Occupational Therapists in Private Practice

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Although increasing numbers of occupational therapists are choosing to work in private practice, little data exist describing this sector of the profession. In the present study, experienced occupational therapists were asked about their moves into private practice, including (a) their motivation, (b) their preparation, and (c) their perceptions of the move’s risks and benefits before and after the move.

A survey was sent to a national random sample of 105 occupational therapists, 74 of whom responded. According to the survey, autonomy was the most important motivating factor for occupational therapists moving into private practice. However, once they were in private practice, the occupational therapists noted that increased income was a major benefit. These occupational therapists had planned for the risks of reimbursement, referral sources, and overhead but had not anticipated problems with staffing shortages.

Incomes increased for occupational therapists who moved into private practice. The survey compared the incomes of occupational therapists before and after they entered private practice. It also compared their income and educational levels. Other comparisons included income and work experience, income and work role, and income and geographic location.

Autonomy and financial considerations appear to be the overriding issues for occupational therapists choosing careers in private practice. Almost unanimously, the survey respondents said that private practice was a good career choice.

Reimbursement, referrals, overhead, quality control, parking, Medicare certification, liability insurance, medical insurance, tax structures, and small business loans are but a few of the concerns of the occupational therapist considering a move into private practice. With so many potential headaches, what can account for the mass exodus of occupational therapists from traditional work settings into private practice?

Literature Review

The private practitioner contracts to provide services for a fee through a small business that provides specific services. An individual practice consists of a single occupational therapist providing contracted services, whereas a partnership has two or more co-owners. An associate private practice typically has one therapist, who serves as director and employer for other professional and technical staff members of the same professional group (Punwar, 1988). The private practitioner may or may not be self-employed; a private practice may include both owners and employees. This paper presents a brief history of the private practice movement as well as current opinion.
The growth of private practice and consultation began in the 1960s, bringing with it an expansion of community services. This growth was fostered by legislation, economic issues, personnel shortages, and technology (Epstein, 1985). In 1973, 7.3% of American occupational therapists were in private practice (Hershman, 1984). That number had grown to 14.4% by 1978 and to 18.3% by 1982. By 1990, 26.4% of registered occupational therapists were self-employed (I. Silvergleit, personal communication, April 3, 1991).

The expansion of private practice is not dominated by one practice area. Occupational therapists have written about private practice in the areas of worker’s compensation and personal injury (Shriver, 1985), pediatric programming (Hinojosa, Anderson, & Strauch, 1988; Shuer & Weinger, 1985), hand rehabilitation (Hershman, 1984), upper extremity rehabilitation (Tiernan, 1991), and skilled nursing facilities (Faust & Meaker, 1991). Usero (1991) described herself as a traveling consultant; in her unique practice, she actually moves from setting to setting assessing departmental operations, systems, and programs and making recommendations for improvement.

It is unlikely that the trend toward private practice will slow. Bruhn’s (1991) projections for the 21st century included the prediction that more occupational therapists will become self-employed and begin to market themselves. Bruhn stated that, as this occurs, payment for services in agencies and institutional settings will become more acute, and institutions will use more and more contract service providers. Bruhn also predicted that in the future more occupational therapists will be consultants, private practitioners, and case or care managers.

According to Howard (1991), it is not theory or research that is driving these changes in service provision, but rather societal influences. She cited health care reimbursement as the key issue affecting the definition of occupational therapy, its practice, management, and ethics. Howard also stated that individualism and private enterprise are valued in our society, and she challenged occupational therapists to become active in health care policy.

Many occupational therapists want to establish their own pay schedules, make their own hours, and use their creativity and imagination in their own programs (Saltz, 1990). According to Epstein (1985), being in business for oneself can be exciting and rewarding, but it requires a major commitment of time, energy, and money.

Not all occupational therapists agree that the proliferation of private practice is a positive trend for the profession. Crabtree (1991) stated that referrals for profit limit free and fair competition among therapy companies and create an ethical dilemma for private practitioners. According to Crabtree, both the consumer and the occupational therapist suffer serious losses in autonomy as a result of behind-the-scenes referrals for profit. To illustrate his point, he presented the following examples of potential conflicts of interest: (a) A group of allied health professionals has a financial interest in a nursing home corporation that contracts with a private rehabilitation practice that it also owns; (b) an occupational therapist provides contract services to an acute care hospital and recommends to patients a long-term care facility where he or she also works on a contract basis; and (c) a hospital owns a skilled nursing facility where it refers patients at discharge. Crabtree noted that, in the third scenario, the possibility existed that patients with Medicare would be referred to the hospital-owned facility, but those patients with poor insurance coverage would be referred elsewhere. According to Crabtree, the reciprocal nature of referral for profit makes fair competition among occupational therapists difficult if not impossible, because both the therapist and the physician stand to gain from the constant flow of patients that occurs in some private settings.

Occupational therapists in private practice are faced not only with new ethical decisions, but also with new legal ones. Steich (1991) stated that private practitioners need an attorney to advise them on applicable laws and help them avoid liability in the areas of business organization, contracts, accounts receivable and collections, employee relations, employee benefits, insurance, and taxes. An attorney can also provide needed advice on third-party reimbursement, fraud, and abuse as well as on licensure, confidentiality, and Medicare. Steich also described sole proprietorships, partnerships, and corporations, which are the three basic types of business organizations, and listed the advantages and disadvantages of each.

Although the literature encompasses many opinions and positions on private practice, little research has been reported on the subject. In a survey of Canadian occupational therapists, 54% said a desire for autonomy was their primary reason for going into private practice (Bridle & Hawkes, 1990). They cited the limitations of institution-based practice as their second reason for entering private practice and the potential for higher income as their third reason.

In the last quarter century, the movement toward private practice has spread to a number of practice areas. This movement appears to be spawned by motives of autonomy and financial reward, and it brings with it new questions of ethics and legal needs. Grady (1991) discussed professional change in terms of being prepared for it. She stated that the process of change must be considered as important as the change itself for it to be successful.

In the present study, we asked experienced American occupational therapists what motivated them to enter private practice and what they did to prepare themselves for the move. We also asked them for their perceptions of
the risks and benefits of private practice, both before and after their move.

Method

Subjects

A random sample of 105 occupational therapists was generated from the pool of registered occupational therapists who indicated that they were in private practice in the American Occupational Therapy Association's (AOTA) 1986 Member Data Survey (AOTA, 1987). The 105 surveys were coded, but the subjects were assured confidentiality. Seventy-four (70%) of the surveys were returned. Of those who responded, 70 were female and 4 were male. The ages ranged from 27 years to 72 years, with a mean of 38 years. Based on the geographic configuration in the Statistical Abstracts of the United States, 1988 (U.S. Department of Commerce, 1987), 22 (29%) of the respondents lived in the Midwest, 19 (25%) lived in the West, 18 (24%) lived in the South, 14 (19%) lived in the Northeast, and 1 (2%) lived in Puerto Rico.

The highest degree held by 45 (61%) of the subjects was a bachelor's degree; the other 29 (39%) held master's degrees. Sixty percent of the occupational therapists in the present study described themselves as co-owners or owners of their practices. Not all of the respondents answered every question, so the total number responding varies slightly across questions.

Instrument

A two-page survey was developed, pilot-tested on a convenience sample of therapists in private practice (N = 6), and revised prior to its use in the present study. The survey was designed to provide demographic information as well as information on the motivating factors and preparation of private practitioners. The survey asked the occupational therapists for their pre-move perceptions of the risks and benefits of private practice and whether those perceptions changed once they became private practitioners. The data were analyzed with descriptive statistics.

Results

Before entering private practice, 39% of the survey respondents worked in general hospitals, 25% worked in rehabilitation hospitals, and 14% worked in school systems. The remaining 22% listed more than one setting. At the time of the study, 25% of the respondents worked in a hand clinic setting, 25% worked in a pediatric setting, and 25% worked in a home health setting. The remainder listed more than one current setting. The respondents' work experience in occupational therapy, prior to private practice, ranged from less than a year to 23 years with a mean of 7 years.

Full-Time Versus Part-Time

Eighty-two percent of the respondents reported that they had worked full-time before their move to private practice, but only 54% reported working full-time after the move. Eleven percent worked more than half-time (but not full-time) before their move into private practice, compared with 36% after the move. Seven percent worked less than half-time before entering private practice; 10% did so after their move.

Preparation

When asked to rank the three most beneficial methods of preparation for a move into private practice, 67% of the respondents listed work experience as the most beneficial. The ability to obtain information from others in private practice was listed as the second most beneficial method, and the opportunity to observe others in private practice was listed as the third most beneficial method. Formal training (e.g., workshops, texts, and courses) was mentioned less often.

Benefits

Survey respondents were asked to list the three most important motivating factors or potential benefits that influenced their decisions to enter private practice. The most common answers to this question related to autonomy. In order of importance, respondents ranked flexible hours first, being their own boss second, and independence in clinical decisions third. Once in private practice, their perceptions changed little. Flexible hours and being their own boss was still ranked first and second; however, the potential of an increased income was ranked third.

Risks

The subjects were also asked to rank the three potential risks they had perceived as greatest before their moves to private practice and the risks they perceived as greatest now that they were private practitioners. Respondents ranked reimbursement as the highest perceived risk and referral sources as the second highest risk both before and after the move into private practice. Respondents considered problems with overhead (e.g., rent and equipment) to be the third highest risk before they moved to private practice; however, after the move, they considered problems with staffing shortages the third highest risk.

Income

The present study indicates that occupational therapists who move to private practice experience dramatic salary changes (see Figure 1). For example, only 4% of the survey's respondents made $35,000 or more before they
moved to private practice; 87% earned this income after they moved to private practice. Several different comparisons were made relative to income.

**Income and Education**

We looked at the occupational therapist’s income in relation to his or her level of education. Of the full-time private practitioners with bachelor’s degrees, 50% had annual incomes above $50,000, and another 17% had incomes between $45,000 and $50,000. Of the full-time occupational therapists with master’s degrees, 43% had annual incomes above $50,000, and another 4% had incomes between $45,000 to $50,000.

Of those occupational therapists with bachelor’s degrees who worked part-time but more than half-time, 20% made more than $50,000 a year. Of those occupational therapists with master’s degrees who worked part-time but greater than half-time, 11% made more than $50,000 a year. It appears a master’s degree is not a financial advantage in private practice.

**Income and Work Experience**

The number of years of work experience (combining both prior work and work within private practice) does relate to income. More than $50,000 a year was earned by 67% of those with 11 to 15 years of work experience, 62% of those with 6 to 10 years of work experience, and 55% of those with 0 to 5 years of work experience. Respondents who earned $45,000 to $50,000 a year included 17% of those with 11 to 15 years of work experience, 20% of those with 6 to 10 years of work experience, and 11% of those with 0 to 5 years of work experience.

**Income and Work Role**

We also compared the incomes of owners and co-owners with the incomes of occupational therapists who had employee status (see Figure 2). Sixty-one percent of the owners and co-owners who worked full-time had incomes above $50,000 a year, compared with 25% of the occupational therapists who worked full-time as employees. Figure 2 also shows that 19% of the owners and co-owners who worked full-time were in the $45,000 to $50,000 income category, compared with 8% of the full-time employees. More employees than owners and co-owners were at the lower ends of the income scale.

A similar comparison was made for those who worked part-time but more than half-time, and similar trends emerged. Of these owners and co-owners, 30% made more than $50,000 annually, compared with 15% of the employees. Another 15% of the part-time owners and co-owners were in the next income category of $45,000 to $50,000, compared with 10% of the part-time employees. Of the part-time employees, 40% earned $30,000 to $35,000.

**Income and Geographic Location**

Figure 3 shows a comparison of salaries by geographic location for full-time private practitioners. The highest incomes were reported in the Northeast, followed by the South. The Midwest and the West reported lower incomes.
Opinion Regarding the Move Into Private Practice

The survey asked the occupational therapists to respond to the statement, "The move into private practice has been a good career choice for me," using one of the following ordinal answers: (a) strongly agree, (b) agree, (c) neutral, (d) disagree, or (e) strongly disagree. Responses were as follows: 68% strongly agreed, 28% agreed, 3% were neutral, 0 disagreed, and 1% strongly disagreed. Survey participants were asked in an open-ended question what the overriding variable was in their decision to move to private practice. Among those who strongly agreed or agreed that their decision to move to private practice was a good one, the most common answers in order of prevalence were flexibility of hours, personal satisfaction, independence with decisions, an increased income, the opportunity to specialize, and more control for quality care.

Discussion

The 70% response rate to the present study is good; however, the sample size is small, given that one-quarter of the profession (10,000 members) is in private practice. Replication of this study with a large sample size is needed.

A number of trends are noted. Those who moved from traditional work settings to private practice tended to move from full-time to part-time work. Those who responded to this survey appeared to have been prepared for the move; they used their work history and observation of others as preparation. However, this may not reflect the current trend. The occupational therapists in the present study's sample were selected from the 1986 Member Data Survey (AOTA, 1987) and had already been in private practice for several years. Recently developed educational resources such as Private Practice: Strategies for Success (Hertfelder & Crispen, 1990) and workshops on the local and national level were not available in the early 1980s. It would be interesting to learn whether occupational therapists who are currently entering private practice are using more formal avenues of training to prepare for their moves.

It is interesting to note that the perceived risks and benefits before and after the move into private practice were similar. These occupational therapists had done their homework and were ready for the benefits of flexible hours and autonomy as well as the risks of reimbursement and referral sources. It appears the therapists were less prepared for the salary increases and the problems with staffing shortages they experienced once in private practice. Staffing shortages have spiraled nationally in the last few years, becoming a worry not only to those in private practice but also to employers in medical, educational, and community arenas.

Although the salary increases may seem graphic, two basic limitations must be considered when interpreting the data. First, the pre-private practice salaries that the respondents reported were an average of 6 years old. Additionally, the study did not take into account the cost-of-living and potential merit raises the occupational therapists may have received if they had stayed in traditional work settings. It did not account for general inflation either. Therefore, it may be assumed that a portion of the gain is due to a general rise in salaries across years. Second, this survey did not address issues of management costs and benefits as a separate salary issue. Questions were simplified to consider only income. We assume the respondents reported accurate information; however, it is possible that the respondents did not calculate the loss of such benefits as health insurance and malpractice insurance into their differential incomes (before and after the move). In this regard, the survey provides a simplistic analysis.

Having a master's degree does not appear to be a financial benefit to the private practitioner, but having substantial work experience does. Those who worked in what might be considered the high-risk categories of owner and co-owner actually made higher salaries than employees of an associate practice. This was true for both full-time and part-time workers. Incomes did vary somewhat by geographic location. Although incomes in the Northeast were highest, when the cost of living is taken into account, those in the South may actually see the largest financial gain by moving to private practice.

The high degree of satisfaction reported with the move to private practice is encouraging. These results are tempered by the possibility that some of the 31 occupational therapists who chose not to return the survey may have done so because they were not happy with their career choices and had returned to their original practices. It would be interesting to see if similar findings would emerge in terms of motivating factors, preparation, and perceived risks and benefits from a survey of those who have made a more recent move into private practice.

References


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