

EXAMINING A RELATIONSHIP-BASED QUALITY OF CARE IN ORGANIZATIONS WITH DIFFERENT OWNERSHIP TYPES

As the difference between the rising population of those in the U.S. who need home health aides services and the declining population of people (primarily poor, disproportionately minority race/ethnicity women) from whom home health aide workers are drawn grows larger, the results of studies related to improving the quality of the work environment and jobs of home health aides become part of critical steps toward ensuring the availability of a quality home care workforce. In this paper, first to better understand various conceptualizations of quality of care, I examine extant industry and academic research community literatures on quality of care in a home health environment. Based on these and interviews with industry personnel, I develop quality care-specific survey questions which, along with items from the shared capitalism research (Kruse, Freeman, & Blasi, 2010), I administer to several hundred home health aides.

Preliminary results are from my dissertation study on quality of care, participation, employee ownership, and employee outcomes in the home health aide industry (Berry, 2011). Using survey results, I construct an exploratory construct of a relationship-based gauge of quality of care. I find that caregivers in a worker-owned environment provide significantly higher ratings for items related to quality care as well as higher levels of other constructs associated with increased productivity at work. My research includes data from three types of home care agency in New York City – worker-cooperative, non-profit, and conventionally-owned for-profit organizations. This focused look at extremely low wage work environments and productivity in a fast-growing industry in the U.S. provides a view of such environments that should result in new insights and advance research in these areas.

What is Direct Care Work and Who Performs It?

Direct care work is a form of “caring labor.” The dual meanings of “care” (Folbre & Nelson, 2000; Himmelweit, 1999) are often invoked when referring to direct care work; one refers to caring activities and the other to caring feelings. When paid employment is involved, lack of ability to monitor and caregiver intrinsic and extrinsic motivations factor into considerations of how the dual meanings might affect the quality of the work. Lack of ability to monitor the work is sometimes viewed as a contributor to the problems associated with low pay for caregivers.

Direct care workers are sometimes referred to as Nursing Assistants (Certified Nursing Assistants – CNAs or Licensed Nursing Assistants – LNAs), Home Health Aides (the participants in this study), or Personal and Home Care Aides. They assist clients with Activities of Daily Living (ADLs) such as eating, dressing, bathing, and toileting and with Instrumental Activities of Daily Living (IADLs) such as using the telephone, doing laundry, shopping, preparing food, travelling, housekeeping, taking medicines, and handling finances. Depending upon state laws, and under supervision of a nurse or therapist, direct care workers also perform clinical tasks such as blood pressure readings, administering of oral medications, administering catheters, or changing surgical dressings. A growing number are employed and supervised directly by consumers rather than working for an agency (Stone, 2004). A report profiling the U.S. direct care workforce indicates that direct care workers provide a majority of the paid hands-on care, supervision and emotional support to the elderly and disabled in the United States; that the majority of direct care workers work in long term care settings, and that the largest occupational group is home health aides - over 40% of the direct care workforce (Smith & Baughman, 2007: 20).

90% of direct care workers are women. 49% are non-Hispanic white, 28% African American, 16% Hispanic or Latino, and the remaining are other races and ethnicities. 23% are immigrants to the United States. Approximately 41% of direct care workers have some college or more and 41% rely on public benefits to live. 26% of all of them are uninsured but this figure is 33% for the home health aide group. These figures help paint a picture of a group of workers who have historically been disenfranchised in some manner in U.S. society. As is evident, the pay and compensation situation for these workers is dire.

Direct Care Pay

Concerns related to the valuation of the work that direct care workers perform are often associated with questions of assessment and monitoring of that work. Numerous studies indicate that extremely low wages and benefits are central among the reasons that direct care workers provide for leaving their jobs (Mittal, Rosen, & Leanna, 2009; Scala, 2008; Eaton, 2000). Scala's (2008) report highlights that the median wage across all direct care occupations is nearly \$2/hour higher than it is for home health aides who made less than \$8/hr in 2008, more than half of the jobs are part-time, and payment to workers is structured by fee-for-service rates based on a participant's (client's) service hours. Performance of their jobs depends upon the knowledge, training, availability, reliability, and use of caring judgment by direct care workers and their motivation and ability to do this work. Still, government reimbursement rates, inability to closely monitor caregiving work, and last but not least, historically-based social pressures regarding the caring work of women coalesce to bring downward pressure on the wages and benefits that paid caregivers receive. In response to concerns regarding lack of specific knowledge of what home health aides actually do while at work with clients in their homes and when they do it, the industry has mandated detailed reporting of tasks completed each day.

Quality of Care in a Home Health Aide Environment

In practice, quality of care is something of a contested topic in the home health aide industry and levels of agreement concerning currently-available and needed measures vary (Mor 2006, 2005; Spector et al., 2002). Donabedian's framework of structure, process and outcome as dimensions of quality assessment related to medical care is the basis of much of the subsequent research in health care settings. He identifies quality of care as a "judgment on the process of care" (Donabedian, 1978: 857). Structure and outcome are dimensions from which inferences regarding process may be drawn in the absence of information related to the process of care. Current quality measures for the home health environment include primarily outcome indicators (CMS, 2011; IOM, 2001) used to identify, for example, how many times a necessary procedure is performed or observed. While such indicators are available, well documented, and currently in use, they are considered best-available rather than comprehensive or sufficient, partly because of differences in client needs and home environments. However, some researchers (Eaton, 2000; Folbre, 2006, 1995; Himmelweit, 1999; Mittal, Rosen, & Leana, 2009; Schmid and Hasenfeld, 1993; Szasz, 1990) have identified the need for study of factors related to the relationship between caregiver and care recipient as very important to quality of care in a direct care environment. Eaton's research (2000) implicates human resource practices in the context of various types of ownership in different outcomes to workers and nursing home clients. Folbre's research (2006; 1995) emphasizes dual meaning of care – caring for, as a performance of certain actions and caring about – as an emotional connection. Mittal, Rosen, and Leana (2009)'s study examines the phenomena surrounding retention and turnover – not opposite manifestations of the same phenomena. They link poor management practices with turnover, and personal relationships between caregivers and clients with retention – and through reduction in disruptions to care – a better quality of care. Schmid and Hasenfeld (1993) contend that structural conditions

(e.g. government reimbursement rates and reporting requirements related to monitoring) of home health aide work may adversely affect work that requires a close interpersonal relationship between the worker and the client. They also point out that the provision of care is made more difficult by complex family relationships into which a caregiver enters. Szasz (1990) addresses how federal policies affect labor practices in the home health industry and can have negative impacts on caregiver's experience of work and on the quality of care provided. In particular, he notes that in a labor intensive organization such as a home health aide agency, reductions in government reimbursements often ultimately result in those employees with the fewest resources being required to be more productive – work faster and under increased managerial control. The aforementioned research and that on the dimensions of quality care led me to a closer examination of the nature of the relationship-building needed on the caregiver's side.

Finally, in my own research (Berry, 2011), I conducted interviews with administrators at several home health aide agencies asking open ended questions about the production of quality care and characteristics of a ideal home health aide. These discussions produced, repeatedly and in different organizations, instructive conversation regarding a lack of understanding on the part of the public regarding the skill and experience required to successfully perform the duties of a home health aide. Specifically, the complex relationship management activities of a caregiver's job are significant. One administrator emphasized that an ongoing part of the job is negotiating the relationships between the client, client's family members, neighbors – whoever is part of the client's home environment. Another emphasized the need for a caregiver to also be mindful of relationships with the nurse assigned to each client case and the coordinator (the first line of agency management and responsible for placement and administration of the contracts for providing care).

Shared Capitalism and Productivity at Work

Among the many factors that influence other types of worker productivity in an organization may be those related to ownership and associated governance processes, participation in decision-making, constraints in the external environment such as government reimbursement rates, and caregiver motivation. Recent research on the effects of shared capitalism (employee ownership, profit and gain sharing, and broad-based stock options) in firms shows a clear link between employee participation in ownership of their firms – through several mechanisms combined with involvement in decision-making within the organization – and increased worker productivity and firm performance, improved worker well-being, reduced reported intent to turnover, increased loyalty, and increased willingness to monitor others for shirking (Freeman, Kruse, & Blasi, 2010; Harden, Kruse, & Blasi, 2010). Worker productivity is associated with factors such as intended turnover, willingness to work hard, loyalty, low effort, suggestions for improvement, and willingness to report shirking. One set of measures referred to as a High Performance Work System (HPWS) are also linked to increased productivity. These include gauges of:

- how much involvement and direct influence workers feel that they have in deciding how to do the job and organize the work, setting goals for their work groups, overall company decisions;
- how satisfied employees are with the influence they have in company decisions; whether they have discretion over decisions such as methods of work and task schedules; and
- whether they are involved in a team, committee, or task force that addresses issues such as product quality, cost cutting, productivity, health and safety, or other workplace issues¹ (Harden et al., 2010).

While the businesses participating in this research were from other industries, there is no reason to assume that the findings related to employee participation in financial rewards associated with employee ownership or employee participation in decision making processes

¹ This list is not all-inclusive.

would not be applicable. Therefore, those items from the measures used in the shared capitalism research that are applicable (e.g. home health aides work alone so most teamwork items do not apply) to my study are used in development of the survey measure. In addition, the home health care industry and caring labor-related studies described above point to the need for a closer examination of how positive relationships in the complex client home environments in which caregivers work are created and sustained. Based on these studies, interviews with caregivers and agency administrators, and survey validation sessions at a home care agency, I modified the measure used in the shared capitalism research for use in my study of quality of care-related productivity in home health aide agencies under different forms of ownership.

Methodology

This study focuses on relationship-based aspects of quality care and an investigation of this concept via interviews, observation, and surveys administered to a larger sample of home health aides from an agency's workforce. The purpose of the interviews is to provide insight into organizational phenomena that might impact quality care and to identify relationship-based indicators of quality in the caregiving process. Attention to process as part of the quality framework includes exploration of factors related to how time is spent with clients. Workplace outcomes to caregivers related to participation and job satisfaction and to clients (as reported by caregivers in the survey) are included. Propositions probe the relationships between agency ownership, participation in organizational decision making, outcomes to caregivers (such as job satisfaction) and a relationship-based construct related to the provision of quality care.

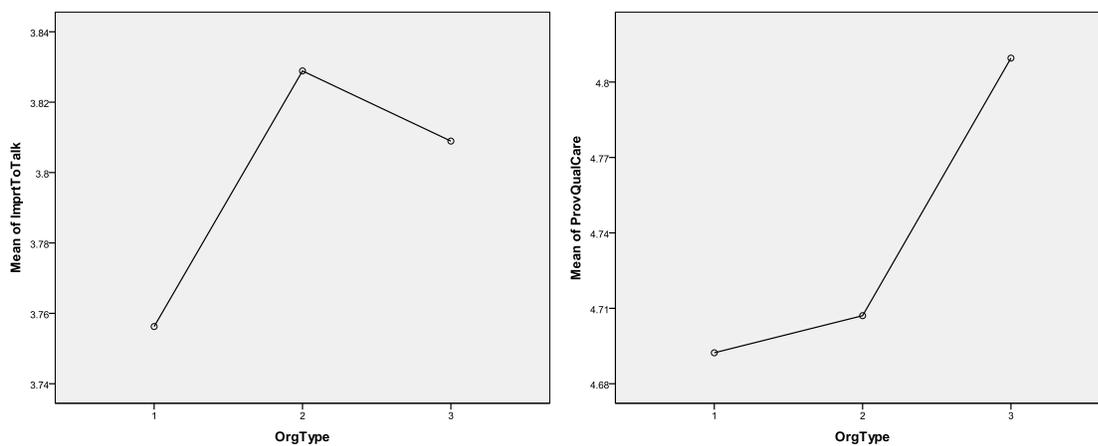
Results: Comparisons of Survey Data

Survey items related to participation in decision-making on the job; job satisfaction; worker – management relationships; and quality of care to clients are among the outcomes

examined. Survey items were modified for appropriate readability, length, and focus on questions specific to participation in a home health aide work environment. The surveys were validated during two sessions with 10-12 home health aides, at least one coordinator, and a trainer at the employee-owned agency participating in the study.

Results using ANOVA and multiple comparison procedures on data from the three organizations indicate that for most items, the responses of the home health aides who work at the worker cooperative were significantly different² from the responses for home health aides at the non-profit and at the for-profit organization, while responses to these items did not differ significantly between the non-profit and for-profit. For several items, there is no difference between either of the organizations (e.g. those related to the importance of pay and benefits. For others, all three organizations differ (e.g. regarding having flexibility in providing services to clients, being involved with the client’s care team, and receiving helpful feedback from their supervisors). Below are means data from some of the survey items of interest.

Figure 1 ANOVA Means Plots, No significant difference³

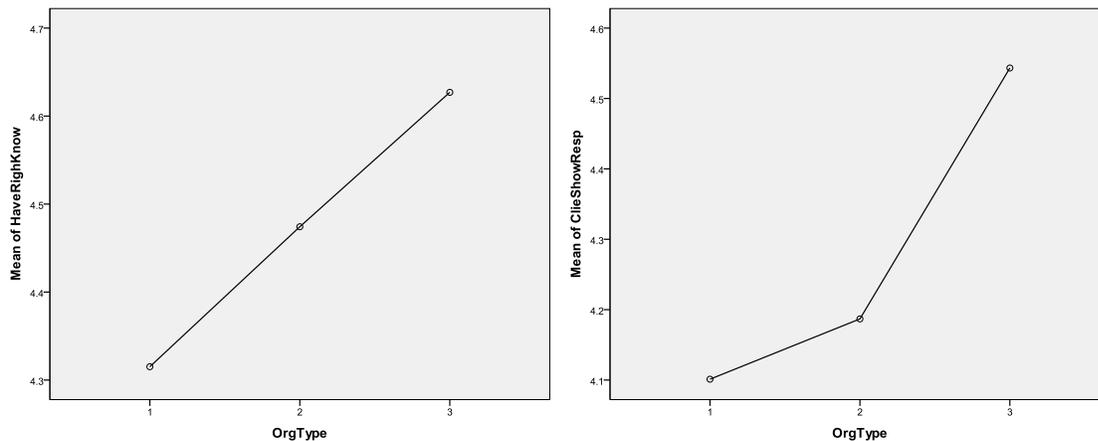


² Difference at $p \leq 0.05$.

³ OrgType- 1: For Profit, 2: Non Profit, 3: Worker Cooperative

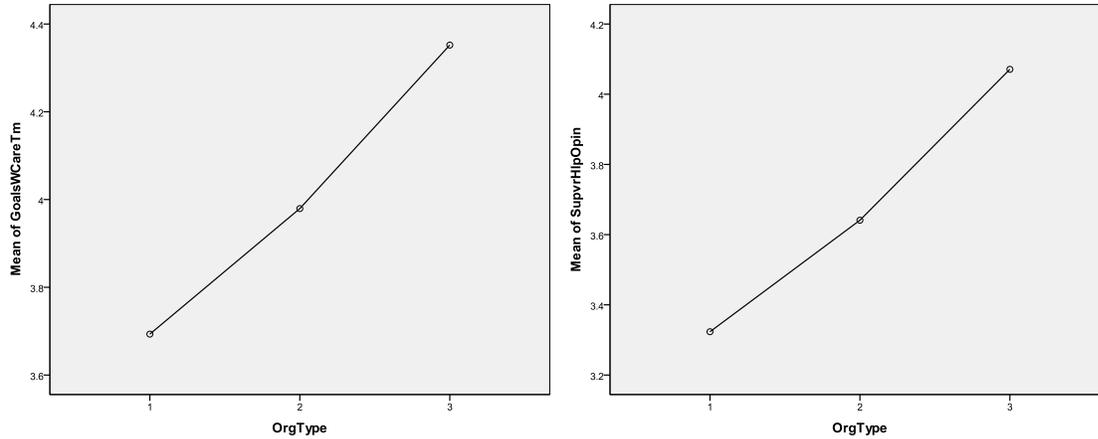
The above figures indicate that the item asking if the caregiver feels that it is important to spend time talking with clients about whatever the client would like is higher for the non-profit than for the worker cooperative and higher for the worker cooperative than at the for-profit organization. These differences are not statistically significant. Differences in mean are also not statistically significant for the item asking if the caregiver provides quality care to clients although it is highest at the worker cooperative, with the non-profit next and lowest at the for-profit agency. Both of these items are part of the quality of care analysis for this study.

Figure 2 ANOVA Means Plots, Statistical difference between Worker Cooperative and other organizations



The graphs above show that the mean response for the item asking if the caregiver feels she has the right knowledge for the job is highest the cooperative, next the non-profit and lowest at the for profit agency. These differences are statistically significant across the cooperative and the other two organizations. They are not statistically significant, however, between the for-profit and non-profit organizations. Relationships between organizations are similar for the item asking if clients show respect to the home care worker. These items are also important as part of the quality of care analysis.

Figure 3 ANOVA Means Plots, Statistical difference between all organizations



Finally, as an example of survey item means that are significantly different each organization from the other are the items referencing caregiver planning input to care teams and supervisor providing helpful input within the last year. For both items, means are increasing from for-profit to non-profit to worker cooperative. These items are important to participatory decision-making and inclusion within the organizations.

Some of the data thought to be directly related to quality of care include those related to caring about patients, pay, spending time talking with clients if not directly related to client care is important to the quality of care they provide or can provide to clients. Items included in the analysis are: “It is important for me to spend time talking with clients about things (anything the client wants to talk about)”, “I provide quality care to clients”, “I provide quality companionship to clients”, “I have the right amount of knowledge about my job”, “My clients show me respect”, “It is important of home health aides to really care about patients”, “I spend time talking with clients about things not related to care”, “Pay and benefits are important to my ability to do my job”, “Pay and benefits are important to the quality of care I provide to clients.”

Participation-related constructs include items very similar or identical to those on the shared capitalism measures⁴ (Kruse et al., 2010): “I am involved in setting goals or planning with

⁴ This list is not all inclusive.

my care team”, “I have the flexibility to provide specific services in the order that would best support my client”, “I am satisfied with the influence I have in decisions that affect my work”, “My company’s culture encourages me to share ideas about improving the company”, “We are kept informed of important issues”, and “I am told about changes that affect my work.”

In this study, I also analyze constructs for items related to high performance work practices, various caregiver outcomes, and a relationship-based quality of care construct. Reliability and validity analyses using factor analysis and Cronbach’s alpha techniques are used and regression analyses for understanding relationships between them. Preliminary analyses indicate that among home health aides, job satisfaction and quality of care are influenced by levels of participation in decision making and inclusion within the organization most of the time and ownership type for the agency some of the time. Since this paper is based on parts of my dissertation study which is still in process and under review, I have not presented more detailed results of the findings here.

Conclusion

When I began this study, I believed that those workers in the worker-cooperative, as owners of the firm would have different outcomes than those at agencies where they were not owners, and that ultimately, employee-owners might provide higher quality of care for clients. My findings indicate that caregivers who are also owners provide notably different responses to survey items related to their productivity and work environment from those home health aides who are not employee owners. They reveal higher levels of job satisfaction and lower intent to leave. They indicate higher levels of respect shown to them by their managers, higher levels of trust in management, and higher alignment of company strategies and practices. Home care workers at the employee-owned agency also reveal higher levels of the quality of care construct – as defined for this study – than those at the non-employee-owned organizations.

The quality of home health care is a frequent topic of conversation and concern in the direct care industry. However, the general agreement that current mostly outcome-based measures are not sufficient for evaluating the quality of care has fostered ongoing research in this area. Researchers from across academic disciplines specializing in work related to caring labor have insisted that outcomes to caregivers are important to quality care. In addition, they argue that the relationship between the caregiver and the client at the site of quality production should not be taken for granted. My research should make inroads in the study of quality care by helping to identify important and specific aspects of what occurs between client and caregiver in the home. In addition, findings related to the employee-owned organization in comparison to other ownership types have provided new information about how ownership can matter. Caregiver-client relationship-based quality items have not previously been considered for inclusion in a measure and this work should help open doors to the study of home health work in general, home care workers, and home care organizations in the discipline of Management.

This work has revealed several areas in which future investigations could contribute to knowledge about quality care in a home care environment. Findings from this study could be the basis for a more in-depth specification of a relationship-based quality of care measure in employee-owned and other types of organizations in the home health industry. Since government-owned organizations are also a significant ownership type in this sector, examining a government agency along with an employee-owned agency would help complete the knowledge of how ownership might matter. Other useful inquiry would examine how different ownership and rates of participatory decision-making within each agency might influence outcomes based on the industry's mandatory training requirements, monitoring levels, and pay and benefits. Since preliminary findings emphasize the need for a caregiver's skill and judgment

in negotiating and managing relationships with people at the work site and negative feelings in caregivers are generated by attempts at highly prescribed electronic monitoring of their jobs (Berry, 2011), a closer look at how required monitoring in the context of various structural factors may impact positive outcomes to caregivers and clients is warranted. Finally, since ownership type and participation in decision making are associated with positive organizational outcomes to caregivers, closer examination of how these matter using a more comprehensive set of outcomes in the home health environment could increase knowledge in this area and possibly impact the high levels of caregiver turnover in the industry.

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