

Beyond ‘Unloving Care:’

Linking Human Resource Management and Patient Care Quality in Nursing Homes

by

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Abstract This study examines the link between human resource management, (HRM), work organization, and patient care quality in U.S. long-term care settings, proposing a key role for both management philosophy and improved front line staffing arrangements in delivering consistently higher quality care, defined to include both physical and psychological outcomes. Using the “high performance” model from industrial relations as a lens, the paper identifies three distinct systems of HR and nursing home management: traditional low-service quality, high service quality medical rehabilitative, and ‘new paradigm regenerative.’ The original research includes case studies conducted in 20 facilities in California and Pennsylvania, USA.

Two critical themes dominate the research literature on the U.S. nursing home industry: 1) many patients receive poor quality care; and 2) most front line employees have low quality jobs and work environments. Often these have been viewed as separate problems studied by academics and practitioners from different disciplines. In this paper, I use data collected from 20 nursing homes to investigate whether these phenomena are linked in a systematic way. I conclude that they are, and argue that alternative ways of organizing front-line work exist that improve on both outcomes. I outline a new model of innovative patient care, in which management philosophy and action is crucial, and argue that this warrants further empirical investigation and testing.

The goals of the paper are: (1) to propose a typology of management systems associated with distinct types of direct care; (2) to theorize the mechanisms through which front-line work organisation and human resources management (HRM) practices are translated into quality care for residents; and (3) to document the crucial importance of management values and choices, relative to structural variables more typically cited as sources of good or poor quality (e.g. economic status of the firm, direct costs, market served, resident mix, etc.). I

conclude that a “bundled” approach of HR practices, combined with innovative management philosophy, is likely to yield the best outcomes (MacDuffie 1995), but that strong institutional forces are arrayed against this combination.

The paper first offers background on the US nursing home industry and the methodology of the study.¹ The second section presents findings from original research; the study identifies two nursing home “models of work and care,” corresponding with “low-wage, low-skill, low-cost” and “high quality” models in industry² These are associated with particular human resource practices for front-line workers. A third model, with qualitatively different outcomes, appears to be least common, and to feature distinctive human resource management (HRM) practices. The final section of the paper proposes a model for predicting varying outcomes, identifies barriers to diffusion of best practices, and suggests future research.

Keywords Long term care, work organisation, front line workers, health care

1. Background on Nursing Homes & HRM Practices

Nursing homes touch the lives of an increasing number of Americans. Today more than 1.5 million individuals live in 17,300 U.S. nursing homes, and nearly 2 million employees work in them. The nursing home population will double in 25 years and triple in 35 years (Dick *et al.* 1992). The number of beds has mushroomed from 500,000 in 1963, to 1,175,865 in 1973, to 1.8 million in 1997. Long -term care is also a big business. The industry grossed \$87.5 billion in 1996, with projections of more than \$100 billion by 2000 (Harrington *et al.* 1999a: 1,11).

Most U.S. nursing home care, while privately delivered, is paid for with public funds. Payments to nursing homes consumed more than 32% of public health funds for poor people, \$36 billion in 1993, although the poor elderly are only 16% of those covered. This amount is predicted to increase more rapidly beginning in 2010 when the first baby boomers turn 65 (Fein 1989: 112;

Harrington 1996: 477-9). Government funding to nursing homes between 1986 and 1991 nearly doubled. Profits of private sector nursing home companies, which are 66% of owners and operators in the industry, also doubled in this time period. Another 28% are not-for-profit voluntary organisations, and 6% are publicly owned (Harrington *et al.* 1999a:20). Recently the private for-profit sector of the industry has experienced a severe downturn in profits and valuation, mainly because of public funding cutbacks, while public and non-profit facilities are also experiencing resource crises.

If auto plants represent the “typical” industrial workplace of the twentieth century, nursing homes could be the quintessential social service sector workplace of the twenty-first century. Nursing homes now employ more workers today than the auto and steel industries combined (US Dept. of Labour 1993: 248), and the number of jobs continues to grow. As in other direct service industries, “emotional labour” is frequently required of nursing home staff, on a near-constant basis (Hochschild 1983).

Unlike unionized industrial jobs, most nursing home jobs are quintessential “low-wage and low-skill.” Front-line caregivers, called nurse aides (NAs), earn an average \$6.94 per hour (AHCA 1998:40) and comprise 85% of all nursing staff. Benefits are well below average; most non-management staff members are not covered by health insurance, and pensions are rare, offered by only 16% of homes in one study (Hunter 1994). Unionisation is low, about 12%, and concentrated in the public and not-for-profit sectors. Turnover rates are high, at more than 100% annually for nurse aides, 56% for registered nurses, and 27% for administrators (Wunderlich *et. al.* 1996:160). In addition, workers are more likely to be injured in a nursing home than in coal mines or manufacturing plants (SEIU 1995a). Lost-time injury and illness rates in nursing homes are twice the U.S. average for private industry at 17 cases per 100 workers (Wunderlich *et. al.* 1996:163).

Most people go to great lengths to avoid nursing homes, and even think of them as “places to die.” In keeping with their sub-average HR practices, too many nursing homes provide low-quality

service. A long series of studies, government reports, and hearings document this problem (GAO 1999; U.S. Senate 1991; U.S. Senate 1988; U.S. Senate 1986; Vladeck 1980, U.S. Senate 1974). Despite decades of public criticism, the quality of care provided to many residents remains abysmal. A full 40% of nursing homes certified by the Health Care Financing Administration (HCFA) repeatedly failed to pass basic health and safety standards over the last four annual inspection surveys, and many more garnered serious patient care deficiencies on at least one survey (Lieberman 1995 :518).³ The average number of deficiencies per surveyed facility was 4.7 in 1997, but this figure disguises patterns that vary widely between facilities and states (Harrington 1999a: 175). A 1999 U.S. public study showed that among all U.S. facilities, one-fourth provided care that either had harmed residents or could have led to death or serious injury (GAO 1999: 23). The condition of nursing home residents regularly deteriorates without medical reasons and many remain depressed. More than 25% of homes have been cited for allowing residents to acquire bed sores, a condition widely considered to be preventable (Lieberman 1995: 524).

Yet not all nursing homes follow this pattern. Most studies find significant differences in quality outcomes that are measured in a variety of ways. A meagre 22% of facilities received no “deficiencies” in the last annual survey, but this is not the whole story. In some places, residents are cared for with dignity, experiencing thoughtful, competent medical care. In others, elders are encouraged to continue their psycho-social growth and development, to “age in place,” and to remain in control of their lives. Some facilities record lower mortality for residents cared for in seemingly simple different ways (Langer 1989). This paper identifies possible sources of variation, examines HRM and other practices for higher and lower-quality facilities and front-line service workers, and proposes a model of contributing factors.

Disciplinary Perspectives

Drawing on prior research from three academic disciplines-- economics, sociology, and medical gerontology-- in which scholars seek to explain variation in nursing home quality and effectiveness. *et al.* Medical economists focus on structural rather than process variables. Researchers find “quality” difficult to define, and no consensus has emerged to date despite many proposals of how to measure it.⁴ A number of economic studies point to structural factors (size, profit status, etc.) associated with various levels of “output” and efficiency (e.g. McKay 1988, Nyman 1988). What is missing from the economic approach is any connection between outcomes and how the front-line work is actually organized to produce them. Sociological research shows that social and informal interaction are as important to quality of residents’ lives as medical or clinical care (Mor *et al.* 1995; NCCNHR 1985).

Sociologists and anthropologists have contributed both ethnographic studies and macro analysis (Diamond 1992, Tellis-Nayak and Tellis-Nayak 1989, Vladeck 1980, Mendelson 1974). Sociologists observe that both the elderly and their caregivers are socially devalued and marginalized. Some argue most “caring” work has been systematically undervalued, in part because society has relied on “free” labour by women in the household (Sacks 1988). Even today, between 70 and 85% of all long-term care services are provided informally by family members and friends. But since most women now work for pay outside the home, this pattern is not sustainable over the long term.

Service sector studies by management scholars have documented “invisible work,” including relational work and specific work processes that are not considered “productive” because they are not routinely measured, billed for, or even documented (Fletcher 1994,1999, Jacques 1993). These include interventions such as conveying information, providing comfort or company, or preventing a problem. Scholars have also investigated “emotional labour,” as outlined by Arlie Hochschild (1983), and begun to measure its value and its impact on workers and customers (Leidner 1993, Morris and Feldman 1996, Ashforth and Humphrey 1995). A parallel in front line nursing home

work is that emotional labour required is not simply the “display” of a felt state, such as kindness, compassion, and cheer, but an ability to behave and complete tasks patiently, gently, and with tolerance, even if one is being physically or verbally attacked or insulted. Some genuinely affectionate long-term relationships are formed, which makes the death of residents or patients difficult. So both real attachment and emotional dissonance combine in these jobs.

A difference between long term care and other service industries (see Frenkel *et al.* 1999; Morris and Feldman 1996) is that the “customers” (or “residents,” as clients or patients in nursing homes are usually called) have very little voice or power. Most cannot easily move to another facility. At least 50% of residents suffer from dementia, and others experience periodic disorientation. Resident councils are rarely powerful enough to change conditions. Family members are frequently absent, and advocacy groups often focus at the policy level.

The strength of these sociological and management analyses is that they demonstrate both the larger social context of gendered labour patterns, and the micro-environment of actual workplaces. However, with few exceptions (e.g. Tellis-Nayak and Tellis-Nayak 1989), they fail to incorporate economic and political factors that structure the health care system or account for variation in work practices. While helpful in identifying emotional work, some do not carefully examine the actual organisation of work (See Frenkel *et al.* 1999, Herzenberg *et al.* 1998, Fletcher 1999 for exceptions). Many excellent management studies focus on work where “pleasing the customer” is of utmost importance (as in hotels, telecommunications, and banking; see studies in this issue, for example), but do not examine customers who lack ‘voice’ and whose satisfaction is not a major goal of the industry (i.e. the provider is paid by third parties whether residents are satisfied or not).

The medical and nursing literature from gerontology contributes important insights on quality (Wunderlich 1996; Harrington 1996; Johnson et. al. 1996 1996; Maas *et al.* 1996; Feldman 1994). Relying on new indices of quality assessment and the recently computerized Minimum Data Set (MDS), these scholars tend to focus on outcomes, more than on processes, or the relationships that

create outcomes on a day-to-day basis. Most of this literature does not study the actual design of work or the daily mechanisms of care delivery and resulting outcomes for residents, though it is promising in its potential for being combined with such types of studies.

Methodology and Approach

An industrial relations/human resources perspective is valuable in understanding both day-to-day operations of nursing homes and larger systemic factors shaping micro-interactions. I focus on relationships and people management to identify the mechanisms that lead from a particular work process design to specific quality outcomes for residents. Past research on such a “high performance” industrial relations model has for the most part been grounded in industrial settings (see Kochan and Osterman 1994; Appelbaum and Batt 1994.) A few researchers have examined nursing homes as multi-level organisations where job design, work group organisation, and organisational design all contribute to quality outcomes. Brannon and her colleagues (Brannon *et al.*, 1992; Brannon and Zinn 1995; see also Zinn *et al.* 1995) examined Total Quality Management (TQM) programs and found them somewhat effective, but the studies provided little detail on actual work organisation or interactions with residents. In a survey of managers, Hunter (1994) found some ‘high performance’ HRM practices were associated with improved outcomes, but were difficult to document and sustain.

The most appropriate methodology for problems where mechanisms are not well understood is qualitative, hypothesis-generating research. Through direct observation, interviews, and intensive case study methods, I conducted research on the mechanisms through which organisation of front-line service work led to quality outcomes for residents in two U.S. states, and what the most important mediating and environmental factors were. This study reports findings from observational field research in 14 nursing homes in California, supplemented with case studies of six homes outside California. I conducted 107 interviews

with workers, managers, corporate officials, advocates, union stewards and representatives, academic experts, and policy makers. I chose California as a field site for several reasons: the many different nursing home settings in the state; a high level of for-profit activity; a strong patient advocacy organisation; careful inspectors; and moderate unionisation. All these factors contribute to variation in outcomes and work systems. I completed 150 hours of field observation on site visits, interviewing residents on site and employees both on and off site.

Interviews and case studies were chosen to ensure a broad representation. The 14 California facilities I studied in 1994 varied in size from 15 to 400 beds, with 80% between 50 and 200 beds (like 70% of the homes in the industry). They included 10 private for-profit and 4 voluntary (including 3 religiously affiliated) homes, 7 chain-owned and 7 freestanding facilities, and 7 union and 7 non-union facilities. “High quality” facilities recommended by industry experts were over-sampled to ensure sufficient representation. High quality facilities were defined as those with few state-identified deficiencies and those recommended by advocates as providing excellent care. I studied six additional facilities in Pennsylvania during 1995 and 1996, including three for-profit and three not-for profit, two union and four non-union, and three owned or managed by chains. I also studied two facilities outside these states.

Potential problems with this methodology include selection bias. Four homes with average to high deficiency ratings denied formal access to me as a researcher, but all were observed in a “visitor” status and several employees and residents at each were interviewed. Low quality facilities may nevertheless be underrepresented. High levels of agreement existed among expert informants in the two states who identified “high quality” and “typical” facilities. “Typical” facilities appeared similar to each other within and across state boundaries. The lowest quality homes were certified and providing reimbursed care, despite multiple citations and warnings from state officials. To protect confidentiality, names of nursing homes and individual informants are disguised unless they agreed to be identified.

A typical nursing home organisation chart is attached as Figure 1.

[Figure 1 about here]

This study focuses on the front-line service workers who are usually termed “nurse aides”(NAs). They make up 85% of nursing workers and deliver 90% of hands-on care. Other important staff include registered nurses (RNs), who supervise record-keeping and overall care planning. Many facilities have few full-time RNs, and they spend on average only 7 to 8 minutes per shift on each resident, including their administrative duties (Harrington *et al.* 1999a: 66-7). Most NAs are supervised by licensed nurses (LVNs or LPNs), who have two years’ training and spend an average of 12 minutes per resident per shift (*ibid.*), most of it in documentation and administering medication. Nurse aides, averaging 43 minutes per resident per shift, provide the overwhelming majority of direct care to residents. Experienced NAs accumulate stores of “tacit knowledge,” including how to lift and turn specific patients safely, how to cheer them, who has grandchildren, who prefers warm water for bathing, who needs glasses for what, and much more. Individualized care is mandated for all residents, but not always received.

Although an industry analysis is essential to understanding nursing home operations in detail (see Eaton 1996, Vladeck 1980), space does not permit an explication here. The extent of variation described in this article suggests that different outcomes are possible for facilities delivering essentially the same “service” to a similar “customer” base

II. From Places to Die to Regenerative Communities: A Typology of Work, HRM, and Care Systems in Nursing Homes

Three distinct systems of work, human resources management, and care organisation characterize the nursing homes observed. The first typifies the majority of nursing facilities studied, and I call it a “traditional low service quality” model. The second delivers higher service quality and focus, and I call it a “high quality high service model.” About one-fifth of homes studied fall into this group. The third category is a “regenerative community” model, representing an innovative paradigm of care and work organisation. The next section describe the models and their characteristic HR practices, work patterns, quality outcomes, and management philosophies of care. While these are presented as “ideal types” (Weber 1947), they are intended to capture key variation in work and care systems.

A. Low Quality Nursing Homes: A Distinct Work and Care System

Nearly 70 percent of the nursing homes I studied are of the “Traditional Low Service Quality.” type as summarized in Column 1 of Table 1.⁵

[Insert Table 1 about here]

The work system of this dominant model is labour-intensive, but not Tayloristic. Workers receive little or no supervision on how to do tasks required of them, no feedback on effects of their work, and virtually no information about the condition of the residents to whom they are assigned. No one helps them make sense of multiple simultaneous demands on their time. Training is minimal, and equipment and essential supplies (such as fresh linen and clean gloves) are frequently unavailable.

Work practices in the low-service quality homes are often antiquated. For example, one HR director said his company's latest innovation was that the chain was installing time clocks in each nursing home. Usually the Director of Nursing (DON) or the administrator hires, disciplines, and fires, despite little or no training in HR. Benefits are rare. "We are not concerned with providing health insurance," said one chain executive. "Most people can't afford the contributory (health) insurance we offer." Training is limited to one hour a month, the minimum required by law, for nurse aides. Often it is provided by whatever nursing home supply vendor happens to be in the neighbourhood.

Managers I interviewed did not trust their workers. Many facilities seem to be in a low-wage, high-turnover cycle: workers do not have much to lose if they lose their job, so they are not too concerned to keep it. NA jobs are virtually always available, since turnover is so high.⁶ When asked about developing work systems with a "customer" or "quality" focus, one official of a large chain said:

We can't involve employees in developing systems with a customer focus... The great majority of people who do nursing aide, housekeeping, laundry, and food service work are there because it is the best job they can get currently... they have a low sense of self-esteem... These people, not like you and me, [they] do not see life as something to take charge of. They see life as one uncontrollable event, something that happens to them.... You cannot walk in the door with a typical TQM project, you can't tell them to accept responsibility for the care giving system, you can't tell them to work in a quality team environment, because to do any of that requires them to take charge of their jobs. And they can't do that.

With such attitudes, perhaps a self-fulfilling cycle exists. Although many aides were poor and not educated formally, many cared deeply for their patients and chose this work despite poor working conditions. "I could go down the street and get a job at Burger King," said one aide. "But I care about these residents. If I weren't here, they would be much worse off." Little information about residents' conditions was shared with workers, even when they asked for it specifically.⁷

Aide turnover in these settings is high, usually exceeding the 100% industry annual average, and recruitment and selection are often not carefully handled. For instance, 87% of employers in Hunter's Massachusetts sample did not require nurse aides to take a written test before hiring, although difficulty with basic writing affected at least 35% of their employees (Hunter 1994: 295). Numerous Beverly Enterprises nursing homes in a Texas study had turnover rates of aides between 160 and 346% (SEIU 1995b). High turnover is expensive (estimated by industry informants at \$4000 per nurse aide, or three months' wages), and has a negative impact on care.

The philosophy of care which fits with this work system is best summarized as "medical-custodial." Yet in many cases this label is too generous. In the low-service model, residents typically do not receive adequate medical care. They make few choices about daily circumstances of

their lives, and have little control over their food, clothing, or their most intimate functions. Such facilities repeatedly garner “deficiencies” in their annual survey because they do not make “care plans” for residents, because they restrain residents without proper orders, because they leave them lying in their own waste, and because they do not staff even at the bare legal minima. Sometimes abuse occurs between workers and patients. One study found the incidence of patient abuse was unrelated to professional education, years of experience, or status, but directly related to stressful working conditions, including those which induced frequent thoughts of quitting and high levels of burnout (Pillemer and Moore 1989).

The relationship of turnover to patient care is clear and well documented: higher turnover interrupts continuity of care and is associated with lower patient care outcomes (Harrington 1996: 466). Many stories of the ill effects of turnover and understaffing circulate at nursing homes.⁸ Quality of care -- and sometimes even life and death-- depend critically on small decisions such as appropriate food to give an individual. In two Pennsylvania facilities where only 19 and 36% of the NAs had three years or more experience in that facility, correctives per 100 residents were 23 and 29, compared to 0 and 2 in two facilities where between 65 and 80% of the NAs were experienced (these latter would be higher quality facilities).

Short staffing also results in poor health outcomes, like high levels of facility-acquired pressure sores when staff are unable to turn bed-bound or wheelchair-bound residents every two hours, and when medications are forced down or spat out. One LVN explained her dilemma in attempting to give quality care:

I have to give medications to 50 patients on my shift, sometimes three times a shift, as well as chart for each patient, document care for each one, supervise the aides, and sometimes help out on direct care. And there is not enough time. You can't just go and put the pill in the person as if they were a machine. These are human beings.

They need to talk to you. They need to know what's new. They need a little conversation. Most of them know me. I know them, and their families.

A union representative explained that according to California State law, patients are supposed to get 3.2 hours of nursing care per 24 hours.

But I have written out one whole 24 hour day of a Certified Nursing Assistant's time showing that each patient only gets an average of 21 minutes, with all the CNA's duties, even if they work fast. At [Facility X], they are not taking breaks, they are not eating.

This observation is supported by research showing the typical resident spends at least 91 of 112 waking hours a week doing nothing whatsoever in the traditional facility, and are directly cared for an average of only 4% of their waking days. Residents in a traditionally organized facility were barely interacting with anyone, mainly waiting, to be gotten up, fed, put to bed, or taken somewhere (Mt. St. Vincent 1994).⁹

When workers cannot finish their work, supervisors often recommend speed-up. "We are trying to get them [the NAs] to do a better job, meaning faster, better, and cheaper," said one HR officer. Another supervisory strategy is to look the other way and make sure the records say what they should. "I couldn't give showers because I had too many 'total care' patients to take care of," said one aide. "So my supervisor told me to write it down anyway because the state might be coming and she had to show that it was done." This instruction puts the aide in an impossible position, since falsifying records is a firing offence-- yet there appears to be no choice with a direct order.¹⁰ Higher-level supervisors also acknowledged to me that they had created documentation for services not performed. They described this as common in the industry, as a way to deal with reporting requirements seen as too demanding.

Researchers have documented serious outcome problems with poorly trained aides, and insufficient staffing (Dresser et. al. 1999; Vladeck 1980; Harrington *et al.* 1999a). Some have attached costs to these practices. The total health care bill for incontinence in nursing homes per year is \$3.26 billion, including direct care and the consequences of incontinence like decubitus ulcers, urinary tract infections, etc. (U.S. Senate 1991). Much incontinence could be prevented with more frequent toileting and training of residents.¹¹ Physical restraints on residents, many of which could be removed with better staffing, require an extra 375,000 hours of nursing care, and cause functional deterioration for patients. Between \$2 and \$12 billion could be saved by preventing pressure sores-- with frequent turning, massage, mobility, and proper skin care. Approximately \$1 billion in hospital treatments for fractures and infections is estimated to be preventable if staffing and training improved, and chemical restraints reduced appropriately (Burger 1994).

The quality of care resulting from this common low-wage, low-skill system of work organisation is documented in the US General Accounting Office's 1999 audit, the Institute of Medicine's 1986 and 1996 studies, Consumer Reports (1995),¹² and state nursing home surveys. One consumer survey gave California nursing homes overall a "C-" grade, noting that for-profit and chain facilities were the worst offenders (CANHR 1993). Academic research confirms the direct relationship between total nursing hours and a variety of carefully measured quality outcomes (Harrington 1996, Harrington *et al.* 1999a, Wunderlich *et al.* 1996), as well as a negative relationship between overall quality and for-profit chain facilities.

Residents' voices are almost absent from studies, though in 1985 the National Citizens Coalition on Nursing Home Reform (NCCNHR) held multiple discussion groups with 457 residents from 107 nursing homes in 15 cities to explore a consumer perspective on nursing home quality. The study showed that residents rarely identified clinical care as the most important factor in their quality of care or life. Rather, it showed that:

Pleasant and positive relationships and feelings and attitudes between staff and residents are crucial to quality of life and care. Individualisation and personalization rank high with them. They want as much independence as possible, and the ability to help themselves whenever possible. When they need help, they want it given cheerfully, with understanding.

(NCCNHR 1985: I-15)

In the kind of work system described here as “low quality service,” residents almost never get this kind of care.

B High Quality Nursing Homes: Different Practices, Different Outcomes

Column 2 in Table 1 describes a second distinct type of nursing home work and care system, labelled “High quality.” The working conditions, HR practices, and quality of care outcomes are all notably different in these facilities. They are often, but not always, non-profit, often part of religious chains. If they are for-profit, they usually are facilities targeting the private-pay market, such as Manor Care, which had only 30% Medicaid patients at the time of this study, compared to an industry mean of 62%. One recent study shows that not-for-profit homes have a higher percentage of high-quality homes (89.6%, $p < .001$) and for-profit chain-owned homes have a higher percentage of low-quality homes (18.3%, $p < .001$) than would be expected, controlling for other factors including facility size, case mix, reimbursement systems, and geography (Johnson et. al. 1996:441). However, it is not their profit status per se, but their philosophies of management and related work organisation systems, especially for front-line caregivers, that yield higher quality.

The most striking characteristic of the working conditions in the higher quality nursing homes was that the facilities were not understaffed. Nurse aides averaged eight residents apiece on the day shift, and most felt they had a reasonable number of patients. Absent aides were replaced. Work organisation also differed. Nurse aides often worked in teams, or “care pairs,” so they could

assist each other in the difficult emotional and physical parts of the job, whether soothing a demented person, or lifting a heavy resident. Information on resident health status was freely shared by nurse supervisors, often in a “team meeting” at the beginning of a shift.¹³ Documentation was a lesser problem, as aides took cards and had time to fill them out while they were with residents. When residents were to be turned or taken to the toilet every two hours, aides could keep to the schedule.

As suggested above, formal HR practices in the “high quality” facilities were also significantly different. Starting hourly wage rates at facilities I studied in California began almost 50% higher, averaging \$7.50 in 1994-5, and workers earned annual raises with seniority. Benefit package had affordable co-payments ranging from 0 to 20% of premium costs. Sick leave and vacation benefits existed, education reimbursement policies were available to and used by workers, and more facilities were unionized (for one case, see Hunter 1994:93-136). Turnover at these facilities was much lower than the annual average 100.4% for the industry, though still higher than in most industries at 30 to 40% on average.

The “high quality” homes are distinguished by more nurses working on each shift at the RN, LVN, and NA levels, more gerontological training for all staff, greater information-sharing, more team-work and more continuity of care. Measurable differences in resident outcomes included a lower incidence of facility-acquired pressure sores (some had 0), less frequent use of restraints on similar patient populations, and fewer hospitalisations per capita, presumably since more infections and falls were prevented. Other quality measures showed differences from low quality homes, such as many fewer cited deficiencies in patient care areas (zero to four, below average, compared to eight to fifteen in ‘low quality’ homes), fewer total deficiencies, 100% of care plans implemented and documented, more successful continence programs, etc.¹⁴ At the facility level, visible differences included lack of odour, higher resident activity levels, and social engagement between residents, visitors, and aides.

Patient-specific knowledge is crucially important in ensuring quality of life, safety, and adequate care. Each resident has preferences, whether she can communicate them easily or not. Researchers have documented that in higher-quality homes, the amount of social engagement between residents and staff, and among residents, is far higher, and even that it could be used as one proxy for quality of life (Mor *et al.* 1995).

Summary: Two Dominant Models of Care

In lower quality nursing homes, staff often feel overwhelmed by the demands confronting them, and appear to manage as if cost efficiency is the overriding goal, with quality care defined as not violating regulations, and front-line workers viewed as replaceable and unskilled. “We are not even beyond the warm-body syndrome here,” one administrator said, referring to NAs. “We just do the best we can.” The results are predictable: high staff turnover, low loyalty from professional and service workers, and minimal quality of care for residents. However, market and regulatory conditions that these mostly private for-profit homes confront do not require them to do anything differently. Available beds are nearly full. The public reimbursement system, which funds two-thirds of all patients, does not link quality and compensation beyond a bare minimum: it requires a written commitment to correct deficiencies found on the annual survey. Because nursing homes only hope to break even on their Medicaid patients, they actively seek both private pay and Medicare patients to increase their productivity and profit margins.¹⁵ But with occupancy at more than 86% nationally, and 25% of homes completely occupied (Harrington 1999a:4), managers do not have to improve quality to attract patients (Nyman 1988).

For those seeking to attract higher-paying customers, a “high quality” model distinguishes them from more common low quality facilities (see Hunter 1994). Private pay patients, who have more choice of facilities, choose homes where the care quality is higher, nursing staff are more

skilled and committed, and activity levels are higher. They may also seek more comfortable physical facilities.

The presence of some “high quality” for-profit nursing homes in the market can be explained in part by “strategic choice” on the part of managers/owners rather than by an economic strategy (Kochan, Katz, and McKersie 1986). Many managers of not-for-profit high quality facilities appeared to have values-based reasons for choosing HR practices which fit this model. “I take care of my staff, and they take care of the patients,” said one DON at a high quality Quaker facility. “If I treat them badly, they will treat the patients badly.” Market niche is less important than serving a particular community, or enacting the values of a religious constituency. “We are part of the Jewish community, and these are their parents and elders,” said one officer of a Jewish facility. “I also depend on their contributions. So we make the families welcome at all hours, and they have to be comfortable with what they see.” Within certain constraints, managers may choose to deliver higher-quality care rather than lower. One religious facility had an above average 70% Medicaid population, but raised 14% of its budget in the community so that it could maintain higher standards of care for everyone. Another not-for-profit drew on funds from a union-negotiated fund to pay for higher quality care.

Employment relations in these settings may involve a labour-management relationship; while relations with unions varied, most managers were not anti-union. One private chain agreed to union-proposed “patient care committees” in which workers met with managers to seek improvements in care practices.¹⁶ In general, front-line workers were more involved in patient care decisions in high quality facilities. This too parallels the “high performance” track in service management (Bowen and Lawler 1992).

After I divided my site visits into these two quality categories, several facilities remained; they were among the “best” recommended by experts and consumers. Their managers organized care, HR, and work differently than in either model above.

III. Regenerative Communities: A Qualitatively Different Model of Care

“One day, at a nursing home in Connecticut, elderly residents were each given a choice of house plants to care for and were asked to make a number of small decisions about their daily routines. A year and a half later, not only were these people more cheerful, active, and alert than a similar group in the same institution who were not given these choices and responsibilities, but many more of them were still alive. In fact, less than half as many of the decision-making, plant-minding residents had died as had those in the other group.” Ellen Langer, Mindfulness (1989: 1)

Langer and Rodin’s quasi-experimental research in the 1970s called attention to habitual “cognitive constructs” which shape thinking about aging (Langer and Rodin 1976, 1977). In my study, a third cluster of nursing facilities which challenged these constructs emerged. I call these “regenerative communities,”¹⁷ and their features are summarized in Column 3 of Table 1. While hardest to define precisely, they represent a different paradigm of care. The approach does not have a single exemplar; multiple examples exist, each distinct but sharing a rejection of dominant cultural assumptions about aging.

The “mindful” philosophies of care seemed to precede, and in fact to require, changes in the way daily work and HRM were organized. Perhaps this approach is evolving piecemeal as innovators try various ways to implement their ideas. Often the leader had worked outside the nursing home industry, and had fought an uphill battle against institutionalized norms about what a nursing home “is.” To show the diversity and commonalty in work organisation and philosophies of care among these regenerative approaches, two examples are outlined below.¹⁸

Example 1: The Eden Alternative

The Eden Alternative, a small-town nursing home in upstate New York, houses some unusual residents along with the elderly of the area. More than 200 birds, four cats, two dogs, dozens of plants, a child care centre, a garden, and a visiting school-children's program help create what founder Dr. Bill Thomas and his wife Judy call "a holistic environment." Thomas, a part-time faculty member at State University of New York (SUNY), was a small-town doctor who hated doing his rounds at local nursing homes, particularly missing a diverse environment in which older people could thrive. Dr. Thomas took over as administrator at the local home, and began to change things. In The Eden Alternative (1992) he tells of the changes he and his wife worked in residents' lives. By offering older people the chance to play and interact with a wide variety of birds, animals and young people, the Thomases and colleagues created a more healthful, generative community. One of the principles they enacted is that people need to give care as well as receive care to feel valuable. The Eden paradigm allowed elders to care for animals, birds, and children as well as each other.

Thomas reorganized the traditional medical model of patient care in Eden. He got rid of restraints, both physical and chemical. Not only did drug bills decline dramatically, but residents who had been restrained and disoriented began walking and talking again, with help. He instituted story telling hours and asked residents to give lessons in skills they had learned over a lifetime, such as gardening and leather working. Compared to a nearby control facility, the Thomases documented statistically significant reductions in mortality and in illness as well as drug use. Workers were redirected to spend more time with residents who needed more help, and residents began to assist each other. Some workers specialized in animal care, and encouraged more resident interactions with pets and children.

Thomas's reorganisation included HR, changing attitudes toward workers and their roles in providing quality care. To start, he asked aides to make their own schedules. Immediately, staff attendance improved as people worked out their responsibilities at home and at work for themselves

rather than having these imposed on them by a supervisor. He also provided training for workers in “holistic care.”

Unlike the high quality models cited earlier, start-up financial costs for Eden were minor, and ongoing costs were no more than before. The entire "capitalisation" cost of “Edenizing” the facility with animals, plants, and staff training can be done carefully for about \$100 a bed, less than 1/300th of a facility's annual budget for a bed. Thomas notes, "the biggest cost is changing your mind." While cost figures are difficult to compare across states, reimbursement areas, and acuity mix, what is striking here is a positive comparison with previous expenditures.

The Thomases have engaged in several projects to replicate and document the results of Edenizing neighbouring facilities. Issues confronting them include how to provide replication "technology" on a larger scale, how to deal with perverse incentives in the Case Mix Index (a system of financing which takes money away from facilities if elders improve in health, as they did at Eden), and how to cope with states which provide unlimited drug money not convertible to other costs if drug use is reduced. In different regulatory and market environments, alterations to the “Eden” model will be necessary. But the basic philosophy, Thomas believes, can stay the same.

Example 2: Sisters of Providence/ Mt. St. Vincent

“ We began our efforts based on the assumption that being sick is not a normal part of the aging process.... We further assumed that if we could ‘correctly’ alter the fundamental way in which we thought about care delivery and provided service, that we could actually retard or reverse the resident decline process...”

(Mt. St. Vincent 1994)“To better nourish the human spirit, we must break with tradition..

During the last two years, as we rewrote our mission statement, our staff and residents had many discussions on human priorities. One dominant theme emerged: seniors

want more control of their lives. The social model is built on flexible, natural human connections... Our residents have made their priorities clear: they want to retain the control and dignity they have known all their lives, in the warmth of a socially-based community.” (Mt. St. Vincent “Vision,” n.d.(a))

At Sisters of Providence/ Mt. St. Vincent (P/MSV), a Catholic long-term care facility near Seattle in Washington State, another visionary leader, Robert Ogden, and colleagues turned a traditional facility into a consciously “regenerative community.” Before a 1993-4 reorganisation of care delivery in one unit, its residents received direct care for only 3.2% of their waking day (typical for other nursing homes). NAs spent two-thirds as much time completing paperwork as assisting residents, again typical. Residents spent only 7 percent of their day interacting with staff, other residents, or visitors. Baseline measures of resident physical and cognitive capacities trended down after entrance to the home, as often occurs in nursing facilities (Mt. St. Vincent 1994). But the observation also confirmed that, according to Ogden, "Staff were doing exactly what they have been trained and were expected to do... We had committed and hard-working staff forced to use an antiquated and stupid system" (Mt. St. Vincent 1994:13).

After this pre-study, staff created several “neighbourhoods” and “families” of residents with helpers. The experimental unit was remodelled to include a living room, kitchen, and small dining room along with individual resident rooms instead of the usual institutional corridors. Care delivery was reorganized so that five residents are supported by a single "resident aide." Because the group becomes like a “family,” consistency of relationships between aides and residents, and among residents, are encouraged. Residents can choose when to rise and to go to bed, what and where to eat (snacks are available 24 hours a day), and what activities they want to take part in. These choices are almost unheard of in either of the other models. Nursing services have been changed to a “home nursing” model, where RNs visit as needed, rather than sitting in the unit as managers. Each neighbourhood has its own “coordinator” and budget.

Residents liked this new system (Mt. St. Vincent 1994). After the changes, they spent more than 15% of their day interacting with others, and 50% of the day engaged in activity of some kind. Residents' functional capacities stabilized or improved (measured in activities of daily living) rather than declining, as they continued to do in control groups. Preliminary health and risk indicators improved, while medication dosages and usage declined significantly compared to the control unit. Infections also declined, as did "incidents" like skin tears or falls (Mt. St. Vincent 1994:27-33).

To implement this values-based philosophy of maximizing resident choice and home-like environments, and to increase interactions, both HR practices and aides' jobs were redefined (Boyd 1994). Activity planning, assistance with individualized food preparation, and social and rehabilitation planning were integrated into resident aide jobs on each neighbourhood. Also, aides' job descriptions now include talking with residents, attending to requests for companionship, and helping them eat at times of their choice. This required that aides be cross-trained and licensed as food handlers. Housekeeping staff were assigned to a "neighbourhood" and cross-trained as nursing assistants, so they could help with toileting and bathing at times when residents preferred, not on an institutional schedule.

Ogden and colleagues redefined the front-line job to focus on providing what residents wanted, not what nurses wanted. They redefined licensed nurses (RNs) as clinical resources available on demand, rather than as controlling figures on a ward. This allowed Providence/ Mt. St. Vincent to substitute resident aides for nurses at the rate of 2 to 1 (in this facility, resident aides earned \$9 an hour and nurses about \$18) and to provide more front-line, hands-on care staff without compromising care quality (Ogden interview 1995). Eliminating some middle management jobs funded the designation of resident coordinators for a neighbourhood (Boyd 1994). The facility even saved 40% on food bills because it disposed of less unwanted food.

Many "resident aides" were satisfied with the change; their jobs were more varied and required more judgment and skill. Some HR problems arose, since not everyone who had worked in

the prior facility was able to adjust to these changes. In some cases, managers began hiring people never previously trained in long term care, to get beyond deeply embedded assumptions. But for most aides, their crucial role in resident care was recognized here as it had not been in the old "nurse aide" role. This simple but far-reaching innovation improved the quality of work for many staff.

This transformation was accomplished without additional cost, according to managers, aside from initial remodelling and the research and documentation effort (funded by a grant). Further, even assuming some costs for start-up, rebuilding units, and staff training, longer-term health care costs may be reduced if overall resident health status improves as it did in this case (Boyd 1994). Clearly, further research is needed to discern if the facility's prior cost structure is maintained or not; but a review of its cost reports confirmed the initial analysis.

No one could argue that either of these models are perfect, or easily replicated. The emphasis on resident choice required helping neighbours in the units cope with disturbed and demented residents. Family support was not always forthcoming, and some families moved relatives. Not only aides' mentalities but those of some managerial and licensed nurses clashed with these practices, so different than the "institutionalized" version of care. Strong leadership is clearly required.

However, despite these practical difficulties, the results are striking. The most important change was reversing the assumption of decline, and substituting a paradigm that emphasized dignity, choice, and growth for residents, and employees.

Summary: Links between "Regenerative" Work Organisation and Quality Care

In the examples cited above, quality outcomes improved after implementation of the new model. The "Edenized" home documented reductions in mortality and illness as well as drug use (Thomas 1992). The Catholic facility found that residents' functional capacities improved rather than declining. Medication dosages and usage in P/MSV's case declined significantly: 11% for routine

usage, 19% for “as needed” medication, 100% for anti-anxiety medication, and 100% for anti-psychotic and sedatives, compared with a control unit (Mt. St. Vincent “Research” n.d.(b): 4). In addition, resident activity levels increased 50% while social interactions increased 100% over baseline, which was at the usual low level. These changes echo experimental social psychological research on increased control for elders: in Langer and Rodin’s quasi-experimental study, depression decreased, while alertness, independence and confidence increased (1976, 1977).

These innovative care settings encourage the creation of new teams and cross training of workers, well beyond the “high quality” model. Broadening job descriptions and cross-certifying front-line workers enlarges the skills, job options, and perspectives of workers and improves service to residents. Giving aides primary responsibility for resident care demonstrably increases their performance and improves resident outcomes. Worker social interactions with residents are crucial to psychosocial outcomes, even though they are hard to measure (Teresi 1993, reported in NCCNHR, 1994; Maas *et al.* 1996:370; Brannon *et al.* 1992). In a paradoxical reverse of cross training for RNs, Mt. St. Vincent separated the roles of nurses and managers, since many nurses prefer nursing to managing.

Effectiveness measures in the service sector typically focus on input as much as on output, using nurse staffing as a proxy for quality, for instance. The "medical model" encourages this, although the “regenerative community" is focused on process and outcomes for residents. As one nurse manager said, “The tasks of nursing cannot be broken down to stations on an assembly line” (Killen 1992 quoted in Jacques 1993:6).

Measures of quality are controversial in any health care model, but are particularly challenging in the “regenerative” homes. Some can be standardized across facilities. Mt. St. Vincent, for instance, cites measures of resident functionality, drug use, and how residents spend their time to evaluate its success. The Eden Alternative researchers use "control" homes and sites to gain additional data on mortality and other measures. Dr. Thomas is seeking replicable measures of

loneliness, helplessness, and boredom. These models in practice are relatively new, all less than fifteen years in effect. Further research is clearly needed on outcome measures as well as new processes developed in these models, and it will be made possible by the growing self-recognition of a coherent set of assumptions among these “Pioneers” (Fagan *et al.* 1997). For a better evaluation of this model, more research is required on its costs, as well as on the type of leadership needed to implement it.

Implications for Managers: Innovative HR Practices

The previous section outlines innovative HRM practices and work structures, and managerial values, that can turn nursing homes into vibrant places for young and old to live and work. Rather than beginning as HRM reforms, however, these models began as new philosophical or religious approaches to the residents (or “customers”), which, to be implemented, actually require changes in work organisation and HR (Fagan *et al.* 1997). In practice, employees’ new roles followed logically from the resident autonomy and growth model, rather than preceding it. So what are the implications for managers of these HR lessons?

Comparing the industrial model of “high performance” work and the models proposed here, we expect to find a consistent link between worker empowerment, a “bundle” or system of HR practices including job security, teams, etc., and higher quality output (Batt 1998; MacDuffie 1995; Appelbaum and Batt 1994). To some extent this is true: in both regenerative and high quality facilities, annual turnover is reduced and wages and staffing ratios are usually higher. Yet in regenerative settings, wages were sometimes lower than in comparable high quality facilities. Worker involvement was not the initial concern of the founders, though they understand the relationship between aides’ work and care quality.

“High performance” models borrowed from industry studies are insufficient, at least in healthcare and related social services. The product here is “care” in both the physical and emotional

senses, not a tangible physical object which can be counted or assessed for quality defects (see Stone 1999).¹⁹ The service is delivered, or possibly co-produced, through a series of interactions between worker and patient (see Lachman, this issue), but the “payer” is often far away (a government, an insurance company, or a family member), leaving unclear the question of who the true customer is. Increasing productivity requires orchestrating complex interactions between professionals, paraprofessionals, service staff, agencies, and clients.

While hospital care is capital-intensive, more than 70% of costs in nursing homes (and in many other service industries) are labour costs. The context is a psychosocial emotional one, where aging, dying, dignity, choice, and families are critical. Much emotional labour, such as described here, requires a “managed heart” from aides as well as a strong back, nursing and relational skills (Hochschild 1983; Fletcher 1999). “Quality” here can consist of a caring conversation, combined with gently performing hard daily physical tasks of lifting, feeding, and cleaning residents.

Theorizing high quality services, at least social services, requires an alternative to the model used in industry. Key to the model is, first, the importance of the actual "ideology" or "culture" of production, in this case of care. A model that encourages growth of residents will produce different care than one that assumes inevitable deterioration.²⁰ The regenerative “philosophy of care” may be based on a religious belief approach to eldercare, or communitarian approaches, but it is not grounded in market niche choices. This philosophy is crucial in guiding the many choices which managers and co-producers of care make on a daily basis. A nursing home may be structured into small family-type units, a multi-generational 'home' atmosphere complete with animals, or a standard set of institutional hallways with no organizing principle of community, for instance. The most innovative managers had a conscious philosophy of care and strove to implement it in daily work organisation.

Second, close links between high-skill labour for workers and improved quality of life for residents are clear, but not easily measured in "productivity" terms. A new analytic frame would

recognize the value and nature of "relational work" and emotions at work (Fletcher 1999; Ashworth and Humphrey 1995; Morris and Feldman 1996). Some crucial NA work is not measured in current regulatory or reimbursement systems. This ensures its devaluing by facility supervisors, in comparison to countable tasks like bed making and record-keeping. Basic care activities, and their related outcomes (of psychological and physical health) need to be measured and considered "productive" work. Financial measures alone (such as profit per bed, or cost per patient day) cannot capture these human outcomes.

Third, multi-layered, cross-functional teams seem crucial to high performance in health services, and perhaps in other customer service industries (see Batt 1998; Frenkel *et al.* 1999) This is not only to improve morale and lower costs. Nursing homes demonstrate the importance of sustained interaction between the lowest-skilled and more highly trained workers. When people are separated by formal qualifications, nevertheless, dealing with the same resident, information rarely rises from the bottom up -- from those actually caring for patients to those in charge of decisions about their medical care. This deprives the more highly trained staff of crucial information of the type they seldom have time to observe personally. The front-line workers would benefit from understanding nursing decisions and why they are made. Cross-functional teams could be tied to training, mentoring, or upgrading opportunities for front-line staff, all of which are mainly absent.

In the next section, I propose a new model which attempts to incorporate these three amendments to "high performance" models of work organisation

IV. Barriers to Diffusion, and A Model of Nursing Home Organisation

Quality outcomes and work organisation with distinct HRM systems co-vary in nursing homes, and they are integrally related. Management philosophy and the dominant institutional environment help to shape both. The traditional medical model of nursing home work is based upon unstated but

powerful assumptions about the nature of aging, and the limited possibilities of improvement. People are assumed to enter nursing homes in a state of permanent irreversible decline, to become "increasingly frail, debilitated, and more dependent"(Mt. St. Vincent 1994:2). This assumption ensures that most care is planned and delivered with at best a rehabilitative model in mind, and at worst with a fatalistic attitude that nothing much can be done, what one administrator calls a "self-fulfilling prophecy." This core philosophy of care is internalized in those who lead traditional facilities, and in regulatory and professional approaches to nursing home care in the U.S., creating an institutionalized climate which is pervasive, depressing, nearly devoid of hope, and stressed for everyone who works in it, particularly front-line employees.

Traditional nursing homes are not seen as communities of people who are in various stages of living life, or "aging in place." Most nursing home administrators have probably never considered alternatives, as they are not widely publicized, nor have they been adopted by large chains. The old paradigm-- combined with traditional measures of costs and benefits of long-term care, and a reimbursement formula focused on containing costs for custodial care rather than on promoting development or growth of residents-- is a major barrier to change in the dominant model. Getting aides to work "faster and cheaper," as one nursing director said was her goal, seldom leaves room for the most important work for quality outcomes -- a few minutes spent turning residents, or taking time for residents to choose when to get up and go to bed.

The data summarized here and reported elsewhere (Eaton 1995), suggest a new model of Nursing Home Quality (Figure 2). This model is an attempt to identify the underlying forces and choices, identifying both agency and structure, that give rise to the three types of nursing homes outlined in Table 1.

[Insert Figure 2 about here.]

In this model, powerful regulatory institutions, labour market conditions, and competitive strategies influence the structure of the facility or chain, and managers' philosophy of care. (The manager or owner can also influence the structure, in entrepreneurial ventures, thus the double-headed arrow.) This philosophy of care is central in determining HRM practices and actual work organisation, which in turn lead together to particular quality outcomes. The implications for managers are clear: as in the "strategic HRM" literature, HR practices and strategies are linked tightly to the larger philosophy and strategy of the organisation at large. (See Baron and Kreps 1999 for an overview.) Reforming key HR practices alone (particularly increasing staffing and team work, as well as training and worker input) may improve quality, to the level of the traditional "high quality" homes, but it requires a larger paradigm shift, accompanied by new forms of work organisation, to achieve the different types of outcomes described in the "regenerative" models.

Organisational dynamics in nursing homes, and other front-line focused service industries, have been insufficiently researched, at least as linked to individual and group-level characteristics, team dynamics, managerial leadership roles, and resident/customer outcomes (Frenkel *et al.* 1999). Results of doing so might be surprising. For instance, a recent study of patient abuse suggests reformers need to consider stress levels, conflict levels, and the home lives of aides and staff when trying to prevent abuse (Pillemer and Moore 1989). These issues are related intimately to philosophy of care, which in turn affects organisational features like supervisory leadership, nature of task assignments, staffing levels, and interaction between staff and residents.

Conclusion

Nontraditional work and care models, particularly the high quality and regenerative ones, enhance our understanding of links between worker conditions and patient outcomes in a \$100 billion service sector employing millions of workers and providing care to two million elderly and frail Americans. A new model has been proposed. It relates structure to choices made by actors, including owners, managers, and supervisors. At the centre of this hypothesized model is what I call the “management’s philosophy of care.”. In an industry where institutionalized norms, and structures like regulations and profit status that support them, are so powerful in traditional settings, its influence is particularly important where the philosophy focuses managers on how the work is actually organized.

This new hypothesis sets the stage for additional research to verify, falsify, or amend the model. To test the model, future research must specify the nature of “management philosophy” carefully, as well as relevant environmental factors. State inspection and reimbursement systems should be controlled for, if sufficient examples of each type can be found in single states. Even more specific work organisation practices (in addition to those identified here) should be included, such as how feedback on resident condition is communicated to decision-makers. Finally, a clear definition of quality is needed; crucial features include resident voice, social engagement, and freedom of choice as well as traditional medical outcomes.

Future survey research should be based on a random sample of facilities within states, allowing for over-sampling high quality and regenerative facilities because of their relative scarcity. Longer observations in each facility, more on-site ethnographic studies of innovative work organisation and patient care, and randomized surveys focused on precise work practices would be valuable, combined with site visits to determine the extent of work practices described here. Resident feedback can be difficult to obtain, but careful observation can show variation in resident distress or comfort levels, and families or friends can be consulted.

Further, with newly improved data collection from facilities in each state, specific process and health outcomes, such as acquired bed sores, emotional distress, worker turnover, improvements in resident continence, activity, and motivation, etc. can be documented on a comparative basis. International comparisons of care for elders and disabled under other regulatory regimes would be valuable, particularly where more coordinated and alternative services are provided than in the U.S.

The model I propose could be tested in other health care settings by creating measures of relational work activity, of resident and patient outcomes (both physical and mental), and of team work organisation as well as the philosophy of care or production. A convincing health care model could contribute to the ongoing discussion of “strategic choices” (Kochan 1986), by showing what managerial latitude is possible in the context of an organisation like a nursing home, in a highly regulated environment with strong institutionalizing pressures. In the regenerative homes, managerial values count for a great deal, as I document here. In other sectors, similar models could be developed and tested by experienced practitioners. The problem of measuring productivity adequately is not unique to nursing homes-- education, mental health, hospitals, home health, child care, government social welfare services, and other important services have no easy way to measure what they produce and how well they do it. This question requires more creative research and experimentation in the future; this study aspires to be a start.

For now, unfortunately, the traditional low-skill, low-wage, low-performance model is the dominant one. "Unloving care," as Bruce Vladeck called it 20 years ago, is still all too common in America's nursing homes (1980). But fortunately, it does not have to be. The evidence demonstrates that alternative models of work and care organisation exist, and at least some actors have the power to enact those alternatives.

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Notes

1. This paper focuses on the U.S. nursing home industry, which is not intended as a model for long-term care in other countries. Most industrialized countries have a form of state-supported home and/or institutional care, but unfortunately cross-national analysis is beyond the scope of this study.
2. Some of the research derives from a larger service sector study on technology, jobs, and productivity for the Office of Technology Assessment of the U.S. Congress (Eaton 1995, 1997). For a summary of the results of the larger study, see Herzenberg *et al.* 1998. An earlier version of this paper was presented at the Academy of Management meetings in 1998.

3. A 1995 study showed that 30% of facilities were given deficiencies for unsanitary food, 25% for inadequate care planning, 20% for unsanitary environments, 20% for hazards in the environment, 19% for failure to maintain personal dignity, 18% for improper restraints, 16% for no comprehensive assessment of patients, 15% for inadequate infection control, 12% for inadequate treatment of incontinence, and 12% for inadequate activities for residents, among others (Harrington 1996: 457). Surveys undoubtedly understate some deficiencies: for example, only 2% of homes were cited for abuse of patients, but one study found 40% of all staff voluntarily admitted to inflicting psychological abuse within the last year and 10% admitted to committing one or more incidents of physical abuse (Pillemer and Moore 1989).
4. These proposals range from constructing an index of 300-plus surveyor-identified “deficiencies” in facilities (both process and outcome) to relying on various ‘objective’ measures of resident outcomes, such as acquired pressure sores, hospitalisation ratios, etc. The default approach seems to be to pick one simple, easily measurable index as a proxy for quality, and then to construct regressions. See Eaton 1995, and Harrington *et al.* 1999a.
5. Certain aspects of these categories were developed jointly with Stephen Herzenberg and colleagues, who later revised them for publication in Herzenberg *et al.* 1998. I use them here as they emerged from these data to apply to the nursing home industry; they are defined more generally in the Herzenberg *et al.* volume.
6. While some might call this a typical “secondary labor market” (Doeringer and Piore 1971, Hunter 1994), this is not the case because workers in this study are not loosely attached to the workforce. Most of the unskilled workers interviewed are women firmly attached to the labor market, and if they lose or quit this job, they get another one immediately-- or they may already be working multiple minimum-wage jobs. Few have husbands earning enough to support the family, and none viewed themselves as housewives. For further evidence on this issue, see Eaton 1995:60-61.

7. One aide explained that she liked working the night shift because she could read the residents' folders and then know if they had family or what was wrong with them, so she could talk with them when they woke up at night. But having this knowledge was officially forbidden.
8. The worst case I heard described was also said to be typical-- because the facility had not replaced aides, an aide was "floated" from another unit. Her duties included care of a man who, unbeknownst to her, had difficulty swallowing. A dietary worker passed her a tray to give to him, and the aide questioned whether he could have the hot dog on the picnic plate. A dietary supervisor told her not to question dietary decisions. She gave the man the tray, and he choked to death a short while later. He was not supposed to have this kind of food, something a regularly assigned staff person would have known (California Advocates for Nursing Home Reform 1993-4)
9. More studies like the one at Mt. St. Vincent should be done to document residents' time and psychosocial activities in alternative types of facilities, to see what patterns exist; little comparative data is currently available.
10. State inspectors found examples of this when they looked carefully at reality vs. records. One reported that he watched a resident who was kept in restraints for six straight hours, and never had them loosened to be exercised, or changed, or even fed. But when he checked the records, although staff knew he was there inspecting, the nurses had documented that the restraints had been loosened every two hours (California state inspector's report, name suppressed for confidentiality, 1995.)
11. Fully 49% of residents are incontinent but only 5% are in training programs (Harrington *et al.* 1999a: 62).
12. On a scale of 0 to 100 measuring 69 critical factors in patient care and including the better-rated chains, more than half ranked between 0 and 50 points, and even the best chains only received marks in the 70s (Lieberman 1995).

13. Ashforth and Humphrey (1995) point out that positive group dynamics can help workers deal with emotional demands, such as those associated with long-term intensive service relationships.
14. Precise comparative measures are difficult to document without a larger quantitative study. The appropriate mix of measures is contested and it is hard to control completely for resident conditions across nursing homes. The measures used here are taken from state inspection forms for the homes visited for the study. Further comparative work across types is needed with larger numbers of facilities, while retaining the focus on actual work structures and interactions.
15. Demand is neither independent of supply nor of the regulatory framework in the US. Each state creates its own criteria for poverty-based (Medicaid) eligibility and benefits, within a framework established by the Federal government. Government policies have a significant effect on the utilisation of nursing homes and the operation and services that they provide. Throughout the 1970s and 80s, many states sought to control spending on nursing home beds by refusing to approve the addition of new beds eligible for public funded care (Cutler and Sheiner 1993: 15) .
16. Such contract language was negotiated between Service Employees International Union (SEIU), AFL-CIO, and Grancare in 1995, according to a personal communication from David Snapp, coordinator of the Dignity Nursing Home Campaign for SEIU in 1996; however, since that date, Grancare has been purchased by a larger company and the fate of ‘patient care committees’ has not been resolved to my knowledge.
17. This phrase was coined by several members of a group now calling themselves the Pioneers, specifically with respect to Mt. St. Vincent-Sisters of Providence in Seattle, Washington. See Fagan, Williams and Burger 1997. Since my original study, they have banded together , call themselves “The Pioneers,” and are meeting regularly to advance this model.

18. A third example, Live Oaks Living Center in El Sobrante, California, is described in Eaton 1995 and 1996, and Fagan *et al.* 1997. Hunter (1994) also describes an innovative facility.
19. Vincent Mor at Brown University and his colleagues are among the few who have begun looking at separating tasks into those which are more easily measurable and replicable, and those which are truly individual and cannot be standardized. See Zinn, Brannon, and Mor 1995.
20. A parallel in manufacturing might be the joint labor-management culture that guided the creation and set-up of GM's Saturn plant, for instance. To ignore that ideological grounding for the factory organization would be to miss the essential element that explains why it was structured as it was. See Rubinstein 1996.

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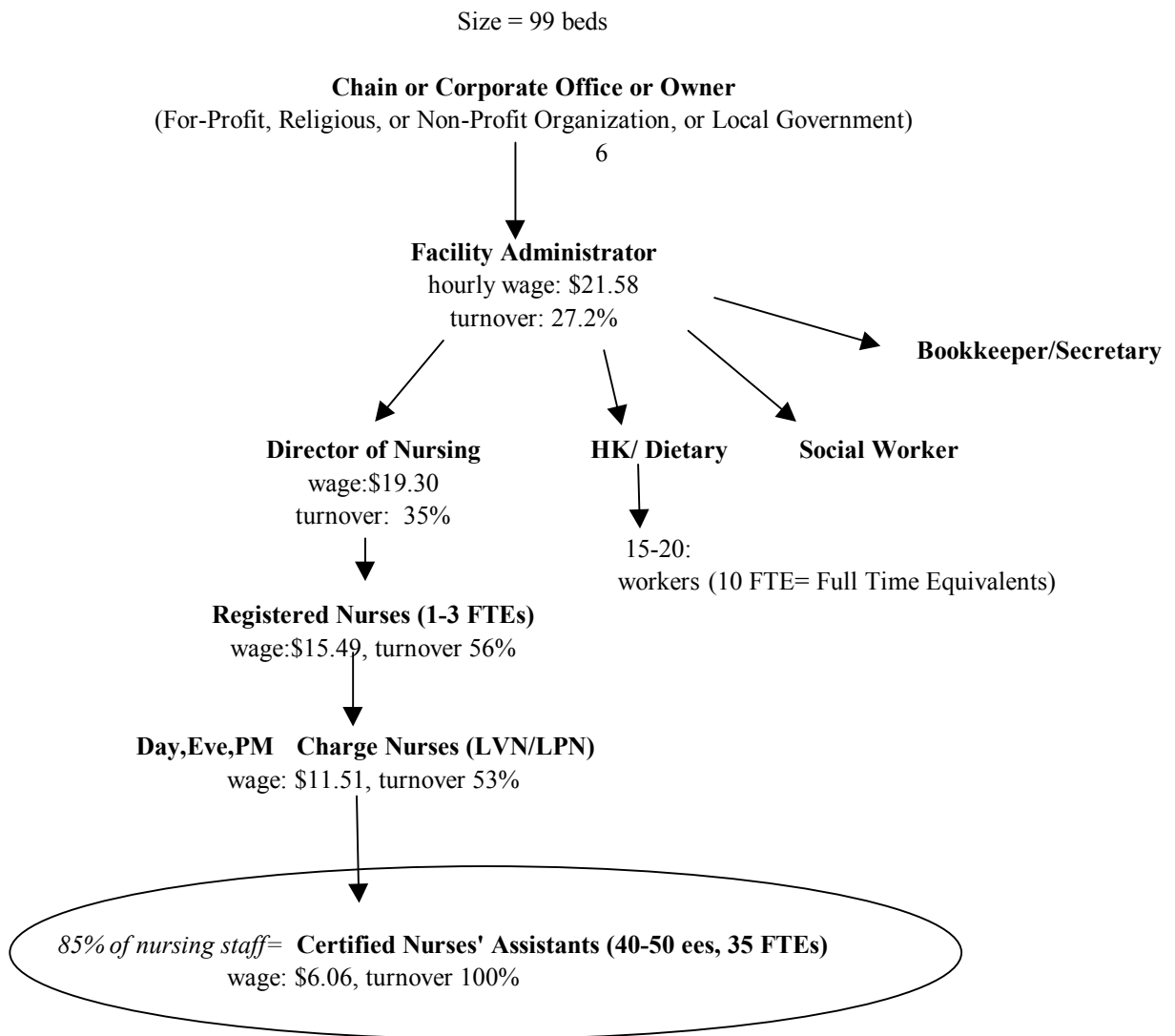
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Table 1 A Typology of Nursing Home Work and Care Organisation for Nurse Aides

	<i>Traditional*</i> Low Service Quality medical-custodial 1.	<i>Semi-skilled semi-autonomous*</i> High Service Quality medical-rehabilitative 2.	"Regenerative community" 3.
Work Patterns	Rigid, traditional Individual only	Teams Flexible, adaptive	Neighbourhood units Resident assts.
Worker Input into Service, Delivery and Quality	Not welcome; actively discouraged	Welcomed and solicited in systemic way	Built into Not work structure in "neighbourhoods"
Information Shared	Little to none	Most	Virtually all
Industrial engineering or time and motion studies	No, staff at legal minimum	No, but can complete work	No, but staff responsible for complete patient
Supervision and Control formal procedure	For tasks only; Compliance w/	For outcomes; help to do job	Coordination; resident choice
Assumptions re: Workers	Theory X	Theory Y	Community members
Staffing ratio: day Nas	Ten + residents	Seven to nine	Five to seven
Wages, avg. NA	\$5.50+	\$7.00+	\$6.50 +
Turnover, annual	More than 80%	30-80 %	20 to 40%
Career paths for Nas	Little or none	Senior NA; Scholarships	Cross-training evolving
Ownership or Reimbursement	"Medicaid mills," for profit chain, 'mom & pop'	Non profit; special chain high-end for profit	Non-profit, religious, or high- private profit
Labour Relations	Mostly non union	The most unionized	Mixed
Cost Structure	Low to average	Average to high	Average to high
Philosophy of Care	Medical-custodial	Medical-rehabilitative	"Regenerative"

* Note: See Herzenberg *et al.* 1998 for further explication of these categories in other settings; they were jointly developed as regards nursing homes in preparing this analysis for the OTA report (Eaton 1995).



Wage Data Source:

Wunderlich, et al, eds. Institute of Medicine Report, 1996, tables 6.5 and 6.6, pp 160-161.

Figure 1: A Typical Nursing Home Organization Chart

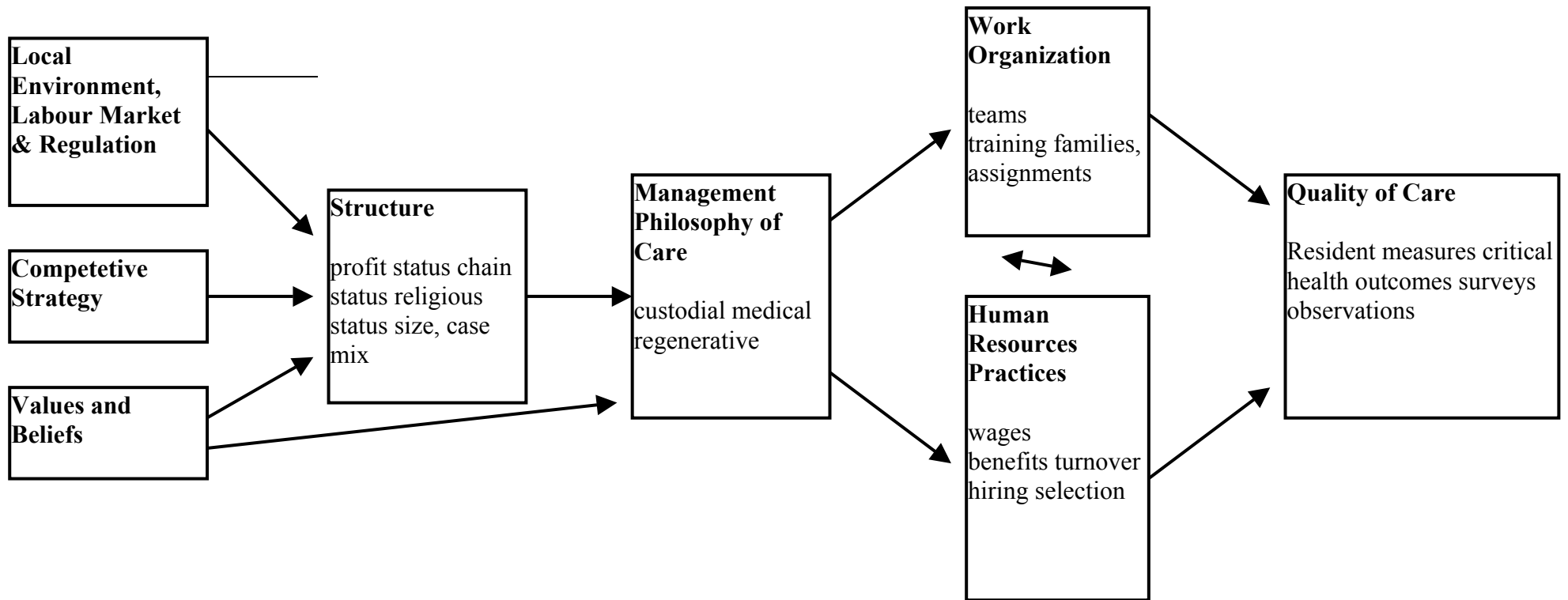


Figure 2: *A Model of Nursing Home*