Radical changes in the health care environment necessitate reevaluating the management skills and competencies required of occupational therapy practitioners. This is true whether focusing on the entry-level practitioner, whose primary concern is client care, or on the experienced practitioner who has assumed the roles of manager and administrator. This article briefly reviews the contextual factors surrounding service delivery, discusses recent evolutions in occupational therapy theory that affect the nature of the service being managed, and identifies critical competencies important to managers now and in the future. These emerging skills and competencies will be described from the perspective of the changes or shifts that have occurred over the past decade. Where available, illustrative literature is cited. Many of these changes have occurred so rapidly that the associated competency demands have not been fully documented in the occupational therapy literature. Rather, emerging requirements have been shared through management networks such as the American Occupational Therapy Association (AOTA) Administration & Management Special Interest Section (AMSIS). Consequently, this article was created on the basis of relevant literature from occupational therapy and health care management that has been augmented by the impressions gained by the authors in their leadership roles with the AMSIS and in the field.

Health Care Context

Over the past 10 years, the escalating costs of health care services, along with the potential to profit from these services, has culminated in a shift from an altruistic to a business orientation. This has manifested itself in the increased focus on cost containment of government programs, the rapid rise and recent consolidation of profit-based corporations, and the attempts of traditionally service-based groups such as schools to recover costs from third-party payers. Foto (1998) has argued that these changes are a necessary outcome of a shift from an historic view of doing everything possible for clients to a more economically feasible approach of only providing treatment that results in meaningful improvement given limited resources. These changes were already beginning to affect occupational therapy a decade ago as evidenced in articles addressing productivity, cost analysis, and marketing in the 1987 special issue of *The American Journal of Occupational Therapy* on management (e.g., Jacobs, 1987; Logigian, 1987). Despite this, it seems unlikely that occupational therapy managers could foresee today's degree of what health care administrators call the "hyper-turbulence" (Wooten & Decker, 1996, p. 11) of the hospital industry.

The effect of competitive market forces and legislation on health care has been considerable. Specifically, there has been a decline in fee-for-service reimbursement, an increase
in managed care, a rise of capitation arrangements, an enhanced role for primary physicians and case managers, a redefinition of service processes, and an increased orientation toward defining expected outcomes (Wenzel, Grady, & Freedman, 1995; Wheatley, Delong, & Sutton, 1997). The goal of the new medical model is a seamlessly integrated, cost-effective system of inpatient and outpatient care for which outcomes can be clearly identified and measured (Gilmore, Hirschhorn, & O'Conner, 1994; Wenzel et al., 1995). Consistent with these goals has been increased attention to a community's health status and associated preventive and primary care strategies (Baum & Law, 1997). The emerging view of health care as a commodity has resulted in greater attention to consumers, including both clients and payers.

**Occupational Therapy and the Changing Health Context**

The shift from retrospective to prospective payment has stimulated increased attention to illness prevention, disability management, and health promotion (Baum & Law, 1997). At the same time, the occupational therapy profession has renewed its attention to occupational performance, the use of occupation as therapy, and the role of context in shaping and influencing the nature of occupational performance (Baum & Christiansen, 1997; Dunn, Brown, & McGaigian, 1994). In the context of health care reform, the field's renewed interest in occupation equates to refocusing on disability and related life skills versus impairment and components of performance. This, in turn, positions occupational therapy to assume additional roles in health prevention and wellness programs, along with the traditional attention to remediation of disability. While the health care system has been changing its focus from medical management to health management, occupational therapy theorists have reenergized the profession's appreciation for the power of authentic occupation in helping clients to both restore lost abilities and develop the adaptive strategies needed to live meaningful lives (Christiansen & Baum, 1997; Clark, Wood, & Larson, 1998). These changes have been accompanied by the development of assessment and documentation tools that permit more effective clinical data collection and analysis (see Ottenbacher and Christiansen [1997] for a concise review). The use of authentic occupation contrasts sharply with medically based occupational therapy interventions, which have used contrived exercises and activities targeted to restoring specific performance components. Not only is the effectiveness of such approaches being challenged (Trombly, 1995), but also consumers do not view such approaches as relevant (Schlaff, 1993), and the emerging health care system is less inclined to pay for them (Fotor, 1995). Both occupational therapy administrators and occupational therapy practitioners would do well to seriously analyze these advances in the profession because they provide the conceptual basis for rethinking occupational therapy in the emerging health care system. Occupational therapy practitioners have a particular appreciation of the role that both performance components and performance contexts play in a person's ability to manage his or her disability and regain desired life skills. As such, occupational therapy practitioners can identify the services and settings needed to support performance as well as prevent and reduce disability. This understanding provides a conceptual framework to guide the nature of services along the continuum, the management of multidisciplinary services, and the innovation of new strategies that are both cost effective and outcome oriented. By understanding the opportunities associated with advances in occupational therapy, both administrative and clinical practitioners are better positioned to meet the management demands of the emerging health system.

**Occupational Therapy Management**

In light of the changes in both occupational therapy and the health care system, it is not surprising that practitioners today are challenged by management concerns. The good news is that many core management skills and competencies have been documented (AOTA, 1996). In 1988, a task group of the AMSIS summarized important managerial competencies in planning, fiscal management, marketing, staff management, operations management, monitoring, and education (Christie, Mansfield, Rausch, & Townsend, 1988a and 1988b). Although these were never adopted officially by AOTA, they serve as an effective baseline for this discussion (see Table 1). What becomes obvious in a review of these competencies is that the familiar areas of planning, organizing, directing, and controlling are still inherent in management. What has changed is the environment in which one exercises these skills, which necessitates new ways of implementing the management processes (McConnell, 1997).

The remainder of this article will address recent shifts that have occurred and highlight the competencies critical to effective management in today's health care arena. Before identifying the specific shifts necessitating different competencies, two brief case studies will serve to illustrate real-life demands.

**The Clinical Practitioner**

Mary reviews her list of "to dos" for the day. She has three new admissions to evaluate on the acute floor, and additionally she is expected to be in the long-term-care unit to meet with her assigned certified occupational therapy assistant so that they can plan a training session for rehabilitation aides. First she must call the case manager about the patient on Unit 4 who has "fallen off" the critical pathway. He is not going to be ready to go home safely, so new discharge plans must be made. She steels herself for the inevitable negotiation that will be required on her patient's...
Debbie looks around her office. Since taking charge of the rehabilitation program, she has learned a lot about managing multiple disciplines. In addition to occupational therapy practitioners, she oversees physical therapists, speech-language pathologists, nurses, and respiratory therapists. Being a program manager has certainly sharpened her diplomacy skills, particularly because the case managers assigned to her program report to a different administrator. It is amazing how much her occupational therapy knowledge, such as how the interplay of performance components and performance context affect patient functioning, along with her group process skills support team functioning. Sometimes she thinks that she is the only one looking at the whole picture.

Right now, she pushes her lunch tray aside and piles up the financial reports next to her payroll and productivity records. She has most of the key information on her spreadsheet ready for her weekly review of cost–productivity ra-

### Table 1
**Management Competencies for Clinical and Administrative Practitioners**

<table>
<thead>
<tr>
<th>Management Area</th>
<th>Clinical Practitioner</th>
<th>Administrative Practitioner</th>
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<tbody>
<tr>
<td>Planning</td>
<td>- Sets achievable professional goals</td>
<td>- Strategically plans as basis for department or program goals</td>
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<td></td>
<td>- Contributes to department or program planning</td>
<td>- Integrates department or program goals with organizational goals</td>
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<td></td>
<td>- Identifies trends in practice in own treatment setting</td>
<td>- Anticipates and analyzes clinical and health care trends</td>
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<tr>
<td></td>
<td>- Understands health care trends</td>
<td>- Strategically develops and changes programs</td>
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<td></td>
<td>- Helps to identify resources for program development</td>
<td>- Develops systems to manage multiple programs across multiple sites</td>
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<td></td>
<td>- Complies with systems, policies, and procedures</td>
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<tr>
<td>Fiscal management</td>
<td>- Understands cost–revenue relationships</td>
<td>- Analyzes costs of service delivery</td>
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<tr>
<td></td>
<td>- Meets productivity expectations or negotiating appropriate responses</td>
<td>- Evaluates cost-effectiveness of services</td>
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<tr>
<td></td>
<td>- Contributes to budgeting and monitoring expenses</td>
<td>- Establishes billing structure consistent with payer requirements</td>
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<td></td>
<td>- Documents in manner sensitive to payer requirements</td>
<td>- Manages department or program budgets</td>
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<tr>
<td></td>
<td>- Understands different payment systems and effect on service delivery</td>
<td>- Negotiates contracts with payers</td>
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<tr>
<td></td>
<td></td>
<td>- Establishes productivity expectations and monitors relative cost–benefit analysis</td>
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<td></td>
<td></td>
<td>- Identifies funding sources and prepares proposals and grants</td>
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<tr>
<td>Marketing</td>
<td>- Identifies and promotes occupational therapy uniqueness in own program activities and emerging new areas</td>
<td>- Designs and implements strategic marketing efforts consistent with organizational goals</td>
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<td></td>
<td>- Participates in professional activities to promote awareness to legislators, consumers, and payers</td>
<td>- Develops and maintains networks supportive of occupational therapy services</td>
</tr>
<tr>
<td></td>
<td>- Develops strong relationships within interdisciplin ary teams</td>
<td>- Recognizes opportunities for occupational therapy services in new arenas and advocates for the profession</td>
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<tr>
<td>Personnel management</td>
<td>- Understands abilities and limitations of different levels of personnel providing services and delegates appropriately</td>
<td>- Designs personnel roles and structure</td>
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<td></td>
<td>- Supervises subordinate levels of professional and technical personnel and service extenders, assuring service competence</td>
<td>- Recruits, assigns, and monitors personnel</td>
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<tr>
<td></td>
<td>- Seeks and responds to supervision to maximize clinical effectiveness and personal growth</td>
<td>- Designs and coordinates staff development activities</td>
</tr>
<tr>
<td>Systems management</td>
<td>- Maintains routine department procedures, inventories, and quality monitoring systems</td>
<td>- Uses effective strategies to promote teamwork</td>
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<td></td>
<td>- Recommends improvements to systems</td>
<td>- Uses leadership to enhance employee commitment to organizational mission and goals</td>
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<tr>
<td>Education and research</td>
<td>- Facilitates students' clinical learning</td>
<td>- Designs, implements, and monitors control systems, including inventory, quality, and risk management to meet internal and regulatory demands</td>
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<td></td>
<td>- Educates clients and community related to improving occupational performance</td>
<td>- Uses information technologies to monitor quality and effectiveness of services</td>
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<td></td>
<td>- Engages in lifelong learning and supports that of others through presentation and collaboration in continuing education</td>
<td>- Develops and maintains communication systems relevant to staff members and department or program in the organization</td>
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<tr>
<td></td>
<td>- Engages in evidence-based practice</td>
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behalf. While she ponders this, she tries to decide whether she should follow up on the opportunity to do some home-based care after work. She is still learning a lot on this job because her caseload ranges from persons with orthopedic and neurological problems to the occasional older adult with a psychiatric problem. If she does home care, she will be able to do some early intervention with children as well, which would be interesting. Besides, she could use the extra money to pay off her school loans. The problem is that she is less confident about her pediatric skills, and she is not sure how she can get the supervision and mentoring she is likely to need. It would be nice to have someone to talk to about this; maybe she can find the senior practitioner on the rehabilitation program between patients.

*The Administrative Practitioner*

Debbie looks around her office. Since taking charge of the
tios. Luckily, it is not so hard to find occupational therapy practitioners and physical therapists to fill positions, so at least she has some productivity to analyze. She checks her e-mail for any new notices before switching to her presentation software. Now it is time to create some overheads that summarize key points of the business plan she has prepared for a new satellite program. She only has 1 hour before presenting it to the administrative team. Then she will run up to the floor to find out whether she must see some patients because one of her occupational therapy practitioners called in sick. Later, she will resume the financial analysis of current programming along with updating the charging guide to reflect the current codes being used in her program for billing.

The management demands on these practitioners are typical in today's health care environment, and this has created a need for new skills and competencies.

Management Skills for the New Age

As changes in the health care environment have intersected with expansions in occupational therapy theory and practice, the focus of management attention has changed both for those in administrative positions as well as for clinicians. Because many of these changes affect both occupational therapists and occupational therapy assistants, the term clinical practitioner is used when addressing those primarily in clinical practice, and the term administrative practitioner is used for those who have primarily management and administrative responsibility. Despite these distinctions, it is important to note that flattening of organizational hierarchies has blurred administrative and clinical roles (McConnell, 1997). Despite this blur, distinctions in competencies relevant to each group can be detected. It is these new competencies, framed within the environmental shifts prompting them, that are examined next.

From Recruitment to Reengineering

In the 1970s and 1980s, shortages of occupational therapy personnel were the norm, fueled in part by the expanding opportunities in health care and school-based practice and in part by the lack of academic programs to meet the expanding need. Key management competencies at that time included the ability to recruit and retain qualified employees, as evidenced by numerous articles devoted to that topic in the Administration & Management Special Interest Section Newsletter (e.g., Dawe, 1988; Youngstrom, 1989). Although recruitment continues to be an issue in some parts of the country where the shortages of personnel continue, in many urban areas, the pool of jobs in hospital-based practice has diminished because of reduced use of inpatient beds, consolidation of organizations, and reengineering of existing organizations. For practitioners in these settings, staff reductions and changes in level of personnel have posed new challenges (Christiansen, 1996; Lemieux-Charles & Hall, 1997; Longest, 1997). Administrative practitioners must

- Evaluate minimum levels of staffing required to meet program demands
- Determine the optimum skill mix of professional, technical, and aide personnel
- Exercise leadership needed to integrate personnel from different organizational cultures that have been merged because of industry consolidations
- Develop flexible staffing plans and train staff members to meet these plans
- Conceptualize and market occupational therapy roles beyond institution-based practice into outpatient and community settings

Clinical practitioners must

- Demonstrate strong generalist skills required for flexible staffing
- Use self-directed learning strategies necessary to support clinical reasoning and service competence in various areas
- Recognize the volatility of the health care environment and be open to emerging roles as occupational therapy continues to shift service delivery to outpatient and community-based practice

From Single-System to Multisystem Management

The rise of managed care has prompted the development of vertically and horizontally integrated health care systems designed to meet the health needs of given populations. These systems coexist with governmental services designed for uninsured or at-risk populations. The goal is seamless care that minimizes duplication and provides needed care at each stage of the continuum in the least costly environment (Wheatley et al., 1997). These changes have resulted in two related management issues: multisite management and the need for case management across settings. No longer does a manager necessarily have daily access on site to all personnel. Broader management responsibilities, along with flattening of organizations, necessitates creating new strategies and the use of new communications technologies to meet organizational demands (Gilmore, Hirschhorn, & O’Connor, 1994). Staff members are expected to manage themselves more effectively with less direct monitoring of supervisory personnel. Administrative practitioners must

- Use communication technologies to support staff member performance at multiple sites
- Develop systems to facilitate collaboration across program sites
- Use visionary leadership and guiding principles rather than direct supervision to support staff member performance
Clinical practitioners must
- Understand the role of their service within the organization's strategic plan
- Use principles derived from their organization's vision and mission, in conjunction with professional knowledge, to guide practice
- Assume case management responsibilities within and across service delivery sites
- Manage time and resources effectively with minimal supervision

From Profession-Driven to Market-Driven Standards
Health care in the United States has become a business and, for many, a profitable business (Foyo, 1998). This is a change from the past views of health care as a nonprofit service best managed in the light of the standards established by professionals who were presumed to have specialized knowledge. The increased costs of health care, combined with a political climate in which the market is seen as the arbiter of standards, has resulted in a fiscally driven, bottom-line approach to planning and service delivery (Landry & Knox, 1996). This has required a major paradigm shift for both clinical and administrative practitioners. Although professions continue to develop practice standards, there has been a shift in autonomy in all professions, with governmental and insurance-based case managers assuming a greater role in resource allocation. The pendulum has swung to the fiscal side of authority, and standards have been revisited in the light of this environment. Administrative practitioners must
- Understand market forces and the implications for service delivery
- Manage financial as well as clinical determinants of care
- Demonstrate marketable outcomes or “products”

Clinical practitioners must
- Demonstrate an understanding of the financial implications of clinical decisions
- Articulate the relevance of services to desired outcomes within specified timelines
- Differentiate occupational therapy services from other health professions’ services

From Clinical Management to Program Management
For much of the profession's history, occupational therapy was delivered primarily within a medical model of care. In the 1970s and 1980s, the predominant mode of organization within the medical model was the department-based approach, in which there was an occupational therapy manager responsible for supervision and management of occupational therapy personnel. The advantage of this approach was a strong sense of professional camaraderie, the availability of mentoring for clinical skill development, and the ability to control the nature of occupational therapy service delivery across multiple programs. There are several advantages to departmentalization. Such an approach is less market sensitive because no one manager has responsibility for viewing the entire constellation of service components. Even more importantly, service outcomes tend to be process oriented (i.e., the number and nature of occupational therapy interventions) rather than outcome oriented. Finally, strong departmental allegiances tend to feed competition among the different disciplines and negatively affect team collaboration (Gilmore et al., 1994). In recent years, many organizations have adopted program management models or a combination of program and departmental approaches known as matrix models. As a consequence, many occupational therapy practitioners in administrative roles are responsible for supervising multiple disciplines in the context of program management. Administrative practitioners must
- Develop systems supporting clinical excellence in occupational therapy and other professions
- Exercise leadership to promote teamwork
- Analyze fiscal data, including revenue, expense, cost-per-unit, and reimbursement patterns relevant to program goals and client outcomes
- Conceptualize the fit of program services into the internal and external market and anticipate the effect of market changes on the program
- Develop and implement marketing and public relations efforts

Clinical practitioners must
- Assume responsibility for seeking clinical supervision and development when needed
- Be effective team members and leaders
- Understand the role that occupational therapy plays in meeting client needs within the context of desired program outcomes and payment constraints
- Tailor flexible communications to meet client, referral, and reimbursment needs

From Direct-Service to Multiple Models
Direct-service delivery by professional and technical staff members has been the primary method of service delivery in medically based care. Variations of this approach have been used, such as group therapy in mental health programs and use of aides to support service by performing nonskilled service-related tasks. The expansion of occupational therapy services into school-based practice, long-term care, and work-related programming promoted the development of alternative models that include consultative, monitored, and educationally based approaches (Jaffe & Epstein, 1992). With the increased pressure on medically based programs to do more with less, there has been a sharp increase in the use of aides as service extenders (Russell & Kanny,
What is “skilled” care versus “nonskilled” or “supportive” care associated with different levels of staffing patterns. As more health care shifts to outpatient and community-based practice, these different intervention patterns need to be examined for their cost-effectiveness in supporting the health of the community (Baum & Law, 1998). What is “skilled” care versus “nonskilled” or “supportive” care becomes an important issue that practitioners must determine and defend (Foto, 1995). Administrative practitioners must

- Negotiate ethical and effective solutions to demands for cost-effective care
- Develop systems that support both professional and nonprofessional staff members to know when skilled versus supportive intervention is appropriate
- Design and implement staff member development systems to support skills in multiple methods of service delivery, including direct, monitored, educational, and consultative models
- Design and implement quality monitoring programs that permit evaluation of effectiveness of staffing patterns and intervention models

Clinical practitioners must

- Articulate the need for skilled and supportive care appropriately
- Demonstrate skills in direct and indirect supervision of technical and aide staff members
- Demonstrate skills in multiple methods of service delivery, including direct, monitored, educational, and consultative approaches
- Use clinical evidence, including research and quality monitoring data, as the basis for improving patterns of service delivery

Conclusion

Effective management skills have become an inherent part of occupational therapy practice for clinicians and administrators. Although most evident in hospital-based practice, the demands for accountability have rippled throughout all avenues of service delivery. Along with these changes have come new opportunities to expand the scope and methods of occupational therapy service delivery to benefit an even larger segment of the community. Occupation-centered practice theories provide important perspectives that clinical and administrative occupational therapists will play an essential role in the health care system of the new millennium.

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