“How do we force six visits on a consumer?”: street-level dilemmas and strategies for person-centered care under Medicaid fee-for-service

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PERSON-CENTERED CARE UNDER FEE-FOR-SERVICE

Title: “How do we force six visits on a consumer?”: Street-level dilemmas and strategies for person-centered care under Medicaid fee-for-service

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Title: “How do we force six visits on a consumer?”: Street-level dilemmas and strategies for person-centered care under Medicaid fee-for-service

This qualitative study examines the delivery of person-centered care in Medicaid-funded supportive housing for adults with serious mental illness. While much work has been done to promote the uptake of a person-centered approach in healthcare, less is known about how this approach functions in homeless services and supportive housing where many individuals with mental health issues receive rehabilitative services. A total of 84 semi-structured interviews were collected from a purposeful sample of 35 frontline providers. Transcripts were analyzed inductively using Boytzis’ thematic analysis. Three principle themes characterize the dilemmas experienced by street-level workers in these programs: (1) Putting the “consumer first” vs. achieving maximum billing; (2) Doing the "real work" vs. paperwork; and (3) Juggling clinical supervision vs. administrative oversight. In order to meet the demands of Medicaid, as well as the expectation for person-centered care delivery, providers enacted several discretionary strategies at the street-level: (1) Staying late and taking work home; (2) Padding the numbers; (3) Offering service recipients small choices; (4) Redirecting small talk to get to billable goal talk; and (5) Keeping consumers home. Findings highlight tensions between the accountability-focused fee-for-service model and the prioritization of consumer choice and individualization of services in person-centered care delivery.
1. Introduction

This study examines person-centered care in Medicaid-funded supportive housing programs for formerly homeless adults with serious mental illness. Supportive housing combines affordable housing with rehabilitative supports (e.g. assistance with daily living skills, symptom management, medication management and training, etc.) in order to help individuals remain housed. A “person-centered” approach to supportive housing provision then is care focused on the individual service recipient’s *own* goals for improving their day-to-day life and maintaining their tenure in the community. While much work has been done to promote the uptake of this person-centered approach in health and mental health services, less is known about how this approach functions in homeless services for adults with serious mental illness. It is also unclear how the delivery of person-centered care is impacted, if at all, by funder requirements for service provision in these settings. With many supportive housing programs now relying on Medicaid funding as a payer for rehabilitative services via “fee-for-service” (a retrospective payment model that specifies the frequency, duration, and type of reimbursable services), it is important to understand the fit between the person-centered service model and this type of services funding.

The purpose of this study is to elucidate the experiences of frontline workers, those tasked with the street-level provision of person-centered care in supportive housing, and examine their views of how external funder requirements imposed by Medicaid fee-for-service, influence practice.

1.1 Person-centered care: A paradigm shift in healthcare provision

In contrast to the traditional hierarchy of healthcare service delivery with provider as expert and primary driver of treatment decisions, person-centered care positions the recipient of services as an equal partner in care decisions, customizing services according to individual needs, desires, and circumstances (Berwick, 2002; Institute of Medicine [IOM], 2001). A person-
centered approach to physical and mental healthcare is now being promoted in countries around the world (World Health Organization, 2007). But this re-orientation of the top-down hierarchy of service delivery systems has been described as involving “some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it” (Berwick, 2009, p. w555).

Like person-centeredness, the concept of “recovery-oriented care” in mental health services emphasizes equality in relationships between providers and consumers (Kinsella, 2000; Marwick, 2013; Tondora, Miller, Slade, & Davidson, 2014). This concept further challenges assumptions of the chronicity of mental illness and broadens the focus of mental health services beyond the assessment, diagnosis, and treatment of pathology to a more holistic focus on individual goals for mental health recovery. Examples of person-centered, recovery-oriented practices include the use of shared decision-making tools (e.g. computerized decision support programs), the promotion of person-centered care planning, and the employment of individuals with the lived experience of mental illness as peer providers.

Recovery and person-centeredness are now guiding principles for healthcare delivery systems in many countries throughout the world (LeBoutiller et al., 2011). Research has shown that person-centered care improves health outcomes and quality of life (Coulter et al. 2015; Lewin et al. 2001; Stanhope et al. 2013) and that it is critical to addressing racial, ethnic, and socioeconomic disparities in health care and health outcomes (Saha, Beach, and Cooper, 2008; Teal and Street, 2009). Yet, it has also become clear that there are limits to what person-centered care can achieve in terms of improved consumer outcomes when implementation challenges at the organizational- or system-level remain in place (Gask and Coventry, 2012; Tondora, Miller, & Davidson, 2012).
1.2 Impact of financing on person-centered, recovery-oriented practice

One prominent system-level challenge to the implementation of person-centered, recovery-oriented care discussed by researchers and policy-makers is the way in which services are financed. In a groundbreaking report on the quality of healthcare in the United States (IOM, 2001), the Institute of Medicine identified “patient-centeredness” along with safety, effectiveness, timeliness, efficiency, and equity as the six dimensions of healthcare performance in need of improvement. But the authors of this report also conclude that improvements in these areas cannot be achieved within the constraints of existing systems of care given the presence of “toxic financing schemes”. Further, the U.S. Federal government’s New Freedom Commission on Mental Health has acknowledged the need for “nothing short of fundamental transformation of the mental health care delivery system in the United States - from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focuses on building resilience and facilitating recovery” (U.S. Department of Health and Human Services, 2005, p. 4).

Those charged with the frontline delivery of person-centered care in services for persons with mental illness have further cited conflicts between the financing of services and putting this approach into practice on the ground. Focus groups conducted with mental health providers in the United Kingdom found that staff viewed funding priorities of the National Health System as “competing” with the priorities of recovery (LeBoutiller, et al., 2015). An ethnographic study of street-level practice in a community mental health clubhouse in the United States noted several “unresolvable contradictions” between funder requirements and local practices when the program underwent a transition from block grant funding to a fee-for-service payment model (Spitzmueller, 2013; Spitzmueller, 2016). The focus of these financial reforms (cost-efficiency,
accountability, and standardization) fundamentally came into conflict with the clubhouse model’s promotion of consumer self-determination and program responsiveness, which impacted workers’ perceptions of problem clients, altered their conceptions of the work role, and increased service rationing. In consumer-driven services predicated on flexibility, changes like these were described as shifting staff relationships “away from primary regard for ‘member well-being’ toward the ‘business’ of productivity” (Spitzmueller, 2016, p. 64).

1.3 The importance of street-level perspectives

Recovery-oriented, person-centered systems of care are intended to privilege consumer choice and the individualization of care. But in healthcare service delivery, frontline providers experience a problem of “dual agency” – providers must act on behalf of the service user and on behalf of service funders in order to keep programs fiscally viable (Ellis and McGuire, 1986). However, little is known about how frontline providers understand and cope with this “dual agent” role.

Previous research on street-level practice has shown that when financial reforms modify organizational resources, incentives, and demands, frontline providers adjust their informal routines and practice in response (Brodkin, 2011). However, these discretionary adjustments can function in ways that are beneficial for the organization but ultimately run counter to the needs of service recipients. Smith (1995) identified several unintended consequences of payment reforms on public sector worker performance, including: 1) diversion of effort away from non-payment activities; 2) manipulation of performance measures such that reported performance exceeds actual performance; 3) gaming (e.g. deliberate underperformance which would allow an organization to keep future service targets relatively achievable; and 4) organizational paralysis/innovation stifling caused by narrow performance targets.
According to Michael Lipsky’s (1980) theory of street-level bureaucracy, frontline providers of public services are beset with barriers at the organizational- and system-level, including large caseloads, ambiguous agency goals and limited resources. However, these workers also operate in environments in which they have considerable discretion in the execution of their work. In response, they develop creative strategies, patterns of practice and informal routines to simplify and manage these challenges. As such, street-level human service workers can been seen as policy makers, not just policy takers (Vedung, 2015). They will interpret and enact strategies in response to these dilemmas, which effectively become policy in practice. Understanding street-level perspectives on service delivery and the informal routines that they employ then is essential to bridging the gap between the rhetoric of person-centered care and effective implementation of these practices in both health and mental health services.

1.4 Medicaid-funded supportive housing for persons with serious mental illness

Supportive housing, a service model that combines housing and psychiatric rehabilitative services for homeless individuals with serious mental illness, exists at the intersection of the mental health and homeless service systems. While housing is a primary goal of these programs, the availability of wrap-around rehabilitative support is considered essential to program success (U.S. Interagency Council on Homelessness, 2016). Supportive housing programs are fertile ground for person-centered care delivery, but little is known about the impact, if any, that funding has on the successful implementation of this approach in this service setting (Tiderington, 2015).

Funding and governance of supportive housing in the United States comes from both mental health and housing-related streams of funding that emanate from a variety of federal, state, local and private sources (Supportive Housing Network of New York, 2016). Housing-
related financing (e.g. low-income tax credits, Section 8 Housing Choice Vouchers, public housing) typically cannot be used to pay for supportive services. Agencies must then seek out separate sources, such as state healthcare dollars, to finance the “support” component of supportive housing.

With the passage of the Patient Protection and Affordable Care Act (ACA) of 2010, housing organizations are increasingly drawing on Medicaid dollars for these purposes (Burt et al. 2014; U.S. Department of Health and Human Services, 2014). The ACA has embraced a social determinants approach to health, which has led to more funds being made available for less traditional health services, such as supportive housing. Many states are making the case that improved housing with reduce hospitalization in order to access increased Medicaid funding (Doran, Misa, & Shah, 2013). While changes are now taking place through state-level redesigns of Medicaid payment systems and many states have already shifted to a managed care approach, several continue to reimburse provider agencies retrospectively using a “fee-for-service” approach. Medicaid only authorizes reimbursement for care that is medically necessary and requires that outcomes to be quantifiable and measurable, which creates a heavy burden on housing programs to provide documentation demonstrating the delivery of services that address the medical needs of residents (Frank & Glied, 2006; Stanhope, Choy-Brown, Tiderington, Henwood, & Padgett, 2016). Under this model programs must keep sufficient reserves on hand to cover expenses while awaiting reimbursement and comply with Medicaid requirements for billable services, including frequency, duration, and type of contact (e.g. To make a full month claim and receive reimbursement, a service recipient must be seen at least four times per month and provided one of 11 “billable” services per visit for a minimum of 15 minutes in duration).
While supportive housing program administrators grapple with balancing budgets and ensuring quality service delivery, frontline workers are those charged with the day-to-day delivery of mental health rehabilitative services. Such services, ranging from medication management to assistance with recovery planning to health care coordination, are essential to housing stability and personal recovery. Fulfilling multiple tasks amidst limits in time and resources is an inherent challenge in healthcare service delivery, but the shift to a person-centered system of care introduces a new dimension to the “street-level bureaucracy” of these services (Lipsky, 1980).

Using a theoretical framework informed by street-level organizational theory, this study examines frontline views and practices in Medicaid-funded fee-for-service supportive housing programs for adults with serious mental illness to address the following research questions:

1) What challenges, if any, do frontline providers experience in the delivery of person-centered care related to Medicaid fee-for-service?
2) What discretionary strategies, if any, do frontline providers employ in response to these challenges?

2. Materials and Methods

2.1 Sampling

Qualitative methods were chosen for the purposes of this study because these methods allow exploration of key actors’ experiences and interpretation of complex phenomena in situ. Frontline providers were purposively sampled for participation in qualitative interviews from two agencies that depend heavily on Medicaid to fund the supportive housing services that they provide to adults with serious mental illness.
Both agencies were located in a large urban area in a northeastern state that at the time of the study utilized a fee-for-service payment model to retrospectively reimburse for mental health rehabilitative services. Site 1 was a larger service agency with both a transitional and permanent supportive housing program. Site 2 was a smaller agency that offered only permanent housing. Providers sampled from these three programs within the two study sites were housing case management staff charged with the day-to-day delivery of supportive services in these housing programs, including mental health rehabilitative services. As Table 1 shows, participants ranged in their level of education, amount of prior work experience with supportive housing populations, as well as in their employment tenure at the agency.

Data for this inquiry were collected between March 2011 and February 2014 as part of a larger parent study funded by the National Institute of Mental Health that longitudinally examined consumer mental health recovery in housing services. Frontline providers were therefore outreached for participation only if the consumer with whom they worked was a participant in the larger parent study and consented to the outreach. All but two of 37 providers agreed to participate in this study, constituting a 95% consent rate and a total of 35 provider participants.
Table 1. Provider Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Site 1 N (%)</th>
<th>Site 2 N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10 (42)</td>
<td>3 (27)</td>
<td>13 (37)</td>
</tr>
<tr>
<td>Female</td>
<td>14 (58)</td>
<td>8 (73)</td>
<td>22 (63)</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1 (4)</td>
<td>4 (36)</td>
<td>5 (14)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>20 (84)</td>
<td>5 (46)</td>
<td>25 (71)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (8)</td>
<td>2 (18)</td>
<td>4 (11)</td>
</tr>
<tr>
<td>N/A</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
<tr>
<td><strong>Employment Tenure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>8 (33)</td>
<td>6 (55)</td>
<td>14 (40)</td>
</tr>
<tr>
<td>1-3 years</td>
<td>10 (42)</td>
<td>2 (18)</td>
<td>12 (34)</td>
</tr>
<tr>
<td>&gt;3 years</td>
<td>5 (21)</td>
<td>3 (27)</td>
<td>8 (23)</td>
</tr>
<tr>
<td>N/A</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
<tr>
<td><strong>Highest Degree Completed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td>1 (4)</td>
<td>7 (64)</td>
<td>8 (23)</td>
</tr>
<tr>
<td>Bachelors</td>
<td>13 (54)</td>
<td>2 (18)</td>
<td>15 (43)</td>
</tr>
<tr>
<td>Associates or less</td>
<td>8 (34)</td>
<td>1 (9)</td>
<td>12 (33)</td>
</tr>
<tr>
<td>N/A</td>
<td>2 (8)</td>
<td>1 (9)</td>
<td></td>
</tr>
<tr>
<td><strong>Prior Experience With Supportive Housing Populations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19 (79)</td>
<td>8 (73)</td>
<td>27 (77)</td>
</tr>
<tr>
<td>No</td>
<td>4 (17)</td>
<td>3 (27)</td>
<td>7 (20)</td>
</tr>
<tr>
<td>N/A</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
</tbody>
</table>

2.2 Data Collection

A total of 84 in-depth, semi-structured interviews were collected from this sample. The first author conducted the majority of the interviews (N=64) and three other trained interviewers conducted the remaining 20 interviews. On average, interviews lasted approximately 45 minutes. Interviews took place either in the study offices or in a private room at the agency, depending on the preference of the participant. In addition to the domains of interest in the parent study (e.g. barriers and facilitators to consumer mental health recovery in supportive housing), providers were asked broad open-ended questions about how they viewed their work in supportive housing (e.g. “What is working here like for you?” “Is there anything that would make
your work easier or more effective?”). Although not originally included in parent study domains of interest, providers brought up unsolicited topics pertaining to macro-systemic influences on practice including availability of resources (affordable housing, income supports, and employment); the role of contracts and funding; and billing and regulatory agencies’ audit requirements. These responses were then followed up with probes in order to elicit further information both in the initial interview, as well as in follow-up interviews.

In the parent study design, interviews with consumer participants took place every six months for a total of 18-months. Following each consumer interview, the frontline provider assigned by the housing program to that consumer was invited to participate in a separate interview. Because provider recruitment was driven by consumer participation and was subject to changes in staffing, the timing and spacing of interviews was rather complex. Ten of the 35 providers in the sample were interviewed once due changes in their caseload or because the consumer participant left the study following the baseline interview. The remaining 25 providers had multiple interviews concerning multiple clients. Only seven of 50 total consumer participants had the same provider assigned to them from baseline through all of follow-up interviews. Overall, 35 providers were interviewed for a total of 84 interviews (35 initial interviews and 49 follow-ups). The university human subjects committee approved all study protocols and every participant provided informed consent.

2.3 Data Analysis

Interviews were transcribed verbatim and transcripts were entered into Atlas-ti software. Saldaña's (2012) first- and second-cycle coding method guided the coding of these data. For the first-coding cycle, the first and second authors independently reviewed and open-coded all of the interview transcripts. We then met together to conduct “consensus coding”, a process used to
ensure agreement and convergence at the level of descriptive coding which increases the rigor and validity of the coding process in qualitative research (Padgett, 2016; Sandelowski and Barroso, 2002). Coded material were sorted into documents according to categories (e.g. “Outside Agency Factors” impacting person-centered care, which referred to “provider views and practice associated with entities outside of the housing agency - including Medicaid billing requirements, State Office of Mental Health standards, or other funder-dictated practices”) and sub-categories (e.g. “External Policies” and “External Resources” being sub-categories of “Outside Agency Factors”). For the purposes of this inquiry, all coded material mentioning the fee-for-service model were extracted, examined, and aggregated into higher order themes using Boyatzis’ (1998) thematic analysis - an inductive process for “encoding qualitative information”.

2.4 Study Limitations

Limitations of this study included a constrained sample group - two supportive housing agencies in one geographical location. Therefore, results may look different in other policy and economic contexts. However, several “strategies for rigor” in qualitative research (Padgett, 2016) were employed to enhance the trustworthiness of the results. Strategies included peer-debriefing with the parent study team to maintain researcher reflexivity, memo-writing and use of an audit trail as a way to document analytic decisions, negative case analysis to seek out and understand disconfirming data, and prolonged engagement in the study setting with data collected over a two-year period.

3. Results

Thematic analysis revealed several recurrent funding-related dilemmas experienced by frontline staff across programs that influenced the organizational culture and ultimately,
providers’ ability to deliver person-centered care at the “street-level”. Frontline providers also described several discretionary strategies that were employed in response to these dilemmas. Themes are summarized in Table 2 and described below.

### Table 2. Street-level dilemmas and strategies for person-centered care under Medicaid fee-for-service

<table>
<thead>
<tr>
<th>Street-Level Dilemmas Encountered By Frontline Providers</th>
<th>Discretionary Strategies Enacted By Frontline Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Putting the “consumer first” vs. achieving maximum billing</strong></td>
<td>“…a consumer might not want to be seen six times, so uh… how do we force six visits onto a consumer?”</td>
</tr>
<tr>
<td><strong>Doing the ”real work” vs. paperwork</strong></td>
<td>“…either the office work gets shorted or the client interaction gets shorted”</td>
</tr>
<tr>
<td><strong>Juggling clinical supervision vs. administrative oversight</strong></td>
<td>“…to me [supervision] is just an audit, it’s not supervision”</td>
</tr>
<tr>
<td><strong>Staying late and taking work home</strong></td>
<td>“I’d rather just deal with trying to do the paperwork later or at home or something like that, than to not see the clients”</td>
</tr>
<tr>
<td><strong>Padding the numbers</strong></td>
<td>“It’s a five-minute service. But it’s a 25-minute service and there’s stuff that they didn’t say, that I didn’t say that’s in the note.”</td>
</tr>
<tr>
<td><strong>Offering small choices</strong></td>
<td>“You know that we have to see you six times minimally. You tell us when, where, what services”</td>
</tr>
<tr>
<td><strong>Redirecting small talk to get to billable goal talk</strong></td>
<td>“…you need to sit down and talk to me so I know what note I can write. If your service plan says ‘housing,’ we’re going to sit here and discuss housing.”</td>
</tr>
<tr>
<td><strong>Keeping consumers home</strong></td>
<td>“So you are telling your clients, ‘From the first day of the month until the 10th just don’t go anywhere, you need to see me.”</td>
</tr>
</tbody>
</table>
3.1 Street-Level Dilemmas

**Putting the “consumer first” vs. achieving maximum billing.** Frontline providers described two, sometimes competing, mandates within their work: the mandate to honor individual care preferences under a “consumer first” model of recovery and the mandate to maximize reimbursement. According to these staff, the demands of a Medicaid fee-for-service model compounded with the demands from each additional contract and overseeing body, which acted to shift the orientation of practice away from the consumers of services toward other actors in the task environment. As one provider explained,

> You know, being told by OMH [the State Office of Mental Health - administrator of Medicaid for behavioral health in this state] or DOHMH [the City Department of Health and Mental Health] or HUD [Housing and Urban Development] or whoever else’s hand is in the pot, what services you’re expected to provide and how many [services] you’re expected to provide and when you’re expected to provide them, while also trying to maintain a consumer-first model, is really frustrating. Because at any given time it’s like ‘Who are we serving here’?” [2104]

Or as a provider from another program put it, “Like, just because OMH says that you need to have four services of 25 minutes…blah blah blah…like I wish that we could just not think toward them, but think toward what do our people need!” [2107].

Case managers were expected to meet the required amount of home visits per month but this requirement did not always coincide with what the consumers wanted or felt they needed. If the consumer did not want or need the pre-specified number of visits or the minimum duration of a billable service, or a consumer preferred to meet in the program office or elsewhere in the community, providers had to grapple with *whose* preferences to prioritize and how to meet both
mandates.

Every session should be at least 25 minutes, four times a week. Not everybody needs that surely, because some clients are more independent than the others. One of my clients told me one time, ‘You know you ask me the same questions every day. Don’t you know the answers to them?’ And I sat there like, ‘Sir, do you know why I get paid? I get paid to sit with you for 25 minutes every day.’ And he’s like, ‘It doesn’t mean it should bore you to death!’ (laughs) So I had to figure out another way to approach that client…because 25 minutes is a long time to bore a man. [2134]

Under a fee-for-service model, frontline staff were expected to meet productivity demands which was reinforced by program administrators. This expectation then forced providers to strategize around how they would use their discretionary power to meet these sometimes-competing demands.

There’s an expected amount. Each ACT [Assertive Community Treatment] consumer, at a minimum, needs to be seen six times a month. And then that turns into money, because when we bill Medicaid they say ‘Okay, if you see them six times you can bill fully,’ which is like $1500 per client. ‘If you see them five times or less, you can get $700,’ like less than half of that money! So there is a big push to see them that sixth time. And that’s one of those places where… okay, a consumer might not want to be seen six times, so uh… how do we force six visits onto a consumer? [2104]

**Doing the "real work" vs. paperwork.** In addition to other accountability measures, frontline providers were expected to document each individual service so the agency could bill Medicaid per service. “You have to do a lot of shit between each client - like Medicaid and medical stuff has to be logged in. And everything in between - their service plan, their progress
notes… it’s a lot” [2112]. Providers described a plethora of rules and guidelines imposed by funders and oversight bodies that set up a juggling act between what some referred to as the “real work” (i.e. assisting consumers in their recovery) and the paperwork (i.e. meeting administrative requirements set forth by funders and the agency), as this provider explained, “OMH, DHS… they don’t work one-on-one with these consumers. I mean these are people! It is just things that they’re throwing on. This has to be done, that has to be done. You really don’t have a lot of time to do things that needs to be done with the consumers” [2111], or as a provider from another program put it, “There’s just a lot of restrictions from like the city or the state and there’s like lots of rules we have to follow… There’s not enough time to get both things done - so either the office work gets shorted or the client interaction gets shorted” [2113]. According to providers, this predominance of paperwork then took a toll on the quality of services, “It takes away when you kind of just spew everything at them in a 15- or 30-minute session, you know? It takes away…a lot of the documenting and writing and chart-work takes away from the actually human part of the job” [2112].

Providers also understood that Medicaid preferred the delivery of certain types of services over other types of services, regardless of consumer preferences. “If it was a GED [high school equivalency diploma] that he wants, there is no way that that much effort would be allowed - because no government agency is coming around checking off whether [name of client] got a GED. But whether or not he has his medication and ended up in the hospital, that’s serious.” [2107]. This created a disconnect between what providers thought they were supposed to deliver (client-centered services) and what of their work was considered reimbursable by Medicaid (system-centered priorities).
I just felt like it would be a lot more like ‘client needs first’-based. Instead of...Like, if OMH came tomorrow, we would pass with flying colors...because we do really well in our audits. We got the max three years! But how did they give us three years? How did they not see that...? Unless I’m being an idealist and naïve and that’s just what we offer these people, just simply a place to be, someone watching you take your medication, and when you flip out you go to the hospital...Maybe that’s just what we are. I don’t know.

[2107]

**Juggling clinical supervision vs. administrative oversight.** According to frontline staff, extensive funder requirements and an excess of documentation requirements impacted not only frontline providers’ work, but also the work of supervisors. Street-level staff in both programs described the supervision that they received as lacking a focus on their “real work” with consumers and clinical issues. Instead supervision primarily focused on oversight of providers’ adherence to documentation standards, “I’ll be the one interjecting about my clients and they’ll be interjecting about the charts. I would say on average [supervision] is probably 75% chart, 25% client.” [2117]

This focus on the chart left some providers without clinical instruction or feedback on their work with consumers,

That’s my biggest problem with this whole place is I’m not by any means confident that I’m good at the part of my job I want to be. I’m really, really good at bullshitting. Like, if you look at my charts they’re just like, perfect! ...But when it comes to meeting with residents, I don’t know how I’m doing. I don’t have anyone supervising that part of my job. I have people supervising the other part of my job, like down my throat! But the
amount of times that someone has come up to me and said ‘How is so and so doing?’”

Like, no one has asked me that. [2107]

Providers attributed this focus on chart to their supervisors’ other role of ensuring the release of program funding. “Our formal supervision, I don’t really care for it because to me it’s just an audit, it’s not supervision. It’s only like ‘what’s not in the chart?’ I guess they’re anal about that because they’re Medicaid billing and they have to make sure everything’s up-to-date.” [2112]

This focus on administrative oversight also created a culture of rigid rule enforcement that negatively affected staff morale.

Sometimes in an effort to get the work done and make sure that it’s done perfectly and by state standards, sometimes the stress and the emotions and aggravation that the worker goes through trying to accomplish these things gets forgotten. It’s the culture. It doesn’t have to be said, it’s implied. You have an in-office auditor who comes here every Thursday looking at our charts. And then you have supervisors doing their supervision, so technically you have a chance of getting audited twice a week. It’s just the culture. [2117]

Additionally, without guaranteed funds provided prospectively, the fee-for-service funding model put organizations in a precarious financial position, one that providers felt at the street-level.

Our money comes from reimbursement, so we have to lay the money out and then we get it reimbursed…fingers crossed that OMH and HUD and DMH are going to send us the money when they’re supposed to. OMH was supposed to send us $1.5 million and they were three months late! So for three months we were like, ‘Uh!’ You know, we couldn’t do anything. It absolutely impacts morale. It impacts the clients directly, because
sometimes the CFO has to decide between paying the IT vendor versus paying rent on clients’ apartments. [2104]

This overarching orientation of providers to the external task environment and rigid oversight of performance reflected an organizational culture in line with that of an “audit culture” rather than the flexible and adaptive culture needed for the work of individualized consumer-oriented practice.

Yet, this system-centered focus had not always been in place across programs. One of the study sites, which started 20 years earlier as a pilot program, was originally funded through smaller contracts, but the culture of person-centeredness shifted as the agency began to draw on Medicaid funding, as this provider explained,

The agency is changing a lot right now. It’s not so consumer-oriented as it was when I first came in. Now it’s about OMH, DHS, and it’s about getting in paperwork - this has to be in or that has to be in, or the medical, the billing, and the words… how you word the note, because it has to be billable. Everyone’s focusing on that more so than on the consumers. And I think that’s a sad, sad situation [starts to cry]. I see it changing. And I don’t wanna be one to change right along with it. I wanna just…I wanna make a difference. [2111]

3.2 Discretionary Strategies

In juggling their responsibility to both funders and consumers, providers enacted a number of discretionary strategies to meet both the goals of their organization, as well as the goals of their clients:
Staying late and taking work home. In order to meet the obligations that they had to do both the “real work” and the paperwork, providers often extended themselves beyond their paid work hours - staying late to write notes or by taking work home, as this provider said:

I’d rather just deal with trying to do the paperwork later or at home or something like that, than to not see the clients. For some of these clients, we’re the only people they will see all day. And I know they’re actually waiting for us to come, so I feel bad if I get there and I can only stay 10 or 15 minutes when they’re there to like have a conversation with me. I’d rather have this [paperwork] stuff get shorted than the clients. [2113]

Padding the numbers. In cases when a consumer did not want a full billable visit or the service didn’t take that long, providers might document a full visit without actually staying the full time. Although a violation of agency and Medicaid policy, providers did this to honor consumer preferences and in response to the realities of service provision.

Let’s say a client has ‘Daily Living Skills, Health Services, Rehabilitation Counseling and Symptom Management [Medicaid-reimbursable services]’, right? A note for each of those needs to be at least 25 minutes long, filed by the 15th and submitted. So, like, to be honest ‘Medication Management’, it takes five minutes to watch them pack, right? Am I going to sit there and talk to them like ‘Oh, what did you think of when you packed Tuesday?’ Like I’m not! It’s a five-minute service. But it’s a 25-minute service and there’s stuff that they didn’t say, that I didn’t say that’s in the note. But I mean it’s one of those things too where it is talked about, but it’s not like ‘go into detail’. But I’m 99% certain that every single person in this office does that on a daily basis. [2107]

Offering small choices. Providers also noted the importance of offering small choices around the day or the time of the visit, so that even if the consumer didn’t want all of the
required visits for that month, they at least had some choice around when the provider would be visiting them.

So what we do on this team is at the beginning of each month we sit with each consumer with a calendar and say, ‘You know that we have to see you six times minimally. You tell us when, where, what services,’ and what have you. So we are still giving the consumer choice, within the guidelines that we need to follow. We are really strong on trying to maintain that ‘consumer-driven’ service while also meeting all these regulatory things.

Providers also described strategies that they used to meet organizational goals in spite of client-centered goals:

**Redirecting small talk to get to billable goal talk.** Providers talked about redirecting consumers away from engagement-building small talk and discussions about their immediate needs if it didn’t meet the criteria for a billable service goal, essentially redirecting small talk to get to billable goal talk, concentrating visits solely on the provision of billable services. As this provider put it, “When I come in and I have to provide services to you, you need to sit down and talk to me so I know what note I can write. If your service plan says ‘housing,’ we’re going to sit here and discuss housing. If it says we’re going to discuss medication management, you’re going to tell me how you manage your medication!” [2137].

Person-centered care is defined by its focus on the person’s own recovery goals, yet Medicaid requirements for the timing and frequency of service goal discussions limited providers’ ability to address the consumer’s recovery goals when and how the consumer wanted to address them. If the person’s immediate need or goal for that day was not included on the service plan, this created a dilemma – whether to accede to the consumer’s wishes or push ahead
with the services that could be billed for on that visit. “I don’t think he realizes that I’m coming to do services about, like ‘health and hygiene’. He’ll take leave of the conversation and rant about whatever he wants to rant about! And I kind of have to sneak the questions in there, you know? I talked to my supervisor about it…they said ‘Just keep trying to talk with him’ [2112].

Alternatively, providers described using small talk to get to goal talk, “I don’t necessarily want to go strictly by the book. You know? You have to talk about other things at least first, then talk about that service. Because it gets dull and then the client loses interest because they already know what’s coming. You become a little too predictable” [2124].

**Keeping consumers home.** In order to document enough visits before the billing period ended, providers discouraged consumers from leaving home or staying overnight with friends or family. “So you are telling your clients, ‘From the first day of the month until the 10th just don’t go anywhere, you need to see me. I don’t care what you have to do, we need to provide this service’” [2107]. This expectation was made clear to consumers and reinforced by management, as this provider explained, “[Medicaid] needs the four notes, and it’s going to be tough for me to get them if [the consumer] continues at his current rate of attendance. And at that point [the supervisors] are going to have this meeting with him like, ‘You have to be there,’ and I just don’t know how he’s going to respond. I don’t know if he realizes” [2107].

4. Conclusions

Findings demonstrate how policies related to financing of services shape implementation of services and the person-centeredness of care delivery. Specifically, the breadth of documentation requirements and measures of accountability were ultimately viewed as impediments to the recovery-orientation and person-centeredness of service delivery. The impact
of these external forces on provider practice is consistent with Damschroder and colleagues’ (2009) Consolidated Framework for Implementation Research (CFIR), which frames outer setting factors, such as external policies and reimbursement mechanisms, as potential barriers to implementing new innovations. In this case, agencies found themselves caught between broad mandates to provide person-centered care and the day-to-day realities of keeping agencies solvent through the pursuit of public funds. In many ways, these tensions were not resolved at the administration level, but instead reinforced by and passed down to front-line providers resulting in significant dilemmas on the ground.

In response to these challenges, providers used their own discretion to enact strategies that allowed them to cope with these competing demands. Some of the strategies worked against person-centered care such as demanding that consumers stay in their apartments to ensure that their interaction would be considered a “home visit” and redirecting conversations to ensure that visits would be covered according to billing requirements. At other times, case managers found work-arounds to achieve person-centered care such as offering the consumer some modicum of choice and completing paperwork at home to give more time for clinical tasks during the work day.

In this way, case managers became the “street-level bureaucrats” that Lipsky (1980) posits, finding some discretion within the demands of their agency to shape front-line services. The actions taken by these frontline workers demonstrate that implementation is not completely determined by outer setting constraints and inner setting organizational factors, but also through direct service providers, as they use creativity and personal agency to negotiate demands from above. Expecting providers to negotiate these complex and competing expectations at the street-level places a considerable burden on those who already must do a lot with little clinical training.
or financial reward, in order to resolve what are deep and persistent tensions within the health care delivery system.

The experience of the frontline workers in this study illustrates potential weaknesses of a fee-for-service approach to healthcare funding, which recent Medicaid reform initiatives have sought to address. A major strategy to achieve the triple aim of promoting population level health, reducing costs and improving the consumer experience is to realign financial incentives to encourage quality over quantity. The fee-for-service approach incentivizes volume over quality, with providers focusing on conducting and documenting services rather than on the care that improves consumer outcomes (Song and Lee, 2013).

In this study, frontline providers questioned the value of having six visits merely to generate the necessary volume to produce Medicaid funding. Bohte and Meier (2000) explain how these accountability demands shape the work of an agency, “When agency performance is evaluated in terms of numerical outputs, bureaucrats have an incentive to maximize outputs, regardless of whether maximizing outputs is the preferred strategy for achieving desired social outcomes (a form of goal displacement)” (p. 173). Addressing this problem requires realigning financial incentives to quality not quantity, which has taken the form of “value based purchasing” initiatives that tie payment to outcomes rather than outputs (VanLare and Conway, 2012). Such reforms, which are beginning to be adopted by Medicaid programs, would certainly go part way to addressing the street-level dilemmas experienced by these providers, giving them more flexibility and consumers more choice in how they receive care. However, the issue of accountability persists and one could argue that this new approach puts even more demands on agencies to measure outcomes in order to qualify for reimbursement. Further research and
attention is needed to estimate the broader impact of funding structures on frontline practice and to realize the transformation of the healthcare system to a person-centered system of care.

5. References


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