Private Practice Occupational Therapy in the Skilled Nursing Facility: Creative Alliance or Mutual Exploitation?

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Occupational therapy private practice appears to play a major role in the provision of rehabilitation services in skilled nursing facilities. A critical look at the meaning of private practice, however, indicates that many of today's private practitioners lack characteristics traditionally associated with that term. Group private practices are well suited to retain the essential qualities of private practice while competing effectively in a corporate environment. They accomplish this difficult task by applying therapeutic principles of growth and change to the complex relationship between the group practice and the skilled nursing facility. Application of these principles allows the occupational therapy group private practice to behave consistently with its professional identity while addressing the competitive demands of the marketplace.

The latest member data survey from the American Occupational Therapy Association (AOTA) (1990) reported that more than 8,000 occupational therapists, or over 25% of the profession's total personnel, work in private practice and that this is our fastest growing sector of employment. This suggests that a substantial proportion of therapists within what has traditionally been an ancillary health profession are now entrepreneurs. Our observation of practice patterns in geriatric occupational therapy and, specifically, long-term-care facilities, fails to confirm such an assumption. A critical look at AOTA's private practice count, therefore, encourages one to examine the definition of private practice.

A common misconception is that any therapy contractor is in private practice. Having a contract with an agency or facility does not make one a private practitioner, nor does it necessarily make one self-employed. The Internal Revenue Service, for example, is intensifying scrutiny of companies that fail to withhold payroll taxes from alleged independent contractors who do not meet stringent tests of self-employment. Back taxes and penalties are levied against violators (Internal Revenue Service, 1991). The first requirement of self-employment, therefore, and, in turn, of private practice, is the ability to function in an autonomous manner as a businessperson.

Other common assumptions about private practice may no longer apply even to the professions that originally engendered them. For example, countless movies and TV series have immortalized the country doctor who, with black bag in hand, travels from town to farmhouse, is paid in produce or chickens, and is intimately associated with community affairs. Today, few doctors carry black bags, they rarely make house calls, they are far more likely to take credit cards than produce, and they are insulated from direct contact with the community. Private practice has become like big business. This example illustrates a second aspect central to the traditional concept of private practice. We assume that work behavior in private practice is guided largely by professional norms and values and not entirely dictated by financial considerations.

Some occupational therapy private practitioners, such as expert witnesses or hand therapists, do operate autonomously. Many of them show exceptional levels of professionalism and dedication. Certain areas of today's health care environment, however, place any solo practitioner, even the most skilled, at a disadvantage. The skilled nursing facility represents just such an environment.

Superficially, this setting appears to be the site of tremendous private practice growth. In the 8 years since the introduction of payment for hospital care by diagnosis-related groups, conventional employment of occupational therapists by nursing homes has remained static (AOTA, 1990). Concurrently, the volume of occupational therapy services provided to nursing home residents has increased as hospital stays have shortened. Assumably, contract providers have supplied the increased personnel required.
Large organizations are flourishing in geriatric care because skilled nursing facilities are scrambling to implement staffing models that provide high volumes of skilled therapy services to their clients. Medicare reimbursement practices encourage facilities to purchase occupational therapy services through contracts written at high hourly rates with guarantees of conformity to Medicare standards. This is a systemized model of health care requiring standardization and the mobilization of large numbers of staff. Organizations, not solo practitioners, are most competitive in this area of practice.

Big money is involved in Medicare-reimbursed health care. In the late 1980s, corporate managers with no therapy background began directing some of the largest therapy providers. Marcial (1990) reported that annual revenues for one of the largest of the rehabilitation providers will exceed $90 million in 1990 after several years of approximately 35% annual growth. Additionally, a number of therapist-owned businesses competing for nursing home contracts have several hundred employees and may use management styles pioneered by non-health-service businesses, such as secretarial and accounting services.

What, then, is the role of private practice in the expanding nursing home therapy market? The solo practitioner usually lacks the autonomy we associate with private practice and has trouble providing the required staffing levels. The corporate provider’s management style tends to be incompatible with that of private practice, which is characterized by low levels of internal bureaucracy and organizational behavior directed by professional values and norms. Is there a competitive private practice model that embodies the essential elements of private practice?

Group private practice organizations incorporate the three key elements of private practice: high autonomy, strong professional identity, and low bureaucracy. Furthermore, such organizations, if they are managed in a way consistent with sound business principles, offer occupational therapists the best prospects for satisfying, successful involvement in long-term-care rehabilitation. Identified below are characteristics of an organization that allow it to function with autonomy, professionalism, and creativity, in sum, as a private practice.

The Integrated Model of Consultation: Recognizing the Human Face of the Organization

Unfortunately, occupational therapists tend to distance themselves from reimbursement, business, and administration—topics that are intimately related to the functioning of organizations. Yet we have excellent tools for understanding organizations in our models of human occupation and activity. Organizations tend to function much like the persons within them. Therapeutic principles of occupational therapy applied to organizations give us a way of understanding the interaction between the occupational therapy service provider (i.e., the therapy company) and the skilled nursing facility. Theoretical principles can also be used to understand the internal functioning of the therapy company and the skilled nursing facility and the subjective experience of the persons working within them.

An occupational therapy model of organizational behavior looks at function more than at structure. Structural elements within organizations are important and diverse. These elements include nurses or therapists, management, and support staff; hardware and software; and financial, technical, and informational resources. An occupational therapy model, however, focuses instead on the capacity of organizations to function in occupational roles.

The Therapy Company as Organism

For the therapy company providing services to the skilled nursing facility, four occupational roles are essential to the fulfillment of its mission. The therapy company must perform effectively in each role if it is to succeed, and the roles must be integrated if the company’s staff is to identify clearly with its mission.

The therapy company fulfills its clinical role through its capacity to provide professional quality therapy services to individual residents of the skilled nursing facility. These services address functional goals and promote continuity of care with other service providers.

The therapy company’s management (consulting) role involves interpretation of occupational therapy principles in ways that are accessible to the skilled nursing facility and enhance its environment for skilled rehabilitation and client functioning.

The third occupational role of the therapy company, the administrative role, involves provision of clinical and management services with a sophisticated awareness of the skilled nursing facility’s reimbursement system. The administrative mission of the therapy company also includes the distribution of resources within its own organization so as to facilitate and motivate personnel to provide the best possible rehabilitation services.

The last aspect, the professional role of the therapy company, serves to integrate behavior in the other three roles so as to be compatible with the underlying professional and ethical principles of the service being provided. Part of this ethical orientation means verification that the value of the service is cost-effective in relation to the social benefit that justifies its funding.
The Skilled Nursing Facility as Organism

The skilled nursing facility also has an overriding mission that should guide its behavior. Effective performance in its occupational roles is essential if the facility is to carry out this mission successfully. The therapy company staff evaluates and facilitates the skilled nursing facility's functional performance in each of these roles in order to assume a therapeutic relationship with the facility.

The clinical role of the skilled nursing facility is embodied primarily in the individual resident's comprehensive care plan, which includes interventions in the areas of nursing, rehabilitation, activities, and social services. Clinically, the facility is responsible for the overall care of each resident.

In its management role, the skilled nursing facility coordinates clinical services so that they interact in a compatible, complementary fashion. We maintain, as does the 1987 Omnibus Budget Reconciliation Act (Public Law 100–203) (Health Care Financing Administration, 1989), that the facility should emphasize the resident's experience of life as meaningful and of activity as purposeful. Additionally, this management role includes the coordination of staff in such a way as to enhance their competence and their commitment to accomplishing the facility's mission.

In its administrative role, the skilled nursing facility uses financial resources to accomplish its objectives. The skilled nursing facility must secure funds and allocate them toward necessary staff, facilities, services, and equipment. Within a private enterprise economic system, the facility also faces an administrative mandate to produce returns on investment for shareholders.

The skilled nursing facility must perform in a professional role because it, like the therapy company, operates within a sociopolitical environment that requires approval from public and private payers. Their support depends on the perception that the skilled nursing facility is fulfilling its mission to care for the frail elderly.

The Contractual Relationship as Therapeutic Interaction

A number of therapeutic principles central to occupational therapy clarify the relationship between the therapy company and the skilled nursing facility. As occupational therapists, we assume that effective, purposeful activity enhances functioning and life satisfaction. We believe that function tends to define the nature of the organism. We recognize intrinsic motivation toward integration within the organism and the drive to respond adaptively to the environment. We recognize that stability provides a foundation for mobility, but that at times mobility must be initiated prematurely to establish the conditions necessary for stability.

In enhancing growth, we are aware that positive stimuli are integrated most easily, and painful ones are generally resisted. We sequence intervention to allow change to proceed according to intrinsic developmental stages. Enhancement and facilitation of a client's intrinsic motivation, activity, and values assists with movement toward inherent potential. We avoid imposing our own standards or predetermined criteria for the outcome.

Therapeutic principles also influence the development of the therapy company and its staff. The therapeutic relationship involves assimilation and accommodation between therapist and client. Both are affected and grow through the interaction. For the therapist, this means professional development through the mobilization of creative capacities toward the enhancement of the client.

Viewing Health Care Through the Therapy Metaphor

Because of favorable reimbursement for therapy services, the skilled nursing facility has become a motivated client in relation to the therapy company's efforts to help. Administrators of skilled nursing facilities have learned that residents and programs can benefit from skilled rehabilitation services and that their costs can be passed on to Medicare, which actually improves the facility's profitability. In turn, therapy companies have discovered that skilled nursing facilities are willing consumers of occupational therapy services at a time when other markets, such as hospitals, are shrinking due to cost-control measures. This situation has allowed rapid expansion of the occupational therapy work force in the skilled nursing facility as well as improved status for the geriatric clinician seeking upward mobility.

This practice area has become competitive, thus inducing the therapy company to offer additional services. For example, the company may assist the skilled nursing facility with marketing rehabilitation services to build volume, or the therapy company staff may work with facility staff to coordinate rehabilitation services into the rest of the facility program. The company may provide in-service training on therapy principles to the skilled nursing facility staff. Finally, the company may provide consultation to restorative programs and develop procedures for a facility-wide rehabilitative approach.

This type of involvement of the therapy company in the skilled nursing facility tends to integrate the facility's overall care approach. It can shift the facility's approach away from custodial care to enhancement of the resident's function and autonomy. How does the therapy company promote this integration systematically?

The nursing facility as client. The therapy company staff visualizes the nursing facility as a client whom they are trying to assist toward inherent potential for integration. This therapeutic stance involves meeting the facility at the state in which one finds it, offering opportunities without imposing perspective, and aligning with the facility's strengths. For example, if a suggested, much-need-
ed program change meets resistance, the staff member must recognize the facility's response as indicative of its current state and growth potential and adjust the intervention accordingly.

Just as successful therapy is based on a grasp of human anatomy, physiology, and development, successful consulting requires an understanding of the underlying organizational structures and dynamics. The consultant must avoid preoccupation with dysfunction. Symptoms of underlying facility problems might include poor nursing care, difficulty with planning, or a management style that tends to leave key staff people feeling pessimistic or demoralized. One must develop a relationship of advocacy, tempered with thoughtful criticism, in one's perception of the facility.

Long-term-care biases. The therapy company staff member must be prepared to challenge biases or distorted perceptions about long-term care. Many persons working in skilled nursing facilities, whether staff members or contractors, perceive their facility as an inherently ineffective system that resists all efforts to effect change. They may perceive the facility as an organization so unmotivated toward growth that it does not deserve genuine alignment. At other times, staff members conclude that the facility is incapable of or disinterested in promoting the resident's positive change. Although these perceptions may possess an element of truth, they ignore the facility's potential for growth. They usually serve to protect the therapy company staff member from the complexity of the facility and from meeting the challenge of consulting.

To change negative biases, the therapy staff must acknowledge the characteristics of the environment that engender negative perceptions. Otherwise, they will fail to change the attitudes of outsiders, of insiders, or even of the therapy company staff themselves. These characteristics include the frailty of the population, the ubiquity of physical and mental infirmity in the setting and its effect on morale, and the expediency of custodial care. Facility management styles rarely show the holistic perspective best suited to rehabilitative care, and high staff turnover is common. Acknowledgment of these characteristics and the feelings they evoke is a precondition to changing them.

Success builds on success. Through the resolution of some of the internal problems within the facility, positive, quantifiable changes, such as improved reimbursement, lower staff turnover, and better surveys, occur. Such changes increase administrative attention to therapy recommendations.

An empathetic yet practical perspective. The therapy company effects change in the skilled nursing facility by maintaining an empathetic yet practical perspective on the facility's behavior. This involves one's engaging in the facility while detaching from its symptoms and from one's personal reaction to them. The therapist must focus on the underlying issues that make the facility dysfunctional and not just on the narrow provision of technical occupational therapy services. Occupational therapists are generally more comfortable treating a client's holistic functioning than they are intervening in a complex care provision system. The same principles used in clinical rehabilitation, however, can be applied to the facility's functional problems. This task is an integral part of the job of a consulting therapist.

The therapy company can effect change by applying a developmental perspective to organizational functioning. This involves the identification of key components in the facility (e.g., staff, facilities, departments, information), the knowledge of how they interact and function normally, and the building of skills and compensatory techniques to allow the system to accomplish organizational goals.

Internal stability. The therapy company must create stability within its own organization so that it can interact therapeutically with the skilled nursing facility. The therapy company staff member entering a skilled nursing facility will encounter a system that has requested intervention and expects change, but that may be ill-equipped to plan those changes or carry out suggested interventions. Such a facility presents a confusing lack of structure, which the staff member must approach with a clear understanding of appropriate concepts and strategies for change. These concepts and strategies must originate in the therapy company's system of training, supervision, and support.

The therapy company must provide a grounding in occupational therapy principles and concepts to prevent its staff from being overwhelmed by a confusing progression of perspectives originating in the skilled nursing facility. An understanding of the conceptual framework for intervention assists therapy staff to establish a clear boundary when providing services within a system that is needy and off balance. A feeling among staff of belonging to a supportive network of therapists will allow meaningful engagement with the facility without absorption in its problems.

The therapy company must provide a context in which staff members can interpret their personal responses to the environment of the skilled nursing facility while maintaining a detached perspective on difficult issues. It must provide interactive experiences for the sorting out of complex dynamics. Solutions are facilitated in the supervision process, rather than imposed on the therapist identifying the problem. Finally, the therapy company must provide a source of regeneration and a position of empowerment for its staff in order to decrease stress and allow staff to intervene effectively in seemingly unmanageable situations in the facility.

This dynamic interaction between the therapy company and the skilled nursing facility leads to effective performance in each of the four occupational roles critical...
Although the contractual interaction between the skilled nursing facility and the therapy company provides exciting opportunities for a creative alliance, actualization of these opportunities for integration rarely occurs. What is it that undermines this potential?

**Lack of managerial support.** Without management’s support, the therapy company staff member loses the base of stability that would allow for a positive effect on the skilled nursing facility. Placement of the therapist in the skilled nursing facility without provision of a conceptual framework to interpret its problems can make the therapist a cog in a malfunctioning system. The therapist experiences contradictions in the facility’s functioning that create dissonance in reference to occupational therapy principles. Without support, the therapist is helpless to influence these contradictions or even to maintain distance from them.

**Conflicting attitudes.** Conflicting attitudes toward rehabilitation in the skilled nursing facility reflect society’s inability to bring technological medicine into perspective with issues of death, aging, and physical survival with dignity. Failure to address these abstract ethical issues leaves the therapy company staff member ambivalent about his or her professional self-image, the value of the work, and the degree of engagement in the treatment process.

### Big Business and Health Care: The Effect of Reimbursement on Therapy in the Skilled Nursing Facility

An integrated model for therapy intervention in the skilled nursing facility has been presented above. In this model of consultation, the occupational therapy company interacts therapeutically with the client and the skilled nursing facility in a way that promotes integration and growth for both. This is indeed a creative alliance. Other interactional styles between the facility and the therapy company are possible, however, and are indeed prevalent. In such relationships, the interaction tends to be exclusively economic. The administrative role of both the skilled nursing facility and the therapy company dominates organizational decision making. Activities related to their clinical, managerial, and professional roles continue but are poorly integrated with the administrative role and are therefore ineffective and inconsistent. The interaction can bring about financial gains to both parties without addressing their overall health care missions. The relationship is mutually exploitive.

Because this exploitive relationship between the skilled nursing facility and therapy company is defined by economics, we must examine the funding mechanism that allows such relationships to flourish. Cost-based reimbursement funds Medicare services in skilled nursing facilities. This accounting system limits reimbursement to the cost of services provided, but it provides financial benefits to facilities in the form of reimbursement for a portion of fixed overhead costs that are allocated to the therapy program. The greater the use of therapy and the higher the costs the facility incurs, the greater overall reimbursement it receives. Control over rates paid by skilled nursing facilities for occupational therapy services are left so vague in the Medicare regulations as to be largely unenforceable.

Cost-based reimbursement is a system that allows and even invites abuse, even though it can also transform a nursing facility into a far healthier environment. The potential for abuse of cost-based reimbursement can be traced to the reversal of the normal influence of competition in a free-enterprise system. Competition is supposed to ensure that the most efficient producer of goods or services eventually captures the largest market share. This producer prevails due to the superior quality and price of his or her product, and the consumer benefits. But this only occurs if two conditions are present: (a) the consumer chooses the goods or services to be purchased and (b) the consumer’s choice is based on a desire to maximize value of what is purchased in relation to what is paid.

This point can be illustrated with a simple example based on commonplace experience. When I buy bread at the market, I choose the cheapest loaf among loaves of equal quality. If one baker’s bread is better, I buy it if the prices are equal. I may even buy it if it is more expensive, but only if the difference in quality is greater than the difference in price and only if I can afford to pay for better quality. Thus, as a discriminating buyer, I take advantage of the choices offered by the marketplace, and because I have choices, competition between bakers works to my benefit.

The dynamics of the marketplace change, however, when a third party pays for the commodity, as occurs when the skilled nursing facility purchases skilled therapy services. According to the terminology of the bread-buying analogy, I am no longer buying bread for myself; as a nursing facility administrator I am instead a distributor and am buying for other people who have bread insurance. I do not get a traditional middleman markup; instead, I am paid a percentage markup based on the cost of the bread and my costs of serving it to my clientele. In this case, I am no longer a discriminating buyer; I am indifferent to the price and quality of the bread, unless the insurer and my clientele place guidelines on my purchase. If the insurer dictates that only bread will do and not muffins or crumpets, regardless of the consum-

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ers’ preferences, my choice is further restricted. Competition seems eliminated from the marketplace.

But there are many bakers out there. They are delighted that I am not concerned about their price. Let us now assume that the insurer not only reimburses me for my costs in handling the bread, but also pays me a little extra for the use of my warehouse to store it and for my cooks who are already on payroll. The bigger the chunk of my total budget represented by bread, the greater the reimbursable portion of my overhead costs. In this situation, my orientation to competition is inverted. Instead of looking for the cheapest baker or the one with the best bread, I want a high price so that my bread budget is high.

I want the baker to identify as much need for bread as possible (not as little as possible) in order to increase my bread use. I want a baker who has expertise in the concerns of the bread inspectors, rather than one who caters to the tastes of the bread eaters.

Competition in such a situation can become uncontrollable. I choose a baker who meets my priorities. Not to be outdone, a second baker raises his price yet higher and becomes even more clever in identifying those eligible to receive the bread. Other bakers throw in premiums, such as butter and jam, and charge still more to finance them. A form of competition flourishes in this cost-based reimbursement system, but it is not competition driven by the consumers’ needs or choices.

This situation may seem oversimplified, but it bears an uncomfortable resemblance to today’s marketplace for long-term-care therapy services. The resemblance is uncomfortable because the situation does a disservice to the intended beneficiaries and invites regulatory intervention that will penalize the providers. In our analogy, we can expect that once the bills for inflated bread catch the insurer’s attention and provided that the bread consumers agree to changes in the system, there will be no more free lunch for the bakers. Similarly, if we, as suppliers of therapy, lose touch with the interests of the consumer, we lose support for our services, and we deserve to lose that support.

This is a plausible interpretation of what happened to physical therapy 8 years ago. Salary equivalency was introduced as a control on cost-based reimbursement (Health Care Financing Administration, 1983). Under this system, the nursing facility can pay a contractual supplier of physical therapy services for little more than it would to hire the same therapist. This is like telling the bread distributors that the takers they use must supply bread for barely more than the cost of their ingredients. One would not expect the bakers to stay in business for long under this system. In actuality, physical therapy contractors seem to have decreasing influence in the staffing patterns of skilled nursing facilities. In many cases, the potential benefits of physical therapy for the client and the facility have gone out with the therapists. Ironically, the resident and facility probably underestimate their loss, because their real needs were not addressed by the previous provision system. Profit was a disproportionate motive.

Demographic trends that tend to increase both the numbers and the needs of the elderly are no assurance of a role for occupational therapy in long-term care. Therapy services shaped solely by a lucrative business opportunity rather than by our clients’ needs will eventually lose their public and financial base of support, regardless of the numbers of aging Americans.

**Resolving the Paradoxes: The Group Practice Model**

Is it in society’s and the elderly’s best interests to promote and reimburse a strong therapy involvement in the skilled nursing facility? One can argue that, although there have been some abuses, the cost-based reimbursement system has given the disabled elderly an opportunity for improved function that would otherwise have been denied to them. The answer to this question will ultimately emerge out of the professional behavior of therapy providers within the skilled nursing facility. If we provide services in a way that meets a true underlying need, society will likely be willing to pay for them. We must find a model of service that allows us to remain financially viable, to realize our clinical potential, and to remain grounded in a stance of professional integrity.

The long-term-care facility and the contracting occupational therapist must make a choice. One alternative is cost-based reimbursement as a pure business opportunity. The apparent sophistication of this approach may appear to elevate the prestige of the practitioner, but it takes us farther from an integration of behavior based on a therapeutic relationship with the facility. It is a path through territory that is likely to shrink as cost-based reimbursement is eliminated or controlled.

The other alternative follows a creative path that attempts to respond to genuine rehabilitation needs with interventions that are financially feasible, enterprising, and able to produce outcomes that stand up under scrutiny of value versus cost.

Solo private practitioners have difficulty operating on the scale of service provision demanded by the skilled nursing facility. The larger therapy providers are ill-suited to integrate business, clinical, and professional aspects of their organizational mission.

The group practice model offers a unique opportunity to integrate the four roles of the therapist who is operating within both business and professional arenas. If the therapy company’s mission is to interact therapeutically with the facility, its nervous system (i.e., administration) must be attuned to both financial and clinical priorities. This requires synthesis of apparently contradictory roles and can happen only if management is fundamentally grounded in clinical principles and values.
A group practice approaches the various roles of its practitioners from a developmental perspective. The entry-level therapist operates with a primary focus on the individual relationship with the client. This perspective matures to a more sophisticated awareness of the client's performance in a broader environmental context. Expertise then develops within the management consultation model. The staff member's skill is finally mature once he or she achieves a grasp of the complex administrative relationship with the nursing facility. An understanding of this relationship is necessary for the development of a viable therapy service in the long-term care environment.

The occupational therapist offers an invaluable contribution to the skilled nursing facility if he or she can integrate varying roles as clinician, consultant, administrator, and independent professional. This setting, with its emphasis on curing the sick, presents a host of contradictions to comprehensive care of the frail elderly. Occupational therapy is equipped to address uniquely environmental and contextual issues that affect quality of life. Physical impairment, behavioral difficulties, the need for extensive medical care, and infirmity all tend to undermine the nursing home resident's freedom and self-determination. Occupational therapy can provide the nursing facility with the tools and skills necessary to enhance human dignity and freedom.

These resources are found in occupational therapy's fundamental orientation to activity. Once the disease is treated and the safety needs and bodily functions of the person are addressed, it is the resident's self-directed, purposeful activity that either breaks down or creates dignity in life. In occupational therapy's pure form, the occupational therapist inflicts no treatment on the client, but instead listens, watches, and attends to the resident's engagement in the environment, no matter how tentative or ineffective. This intervention builds on ability, not disability, and values accomplishment, not elimination of problems.

This approach allows us to mobilize resources against the impotence of disability without obliterating the substance of the client. Overzealous efforts to cure can eliminate not only the problem but also the client's autonomous life force. The capacity of occupational therapy to establish a durable position in the field of long-term care hinges on its commitment to aligning with the activity of the frail elderly person. For the individual therapist, this means reconciling the paradoxes of rehabilitation and aging. For the therapy company, it means reconciling the constraints of finite resources with an ethical response to the rehabilitative needs of the aging population. The group private practice model in long-term care, to the extent that it reconciles the contradictions of involvement with the facility and the individual and of business and professional calling, facilitates the unique contribution of occupational therapy to gerontology and to the long-term care facility.

References


