had been found. Over time, the number of clients coming to CCA increased as did the number of referral sources. The principals were reengaging with their professional colleagues, increasing their visibility and improving CCA's public relations. However, it was also true that a business built on counseling services was not sufficiently diversified to insure CCA's viability. The marketing effort was thus incomplete and the CCA management team realized it would need to engage a broader constituency.

Marketing for Capital Acquisition

Engaging the public as a stage of program development is not limited to contacting consumers or potential consumers of products or services. Program managers may also want to locate additional resources in their communities that will support or augment their efforts, joining forces with other organizations or service providers that will facilitate the effective implementation of their program design (Tripodi, Fellin & Epstein, 1978). Attracting these resources to the effort ought to be seen as an essential part of an organization's fundamental marketing plan (Stoner, 1986).

The effective marketing of CCA's counseling services was not sufficient to insure the organizational viability

of the professional corporation. Therefore, the management team had to look beyond themselves for additional capital resources - time, clients and money. Much of this effort was described in Chapter 4 under the heading "Capitalization." As recounted earlier, the marketing plan to achieve this goal had a dual focus.

Shortly after XM abandoned the continuum of care in February 1994, the partners began looking for other social workers in their region who might become shareholder investors. Through their contacts in the professional community, the principals solicited social workers who were both active and successful in private practice and who expressed interest in a proactive response to managed care. The search located two appropriate and interested parties. However, despite many meetings and conversations, CCA was unable to convince either of the social workers to participate in the entrepreneurial risk. The marketing strategy to engage additional partners from the field of social work was never effective.

A second effort to market for capital acquisition extended beyond the local community when CCA used the services of a practice marketing consultant from California. She acted as a facilitator for providers who were looking to form managed care accommodating practice groups. The consultant was successful in bringing together CCA and a physician psychiatrist with an active practice in the

region. Conversations and acts of due diligence proved that an affiliation would be mutually beneficial to both parties. CCA would gain a multi-disciplinary profile for its organization and the psychiatrist would benefit from the managed care expertise of the partners; both parties agreed to begin examining the legal and administrative arrangements necessary to merge their businesses. Marketing to contact and engage additional resources for CCA in this instance was effective.

However, the affiliation was never cemented owing to a confusion between partnership with the psychiatrist as a marketing strategy to engage additional resources for CCA and his partnership as a business survival strategy. On the positive side, the potential affiliation represented a successful result from the marketing effort. The psychiatrist offered CCA a unique opportunity in the managed care market and none of the other regional practice groups competing with CCA had a physician as a principal. This could have provided a public relations advantage in dealing with national managed care organizations and the regional medical establishment. Secondly, the incorporation of the psychiatric practice would have extended the range of the CCA catchment area into the neighboring urban county. The urban sector of the region, at the time, was not part of the competition's focus; they were most active in the suburban area.

The positive potential of affiliating with the psychiatrist was driven off course, however, by the financial crisis which emerged during negotiations with him. When the fourth principal partner resigned from the practice in the spring of 1995, the psychiatrist's participation was no longer evaluated as a means to attain additional opportunities for engaging business, but was analyzed from the perspective of a psychiatrist as a means of fiscal survival for CCA. Affiliation had much potential as a point of engagement for new business opportunity, but, as we saw in the discussion of capitalization in Chapter 4, it had little potential to address the immediate crisis in financing operations.

The struggle for survival began to subvert the effective implementation of CCA's post XM strategic marketing plans. The experiences associated with marketing for capital acquisition further validates Stoner's (1986) observation that a marketing strategy can not be interchangeable with a survival strategy. Confusion over marketing goals and objectives brought on by the shortage of operating funds continued to be a problem for the CCA management team throughout the ensuing months of 1995.

Confusion of purpose was evident as CCA began to approach other regional health care systems as potential customers and partners. Timothy Troy (1995b) observes that single specialty practice groups are rapidly becoming less

viable as care centers under managed care. Integrated systems of care, which offer a comprehensive range of health related services, are now developing as the next phase of industrialized health care. Frequently, these integrated systems are being built around larger regional teaching hospitals; this phenomena was occurring in the CCA region. During CCA's organizational life, local health care institutions, businesses and practice groups were being dissolved into four competing integrated systems of care.

These developing systems emerged as a potential focus for CCA's marketing effort, but, simultaneously, the principals saw them as a potential factor in CCA's survival. Initially these systems were approached as potential users of CCA's services.

A national psychiatric service corporation opened a partial hospital and intensive outpatient treatment center for the chronically ill and for adolescents and adults newly discharged for acute inpatient care. The facility had no associated outpatient services as a step down from its intensive programs. CCA hoped this might be a opportunity to use some of the programing developed for the CCA/XM continuum of care. The CCA management team made contact with the organization and began soliciting their business.

Another private psychiatric hospital was located near CCA's primary site. The institution was struggling under the impact of managed care and the reduction of inpatient

days; rumors circulated about its likely demise and/or a restructuring of its services. Again the principals approached the hospital, exploring their use of CCA's social work services or perhaps finding a niche for CCA in their developmental plans.

As CCA approached these institutions, the principals tried to implement a marketing strategy called *zero based programming*. It was an orientation toward potential consumers learned from CCA's association with the Council of Behavioral Group Practices. Council members approached potential users with the notion that their experience and expertise made it possible for them to partner with consumers in creating programs and services that met their particular needs; thus, beginning at zero, the customer and provider worked together in tailoring service. CCA tried to approach potential business with this principle in mind. A Council member advising CCA said: "Just say yes if someone asks if you can do it. Your approach to behavioral care has to be absolutely flexible and you can build any program a customer could want. We can help you." The approach is a resource conserving perspective on product development, capital is held in reserve and only expended when there is demand in the marketplace.

During 1994, two large teaching hospitals were active in purchasing health care facilities and physician specialty practices in the CCA region; they were aggressively building

the infrastructure for their integrated systems of care. One of the competitors bought the local hospital used by CCA for substance abuse detoxification. There had been conversations between CCA and the facility prior to its sale concerning an integration of services. After the purchase CCA approached the new owners. The principals were personally acquainted with one of the hospital's chiefs of service and they sought to interest him in partnership with CCA's state licensed clinic since the hospital had no licensed outpatient substance abuse treatment capacity.

The principals were scanning the market looking for any opportunity to engage potential partners or users. All of these conversations were occurring simultaneously and often with competing interests. For example, while speaking with the neighboring hospital, CCA was also engaged in conversation with the other teaching hospital located in the urban center of CCA's region. The hospital was making rapid inroads into the suburban area as a means to feed its extensive inter-city research and training facility. In the fall of 1994, the institution had purchased an internal medicine practice which covered a significant portion of CCA's catchment area. Through contacts at the institution, CCA learned that none of the medical facilities had a mental health or social work component in their array of services.

It was with this particular urban institution that the most serious discussions occurred. CCA was in an excellent

position to service their patients since its offices were centrally located and the administration of the hospital was partial to the field of social work. The profession was well established at the hospital and the social work department often played a leading role in the development of new programs and services.

Affiliation with the urban hospital was an attractive marketing opportunity for CCA. It fulfilled the original CCA mission: placing its practice on a continuum of care within an integrated system of care. As the discussions with the institution progressed, the principals encouraged the perception that CCA could offer a wide variety of social work services that would extend the range of its practice beyond a mental health focus.

A subtext to all the marketing efforts was the search for a survival strategy through affiliation or capital acquisition. As CCA spoke with the partial hospital, the local private psychiatric hospital and the two competing teaching hospital centers, the principals sought to locate a place for CCA in the regional health care market. The principals continued to believe that finding a partner in a larger system would fill the original place that XM had played in the strategic thinking of the partners. Partnership with a larger entity would provide a dependable client flow and a pool of capital to sustain the developing business.

None of the described marketing initiatives produced the desired results. CCA received no referrals from any of the larger services, nor did CCA find a means to integrate its mission with any of the four larger systems. The effort, therefore, succeeded neither as a marketing strategy, engaging new clients, nor as a strategy for capital acquisition. There were two likely reasons for this lack of success.

Perhaps most important was the fact that CCA was attempting to form an alliance with institutions that were engaged in their own survival efforts; each of the four organizations was looking to form or maintain a niche in the regional health care market; not unlike CCA. Consequently, they were unable or unwilling to aid a smaller entity that brought no unique resource to their effort. In speaking with the chief of service, CCA was told that the hospital was not going to buy or support the development of services it was quite capable of building for itself. Cut backs in insurance reimbursement and in public money through Medicare and Medicaid left the hospitals with diminished capital. They were not willing to invest in nonessential development projects when they were themselves looking for capital acquisition. It was a mistake then for CCA to invest in marketing the large systems as aggressively as it did.

Timing was also a problem in marketing these larger systems of care. Each of the programs of service CCA was

marketing was not fundamental to the successful operation of their business. Discussions with the urban hospital are illustrative of this point. Purchase of the internal medicine practice proved to be a destabilizing event in the organizational life of the local medical group. When the practice administrator was approached about incorporating a social work mental health component into his operation, he demurred. He saw this as an added stress to his transition. While mental health, substance abuse and social work might be a valuable addition to a comprehensive health care program, the need for a comprehensive set of services was seen as a future goal. CCA's product line was not essential to the stability of the medical practice nor of the other entities CCA approached.

In and of itself, the marketing plan was not without merit. As a player in the regional market, CCA's marketing efforts with these larger organizations were essential to its public relations visibility in its region. But visibility was not a real source of capital acquisition nor of referrals for CCA's programs. It was not an effective or an efficient utilization of CCA's limited resources since it did not make an immediate contribution to CCA's need to engage a larger and dependable source of business and capital acquisition.

Analysis

Marketing theory has been helpful in describing the program contact stage of CCA; therefore, a marketing perspective will be used to analyze and evaluate the effectiveness and efficiency of CCA's effort to engage the consumer publics. The continuum of care was the centerpiece of the CCA product line. As such, it framed the design and implementation of the organization, the affiliation with XM, the expenditure of capital resources and CCA's marketing strategy. Despite this tremendous effort, the continuum of care was not marketable; a service for which there is no demand cannot be sold.

It is not unusual for an entrepreneurial endeavor to falter due to a misreading of the marketplace (Otterbourg, 1989). We saw in the earlier analysis how the continuum of care represented a misunderstanding of the strategic interests of the MCOs. Industrialized managed care was more committed to cutting cost and utilization than to extending or improving the quality of care. This was particularly true at the time CCA went public with its services. In January 1994, there was no demand among MCOs for a continuum of mental health care.

The negative results of CCA's initial marketing effort also demonstrated that the continuum of care misread the service needs of XM. The line staff at XM's inpatient

facilities did not require the programs which the CCA/XM continuum of care sought to provide. This may have been due to the changing demographics of XM's patients, and/or to the fact that XM's executive management staff had different goals in mind for the continuum of care than the discharge needs of its hospitals. Market demand for CCA's product line was absent, there were no clients to engage.

Lack of demand was not the only flaw in the CCA/XM continuum of care. A clearly defined and articulated service and market focus is a prerequisite for an entrepreneur's successful engagement with the market (Upton, 1992). The CCA/XM care continuum fits this criteria nicely, but when the wrong service is offered, such a narrow focus becomes a liability. It was difficult for CCA to change its image with the MCOs, and, internally, with itself once the continuum of care and the affiliation with XM had been promoted. The principals found themselves in the position of down playing CCA and marketing their individual psychotherapy skills. CCA's primary identity as an organization had been contaminated by promoting a service which the MCOs saw as counter to their best interests. This made it more troublesome to engage clients for CCA's other services.

The continuum of care had a third flaw that made its marketing problematic. It did not offer an appeal to a large enough mix of potential users. Initial product and

service offerings of entrepreneurs have more chance of engaging consumers when they are not dependent on one or two users in their market (Scarborough & Zimmerer, 1987). Tailoring the continuum of care for the MCOs made CCA too dependent on one service and one possible consumer group. When demand faltered there were no alternative services to offer or consumers to target.

Narrowness of product and consumer mix created yet another problem. The initial burst of advertising and public relations was directed entirely at MCOs and when this effort did not bring results, the major portion of CCA's marketing capital had already been spent. Marketing resources are used to best advantage when the advertising and public relations effort is directed to as many potential consumers as possible. There needs to be a balance between focus and breath of appeal (Lauffer, 1986; Yankey, Lutz & Koury, 1986). CCA's marketing strategy lacked this balance and, as a consequence, its limited marketing resources were not used efficiently.

XM and CCA were treading new ground in offering the continuum of care, as it was a service that did not reflect the experience or expertise of either organization. XM was a provider of inpatient mental health and substance abuse care and CCA's principals were experienced and successful providers of outpatient mental health counseling. The continuum of care, on the other hand, was a complex and

comprehensive program of services which neither XM or CCA had the perspective of experience or capital commitment to fully implement. It would have been a more effective if CCA/XM had moved slowly and incrementally to engage users based on what they knew how to do well rather than on what they wished to become (Brokaw, 1991).

It took the CCA management team several more tries before they were more aware of the principles of successful marketing. There were false starts in locating a new service. For example, the group program did have a broader appeal to more clients - the MCOs, professional colleagues, individual consumers, but, as we saw, there was no real demand for the service as a self sustaining program. The practice management billing system was also a false start. It was a service far afield of CCA's expertise and required market contacts and the expenditure of resources unrelated to the organization's founding mission. Major investment in either of these programs would have meant engaging an entirely new client base for CCA. The management team was wise in not committing significant resources to these experiments in a new phase of market research and development.

It was in the area of counseling psychotherapy that CCA found the most appropriate and successful means of engaging the mental health care market. Outpatient counseling was parallel to the expertise and successful

experience the social worker principals brought to CCA. There was demand in the market, as evidenced by the rapid increase of referrals to the counselors' caseload. There was a rich client mix, referrals came from MCOs, EAPs, professional colleagues and former clients. The fact that the principals were well represented on the MCO's provider networks allowed them to benefit from the increased market penetration of managed care in their region.

Counseling psychotherapy was also a very effective use of CCA's capital resources because it was not an expensive service to bring to the public, to advertize and promote. The sales and public relations effort could be focused using methods and contacts with which the principals were familiar and had successfully implemented in the past. Consequently, the counseling psychotherapy program proved the most effective and efficient use of CCA's experience, skills and resources in engaging the market for its organization's programs.

Directing the marketing effort to other professionals and health care organizations represented the second and third stage of CCA's attempts to contact and engage the public. Initially, these individuals and groups were marketed as potential sources of referrals and then, in a final effort, CCA solicited partnership and affiliation with them as a means to acquire additional capital resources. However, none of the marketing activities

were effective in achieving these ends. A common theme of psychological and organizational caution, which CCA's marketing strategies could not surmount, worked against these efforts.

As traditional sources of referral and reimbursement shifted toward the control of managed care, none of the individuals or organizations providing care in the CCA region were sure where security might lie. In this practice environment, no one was willing to risk affiliation or the expenditure of capital funds in ventures of questionable certainty. CCA's history was too short and its capital resources too shallow to attract the attention of potential investors or affiliates.

The one exception to this conclusion was the interest of the physician psychiatrist. However, by the time CCA was prepared to form a partnership with him, the management team believed the practice was not stable enough to utilize his contributions. His participation would have made restitution for the loss of the fourth partner, not increased the capital resources of CCA. The assets of time, clients and money were deemed too small to sustain the viability of the practice. As a consequence CCA, like the other providers in the regional market, was too unsure of its future stability to risk investment in a venture that was untested. Once again the climate for engaging with another provider was not amiable and the effort was ineffective as a means for capital acquisition.

As time progressed and there were repeated failures to locate business and engage CCA with other health care providers and organizations, the attention of CCA's management team became confused as to means and ends. It was increasingly difficult for the team to differentiate between efforts to design an effective market strategy and solutions that might insure the survival of CCA.

CHAPTER 6

Program Implementation:
An Action Stage of Program Development

Program implementation is the third stage of program development; having achieved the necessary conditions of initiation and contact, the program applies its resources and services toward the attainment of ultimate program goals. As the implementation stage is described and evaluated, the outcome of program activity is detected, and the achievement, or failure to achieve, program objectives are clarified. Directors use this analysis to inform management behaviors and operations, to modify program content or procedures to improve outcomes, or in some cases, to terminate the program (Tripodi, Fellin & Epstein, 1978 p.7, 53-55, 132-141).

Presentations of program implementation are rather well represented in the contemporary social work literature (Bartelt & Colon, 1982; Dolan, 1994; Fellin, 1994; Frenkel, et. al., 1984; Ginsberg, 1991; Goldberg, 1995; Grasso, 1989; Lovell & Richey, 1991; Merlone, 1994; Orwin, et. al., 1994; Rindfleish & Hicho, 1987; Teare, et. al., 1994; Werrbach, 1994; Wilson, Adams, Carlson 1993). Typically, these studies report on the experiences of single agencies; Gertrude Goldberg's (1995) research of the planning and

implementation stages of fourteen successful agency based programs is the exception. Implementation stage failure is illustrated by only one example (Ginsberg, 1991). There are no reports of private sector or entrepreneurial business social welfare program implementation represented in this literature. Alternative evaluation design for the implementation stage is suggested by Leithwood and Montgomery (1980), Mayntz (1983) and Westhues (1980). However, the Tripodi, Fellin and Epstein (1978) model is the most comprehensively articulated.

Describing and evaluating the implementation of CCA's outpatient counseling program by the criteria described by Tripodi et.al. (1978) is the aim of this chapter. As noted in the previous discussions, the counseling service was intended to be one element in the CCA/XM continuum of care. However, when the continuum failed to attract business and when alternative service planning proved beyond the scope of CCA's resources, the counseling program became the only service to reach full implementation. Nonetheless, through its operation, the CCA management team hoped to achieve all organizational objectives: providing outpatient mental health services to the beneficiaries of managed care health plans; maintaining control of the partners' professional practice conduct and environment; and, establishing of profitable entrepreneurial business venture.

Implementation is an action stage of program development (Westhues, 1980). In this chapter, focus will be on the actors - the staff and clients, the actions taken - the services offered, and, finally upon the results - the outcome for clients, staff and for the organizational integrity of CCA.

The Staff

The full time staff of the counseling program consisted of the four principal partners. All were senior clinicians with education and experience in mental health service and treatment. In recruiting potential shareholders, the convener of CCA used clinical diversity as one of the selection criteria when considering appropriate candidates. Each of the partners was experienced in adult outpatient care, two were also involved in the treatment of children, and one had worked with geriatric clients. Three of the principals had postgraduate training in psychodynamic psychoanalytic psychotherapy. The fourth partner was trained as a family therapist with a clinical orientation guided by systems theory. A respect for a bio-psychosocial approach to problem and symptom resolution was a perspective shared by both full and part time staff, and all had some

training or experience in short term focal treatment methods.

Areas of special need or therapeutic approach not covered by the full time male staff were supplemented by hiring part time clinicians. In order that CCA could offer gender diversity to potential consumers, two female social workers were invited to join the treatment team and a female and male psychologist were available for psychological testing. Psychiatric evaluations and pharmacological treatment were provided by two part time consulting psychiatrists who worked on site two days a week. One psychiatrist was credentialed and board certified in treating adults, geriatric and chemically addicted patients; a second psychiatrist was credentialed in child and adolescent psychiatry. A certified alcoholism and drug counselor (CAC) rounded out the part time staff. He led the substance abuse relapse prevention services and group for CCA.

These staffing arrangements met the criteria of the MCOs, who expected multi-disciplinary, gender, and treatment specialty diversity in their provider networks. Additionally, CCA developed its own provider network in preparation for serving managed care business. The network afforded professional discipline and geographic distribution of clinicians throughout the CCA region. It also anticipated the infrastructure needs of the zero based

programming marketing strategy described in Chapter 5. Network providers included ten psychiatrists, fifteen psychologists and thirty social workers who were contracted to receive CCA clients; several members did accept referrals from the counseling program but the network was essentially inactive.

Supervision of the clinical staff had a planned formal structure. Case conferences, treatment planning and review meetings, with both individual and peer consultations were scheduled. The Clinical Director was responsible for administering these activities as well as the other functions associated with care management. Monitoring of utilization and quality indicators were to be under the direction of the partner assigned as the Director of Quality Management.

However, the formal structures of clinical care management were never fully utilized. Full time staff tended to address care management issues informally as part of their routine contact with one another. Clinical concerns might be raised in administrative and practice management meetings or in ad hoc encounters on shared cases or referrals. Supervision of the part time staff was more rigorous since they were more loosely associated with the daily operation of the practice. They were asked to be in regular contact with the clinical director regarding the administrative and clinical needs of their clients.

There were several reasons why the practice came to rely on informal clinical supervisory structures. Time and attention were probably the most important. As the counseling program became the only source of revenue for CCA, the partners were required to maximize their clinical caseload. At the same time they were also engaged in pursuit of a survival strategy for the business. As was demonstrated in Chapter 4, large blocks of time and attention were devoted to marketing, capital acquisition and affiliation. In addition, the partners remained responsible for the routine operations management roles they were expected to perform. Consequently, the formal clinical supervisory structures were seen as less essential to the immediate survival of CCA and were often postponed or ignored. Unless there was a clinical crisis or emergency, the organizational needs of CCA took precedence.

This same approach to care management was observed in the comparison groups as well. All three of the interviewees reported that the time and energy devoted to the operations of a managed care oriented practice tended to push concerns for clinical supervision into the background. As one subject commented; "We rely on the experience of our clinical staff, they are all senior people with extensive training. We provide very little direct supervision of their cases. I think I tried to have one meeting with the clinical staff - it was actually an orientation to our

organization." These practice groups, as did CCA, depended upon the senior status of their clinical staff to be responsible for autonomous quality professional service. The most important concern in staff management center around compliance with administrative procedures: collecting insurance information, establishing and collecting fees, billing data, and the telephone and paperwork needed to fulfill the certification requirements of the MCOs.

Focus on administrative procedures and support is a direct consequence of doing business with managed care. CCA employed one office manager/billing specialist who worked twenty five hours a week, a full time secretary/receptionist, and two part-time twenty hour a week clerical staff members to accomplish these tasks. Accurate record keeping and billing are essential functions of insurance reimbursement and fee collection from clients. Payment is dependent upon pre-certification and the continuing certification of clients' visits; determining eligibility, benefits, and co-payment requires considerable non-reimbursable staff time. Typically, the clerical staff would spend fifteen to thirty minutes on the telephone registering each new client with their insurance carrier/MCO. The mergers of MCOs made the process more time intensive, the resulting changes in policies and procedures complicated the administrative tasks. Bills frequently had to be resubmitted with additional non-reimbursable cost to

the practice.

The CCA support staff was extremely effective and efficient in its operation. Billing was done biweekly and payment conflicts addressed immediately. There was never a time when the support staff failed to perform its functions in maximizing income. Nevertheless, effective support was expensive. In 1994, the one full year of CCA's operation, the salaries and benefits for the office staff totaled \$50,600; in 1994, 17% of the organization's accounts receivable went to this fixed expense. The overhead expense of the administrative staff required by managed care operations cost CCA a large measure of its operating and capital resources.

The Clients

Providing counseling services began the first day CCA opened its offices in December, 1993, and continued until the practice suspended services on September 30, 1995. Although the principal partners were deeply involved in the development and management of the business, their primary daily professional responsibility was service provision to their clients. During the twenty two months CCA was in operation, 691 clients were registered for care. In this section, a profile of a sample of these clients will be presented. The statistical data was compiled with the aid

of the practice's computerized management information system, and represents a sample drawn from the eight month period between September 1, 1994 and April 30, 1995 when CCA's counseling psychotherapy services were fully implemented. In the eight month period, 300 different individuals received care.

The greater majority of CCA's clients were adults between the ages of nineteen and sixty five (see Figure 1). While counseling services were offered to children and adolescents, they represent only about 5% of the clients seen in this period. Senior adults over sixty five represent an even smaller portion of the client population at .5 % of the total.

Figure 1.

Client Population by Age

AGE GROUP	NUMBER	% OF CLIENT GROUP
=====		
Adults	236	93.5%
Adolescents	5	2.0%
Children	9	3.5%
Adults over 65	2	.5%
<hr/>		
	N = 252	99.5%

Note: Computer data set was incomplete for 48 clients.

Clients' presenting problems had to be categorized using the diagnostic nomenclature of the American Psychiatric Association's diagnostic manual, DSM - IV. Mental health treatment is considered a medical procedure by the MCOs and all reimbursements for services are made only under a recognized psychiatric diagnosis. CCA complied with this requirement.

There were sixty nine different diagnoses used to categorize clients' symptoms and presenting problems addressed in counseling sessions; 72% of them fell within five broadly defined clusters, see (Figure 2). Disorders of mood represented the most frequently treated symptom or 33% of the total. Life adjustments disorders followed, with 20% of the clients falling into this group. It is under this diagnostic cluster that most family, marital and relationships problems are identified. Clients with anxiety disorders represented 7.6% of those treated, and post traumatic stress disorder (PTSD) 7.3%. PTSD was a specialty treatment niche for CCA.

Substance abuse as a primary diagnosis was the smallest cluster with only 4.3% of the clients; this despite the fact that many of CCA's clients had chemical dependency problems. There were several factors operating to statistically hide the depth of this problem: the practice computer software could only register one primary diagnosis; for similar reasons, most insurance companies also list one diagnosis

for each procedure given; but, more important perhaps was the issue of client confidentiality. Unless the chemical dependency problem called for direct access to the client's drug or alcohol abuse benefit, it was seldom listed as a primary diagnosis in any official documentation.

Diagnostic categories not fitting into the five clusters were represented by one to ten individuals with that problem. These clients accounted for 27.8% of those seen at CCA and included, for example, such issues as bereavement, learning disability, hyper-activity, sexual dysfunction, gender identity conflicts, conduct disorders, personality disorders, Tourette's syndrome, and parent/child problems.

Figure 2.

Client Population by Primary Diagnosis

DIAGNOSTIC CLUSTER	NUMBER	% IN CLUSTER
Disorders of Mood	99	33%
Life Adjustment Disorders	60	20%
Disorders of Anxiety	23	7.6%
Post-traumatic Disorder	22	7.3%
Substance Abuse Disorders	13	4.3%
All other disorders	83	27.8%
	N = 300	100%

Problem or symptom resolution was the typical focus and goal of counseling. CCA counselors in general followed a short term treatment protocol. Eight sessions was the average length of treatment for a client during the eight month period under review. To determine average length of treatment, forty eight clients were randomly selected from the 300 registered patients; one subject with forty three counseling sessions was dropped from the sample as an outlier, see (Figure 3). More than half, 59%, of CCA's patients were treated in ten or fewer sessions, only 40% in eleven sessions or more. Statistically, CCA was following the length of outpatient treatment consistent with managed care guidelines.

Figure 3.

Length of Treatment

LENGTH OF STAY	NUMBER	% IN CATEGORY
1 - 5 Sessions	19	40%
6 - 10 Sessions	9	19%
11 - 20 Sessions	16	34%
21 - 30 Sessions	3	6%
N = 47		99%

Based on the analysis of the diagnosis at the beginning of treatment and the average number of counseling sessions, it would be appropriate to conclude that most of CCA's clients were adults seeking treatment for mild to moderate psychiatric symptoms and/or for common adjustment problems in living. A more conclusive reading of this data would have been possible had CCA included the global assessment of functioning scale, Axis V, as part of its computerized diagnostic information. These conclusions, however, were confirmed in interviews with three of the full time clinical staff.

Services and Interventions

The array of services in the counseling program was both a reflection of the expertise the principal partners brought to the practice and those developed in response to the needs of the consumer public. Private practice experience had prepared the management team to be sensitive to possible niche opportunities in service provision; that is, services developed as a means to stand out from the other social work and mental health providers in their region. During their years of solo practice, each partner had developed a repertoire of techniques or special interests which enriched CCA's list of possible interventions.

Adults, as demonstrated, represented over 90% of CCA's clientele; consequently, individual counseling addressing the psychiatric symptoms or life problems of this group was the "stock and trade" of CCA's practice. Most of CCA's clients (78%) also came with a mental health benefit structured by the restrictive utilization requirements of managed care. Therefore, the treatment approaches employed had to be short term and problem focused - sensitive to a limited number of sessions or time restrictions in their application. Techniques such as hypnosis, bio-feedback, psycho-education, and cognitive behavioral methods supplemented all forms of talk therapy which were intended to meet the treatment needs of the adult clients within the limits of their health care benefit.

Disorders of mood and anxiety accounted for just over 40% of CCA's clients (see Figure. 2). Such conditions are best managed when a possible combination of environmental, talk and chemo-therapies are available to the treating clinicians (American Psychiatric Association, 1993). Psychoactive medications, prescribed by CCA's consulting psychiatrists, were used to reduce symptoms and improve levels of functioning in about 10% of the clients.

Group therapy was available to supplement or as a primary treatment alternative to individual and couple/family counseling sessions. Eight special topic groups were operating during the eight month period under review; these

included: women in transition, substance abuse relapse prevention, overeaters, young adult professionals, children with ADHD, men's discussion group, discharge planning implementation for inpatient psychiatric patients and their families, and a support group for gay men. Groups were promoted, it may be recalled, as a part of CCA's market research and development strategy as well.

Services were also structured to meet the needs of special populations or other professionals in the region. One such group was for individuals suffering from post-traumatic stress disorder. All four of CCA's full time counselors were trained in a relatively new technique of post-trauma desensitization know as eye movement desensitization and reprocessing (EMDR). Two of the partners were credentialed as senior facilitators of the technique, and were available as clinical trainers and consultants. Interventions using EMDR became a specialized niche for attracting clients to CCA. The practice marketed this special approach to MCOs as an effective and time efficient treatment for PTSD, a disorder that can often take years of therapy to resolve (Shapiro, 1995). Other mental health clinicians and professionals such as physicians and attorneys who had contact with trauma victims were also targeted for marketing the EMDR specialization.

Diversification in approaches to clinical intervention and appeals to other segments of the consuming public

increased CCA's clinical caseload significantly. Much of this specialized service was included in the residual category "other" in our earlier analysis of client presenting problems. These represented nearly 28%, or a quarter, of CCA client referrals, (see Figure 2).

One full time social worker was board certified in behavioral medicine, which employed techniques related to the psychophysical connection in psycho-immunology, stress and pain management. Forensic social work was yet another specialty represented. Attorneys referred clients for psychosocial assessment and recommendation as part of court case preparation. Two of the participating social workers were on the county's family court forensic referral network. The entire full time staff was approved by the state to do drug and alcohol treatment screening for the department of motor vehicles. Seven national and local employee assistance programs used CCA as a diagnostic assessment and referral center for their enrollees.

This discussion represents a catalogue of the clinical services that were operational and actually utilized in the counseling and psychotherapy program, the one program that CCA was able to fully implement and, ostensibly, from which its viability as a business was to have been determined.

Implementation Outcomes

The monitoring of implementation outcomes is recognized as a central component of program development and differential program evaluation. Information concerning implementation outcomes is critical to the analysis and evaluation of organizational goal attainment, informs and enables the modification of program content and procedures, and ultimately determines program viability (Tripodi, Fellin & Epstein, 1978). The need for and benefits of outcomes management in social welfare programming is well represented in the social work literature (Blyth & Blair, 1985; Briar, 1980; Gordon, 1983; Lewis, 1980; Reid & Hanrahan, 1982; Rubin, 1985; Thomlinson, 1984; Tripodi & Epstein, 1978). As the industrialization of social services and health care gains momentum, the expectation for standardization and accountability in determining implementation efficiency and effectiveness in social welfare productivity are the same as for any other industrialized process, outcomes monitoring is a natural effect of this trend (Coke, 1993; Fuchs, 1986; Gould, 1993). Consequently, the managed health care industry has put much emphasis on outcomes monitoring as part of its business planning to insure profits, containing costs, controlling utilization and its stated desire to improve quality (Eddy, 1990; Eddy, 1993; Ellwood, 1989; Epstein, 1990; Gould, 1993; Lansky, Knudsen & Werzler, 1993;

Mirin & Namerow, 1991; Relman, 1988; Roper et. al., 1988).

CCA's social work principals were well aware of these trends and incorporated outcomes monitoring, utilization and management design into the infrastructure of the organization. The commitment to outcomes monitoring was made evident in several ways. First, one of the four principal partners was designated Director of Quality Management. The job description required building the capacity to collect business and clinical data and the on-going utilization of the data to monitor and improve the functioning of the organization. Secondly, CCA committed considerable capital resources in time and money to the outcomes enterprise. Computer hardware and software were purchased and the director of quality management expended time and energy in gaining expertise in managed care clinical and business oriented operations by reading, attending workshops and in consulting with other managed care affiliated practice groups.

In fact, much of the quantitative and qualitative data used to support the analysis of this case study was made possible by the outcomes management capacity built into CCA's organizational design. Analysis of the outcomes of CCA's program implementation will be discussed under two headings, one pertaining to clinical services and the other with the business, principally, the financial results.

Clinical Outcomes

The Director of Quality Management was responsible, with the Clinical Director, for the monitoring of clinical services. After a review of several alternatives, the principal partners decided to use the outcomes protocol developed by the Council of Behavioral Group Practice (CBGP). The decision was based on a number of pragmatic considerations; the initial effort at clinical outcomes monitoring could not be too capital intensive, using CBGP's pre-packaged program was expedient and cost effective. Secondly, the CBGP protocol had scientific integrity. It was built with standardized, valid and reliable, instruments and all of the evaluation materials were in the public domain and inexpensive to use. Finally, the Council had developed software for computerized data analysis and intended to establish a national data base to improve statistical significance among participating outpatient mental health treatment facilities. By using the protocol, CCA would be able to pool its data and compare its service outcomes with similar practice groups in other regions.

Several factors motivated the Council to generate its own outcomes monitoring initiative. Most important was the desire to have a clinically based information system that was developed and controlled by the providers. This was an attempt to preempt the MCOs and to help insure that outcomes

management was not left entirely in the hands of the exogenous business interests of managed care organizations. The second goal was to offer a protocol for wide distribution which was not expensive or labor intensive to administer. Clinical utility was a third objective; Council members wanted an outcomes process that could be used to monitor care and improve quality control measures at the time and point of service.

The protocol adopted has five instruments administered either before, during and/or after treatment; items 2, 3 and 4 have direct clinical application and may be used concurrently with care:

1. *Personal Characteristics*, collects demographic information on each client at first contact.
2. *Health Status Questionnaire* (the Rand HSQ 2.0), a comprehensive survey of client's perceived health status and daily functioning.
3. *Behavioral and Symptom Identification Scale* (BASIC 32), a mental health and substance abuse symptom and functioning survey.
4. *Progressive Evaluation Scale* (PES), survey measure of daily psychosocial functioning.
5. *Satisfaction Survey* (Larsen Client Satisfaction Questionnaire), a client survey evaluating the services of the provider and clinical organization during and after treatment.

While the principals had agreed to use the CBGP outcomes protocol, CCA never implemented it. The materials became available to Council members in the fall of 1994,

during the time when the CCA management team was most fully involved in developing a survival strategy for the practice. Concurrently, there was also a great deal of pressure on the social work partners to maximize client contact hours to improve cash flow. Consequently, the management team decided to postpone the implementation of the clinical outcomes monitoring until the organization stabilized and there was more time to administer the protocol.

However, the Director of Quality Management did run one application of the Client Satisfaction Survey in October of 1994 to pilot a formative evaluation for the practice. An availability sampling technique was used: the CBGP satisfaction survey was left in the waiting room and clients were encouraged by the receptionist during a five day period to fill out the questionnaire. Twenty two surveys were completed and returned. The survey contains twenty six items, three items have been selected and reported here as an example of the clients' evaluation of the care they received at CCA (see Figure. 4).

Although no general conclusions concerning CCA treatment outcomes may be drawn from this formative study, it does suggest that CCA's clinical services were meeting the mental health needs of the twenty two clients surveyed and that they were generally satisfied. In their eyes, CCA's counseling program was providing effective care. We see that no responses fell in the lowest evaluative ranges.

This was true for the other twenty three items on the questionnaire as well.

Figure 4.

Satisfaction Survey Results

Are our services helping you deal more effectively with your problems?

Possible Responses	Number	Percent Responding
1. No, they seem to make things worse.	-	-
2. No, they have not helped so far.	-	-
3. Yes, they have helped somewhat.	10	45%
4. Yes, they have helped a great deal.	12	55%
	N=22	100%

In an overall, general sense, how satisfied are you with the service you receive?

Possible Responses	Number	Percent Responding
1. Quite dissatisfied.	-	-
2. Indifferent or mildly satisfied.	-	-
3. Mostly satisfied.	6	27%
4. Very satisfied	16	73%
	N=22	100%

Your (the client's subjective experience) improvement due to counseling psychotherapy?

Possible Responses	Number	Percent Responding
1. Poor.	-	-
2. Fair.	-	-
3. Good.	5	33.3%
4. Very good.	5	33.3%
5. Excellent.	5	33.3%
	N=15	99.9%

Note: This item was on the second side of the survey. Some clients did not follow directions to continue to page 2.

Perhaps the more important lesson gained from this study is to call attention to the way in which relatively simple efforts at outcomes monitoring might provide important information to clinical and administrative managers about their care giving practices. Nevertheless, CCA did not make outcomes monitoring of its counseling program a first priority. This was not unusual, since none of the three practices in the comparison group had an outcomes protocol in place. During the interview process, one director did mention that his group was working on the implementation of a client satisfaction survey.

Information concerning the effectiveness of CCA's

clinical care efforts is sparse indeed. This is not unusual for social work and mental health practices. Placing and using outcomes monitoring structures within the process of care are not seen by providers as a routine part of professional interventions (Briar, 1980; Coke, 1993; Eddy, 1990; Gould, 1993; Grasso & Epstein, 1987; Tripodi & Epstein, 1978). CCA's experience confirms these observations. The shortage of empirical evidence for clinical effectiveness and efficiency has been a tool used by MCOs to challenge the dominance of providers in determining standards of care (Coke, 1993; Eddy, 1993; Gould, 1993; Mirin, & Namerow, 1991; Relman, 1988).

Business Outcomes

The results of implementing the counseling psychotherapy program on the viability of CCA as a business are more easily assessed. CCA's management information systems were geared to the administrative activities of the practice. The computer software and procedures implemented by CCA's management team were oriented more toward sound accounting principles and the legal requirements of business operation and less to the core activity of counseling; this administrative emphasis in information gathering is also representative of many social welfare organizations (Briar, 1980; Grasso & Epstein, 1987; Weissman, 1977).

We do find that implementing and marketing the

counseling psychotherapy program were effective at increasing the flow of clients and income into CCA. There was a steady growth in the number of billable client contact hours during the eight months the program was in full operation (see Figure 5). These figures confirm the effectiveness of the principal partners, the full time social work staff, in maximizing their income producing capacity. They were responsible for providing 3,560 or 93% of the counseling sessions during the time period under review, 259 sessions were conducted by the part-time staff. (Note: Part-time staff utilization could not be substantially increased because most all MCO referrals were coming to the principals as individual network providers, not to CCA).

Figure 5

Client Contact Sessions - September 1994 to April 1995

Month	Contact Sessions
=====	
September 1994	416
October	457
November	556
December	400 (Holiday Season)
January 1995	432
February	470
March	592
April	496
Total	<u>3,819</u>

At this level of service intensity, the principals had nearly reached the limit of their capacity to produce income from providing clinical care. There was some additional income from partner consulting fees, but these services generated on average less than \$500 a month; XM contributed \$1,480 monthly for shared expenses and office rental until March, 1995. However, without MCO group contracts and managed care reimbursable programming, the principals themselves could not generate enough service volume to cover the cost of doing business. As we review income and expenses, this conclusion will become evident (see Figure 6).

Figure 6.

Income and Expenses

Month	Income	Expenses	Result
Sept. '94	\$27,046	\$34,409 *	-\$7,363
Oct.	35,832	37,178	-1,346
Nov.	36,137	38,062	-1,925
Dec.	35,069	39,441	-4,372
Totals	<u>\$134,084</u>	<u>\$149,090</u>	<u>-\$15,006</u>
Jan. '95	36,069	18,864 **	17,205
Feb.	31,270	14,273	16,997
Mar. ***	33,207	12,806	20,401
Apr.	36,583	21,305 ****	15,278
Totals	<u>\$137,129</u>	<u>\$67,248</u>	<u>\$69,881</u>

* Partner salaries are part of the monthly expenses.

** Partner salaries no longer part of the monthly expenses.

*** Last payment by XM for rent and shared services as part of income.

**** Increased expense related to CCA Recovery Services program implementation.

For the four month period, September through December, CCA showed a deficit of slightly over \$15,000; there were equivalent losses in each of the previous quarters for 1994. These monthly shortages were covered with funds from the capital account; thus, by the end of fiscal 1994, capital resources after start-up costs were essentially exhausted. To bring the budget into balance and to facilitate equity in income disbursement, the partners agreed in November of 1994 to stop taking a salary from CCA.

Partners' reimbursement, in fiscal 1995, was to be based on income after expenses. As seen in Fig. 6, this strategy brought the budget into balance in January '95 resulting in a positive cash flow. However, these figures alone do not represent an accurate picture of CCA's financial prospects, nor the financial condition of the partners.

In December 1994, after the breach in the CCA/XM affiliation, XM informed the principals that they would be moving their regional marketing operation out of CCA's offices. This action decreased monthly income by \$1,480, with no equivalent decrease in expenses. Furthermore, at about the same time, expenditures were increased by the need to begin funding CCA Recovery Services, represented in the April 1995 expenses. The state informed CCA in March of 1995 that it would issue the operating license for the alcohol and substance abuse clinic by April 30. It was

anticipated that operation of the clinic would put an additional burden on the expense side of the budget without generating any income for at least six to eight months.

In addition, residual income after expenses was not sufficient to meet the personal income and security needs of the principals. Allocation of the \$69,881 profit (see Fig.6) after expenses divided among the four principals, allowed for a pre-tax income of less than \$4,400 per month for each. Partners were also required to cover the cost of social security, Medicare, and their medical and disability insurance from these same funds.

By 1995, the financial realities were these: 1) the capital account was depleted; 2) fixed expenses were set to increase with the funding needs of the substance abuse clinic license; 3) the staff was generating as much income as possible through client services; and, 4) income after expenses was not projected to be sufficient to meet the personal financial needs of the principal partners. A review of fixed costs suggested to the management team that during 1995 they could expect the monthly residual income after expenses to steadily decrease.

Evaluating the clinical effectiveness of CCA's counseling psychotherapy program suggests success: it provided satisfactory care to 300 clients with sixty nine different psychiatric disorders; in the eight months of full operation, it generated \$271,213 of income to the practice

by providing 3,819 counselling sessions with a staff of four full time social workers and eight part-time clinical associates. However, the success of implementing the treatment program was insufficient for the purpose of achieving the fiscal stability of the organization.

Perhaps a significant finding gained from the CCA experience is the diminished significance of the quality of care in determining the economic viability or the survival of health care businesses in the current practice environment. The CCA social workers and clinical staff were effective at providing quality care, but service quality neither improved the flow of patients from MCOs nor sufficiently distinguished CCA from the its competitors in the local market so as to increase its market share. In an industrialized health care marketplace, service quality is probably not a critical variable to success or survival as a business.

Program Stabilization: An Unstable Outcome

The desired result for any social welfare organization or program is to attain a successful, stable operation, that is, the ability of the organization to maintain and improve itself over time (Bielawski & Epstein, 1984). There are certain indicators which suggest stabilization has occurred within organizations. First, the organization has achieved

a measure of autonomy in its external environment: there is a recognized and distinctive area of competence for which the organization is known, there is a clearly defined clientele, and the organization has an acknowledged jurisdiction over a service. Stability is evidenced, secondly, when an organization can make a claim on sustaining resources, it can appeal to the market and anticipate a positive response to its offerings.

Institutionalization is the third indicator of program stabilization; the infrastructure is securely placed and the immediate continuation of the operation is not in question, it has successfully negotiated the stages and tasks associated with program initiation, contact and implementation (Bielawski & Epstein, 1984 pp. 15-18). If these criteria are applied to CCA, we discover that the practice was not able to achieve organizational stability during its time of operation.

Autonomy in the managed care service market place in its region was not accomplished by CCA. We recall that several small and one large MCO did sign a group contract with CCA, however, no MCO sent a significant volume of referrals to the practice. This lack of successful program contact made it almost impossible for CCA to establish a jurisdictional claim among its potential competitors. The principal social workers were able to increase their managed care referrals, but only as individual practitioners. They

were never more sufficiently secure in their association with the major MCOs than the other individual mental health professionals in the region. Although mental health care was successfully provided inside of CCA's structure, the organization itself was not able to attain stable jurisdiction over a clientele or service.

Consequently, CCA had no confidence in claiming a share of managed care referrals in its region, the second indicator of stabilization. Without a dependable and consistent source of referrals, CCA was unable to successfully complete the stages and tasks necessary for institutionalization.

The initiation stage did produce several positive results: the principals were able to design a provider led response to the pressure managed care posed to the control and direction of their clinical practices. Secondly, the management team was successful at developing an organizational infrastructure for their enterprise. They established the legal and administrative structures for a professional corporation and a licensed alcohol/substance abuse clinic, they developed and marketed the continuum of care and the counseling psychotherapy program, they located and appointed a site, assembled a clinical and administrative staff, and initiated client contact.

However, CCA was unable to adequately fulfill the objectives of the client contact stage, a requisite of

stability. While many individuals were served by the implementation of the counseling psychotherapy program, the MCOs were not successfully engaged to use CCA as an outpatient psychiatric care facility. This was a significant failure in the contact stage since providing care for MCOs was the essential motivating objective behind the entrepreneurial risks taken by the partnership.

As a result of this failure, CCA's organizational plan could not be fully implemented. Those aspects of the design that did function with a measure of success, functioned at a level insufficient to sustain the capital and management needs of CCA as an organization devoted to profitable activity. There was then a cumulative outcome to these developments: as it became apparent that the practice was unable to find a strategy for stable operation, the commitment of the partners and the ability of the partnership to function as an effective management team began to falter.

De-stabilization of the Partnership:

The End of Business

Belief in the innovative ideas behind an entrepreneurial endeavor is essential to its ultimate success; commitment and significant risk taking are impossible without it (Sage, 1993; Shapero, 1984). During 1994 there was a gradual erosion of confidence in the

founding assumptions which stimulated the incorporation of CCA. If we review the findings and the cumulative outcomes which have been summarized in this case study, we discover the conditions which led to the loss of confidence and the growing perception within the partnership that CCA would not become a stable organization or meet the professional and financial goals of its shareholders.

These conditions may be summarized in the following statements:

> In the effort to engage managed care business, it was discovered that the strategic statements of the MCOs for mutually beneficial partnership with providers was not consistent with their operating realities. Industrialized managed care's involvement in competition for market share and profitability supersede all other considerations. Cuts in reimbursement rates and utilization undermine the ability of CCA and other social welfare organizations to provide service and meet the cost of operations.

> Industrial managed care is in its infancy, the rules of engagement are in formation and the business environment volatile. These conditions require organizational flexibility, and the risk of capital resources necessary to sustain long term involvement in the process. CCA was undercapitalized to meet these challenges.

> Affiliation with XM was based on a strategic plan where some of the operating assumptions were either withheld, not clearly articulated or misunderstood by the parties involved. CCA/XM had neither the organizational nor legal integration sufficient to withstand the tension created by a unresponsive market for the continuum of care. Failure of the affiliation left CCA's principals without a feasible business plan and an alternative means of achieving their entrepreneurial goals.

> Participation in industrialized healthcare brings two potentially divergent ends into close proximity: the desire for positive outcomes in care giving and in business profits. It is difficult for the same individuals to expend appropriate levels of attention to both goals simultaneously. CCA's management team may have faltered in trying to remain equally active as primary care providers and as business managers.

> CCA's principals were unable to locate and engage the appropriate business management talent necessary to compensate for their lack of experience and education in business theory and practice. Business knowledge and acumen are a prerequisite for successful operation in the current health care market place.

> The value orientation of the social worker partners is driven by their social work training and professional affiliation. These values are significantly different from those of individuals schooled in business for profit. The struggle to locate a survival strategy for CCA intensified the awareness of value dissonance between the principals' role as business men and care givers.

> The overhead expenses of an organized group practice and the reimbursement rates from MCOs do not provide a level of income sufficient to meet the personal financial needs of the partners and their business. (This realization became increasingly dispiriting to the partners as they began to observe social worker colleagues in private practice maintain, develop and expand practice opportunities outside the industrialized health care market place and managed care).

Toward the end of 1994 and early 1995, the impact of these findings led to a high level of frustration and contributed to a growing doubt in the wisdom and feasibility of their endeavor. Oliver (1991) suggests that individuals operating organizations may respond to perceived threats in the environment in a number of ways. They may acquiesce to them, compromise, avoid, defy or manipulate the threats. When these responses do not work, the organizational

response is to exit or escape from the perceived peril. We find the principals of CCA engaged in all of these behaviors.

CCA's primary mission was an acquiescence to the impact of managed care on the private practice of social work; the strategic intentions of managed care seemed to point to the end of the successful solo practitioner. The principals believed that in creating CCA/XM they had found a way to accommodate to industrialized health care. Compromise came as the principals tried to find the means to accept the lower utilization and financial reimbursements from MCOs and still work within the administrative and clinical requirements of a managed care accommodating practice.

There were attempts to avoid managed care dominance by developing relationships and services for attorneys, the courts, the department of motor vehicles, physicians, and a self-pay clientele. Defiance and manipulation appeared in the administrative handling of outpatient treatment reports to the MCOs, saying what needed to be said in the parlance of managed care to establish medical necessity, or the billing of sessions around the limitations imposed by the seemingly arbitrary rules of certification. For example, a first session with a client could be dated to a later time, after the authorization had been given by the MCO. When such strategies failed to insure the survival of CCA, the principals began thinking of an exit or escape

strategy.

It was in the exit from the practice that the most serious interpersonal tensions emerged. Tropman (1989) observes that interpersonal strain is one of the risks of entrepreneurship. The bond of cooperation was firm between the partners during the initiation stages of CCA's development. Each social worker had a designated role in the organization that paralleled their temperament and interest. Consequently, working relationships were positive as the shared vision was built. Serious tension began to emerge after it became evident that the XM affiliation would not produce the expected results. It had been anticipated that referrals from the XM inpatient facilities would sustain the financial burden until business from the MCOs matured. When this assumption proved false, financial pressure on the partners increased and they began to express differences about how the limited resources might be used.

Personal financial need began competing with the corporate interests of CCA. Interpersonal tension among the principals was one significant result. Faith in the mission of CCA did not dissolve at the same rate in each principal. Giving in to a sense of failure was at times interpreted as a personal act of disloyalty to others in the partnership, doubt was masked by disagreements over trivial expenditures. Since scarce capital resources were the primary source of tension, discussions among the

partners were not successful at resolving the strain. An infusion of capital from a new partner or a significant MCO contract were the only meaningful solutions to the dilemma faced by CCA. When neither of these things occurred in fiscal 1994, the partnership began to unravel.

In January 1995, one partner began to inform the others that he was near the end of his risk taking capacity. The others wanted more time to seek a survival strategy; the substance abuse clinic license was close to approval, and conversations with a potential fifth partner were going well. The threat of a resignation, however, threw the partnership into confusion and consensus in decision making became more difficult. The disaffected partner maintained that his need to support his family over the needs of CCA was not appreciated by the others. To the other three, a resignation at this juncture felt like a sabotage that would lead to the ultimate scuttling of CCA.

A letter of resignation with intent to sell his shares in CCA was submitted to the Board in March 1995. Simple arithmetic calculation demonstrated that the three remaining founders, even with an eventual new fourth partner, could not maintain the practice on their own. At this point CCA's capital funds were at about \$5,000 or equivalent to one month's rent.

Dissolving the partnership became concurrent with the dissolution of the practice. In the end, the one partner's

resignation was less a factor in the failure of CCA, than a symptom of the loss of faith in the CCA innovation and of the personal capacity of all the principals to absorb more entrepreneurial risk. The outcomes and experience of fully implementing the counseling psychotherapy program led to the conclusion that CCA could not survive as a profitable enterprise and meet the personal and professional goals of the founders. At the June 1995 Board meeting it was decided to close the practice as soon as possible.

Coming to this conclusion and its emotional consequences were of considerable import. It was difficult for the principals to remain committed to the tasks of disassembling the organization once the exit decision had been made. Their investment of time and money continued despite their resolve to close the practice. Rent, utilities, salaries, loans, legal fees, negotiations with the landlord and regulatory personnel, thousands of expensive details had to be managed until the exit strategy was in place. These plans took until December 1995, almost six months to fully implement.

In the exit strategy, the principals had made the decision to pay all creditors and in this way "moth ball" the practice in the hope that some other opportunity might arise before the close of business. In so doing, they tried to maintain a glimmer of a survival strategy, the possible sale of the substance abuse clinic license or finding an affiliation with another group or larger system of care;

perhaps all in the service of avoiding a complete admission of defeat in implementing their entrepreneurial design. CCA however was only a shell of an organization after June 1995. On September 30, 1995, the practice left its site and ended formal operations as a business. The partners returned to their solo social work practices.

Acceptance of these realities resulted in considerable emotional pain for the principals. There was a public and a private edge. Colleagues, friends and families learned that CCA had foundered. Explanations were difficult and complex and needed to be repeated many times. On the private side the losses mounted: the principals mourned the loss of their ideas, their considerable capital investment, and the bond between them. One of the principals made this observation during a final CCA board meeting in December, 1995.

I was reading DSM (the Diagnostic and Statistical Manual of psychiatric disorders) the other day reviewing the diagnosis for one of my clients: post traumatic stress disorder. As I read the indication, I realized all of these things applied to me. Checking them off, they were all positive. We need to recover from what we've been through - this is serious.

CHAPTER 7

Discussion

Schon (1983) suggests that as practitioners confront problems which occur in the course of their professional activity, they develop and test hypothetical solutions based on their education, experience and accumulated practice wisdom. Professional practice becomes a series of problem solving events which Schon refers to both as "reflection in action" and as "frame experiments" (Schon, 1983, p.63). Reflection in action and the experimental metaphor derive from the reflective process which is a typically human, purposeful and ordered response to what is new and unexpected. By superimposing the five characteristics of a frame experiment, to be discussed shortly, on the activities just reported, we begin to see CCA as a particular reflection in action or a hypothesis regarding an organized response to industrialized health care by the individuals and corporate sponsor who established Counseling Care Associates. The proposition can be simply stated: group practice within a continuum of care is a way for providers to respond to industrialized managed care, addressing the social workers' need to protect their economic security and their perceived professional autonomy.

In the first of these five characteristics, the practitioner is called upon to make sense out of a situation which is puzzling, troubling and uncertain. Managed care, the principal strategy of industrialized health care to limit costs to its constituents and to maximize profits to its investors, was a clear threat to the way in which the CCA principals and XM has been doing business over the last decade. Participation in the current market place and in professional forums such as the Behavioral Healthcare Conferences only made the encroachments of managed care seem more apparent. Clinicians from the west coast reported their experiences with managed care. Fees were falling and length of stay was being reduced for both inpatient and outpatient care. The participants came to believe that maintaining past patterns of practice under managed care strategies was not possible. The days of the solo practitioner supported by fee for service insurance reimbursement seemed numbered. Psychiatric facilities could no longer depend on extended hospitalizations. The perceived reality of these changing conditions was corroborated in the daily experiences of the parties involved.

Words like "puzzling", "troubling" and "uncertain" invoke a sense of anxiety, and it was anxiety about the future that led to the second stage of framing a response. Making sense is the attempt to bring coherence or logic to

the experienced anxiety or confusion. Participation in the managed care task force and attending the many forums in which managed care was discussed helped to increase knowledge of managed care and how it operated within the practice environment. Meeting managed care personnel put a human face on managed care organizations (MCOs). There were reassurances that providers and MCOs could find ways to respect the interests of all the players including those of the clients.

Contacts with providers in California, Minnesota and Connecticut who were successfully working with MCOs was encouraging to CCA's principals. Despite lower discounted fees, providers were reporting increases in their referrals and a belief that MCOs and providers could find a mutually beneficial accommodation. In the fall of 1992, there were few discouraging words from providers doing volume business with MCOs. Organizational structures appropriate for managed care business were there to be modeled. Multi-disciplinary group practice was portrayed as the most likely to bring success. CCA's organizational plans mirrored the mission and structures of these successful practices.

Coherence imposes boundaries around which thought, planning and action can be ordered. This represents the third of Schon's characteristics of reflection in action. Considering the formation of an outpatient group practice as part of a continuum of care seemed a coherent boundary

around which to order thought and action. Both for the social work principals and the XM corporation, group practice represented a way to respond to the inroads of managed care. For the social workers, a group practice became a possible means to transcending the limits of their solo practice and to become affiliated with an extended continuum of care. XM saw affiliation with outpatient services as a method to support its inpatient facilities and maintain its place in the local market.

Conceptualizing and amplifying the notion of group practice became a focus for thought, planning and action. A secondary gain from such concentration was a reduction in anxiety based on the belief that the group could cope with the phenomenon of managed care. As the events of the narrative demonstrates, all the individual participants became centered on a common intent. They began to believe they had found a way to maintain their practices and perhaps flourish as providers of mental health care. Group practice began to move from a passing thought to a viable reality. Weekly meetings, telephone conversations in the hundreds, consultations with experts, assignments and reports, became the activity of the reflective process.

If the reflective process continues, the fourth of Schon's characteristics becomes apparent: the order is named and becomes the setting for reflective action. The incorporation of CCA literally named and framed the

reflective action, the frame experiment. This was a critical moment in the reflective process for CCA. From this point on the parties were making a commitment to their hypothetical vision for a managed care accommodating practice. To test the hypothesis they built an organization which required the investment of real capital, money and time. They also accepted the personal risks of any experiment: the possibility that the hypothesis may not prove correct.

Naming and framing are essential to reflection in action because this also sets the boundaries for evaluation, the fifth characteristic - reflection on action. At the end of the evaluative process, a judgement can be rendered about the validity of the hypothetical formulation which tested group practice as an appropriate provider response to managed care and of CCA as a particular expression of the phenomenon.

Viability of Managed Care Oriented Group Practice

There were two aspirations addressed in the group practice hypothesis as a way for social workers to manage managed care. The first was a desire to maintain autonomy in professional conduct and the second, the maintenance of

economic security. The second aspiration will be discussed first.

From the analysis of CCA's experiences, it is fair to say that a primary reason behind CCA's lack of success in fully implementing its business plans had to do with insurmountable problems of under capitalization and capital management, that is, in meeting the expenses of doing business and in supporting the economic needs of the partners. This one experience, however, does not suggest that the economic viability of group practice is untenable. To the contrary, Psychotherapy Finances (May, 1996), reporting on a survey of 172 group practice subscribers, finds that group practice formation is continuing at an increasing pace. Although the vast majority of the groups are new and have been in operation for less than five years, they do report successful operation. The Psychotherapy Finances survey finding is validated by interview data from the comparison group, CCA's competitors in its region. The three practices examined during the course of the case study are currently functioning satisfactorily. As of August 1996, all three continue to be financially sound, are successfully obtaining managed care contacts, adding staff and providing outpatient clinical services.

In addition, managed care organizations are using groups with the exact mission and structure as CCA in increasing numbers to manage their mental health benefits. Directing business to provider groups continues to be part

of the strategic thinking and operation of the major MCOs. In October 1995, one month after CCA ceased operation, two of the largest MCOs in the CCA region sent RFPs (request for proposals) to the practice soliciting its participation in grouping regional providers. The MCOs are laying the ground work for capitation contracting, a strategy that is possible only with provider groups. As of this writing, therefore, data from a local and a national survey indicate that group practice is currently an economically viable way for mental health providers to structure outpatient mental health care and is continuing to gain support from the major MCOs (Lazarus, 1995). The failure of CCA does not then invalidate the premise that group practice is a way for mental health providers to adapt to the industrialization of health care.

A second possible perspective on CCA's inability to survive economically may relate to the principal managers lack of experience or facility in business operations. While this explanation is supportable from the results of the case study, lack of business acumen in its social worker managers does not fully account for CCA's failure. The Psychotherapy Finances (May 1996) survey provides perspective. Problems in business management and/or a lack of managerial sophistication are not unusual in fledgling provider groups. Such deficits, however, do not necessarily lead to business failure.

The survey finds, for example, that over half the groups do not operate with full financial integration among partners. While 85% have some administrative structures, the administration is typically organized to provide basic services such as centralized reception, referral routing and billing, but most do not have a strong centralized authority. Only 50% of the surveyed practices had *complex* marketing plans, quality management or outcomes protocols and only 50% utilized *trained business advice* in planning group business. (Note: in the report the categories *complex* and *trained business advice* are not defined). Computers and/or rudimentary management information systems are used by 35% of the group practices surveyed. Low levels of sophistication in business management or operations do not necessarily cause groups to fail; in fact lack of business sophistication may be more typical than not.

Data from the local comparison group corroborates this observation. Only one of the three had a trained business professional involved in daily operations. The other two groups were directed by mental health professionals with no more administrative or business expertise than CCA's principals. Yet each practice in the comparison group continues operation, having survived the volatility of managed care reorganizations, absorbed the reductions in reimbursement rates and the machinations of trial and error learning without trained business advice and counsel. Lack

of business knowledge and experience does not therefore wholly explain the failure of CCA, although it was contributory.

The reason why it is believed to have contributed to CCA's organizational failure is related to the level at which CCA's founders chose to enter the marketplace. By building the continuum of care as the first product line and by targeting national managed care organizations as its primary marketing focus, the CCA principals were ahead of themselves and their market. The social workers overreached their understanding of industrialized managed care, their business knowledge and experience as well as their capital resources. Entering business at too high a level is the probable cause for CCA's lack of success.

This conclusion is at least suggestively supported by the findings of the Psychotherapy Finances (May, 1996) survey. In the report, a "vast majority" of the group practices surveyed had modest aspirations in dealing directly with industrialized managed care. Only a "hand full" of the groups reported having formal contracts with MCOs and/or were actively marketing managed care companies; and, a very small number, 8% of the responding groups, said they were located within a formal continuum of care. While the surveyed practices are dealing with MCOs, they are not primarily dependent on managed care oriented business. CCA's total focus on working for the MCOs appears to have

exposed the organization to a level of business operation and risk for which the social worker managers were not prepared. While managed care has been a stimulus for group practice formation nationally, most groups are not completely dependent on managed care as a source of business.

This level of entry error was compounded by the affiliation with XM. Partnership with XM was based on an apparent exchange of equal risk and value to the two organizations (Blau, 1964). XM was able to test an innovative practice design, the continuum of care, and to prospectively add an outpatient component to its inpatient services. As a national corporation, XM was well aware of the growing trend toward consolidation among hospitals and medical service organizations. XM was active in positioning itself to be a player in these consolidated systems. One month after the affiliation with CCA, in December 1993, XM was purchased by a national health care organization. Partnership with CCA allowed XM to test market and participate in this entrepreneurial innovation without any substantial risk to XM's capital resources.

In exchange XM appeared to offer the CCA principals an entry into the marketplace with a powerful partner. Affiliation with XM held out a means for the principals to compensate for their lack of training as business people, to benefit from XM's long and successful history of profitable

operation as a mental health care provider, and to have access to XM's marketing and referral capacity. On the surface this exchange looked more than fair.

In fact, the exchange proved inequitable because XM was not contractually bound to put its capital resources at risk to insure the full testing or implementation of CCA's entrepreneurial innovation. This is where the social worker partners were seriously hurt both by their lack of business experience, their excessive trust and by the level at which they choose to begin their business. They believed their personal discussions and relationship with the XM's executive staff insured that the verbal agreements and understandings would be honored.

Parenthetically, CCA's principals did have one opportunity, as the affiliation was deteriorating, to confront the XM executive most responsible for the affiliation. She agreed that the CCA/XM affiliation had not worked as either had planned, but she refused meaningful responsibility for helping CCA sustain operation through the development and implementation of a new business plan or to aid in the stabilization of the practice. When the principals suggested this lack of help was a betrayal of the relationship they had established over the two years of their association, her response was: "You know it doesn't mean a thing if it isn't in writing." CCA's attorney agreed that without a contractual hold on XM there was

little that could be done to make XM accountable for the implied intent of the CCA/XM affiliation.

When the stakes are high, and when the size and level of sophistication in operation increases, the requirement for knowledgeable and skilled business managers also increases. This is an important finding of the CCA case study, because it is a conclusion which appears not to be penetrating deeply into the thinking of those mental health care professionals who are starting group practices or taking ownership of care providing organizations.

The results of the Psychotherapy Finances (May, 1996) survey support this finding. The survey notes that providers in group practices are reluctant to be involved in expensive and complex practice organizations, yet the tenor of the information being relayed to the provider community in such trade publications as Psychotherapy Finances and Behavioral Healthcare Tomorrow and by this case study suggest that the contrary ought to be true. Sophisticated business planning, practices and procedures appear to be essential to provider owned practice success.

This advice is based on the continuation of developing trends in the industrialization of health care more solidly fixed than when the CCA project began. Behavioral health care group practice formation on the level represented by the Psychotherapy Finances survey or of CCA does not approach a defining organizational structure for mental

health care delivery in the near term, nor are there any definitive models forthcoming. Only trends can be noted. There are four which are most pertinent and were evident in the CCA experience.

First, corporate interest and domination of health care will continue to grow and will have a controlling voice in every aspect of health care policy and operation (Freeman, 1995; Robinson, 1995; Robinson, 1996). The second trend is a natural consequence of the first: competition for profits and market share will be the dominant value shaping health care policies and strategies in the near future. As part of this delivery system, providers will have to respond to these values. Participation with corporate interests will oblige providers and provider groups to share business oriented risks through such strategies as capitation and managed competition (Cave, 1996; Frank, McGuire & Newhouse, 1995; Robinson, 1995; Robinson, 1996). Thirdly, the struggle for market share and profitability will compel all health care delivery structures, including provider groups, into larger and larger organizational entities. Although Robinson (1996) believes this trend will moderate in the near future, corporate consolidation will continue as a determining force in the way in which care is structured. And finally, within these large consolidations, behavioral health, mental health and substance abuse treatment, will have to compete with all the other medical specialties for

limited resources. In these consolidated systems behavioral health is not a high priority (Psychotherapy Finances, March, 1996).

These trends profoundly shape the environment in which the CCA social workers and other mental health professional provide service. It is important to note that all are concerned with the structures of care as defined by the industrialization process, none are concerned with care technologies, processes or outcomes. This environment by its very nature requires that providers and provider groups must operate with sufficient business acumen to make their practice organizations economically stable. The CCA experience demonstrates how deeply the industrialization process affects the entrepreneurial social worker who wishes to remain active in the health care marketplace.

However, the outcome of the CCA venture also demonstrates how unprepared the social worker provider may be in responding to these trends. There is little in the experience or training of social workers that is preparatory for the kinds of problems encountered by the CCA principals from the early phases of their program initiation stage. This lack of experience in the field is true both by design and inclination. Educational programs for social workers are not tailored to train workers for the private sector. There is scant preparation for public sector organizational and program management. Much of the literature offering commentary on curriculum development suggests that training

in management and operations is one of the thinner parts of the social work course of study (Hart, 1988; Lurie, 1987; McNutt, 1995; Neugeboren, 1986). But this is also demonstrative of the lack of interest social workers have shown in macro practice issues. The vast majority of students entering the field are inclined toward direct practice, not policy or administrative science (McNutt, 1995). Perhaps it is only when threats to economic security and professional autonomy arise that the connection between direct practice and the ability to manage the organizational aspects of practice become apparent.

Although CCA's principals were aware of this deficit in their experience, they choose largely to ignore it by trusting that their affiliation with XM would make up for their deficiencies. A wiser course would have been to hire a business manager appropriately trained for their level of operation or to have training themselves for small business management. But both of these choices are dependent on a perspective gained from experience that CCA's principals did not have. The interface between the practice of social work and the practice of business is largely unexplored. The results of the CCA case study suggest that this is an area of investigation that ought to gain attention. Without this perspective operating in the field, there will be little power to effectively fulfill the aspiration of maintaining professional autonomy in an industrialized service economy.

Professional Autonomy

It is from this perspective on economic stability that the second aspiration, professional autonomy, must be discussed. Key to autonomy in professional practice is personal discretion in performing the services for which the social worker is trained. The uses of personal discretion however are dependent upon which position the social worker fills, as business person/manager the focus is on organizational maintenance. When personal discretion is exercised by the clinical practitioner, the focus is on the care needs of the client. This is not a new or unusual problem in professional care. Balancing the maintenance needs of the caregiver and the care providing organization with the needs of the client are at the heart of ethical professional behavior. However, in an industrialized system this balance becomes more difficult to maintain.

The case study is illustrative of this problem. The complexity of CCA's mission required the principal social workers to devote their capital and personal resources of time and energy to the maintenance of their business organization. They were never able to find an acceptable balance of resource allocation which allowed them to be successful as business operators and as social worker practitioners.

It is easy for providers to assign responsibility (or blame) at the feet of corporate interests for many of these

conditions or trends. However, social workers have been actively involved in the pursuit of privatized goals and interests for the past twenty years. What they do not like are the consequences of these developing models of practice which result, when the balance of business and clinical interests tilt toward the side of organizational management.

This puts social workers active in the private marketplace in a conflict about how to respond and how to use themselves professionally. If they continue to desire entrepreneurial participation in the emerging health care system, then they must do so at a level of sophistication sufficient to the level at which their entrepreneurial interests operate. Higher levels of involvement mean less time for direct practice and more resources devoted to organizational management and survival.

We recall from the introduction, that dealing with these conflicts has been a primary reason why social workers have left the public agencies for independent practice over the last twenty years. Fabricant and Burghardt (1992) demonstrate how the industrialization of social welfare in the public sector has displaced resources away from service to organizational management and survival to the detriment of service quality. Private entrepreneurial practice has been a way for social workers to circumvent this development.

Industrialized managed care has effectively narrowed the door of opportunity to the private practice strategy as

a way for social workers to circumvent the industrialization process (Gibelman & Schervish, 1993). The CCA experience is a clear demonstration of this. As the social worker principals became engaged with the details of their business, they were drawn to invest increasing amounts of money, time and energy into the operations and survival needs of CCA. While their counseling activities continued to be a primary concern, client service became increasingly a means rather than an end, a means to sustain their business. When CCA faltered it was not due to inept practice or poor clinical outcomes; the empirical evidence indicates the contrary. CCA failed as a business. One of the important findings from the CCA case study is that it is very difficult now for health care practitioners and services to privatize and not industrialize.

Industrialization changes the nature of autonomous practice as traditionally defined; that is, the perceived freedom from the control by nonprofessional or by professions other than one's own (Greene & Kulper, 1990). Industrialization by its very nature suppresses and undermines this traditional expectation of autonomy (Hillman, 1991; O'Connor & Lanning, 1992; Matthews, 1991; Schlesinger, Dorwart & Epstein, 1996; Wallace, 1995). This occurs in one of three ways as professionals become employees, managers or owners of the industrialization process. At times, as in the case of CCA, all three roles are working simultaneously to impact on practice freedom.

As employees, professional autonomy is constrained by the established rules of the corporations which employ them (Hillman, 1991). In a survey of 2,500 psychiatrist employed by health care systems, Schlessinger, Dorwart and Epstein (1996) reported that 75% experienced management pressure to limit length of stay and 50% reported that admissions of seriously ill patients to acute care were affected by the patients' ability to pay or their status as Medicaid insurees. Employee status is not new for social workers. Traditionally, social workers have functioned primarily in host settings, however what is different is the mission of the host employer. Under pre-industrialized public auspice social workers functioned as employees of agencies where the mission was defined by public service (Greene & Kulper, 1990). Under corporate auspice the mission is defined by profitability for shareholders. Advancement and success for employees within such corporate structures are more likely than not to be based on criteria related to the employees contributions to profitability (Hillman, 1991). Employee autonomy within industrialized systems therefore is constrained by the rules and incentives of the corporate mission to be profitable.

Secondly, when professionals become industrial managers their autonomy is constrained not only by corporate rules and incentives but by their corporate roles. Corporations who employ professionals have discovered that the clash between professional autonomy and corporate interest is

muted when professional employees are supervised by other professionals (Abernethy & Stoelwinder, 1995; Hefner, 1994; Wallace, 1995). Kenney (1990) notes that social workers who become managers within industrialized organizations are confronted with the necessity of finding a balance between their professional identities and their role as institutional or corporate "team players". The role of the managing professional is used by the corporation to insinuate its business interests into professional decision making. Furthermore, immersion in the organizational culture leads to some loss of attachment and identification with the manager's professional roots and values as the manager identifies with the goals of their corporate employer and not just with their profession (Kenney, 1990; Wallace, 1995).

Ownership is the third constraint on professional autonomy within an industrialized health care system. Whether as owner or as shareholder, the social worker entrepreneur becomes bound to an additional set of responsibilities when they own the process. For example, in CCA's corporate by-laws the board of directors were pledged to act in the best interest of the corporation. This fiduciary responsibility is legally binding on corporate board members by state statute. For the social worker/owner an inherent conflict is forged since the social worker is concurrently bound to a professional code of ethics that requires conduct in the best interests of the

client. This responsibility too is commended by state statute through professional certification or licensure.

Illustratively, one of CCA's principals was caught in a conflict between an MCO and a patient over the continuation of care after the MCO had denied treatment and all appeals were exhausted. Both the social worker and the client believed that symptoms of post traumatic stress continued to significantly limit the functioning of the client, and that continued counseling would enhance progress already made. The principal advised the client to protest her termination to the MCO and to her union representative. This professionally appropriate action however conflicted with the corporate interests of CCA since such protest is likely to jeopardize the affiliation between CCA and the MCO.

Apparently, such conflicts are neither atypical nor extraordinary in provider owned services. Psychotherapy Finances (July, 1996) advised its professional readers that good business relationships with managed care are jeopardized when they encourage clients to dispute or complain about MCO behavior. In a survey of provider owned practices, 62% of the one hundred respondents stated that in determining a course of treatment, "financial control" affected utilization management the most. Only 23% said the "quality of care" was the most important consideration (Psychotherapy Finances, February, 1996).

As their involvement with CCA unfolded, the social worker principals were required to fill all three roles; they functioned as employees, managers and owners with all the attending consequences enumerated above. The roles of employee and manager were more familiar from their work in the public sector, but it was in their role as owners where the most important consequences occurred for them and probably for the larger social work professional community as well. As a CCA owner put it:

I was surprised by how intrusive all the business stuff came to be. I had no idea that so much effort would have to go into trying to keep our heads above water. I went into CCA believing that I would be able to be my own boss, make some good money and do the work I love. There was a big part of me that even thought I would enjoy being a business man, being in the position of having people work for me. I felt that managed care was going to rob me of my chance to make money and stay in control of my practice. My fantasy was that CCA would put me in the driver's seat. But that turned out not to be the way things worked out. We were never really in control of anything, I think we had less freedom to do what we wanted than before, much less. I couldn't even pay my bills. All our money and effort went into keeping the operation solvent and going on, looking for a contract or finding some way to save our skins. There was no joy in it, maybe if we had made some money that would have changed things, but by the end I didn't like the business and I didn't even enjoy working with my clients.

The quote suggests there were unarticulated expectations for a particular kind of professional autonomy at the inception of the CCA experiment, an autonomy that included both the perks and rewards of business ownership as well as the freedom to engaged in self-directed clinical

practice. The speaker is addressing each of these issues simultaneously and each is superimposed upon the other. Perhaps it is this role conflict and confusion which is the most important finding of the CCA case study. As the structures of industrialized care determine the structures of care they also impinge upon and determine the process of care. It becomes more difficult to discern which thread of autonomy is operating and which end is being served. Private practice as a one person operation is less confusing and conflictual because the structure of the business is much less complicated with less capital risk. However, when a practice ownership reaches the size of CCA the challenge of discernment becomes much more complex.

This case study highlights the ways in which the social worker principals were unprepared for the consequences of their corporate experiment. Nothing in their professional experience or training provided the background for assuming the risks and responsibilities of industrialized business ownership and nothing in their professional experience or training had them anticipate its ethical dimensions. This predicament is not isolated to the CCA experiment. Participants from the comparison group expressed similar confusion. It is a consequence of social workers attempting to own their work environment in a privatized and industrialized health care economy.

Issues in Ownership

Is ownership of an industrialized social welfare organization incompatible with the social work code of ethics? If it is not, how do the conflicting values and objectives of ownership and social work practice get addressed? How does ownership relate to the goals of client focused service and social justice seeking, the hallmarks of social work ethical principles. At this time, issues of ownership are not directly addressed in the professional literature of social work. The thinking that is available relates to the social worker as employee and manager using their practice skills inside industrial structures, but not in the role of upper management or owner (Abramovitz & Epstein, 1983; Bargal & Schmid, 1992; Greene & Kulper, 1990; Kenney, 1990; Kurzman, 1984; Perlmutter & Adams, 1990; Tudiver, 1982). To discuss these issues here is premature and beyond the purview of this case study.

Research which looks at the many social workers who have entered corporate life is needed to explicate the issues. Based on the findings of this case study the research should focus on at least two areas of involvement. The first is on social workers who are executives and managers in areas of corporate work untraditional to the field. These new roles and settings may or may not present different concerns than have been found for social workers

who move into executive management positions in the public sector (Joelson, 1996). Information from these explorations will likely have an impact on planning the education for the next generation of social work practitioners and on the policies of social work professional organizations. The second focus ought to be directed at the experiences of social workers who own for-profit social welfare organizations. Clearly, industrialized ownership is an uncharted area of social work involvement.

Perceptions of Influence

Research in these emerging areas of practice is potentially important in protecting the character of social work by providing social workers inside the corporate environment with information and perspective. It might also offer clues to the field concerning ways to assume and utilize the potential influence social work might have in directing the course of social welfare industrialization. Certainly the case study is indicative of the importance of social work participation in achieving profitability for the health care industry. There are a number of responses that could follow from this realization; building a better CCA might be one; participating with and increasing the involvement of social work in all areas and phases of the industrialization process, including ownership. Other

social workers might opt out and refuse to be part of the industrialization of social welfare services, a variation on the private practice model of the last forty years. Social workers could also advocate against the current trend and seek to subvert it.

Whatever the strategic choice or choices, necessity will continue to bind corporate and social work professional interests to each other. Health care corporations need the participation of social workers to achieve their ends. Sixty five percent of all mental health care is provided by social work clinicians (Gibelman, 1995). But, as private ownership of care systems expands, social workers will have to depend on private industry for employment opportunities. In 1988 the private for-profit sector of the economy employed 19.8% of the NASW membership, by 1991, it had increases to 23.8% (Gibelman, 1995).

There may be an ethical dimension to these shared mutual interests as well. Social work clients will be dependent on privately held industrialized systems for their health care and social welfare needs. Corporate interests are now looking for ways to exploit the 1996 Federal legislation on welfare reform for private sector business opportunities (Bernstein, 1996). Ethical practice suggests that the field must continue to serve its clients where they are, increasingly inside for-profit care systems. There are few principled alternatives.

Recognition of these mutual interests and dependence may suggest ways social workers and their professional organizations might bring their influence to bears in shaping the future of service under private ownership. This influence derives from a number of critical roles and functions professionals play in the successful operation of industrialized systems. A discussion of three of these roles will be used to illustrate potential sources of professional impact.

First, corporations have come to depend upon professionals trained in autonomous and ethical conduct for the successful operation of their complex systems of care. The products and services which industrial welfare organizations offer are not amenable to routine and standardized operations; they address complex problems with complicated and unpredictable courses. As a consequence, these organizations are difficult to administer with obtrusive or highly structured forms of management control. To address their administrative problems, health and welfare corporations have come to rely on highly trained professional employees to meet the challenges of size and complexity. Social workers and other health care providers are schooled to work with the complexity of human problems and their often complex solutions. Consequently, professionals trained in autonomous behavior are a necessary and valued resource for the smooth operation of corporate

welfare (Abernethy & Stoelwinder, 1995).

The dimension of trust which corporations place in the autonomous competence of their professional employees is enhanced by the ethical character of their training. Corporations depend on professional employees to adhere to their professions' codes of ethics which fosters a perspective of working for the common good and the good of the client (Thomasma, 1992). Trading on these learned behaviors, corporations expect that professional employees will include the good of the corporation in their decision making as they balance the interest of many parties and services in providing appropriate care (Heintz & McNerney 1992). It is to the mutual benefit of both social work and executive management to recognize the importance of professional training and identification, and for social workers to insist that the character of their profession and their ethical codes be respected and maintained.

Expert knowledge of care technologies is a second source of influence inside the industrialization process which professionals may use to assert their point of view. In the CCA case study, it was clear that the social workers lacked the business knowledge and experience to operate their venture at the highest level of proficiency. The converse is also true, corporate shareholders and managers do not have the technical knowledge and experiences of the professional helper (Hefner, 1994; O'Connor & Lanning, 1992). During the current phase of the industrialization of

health care the caregiver may be at a momentary disadvantage as notions of professional roles, functions and autonomy are redefined and renegotiated. However, it is also true that unless the professionals are given the opportunity to practice, manage their behavior in ethical ways and maintain self respect, the high quality of care technologies will be difficult to maintain (Hefner, 1994). Social workers need to have a sense of this dynamic, and not lose sight of the importance their professional skills have in making the industrialization process work.

Perhaps there is opportunity in this mutual dependence. Social workers provide a vital service and with it the potential leverage to bring the interests of their clients and themselves into sharper focus. Unless this influence is recognized and played upon, the exchange between the interests of social workers and the corporations who employ them will not be acknowledged (Blau, 1964).

In their place in corporate health care, Mechanic and Light (1991) suggests that physicians have to make the distinction between their individual subjective experience of the loss of power and influence and the vital role their profession plays in making the process of industrialized health care successful. The same point might be made for social workers. The subjective experience of CCA's principals in the failure of CCA ought not be taken as an over determining experience either for the social workers

involved or for the profession as a whole. While the findings of the case study do point out some current problems that social workers have in finding a place within industrialized care, the failure of CCA ought not to be seen as a closed door to significant influence and involvement.

In evaluating CCA the importance of sensitivity to the marketplace, product development, sales and public relations, was determined to be an essential component of successful industrial operations. This finding is a potential third source of power and influence the professions have within the corporate environment. A key aspect of public trust in corporate health care derives from the accumulated trust the public has come to place in the helping professionals. Consumers of health care realize there is a vast disparity between their ability to know and understand the application of care technologies to their physical and emotional vulnerabilities and the ability of the care giver. Trust that the healer will use his or her expertise for the good of the client is at the heart of continued public confidence in corporate run health care (Blumenthal, 1994; O'Connor & Lanning, 1992).

Corporations may put their profits in peril if they ignore and underestimate the power of this public trust. While corporate interest in profitability have caused them to force the helping professions into their systems and use their rules to restrain utilization, these constraints

on professional autonomy may have their limits if the confidence of the public is to be maintained. Social workers will need to use the same techniques of marketing, sales and public relations as an opportunity to influence the corporate structures and processes which use their labor and trade on their good name.

Much of this influence is potential; how to collect it and direct it are important challenges. Professional organizations are providing education to their members about the impact of the industrialized managed care. NASW, for example, has produced a Managed Care Resource Guide (Jackson, 1996) for social workers both in agency and in private practice to serve as a primer for engaging with managed care, but this is one of hundreds of monographs and articles recently published. The professional organizations of nursing, psychiatry and psychology have also done much to inform their constituencies. For example, the National Coalition of Mental Health Professionals and Consumers, Inc., founded in 1993, has become a powerful and influential force addressing issues of public policy and legislation having to do with managed care. Over the last several years there has been a flood of conferences and professional meeting devoted to the topic.

Much of this effort has been narrowly focused on addressing issues related to the direct impact of managed care on the professions and on service delivery. The CCA

case study is reflective of this focus, but while an important concern, managed care is only one aspect of industrialized social welfare. CCA was a social work response to managed care, but as an experiment the social workers who conceptualized it did not appreciate the depth or breath of the forces at work in their entrepreneurial endeavor. To improve on future experimentation, social workers will need to broaden their knowledge and experience of social work practice and industrialized social welfare.

Bibliography and References

- Abernethy, M.A. & Stoelwinder, J.U. (1995). The role of professional control in management of complex organizations. Accounting, Organizations and Society, 20, (1), 1-17.
- Abramovitz, M. & Epstein, I. (1983). The politics of privatization: Industrial social work and private enterprise. Urban and Social Change Review, 16, (1), 13-19.
- Alexander, M.P. (1987). Why social workers enter private practice: A study of motivation and attitudes. Journal of Independent Social Work, 1, (3), 7-18.
- American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders 4th edition. Washington D.C.: American Psychiatric Association.
- American Psychiatric Association (1993). Practice guidelines for major depressive disorders in adults. Washington D.C.: American Psychiatric Association.
- Bakalinsky, R. (1980). People vs. profits: Social work in industry. Social Work, 24, (6), 471-475.
- Bargal, D. & Schmid, H. (1992). Organizational change and development in human service organizations: A prefatory essay. Administration in Social Work, 16, (3/4), 1-13.
- Barker, R. (1987). Private and proprietary services. In A. Minahan, et. al. (Eds.). Encyclopedia of social work, 18th edition. Washington DC: National Association of Social Workers.
- Barren, B.W., (1989). Avoiding under-capitalization. Small Business Reports, 14, (8), 45-50.
- Barsley, G., & Kleiner, B.H. (1990). Small business management: Ensuring your client's success. National Public Accounting, 35, (2), 30-33.
- Bartelt, R.F. & Colon, I. (1982). Implementation of goal attainment scaling in residential treatment: an administrative model. Child Welfare, 61, (7), 424-434.
- Bates, T. (1990). Entrepreneur human capital inputs and small business longevity. Review of Economics and Statistics, 71, (4), 551-559.

- Beam, H.H. & Carey, T. (1989). Could you succeed in small business. Business Horizons, 32, (5). 65-69.
- Belser, E. (1987). Marketing: A survival tool for private social work practice. Journal of Independent Social Work, 2, (2), 47-56.
- Bernstein, N (1996). Giant corporations entering race to run state welfare programs. The New York Times, CXLV, 50,551 (Sunday, Sept. 15), 1&26.
- Bickerton, R.L. (1990). Employee assistance: A history in progress. EAP Digest, 11, (1), 34.
- Bielawski, B. & Epstein, I. (1984). Assessing program stabilization: an extension of the differential program evaluation model. Administration in Social Work, 8, (4), 12-23.
- Blau, P.B. (1964). Exchange and power in social life. New Brunswick: Transaction Publishers.
- Blumenthal, D. (1994). The vital role of professionalism in health care reform. Health Affairs, 13, (1), 252-256.
- Blyth, B.J., & Briar, S. (1985). Developing empirical based models of practice. Social Work, 30, (6), 483-487.
- Bogdanich, W. (1991). The great white lie: Dishonesty waste, and incompetence in the medical community. New York, Simon and Shuster.
- Booth, R. (1995). Clinical social work: A market place appraisal. The Diplomat, 8, (3), 5.
- Borenstein, D.B. (1990). Managed care: A means of rationalizing psychiatric treatment. Hospital and Community Psychiatry, 41, (10), 1095-98.
- Boyle, R.D., & Desai, H.B. (1991). Turnaround strategies for small firms. Journal of Small Business Management, 29, (3), 33-42.
- Brazell, J.L. (1991). Starting a small business. Business and Economic Review, 37, (4) 10-14.
- Briar, S. (1980). Towards the integration of practice and research. In D. Fanshel (Ed.), Future of Social Work Research (pp. 31-37). Washington DC: National Association of Social Workers.

- Brokaw, L. (1991). The truth about start-ups. Inc., 13, (4), 52-67. Brown, P. (1990). Social workers in private practice: What are they really doing. Clinical Social Work Journal, 18, (4), 407-21.
- Bryson, J.M. (1990). Strategic planning for public and nonprofit organizations. San Francisco: Jossey-Bass Publishers.
- Budman, S.H. (1995). New clinical challenges: Managed behavioral health care and the chronic psychiatric patient. Behavioral Healthcare Tomorrow, 4, (2), 49-51.
- Carlton, T.O. (1977). Social work as a profession in process. Journal of Social Welfare. 4, (1), 15-25.
- Caroff, P. (1988). Clinical social work: Present and future challenge. Social Work in Health Care, 13, (3), 21-33.
- Cave, D. (1996). The market basket approach. Managed Healthcare, 6, (5), 46-48, 50, 53, 58-60.
- Cohen, M. (1966). Some characteristics of social workers in private practice. Social Work, 11, (2), 69-77.
- Coke, J. (1993). Government reforms, market mandates and trends in behavioral technology. Behavioral Healthcare Tomorrow, 2, (5), 1-26.
- Coleman, D. (1994). Beyond the beltway. Managed Healthcare, 4, (5), 1 & 20.
- Coopers & Lybrand. (1991). The managed care industry-1991 (Industrial Profile Series). New York: Author.
- Cornelius, D.S. (1994). Managed care and social work: Constructing a context and a response. Social Work in Health Care, 20, (1), 47-63.
- Courtney, M. (1992). Psychiatric social work and the early days of private practice. Social Service Review, 66, (2), 199-214.
- Defino, T. (1995). Carving out costs: Mental health benefits are a booming business all by themselves. Managed Healthcare, 5, (3), 26-28.
- DiGiulio, J.F. (1984). Marketing social services. Social Casework, 65, (4), 227-234.
- Dolan, B. (1994). Teen hot line. School Social Work Journal, 18, (2), 36-41.

- Donahue, J.D. (1989). The privatization decision. New York: Basic Books.
- Drew, N. (1989). The interviewer's experience as data in phenomenological research. Western Journal of Nursing Research, 11, 431-39.
- Eddy, D.M. (1990). Clinical decision making: From theory to practice: Connecting value and cost, whom do we ask and about what do we ask them? Journal of the American Medical Association, 264, 1737-1739.
- Eddy, D.M. (1993, April). Who should be measuring what about whom. Paper presented at the fifth annual Managed Care Congress, Washington, DC.
- Edinburg, G., Cottler, J. (1990). Implications of managed care for social work in psychiatric hospitals. Hospital and Community Psychiatry, 41, (10), 1063-64
- Edli, M. (1994a). The bigger the better. Managed Healthcare, 4, (2), 43 & 44.
- Edlin, M. (1994b). The urge to merge. Managed Healthcare, 4, (9), 12 & 14.
- Edlin, M. (1995). Howdy, partner. Managed Healthcare, 4, (8), 1 & 11.
- Ellwood, P.M. (1989). Shattuck lecture - Outcomes management: A technology of patient experience. New England Journal of Medicine, 318, 1549-1556.
- Epstein, A.M. (1990). The outcomes movement: Will it give us what we want? New England Journal of Medicine, 323, 266-269.
- Fabricant, M. (1985). The industrialization of social work practice. Social Work, 30, (5). 389-395.
- Fabricant, M. & Burghardt, S. (1992). The welfare state crises and the transformation of social service work. Armonk: M.E. Sharpe, Inc.
- Fellin, P. (1994). Evaluating continuing education programs for mental health professionals. Journal of Continuing Social Work Education, 6, (10), 15-20.
- Field, A. (1991). Eight steps from dream to reality. Money, Supplement, Summer, 34-42.

- Field, M.H. (1980). Social casework practice during the psychiatric deluge. Social Science Review, 54, (4), 482-507.
- Fine, S.H. & Fine, A.P. (1986). Distribution channels in marketing social work. Social Casework, 67, (4), 227-233.
- Finley, J.K. (1995). Congress seeks greater privatization of medicaid and medicare. Behavioral Healthcare Tomorrow, 4, (2), 71-72.
- Fizdale, R. (1974). Social agency structure and accountability. Fair Lawn: R.E. Burdick, Inc.
- Flynn, L.M., Panzetta, A.F., & Shumway, D.L. (1994). Can managed behavioral healthcare plans serve the severely mentally ill? Behavioral Healthcare Tomorrow, 3, (2), 40-48.
- Frank, R.G., Goldman, H.H., & McGurie, T.G. (1992). A model mental health benefit in private health insurance. Health Affairs, 11, (3), 98-117.
- Frank, R.G., McGuire, T.G., Newhouse, J.P. (1995). Risk contracts and managed mental health care, Health Affairs, 14, (3), 50-64.
- Frank, R.G., Salkever, D.S., & Sharfstein, S.S. (1991). A new look at rising mental health insurance costs. Health Affairs, 10, (2), 116-123.
- Freeman, M. (1995). Providers at the crossroads. Behavioral Healthcare Tomorrow, 4, (4), 5-6.
- Frenkel, E.R., Sherman, S.R., Newman, E.S., & Derico, A. (1984). The continuum of care within psychogeriatric day programming: A study of program evaluation. Journal of Gerontological Social Work, 7, (4), 17-27.
- Frisman, L.K. (1990). Social work and private practice opportunities. Administration and Policy in Mental Health, 18, (1), 65-77.
- Fuchs, V. (1975). Who shall live? Health, economics and social choice. New York: Basic Books.
- Fuchs, V. (1986). The health economy. Cambridge: Harvard University Press.

- Gary, W.B. (1991). Implementing managed health care (Report Number 968). Washington D.C.: The Conference Board.
- Gaskill, L.R., Van Auken, H.E., & Manning, R.A. (1993). A factor analytic study of the perceived causes of small business failure. Journal of Small Business Management, 31, (4), 18-31.
- Genkins, M. (1985). Strategic planning for social work marketing. Administration in Social Work, 9, (1), 35-46.
- Geraty, R., Bartlett, J., Hill, E., Lee, F., Shusterman, A. & Waxman, A (1994). The impact of managed behavioral healthcare on the cost of psychiatric and chemical dependency treatment. Behavioral Healthcare Tomorrow, 3, (2), 18-30.
- Gibelman, M. (1995). What Social Workers Do. Washington D.C.: NASW Press.
- Gibelman, M. & Schervish, P. (1993). Who are we: The social work labor force as reflected in the NASW membership. Washington, D.C.: NASW Press.
- Ginsberg, L. (1991). Administrative issues in the implementation and evaluation of community mental health programs: A case study. Administration and Policy in Mental Health, 18, (3), 187-194.
- Goering, P.N. & Strauss, J.S. (1994). Intensive studies of patients and the experience of investigators and clinicians. Psychiatry, 57, (2), 166-170.
- Goldberg, G.S. (1995). Theory and practice in program development: A study of the planning and implementation of fourteen social programs. Social Service Review, 69, (4), 614-655.
- Goldman, H.H., Morrissey, J.P., Ridgely, M.S., Frank, R.G., Newman, S.J., & Kennedy, C. (1992). Lessons from the programs on chronic mental illness. Health Affairs, 11, (3). 51-68.
- Goldmeier, J., (1990). Combining agency and private practice: A reevaluation. Families in Society: The Journal of Contemporary Human Services, 71, (10), 614-619.
- Goldmeier, V.J., & Wells, R.A. (1986). Private practice and the purchase of services: Who are the practitioners? American Journal of Orthopsychiatry, 56, (1), 89-102.

- Goldstein, E.G., (1996). What is clinical social work? Looking back to move ahead. Clinical Social Work Journal, 24, (1), 89-104.
- Gordon, M.S. (1984). Social work practice in health care: Some ethical considerations. S. Dillick (Ed.) Value foundations of social work: Ethical basics for a human service profession. Detroit: School of Social Work Wayne State University.
- Gordon, W.E. (1983). Social work evolution or revolution. Social Work, 28, (3). 181-185.
- Gould, B.S. (1993). Improving managed behavioral health care through outcomes management. Behavioral Healthcare Tomorrow, 2, (2), 36-49.
- Grasso, A.J. (1989). Integrating management information and program evaluation at Boyssville of Michigan. Unpublished doctoral dissertation, City University of New York.
- Grasso, A.J. & Epstein, I. (1987). Management by measurement: Organizational dilemmas or opportunities. Administration in Social Work, 11, (3/4), 89-100.
- Greene, G.J. & Kulper, T. (1990). Autonomy and professional activities of social workers in hospitals and primary care settings. Health and Social Work, 15, (1), 38-44.
- Grob, G.N. (1991). From asylum to community: Mental health policy in modern America. Princeton: Princeton University Press.
- Grob, G.N. (1992). Mental health policy in America: Myths and realities. Health Affairs, 11, (3). 7-22.
- Grobman, M. (1994). State benefit plans mirror reform efforts. Managed Healthcare, 4, (4), 40-42.
- Grosser, R.C. & Bolck, S.R. (1983). Clinical social work practice in the private sector: A survey. Clinical Social Work Journal, 11, (3), 245-262.
- Guba, E.G. & Lincoln, Y.S. (1981). Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches. San Francisco: Jossey Bass.
- Gummer, B. (1992). Ready, fire, aim!: Current perspectives on strategic planning. Administration in Social Work, 16, (1), 89-106.

- Gustavesson, N.S., & Balgopal, P.R. (1991). Training social workers in work settings: Response of the academia. Employee Assistance Quarterly, 6, (4), 79-89.
- Hart, A.F. (1988). Training social administrators for leadership in the coming decades. Administration in Social Work, 12, (3), 1-11.
- Haswell, S., & Holmes, S. (1989). Estimating the small business failure rate: A reappraisal. Journal of Small Business Management, 27, (3), 68-74.
- Hefner, L.L. (1994). Resolving conflicts between records professionals and managers: An elusive organizational goal. Records Management Quarterly, 28, (4), 14-20.
- Heintz, D.H. & McNerney, W.J. (1992). Outlook bright for provider owned systems. Healthcare Executive, 7, (4), 21-23.
- Helf, C. (1995). An update on healthcare reform in the states: Mental health and substance abuse coverage. Behavioral Healthcare Tomorrow, 4, (1), 69-72.
- Hillman, A.L. (1991). Managing the physician: Rules versus incentives. Health Affairs, 10, (4), 188-146.
- Hogan, M.F. (1992). New futures for mental health care: The case of Ohio. Health Affairs, 11, (3), 69-83.
- Holmes, J. & Riecken, G. (1980). Using business marketing concepts to view the private, non-profit social service agency. Administration in Social Work, 4, (3), 43-52.
- Hoy, E.W., Curtis, R.E., & Rice, T. (1991). Change and growth in managed care. Health Affairs, 10, (4), 18-36.
- Hutchinson, W.S. & Lewis, B.Y. (1987). Marketing social work services in the workplace. Social Work Papers, 20, 21-29.
- Huxley, P., Mohamad, H., Korner, J., Jacob, C., Raval, H., Anthony, P. (1989). Psychiatric mobility in clients of social workers: Social outcomes. Social Psychiatry and Psychiatric Epidemiology, 24, (5), 258-265.
- Jackson, V.H. (1996). Managed care resource guide. Washington, DC: NASW Press.
- Jayaratne, S., Siefert, K. & Chess, W.A. (1988). Private and agency practice: Some data and observations. Social Service Review, 62, (2), 324-336.

- Joelson, R.B. (1996). Thriving on transition from clinician to administrator: The experience of "hardy" transition-makers. Unpublished doctoral dissertation, the City University of New York.
- Kamerman, S., & Kahn, A. (1989). Privatization and the welfare state. Princeton: Princeton University Press.
- Kenney, J.J. (1990). Social work management in emerging health care systems. Health and Social Work, 15, (1), 22-31.
- Keys, P. (1988). Administrative entrepreneurship in the public sector. Administration in Social Work, 12, (2), 59-68.
- Kleinman, S. (1991). Field worker's feelings: What we feel, who we are, how we analyze. In W. Shaffir & R. Stebbins, (Eds.). Experiencing fieldwork: An insider view of qualitative research. Newbury: Sage Publications.
- Klerman, G.L. (1990). Paradigm shifts in the USA: Psychiatric epidemiology since world war II. Social Psychiatry and Psychiatric Epidemiology, 25, (1), 27-32.
- Klerman, G.L., Olfson, M., Leon, A.C., & Weissman, M.M. (1992). Measuring the need for mental health care. Health Affairs, 11, (3), 23-33.
- Knight, R.A., & Knight, L.G. (1993). Planning: The key to small business survival. Management Accounting, 74, (8), 33-34.
- Koyanagi, C. & Goldman, H.H. (1991). The quiet success of the national plan for chronically mentally ill. Hospital and Community Psychiatry, 42, (9), 899-905.
- Krieger, S. (1985). Beyond subjectivity: The use of self in social science. Qualitative Sociology, 8, (4), 309-325.
- Kurzman, P. (1984). Ethical issues in industrial social work: Towards a framework for practice. In S. Dillick, (Ed.), Value foundations of social work ethical basis for a human service profession, Detroit: School of Social Work Wayne State University.
- Kurzman, P. (1976). Private practice as a social work function. Social Work, 21, (5), 363-368.
- Kurzman, P. (1973). Third-party reimbursement. Social Work, 18, (6), 11-22.

- Land, G., & Jarman, B. (1993). In the beginning: Finding the critical pattern of success. Success, 40, (5), 80.
- Land, H. (1988). The impact of licensing on social work practice: Values, ethics, and choices. Journal of Independent Social Work. 2, (4), 87-96.
- Langley, A. (1989). In search of rationality: The purposes behind the use of formal analysis in organizations. Administrative Science Quarterly, 34, (4), 598-631.
- Lansky, D., Knudsen, K., & Werzler, H. (1993). Health outcomes accountability: Methods for demonstrating and improving health quality. Jackson Hole, Jackson Hole Group Discussion Paper.
- Lauffer, A. (1986). To market, to market: A nuts and bolts approach to strategic planning in human service organizations. Administration in Social Work, 10, (4), 31-39.
- Lazarus, A. (1995). A business plan for starting a behavioral group practice, Behavioral Healthcare Tomorrow, 4, (4), 28-32.
- Leaf, P.J., Bruce, M.L., Tischler, G.L., Freeman, D.H., Weissman, M.M. & Myers, J.K. (1988). Factors affecting the utilization of specialty and general medical mental health services. Medical Care, 26, (1), 9-26.
- LeGrand, J. & Robinson, R. (1984). Privatization and the welfare state. London: George Allen & Unwin.
- Leithwood, K.A., & Montgomery, D.J. (1980). Evaluating program implementation. Evaluation Review, 4, (2), 193-214.
- Levy, C. (1984). Values and ethics: Foundations for social work. In S. Dillick, (Ed.), Value foundations of social work: Ethical basis for a human service profession, Detroit: School of Social Work Wayne State University.
- Lewis, H. (1980). Toward a planned approach to social work research. In D. Fanshel (Ed.), Future of Social Work Research (pp. 19-28). Washington DC: National Association of Social Workers.
- Leyerle, B. (1984). Moving and shaking medicine: The structure of a socioeconomic transformation. Westport: Greenwood Press.

- Liberman, R.P., & Corrigan, P.W. (1993). Designing new psychosocial treatments for schizophrenia. Psychiatry, 56, (3). 238-249.
- Lindorff, D. (1992). Marketplace medicine: The rise of the for-profit hospital chains. New York: Bantom.
- Lindsey, R.T. (1992). Trends in managed care and behavioral health care for the future. EAP Digest, 12, (2), 32-35.
- Lohmann, R.A. (1987). Private social services in a welfare society. Journal of Independent Social Work, 2, (2), 7-19.
- Lovell, M.L., & Richey, C.A. (1991). Implementing agency-based social-support skill training. Families in Society: the Journal of Contemporary Human Services. 72, (9), 563-572.
- Lurie, A. (1987). Entrepreneurialism in health care: Implications for social work practice and education. Journal of Independent Social Work, 2, (1), 7-18.
- Lussier, R.N. (1995a). A nonfinancial business success versus failure prediction model for young firms. Journal of Small Business Management, 33, (1), 8-20.
- Lussier, R.N. (1995b). Startup business advice from business owners to would-be entrepreneurs. SAM Advanced Management Journal, 60, (1), 10-13.
- Lynn, J.T. (1991). Promise of managed care: An insurer's perspective. Health Affairs, 10, (4), 185-188.
- Maher, T. (1993). Personal publicity. Life & Health Insurance Sales, 136, (6). 37-39.
- Main, J. (1990). A golden age for entrepreneurs. Fortune, 121, (4), 120-125.
- Major, M.J. (1995). For profit or not for profit. Managed Healthcare, 5, (5), 24-28.
- Matthews, R.C. (1991). The economics of professional ethics: Should the professions be more like business? Economic Journal, 101, (407), 737-750.
- Matorin, S., Rosenberg, B., Levitt, M., Rosenbaum, S. (1987). Private practice in social work: Readiness and opportunity. Social Casework, 68, (1), 31-37.

- Mayntz, R. (1983). The conditions of effective public policy: A new challenge for policy analysis. Policy and Politics, 11, (2), 123-143.
- McCuan, E.R., Harbert, T.L., Fulton, J.R. (1991). Evaluation as an imperative for social services preservation: A challenge to the Department of Veteran Affairs. Journal of Social Work Education, 27, (2), 114-124.
- McNutt, J.G. (1995). The macro curriculum: In graduate social work education results form a national survey. Administration in Social Work, 19, (3), 59-72.
- Mechanic, D. & Light, D.W. (1991). Sources of countervailing power in medicine; Professionalism as a countervailing power. Journal of Health Politics and Law, 16, (3), 485-506.
- Mechanic, D. & Rochefort, D.A. (1992). A policy of inclusion for the mentally ill. Health Affairs, 11, (1), 128-150.
- Mechanic, D. & Surles, R.C. (1992). Challenges in state mental health policy and administration. Health Affairs, 11, (3), 34-50.
- Merlone, L. (1994). Parent education in a cross categorical early childhood program. School Social Work Journal, 19, (1), 19-23.
- Midanik, L.T. (1991). Employee assistance programs: Lessons from history. Employee Assistance Quarterly, 6, (4), 69-77.
- Mirin, S.M. & Namerow, M.J. (1991). Why study treatment outcomes? Hospital and Community Psychiatry, 42, (10), 1007-1013.
- Monkman, M.M., (1991). Outcome objectives in social work practice: Person and environment. Social Work, 36, (3), 253-258.
- Moran, D., & Wolfe, P. (1991). Can managed care control costs? Health Affairs, 10, (4), 120-128.
- NASW, (1995). Register of clinical social workers 8th edition. Washington D.C., National Association of Social Workers.
- Nelton, S. (1992). Ten key threats to success. Nation's Business, 80, (6). 18-28.

- Neugeboren, B. (1986). Systemic barriers to education in social work administration. Administration in Social Work, 10, (1), 1-14.
- O'Connor, S.J. & Lanning, J.A. (1992). The end of autonomy? Reflections on the post-professional physician. Health Care Management Review, 17, (1), 63-72.
- Olfson, M. (1990). Assertive community treatment: An evaluation of the experimental evidence. Hospital and Community Psychiatry, 41, (6), 634-641.
- Oliver, C. (1991). Strategic responses to institutional processes. Academy of Management Review, 16, (1), 145-179.
- O'Neil, H.H. & Duker, J. (1986). Survival and failure in small business. Journal of Small Business Management, 24, (1), 30-37.
- Ortiz, E.T. (1987). For-profit social services and social work education: Rapid change and a slow response. Journal of Independent Social Work, 2, (1), 19-32.
- Orwin, R.G., Goldman, H.H., Sonnerfeld, L.J., Ridgely, M.S., Smith, N.G., Garrison Morgan, R., O'Neill, E., & Sherman, A. (1994). Alcohol and drug abuse treatment of homeless persons: Results from the NIAAA community demonstration program. Journal of Health Care for the Poor and Underserved. 5, (4), 326-352.
- Oss, M.E. & Sipkoff, M.Z. (1995). How to avoid strategic planning pitfalls. Open Minds, 8, (11), 8.
- Otterbourg, R.K. (1989). The hidden agenda behind business failure. Small Business Reports, 14, (1), 19-20.
- Patterson, D.Y. (1990). Managed care: An approach to rational psychiatric treatment. Hospital and Community Psychiatry, 41, (10), 1092-95.
- Patti, R. (1978). Toward a paradigm of middle-management practice in social welfare programs. In R. Sarri & Y. Hasenfeld, (Eds.), The Management of Human Services, New York: Columbia University Press.
- Pauly, M.V., Hillman, A.L., & Kerstein, J. (1990). Managing physicians incentives in managed care: The role of for-profit ownership. Medical Care, 28, 11, 1013-1024.

- Peek, J., & Plotkin, C. (1951). Social casework and private practice. Smith College Studies in Social Work, 21, (3), 165-197.
- Perez-McCall, F. (1995). The new competitive enterprise: The behavioral healthcare PHO. Behavioral Healthcare Tomorrow, 4, (4), 35-39.
- Perlmutter, F.D., & Adams, C.T. (1990). The voluntary sector and for-profit ventures: The transformation of American social welfare. Administration in Social Work, 14, (1), 1-13.
- Petersen, C. (1994). Politics, anti-managed care sentiments stall health care reform plan in the sunshine state. Managed Healthcare, 4, (8), 9-10.
- Popple, P.R. (1981). Social work in business and industry 1875-1930. Social Service Review, 55, (2), 257-269.
- Psychotherapy Finances (June, 1995a). Crusading coalition continues to battle managed care. Psychotherapy Finances 21, (6) 1-2.
- Psychotherapy Finances (May, 1995b). Managed care: Happy days are here again for managed care executives. Psychotherapy Finances, 21, (5) 2-3.
- Psychotherapy Finances (December, 1994). Managed care: The industry is preparing for rapid growth in 1995. Psychotherapy Finances, 20, (12), 3-4.
- Psychotherapy Finances (February, 1996). Practice issues: Has the current phase of managed care run its course? Psychotherapy Finances, 22, (2), 2-3.
- Psychotherapy Finances (May, 1996). Practice profile: Here is one formula for starting a successful group practice. Psychotherapy Finances, 22, (5), May, 6-8.
- Psychotherapy Finances (July, 1996). Practice issues: Three steps to establishing a solid group practice. Psychotherapy Finances, 22, (7), July, 4-5.
- Psychotherapy Finances (March 1996). Practice issues: What does the future of behavioral healthcare look like? Psychotherapy Finances, 23, (3), 4-5.
- Psychotherapy Finances (May, 1996). Special report: It's not too late to form a group practice. Psychotherapy Finances, 22, (5), 5-6.

- Rainwater, L., & Rein, M. (1986). The public-private interplay in social protection. Armonk: M.E. Sharpe.
- Ray, C.G. & Knight, M.A. (1991). Marketing innovation to mental health providers. Administration and Policy in Mental Health, 19, (2), 93-129.
- Reichert, K. (1977). The drift toward entrepreneurialism in health and social welfare: implications for social work education. Administration in Social Work, 1, (2), 123-133.
- Reid, W.J., & Hanrahan, P. (1982). Recent evaluations of social work: Grounds for optimism. Social Work, 27, (4), 328-340.
- Relman, A.S. (1988). Assessment and accountability: The third revolution in medical care [editorial]. New England Journal of Medicine, 319, 1220-1222.
- Rindfleisch, N. & Hicho, D. (1987). Institutional child protection: issues in program development and implementation. Child Welfare, 66, (4), 329-342.
- Robinson, J.C. (1995). Health care purchasing and marketing changes in California. Health Affairs, 14, (4), 117-130.
- Robinson, J.C. (1996). The dynamics and limits of corporate growth in health care. Health Affairs, 15, (2), 155-167.
- Roper, A.S., Winkenwerder, W., Hachbarth, G.M., & Krakauer, H. (1988). Effectiveness in health care: An initiative to evaluate and improve medical practice. New England Journal of Medicine, 319, 1197-1202.
- Rosenberg, G. & Weissman, A. (1981). Marketing social services in health care facilities. Health and Social Work, 6, (3), 13-20.
- Rosenberg, G. & Weissman, A. (1995). Preliminary thoughts on sustaining central social work departments. Social Work in Health Care, 20, (4), 111-116.
- Royce, D. (1988). Newspaper exposure, community knowledge of services and marketing: Implications for the private sector. Journal of Independent Social Work, 2, (4), 19-29.
- Rubin, A. (1985). Practice effectiveness: More grounds for optimism. Social Work, 30, (6), 469-476.

- Sage, G. (1993). Entrepreneurship as an economic development strategy. Economic Development Review, 11, (2), 66-67.
- Salamon, L.M., (1989). The changing tools of government action: An overview. In L.M. Salamon (Ed.). Beyond privatization: The tools of government action, Washington DC: The Urban Institute.
- Savas, E.S. (1987). Privatization: The key to better government. Chatham: Chatham House.
- Scallet, L.J. (1995). A new order in Washington: Implications for mental health and substance abuse. Behavioral Healthcare Tomorrow, 4, (1), 75-78.
- Scarborough, N.M. & Zimmerer, T.W. (1987). Strategic planning for small business. Business, 37, (2), 11-19.
- Schlesinger, M., Dowart, R.A., & Epstein, S.S. (1996). Managed care constraints on psychiatrists' hospital practices: Bargaining power and professional autonomy. American Journal of Psychiatry, 153, (2), 256-261.
- Schnall, S.M. (1989). How business can help the human services and vice versa. Public Welfare, 47, (3), 6-17.
- Schneller, E.S. (1991). The leadership and executive potential of physicians in an era of managed care systems. Hospital Health Services Administration, 36, (1), 43-55.
- Schon, D. (1983). The reflective practitioner: How professionals think in action. New York, Basic Books.
- Schwartz, W.B., & Mendelson, D.N. (1992). Why managed care cannot contain hospital costs. Health Affairs, 11, (2), 100-107.
- Seeling, J.M. (1987). Marketing social work skills and negotiating personal contracts. Journal of Independent Social Work, 1, (4), 19-30.
- Segal, V.A. (1991). Marketing and social welfare: Matching goals and dual constituencies. Administration in Social Work, 15, (4), 19-34.
- Shapero, A. (1984). The entrepreneurial event. In C.A. Kent (Ed.), The Environment for Entrepreneurship, Lexington, MA.: Lexington Books.

- Shapiro, F. (1995). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures. New York: The Guilford Press.
- Sharfstein, S.S., & Stoline, A.M. (1992). Reform issues for insuring mental health care. Health Affairs, 11, (3), 84-97.
- Shatkin, B.F., Frisman, L.K., & McGuire, T.G. (1986). The effects of vendorship on the distribution of social services. Social Service Review, 60, (3), 437-448.
- Sherrill, R. (1995). The madness of the market. The Nation, 260, (2), 45-72.
- Shortell, S.M., Gillies, R.R., & Anderson, D.A. (1994). New world of managed care: Creating organizes delivery systems. Health Affairs, 13, (5), 46-64.
- Skipoff, M.Z. (1994). \$54 billion spent on behavioral health treatment. Open Minds, 8, (8), 12.
- Smith, B. (1981). How to prosper in your own small business: Getting started and staying on course. Brattleboro: The Stephen Green Press.
- Smith, S.R., & Stone, D.A. (1988). The unexpected consequences of privatization. In M.K. Brown (Ed.) Remaking the welfare state, Philadelphia: Temple University Press.
- Specht, H. (1990). Social work and the popular psychotherapies. Social Service Review, 64, (3), 345-357.
- Specht, H. & Courtney, M. (1994). How social work has abandoned its mission: Unfaithful angels. New York, The Free Press.
- Starr, P. (1989). The meaning of privatization. In S.B. Kamerman and A.J. Kahn (Eds.), Privatization and the welfare state, Princeton, Princeton University Press.
- Starr, P. (1982). The social transformation of American medicine. New York: Basic Books.
- Steele, W., & Hazelton, M. (1991). Perceptions and marketing positions in nonprofit agencies. Administration and Policy in Mental Health, 19, (2), 81-92.

- Stoesz, D. (1986). Corporate welfare: The third stage of welfare in the United States. Social Work, 31, (4), 245-249.
- Stoner, M.R. (1986). Marketing social services gains prominence in practice. Administration in Social Work, 10, (4), 41-52.
- Strom, K. (1993). Reimbursement demands a treatment decisions: a growing dilemma for social workers. Social Work, 37, (5). 398-403.
- Strom, K., & Gingerich, W.J. (1993). Educating students for new market realities. Journal of Social Work Education, 29, (1), 78-87.
- Surles, R., Blanch, A.K., Shern, D.L., & Donahue, S.A. (1992). Case management: Strategy for system change. Health Affairs, 11, (1), 151-163.
- Teare, J.F., Peterson, R.W., Furst, D., Authier, K., Baker, G., & Daly, D.L., (1994). Child Welfare. 73, (3), 271-281.
- Teare, R.J. (1987). National survey of occupational social work. Washington D.C., National Association of Social Workers.
- Thomasma, D.C. (1992). Health care management and ethics: In search of internal morality. Healthcare Executive, 7, (6), 31.
- Thomlison, R.J. (1984). Something works: Evidence from practice effectiveness studies. Social Work. 29, (1), 51-56.
- Thompson, R. (1988). Business plans: Myth and reality. Nation's Business, 76, (8), 16-23.
- Tripodi, T., & Epstein, I. (1978). Incorporating knowledge of research methodology into social work practice. Journal of Social Service Research. 2, (1), 65-76.
- Tripodi, T., Fellin, P. & Epstein, I. (1978). Differential social program evaluation. Itasca, Ill.: F.E. Peacock, Inc.
- Tropman, J.E. (1989). Human service entrepreneurship: The four "C" approach. Administration in Social Work, 13, (4). 219-242.

- Troy, T.N. (1995a). Managed care's merger mania. Managed Healthcare, 5, (11), 30-32.
- Troy, T.N. (1995b). That was then...this is now. Managed Healthcare, 5, (12), 18-20.
- Tryon, G.S. (1983). How full-time practitioners market their services: A national survey. Psychotherapy in Private Practice, 1, (1), 91-100.
- Tudiver, N. (1982). Business ideology and management in social work. Catalyst, 4, (1), 25-48.
- Upton, H. (1992). Management mistakes in a new business. National Petroleum News, 84, (10), 50.
- Veeder, N.W. (1991). Human service marketing: Planning and implementation. Administration and Policy in Mental Health, 19, (2), 73-80.
- Venkataraman, S., Van de Ven, A.H., Buckeye, J. & Hudson, R. (1990). Starting up in a turbulent environment: A process model of failure among firms with high customer dependency. Journal of Business Venturing, 5, (5), 277-295.
- Wagman, J.B., and Schiff, J. (1989). Managed mental health care for employees: Roles for social work. Employee Assistance Quarterly, 6, (3), 1-12
- Wagner, D. (1989). Fate of idealism in social work: Alternative experiences of professional careers. Social Work, 34, (5), 389-395.
- Wakefield, J.D., (1988a). Psychotherapy, distributive justice, and social work: Part 1 distributive justice as a conceptual framework for social work. Social Service Review, 62, (2), 187-210.
- Wakefield, J.D. (1988b). Psychotherapy, distributive justice, and social work: Part 2 psychotherapy and the pursuit of justice. Social Service Review, 62, (3), 353-382.
- Wallace, J.E. (1995). Organizational and professional commitment in professional and nonprofessional organizations. Administrative Science Quarterly, 4, (2), 228-255.
- Wechsler, J. (1995). Can managed care rescue Medicare? Managed Healthcare. 5, (4). 16-17.

- Weissman, H. (1977). Clients, staff and research: Their role in management information systems. Administration in Social Work, 1, (1), 43-51.
- Weissman, H. (1966a). Community development in the mobilization for youth experience. New York: Associated Press.
- Weissman, H. (1966b). Employment and educational services in the mobilization for youth experience. New York: Associated Press.
- Weissman, H. (1966c). Individual and group services in the mobilization for youth experience. New York: Associated Press.
- Weissman, H. (1966d). Justice and the law in the mobilization for youth experiences. New York: Associated Press.
- Westhues, A. (1980). Stages of social planning. Social Service Review, 54, (3), 331-343.
- Werrbach, G.B. (1994). Intensive child case management: Work roles and activities. Child and Adolescent Social Work Journal, 11, (4), 325-341.
- White House Domestic Policy Counsel (1993). The president's health security plan. New York: Times Books.
- Wilson, J., Adams, H., & Carlson, D. (1993). Cal-Pal: A county wide volunteer service program. Iowa Journal of School Social Work, 6, (1/2), 75-85.
- Wood, G.G., & Middleman, R. (1989). The structural approach to direct practice in social work. New York: Columbia University Press.
- Yankey, J.A., Lutz, C. & Koury, N. (1986). Marketing welfare services, Public Welfare, 44, (1), 40-46.
- Yin, R.K. (1989). Case study research: Design and methods. Newbury Park, Sage Publications.
- Zola, I. (1991). Bringing our bodies and ourselves back in: Reflections on a past, present and future. Journal of Health and Social Behavior. 32, (1), 1-16.