SATISFACTION RELATED ELEMENTS OF SURROGATE SITUATIONS AS TYPIFIED BY NURSING HOME PURCHASE TRANSACTIONS

Dissertation for the Degree of Ph. D.
MICHIGAN STATE UNIVERSITY
RICHARD W. BUCHANAN
1975

This is to certify that the

thesis entitled

Satisfaction Related Elements of
Surrogate Situations as
Typified by Nursing Home Purchase Transactions

presented by

Richard W. Buchanan

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Marketing

Major professor

Date April 21, 1975

O-169

ABSTRACT

SATISFACTION RELATED ELEMENTS OF SURROGATE SITUATIONS AS TYPLIFIED BY NURSING HOME PURCHASE TRANSACTIONS

By

Richard W. Buchanan

This work constituted exploratory research into some origins of dissatisfaction regarding nursing homes. Its distinguishing features was that, unlike some other research into nursing homes, its emphasis was not upon situations involving callous neglect. Instead, it started with the premise that neglect, alone, might not be the source of the seemingly universal displeasure with nursing homes.

This approach was taken after a through analysis revealed that most patients admitted to nursing homes do not participate in (and in some cases actively resist) the decision to place them in a home. They are placed there by others (children, relatives, etc.) who are known as sponsors. These sponsors negotiate initial admittance and frequently monitor the care provided throughout the patient's stay. Accordingly, the purchase of long term nursing care represents a surrogate situation in which one party makes a purchase on the behalf of another who consumes it. In order for satisfaction to result from such a purchase, both groups, consumers and surrogates,

must be seeking to serve the same set of needs. Further analysis indicated that patient needs and sponsor needs frequently conflicted and resulted in nursing homes having to "choose sides" in situations which would, by definition, leave someone unhappy. Further discord (and attendant dissatisfaction) was felt likely to stem from conflicts between nursing home administrators and the patients/sponsors they served. Nursing home administrators seemed to feel that their position as "almost doctors" justified any actions taken for medical reasons despite the feelings expressed by patients and/or sponsors about those actions. In light of all of these factors the following guiding hypothesis was felt justified.

H_I Guiding Marketers of long term nursing care seeking to provide services to patients who have interested sponsors are faced with a surrogate purchase situation containing conflicting sets of needs. Among these needs are those of the sponsor, those of the patient, and those of the marketing organization. Conflicts resulting in the failure to serve the needs of the patient, his sponsor, or both are a major contributor of dissatisfaction among patients and sponsors that is more or less inevitable.

Surrogate situations under conditions of conflicting needs have not been researched previously in a consumer setting, and have only obliquely been mentioned in industrial marketing literature. The nursing home market was thought to represent an ideal laboratory for research into the broader aspects of surrogate situations due to the intensity of emotion surrounding the purchase and the geographical concentration of the surrogates and consumers involved. The author's interests in surrogate situations concentrated in the

following areas; (1) how do marketers faced with surrogate situations involving conflicting sets of needs formulate market policy, (2) if marketers "take sides," do the consumers and surrogates perceive it, and (3) if marketers do "take sides," do the favored/(unfavored) parties express more/(less) satisfaction with the purchase involved? Accordingly, the author developed the following guiding hypotheses and research hypotheses:

H_{II} Guiding	Marketers faced with need conflicts formulate market policy on the base of their org's. need structure.	H_2	Nursing homes faced with need conflicts formulate market policy according to their own need structure.
H_{III} Guiding	Marketer orientation consistently favoring consumers or surrogates is perceived by both groups.	H_3	Consistent nursing home orientation to patients or sponsors is perceived by both groups.
H_{IV} Guiding	The groups not favored by marketer orientation will express dissatisfaction if favoritism is perceived as unfair.	H_4	Groups not favored express more dissatisfaction than favored groups.

The preceding hypotheses were researched within a sample consisting of the 257 member homes of the Health Care Association of Michigan (a professional organization of nursing home administrators). The subject administrators were mailed a questionnaire which probed the need structure of their homes and asked them to resolve small case problems representing conflict situations between patients and sponsors or administrators and patients/sponsors. (i.e., two residents of a nursing home have fallen in love and the sponsor of one of them demands you "break it up"--would you?) By studying the responses to these cases, the basic orientation of the home (towards

patients, sponsors, etc.) could be identified, measured, and analyzed. Seventy-six percent of the sample responded.

From the respondents six of the most patient-oriented and five of the most sponsor-oriented homes were chosen for further analysis. These homes supplied relatively equal samples of patients and sponsors who were studied still further.

A total of sixty-five patients were administered personal interviews by an independent market research agency in an attempt to measure patient satisfaction. The basic format of the interview utilized was similar to that developed by Allen Pincus, a University of Wisconsin sociologist.

Phone interviews with sixty-one sponsors were conducted by the same independent agency in order to measure sponsor satisfaction. The telephone interview was based upon a patient questionnaire developed by Barbara Tomlinson of the Ann Arbor Institute of Gerontology.

Although none of the samples were random samples, a Mann-Whitney U test was administered to all comparisons made in order to indicate the relative importance of any differentials manifested.

Support was found for H_2 (linking need structure and orientation), and further analysis implied that the generalizations of H_{II} might be tenable.

Support was not found for H_3. The directional emphasis of the data did indicate perception of nursing home orientation, but the differences manifested were not statistically significant at the .10 level. Accordingly, the generalization of H_{III} could not be made.

Likewise, support was not found for H_4. Even though the data conformed to the hypothesized directions of greater satisfaction for groups favored by nursing home orientation, the differences manifested were not significant at the .10 level. Once again, no generalization like that posited by H_{IV} was possible.

Due to the failure to find support for H_3 and H_4, H_I could not be supported. Conflict between patients and sponsors clearly was <u>not</u> a major source of dissatisfaction regarding nursing homes.

One of the reasons for the author's failure to find conclusive support for the above hypotheses was felt to be the relative insensitivity (and highly subjective nature) of the instruments utilized. The author did feel that the satisfaction related ramifications of conflict hinted at by his findings did indicate that further research into elements of satisfaction produced by conflict resolution might be warranted both within and without nursing homes.

SATISFACTION RELATED ELEMENTS OF SURROGATE SITUATIONS AS TYPIFIED BY NURSING HOME PURCHASE TRANSACTIONS

By

Richard W. Buchanan

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Marketing

1975

To Grandmother Buchanan

ACKNOWLEDGMENTS

Let all who read this work know one fact with certainty--a dissertation does not have to be a totally unpleasant experience. Prior to beginning, the author was prepared by his peers for an ordeal roughly approximating the Spanish Inquisition. At each step he was prepared for a host of inequities and indignities that never materialized. On the contrary, the author found his own experience to be largely positive.

Though not particularly anxious to test this hypothesis by repeating the experience, the author believes the main reason for his positive feelings is the uniquely productive treatment extended him by his committee. While far from being "easy," they always remembered to place their emphasis on instruction (and not obstruction). Their demands were never unreasonable, and almost always made significant improvements in the finished product. Their encouragement and willingness to be "on call" (even at odd hours of what should have been their personal time) continually amazed the author and his negative-thinking peers. The author knows full well how exceptional they were, and wishes to express his gratitude to them.

So, to Dr. Stanley Hollander, go the author's deepest thanks for the helpful guidance and personal attention which never stopped despite times that must have been very difficult for him.

The author is indebted to Dr. Frank Bacon for his many contributions to this project's structure and implementation.

Dr. Gerald Miller is owed a debt of gratitude for his encouragement and insights into the science of communication.

Beyond the author's committee, there exist a host of other individuals whose contributions to this project must be recognized.

First among these is Mr. Harold Creal, president of the American College of Nursing Home Administrators. Without Mr. Creal's support this project could never have been undertaken. Without him the author could never have secured the assistance of the American College of Nursing Home Administrators and the Health Care Association of Michigan, two groups who figured so strongly in this research.

To these two groups, their members and officers (particularly Mr. Chuck Harmon and Mr. Ralph Schmuckle of HCAM) go the author's sincerest regards for their generous support of his efforts.

The author wishes to express his appreciation to Mr. Sam Anema of the Western Michigan University computer center who helped unravel the mysteries of the computer (while adding a few of his own!!)

Finally, I wish to thank my wife, Margaret, for being understanding while coping with the various pre-occupations, mood changes, and absences prompted by this research.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

This work chronicles exploratory research into some elements of dissatisfaction with nursing homes. Its distinguishing feature is that, unlike other research into nursing homes, it does not emphasize situations in which the dissatisfaction stems from callous neglect of the homes' patients.

Chapter I shall deal with the analytical framework that shaped the author's research. Chapter II shall detail the methodological considerations suggested by that analysis. Chapter III will present the findings of the research, and Chapter IV shall set forth the conclusions and recommendations emanating from those findings. As shall be discussed more thoroughly later, the topic areas covered in this study do not appear to have been researched extensively in the past. For this reason, no single "literature search" section shall be presented. Instead, appropriate prior works shall be identified and analyzed as the subject areas to which they relate are covered.

The beginnings

The beginnings of the author's interests in nursing homes are traceable to a time when a favorite grandparent (to whom this work is dedicated) spent the last two years of her life in such a

place. The author can remember no unhappier period for him or his family. Quite literally, nothing that took place during these two years seemed to produce anything but unhappiness and conflict for those involved.

Informal discussions with others in similar circumstances prompted the realization that this was far from being a unique experience. Indeed, it seemed that few who spoke with the author about their contacts with nursing homes had anything good to say about them. Subsequent research into the "popular press" treatment of nursing homes revealed that this theme of dissatisfaction was a common one.[1] However, in reviewing the circumstances of his own experience with nursing homes, the author could not agree with such critics. Unlike them, he could not honestly say that his negative feelings were the result of " . . . cynical exploitations . . ." of " . . . the commercially-operated nursing homes and corporation-owned hospitals that have sprung up to take advantage of Medicare."[2] When being totally objective the author had to conclude that the nursing home and staff serving his family honestly were striving to do the

---

[1]See Claire Townsend, Old Age: The Last Segregation, Ralph Nader's Study Group Report on Nursing Homes (New York: Grossman Publishers, 1971); Mary Mendelson, Tender Loving Greed (New York: Alfred A. Knopf, 1974); and Susan Jacoby, "Waiting for the End: On Nursing Homes," New York Times, March 31, 1974, p. 5.

[2]Sidney Margolis, "The Older Consumer as a Force in the Marketplace," The Aging Consumer. Papers from the 22nd Annual Conference on Aging (Ann Arbor: Institute of Gerontology, 1969), p. 1.

best they could. When he objectively investigated some of the "horror stories" told him by friends, he frequently found these tales the result of actions that seemed in the best interests of all.

This was not to say that the author felt that the nursing home industry was without corruption. Rather, the impression was that the "callous exploitation" he could find connected to those experiences he investigated did not seem to justify the negative feelings he and his friends felt toward the nursing home industry.

The author was intrigued by these feelings of dissatisfaction without apparent justification. Although he realized they could be isolated manifestations, his suspicions to the contrary were strengthened by the current climate of public/governmental attention to nursing home operations.

As might be expected, public disdain for nursing homes was generating a great deal of legislative attention to the industry.[3] This attention was resulting in ever more strict regulation.[4] Logically, this increased governmental presence should have

---

[3]See U.S., Congress, Senate, Special Committee on Aging, Hearings Before the Subcommittee on Long Term Care of the Special Committee on Aging, parts 1-15 (Washington: U.S. Government Printing Office, 1971); Comptroller General of the United States, Report to the Congress, Continuing Problems in Providing Nursing Home Care and Prescribed Drugs Under the Medicaid Program in California (Washington: U.S. Government Printing Office, 1970).

[4]Jonathan Spivak, "HEW Plans to Issue Regulations to Improve Safety and Medical Care at Nursing Homes," Wall Street Journal, January 14, 1974, p. 8.

directly eliminated some callous exploitation and indirectly limited other abuses due to the intimidation of nursing home operators fearful of even more restrictive measures. However, the amount of abuse directed at the industry was trending upward, not downward (as should have been the case if it stemmed from callous neglect alone).

This indicated that neglect, alone, might not be the source of all the dissatisfaction directed toward the nursing home industry and hinted at the presence of some hidden causes of dissatisfaction not previously researched. If such were the case, the industry was suffering unjustly from public opinion and legislative action that could not be in its best interests. The chance of correcting this injustice was interesting enough, but the possibility of isolating these hidden factors was doubly exciting. If hidden sources of dissatisfaction could be found, the unhappiness associated with them might be capable of control or reduction and this was particularly interesting to the author. So it was that the author decided to conduct exploratory research into the causes of dissatisfaction with nursing home purchases. He realized that his resource limitations might preclude definitive determination of all the satisfaction related elements. However, he did hope to develop strong indicators of where the potential problem(s) might lie so that subsequent research would be provided with appropriate direction.

The Aged

A logical starting point for any discussion of nursing homes is an analysis of the aged who are the major consumers of nursing home services.[5] However, definition of "the aged" is somewhat difficult. At least one author recognizes that anyone over the age of 60 could be considered to have attained "old age,"[6] while others do not consider anyone under 75 as having reached that stage of life.[7] As it is with so many categorizations, the choice of limits defining "old age" must be somewhat arbitrary.

For his purposes, the author chose to define the aged as anyone who had attained or passed their sixty-fifth birthday--agreeing with Sheldon that this "lower limit is sanctioned by tradition and by legislation relating to retirement."[8]

---

[5]Division of Health Insurance Studies, Office of Research and Statistics, Social Security Administration, Estimated Personal Health Care Expenditures by Type of Expenditure and Source of Funds for Three Age Groups, Fiscal Years 1970-1972, cited in ANHA Facts in Brief (Washington: American Nursing Home Association, 1972), p. 4.

[6]Henry Sheldon, "The Changing Demographic Profile," Handbook of Social Gerontology, ed. by Clark Tibbits (Chicago: University of Chicago Press, 1960), p. 28.

[7]Herman B. Brotman, Who Are the Aged: A Demographic View (Ann Arbor: Institute of Gerontology, 1968), p. 2.

[8]Sheldon, p. 28.

Defined in this manner the aged currently constitute approximately 9.8 per cent of the total United States population.[9] Since 1900 this over-65 segment has grown more than twice as fast as the rest of the population[10] and is expected to constitute between 9 and 11 per cent of the total population by 1990.[11] Although these statistics portray a relatively important total aged segment both now and in the future, what is taking place within this segment is even more meaningful for anyone studying the importance of nursing homes.

Currently, less than 5 per cent of the total aged population (i.e., about .5 per cent of the total population) resides in "institutions."[12] Unfortunately, this "institution" figure is a composite of jails, hospitals, homes for the aged, nursing homes, etc., and the figures delineating all the sub-totals within these classifications for the 1970 census are not yet available. However, some approximation of the relative make-up of this "institutional" category may be derived from other sources. As of 1969 approximately

---

[9] U.S., Bureau of the Census, Current Population Reports, Series P-23, No. 43, "Some Demographic Aspects of Aging in the United States" (Washington: U.S. Government Printing Office, 1973), p. 5.

[10] U.S., Office of Human Development, Administration on Aging, New Facts About Older Americans (Washington: DHEW, 1973), p. 1.

[11] U.S., Bureau of the Census, We the American Elderly (Washington: U.S. Government Printing Office, 1973), p. 14.

[12] U.S., Bureau of the Census, Current Population Reports, p. 27.

four individuals per thousand (.4 per cent of the total population) resided in "nursing and personal care homes."[13] Of those individuals within "nursing and personal care homes," over 95 per cent resided in homes offering some degree of nursing care.[14] As shall be discussed later, the definition of a "nursing home" presents many problems, but proceeding at this point with a definition requiring only an institution offering some degree of nursing care, it appears that residents of nursing homes constitute somewhat less than .4 per cent of the total population (i.e., .95 x .4 per cent).

Although the population residing within nursing homes is relatively small, it may be expected to grow in size. Despite advances in medical technology the maximum age at death has not greatly increased, but the number of Americans attaining the advanced stages of old age has.[15] This phenomena has led to the population trends depicted on the following page. This evidence of a rapid growth rate for the older members of the aged population is particularly significant, for the rate of institutional residence increases

---

[13]U.S., Department of Health, Education, and Welfare, Characteristics of Residents in Nursing and Personal Care Homes (Rockville, Md.: National Center for Health Statistics, 1973), p. 5.

[14]Ibid., p. 6.

[15]Ewald Busse, "The Modern Challenge of Threescore and Ten," Journal of the American Geriatrics Society, XVII (September, 1969), p. 889.

rapidly for those 75 or older.[16] Assuming that these older aged segments continue to grow in size, it would seem likely that the relative number of individuals residing within nursing homes might also increase in the years ahead.

TABLE 1

PERCENTAGE CHANGE IN U.S. POPULATION
BY AGE SEGMENT

Age	Per Cent Change 1960-69
All ages	+12.9
Under 5	-11.6
5 - 24	+27.6
25 - 44	+ 1.7
45 - 64	+14.7
65+	+17.6
65 - 69	+ 8.5
70 - 74	+ 8.9
75 - 79	+28.2
80 - 84	+46.3
85+	+38.8

Source: Herman Brotman, The Older Population: Some Facts We Should Know (Washington: U.S. Government Printing Office, 1970), p. 3.

In light of the preceding analysis, the author felt that the aged population residing within nursing homes merited further study. This market's manageable size and likelihood of continued growth made

---

[16] U.S., Bureau of the Census, Current Population Reports, p. 27.

it an attractive candidate for research both now and in the future. Its human importance to those involved with long term nursing care also impressed the author, and shaped his decision to further study the specifics of the nursing home industry.

The nursing home industry

Developing background statistics for the total U.S. nursing home industry represents a definition problem every bit as difficult as that surrounding "the aged." The exact definition of what is, and is not, a "nursing home" varies greatly from state to state.[17] Perhaps due to these difficulties the major resource agency for statistics regarding nursing homes, the National Center for Health Statistics, does not explicitly define the term "nursing homes." Instead this agency groups data concerning such facilities into four loose categories: Nursing Care, Personal Care Homes with Nursing, Personal Care Homes without Nursing, and Domiciliary Care. Using these rough definitions there were, in 1971, a total of 22,538 such "nursing care and related homes" in the U.S.[18]

The aforementioned heterogeneity of "nursing homes" definitions across state lines troubled the author. Although his study would probe satisfaction issues universal to all nursing homes,

---

[17]Jordan Braverman, Nursing Home Standards . . . A Tragic Dilemma in American Health (Washington: American Pharmaceutical Association, 1970), p. 1.

[18]U.S., Department of Health, Education, and Welfare, Health Resources Statistics, 1972-73 (Rockville, Md.: National Center for Health Statistics, 1973), p. 385.

the mechanical problems associated with sampling potentially diverse populations indicated some definitional uniformity would be desirable. Therefore, the scope of this study was limited to nursing homes within the state of Michigan. This decision guaranteed some homogeneity for the institutions to be studied, and fell well within the resource constraints of this, the author's, doctoral dissertation.

Changing the focus of analysis to the state level greatly improves the definition of the term "nursing home." Within the state of Michigan a nursing home is defined as "an establishment or institution other than a hospital having as one of its functions the rendering of healing, curing, or nursing care for periods of more than 24 hours to individuals afflicted with illness, injury, infirmity, or abnormality."[19]

Using this definition, there were 338 nursing homes in Michigan with 35,311 beds.[20] This same classification also included County Medical Care Facilities and Hospital Longterm Care units.

The Medical Care Facilities and Hospital Units provide approximately the same care as nursing homes, but are operated by county governments and independent hospitals respectively.

---

[19]Bureau of Health Facilities, February 1974 Directory of Hospitals, Nursing Care Facilities, and Homes for the Aged (Lansing: Michigan Department of Public Health, 1974), p. 13.

[20]Ibid., p. 13.

In 1974 there were 39 county medical care facilities (4,301 beds) and 28 hospital longterm care units (2,349 beds).[21] Due to similarity in function of these units as well as a desire to build the total research population as much as possible, the author included these last two institutions within the scope of his study.

At this point it should be mentioned that one institutional classification, homes for the aged, serves a population similar to that of nursing homes. In Michigan, a "home for the aged" is defined as follows:

> . . . an establishment or institution other than a hospital, hotel, or nursing home which provides room and board to non-transient unemployed individuals 65 yrs. of age or older. Generally speaking, their purpose is to provide supervised personal care for elderly persons who do not need organized nursing care.[22]

Because homes for the aged do not provide any nursing care, the author decided to exclude them from the main focus of his research except for those cases involving nursing homes licensed both as a "nursing home" and as a "home for the aged." Given the relatively small number of homes for the aged (119 homes with 7,680 beds)[23] the author saw no harm in such an exclusion.

---

[21] Ibid., p. 13.

[22] Ibid., p. 33.

[23] Ibid., p. 33.

Within the Michigan classification of "nursing homes" there exist three different types of homes: intermediate care facilities, skilled nursing homes, and extended care facilities.[24] These facilities are defined as follows:

> An intermediate care facility is for people who need some nursing supervision in addition to help with eating, dressing, walking, or other personal needs. Medicaid programs in some states pay for intermediate care but Medicare never does.
>
> A skilled nursing home is staffed to make round-the-clock nursing services available to residents sick enough to require them. Medicaid programs in all states pay for skilled nursing home care if a physician says such care is needed.
>
> An extended care facility also provides round-the-clock nursing services as an extension of hospital care. Medicaid programs do not apply here. Medicare pays for up to 100 days only if patients have spent at least three days in a hospital and extended care is recommended by a physician.[25]

At least some of the preceding definitions are now academic and were included only to provide greater clarity for any reader familiar with the industry. As of January, 1973, the two home classifications, "extended care facilities" and "skilled care facilities," were merged into a common federal definition, "skilled nursing facility,"[26] but this new term has not yet attained widespread

---

[24]U.S., Department of Health, Education, and Welfare, Nursing Home Care, Consumer Information Series #2 (Washington: U.S. Government Printing Office, 1972), p. 5.

[25]Ibid., p. 5.

[26]U.S., Congress, Senate, Committee on Finance and U.S., House of Representatives, Committee on Ways and Means, Summary of Social Security Amendments of 1972, Public Law 92-603 (Washington: U.S. Government Printing Office, 1972), p. 15.

usage. For his part, the author included nursing homes which fit any of the preceding definitions within the scope of his inquiry.

At this point in his background analysis the author decided that the total number of nursing homes within the state of Michigan was an interesting population of reasonable research size. So it was that he continued to pursue this topic and next turned his attention to the market represented by nursing home consumers.

The nursing home market

The expenditure of funds for nursing home care constitutes a sizeable market. For calendar year 1972 it has been estimated that a total of over three billion dollars was spent for aged nursing home care in the United States.[27] Broken out on an individual basis the expenditures for aged nursing home care are even more significant.

As of 1969 the average monthly charge for nursing home care in the United States was $328.[28] Given current rates of inflation, it seems highly possible that this 1969 figure is understated. Although more current statistics are not available, some reasonable approximation may be developed from existing sources.

---

[27]Administration in ANHA Facts in Brief (Washington: American Nursing Home Association, 1973), p. 4.

[28]U.S., Department of Health, Education, and Welfare, Charges for Care and Sources of Payment for Residents in Nursing Homes (Rockville, Md.: National Center for Health Statistics, 1973), p. 3.

Currently, the maximum reimbursable rate for aged nursing care under the Michigan Medicaid program is $21.35 per day.[29] As shall be discussed more thoroughly later, this sum is probably somewhat less than the average selling price per day, but may be utilized as a good estimate for current nursing home fees. Using this figure, the average monthly charge for aged nursing care is approximately $640.00 ($21.35 x 30). This sum becomes still more significant in light of the fact that most aged residents of Michigan nursing homes stay for an average of 2.1 years.[30] Thus, an average purchase of nursing care within the state of Michigan represents an eventual expenditure of over sixteen thousand dollars ($640 x 12 x 2.1).

Given the magnitude of this purchase and the public interest in it, it seemed a likely candidate for extensive business research. However, the author's literature search indicated that such was not the case.

The author's first step, an intensive search through the index of Dissertation Abstracts from its inception to the present, yielded only four works related to the business aspects of nursing home care.

---

[29] State of Michigan, Medical Assistance Program Bulletin No. B-3 (Revised Reimbursement Rates) (Lansing: Department of Social Services, 1974).

[30] Jane Barney, Patients in Michigan's Nursing Homes (Ann Arbor: Institute of Gerontology, 1973), p. 69.

In "The Nursing Home Industry in Washington State,"[31] John Trainor attempted to research some economic aspects of the nursing home market. But, assessing the contributions of his research was extremely difficult. It proposed no finite hypotheses and utilized mostly unstructured interviews with nursing home administrators as its major research tool. Because these interviews proceeded without direction or uniformity, few general conclusions about nursing home care could be drawn from this work. Trainor did mention that these operators were aware of a "bad image" attached to the nursing home industry, but did not attempt to research its underlying causes.

Both "The Effect of the Introduction of Medical Assistance and Medicare on the Structure of the Michigan Nursing Home Industry," by L. A. Bair[32] and "The Effect of Medicare and Medicaid on the Supply and Demand Conditions of Nursing Homes," by L. H. Henry[33] dealt with macro economic dimensions of the market for nursing homes. As such, they made few contributions to the micro dimensions of purchase satisfaction of interest to the author.

---

[31]John Trainor, "The Nursing Home Industry in Washington State" (unpublished Ph.D. dissertation, Washington State University, 1970).

[32]L. A. Bair, "The Effect of the Introduction of Medical Assistance and Medicare on the Structure of the Michigan Nursing Home Industry" (unpublished Ph.D. dissertation, Michigan State University, 1973).

[33]L. H. Henry, "The Effect of Medicare and Medicaid on the Supply and Demand Conditions of Nursing Homes" (unpublished Ph.D. dissertation, Notre Dame, 1970).

Only one dissertation, Frederick Miller's "An Analysis of the Marketing Strategy of Florida Nursing Homes,"[34] concerned itself with issues of home marketing in a form directly relevant to the author's interests. Using a survey mailed to administrators, Miller derived a large amount of background information pertinent to the marketing of nursing homes. However, given the choice of his technique, Miller could not delve beyond the rather one-sided purview of his sample. As such, he did not touch directly upon the issues of purchase satisfaction. Interestingly enough, Miller defended his choice of research technique by stating the following:

> A major restriction was the limited amount of secondary materials available. Published information on nursing homes is primarily on medical and other technical aspects. Marketing receives only limited attention in nursing home journals. The main source of information for this project was primary research on nursing homes in Florida.[35]

Due to state-to-state differences between nursing homes, the author recognized that any attempt to generalize from others' data for his own purposes represented some risks. However, as the paucity of secondary data noted by Miller would prove to be reflected by his own literature search, he eventually accepted such risks as justifiable.

---

[34]Frederick Miller, "An Analysis of the Marketing Strategy of Florida Nursing Homes" (unpublished Ph.D. dissertation, Louisiana State University, 1970).

[35]Miller, p. 12.

Having exhausted available business dissertations, attention was next focused upon other business sources of secondary data. This step proved even less satisfying than the first.

A review of the Journal of Marketing and the Journal of Marketing Research for the past five years yielded no articles about the marketing of nursing home care. A search through Business Periodicals Index from 1969 to the present uncovered a number of articles related to nursing homes in general, but none devoted to unbiased research into the satisfaction issues of interest to this project.

Finding so little material related to the business aspects of nursing homes, the author next turned his inquiry toward similar topics in related fields. A search through Dissertation Abstracts since its inception and Sociological Abstracts since 1969 yielded three works in the sociology discipline at least obliquely related to nursing home satisfaction. As all three of these dissertations dealt with homes for the aged, a classification already excluded from the author's research focus, their relevance was somewhat diluted. However, as shall be explained later, the plan was to deal with the purchase satisfactions of nursing home residents who were more or less healthy. As such, the importance of the nursing care which distinguished between nursing homes and homes for the aged might not be too great, and some of the generalizations discernible from home-for-the aged study might also be applicable to nursing homes.

In "Expert vs. Consumer Viewpoints: An Organizational Analysis of the Contrast in Descriptions of Homes for the Aged by Administrators and Indigenous Residents,"[36] B. M. Silverstone, a sociologist, used homes for the aged as a laboratory for research into the difference between residents' and administrators' perceptions of the environment within the subject homes. This dissertation focused on communication linkage adequacy in explaining any such differences. Silverstone's work did deal indirectly with aged resident dissatisfaction when it zeroed in on environmental deficiencies of home-for-the-aged residences of which administrators were unaware. However, the dissatisfaction so studied was not directly researched, but rather was the by-product of Silverstone's main research interests. Combining this factor and the conclusion that Silverstone's hypothesized importance of communication linkage was not supported, it appeared that this work had little to contribute to the study of nursing home dissatisfaction.

"A Study of Family Factors Relating to Application to a Home for the Aged,"[37] by sociologist Sidney Saul was a comprehensive collection of background factors relating to the admission of

---

[36]B. M. Silverstone, "Expert vs. Consumer Viewpoints: An Organizational Analysis of the Contrast in Descriptions of Homes for the Aged by Administrators and Indigenous Residents" (unpublished Ph.D. dissertation, Columbia University, 1973).

[37]Sidney Saul, "A Study of Family Factors Relating to Application to a Home for the Aged" (unpublished Ed.D. dissertation, Columbia University, 1968).

patients to a home for the aged. Its immediate usefulness was reduced by the fact that the homes studied admitted only blind residents.

As only about 4 per cent of all U.S. nursing home residents are blind,[38] this factor could detract from the ability to generalize from this study either to nursing homes or other homes for the aged.

However, to the extent that generalizations are possible, Saul's work was similar to Miller's in providing a wealth of data about the admission of patients to homes. Still, Saul did not directly deal with the satisfaction of these residents once admission was accomplished, so its usefulness to the study at hand was limited.

Allen Pincus, also a sociologist, attempted to develop operational tools for studying institutional environments in his "Toward a Conceptual Framework for Studying Institutional Environments in Homes for the Aged."[39] The main thrust of this work was the creation and validation of tools which might be utilized to measure different aspects of the environments within institutions. Developing applications for these tools was, for the most part, left

---

[38]U.S., Department of Health, Education, and Welfare, Chronic Conditions and Impairments of Nursing Home Residents (Rockville, Md.: National Center for Health Statistics, 1973), p. 13.

[39]Allen Pincus, "Toward a Conceptual Framework for Studying Institutional Environments in Homes for the Aged" (unpublished Ph.D. dissertation, University of Wisconsin, 1968).

to other researchers. As shall be discussed under "methodology," at least one of these tools appeared applicable to the author's research interests and will be analyzed more completely in that section.

Once again, having exhausted available dissertations, the author probed more general sources of secondary data. A journey through the Reader's Guide to Periodical Literature from 1969 to the present produced many of the "muck-raker" articles about nursing homes discussed in the beginning of this paper. However, it uncovered no research concerning itself with dissatisfaction not stemming from callous neglect.

The Public Affairs Information Service Bulletins from 1969 to the present and a search through Western Michigan University's extensive gerontology collection produced a great deal of background information from the U.S. government, etc., but no real insights into the satisfaction issues of interest to the author.

In summary, the author discovered very little prior research relating to the marketing activities of nursing homes in general. He found virtually none dealing with nursing home purchase satisfaction issues that did not presuppose nursing home operator guilt. The paucity of prior work, when combined with the author's aforementioned intuitions, indicated further research into this dissatisfaction-without-neglect issue was merited. Thus the author embarked on the first step of studying this issue, the understanding of the process by which individuals arrive at the need for a nursing home.

The health care process

The process by which individuals reach varying levels of health care has been conceptualized by Harold Baumgarten, an authority in the field of nursing home administration. His thoughts have been summarized in the framework presented as Figure 1.1.

As shown by this framework, the individual more or less "falls" through a funnel of health care; coming to rest at that level which best fits his needs. If the individual returns to health, he is free to progress through the process anew. As shown by Figure 1.1, the need for a nursing home is normally preceded by some prior medical condition that necessitates professional care. Most frequently this care would have to be administered in a hospital setting. Once the immediate medical emergency is judged not to necessitate hospital care, the patient is free to proceed down the funnel.

Some parts of the health care funnel concept were well supported by existing research. For instance, in his study Miller found that the major source from which nursing home residents came was the hospital.[40] On the other hand, the part of the health care funnel depicting the nursing home as a temporary stop on the road back to health appeared to be more of a governmental "ideal" than an actual fact. Dr. Baumgarten explained to the author that flow

---

[40]Miller, p. 113.

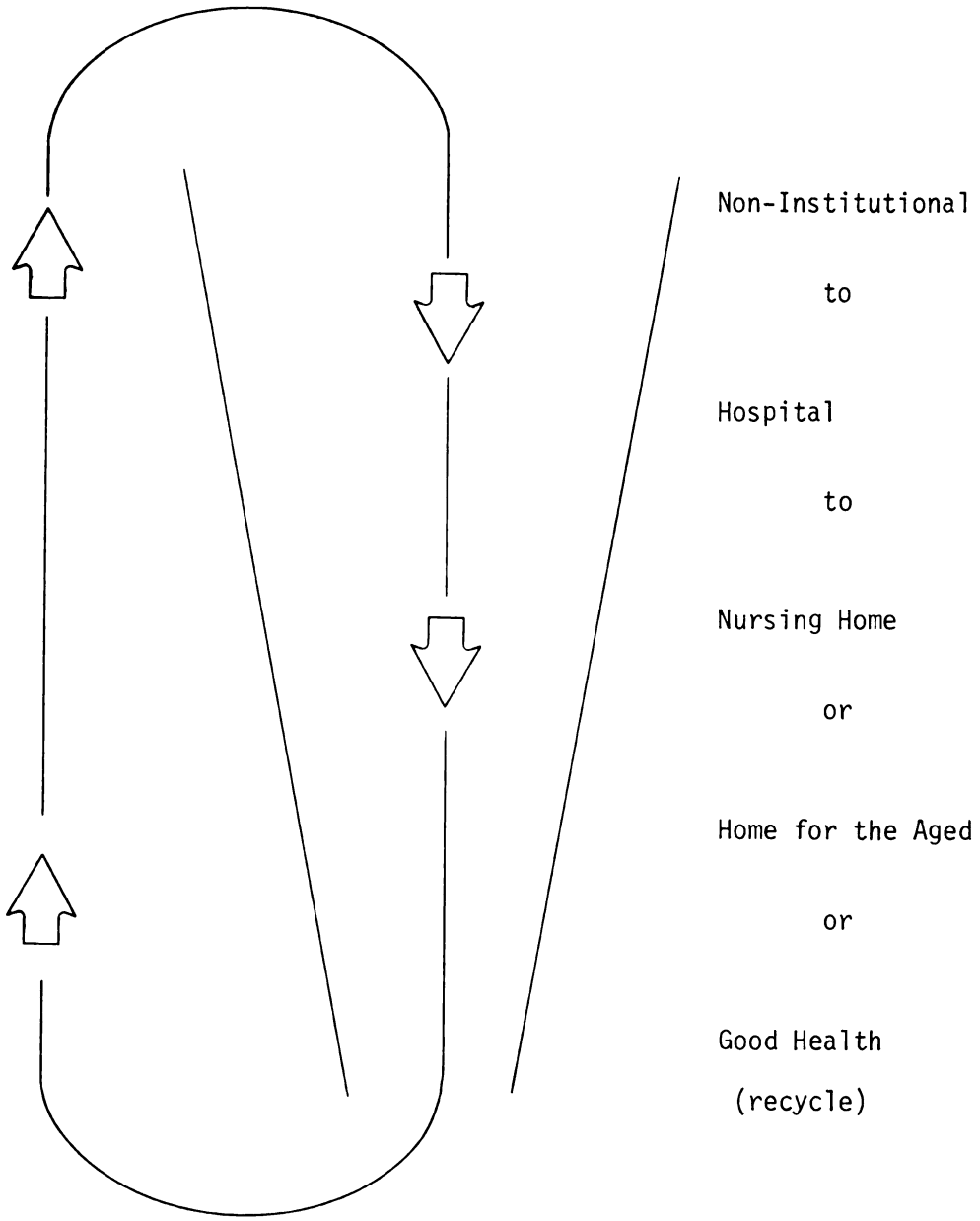


Figure 1.1--The Health Care Process

Source: Harold Baumgarten, The First Kuttnauer Seminar on Nursing Homes and Extended Care Facilities (December 8-9, 1967) as related by Harold Creal, Past President of the Michigan Nursing Home Association in a personal interview February 5, 1973.

down the funnel was due to the progressively lower costs per day within the institutions depicted on its lower levels.[41] If individuals took the expected course of minimizing the total costs per day of their care, they would proceed down the funnel to progressively lower levels as shown. However, it did not appear that this was the case.

As previously mentioned, the Institute of Gerontology found the average nursing home stay to be just over two years in Michigan and a similar nationwide study found it to be 2.8 years.[42] This apparently precluded very many short stays of the type proposed by the funnel. In fact the long length of the stay when coupled with the resident's advanced age, indicated that their stay usually lasted until death.

Still, some aged patients do undoubtedly go home after a brief convalescence, and some homes also serve younger individuals recuperating from serious accidents, etc. It is plausible to assume that those patients who utilize the nursing home only temporarily would find their dissatisfaction with it less important than those for whom it represents a last residence.

Therefore, the nursing home residents of interest to this research were limited to those patients over 65 whose stay is regarded as being permanent until their condition becomes terminal.

---

[41] Letter from Dr. Baumgarten to R. W. Buchanan, March 18, 1974.

[42] U.S., Department of Health, Education, and Welfare, Characteristics of Residents in Nursing and Personal Care Homes (Rockville, Md.: National Center for Health Statistics, 1973), p. 3.

It would be justifiable to raise the question of whether many patients in the above category would be well enough (in a physical and mental sense) to feel and express dissatisfaction with their nursing home residence. The available evidence regarding this issue is presented in Table 2.

Though defining exact levels of physical and mental competence is extremely difficult, Table 2 shows the majority of nursing home patients still possessing most of their original faculties. This agrees nicely with an Institute of Gerontology finding that over two-thirds of the patients in nursing homes do not need the extensive medical and personal care available there.[43] These figures indicate that a majority of nursing home patients are healthy enough to both feel and express dissatisfaction with their environment. In light of this finding it appeared both possible and desirable to define the dissatisfaction of interest to the author.

Webster's Seventh Collegiate Dictionary defines satisfaction as "fulfillment of a need or want." However, just inserting "non" in front of this definition does not fulfill the author's needs, as the earliest beginnings of this study are traceable to expressions of dissatisfaction evidenced by many parties. Granted, dissatisfaction could exist in quantities minute enough that it might not be expressed,

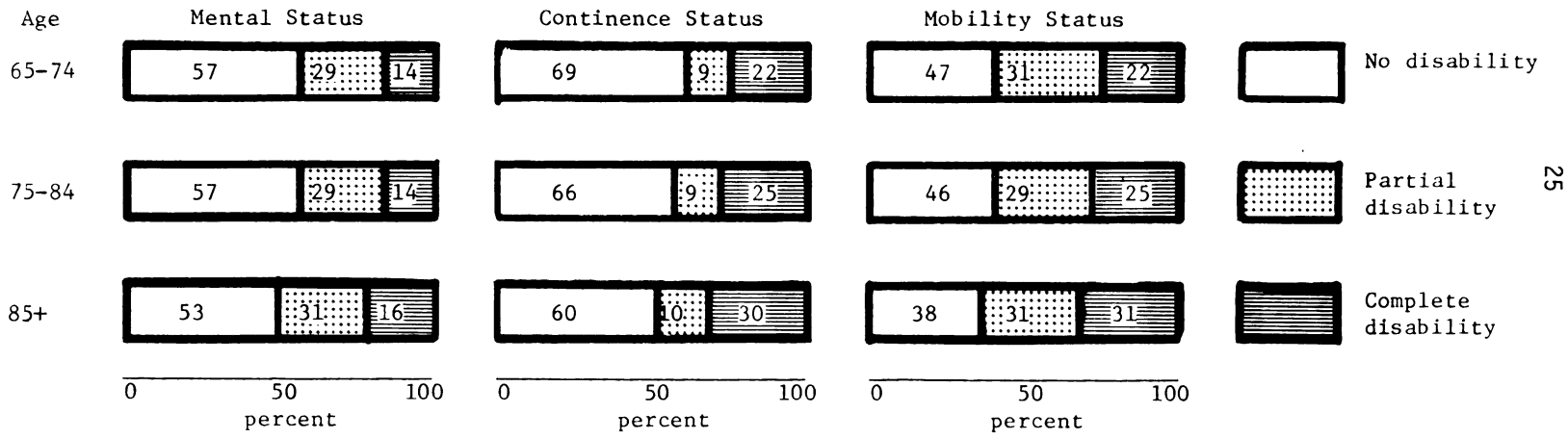
---

[43]Barney, p. 16.

TABLE 2

PHYSICAL/MENTAL CONDITIONS OF PATIENTS IN NURSING HOMES

Residents, Aged 65 and Over in Nursing and Personal Care Homes, by Extent of Disability for Selected Characteristics, United States



Source: U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Center for Health Statistics, Rockville, Maryland, 1972 in ANHA Facts in Brief.

but how important this dissatisfaction is seems a moot point. Furthermore, an expression of dissatisfaction could take either verbal or non-verbal form.

As the easiest form of expression to measure is verbal, the dissatisfaction of interest to this research was defined as nonfulfillment of wants or needs sufficiently important to prompt verbal expression on the part of the individual experiencing it.

It should be understood that this verbal expression was not limited to complaints about the specific nonfulfilled need. As shall be shown later, nonfulfillment of one need can result in dissatisfaction expressed through complaints about others.

In recognition of the fact that the nursing home population probably could include some patients incapable of expressing dissatisfaction of the type defined above, the population of interest to this study was further limited to include only those patients cognizant enough of their environment to be able to experience dissatisfaction from specific elements of it.

Although this limitation might sound very non-specific, it shall be shown that it is sufficient for the research methodology to be employed by this study.

The purchasers of nursing care

That part of the health care funnel which predicated nursing home admission upon prior hospitalization led to a suspicion that nursing home residents might not be the ones who decided upon the

actual purchase of any given home. Logically, if patients were hospitalized prior to their admission, they probably were not physically capable of much participation in the shopping and decision making preceding their admission to any given home. This assumption was supported by a sociology study which stated, "Crisis situations--emotional problems or failing health--frequently prompt a move to an institution. The individual has little control over the situation in such a crisis, and the move is involuntary and often traumatic."[44]

Furthermore, it has been shown that admittance to a long term care institution is probably not very attractive to aged individuals regardless of their health. Two researchers into this phenomenon commented as follows:

> The personal meaning which institutionalization had was dependent upon the sex of the individual. For the male it was a severe blow to an already shaky self-concept as an adequate, potent person; for the female it symbolized being unwanted and rejected.[45]

Clearly the above findings show that the aged would not have much enthusiasm for the nursing home purchase decision even if they were physically capable of making it.

---

[44]B. A. Yawney and D. L. Slover, "Relocation of the Elderly," Social Work (May, 1973), p. 87.

[45]Morton A. Lieberman and Martin Lakin, "On Becoming an Institutionalized Aged Person," in Processes of Aging, ed. by Richard H. Williams (New York: Atherton Press, 1963), p. 502

These two factors of physical incapacitation and lack of desire led the author to surmise that someone other than the nursing home resident probably had to be involved in the purchase of accommodations in any specific home. This was supported by the following data:

TABLE 3

PERSONS RESPONSIBLE FOR ADMISSION TO A NURSING HOME

Responsible Person at Admission	Per Cent	
Spouse	7.1	
Child	38.3	
Other:	20.2	65.6
Sibling	7.2	
Other relative	9.6	
Non-relative	3.0	
Self* (Patient)	31.0	

*Includes social worker and legal guardian (about 6 per cent)
Source: Jane Barney, Patients in Michigan Nursing Homes, p. 70.

As can be seen from the preceding, the person who negotiates the market transaction of admittance to a nursing home is likely to be other than the patient in approximately two-thirds of the cases. As shall be discussed later, his relative importance to the specifics of any purchase of long term nursing care may vary with the case involved, but the fact of his existence is undeniable.

In light of this finding the author felt it important to include these "other" individuals within the focus of this research.

Henceforth they were referred to as sponsors, a group defined as the responsible parties who are involved with negotiating the admittance of the patient and are the ones designated as the first to be contacted in the event of an emergency.

The above definition needed still further clarification to be of use to this study. If this research was to uncover some of the elements of dissatisfaction surrounding nursing home purchases, it had to concern itself with sponsors interested enough in the topic to be aware of any dissatisfaction throughout the duration of the care extended.

Occasionally sponsors are appointed guardians (lawyers, banks, or other outside parties) who may visit the patient infrequently, and take little interest in his day to day affairs. Furthermore, there are other sponsors who are completely callous to the needs of the patient and almost never concern themselves with him.

Clearly, both these groups were less likely to express the dissatisfaction of interest to this study than someone who was actively involved with the issue of nursing home care. Therefore, the sponsors of interest to this study were further limited to those interested enough in nursing home care to visit the patient they represent at least once a month. This "once a month" average indicated a minimum level of interest to a panel of experts concerned with the industry whose composition is presented in Appendix A.

In the author's opinion, this issue of continued sponsor involvement with nursing home care was a major one. Given that the nursing care purchased normally extended over a period of two or more years, it was obviously important to investigate the sponsors' impact on the long (as well as short) term dimensions of nursing care. In order to accomplish this, some understanding of the "market" for long term nursing care was required.

The market for long term nursing care

The Michigan market for long term nursing care may be divided into two basic segments, private pay and public pay, which comprise respectively about 16 and 84 per cent of all Michigan nursing home patients.[46] As their names imply, the basic distinction between the two is the origin of the revenue supporting the patients' stay. In the private pay sector all of the patients' expenses come from internal resources accessible to him and his family. The public pay sector is reimbursed mostly from public funds made available under the provisions of original federal Medicare/Medicaid act (Title 18 and 19 of the 1965 Social Security Amendments).[47] Of the two public sources of funds, the state directed Medicaid program is much the more important. The original Medicare program only covered

---

[46]Barney, p. 71.

[47]Robert J. Meyers, Medicare (Homewood, Ill.: Richard D. Irwin, 1970).

a maximum of 100 days in a nursing home, and the federal government has been extremely reluctant to reimburse such stays fully.[48] Due to this reluctance many nursing homes have largely abandoned the Medicare program,[49] which now only constitutes approximately 3 per cent of all nursing home revenues.[50] As such, the author was content to interest himself with only the Medicaid aspects of public funding.

The amount of revenue generated by patients within the private and public sectors is quite different. As previously discussed, if a patient is unable to pay for all his care, the maximum which the state reimburses the nursing home housing him, is $21.35 per day. This maximum is currently the center of much controversy within the industry, for many nursing home owners claim that their costs are greater than this sum. As one nursing home operator put it, "In most states Medicaid rates are too low to allow for any profit, but they allow you to spread your overhead over a broader base. Then, if you have enough private patients, you can make a reasonable return on equity."[51]

---

[48]Jim Hyatt, "Medicare Woes, Nursing Home Benefits Grow Harder to Collect," The Wall Street Journal, April 8, 1970.

[49]ANHA, "Proposed Position Paper," in ANHA Governing Council Report (Chicago: ANHA, August 19, 1973), p. 33.

[50]Barney, p. 25.

[51]David A. Loehwing, "Recovery in Nursing Homes," Barron's, March 26, 1973, p. 14.

The price discrimination hinted at by this operator was also mentioned by Trainor who commented as follows:

> The question may be asked how the nursing home industry has been able to survive and grow despite levels of compensation for the care of public assistance patients which much of the time have not been high enough to cover a substantial proportion of the efficient operators' full costs. The answer to this important question is that nursing homes practice price discrimination, openly and unabashedly charging their private patients more than they receive from the state.[52]

In various informal interviews with nursing home administrators, the author found such price discrimination was the rule within Michigan, as well. As such, the private-pay patient was perceived as being the most profitable patient in any nursing home. Under these circumstances, it seemed likely that some homes might seek out this more profitable patient to the exclusion of all others. But, this was not the case.

As previously mentioned, the relative size of the total private pay market is not very great. In order to "draw" enough patients to fill a private nursing home, that home would probably have to attract patients from either an extremely wide area or one of high population density. As a majority of nursing home residents come from a twenty-five mile radius of their nursing home,[53] the possibility of drawing from such wide areas is minimal. This market area factor probably helps explain why the author uncovered evidence

---

[52]Trainor, p. 242.

[53]Miller, p. 63.

of only a few homes catering to private patients exclusively, and these were mostly in metropolitan areas.

Given the common necessity of price discrimination against the private sector, the attainment of some private patients appeared absolutely essential for continued financial stability. In light of the importance attached to attaining private pay patients, the author felt it logical to next study any unique features of marketing to such individuals. A major distinguishing characteristic of the private pay market was found to be the role played by private pay sponsors.

The role of private pay sponsors

In general, sponsors play two separate roles in the purchase of long term nursing care. As previously introduced, they usually seem to be the ones who negotiate the initial admittance of their patient to any given nursing home. Furthermore, depending upon the circumstances, some of them continue to monitor the long run acceptability of care afforded the patients they represent. Apparently, the extent of the sponsor's activities, as well as the complications caused by them, can depend upon whether or not the patient they represent is a member of the private or public pay sectors.

Though generalizations about the nursing home industry are difficult to make, the author sensed that publicly supported patients were felt to be easier to take care of than private pay patients.

The impression received was that Medicaid patients were less likely to have the complicating factor of sponsors whose own needs (as well as those of the patient) had to be satisfied. The following data supported this impression.

Table 4 clearly illustrates that Medicaid patients are unlikely to have anyone interested enough in them even to visit. Unfortunately, no data is available to prove that the person doing the visiting in the above situation is always the sponsor. Obviously, patients on Medicaid receiving few (if any) visitors would be highly unlikely to have sponsors of the type defined as the interests of this study. On the other hand, it is reasonable to assume that some of the many visitors to private pay patients are their sponsors. Therefore, at the very least, sponsors of private pay patients apparently may be inclined to play a more active role in the continuing aspects of long term nursing care. This should not be construed to mean that only private pay sponsors take an active interest in the care afforded their patients. This would very probably be a gross overstatement of the facts. Rather it is meant that private pay sponsors seem to take an active interest in both the initial and continuing aspects of long term nursing care, while such involvement on the part of public pay sponsors may be less universal.

Given the intricacies of the preceding sections, it is probably wise to summarize them as follows:

TABLE 4

NURSING HOME VISITORS BY REVENUE CONTRIBUTED BY PATIENT

Person Visiting	Revenue Contributed by Patient			
	Private	$151+	$51-$150	$0-$50
Spouse	18%	5%	4%	2%
Child	54%	48%	40%	34%
Other	22%	28%	26%	15%
No one	6%	19%	30%	49%
Total	100%	100%	100%	100%

Source: Jane Barney, Patients in Michigan's Nursing Homes, p. 421.

-The purchase of long term nursing care involves two dimensions, an initial phase in which a home is chosen and a continuing phase (lasting over two years) during which those involved with the care must be satisfied.

-The initial phase is not negotiated by nursing home residents, but rather by their sponsors.

-The continuing phase of nursing home care must satisfy both patients and sponsors if an interested sponsor is involved.

-Interested sponsors are particularly likely to be present in the all important private-pay segment (and may be present in others as well).

These findings indicated that nursing homes in general and profit oriented ones in particular were frequently faced with what seemed to be a surrogate purchase situation.

Surrogate purchase situations

A surrogate is defined as "a person appointed to act in place of another."[54] Applied to the situation at hand, it would mean

[54] Webster's Seventh Collegiate Dictionary, p. 886.

that one party to a purchase negotiates for goods/services on the behalf of someone else who must then "live with them" (in this case in both a figurative and literal sense).

Such circumstances would normally mandate that both groups (surrogate and consumer) be seeking to serve the same set of needs in the same manner for satisfaction to result. However, in regard to the nursing home purchase situation, there is little to indicate that this is the case.

The heterogeneity of individuals insures that some differences of opinion are likely to exist in any surrogate situation. Furthermore, as shown by Rokeach, value systems differ for different age groups.[55] As sponsors are most frequently patients' children,[56] the likelihood of such age induced differentials is particularly great.

The author felt the importance of these differentials was further heightened by the fact that the commodity being purchased represented an entire life for many of the patients involved. Logically, any deviation from the patient's ideal was likely to produce intense dissatisfaction on top of that already precipitated by the move itself.

---

[55]Milton Rokeach, The Nature of Human Values (New York: The Free Press, 1973), pp. 72-82.

[56]Barney, p. 70.

Therefore, the author felt it likely that marketers of long term nursing care seeking to serve patients with interested sponsors had to satisfy two distinct sets of needs. If these needs proved to be different, the marketer would be faced with the dilemma of choosing which set to satisfy. Obviously, for those situations in which the needs did conflict and one side or the other was favored, some dissatisfaction was potentially present. In light of these conditions the next logical step was to determine whether sponsors and their patients did have the conflicting need structures suggested by the preceding.

In order to research sponsor/patient need structures, the author interviewed the panel of experts already presented as Appendix A. This panel was composed of nursing home administrators who formed the entire governing board of the Michigan chapter of the American College of Nursing Home Administrators. That association, " . . . devoted to the professional advancement of the long term care administrator through education, professional representation, leadership and research,"[57] had contributed to this project from its inception by lending professional insights and a small ($100) research grant. These interviews yielded the list of typical patient/sponsor needs included as Figure 1.2. A glance through this list quickly revealed many that could be conflicting and subsequent probing of the panel members confirmed that

---

[57]American College of Nursing Home Administrators, Membership Information (Silver Springs, Md., 1974), p. 1.

Patient Needs

To control their own environment regarding:

- care afforded them (by nurses and other professionals)
- their physical mobility
- configuration of physical facilities in which they reside
- physical demands made upon them (rehabilitation therapy, etc.)
- social contacts with their peers
- recreational activities they undertake
- choice of roommates
- sexual/social contacts with others of the opposite sex
- social contacts with members of their family
- food items consumed
- additional "luxury" services they receive (beauty shop, etc.)
- their continued physical existence

Sponsor Needs/Goals

To control their own environment regarding:

- having other individuals (the patient) present or absent in their life
- guilt reduction through seeing that their perceptions of the needs of the patients they represent are met
- the continuation of their perception of their patient's physical and mental abilities (e.g., no physical restraints, etc.)
- protection of previous family relationships from disturbing new elements (such as a parent remarrying)
- continuation of sibling rivalries (through keeping other relatives from seeing a patient)
- personal (or estate) finances expended to supply a patient's needs (not met from other resources)

Figure 1.2--Assumed Patient/Sponsor Needs Served by Nursing Care

patient/sponsor confrontations frequently do stem from such conflicts. In light of these facts, the following initial guiding hypothesis for research appeared reasonable.

H_I Guiding — Marketers of long term nursing care seeking to provide service to patients who have interested sponsors are faced with a surrogate purchase situation containing conflicting sets of needs--those of patients and those of sponsors. Conflicts resulting in the failure to serve one or the other of these sets is a major contributor of dissatisfaction among patients and sponsors that is more or less inevitable.

The notion of such conflicting value systems within an aged consumer surrogate purchase decision situation has not been extensively researched. One nursing-home-administration-manual writer theorized that problems of dealing with resident relatives could be expected to emerge from the emotion-laden admission of a patient, but did not present any research into the origins of these problems.[58] One work was uncovered which concerned itself with surrogate management of the assets of the aged. However, this research dealt with the process by which aged individuals were declared mentally incompetent so that their assets could be usurped by others.[59] Because the topic was so far removed from the author's interests, the only useful input gained from it was a cynical observation that sponsors do not always act in the best interests of those they represent.

---

[58]Harold Baumgarten, Concepts of Nursing Home Administration (New York: Macmillan, 1965), pp. 121-25.

[59]George Alexander and Travis Lewin, The Aged and the Need for Surrogate Management (Syracuse, N.Y.: Syracuse University, 1972).

Within the field of consumer marketing little prior research into surrogate market situations was found. In fact, only one marketing scholar, Dr. Stanley Hollander, appears to have evidenced much interest in this topic area.

In one essay Dr. Hollander exhaustively traced the historical background of consumer purchase surrogates. However, the surrogate situations dealt with in this work were of "interior decorator" or "professional shopper" situations that didn't seem directly analogous to the author's interests.[60] In a later journal article Dr. Hollander further detailed a number of different consumer surrogate classifications. Among these were the following:

-Evaluators and Appraisers
-Diagnosticians and Recommenders
-Service locating agencies
-Product finding agencies
-Package suppliers

Only one of the preceding categories, the "Diagnosticians and Recommenders" seemed even remotely analogous to the interests of this study. Conceivably, doctors could be involved in surrogate situations in which their needs might conflict with those of the relatively powerless consumers they serve (i.e., a physician might choose treatments for their convenience of application, not the consumer's pleasure or comfort). However, this recognition of a similar situation lent few insights to the problems at hand. In

---

[60]Stanley C. Hollander, "The Shops for You or with You," in New Essays in Marketing Theory, ed. by George Fisk (Boston: Allyn and Bacon, Inc., 1971), pp. 218-40.

this same article Hollander noted that almost no research into surrogate situations had been conducted despite their potential importance.[61]

Finding so little prior work concerned with consumer surrogate purchase situations, attention next turned to the field of industrial marketing. Fortunately, this field, which frequently is concerned with surrogate purchase agents, has dealt with surrogate purchase conflicts in terms meaningful to the author's interests.

One theoretician, Philip Kotler, has suggested that conflicting sets of goals between the purchasing agent and the organization he represents often exist in industrial surrogate purchases.[62] Rewoldt, Scott, and Marshall have built Kotler's concept into a model by showing how these sets of goals may be conceptualized by Venn diagrams showing individual/organizational goals and the areas of agreement and conflict between them.[63] Figure 1.3 is a depiction of three possible alternatives for such a situation.

Although this model was intended to deal with conflicts (over gifts, entertainment, etc.) between purchasing agents and their respective firms, it did seem applicable to the purchase of nursing care for a number of reasons.

---

[61]See Stanley Hollander, "Buyer Helping Business . . . and Some Not-So-Helpful Ones," MSU Business Topics, Summer, 1974, pp. 52-68.

[62]Philip Kotler, "Behavioral Models for Analyzing Buyers," Journal of Marketing, XXIX (October, 1965), p. 45.

[63]Stewart H. Rewoldt, et al., Introduction to Marketing Management (Homewood: Richard D. Irwin, Inc., 1969), p. 95.

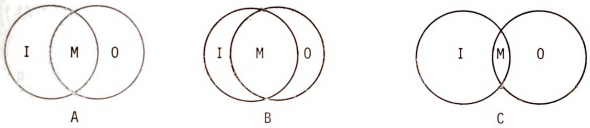


Figure 1.3--Goal* Conflict in a Surrogate Purchase Situation

Note: Individual Goals (I), Organizational Goals (O) and areas of goal mutuality (M).

*The author assumes that, for the purpose of this research, goals and needs are interchangeable.

First, both situations deal with purchase being made by one individual for use by others. True, the industrial purchasing agent is paid for his efforts, while the surrogate purchaser of nursing is not. However, the "for pay" aspects of the purchasing agent seem obviated by the model which assumes the financial rewards of his job are not enough. Were his rewards adequate, he would not have as much need to seek fulfillment of his personal goals through manipulating his professional position. For his part, the sponsor may have a financial stake in the situation (see needs) either directly (by assuming some responsibility for some costs of the care) or indirectly (by seeking to avoid any costs or by striving to protect an estate from erosion). As such, the sponsor and the purchasing agent appear to approach similarity; albeit from opposite directions.

Although the Kotler model does not specifically state this fact, it seems to imply a situation in which the purchasing agent can capitalize upon his position by awarding business to one of several competitors perceived as equals (or near equals). Were this not the case it would be hard to see how the purchasing agent could accrue much personal benefit without making purchases representing disproportionate risk to his continued employment.

This choice among perceived equals seems to be the situation for nursing care, as well. The state, through a stringent set of standards,[64] tries to put a floor on the minimum acceptable level of care. This ensures that all the competitors are likely to be more or less uniform in terms of minimum quality. This "floor" provided by the state helps ensure that the sponsor's probable lack of detailed knowledge about the "product" of nursing care[65] is not a major factor in its purchase. In effect, the state tries to ensure that what is not known by purchasers hurts no one. Except for the cases of dishonorable neglect already excluded by the author's interests and his choice of methodology (to be discussed later), it appears that this end has been accomplished.

---

[64]See Michigan Division of Health Facilities Standards and Licensing, Rules and Regulations for Nursing Homes and Homes for the Aged (Lansing: Department of Public Health, 1974).

[65]Stephani Fenelon, "Patients' Families Need Information," Modern Nursing Home, January, 1974, p. 8.

Frequently industrial purchases (particularly of fabricating materials and parts) represent more or less long run relationships between producer and consumer where the emphasis is placed upon the continuing nature of the market transactions being conducted. This appears to be the case for nursing homes, as well, where the initial purchase decision must be followed by continued satisfaction for a relatively long period of time after the initial purchase.

Finally, a great deal might be made of the fact that industrial purchases are more "rational" (in the sense of being economically motivated) and consumer purchases less so. There can be no denying that the purchase of long term nursing home care is probably packed with emotion. However, by its very nature, the Kotler model seems to insure that the industrial purchase decision it depicts is somewhat emotional as well. Of course, the organizational goals to be serviced by an industrial purchase are usually highly economic in nature. However, the situation conceptualized by Kotler is one where satisfying those goals alone may not be enough. Presumably, the personal goals of the purchasing agent must be satisfied as well. It is hard to conceive of any situation where these personal goals could be deemed less than partly emotional. As such, the industrial purchase decision focused on by Kotler would seem to have its emotional elements too. The only difference might be in their degree of intensity.

Actually, the only place where the author sees the analogy drawn between patient/sponsors and purchasing agents/organizations

as encountering any difficulty is in the arena of prior relational dynamics between these two "actors" of typical surrogate situations. As so many sponsors are the children of the patients they represent, prior emotional ties and guilt over placing the patient in a home could be seen as making the sponsor more dedicated to the patient's needs than their own. This would be in stark contrast to the situation of purchasing agents and the organizations they represent.

This possibility would certainly lessen the dissatisfaction that might attend the surrogate not getting his own way. However, the aged parent/adult child relationship is not uniformly positive.[66] What relational dynamics might emerge from occasionally antagonistic parent/adult child relationships are not clear, but it is certain they would probably not always motivate the sponsor to give up his needs for those of the patient he represents.

The issue of guilt is equally hard to assess. There can be no denying the presence of sponsor guilt--its universality is so great that the "popular press" is now devoting articles to ways of coping with it.[67] However, the behavior emanating from this guilt is difficult to predict.

---

[66]Bertha Simos, "Adult Children and Their Aging Parents," Social Work, XVIII (May, 1973), 78-85.

[67]See Jim Gallagher, "Family Faces Guilt Feelings--Easing Parent's Move to Nursing Home," Detroit Free Press, November 10, 1974, pp. 1C, 9C.

Baumgarten sees intense sponsor guilt over placing a patient in a home as being likely to result in one of two extremes: (1) total abandonment of the patient involved, or (2) total domination of the patient through constant visiting, often coupled with criticism of the nursing home and its service.[68] The first of these alternatives would clearly exclude the parties involved from the defined interest of this research. The second could result in the sponsor's making his interests subservient to those of the patient, but it is not clear that this would always be true. For instance, the patient might not want to be dominated, or might want things of which the sponsor was unaware. Thus, such guilt motivated behavior could result in dissatisfaction of the type to be researched by this paper.

For his part, the author was content to accept that sponsor motivations might represent a flaw in the analogy between sponsors/patients and purchasing agents/industrial organizations. However, the seriousness of the flaw was felt to be mitigated by the above considerations.

In light of his total analysis, the author decided that the Kotler/Rewoldt et al. model did represent a fair depiction of nursing home purchases. Changing the "individual" to "sponsor" and "organization" to "patient," the author arrived at Figure 1.4, need conflict in a nursing home purchase situation.

---

[68] Baumgarten, Concepts of Nursing Home Administration, p. 123.

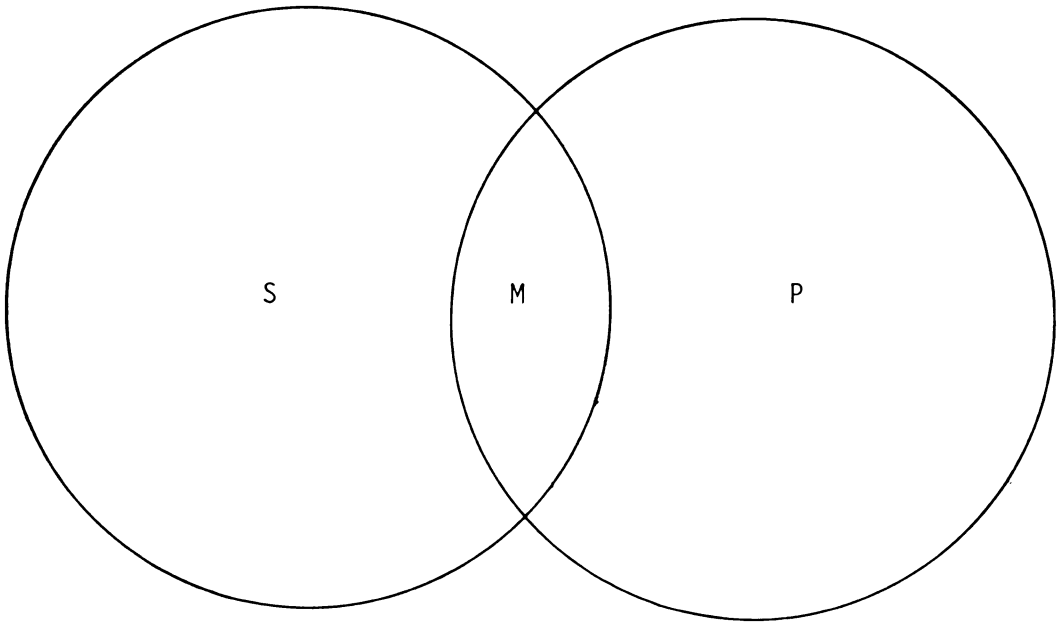


Figure 1.4--Need Conflict in a Nursing Home Purchase Situation

Note: Sponsor's Needs (S), Patient's Needs (P), and areas of mutuality (M).

The Kotler/Rewoldt model typified by Figures 1.3 and 1.4 struck the author as being somewhat lacking. Although it illustrated the dilemma of conflicting consumer/surrogate needs, it proposed no operational strategies for dealing with such conflicts, and yielded no assessments as to the costs of any alternatives that could be chosen. Furthermore, as shall be shown later, it overlooked a third possible area of goal conflict. For these reasons the necessity of constructing further theoretical devices with which to research the purchase of long term nursing care became apparent.

Beyond Kotler/Rewoldt

The Kotler/Rewoldt conceptualization apparently assumes that marketers facing its situations have only the goals of surrogates and those whom they represent to consider in developing a marketing program to meet them.

Of course, the marketing concept proposes that the ultimate goal of any marketing plan must be to satisfy the needs of the consumers it serves.[69] However, the Kotler/Rewoldt model poses the questions of "Who is the consumer?" and "Whose needs shall be served?" A simple answer to these questions is quite difficult, for if a marketer served only the needs of the actual consumer and ignored those of the surrogate doing the buying, he might never make a sale. At the other end of the spectrum, were a marketer to service the needs of a surrogate to the extreme of conspiring with him to defraud those consumers he represents, the ultimate loss of the customer (and possible legal action) would be likely.

The non-acceptability of the preceding extremes hints that a marketer faced with a surrogate purchase situation has a set of his own needs to consider in formulating appropriate market action. This is nothing new to marketing science which presupposes marketers' objectives as an important foundation of any attempt to serve

---

[69]William J. Stanton, Fundamentals of Marketing (New York: McGraw-Hill, 1971), p. 9.

consumer needs.[70] What is new is the integration of this third set of needs into a situation where the identity of the "consumer" to be served is not clear. This inclusion implies that how a marketer resolves a surrogate/consumer conflict may be a product of both his own organizational needs and those of the parties he serves.

The integration of marketer needs with those of consumers and surrogates was conceptualized as Figure 1.5. This figure illustrated the most general case in which the needs of the marketing firm could share mutuality with those of the purchasing agent surrogate, the consuming organization represented, both consumer and surrogate, or neither of them.

As has already been discussed, the purchasing agent/consumer conflict seemed analogous to that of the sponsor and his patient. Furthermore, as shall be discussed in depth later, the author was convinced of the existence and importance of nursing home organizational inputs to the marketing of nursing care to patients and sponsors. What was deemed "proper" for any situation appeared to vary with the individual orientation of the organization delivering the nursing care. For this reason the author believed that the situation of sponsor/patient conflict might be utilized

---

[70]Philip Kotler, Marketing Management (Englewood Cliffs: Prentice-Hall, 1972), pp. 229-34.

to study the broader issues of purchasing agent/organizational conflict. With this in mind, the sponsor/patient labels were included in Figure 1.5.

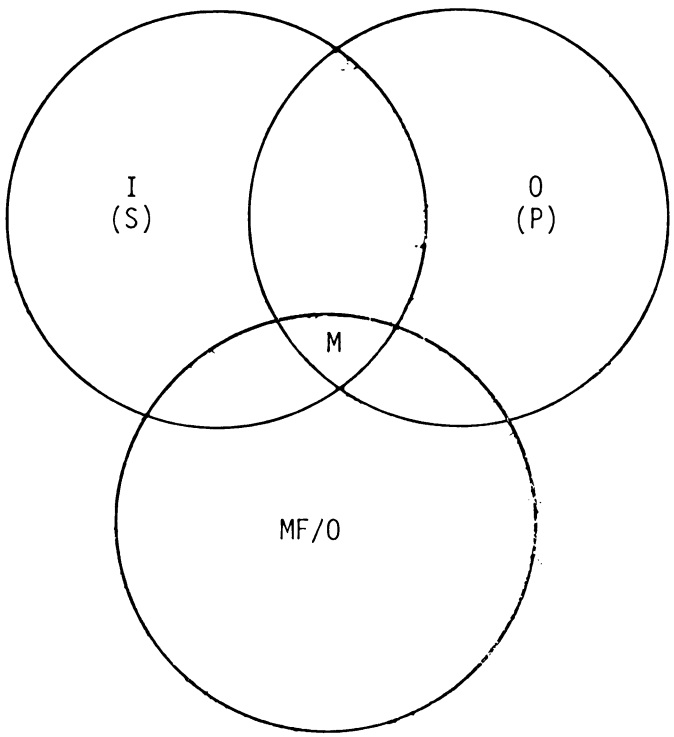


Figure 1.5--Need Conflict in a Surrogate Purchase Situation

Note: Individual (Sponsor) Needs, Organizational (Patient) Needs, Marketer Firm/Organization Needs, and areas of Mutuality.

At this point it should be mentioned that "organization" was included in Figure 1.5 to cover those instances (approximately 16 per cent)[71] in which non-profit institutions sponsor the nursing

---

[71]U.S., Department of Health, Education, and Welfare, Health Resources Statistics, p. 327.

homes. Whether or not such charitable organizations could properly be included in a marketing analysis was known to be a matter of some debate.[72] The author was content to accept that they were within his interests. As shall be shown, he expected non-profit goal orientation to produce behavior somewhat different from their commercial counterparts.

As was the case with surrogate/consumer needs, the introduction of marketer needs to the surrogate transaction need not mandate dissatisfaction unless some of the three groups of needs are conflicting. In the case of nursing homes, such conflict appeared likely.

In interviews with the aforementioned administrators, the author developed the following list of needs that represented the determinants of nursing home action:

-The need to make a profit or (in the case of non-profit homes) to maintain financial solvency.

-The need to comply with various legislative regulations.

-The need to protect the home from threats to its existence (e.g., law suits, etc.).

-The need to be well thought of by fellow health care professionals (doctors, other nursing homes, etc.).

-The need to be well liked by staff, patients, and sponsors.

-The need to feel that "the right thing" is being done for patients in terms of their individual care.

---

[72]See Philip Kotler and Sidney Levy, "Broadening the Concept of Marketing," Journal of Marketing, XXXIII (January, 1969), pp. 10-15; and David J. Luck, "Broadening the Concept of Marketing--Too Far," Journal of Marketing, XXXIII (July, 1969), pp. 53-55.

It took little time for the participating administrators to describe possible incidents of potential conflict between the needs of sponsors, patients, or both. This fact necessitated additions to H_I Guiding which resulted in the following:

H_I Guiding — Marketers of long term nursing care seeking to provide services to patients who have interested sponsors are faced with a surrogate purchase situation containing conflicting sets of needs. Among these needs are those of the sponsor, those of the patient, and those of the marketing organization. Conflicts resulting in the failure to serve the needs of the patient, his sponsor, or both are a major contributor of dissatisfaction among patients and sponsors that is more or less inevitable.

By testing this guiding hypothesis the author believed many truths about the dissatisfaction surrounding the purchase of long term nursing care could be uncovered. Hopefully, some new light would be shed upon previously unresearched aspects of surrogate purchase situations as well. The latter seemed likely as the nursing home industry proved to be an almost ideal laboratory for conducting research into surrogate situations.

Nursing homes as a laboratory for the study of surrogate purchase situations involving conflicting need structures

As discussed earlier in this paper, the purchase of long term nursing care does represent an almost classical surrogate purchase situation (particularly in the private sector). Furthermore, several unique attributes surround nursing care purchase dynamics. These unique characteristics help make research into nursing home

markets generalizable to the broader issues of conflicting-need surrogate transactions as a whole. These characteristics include the following:

Importance of Purchase Satisfaction	It would be hard to think of any surrogate situation in which the product being purchased would be more important than the nursing home is to the patient residing in it. For him it represents an entire way of life. As such, it is likely to strongly exhibit any dynamics typical of such situations.
Likelihood of Conflicting Needs	Although the sponsor's insistence upon his own way may be diluted by guilt, etc., the already discussed differences between sponsors and the aged they represent is likely to be great. This facilitates study of these differences for such surrogate situations.
Ease of Identifying/ Studying Marketer Policy Makers	Given the complexity of industrial personnel structures, it might be nearly impossible to isolate the main formulator of market policy. This is not the case for nursing homes which, due to their small size, have only one easily identifiable policy maker, the administrator.
Ease of Studying Surrogate Purchase Participants	Unlike industrial situations which could find suppliers, surrogates, and consumers scattered geographically, all participants in the nursing home purchase situation are congregated together. Patients/consumers are all present within the home and, by research definition, sponsor/surrogates must pass through the same area at least once a month; this makes their study considerably easier.
Ease of Studying the Resolution of Surrogate Dilemmas	Because of the above mentioned geographical dispersion of industrial surrogate situations, studying marketer response to conflict dilemmas might be difficult. This is not true for nursing homes in which the resolution of such conflicts must take place within the narrow confines of the nursing home, itself.

The preceding analysis indicated two things: (1) that nursing home purchases should strongly demonstrate typical surrogate purchase characteristics and (2) studying nursing home purchase dynamics appeared easier than studying other types of surrogate situations. As such, using nursing homes as a laboratory for the study of surrogate situations seemed a good idea. Reflection upon the most important unstudied issues of surrogate purchase situations produced the following list of questions:

- -Given the existence of conflicting needs between surrogates, consumers, and marketers, how does a marketing firm choose which sets of needs to serve?
- -If a marketer favors any set of needs consistently, are those parties favored/(not so favored) aware of the fact that they are receiving more/less than the other group?
- -Is the group favored/(not favored) appreciative/(resentful) of the marketer's actions and do they develop greater/(less) satisfaction over the purchase involved? (Or do they just accept it as the way the world is?)

Determining market behavior in a surrogate purchase situation under conditions of conflicting needs

As developed thus far, the surrogate market situation represented by nursing homes contained three possibly conflicting groups of needs which any marketing had to satisfy. It was reasonable to assume that whom a marketer in such a situation chose to satisfy was probably a product of how the need satisfaction of consumers or surrogates would fit into the structure of needs of the firm doing the marketing. In other words, a marketer would probably satisfy the consumer's needs

over those of his surrogate if so doing would best satisfy the need structure of the marketer. This not too profound conclusion resulted in the following:

H_{II} Guiding — A marketer confronted with a surrogate purchase situation containing conflicting needs of consumers and surrogates will formulate actions that best satisfy the need structure of the marketing organization.

The apparent similarity between nursing homes and surrogate purchase situations indicated that H_{II} could be tested through the following research hypothesis:

H_2 — A nursing home confronted with conflicting needs of patients and sponsors will tend to satisfy the group whose satisfaction will best serve the nursing home's need structure.

Under typical market conditions it would be extremely difficult to test H_2. Normally, the profit motive would be the number one motivation of all marketers, and the uniformity of such a situation would deny the kind of comparisons that make hypothesis testing possible. Fortunately, this was not the case for nursing homes which, as previously mentioned, are comprised of both proprietary and non-profit organizations.

Presumably, the key distinction between these two, their respective emphasis on profit, should be reflected in their market orientation. Logically, the non-profit homes would have no particular reason to favor either patients or sponsors. If the profit motive was as unimportant as their non-profit name implied, they could "afford" to favor either group (or neither) at their leisure.

Conversely, proprietary homes had ample cause to lean toward favoring the private-pay segment. Therefore, proprietary homes were expected to favor private-pay sponsors more than non-profit organizations favored sponsors in general.

The predicted difference in orientation was thought to be particularly great for comparisons between non-profit orientation to Medicaid sponsors and proprietary treatment of their private-pay equivalents. Clearly, non-profit homes had two good reasons not to favor Medicaid sponsors: (1) Medicaid sponsors respresented a plentiful group of patients who were comparatively unimportant to profits, and (2) profits were supposedly unimportant to non-profit institutions anyway. As just the opposite was true for proprietary homes and private-pay sponsors the following hypothesis seemed reasonable.

H_{2A-1} Proprietary homes will be more sponsor oriented when dealing with private-pay patient/sponsor conflicts than non-profit homes are in similar conflict situations involving Medicaid patients/sponsors.

The author was concerned that the small number of non-profit homes available to test H_{2A-1} might not prove sufficient. Therefore, he was anxious to have another test available for H_2 which would proceed along similar lines.

A good basis for such a stand-by test was thought to be in the dynamics surrounding proprietary homes' treatment of patients/sponsors. As sponsors of private-pay patients were apparently more important to profits than sponsors of Medicaid patients, a prediction that for-profit homes would favor private-pay patient sponsors more

than Medicaid patient sponsors made good sense. Furthermore, if the key mechanism affecting choice of orientation were profits, then highly profit oriented homes should demonstrate this favoritism more than homes less committed to the profit motive. Putting the preceding together, the greatest differential in orientation should be displayed by comparing highly profit oriented homes' treatment of private-pay patients/sponsors with the treatment of Medicaid patients/sponsors by homes less motivated by profit. This resulted in the following:

H_{2A-2} Proprietary homes run by administrators totally committed to the profit motive will be more sponsor oriented when dealing with private-pay patient/sponsor conflicts than homes run by administrators less motivated by profits are in dealing with similar conflicts involving Medicaid patients.

The author believed that the preceding hypotheses adequately dealt with the dilemma between patients and sponsors. However, as was evident from the preceding analysis, the only marketer need utilized to determine patient/sponsor orientation was the profit motive. As was introduced earlier, other needs (i.e., legal, professional, personal, etc.) could also influence marketer orientation.

The indications were that these "other" needs (not related to profit) were particularly powerful for the nursing home industry. Though difficult to prove, the assessment was supported by the following observations about the industry:

- -The industry didn't seem highly competitive (at least when compared with other industries).
- -The industry apparently was very profitable and could "afford" to be interested in things other than profit.

-Many administrators were not businessmen, but instead exhibited a variety of backgrounds (sociology, the clergy, ex-nurses, etc.) not normally committed to profits, alone.

Taken altogether, the preceding implied that some orientation other than the profit motive might be present in the nursing home industry. Subsequent probing showed that this might be true. The majority of the administrators the author interviewed indicated that they considered themselves health care professionals first and businessmen second. This same theme was evidenced by the nursing home journals examined during the author's literature search. Most of them emphasized things other than business profits as their main focus.

This health care orientation was understandable given the industry's profit picture and close relationship with the medical profession. Those administrators embodying this orientation seemed to place a very high priority upon operating their homes like a hospital. Apparently, they were willing to deprecate the profit motive in order to "do what's right" no matter what the market implications of their actions. The author's impression was that they thought of themselves as "almost doctors" handing out what they considered to be "correct" to individuals who obviously did not know what was good for them. As this lofty orientation could be expected to sometimes conflict with the needs of patients and/or sponsors, it was thought important enough to study.

Obviously, if this role as a health care professional did conflict with the needs of patients and/or sponsors, it could be

expected to threaten profits (if patients or sponsors became angry enough to change homes). Therefore, administrators of proprietary homes could generally be expected to manifest this "professional" orientation more with Medicaid patients/sponsors than with their private-pay counterparts.

Furthermore, those individual administrators who were committed to such an orientation would presumably manifest this behavior more than those who didn't. Putting the above together indicated that the most "administrator" oriented behavior should be found in the treatment afforded Medicaid patients/sponsors by homes placing great emphasis on the administrator's role as a health care professional. And, the opposite extreme should be registered by the care afforded private-pay patients/sponsors by homes assigning a low priority to the administrator's role as a health care professional. Combining the preceding resulted in the following hypothesis:

H_{2B} Proprietary homes run by administrators totally committed to their role as a health care professional will be more oriented to behavior associated with this role when it conflicts with the needs of Medicaid patients and/or sponsors than will homes run by administrators with lesser commitments to this role when faced with similar private-pay patient and/or sponsor conflicts.

H_{2A-B} proposed several situations in which the needs of sponsors, patients, or both might be neglected. However, the author did <u>not</u> intend to test for or uncover any cases of gross neglect of either group. He recognized the futility of hoping that any methodology could persuade any marketer who was doing this to admit it.

Furthermore, as proposed during the discussion of the Kotler model, there almost always are definite limits upon how far a marketer can go in favoring surrogates or consumers before the situation becomes intolerable. This is definitely the case with nursing homes. As previously mentioned, the state-mandated minimum limits of care do define a "floor" for nursing home operations. Clearly, this would limit how far a nursing home marketer could go in satisfying needs other than those of the patients. Finally, as shall be discussed under "methodology," the author's choice of sample would seem to obviate the marketers who might be guilty of any such gross neglect.

Apparently, the surrogate-situation favoring of needs that interested the author had to be of a very subtle type--more of a philosophy or orientation than overt action. The author hoped that such an orientation would be significant enough to display its presence through the workings of the research methodology. However, given its assumed subtlety, he was not certain that its presence was at all obvious to those patients and sponsors affected by such favoritism. Consideration of this possibility led to the issue of consumer/surrogate perception of marketer orientation in situations involving conflicting needs.

The perception of marketer orientation in a surrogate purchase situation involving conflicting needs

As previously discussed, if a marketer "chooses sides" in a surrogate purchase situation the behavior manifesting his choice is likely to be of an extremely subtle nature. In some industrial situations in which the surrogate might be favored, such behavior could take some time to be recognized by the consuming firm. In such cases, there would be no one (purchasing agent or salesman) who would be likely to talk about gifts, entertainment, etc., that might be "consumated" far from the eyes of the firm employing the surrogate. Furthermore, the firms represented by the agent might be too occupied with other matters to take immediate interest in such behavior unless it directly threatened their welfare. However, even the most oblivious consuming firms would (at some point) probably realize that such behavior was taking place. Likewise, were the orientation to run toward the consuming firm disproportionately, eventual discovery of this bias by the involved purchasing agents (through conventions, the grape-vine, etc.) was probable.

Speculation about such perception produced H_{III} as follows:

H_{III} Guiding — Marketer orientation favoring the needs of either consumer or surrogates in a surrogate market situation is eventually perceived by both groups indigenous to that situation.

Fortunately, the nursing home market appeared likely to perceive such actions more quickly, and this made it highly suited to any research related to H_{III}.

As mentioned earlier, all elements of the nursing home surrogate purchase come together under one roof where any "covering up" would be unlikely. Furthermore, for the patient/consumers, the purchase activity involves their whole life style and so might be considered even more important than normal. For some sponsor surrogate as well, the emotional importance of the situation is likely to command their attention greater than would normally be the case.

Thus, in the author's opinion, perception of marketer orientation was likely to be displayed by nursing home consumers/surrogates if it was present at all. This resulted in H_3.

H_3 Nursing home orientation consistently favoring the needs of patients or sponsors in situations involving need conflicts between these two groups is eventually perceived by both groups indigenous to the situation.

Reflection upon the issues involved in H_3 led to the following research hypotheses:

H_{3A} Patients in patient-oriented homes will perceive more attention to their needs (vs. those of their sponsors) than will patients in sponsor-oriented homes.[73]

H_{3B} Sponsors of patients in sponsor-oriented homes will perceive more attention to their needs (vs. those of their patients) than will sponsors of patients in patient-oriented homes.

Despite interest in the perceptual issues summarized by the above, no similar test for perception of nursing home orientations

---

[73]For the sake of convenience "patient oriented" and "sponsor oriented" shall be used forthwith to refer to those homes consistently favoring the needs of patients or sponsors in situations involving need conflict between these two groups.

favoring organizational/personal needs was proposed. Quite frankly, the author was at a loss to tell how awareness of this orientation might be demonstrated by the methodology available to him. Furthermore, he was extremely doubtful that conscious awareness of such an orientation was likely to be present.

Presumably, both the patients and sponsors defined to be the focus of this research would have a multitude of experiences which would demonstrate to them which of these two groups the home favors (e.g., "On a number of occasions, my sponsor got his way and I didn't," or vice versa). Experiences of the same type are not likely to be present in a marketer orientation to personal/organizational goals. In this case all the non-favored person is likely to be certain of is "I didn't get my own way" and he probably does not have enough experience with other nursing home operations to know why (or to recognize that such is not always the case).

Viewed from another perspective, that of marketing science, such extreme orientation to organizational needs other than profit is probably not common outside of the walls of nursing homes. Therefore, the failure to test for the perception of such an orientation does not detract seriously from the general utility of the author's research.

The possibility that marketer orientation toward any group's needs might go undetected at the conscious level was believed to be great. This was due to two factors: (1) the assumed subtlety of such favoritism, and (2) sponsors' conscious or subconscious suppression

of their favored status due to the emotional pressures calling for favoring of patient's needs. However, whether or not conscious perception of marketer orientation was visible, satisfaction related issues could still be present. Conceivably, any consistent favoring of one group's needs over those of another could result in satisfaction/dissatisfaction regardless of whether or not its true focus was understood. Given the interests of this research, investigation of this satisfaction related issue was thought most crucial, and attention was next focused on it.

Satisfaction emanating from marketer orientation in a surrogate market situation under conditions of conflicting needs

If a marketer chooses to favor one group's needs over those of another, two issues of interest develop whether that action is perceived on the conscious level or not. They are:

- Do the favored parties express more satisfaction with the purchase involved than those not favored in similar circumstances?

- Do the groups whose needs are neglected in favor of another become less satisfied with the purchase involved than those whose needs are favored?

If favored parties do not express more satisfaction with the purchase involved than those not favored there would be much less justification for taking this action. However, it does not seem obvious that such must necessarily be the case as the "favoring" might be considered so minor to the individuals involved as to be unimportant to overall purchase satisfaction.

Conversely, if one group's needs are consistently favored, then another group's must be ignored. Logically the non-favored group could be expected to develop dissatisfaction over being ignored consistently by the marketer's orientation. Once again, however, it does not seem certain that this dissatisfaction would "carry over" to the purchase involved as it might be considered unimportant (or even justifiable) to those ignored.

Consideration of whether or not purchase satisfaction/dissatisfaction might stem from marketer orientation forced this research to look beyond marketing for disciplines which have researched such situations in general terms. Fortunately, the field of communication science has dealt with situations of conflict similar to the surrogate/consumer/marketer dilemma in highly meaningful terms.

One of the most useful treatments of conflict was found in Gerald Miller's discussion of interpersonal communication. According to Miller, the basis for communication science's analysis of conflict is to be found in its definition of the basic function of communication. He has summarized this basic function as being " . . . to control the environment so as to realize certain physical, economic or social rewards from it."[74] Miller perceives successful environmental

---

[74]Gerald Miller and Mark Steinberg, Between People: A New Analysis of Interpersonal Communication (Palo Alto: Science Research Associates, 1975), p. 62.

control as being vital to the self concept of all individuals. Those instances of successful environmental control in which " . . . desired and obtained outcomes of the communicator correspond exactly" are defined as compliance situations.[75]

However, Miller recognizes that all individual attempts at compliance cannot be successful, for not everyone can have his own way at once. Thus, the element of conflict between individuals' desires must be dealt with.

There are a number of ways in which a conflict between two or more individuals might be resolved. One alternative, conflict resolution, is defined as occurring " . . . when two or more competing parties reach a solution about the allocation of some physical, economic, or social resource, and the solution is perceived as relatively equitable by the competing parties."[76] The converse of this situation, conflict management, is a forced compliance situation in which the competing parties do not perceive the solution as being relatively equitable. Miller then theorizes that such dampening is likely to result in the aggrieved party being so dissatisfied as to bring up the conflict again at a later date, or to stimulate conflict about other matters. In other words, if one party does not perceive himself as being treated fairly, he will exhibit dissatisfaction not only with the conflict involved, but also with other items indirectly related to it.

---

[75]Ibid., p. 66.

[76]Ibid.

Miller's analysis seemed very appropriate for the interests of this research. Its foundation, the conception that communication was an attempt to control one's environment nicely paralleled the motivating factors behind the self serving purchasing agent behaviors alluded to by Kotler. The recognition that conflict could result from the failure to serve all needs was similar to the situations conceptualized by Rewoldt, et al. Finally, the assertion that such conflicts could result in either resolution or management lent predictive insights to the issues at hand. If conflict resolution stemmed from marketer orientation to conflicting needs, no dissatisfaction need stem from it. This was congruent with the author's earlier reflections. However, if marketer orientation was perceived as unfair and conflict management between sponsor and surrogate resulted, then dissatisfaction with the implied favoritism could exist. According to Miller, this dissatisfaction would be directed at both the marketer's orientation as well as other items related to it. Given the communications discipline from which this analysis ensued, the dissatisfaction to be expressed presumably would take the verbal form already defined as the interest of this research. Furthermore, one of the "other" items to which this dissatisfaction could be addressed was clearly the item being purchased by the surrogate (for what other criticism could harm an "unfair" marketer more?). The preceding reflections were synthesized into the following:

H_{IV} Guiding In a surrogate purchase situation containing conflicting needs, the group not favored by marketer orientation will express greater dissatisfaction with the purchase involved than the favored groups if the favoritism is perceived as unfair.

The author felt many of the surrogate situation variables contained in the above could be tested in the "laboratory" represented by nursing homes. Therefore, he proposed H_4 as follows:

H_4 Marketers of long term nursing care faced with conflicting needs of patients and sponsors create dissatisfaction on the part of one of these groups when the needs of the other are favored as this favoritism is perceived as unfair.

At this point it was well understood that H_4 contained two major weaknesses: (1) only one-half (that involving orientations perceived as unfair) of H_{IV} could be tested, and (2) even that one-sided investigation rested upon an assumption that the "actors" involved in sponsor/patient conflicts perceived the nursing home's orientation to be unfair.

The first defect caused no great concern--situations likely to result in dissatisfaction were more interesting research subjects than those that were not. The second weakness struck the author as more serious, but the "unfair" premise involved was thought justified.

In the most general case finding a surrogate situation with definitive external indicators of whether or not the conflict "actors" thought any favoritism just or unjust would be unlikely. But, for the special situation of nursing homes such was not the situation.

As nursing home patients are frequently institutionalized against their will, a belief that they would view any further

orientation to needs other than their own with great hostility seems justified. Though the reactions of sponsors are more difficult to predict (due to the "moral issues" surrounding patient care) it is not apparent that inattention to sponsor needs would be viewed with any favor, either.

Therefore, the following hypotheses ensued.

H_{4A} Patients in sponsor-oriented homes are more dissatisfied with the nursing care provided than are patients in patient-oriented homes.

H_{4B} Sponsors of patients in patient-oriented homes are more dissatisfied with the nursing care provided than are sponsors of patients in sponsor-oriented homes.

The author regretted that his limited resources would not allow the proposal or testing of a similar set of hypotheses dealing with dissatisfaction stemming from orientation to administrators' roles as health care professionals. As such an orientation was not typical for marketers other than nursing homes, the failure to test its effects did not detract from any desire to advance marketing science. Although the testing of such an orientation's effects would have contained meaning for the study of nursing home satisfaction, so would H_{4A-B} (which could contribute to marketing science as well). Therefore, the author thought this compromise acceptable.

This decision was based upon the premise that findings supporting H_{4A-B} would support H_4 which would (in turn) point to a rather important conclusion--that each time a nursing home "chooses sides" in need conflicts involving patients and sponsors, one side would become more satisfied and the other less so. Therefore, some

dissatisfaction resulted from any resolution of such dilemmas, and this dissatisfaction extended to the care provided by the nursing homes involved. In addition to answering some interesting theoretical questions regarding surrogate market behavior, such findings would support the H_I (Guiding) hypothesis. This would provide the nursing home industry with a new argument against those muck-raking critics who used dissatisfaction emanating from it to "demonstrate that" all nursing home operators are bad." Furthermore, if the universal presence of such dissatisfaction was demonstrated, nursing home operators might better understand it and work at developing strategies for dealing with it.[77]

Because the above goals were so important (and this chapter indicated they were attainable) the author next directed his attention to development of a methodology which would evaluate the factors to which they related.

---

[77]For an illustrative description of such strategies, see Bertram H. Raven and Ariel W. Kruglanski's "Conflict and Power" in Paul Swingle's The Structure of Conflict (New York: Academic Press, 1970), pp. 69-104.

CHAPTER II

METHODOLOGY

The research structure suggested by chapter one was synthesized and presented as Figure 2.1. As shown by this exhibit, a number of methodological requirements stemmed from the author's interests. Among these were the following:

- -The separation of homes guilty of callous neglect from the research sample.
- -The development of a means of identifying individual nursing homes' orientation (patient oriented, sponsor oriented, etc.).
- -The creation and application of a technique that would relate nursing homes' choice of orientation to their organizational need structures.
- -The creation and application of instruments capable of testing and comparing patient/sponsor perception of nursing home orientation.
- -The creation and application of tools capable of testing and comparing patient/sponsor satisfaction with care provided by nursing homes.

Although the preceding represented the major task confronting the author, he recognized that other ancillary problems existed which would also have to be resolved. This chapter will detail the methods developed to deal with the project's major and ancillary problems. Once this methodology has been presented in its entirety the final section shall discuss the limitations imposed by the chosen techniques.

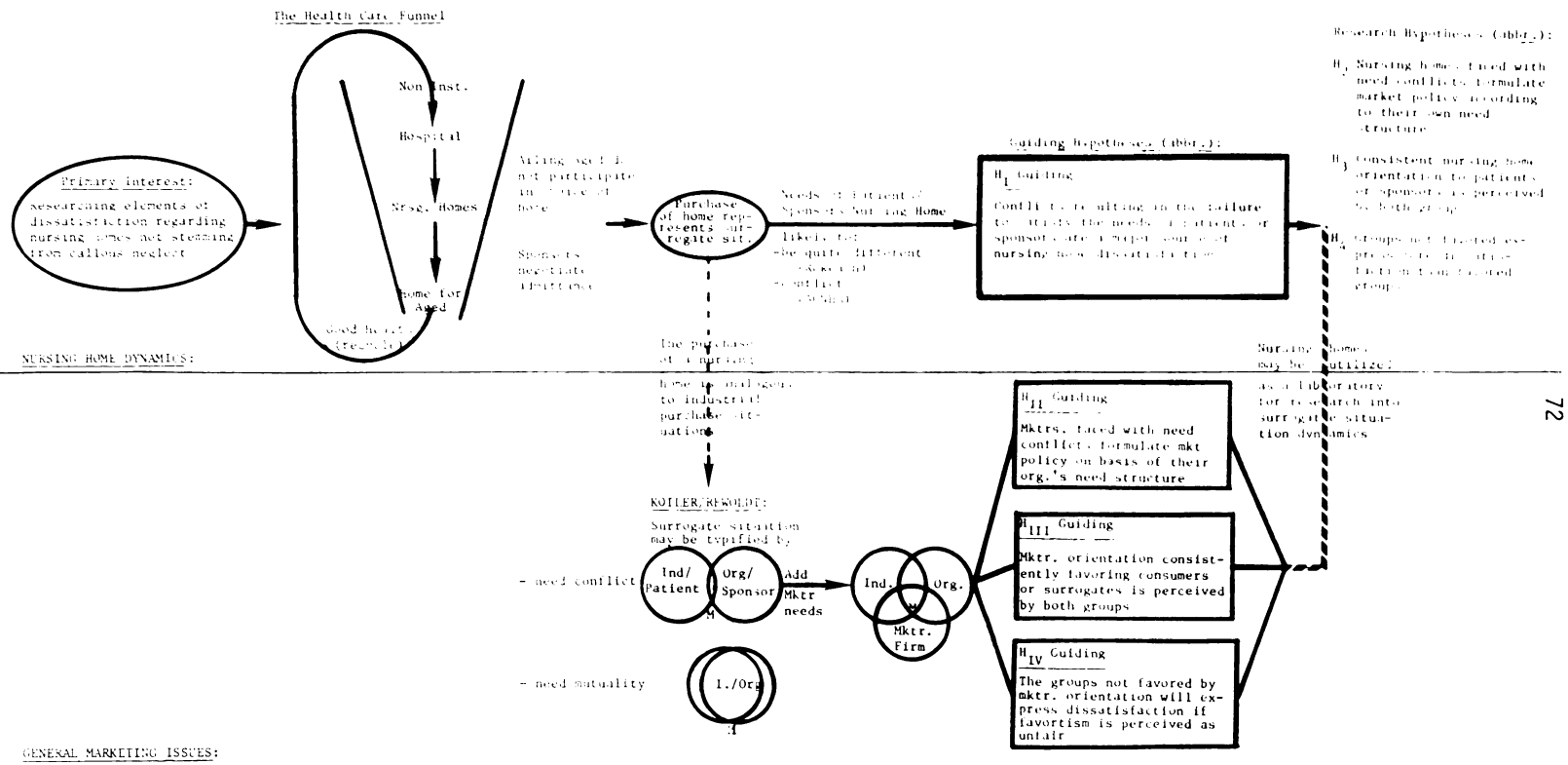


Figure 2.1--Research Structure

Figure 2.1--Continued

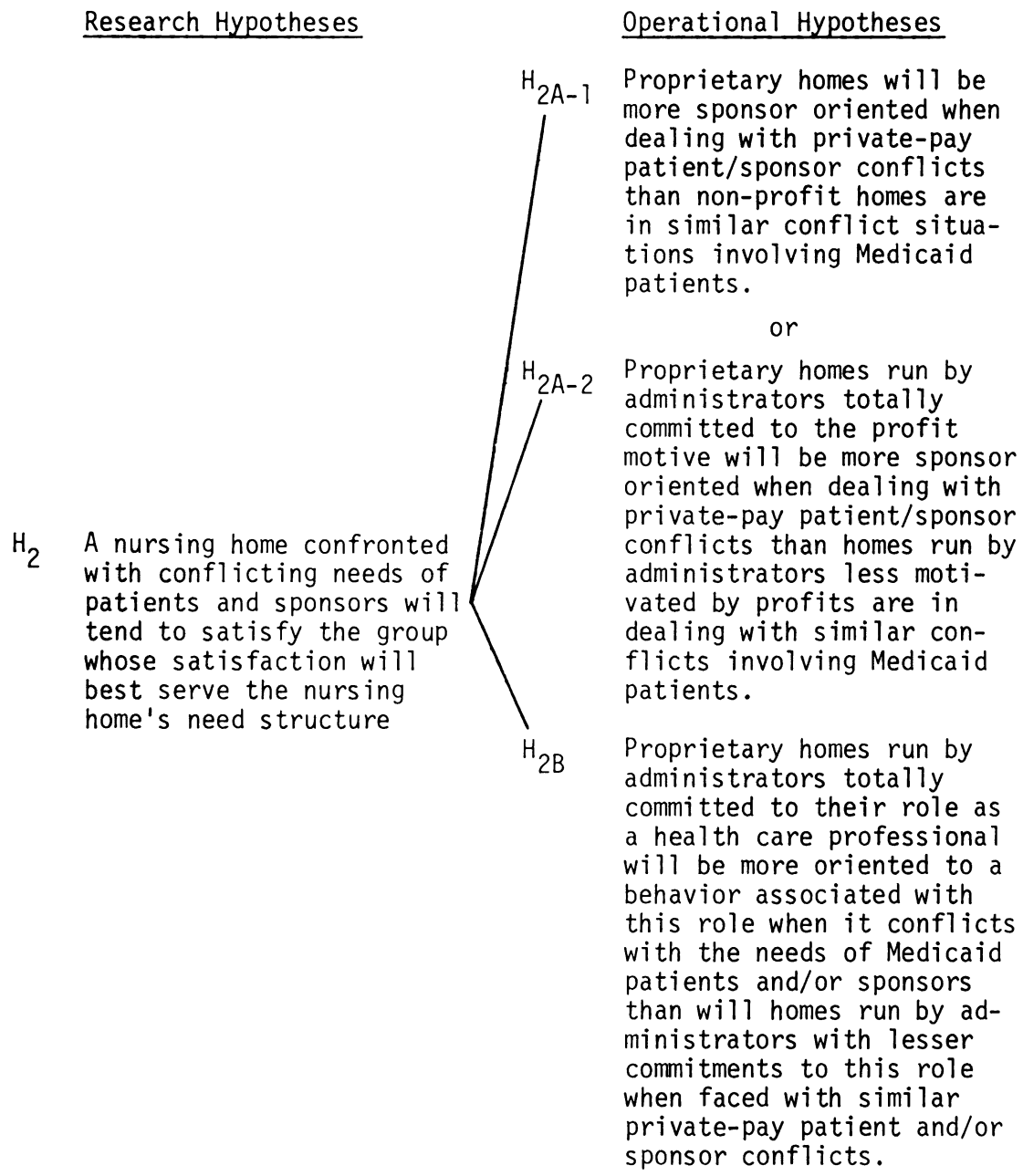


Figure 2.1--Continued

Research Hypotheses		Operational Hypotheses
H_3	Nursing home orientation consistently favoring the needs of patients or sponsors in situations involving need conflicts between these two groups is eventually perceived by both groups indigenous to the situation.	
	H_{3A}	Patients in patient-oriented homes will perceive more attention to their needs (vs. those of their sponsors) than will patients in sponsor-oriented homes.
	H_{3B}	Sponsors of patients in sponsor-oriented homes will perceive more attention to their needs (vs. those of their patients) than will sponsors of patients in patient-oriented homes.
H_4	Marketers of long term nursing care faced with conflicting needs of patients and sponsors create dissatisfaction on the part of one of these groups when the needs of the other are favored as this favoritism is perceived as unfair.	
	H_{4A}	Patients in sponsor-oriented homes are more dissatisfied with the nursing care provided than are patients in patient-oriented homes.
	H_{4B}	Sponsors of patients in patient-oriented homes are more dissatisfied with the nursing care provided than are sponsors of patients in sponsor-oriented homes.

The sample

As previously discussed, the author limited his study to nursing homes within the state of Michigan. However, because he was interested in researching dissatisfaction with nursing homes that did not arise out of callous neglect, he wanted to go beyond this broad constraint to eliminate from his sample as many homes guilty of such neglect as possible. Making such a distinction did not appear easy since no uniformly accepted index of nursing home quality existed.

In addition to the preceding dilemma the author expected to encounter another problem with any sample he chose, that of sample non-response. In his interviews with nursing home administrators, he sensed a reluctance to participate in any study of the industry. The prevailing attitude seemed to be that every time the nursing homes cooperated with a researcher, that researcher then did his best to exploit any negative findings he encountered by publishing "exposés" of the industry. Given the prior analysis of the "popular press" treatment of nursing homes, the above apprehensions appeared well founded.

An analysis of scholarly research into nursing homes indicated that such distrust of researchers apparently manifested itself in a low response rate to research inquiry. Miller's study of Florida nursing homes achieved only a thirty-six per cent response to a mail questionnaire,[1] and in Trainor's Washington State study

[1]Miller, p. 18.

even worse results were produced by a mail contact soliciting later interviews.[2] Because the author anticipated using a mail questionnaire as one of his research instruments, he was very troubled by such low response rates. A similarly low response rate when coupled to the small number of nursing homes within Michigan could cripple the project.

The author's response to the above problems was to choose as his sample the nursing home membership of the Health Care Association of Michigan (HCAM). This trade association for nursing home administrators represented 257 member nursing homes at the time of this study.[3]

When apprised of the author's interest, this association proved eager to cooperate. Its education committee provided a $400 grant and agreed to assist in whatever other ways it could. Although HCAM was obviously attracted by the positive stance taken by the proposed research, it imposed no "strings" in return for its participation, and granted the total freedom needed to maintain objectivity. This was fortunate, for subsequent experience would show that the choice of this association's membership as a research sample was invaluable to achieving the research objectives of this project.

With regard to eliminating callous neglect from his sample, the author believed that many of the least desirable nursing homes

---

[2]Trainor, p. 10.

[3]This organization has within its membership both nursing homes and homes for the aged. Because of the definitional considerations already discussed, homes for the aged were excluded from the sample.

probably would eliminate themselves by not investing the time and money necessary for membership in a trade association. Furthermore, the vast majority of HCAM members had faced other, more tangible mechanisms likely to screen out the worst offenders.

Unfortunately, because of historical factors, the barriers to membership in HCAM had not been entirely uniform. The Health Care Association of Michigan was formed during the initial phases of this research from what had formerly been the Michigan Nursing Home Association (approximately 190 members) and the Michigan Health Facilities Association (approximately 70 members) which was the Michigan chapter of the prestigious national American Nursing Home Association.

All former Michigan Nursing Home Association (MNHA) members had to undergo rather careful scrutiny prior to their acceptance as full fledged members, and had agreed to adhere to a rigid code of ethics as a condition of membership.[4] One relevant provision of the MNHA code was that members be subject to the scrutiny of an ethics and standards committee that investigated all complaints about member conduct and did have the power to revoke membership if conditions warranted. Although the author assumed that these procedures probably did not eliminate all undesirable

---

[4]See MNHA, Application for Membership (Lansing: Michigan Nursing Home Association, 1974), and MNHA, Michigan Nursing Home Association Operational Code (Lansing: Michigan Nursing Home Association, 1972).

members, he felt they were about as effective a screening device as he was likely to find.

Unfortunately, identical procedures were not operative for the Health Facilities Association members, so the author was faced with the decision of whether or not to include them in his sample. Ultimately, he did decide to include them. Talks with MNHA members indicated that the Health Facilities Association members were thought to be as ethical as the MNHA nursing homes (or else the two organizations would not have merged). Furthermore, the Health Facilities Association members were a part of a larger prestigious nursing home trade association (the American Nursing Home Association) which was well thought of nationally, but had never attained any size in Michigan. Taken altogether, the author felt his choice of sample did meet his objective of screening out as many undesirable homes as possible, so he next turned his attention to the development of a research instrument to be applied to this sample.

Identification of nursing homes' orientations and need structures

The task of developing a technique for assessing what orientation (patient, sponsor, etc.) a nursing home took in patient/sponsor conflicts was a difficult one. Any long-run direct observation was likely to be extremely difficult and subject to many methodological drawbacks.

Furthermore, second hand assessments of homes' orientation by outside "experts" seemed likely to be fraught with error. The obvious need was for some instrument which would honestly reflect whose side the nursing homes took when dealing with actual conflict situations.

To this end the "Administrator Questionnaire" presented as Appendix "B" was constructed. The relationships between its component parts and the hypotheses already proposed was synthesized in Figure 2.2.

As can be seen from Figure 2.2, there were two groupings of interest to this research project; (1) a set of simple questions related to nursing homes' needs structures, and (2) a series of cases intended to determine nursing homes' orientations in various conflict settings.

All the cases and questions were derived from interviews with the aforementioned governing board of the American College of Nursing Home Administrators. They represented actual conflict situations these administrators had encountered in the nursing homes they managed. Cases "one," "three," and "five" represented situations in which the needs of the patient were in conflict with those of the sponsor and the nursing home administrator had to choose which set to favor. Cases "two," "four," and "six" presented similar dilemmas in which the needs of patients and/or sponsors conflicted with the administrator's prerogatives as a health care professional.

	Research Hypothesis (From Figure 2.1)	Administrator Questionnaire Cases	Questions
H_{2A-1}	Proprietary homes will be more sponsor oriented when dealing with private-pay patient/sponsor conflicts than non profit homes are in similar conflict situations involving Medicaid patients/sponsors.	1,3,5	3
H_{2A-2}	Proprietary homes run by administrators totally committed to the profit motive will be more sponsor oriented when dealing with private-pay patient/sponsor conflicts than homes less motivated by profits are in dealing with similar conflicts involving Medicaid patients.	1,3,5	3,5a
H_{2B}	Proprietary homes run by administrators totally committed to their role as a health care professional will be more oriented to behavior associated with this role when it conflicts with the needs of Medicaid patients and/or sponsors than will homes run by administrators with lesser commitments to this role when faced with similar private-pay patient and/or sponsor conflicts.	2,4,6	3,5e

Figure 2.2. Research structure and administrator questionnaire development

The cases and questions referred to took the following format:

Case One

Sara M. is a 68-year-old resident of the X nursing home. She is mentally alert and in good physical condition for her age. Lately, James L., a 71-year-old widower who was admitted to the home as a private pay patient after a mild stroke which left him only minimally impaired physically has developed an interest in Sara. Sara and James have been visiting each other's rooms and holding hands. Mr. L's sponsor observed this and became very upset. He has repeatedly demanded that the home "break-up" this budding romance, and your attempt to dissuade him has failed.

Definitely Yes 1 2 3 4 5 Definitely No

___ 1a. Would you "passively" try to keep Sara and James apart by arranging activities for them at different times and/or places.

___ 1b. Would you "actively" try to break up this romance by instructing your staff not to allow Sara and James to hold hands or be alone together, etc.

___ 1c. Would you have been more likely to do either a or b had Mr. L's sponsor threatened to withdraw James from your home if you did not "do something"?

Desiring to gather as much information as possible, the author offered three alternative (although sometimes related) courses of action for the respondents to select in each case. This step enabled him to keep the instrument's length manageable while trebling the inputs available for analysis. In order to determine the nursing home's orientations, the responding administrators were asked to indicate (on a five point semantic scale) whether or not they would take each of the actions suggested. Hoping to test the apparent validity of the questionnaire, two different versions were used, one identifying the patients as "private pay" and another identical in content except the patients were described as "Medicaid" recipients. This was an attempt to circumvent the problem associated with asking nursing homes to indicate that they treat patients/sponsors differently depending upon the source of revenue supporting them. Because the author doubted that any questionnaire (no matter how well designed) could get individual administrators to admit to such a distinction, he decided to see if he could get the industry as a whole to indicate any differential treatment by unknowingly responding to different questionnaires. However, if the instrument was functioning properly, nursing homes answering a "private-pay" questionnaire should be more sponsor oriented (in patient vs. sponsor conflicts) than those responding to the "Medicaid" instrument, etc.

As is obvious from studying the various response alternatives, all questions except those associated with case "one" arrange

the choices in such a way that the polar semantic choices reflect parallel "side-taking" action. That is, a response of "definitely yes" to question "3a" would clearly indicate action more favorable to the patient's side than the sponsor's. Careful analysis shows similar results for all the odd-numbered response alternatives except for those associated with case "one" (where they are all reversed). Similarly, an answer of "definitely no" to question "2a" manifests behavior placing the prerogatives of the administrator superior to the expressed needs of patients and sponsors. Again, this indication of administrative side-taking is similar for all even numbered responses.

In order to simplify analysis, a decision was made to reverse all indicated responses to the questions of case "one" (a response of "five" would become a response of "one," etc.). Once this was accomplished and all responses "ran the same direction," it was possible to develop a simple decision rule for assessing the orientation of individual nursing homes.

Clearly, in assessing patient/sponsor orientation, a response of "3" to any of the odd-numbered responses would indicate a situation in which the administrator was undecided about the correct course of action to follow. (In fact, this response was included to keep normally uncooperative administrators from "giving up" on a questionnaire which undoubtedly would present them with many difficult choices). However, it was felt that any response on either side of this neutral position did indicate side taking.

Therefore, the author defined any response of "four or more" or "two or less" as indicating "sponsor" and "patient" orientation (respectively) when made in response to odd numbered questions. Likewise, he defined any response of "four or more" or "two or less" as representing "patient/sponsor" and "administrator" orientation (respectively) to the patient and/or sponsor vs. administrator conflicts posed by even numbered questions. But, this side-taking was not expected to be one hundred per cent uniform for all questions. The situations described and the individuals responding were too heterogeneous to create much likelihood of that happening. Therefore, very strong orientations could be displayed by response patterns in which all answers were not of identical intensity. Any decision rule chosen would have to reflect this fact. The only question was, "where to draw the line."

Since each of the two conflict types offered nine possible responses, the author recognized that the number "five" represented a logical breaking point of just over half of the total possible response alternatives. Because he felt nursing home administrators might be timid about expressing their choices, he elected to use this point to differentiate between the various nursing home orientations. Coupling this decision with the preceding produced the following operational definitions:

- -A patient-oriented home is one in which the administrator responds "four or more" to "five or more" of the nine responses to odd numbered cases.
- -A sponsor-oriented home is one in which the administrator responds "two or less" to "five or more" of the nine responses to odd numbered cases.

-A patient/sponsor-oriented home is one in which the administrator responds "two or less" to "five or more" of the nine responses to even numbered cases.

-An administrator-oriented home is one in which the administrator responds "four or more" to "five or more" of the nine responses to even numbered cases.

-Homes which fit none of the above definitions are considered to be indeterminate in their orientation.

Once the preceding decisions were made, the questionnaire was pretested by a panel of nursing home administrators attending a summer training seminar conducted by the Michigan Nursing Home Association. In order to keep from "spoiling" a large portion of the total potential sample, the size of this panel was purposely kept small. Ultimately, nine nursing home administrators responded to "Medicaid" questionnaires and nine others responded to "private-pay" questionnaires. Applying the above decision produced the results shown in Table 5.

The author was quite encouraged by the preceding results. Intuitively, the hospital/medical overtones associated with nursing homes would seem to dictate that the majority of homes responding be patient oriented for patient vs. sponsor conflicts and administrator oriented for administrator vs. patient and/or sponsor conflicts. For the most part, the above data conformed to these expectations and lent some face validity to the research instrument. Equally promising was the indication of a small group of homes taking the "other side" of the proposed choice dilemmas. As shall be shown later, this factor was vital to the comparisons necessary for a thorough testing of the proposed hypotheses.

TABLE 5

RESULTS OF ADMINISTRATOR QUESTIONNAIRE PRE-TEST

Orientation Exhibited by Home	Patient/Sponsor Identified as . . . Medicaid	Private-pay
Patient vs. Sponsor Conflicts (Cases 1, 3, 5)		
Patient	7	3
Indeterminate	1	5
Sponsor	1	1
Administrator vs. Patient and/or Sponsor Conflicts (Cases 2, 4, 6)		
Administrator	4	3
Indeterminate	3	4
Patient/Sponsor	2	2

Finally, although the sample was judged too small for further statistical analysis, the directional emphasis of the data did conform to the already proposed relationships. To the extent that less patient orientation indicated greater sponsor orientation the homes were more sponsor oriented for private-pay patients than they were for Medicaid patients. Likewise, the degree of administrator orientation was (weakly) greater for Medicaid patients than for private-pay patients (as the author had conjectured it would be).

In light of these results the author decided to adopt the proposed questionnaire as one of his research instruments. However, in consultation with the individual who supervised the pre-test, he added some clarifying instructions, slightly reworded some choice

alternatives, and minimally revised the wording of a few of the cases. As can be seen by examining Appendices "C" and "D," the revised questionnaires, no substantial changes were made. Once these were revised, the questionnaires were reviewed by the executive director of the nursing home association who attested to their apparent validity and ease of interpretation.

The reason for any unusual caution indicated by the preceding was that the author found himself working with a relatively untried methodological technique. The concept of presenting conflict cases and deducing the nursing home's orientation from their handling of them was developed jointly by the author and his dissertation committee. The author knew of no other such studies, and he was unable to find any within the marketing literature. So, he looked to other disciplines for similar methodological approaches.

The findings in these other areas were equally sparse. The only similar methodology that was uncovered had been utilized in the study of risk taking. In their Risk Taking, A Study in Cognition and Personality, Kogan and Wallach described what they called a "choice dilemma procedure."[5] This technique, which was borrowed from an earlier work,[6] tried to determine whether an individual was a risk taker or a risk avoider by assessing his

---

[5]Nathan Kogan and Michael Wallach, Risk Taking, A Study in Cognition and Personality (New York: Holt Rinehart and Winston, 1964).

[6]See Wallach, et al., "Group Influence on Risk Taking," Journal of Abnormal and Social Psychology LXV, No. 2 (1962), 75-86.

responses to a number of dilemmas indicating varying degrees of risk. Although conceptually similar, these studies were quite different from the author's in terms of the actual techniques employed. Because of this fact (and the paucity of other similar studies), the author was reasonably sure that the case dilemmas component of his methodology represented unusual (perhaps pioneering) research. Insights gained from his utilization of this technique will be presented in chapter four.

Once judged to be satisfactory, the questionnaires were numerically coded and mailed to the nursing home administrators who comprised the membership of the Health Care Association of Michigan. In order to further test the questionnaires' apparent validity (as well as to increase the expected size of any orientation differences manifested) a decision was made to retain the two-sided (private-pay vs. Medicaid) feature of the pre-test instrument. Accordingly, the respondents received instruments that were identical in content except for the description of the patients/sponsors involved. One half of the sample received questionnaires identifying the patients/sponsors as "private-pay" and the other half received questionnaires which described the same subjects as "Medicaid" patients/sponsors. In order to implement these actions, an alphabetical listing of the association's members was numbered. All odd numbers were sent a "Medicaid" questionnaire and all even numbers a "private-pay" questionnaire. To help keep the records "straight" these two different questionnaires

were color-keyed ("Medicaid" questionnaires were white and "private-pay" questionnaires were buff).

In an attempt to increase the response rate, the questionnaires were mailed out under the cover letter of the executive director of HCAM. As can be seen from examining this letter (presented in Appendix "E"), the questionnaire was presented as a project of the education committee of the association into how administrators "perceive the best ways to do their jobs." The accompanying return envelope was addressed to the executive office of the association (which then forwarded them to the author). All of these actions were taken to minimize any apprehensions the sample respondents might have had about participating in the study.

After a month had elapsed the reminder letter presented as Appendix "F" was mailed out to the sample non-respondents. With it went another numerically coded questionnaire (of the same type as before) and another return envelope addressed to the association.

As shall be discussed in chapter three, the response to the mailed questionnaire was most gratifying. This was fortunate, for a large sample of respondents was absolutely necessary for resolution of the last major dilemma confronting the author, that of comparing the reactions (in regard to perception and satisfaction) of patients to different nursing home orientations.

The testing and comparing of patient/sponsor reactions to different nursing home orientations

In order to test/compare reactions to different nursing home orientations, four tasks must be undertaken: (1) a sample of nursing homes manifesting the different orientations must be identified and chosen, (2) a sample of patients and sponsors within each of the identified homes must be secured, (3) some instrument capable of measuring both perception of nursing orientation and satisfaction with nursing care must be developed, and (4) this instrument must be applied to the sample of patients/sponsors. The ensuing section of this chapter shall relate how the above tasks were accomplished.

Choosing a sample of patient/sponsor-oriented nursing homes

The task of identifying a sample of nursing homes with the desired orientation was accomplished with the aid of the Western Michigan University Computer Center. Four print-outs (two for "Medicaid" and two for "private-pay" respondents) were created. Each of these print-outs grouped the respondents according to which questionnaire they answered ("private-pay" or "Medicaid"), and then rank ordered them on the basis of their manifestation of the subject behavior. That is, one group who responded to "Medicaid" questionnaires and qualified as "sponsor oriented homes" was ranked from least extreme to most extreme according to this variable. Homes who

responded "four or more" to five of the nine odd numbered questions were ranked first. Homes who responded "four or more" to six of the nine odd numbered questions were ranked next, etc. The same procedure was utilized with the other groupings as well. Once this was done two lists of sixteen of the most patient-oriented and sponsor-oriented homes (respectively) were drawn up. Because these two lists represented the polar extremes in nursing home orientation, the author wanted to test and compare the reactions of patients and sponsors to the care provided by them.

As shall be discussed later, he saw interviewing techniques as being the best way of accomplishing this end. However, the cost of interviewing was known to be sizable and this factor mandated that patients/sponsors in a maximum of twelve homes could be interviewed. Therefore, the above sample had to be distilled still further.

In order to ensure a reasonable population of lucid patients and cooperative sponsors to sample from, all small (under 40 beds) homes were eliminated from the lists of "possibles." Similar thinking prompted the removal from the lists of as many "private-pay" respondent homes as possible. Because the subject homes had identified their orientation by responding to questionnaires identifying the patients/sponsors as either "private-pay" or "Medicaid," the author felt any patients or sponsors later drawn from these homes for interviews would have to be of the same type (for he didn't know if individual homes treated the two categories of patients/sponsors differently). For homes responding to a "private-pay"

questionnaire this situation posed a potential problem as the relative number of such patients/sponsors was small, and drawing from them a reasonable sample to interview might prove impossible. In order to avoid this difficulty the majority of homes who had responded to "private-pay" questionnaires were eliminated from further consideration.[7] Ultimately, this left two lists of eight homes apiece; one list of eight patient-oriented homes (all "Medicaid" respondents), and one list of eight sponsor-oriented homes (six "Medicaid" and two "private-pay" respondents).

From the above two groupings the executive director chose two final lists of six patient oriented and seven sponsor oriented homes. These final lists were based upon his judgment as to which homes would be most likely to cooperate with a study requiring the interviewing of the homes' patients and sponsors. (The reason seven sponsor oriented homes were chosen was that he was not sure all of them would cooperate). The six patient-oriented homes were all "Medicaid" respondents while the seven sponsor-oriented homes contained one "private-pay" respondent. It was from these homes that samples of patients and sponsors would be drawn for future study.

---

[7]The reason all such homes were not eliminated was due to the disparity in numbers between patient-oriented and sponsor-oriented homes. Patient-oriented homes were so numerous that eliminating all private-pay respondents still left an adequate number of such homes to study. However, sponsor-oriented homes were so small in numbers that the biggest of the "private-pay" sponsor-oriented homes had to be retained in order to achieve a reasonable sample size.

Developing a sample of patients and sponsors

HCAM assumed the responsibility of securing the cooperation of each of the chosen homes. As shall be explored more thoroughly in the following chapter, this task proved much more difficult than anticipated. Eventually, all of the patient-oriented homes and five of the sponsor-oriented homes agreed to participate in this project. Each of these homes was asked to send the association a list of six mentally competent patients (who could be interviewed) and ten co-operative interested sponsors (from which a total of six sponsor interviews would be secured). The only condition imposed upon the homes' choices was that the patients/sponsors be of the desired (private-pay or Medicaid) type. These lists were then forwarded to the author and served as the sample against which his measures of patient/sponsor response to nursing home orientation would be applied.

An instrument for assessing patient response to nursing home orientation

It was anticipated that assessing patient response to nursing home orientation might represent a difficult task. Because older people frequently have failing eyesight and may be functionally illiterate, any form of mailed questionnaire was deemed inappropriate. Similar problems with hearing and lack of access to telephones pretty well precluded telephone interviews. Therefore, the only viable alternative appeared to be personal interviews. Because the interviews

were to be utilized for comparison purposes, their content had to be structured so as to ensure uniformity. Given the two preceding factors, the only remaining question for the author to decide was "what shall the interview contain?"

Because the author knew the people being interviewed would be fairly old, he wanted to limit the length and complexity of any instrument chosen in order to minimize respondent fatigue. Despite this limitation, the interview's content would have to probe two diverse issues, the perceived quality of the nursing care provided and the comparative orientation of the nursing home to the patient's needs (vs. those of his sponsor).

In determining the quality of the nursing home as perceived by patients, the author did not wish to probe too deeply all of the finite facets of nursing home care (food, service, etc.). He felt that doing this with patients might take inordinately long to discuss and evaluate. He also didn't want to "make waves" about these issues by discussing them with nursing home residents who might not previously have thought about them. Given the apprehensions of nursing homes about researchers, such questions might have caused the homes to bar all interviewers.

Similar concerns plagued the issue of determining patient perception of nursing home orientation. There was no way the author wanted to ask the patients, "does this nursing home favor the needs of your sponsor over yours?" Once again this was thought to be a potential cause of trouble for the nursing homes (whose patients might not have thought about it before).

Reflection upon these problems (and an active literature search) culminated in the Patient Interview Format presented as Appendix "G." All but questions "five" and "ten" were intended to rate the patient's satisfaction with his nursing home. "Five" and "ten" were included to test the patient's perception of the orientation of the nursing home toward patient/sponsor needs.

The satisfaction related questions were part of a "Gratification From the Home Environment (GH)" instrument developed by Pincus.[8] The interviewer using the GH instrument was to distill the responses to questions 1-4, 6-9, and 11-12 down into one single satisfaction rating arrived at from a careful study of the "Rating Scale for Gratification From the Home Environment" developed by Pincus and presented as Appendix "H." Although this instrument was intended to study homes-for-the-aged residents, the author decided that it also could be utilized to study nursing home residents if they were in good enough condition to be able to understand it.

According to Pincus, the satisfaction rating obtained from the "GH" instrument was intended to be independent of a number of other environmental factors (i.e., the patients' health, how they felt about being placed in an institution, etc.) that might surround their residence. When Pincus compared patients' GH rating with various measures of these factors he found no significant correlation. The only factor which he did find to have any effect on GH was the

---

[8]Allen Pincus, pp. 81-86.

length of time the individual had been in the institution, and even the impact of this element was not profound.[9] Finally, in testing the actual application of the GH rating scale, Pincus found no variation between evaluators (albeit from a small sample).[10]

In light of these findings the author felt confident of his decision to use the Pincus instrument for the purpose of evaluating patient satisfaction with the nursing homes in his sample. This left assessment of patient perception of nursing home orientation the only remaining dilemma to be resolved.

In order to assess patient perception of nursing home orientation, questions "5" and "10" were added to the patient interview format. These questions were reviewed with the executive director of HCAM prior to their inclusion and were adjudged sufficient. With the patient issues resolved, the focus next turned to the similar problems associated with sponsors.

Assessing sponsor response to nursing home orientation

It was the author's judgment that measuring sponsor response to nursing home orientation should present fewer problems than the already discussed assessment of patient response. Presumably, the sponsors would be in good physical condition with adequate hearing and eyesight. These factors indicated that any of a number of techniques might be applicable.

---

[9] Pincus, p. 86.

[10] Pincus, p. 82.

However, because of a desire to obtain a quick reply and keep the response rate high, a decision was made to utilize an interview format. But, in order to conserve resources, these interviews were to be done via telephone.

Turning to the issue of what to include in the interview, an assessment of the patient interview format indicated that there was no way it could be "bent" to assess sponsor response. Furthermore, because sponsors were physically removed from the nursing home setting they could be probed more intensively about detailed aspects of the nursing homes' services.

After studying the few instruments available, the author decided to use a "Relative Interview Questionnaire" that had been prepared for the Institute of Gerontology by Barbara Tomlinson.[11] Because it appeared so appropriate to the needs at hand, the Tomlinson questionnaire served as the basis for the Sponsor Telephone Interview presented as Appendix "I." The first two questions of the Sponsor Telephone Interview were of a demographic nature and were intended to see whether the respondent met the definitional requirements discussed in the beginning of this paper.

All of the remaining questions except "4" and "11" were from the Tomlinson questionnaire and were intended to measure sponsor

---

[11]See Barbara Tomlinson, "The Nursing Home Research Project and the Relative Sub-Study" (unpublished paper, Institute of Gerontology, 1971).

satisfaction with a number of quality related variables. The Tomlinson questions had been pre-tested by a small panel of nursing home administrators and directors of nursing.[12] Because of this pre-test and their apparent validity, they were used without modification to evaluate sponsor satisfaction with the nursing homes' services.

Questions "4" and "11 were included to test sponsor perception of nursing home orientation. Because they used the same format as the Tomlinson questions (and were reviewed by the executive director of HCAM) no further pre-test was felt to be necessary.

Because he was concerned that sponsors might be reluctant to respond to a "blind" telephone interview, the author constructed the letter presented as Appendix "J." The "patron" letter was to be signed by the home housing his patient and mailed to the sponsor prior to his actual telephone contact. This was intended to reassure the sponsor as to the motives and use of interview.

With the completion of the patron letter the only remaining dilemma was how to apply all the patient/sponsor measures to the sample selected. Because the author knew how the responses should "come out," he did not wish to risk injecting bias by applying the instruments himself. Therefore, he sought some other means to do it.

---

[12]Tomlinson, pp. 11-13.

Application of patient/sponsor measures to the research sample

In order to apply his patient/sponsor measures the author secured the services of Michigan Interviews, a Lansing based professional market research agency with trained interviewers all over the state of Michigan. Because these services were relatively expensive, a small ($250) research grant was secured from Michigan State University to help defray their cost.

Because of these interviewers' professional backgrounds,[13] no attempt at further training was made. However, each of the interviewers was provided with a carefully prepared packet of all the items they would need for each home. In addition to adequate supplies of all the instruments already discussed, this packet included envelopes addressed to the patron-letter recipients, a list of the patients and sponsors to be interviewed, the instruction sheet presented as Appendix "K" and the letter of introduction from HCAM presented as Appendix "L."

As can be seen from the instruction sheet, the interviewers were to make phone contact with the nursing home administrator prior to their visit. Upon arrival, they were to show the letter of introduction if they encountered any difficulties caused by an administrator who had forgetten about his pledge to cooperate, was absent, etc.

---

[13] Three were former Gallup pollsters, one was a supervisor for Audits and Surveys, Inc., and one was a professor of sociology at a community college.

Once admitted the interviewers were to verify that the patients/sponsors to be interviewed fit the desired private-pay/Medicaid category. Then, they were to ask the nursing home administrator to sign the patron letters and lead them around to the chosen patients.

Upon completion of the patient interviews, the interviewers were to mail the patron letters and wait a few days before initiating the sponsor telephone interviews.

The author reviewed all of the packet materials with a panel of research experts and the director of Michigan Interviews prior to their dissemination. These individuals judged them to be entirely adequate. However, in order to prevent any unforeseen complications, he also discussed the project with each of the interviewers by telephone prior to their interviews.

These preparations completed the creative phase of the project's methodology development. Of course, the eventual analysis of the instruments utilized had always been an important parameter of their construction. However, when they were finalized it became much easier to discuss appropriate statistical techniques for the analysis phase of this research.

Analytical techniques employed

As discussed earlier, this study constituted exploratory research into the origins of dissatisfaction with nursing homes. This emphasis greatly complicated the choice of appropriate statistical

techniques with which to analyze the findings. As should be evident by now, the research design concentrated upon studying those groups judged most likely to display the behaviors of interest to the author.[14] The general methodological limitations of such a choice mechanism are explored more fully in the following section. But, from an analytical point of view, the groups chosen for study all have one common shortcoming, none of them constitute a random sample. Therefore, any statistical technique utilized could not be considered a conclusive measure of the power of the findings. Rather, the tests employed should be understood to represent a relative indicator of the importance of the behavioral differentials manifested. Strongly "significant" findings would indicate whether or not the author's hypothesized sources of dissatisfaction with nursing homes seemed justified. If so, subsequent research under more ideal conditions could determine whether or not his findings were true for nursing homes in general. Accordingly, the author was not troubled by his decision to choose an appropriate statistical test and employ it as though his data met the assumptions of the test (even though it most assuredly did not).

The test decided upon for all of the comparisons of interest to this research was the Mann-Whitney U test. This non-parametric test was indicated due to the ordinal nature of the data and the fact that

---

[14] i.e., the Administrator questionnaire was administered only to HCAM members because they were thought less likely to include homes guilty of callous neglect. Furthermore, the patients and sponsors interviewed were chosen by administrators in homes identified to represent the extremes in orientation.

it could analyze very small cell sizes (a property not available from its closest equivalent, the chi-square test).

The procedure for applying the Mann-Whitney test (which is demonstrated and explained in Appendix "M") was, of course, the same for each application. And, the same confidence level of .10 was utilized each time the test was applied. However, the mechanics of preparing the data for the test was different each time.

In order to test the hypotheses (H_{2A-B}) linking orientation to need structure, data fitting the dimensions of the research hypotheses first had to be broken out of the assembled raw totals. For H_{2A-2} and H_{2B} this involved arriving at a definition hinted at by these hypotheses. For H_{2A-2} administrators "totally committed to the profit motive" were defined as those who answered "1" to question 5a, and the opposite extreme was assigned those who answered "2 or more" to the same question. Likewise, the administrators of H_{2B} who were "totally committed to the profit motive" were defined as those who answered "1" to question 5e, while their less extreme counterparts were defined to be those who answered "2 or more" to the identical query. These breaking points were chosen because it was felt that most of the responses to these questions would cluster around the first two response choices, and any differences would have to be determined from within their ranks. Once this decision was made there was no problem in sorting out the various information sources that fit the hypothesis to be tested. But, this still left unresolved the question of what individual inputs should be analyzed.

Originally, the author had considered analyzing the various categories on the basis of the relative number of "sponsor-oriented," "patient-oriented," indeterminate, etc. homes they contained. However, this approach was rejected because the decision rules that defined these groups could mask the comparative intensity of responses to individual items (i.e., according to the definition, a response of "4" was considered to be same as a response of "5," etc.).

A better approach was thought to consist of applying a Mann-Whitney test to the relative response patterns to each of the questions that defined the dimension under consideration. However, this necessitated the development of an appropriate decision rule to utilize once the tests had been performed on each of the questions. Relying upon the same logic that produced his earlier definitions, the author decided to accept the research hypothesis under consideration if five or more of the nine relevant items were in the presumed direction at the .10 confidence level.

The testing of H_{3A} and H_{3B} concerning patient/sponsor perception of nursing home orientation presented rather more of a problem. Though both the patient and sponsor instruments each had two questions ("5 and 10" and "4 and 11" respectively) evaluating this issue, the question was how to compare them.

The patient dimensions of this dilemma were resolved in the following manner:

(1) The response to questions five and ten were coded on a four point scale ("1" for strongly agree, "4" for strongly disagree, etc.)

(2) For each respondent the difference between question five and question ten was recoded in the following manner.

Response Difference Category		-3	-2	-1	0	+1	+2	+3	
New Code	Relatively more attention to sponsor needs	1	2	3	4	5	6	7	Relatively more attention to patient needs

(3) The newly coded response differences were compared via a Mann-Whitney test at the .10 level of confidence.

As can be deduced from the above, if patients in patient-oriented homes displayed significantly more responses in the direction of "7" than did patients in sponsor-oriented homes, the null hypothesis would be rejected and H_{3A} would be supported.

Sponsor perception of nursing home orientation was assessed in an identical fashion:

(1) The response to questions four and eleven were coded on a four point scale ("1" for very satisfied, "4" for very dissatisfied)

(2) For each respondent the difference between question eleven and question four was recoded as shown:

Response Difference Category		-3	-2	-1	0	+1	+2	+3	
New Code	Relatively more attention to sponsor needs	1	2	3	4	5	6	7	Relatively more attention to patient needs

(3) The newly coded response differences were compared via a Mann-Whitney test at the .10 level of confidence.

This time, if sponsors of patients in sponsor-oriented homes displayed significantly more responses in the direction of "1" than sponsors of patients in patient-oriented homes support would be indicated for H_{3B}.

Analyzing the data related to patient/sponsor satisfaction with nursing care proved much more straightforward. In order to compare patient satisfaction with the nursing care provided all that had to be done was to array the two groups' responses to the "overall satisfaction with the home rating" and run the Mann-Whitney test.

The evaluation of sponsor satisfaction with the nursing care provided was done in a somewhat similar manner. The responses to each of the sponsor interview questions numbers "three" through "ten" (except for "four") were coded and a Mann-Whitney comparison was run. However, because of the large number of different response sets to be compared, this approach raised the question of how to evaluate all comparisons in order to support or reject H_{4B}. The decision rule created in response to this issue was that the author would accept H_{4B} if four or more of the seven comparisons to be made assumed the expected directions at the .10 confidence level. With this decision the author's methodology was complete, and he was now able to assess the limitations contained within it.

Methodological limitations

This study, like any other done with a limited sample, could be considered constrained by the "classic" general limitation, that its respondents might not be representative of the population outside of Michigan. However, the author is not convinced how valid this particular argument is in regard to this project.

The main issue of interest, dissatisfaction with nursing homes, appeared to be a nation-wide phenomenon. Although the official

definition of what constitutes a nursing home varies from state to state, the author doubted that the people dissatisfied with nursing homes knew (or cared) about these distinctions. And, the criticism of Michigan nursing homes seemed no different than that produced by other areas. Further, the hypothesized source of dissatisfaction-without-neglect (conflict between patients and sponsors) appeared likely to be more or less universal. Apparently, about the only strong argument for this geographical limitation was that the patients and sponsors drawn for analysis might somehow be "different" from their non-Michigan counterparts. Because of the dynamics introduced by varying state Medicaid programs, this difference was thought possible. Just how great its impact might be was felt to be debatable, but the possibility of differentials between Michigan and other areas indicated additional research to prove (or disprove) their existence might be useful if this research pinpointed potentially fruitful areas for further scrutiny.

A more troublesome general limitation was an inability to indicate how much dissatisfaction with nursing homes was due to inherent patient/sponsor conflicts (even supposing strong support of the author's research hypotheses). The cause of this deficiency was the apparent lack of prior research into patient/sponsor conflict within nursing homes. As was discernible from chapter one, the author had ample indication that such conflicts existed, but had no way of assessing their exact source (i.e., specific patient needs vs. specific sponsor needs) or relative importance. Instead the existence of these conflicts was simply accepted and further research structure development proceeded from there. To have done otherwise would have constituted an entire

research project in itself. Such an excursion into medical sociology would not have lent any insights to the surrogate/consumer dimensions of marketing science. Furthermore, preliminary research into patient and sponsor needs might eventually prove needless if subsequent study into their "proven" impact on nursing home satisfaction netted no positive results. Given the exploratory nature of this study, a better approach was thought to consist of accepting these conflicts as givens and concentrating upon whether or not they seemed to affect patient/sponsor satisfaction with nursing homes. If such a relationship was shown to exist, subsequent research into the specifics of patient/sponsor conflicts could evaluate its relative magnitude and importance.

Moving from the general to the specific, the author saw several other criticisms that could be leveled at his methodology. First among these was the possibility that the administrator questionnaire might not be a valid indicator of nursing homes' orientation. Basically, this possibility revolved around three potential areas of concern: (1) the questionnaire might not really reflect administrators' orientations; (2) the administrators might not answer it truthfully; and (3) the administrators might not really be the ones to decide what was to be done in conflict situations.

With regard to the inherent validity of the questionnaire, every step possible had been taken to ensure its efficacy. Its origin (ACNHA board members' experiences), its pre-test, and its approval by the executive director of MNHA all seemed to indicate that the instrument did perform its function. Lacking the ability to compare indicated

responses with actual action (over a long period of time in many different homes), there were few choices other than to accept it.

Even if the instrument was an accurate indicator, the argument could be made that the administrators might not answer it truthfully. With this danger in mind, the conflict situations portrayed had been kept as free from apparent morality considerations as possible. Furthermore, in asking MNHA members to respond to a supposedly in-house project (in which individual anonymity was assured), individual responses could be expected to be more truthful than they would be if some independent or governmental researcher was involved. Beyond these considerations, there was no reason to assume that any other falsification might not be uniformly distributed (and therefore cancel itself out).

A more vexing argument could be found in an assertion that administrators are not the ones who actually implement the action to be taken in conflict situations and so their responses might not really reflect the nursing homes' "true" orientation. Those who held this view would argue that members of the nursing staff are more likely to be the ones who actually adjudicate conflicts on a day-to-day basis. Because the actions they take might (or might not) parallel administrator policy, the nurses should be the ones contacted to determine orientation.

The author saw determination of whether or not nurses' actions reflected administrators' policies as being beyond the scope of this study. Still, he was concerned enough about this issue that he talked individually with various heads of nursing and their respective administrators. These groups exhibited no strong differences in orientation and the nursing staff did seem to look to the administrator for direction

in policy-related issues. This factor was made particularly clear when the author suggested to both administrators and nurses that he was considering mailing his questionnaire to heads of nursing. The response to this suggestion was that (in addition to lowering the probable number of respondents) many of the heads of nursing would "clear" their responses with their administrator before they sent them in. In light of these factors, the original decision to contact administrators was felt to be justified.

The author was not as concerned about the content validity of his patient and sponsor interview instruments. Because most of the items contained in these instruments had been developed and tested by other researchers, they were accepted without much further scrutiny. He did realize that patients and sponsors could, conceivably, be afraid to answer them truthfully. However, patient satisfaction was being rated one time from a number of different interviewing probes. Presumably, the subtle nature of the evaluative device when coupled with assurances of anonymity should have screened out most of this type of bias.

As sponsors were further removed from the influence of the home, the only source of bias in their answers should have been some emotional considerations (already discussed in chapter one) and fear of reprisals against their patient. Assurances of anonymity should have calmed most of these fears and the patron letter from the home, itself, should have erased the remainder of them. With these factors dismissed, the only remaining validity issue was the amount of subjectivity involved in applying the instrument.

The main concerns here centered on two separate issues: (1) whether the interviewers would be capable of judging the subtle distinctions implied by the instruments, and (2) the possibility that one "bad" interviewer might unduly bias an admittedly small sample. The potential for judgmental error was much greater for the Pincus instrument than for the telephone interviews. The only offsetting factors were the assumed professionality of the interviewers and the Pincus finding (earlier introduced) indicating no variation in application among his interviewers. The author found these assurances less than satisfactory, but the apparent desirability of the Pincus instrument led him to utilize it despite its limitations.

The author's apprehensions about one "bad" interviewer biasing his findings were easier to dismiss. The interviews were almost uniformly distributed among the five interviewers (i.e., in most cases, the interviewers had almost equal numbers of patient-oriented and sponsor-oriented homes to contact). Only one interviewer had a concentration of homes all on "one side" of the orientation conflicts being studied.

In general, the author believed the validity of all of his instruments was as satisfactory as circumstances permitted. He felt the individual inadequacies that might surface in his findings would not be totally undesirable. The fact of their existence would serve as a guide to future researchers who might follow.

The author entertained similar feelings about the reliability of the samples to which these instruments were applied. Besides the statistical limitations already introduced, his chief concerns in this area centered around two broad issues: whether the nursing homes

chosen for interview activity were not "typical" of the total population of nursing homes, and whether the patients and sponsors chosen by the homes for interviewing were not "typical" of all the patients within the home.

To begin with, the list of homes typifying patient orientation and sponsor orientation most certainly were not "typical." By definition they were the most extreme homes the author could find.

Still, it must be remembered that this study was interested in studying dissatisfaction with nursing homes that resulted from resolution of patient/sponsor conflicts. In theory, such dissatisfaction should arise any time patient/sponsor needs conflict and the conflict is resolved (by definition to someone's dismay). Discerning a causal effect between such conflict management and patient dissatisfaction would be impossible in a home which did not consistently take one side or the other (i.e., at some time everybody would be unhappy and the dissatisfaction would be equal for both sides).

In light of these considerations, the only hope for relating conflict and dissatisfaction was to be found in comparing the relative satisfaction of patients/sponsors in homes who consistently took one side or the other. If a causal relationship was discerned in these extreme cases, generalization to the dissatisfaction produced every time a nursing home faced a conflict resolution setting would be possible. Therefore, the choice of these extreme homes was not only justified, but absolutely essential.

However, even within the two categorical extremes, there could be no doubt that the nursing homes chosen by HCAM were not a random

sample. The already discussed nursing home size limitations mandated the culling of all small homes from the list of "possibles." The subsequent reduction of these lists by HCAM further detracted from any random nature they might have had. But, the direction assumed by HCAM choice was not easy to predict.

Admittedly, HCAM could have chosen only sterling examples for the author's interviewing activities. However, such a choice would not seem logical as it would imply that all patients and sponsors interviewed would have a uniformly high estimate of their nursing homes' quality. Such findings would not have supported the author's guiding hypothesis that dissatisfaction with nursing homes was not always related to callous neglect, and such an action would not have been in the best interests of the nursing home association.

On the other hand, an argument could be made that the association would conspire to choose homes that would, because of some combination of good and bad, produce interviews that would support the author's hypotheses. Careful scrutiny of this project's research structure showed that such manipulation of findings would be theoretically impossible (even if HCAM was sophisticated and interested enough to attempt it). At any rate, the easy access to patients and sponsors facilitated by HCAM participation more than compensated for any accompanying sacrifices in sample reliability.

The only element that really troubled the author about HCAM choice was whether or not the supposedly "unco-operative" homes might have provided stronger demonstrations of the behavior he wanted to test. However, if HCAM could not get the homes to co-operate, it was doubtful

that anyone could. Therefore, the chosen sample of homes was judged as adequate as possible.

In the author's opinion the likelihood of working from an unrepresentative sample was even greater for the patients/sponsors to be interviewed than it had been for the homes from which they were chosen. He suspected that administrators might choose from their ranks those patients and sponsors whom they expected to reflect most favorably upon the services offered by their home. There seemed to be no way to stop such a choice, for even if the interviewers had been allowed to choose their own "random" sample from a list of the "competent" patients and "co-operative" sponsors, a skilled administrator could still bias the sample by whom he chose to submit for consideration. Furthermore, administrator resistance to such a complicated plan might have been gaining entry to the homes impossible.

However, even assuming that administrators could (and did) choose their patients/sponsors according to expected responses, this practice, if uniformly distributed, would not necessarily harm this research. The research hypotheses called for a comparison of the relative satisfaction of patients/sponsors within the different homes. Unless all patients and sponsors rated all aspects of their homes at the very top end of all evaluative scales, the required comparisons should still be available (albeit at the high end of the scale). Feeling such uniform polarization to be unlikely, acceptance of the non-random nature of patients and sponsors samples chosen by the nursing homes seemed reasonable.

In summary, the author thought his methodology was sound. Any inherent flaws were either unavoidable compromises or calculated risks that appeared justifiable at the time. Secure in this knowledge, the focus of attention was next shifted to the findings produced by this methodology.

CHAPTER III

FINDINGS AND ANALYSIS

Introduction

As is evident from Chapters I and II, this project proceeded by first developing a number of general guiding hypotheses which (after a careful analysis of the situation involved) resulted in the formulation of more specific research hypotheses. In turn these research hypotheses were exploded into still more specific operational hypotheses which were to be tested with the elements developed in the proceding chapter.

This chapter shall be devoted to the operational hypotheses and the elements used to test them only. Once these findings have been analyzed their implications for broader levels of abstraction will be discussed in the "conclusions" section of the final chapter. For the sake of convenience, a summary of the relevant findings shall first be introduced. The detailed analysis used to produce these findings will then be examined in subsequent sections of this chapter.

Summary of findings

An extensive analysis of the research findings resulted in the following:

-Response to the author's questionnaire was so high (76%) as to be judged exceptional for the industry.

-The findings indicated the questionnaire was a valid indicator of orientation choice for patient/sponsor conflicts. But, the data pointed to a conclusion that the questionnaire might not be a valid indicator of orientation choice for administrator vs. patient and/or sponsor conflicts. It only weakly reflected administrator commitment to the health care professional role and unexpectedly manifested more patient/sponsor orientation for Medicaid patients than for private-pay patients (albeit at a low level of statistical significance).

-As suspected earlier, inadequate data was available to test H_{2A-1} comparing orientation choice for proprietary and non-profit homes. Accordingly, H_{2A-2} was tested.

-Of all the hypotheses tested, the strongest support was found for H_{2A-2}. Proprietary homes run by administrators totally committed to the profit motive were more sponsor-oriented when dealing with private-pay patient/sponsor conflicts than homes run by administrators less motivated by profits were in dealing with similar conflicts involving Medicaid patients.

-Support was not found for H_{2B}. Proprietary homes run by administrators totally committed to their role as a health care professional were not more oriented to behavior associated with this role when it conflicted with the needs of Medicaid patients and/or sponsors than were homes run by administrators with lesser commitments to this role when faced with similar private-pay patient and/or sponsor conflicts. In fact, the opposite was weakly indicated. However, the importance of this finding was felt to be diminished by the low level of statistical significance manifested as well as the validity considerations already mentioned.

-A strong finding consisted of demonstrated variation in the "side-taking" of nursing home marketers. This was true despite strong social considerations that seemed to mandate otherwise.

-An unexpected finding consisted of an indication that sponsor-oriented homes were much more reluctant to cooperate with nursing home research than were their patient-oriented counterparts.

-Hypotheses H_{3A} and H_{3B} assessing patient/sponsor perception of nursing home orientation were not conclusively supported. The data hinted at a finding that patients in patient-oriented homes and sponsors of patients in sponsor-oriented

homes did perceive relatively more attention to their own respective needs. However, the differences found were not statistically significant.

-H_{4A} could not be conclusively supported. Although patients in sponsor-oriented homes did manifest slightly more dissatisfaction with the nursing care provided than patients in patient-oriented homes, as the differences displayed were not statistically significant.

-Equally frustrating results attended the data relevant to H_{4B} which could not be supported. Even though six of the seven variables tested displayed slightly more sponsor dissatisfaction with the nursing care provided by patient-oriented homes than was the case for the sponsor-oriented equivalents, only two of the differences were statistically significant. This fell far short of the four required by the acceptance decision rule discussed in Chapter II.

The remainder of this chapter shall detail the findings which resulted in the above.

Questionnaire response

Response to the author's questionnaire was extremely high. Once all parties with prior knowledge of the study were culled from the sample,[1] a total of 246 questionnaires were mailed, and 188 of these were returned (resulting in a gross response rate of 76 percent). However, 23 of these were judged unusable due to extensive (more than two items) omissions and 9 others were not analyzed as they were received after the author's data cut-off date. Only 6 questionnaires were received from non-profit homes and these responses (along with the hypotheses they were to test) were also deleted as this was thought to be too small a sample for adequate analysis. Subtracting all these

---

[1]These included ACNHA/HCAM officers as well as pre-test respondents.

from the total response left 150 questionnaires and a net response rate of 61 percent. Considering the response rates of other researchers into nursing homes, this was considered to be exceptional and no further sampling of non-respondents was thought necessary.

Although this quantitative response was most encouraging, the qualitative reply was equally gratifying. Despite the fact that no space on the questionnaire had been provided for open-ended response, several respondents attached personal notes to their questionnaires. Without exception these were uniformly positive. The following was typical:

> I really enjoyed completing the questionnaire. I found the questions were the type we face quite frequently and hope that we always make the proper decisions. These would be good to use in conjunction with the state exam and PES test for licensure. Reasons for specific answers would be given afterwards in oral form. Thank you.

The author would like to think that the positive feelings expressed by such gratuitous comments were in some small part responsible for the unexpectedly high response rate (although the factor of HCAM involvement was probably more important). At any rate, heartened by the encouraging response to his questionnaire, the author next set about assessing its apparent validity.

Assessment of questionnaire validity

The first step in assessing questionnaire validity was the creation of Table 6 which displayed the responses by orientation and patient identification. As can be seen from Table 6, the raw data conformed to the expectations demanded of the trial questionnaire in

TABLE 6

ADMINISTRATOR QUESTIONNAIRE RESPONSE BY ORIENTATION AND PATIENT IDENTIFICATION

Orientation Exhibited by Home	Patient/Sponsor identified as: Medicaid	Private-Pay
Patient vs. Sponsor Conflicts (Cases 1, 3, 5)		
Patient	54 (76%)	54 (68%)
Indeterminate	8 (11%)	17 (22%)
Sponsor	9 (13%)	8 (10%)
Administrator vs. Patient and/or Sponsor Conflicts (Cases 2, 4, 6)		
Administrator	37 (52%)	46 (58%)
Indeterminate	16 (23%)	16 (20%)
Patient/Sponsor	18 (25%)	17 (22%)

Chapter II. The majority of the homes were patient-oriented (for patient/sponsor conflicts) and administrator-oriented (for administrator vs. patient and/or sponsor conflicts). These findings about the "normal" orientation taken lent face validity to the instrument. But, the author was interested in going beyond them to determine whether the orientations shown reflected the behavioral manifestations expected to stem from the identified source (private pay/Medicaid) of patient revenue.

Clearly, when defined only by the orientation parameters of Table 6, the findings were so similar as to defy revenue source

comparison. However, as discussed earlier, very real differences could be masked by the macro nature of the definitions concerned.

Reflection upon this point resulted in Tables 7 and 8 which displayed the response totals to individual items according to patient identification (private-pay/Medicaid) only. Because the response patterns were frequently very similar, a simple arithmetic mean was included to assist the reader in identifying the relative direction (or orientation) indicated by the paired response patterns as well as the differentials compared via the Mann-Whitney.

As can be seen from examining Table 7, seven out of the nine patient/sponsor conflict comparisons took the assumed direction of greater sponsor orientation for private-pay patients. Two of the differences displayed were statistically significant enough to reject the null hypothesis of "no difference." The author felt this supported the apparent validity of his instrument, and he decided to test it no further. When the data of Table 7 was refined still further on the basis of administrator emphasis on profit, he expected to find (and found) even greater behavioral differentials which would conform to the directions already hypothesized.

However, an examination of Table 8 produced a different story. Here the comparative response patterns for administrator vs. patient and/or sponsor conflicts indicated eight out of nine comparisons that were in the "wrong" direction of greater sponsor/patient orientation for Medicaid patients. This unexpected finding indicated that something was probably wrong. But, determining the exact source of the problem was difficult as Table 8 displayed response <u>totals</u> that contained two

TABLE 7

TOTAL RESPONSE TO PATIENT VS. SPONSOR CONFLICTS BY PATIENT IDENTIFICATION
(From Administrator Questionnaire)

Alternative	Patient Identified as	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Assumed Direction at Mann-Whitney Confidence Level of:
Case One (Romance between patients; sponsor wants it stopped)										
1a "Passively" keep patients apart	Private	13	28	11	9	18			2.89	
	Medicaid	9	21	11	12	18			3.13	.1539
1b "Actively" keep patients apart	Private	0	2	9	15	53			4.51	
	Medicaid	1	1	9	14	46			4.45	(.3974)
1c Take action if sponsor threatened withdrawal	Private	14	11	4	11	39			3.63	
	Medicaid	8	7	8	4	43			3.96	.0823**
*Definitely Yes = sponsor oriented, Definitely No = patient oriented										
Case Three (Patient wants to go out for ice cream cone with person forbidden by sponsor)										
3a Call sponsor to get him to let pt. go	Private	53	12	3	3	8			1.747	
	Medicaid	43	14	6	3	5			1.775	(.294)
3b Cannot reach sponsor, let patient go	Private	15	12	8	11	33			3.443	
	Medicaid	17	11	12	6	25			3.155	.1562
3c Sponsor refused, still let pt. go	Private	10	11	5	13	40			3.785	
	Medicaid	13	9	8	16	25			3.437	.0582**
*Definitely Yes = patient oriented, Definitely No = sponsor oriented										

TABLE 7 (cont'd.)

Alternative	Patient Identified as	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Assumed Direction at Mann-Whitney Confidence Level of:
Case Five (Patient wants beauty shop money; sponsor refuses)										
5a Ask sponsor for enough for weekly visit	Private		48	17	5	4	4		1.705	
	Medicaid		44	21	1	3	2		1.563	.3669
5b Ask sponsor for enough for bi-weekly visit	Private		51	24	3	0	1		1.430	
	Medicaid		48	21	1	0	1		1.380	.352
5c "Shame" sponsor into giving the money	Private		18	9	14	12	26		3.241	
	Medicaid		19	10	11	13	18		3.014	.1949

*Definitely Yes = patient oriented, Definitely No = sponsor oriented

**Null hypothesis of "no difference" may be rejected at proposed confidence level of .10

TABLE 8

TOTAL RESPONSE TO ADMINISTRATOR VS. PATIENT AND/OR SPONSOR CONFLICTS BY PATIENT IDENTIFICATION
(From Administrator Questionnaire)

Alternative	Patient Identified as	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Assumed Direction at Mann-Whitney Confidence Level of:
Case Two (Sponsor and patient want patient hand-fed; home refuses)										
2a Hand feed evening meal only	Private		9	16	15	18	20		3.308	(.015)**
	Medicaid		11	23	16	10	11		2.817	
2b Let sponsor hand feed patient when present	Private		12	29	12	6	19		2.885	
	Medicaid		15	25	11	11	9		2.634	(.15)
2c If above not acceptable, hand feed patient anyway	Private		8	9	7	14	41		3.899	
	Medicaid		6	9	4	15	37		3.958	.45
Case Four (Patient won't use cane, has been restrained; family and patient object)										
4a No restraints on night following use of cane	Private		22	21	10	4	22		2.758	
	Medicaid		30	19	5	4	13		2.310	(.03)**
4b "Last chance" trial period without restraint	Private		8	18	10	16	26		3.436	
	Medicaid		10	16	14	10	21		3.225	(.20)
4c More inclined to the above if withdrawal	Private		2	3	6	18	48		4.390	
	Medicaid		4	3	13	6	45		4.197	(.34)

TABLE 8 (cont'd.)

Alternative	Patient Identified as	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Assumed Direction at Mann-Whitney Confidence Level of:
Case Six (Patient wants to use wheel chair she doesn't need in main dining room or be fed in her room)										
6a Let patient eat in room if walker used during day	Private		16	26	11	12	13		2.744	
	Medicaid		22	21	10	8	10		2.479	(.11)
6b Let patient take wheel chair in dining room if walker used during day	Private		3	11	6	22	36		3.987	
	Medicaid		12	5	6	18	30		3.690	(.17)
6c If above unacceptable, let patient use wheel chair in dining room	Private		7	7	5	17	43		4.038	
	Medicaid		9	6	6	13	37		3.887	(.32)

*Definitely Yes = patient/sponsor oriented, Definitely No = Administrator oriented

**Null hypothesis of "no difference" may be rejected at proposed confidence level of .10

different variables, patient identification and administrators' commitments to their roles as health care professionals. Conceivably, either the "private pay" or "Medicaid" respondents could be comprised of inordinate numbers of individuals expressing polar extremes of the health-care-professional variable. The concomitant behaviors could be masking the differences manifested by varying the identified source of patient revenue.

Accordingly, Table 9 was constructed which held constant the administrator commitment to the health care professional role (as identified by question "5e") while varying the identified source of patient revenue. Table 9 indicated that respondents were manifesting orientation choices that were in direct opposition to those assumed to stem from patient revenue distinctions. Fifteen out of eighteen comparisons indicated the "wrong" direction and three of these were statistically significant. This finding pointed to a conclusion that either the assumptions about patient revenue distinctions were incorrect for this administrator perogative conflict variable, or the questionnaire was not a valid indicator of the orientations chosen for such conflicts.

The author hoped to determine which of the above was the apparent difficulty by constructing Table 10. Table 10 held the identified source of patient revenue constant while comparing the responses of those who indicated commitment to the administrator's role as a health care professional as being most important (5e = 1) with those who indicated somewhat less commitment to this role (5e >1). If the questionnaire was at all valid in reflecting orientations chosen for

TABLE 9

RESPONSE TO ADMINISTRATOR VS. PATIENT AND/OR SPONSOR CONFLICTS BY PATIENT IDENTIFICATION--
ADMINISTRATOR COMMITMENT TO HEALTH CARE PROFESSIONAL ROLE HELD CONSTANT
(From Administrator Questionnaire)

Alternative	Medicaid Patient I.D.						Private-Pay Patient I.D.						Response Pattern In/(Not In) Assumed Direction at Mann-Whitney Confidence Level of:
	Response*					Mean	Mean	Response*					
	1	2	3	4	5			1	2	3	4	5	
Total Administrator Commitment to Health Care Professional Role (5e = 1)													
2a	7	15	13	6	8	2.857	3.200	8	13	13	11	15	(.10)**
2b	11	13	8	9	8	2.796	2.933	9	20	11	6	14	(.30)
2c	4	6	3	9	27	4.000	3.885	7	7	5	9	33	.39
4a	19	14	4	4	8	2.347	2.770	18	15	8	3	17	(.09)**
4b	5	11	13	5	15	3.286	3.450	7	12	8	13	20	(.28)
4c	4	2	8	4	31	4.143	4.407	1	3	5	12	38	(.30)
6a	13	14	9	5	8	2.612	2.783	14	17	8	10	11	(.28)
6b	7	4	4	13	21	3.755	3.950	3	8	5	17	27	(.31)
6c	5	4	4	9	27	4.000	3.967	7	5	4	12	33	.16

TABLE 9 (cont'd.)

Alternative	Medicaid Patient I.D. Response* 1	2	3	4	5	Mean	Private-Pay Patient I.D. Mean	Response* 1	2	3	4	5	Response Pattern In/(Not In) Assumed Direction at Mann-Whitney Confidence Level of:
Less Than Total Administrator Commitment to Health Care Professional Role (5e >1)													
2a	3	7	3	4	3	2.850	3.625	1	3	2	5	5	(.05)**
2b	3	11	3	2	1	2.350	2.625	3	8	1	-	4	(.43)
2c	1	3	1	5	10	4.000	4.063	-	2	2	5	7	(.46)
4a	10	5	1	-	4	2.150	2.563	4	6	2	1	3	(.12)
4b	5	4	1	5	5	3.050	3.188	1	6	2	3	4	(.36)
4c	-	-	5	2	13	4.400	4.250	1	-	1	6	8	.34
6a	8	7	1	3	1	2.100	2.625	2	8	2	2	2	(.08)**
6b	5	1	1	5	8	3.50	4.00	-	3	1	5	7	(.24)
6c	4	2	1	4	9	3.60	4.188	-	2	1	5	8	(.21)

* 1 = Patient/Sponsor Oriented, 5 = Administrator Oriented

**Null hypothesis of "no difference" may be rejected at .10 confidence level

TABLE 10

RESPONSE TO ADMINISTRATOR VS. PATIENT AND/OR SPONSOR CONFLICTS BY ADMINISTRATOR COMMITMENT TO THE HEALTH CARE PROFESSIONAL ROLE--PATIENT IDENTIFICATION HELD CONSTANT
(From Administrator Questionnaire)

Alternative	Total Administrator Commitment to Health Care Professional Role (5e = 1)						Less Than Total Administrator Commitment to Health Care Professional Role (5e >1)						Response Pattern In/ (Not In) Assumed Direction at Mann-Whitney Confidence Level of:
	Response* 1	2	3	4	5	Mean	Mean	Response* 1	2	3	4	5	
Private-Pay Patient I.D.													
2a	8	13	13	11	15	3.200	3.625	1	3	2	5	5	(.15)
2b	9	20	11	6	14	2.933	2.625	3	8	1	-	4	.19
2c	7	7	5	9	33	3.885	4.063	-	2	2	5	7	(.27)
4a	18	15	8	3	17	2.770	2.563	4	6	2	1	3	.38
4b	7	12	8	13	20	3.450	3.188	1	6	2	3	4	.25
4c	1	3	5	12	38	4.407	4.250	1	-	1	6	8	.24
6a	14	17	8	10	11	2.783	2.625	2	8	2	2	2	.41
6b	3	8	5	17	27	3.950	4.000	-	3	1	5	7	(.37)
6c	7	5	4	12	33	3.967	4.188	-	2	1	5	8	(.45)

TABLE 10 (cont'd.)

Alternative	Total Administrator Commitment to Health Care Professional Role (5e = 1)						Less Than Total Administrator Commitment to Health Care Professional Role (5e >1)						Response Pattern In/ (Not In) Assumed Direction at Mann-Whitney Confidence Level of:
	Response* 1	2	3	4	5	Mean	Mean	Response* 1	2	3	4	5	
						Medicaid Patient I.D.							
2a	7	15	13	6	8	2.857	2.850	3	7	3	4	3	.24
2b	11	13	8	9	8	2.796	2.350	3	11	3	2	1	.15
2c	4	6	3	9	27	1.369	1.298	1	3	1	5	10	.43
4a	19	14	4	4	8	2.347	2.150	10	5	1	-	4	.26
4b	5	11	13	5	15	3.286	3.050	5	4	1	5	5	.26
4c	4	2	8	4	31	4.143	4.400	-	-	5	2	13	(.36)
6a	13	14	9	5	8	2.612	2.100	8	7	1	3	1	.08**
6b	7	4	4	13	21	3.755	3.500	5	1	1	5	8	.33
6c	5	4	4	9	27	4.000	3.600	4	2	1	4	9	.19

* 1 = Patient/Sponsor Oriented, 5 = Administrator Oriented

**Meets or exceeds proposed confidence level of .10
Null hypothesis of "no difference" may be rejected at .10 confidence level

administrator role conflicts, it should indicate relatively greater orientation to administrator perogatives for "totally committed" administrators than for those "less committed." As can be seen, Table 10 did indicate the assumed orientation for thirteen out of the eighteen comparisons made. This suggested the problem was with the assumptions, not the validity of the instrument. Unfortunately, the statistical significance of the "correct" comparisons was so small that the author fully expected the "right" differentials provided by administrator role commitment to be more than offset by the "wrong" differentials of patient identification when combined in the comparisons suggested by H_{2B}.

The author was able to determine only a few clues as to why the questionnaire produced the preceding results with administrator perogative conflicts. Interviews with various administrators indicated that the question (5e) used to define relative administrator commitment to the health care professional role may not have been well phrased. Stating that "being professionally satisfied by all actions taken by myself or my staff" was "very important" may have been the kind of "God, motherhood, and the flag" response that almost everyone (regardless of their true feelings) would automatically choose. The fact that 75 percent did indicate being "professionally satisfied" was "very important" added strength to this suspicion that the indicated commitment to the health care professional role may be so trite as to be a poor item to use in assessing questionnaire validity.

The administrators interviewed were totally at a loss to explain why greater patient/sponsor orientation was manifested for Medicaid situations than their private-pay counterparts. The only

possible explanation seen by the author was that pressing administrator perogatives too far with Medicaid patients might result in complaints to the state Medicaid authorities which, in turn, might result in greater scrutiny being paid to the home by the various licensing authorities. Such a motivation would be operative for administrator vs. patient and/or sponsor conflicts and not for patient vs. sponsor situations. In the first instance the home would be taking actions possibly repugnant to both patient and sponsor--clearly a possible "flag" for further scrutiny. In the case of patient vs. sponsor conflicts the whole issue would be a "family matter"--presumably of less general interest. These differences could be responsible for the apparently conflicting findings. Of course, this was only conjecture which would have to be investigated by later research (that would seem to face more than a few methodological difficulties).

In the author's opinion this total analysis indicated that his questionnaire apparently was a valid indicator of the orientations chosen for patient vs. sponsor conflicts. However, enough unanswered questions emanated from the data regarding administrator vs. patient and/or sponsor conflicts to make generalizing from this data to any other issue under consideration highly suspect. Therefore, he decided to discount any subsequent findings stemming from administrator perogative conflicts. The fact that the most positive findings were in the patient vs. sponsor area lent further support to an earlier decision to investigate the perceptions/satisfactions resulting from orientation choices available to patient vs. sponsor conflicts (and not their administrator perogative counterparts). With these thoughts about his instrument's validity in

mind the author next focused his analysis upon the data needed to evaluate the hypotheses linking orientation choice and need structure.

The existence of variation in marketer-orientation choice

Implicit to both the preceding discussion and the author's operational hypotheses was an assumption that some variation in marketer orientation choice did exist. Otherwise, the comparisons necessary to hypothesis testing could not be undertaken. The presence of such variation was not clear prior to this study. Because of "moral" considerations, nursing home marketers might be expected to always favor the hapless patient in patient vs. sponsor conflicts. Similarly, administrators (in light of their "almost doctor" self-images) might be expected to always favor their administrative perogatives in administrator vs. patient and/or sponsor conflicts.

As is obvious from Tables 6-10, such uniform orientation choice was clearly not the case. Considerable variation was shown to exist for individual response items and extremes in orientation strong enough to permit identifying patient-oriented, sponsor-oriented, (etc.) homes were shown to be present. The author felt these findings were significant by themselves in addition to their importance for the remainder of his research.

Detailed findings relative to H_{2A-1}

H_{2A-1} Proprietary homes will be more sponsor oriented when dealing with private-pay patient/sponsor conflicts than non-profit homes are in similar conflict situations involving Medicaid patients.

As discussed earlier, the author's fear that inadequate numbers of non-profit respondents would be available to test H_{2A-1} were realized. Accordingly, he turned to its conceptual equivalent, H_{2A-2}.

Detailed findings relative to H_{2A-2}

H_{2A-2} Proprietary homes run by administrators totally committed to the profit motive will be more sponsor oriented when dealing with private-pay patient/sponsor conflicts than homes run by administrators less motivated by profits are in dealing with similar conflicts involving Medicaid patients.

Table 11 detailed the information pertinent to H_{2A-2} in a format similar to that utilized for Tables 7 and 8. The only new factor, the administrator's relative commitment to profit, was determined from the response to question "5a" in the manner discussed in Chapter II.

As the author had expected, when the profit orientation parameters were combined with patient revenue distinctions so as to portray the most extreme cases, the response patterns assumed the hypothesized directions even more positively than they had in Table 7. Seven out of the nine comparisons assumed the hypothesized directions and five of these were statistically significant. In light of the decision rules developed in Chapter II, this indicated support for H_{2A-1}. As the author had predicted earlier in this chapter, similar findings were not to be found for H_{2B}.

Detailed findings relative to H_{2B}

H_{2B} Proprietary homes run by administrators totally committed to their role as a health care professional

TABLE 11

RESPONSE TO PATIENT VS. SPONSOR CONFLICTS BY PATIENT IDENTIFICATION COMBINED WITH ADMINISTRATOR COMMITMENT TO PROFIT--EXTREME CASES ONLY
(From Administrator Questionnaire)

Alternative	Patient I.D./ Administrator Commitment to Profit∞	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Hypothesized Direction at Mann-Whitney Confidence Level of:
Case One (Romance between patients; sponsor wants it stopped)										
1a "Passively" keep patients apart	Pvt./TCP		8	14	5	5	9		2.83	
	Med./LTCP		3	8	7	4	9		3.26	.0968**
1b "Actively" keep patients apart	Pvt./TCP		-	1	5	8	27		4.49	
	Med./LTCP		-	1	3	8	19		4.45	(.40)
1c Take action if sponsor threatened	Pvt./TLP		8	4	2	8	19		3.63	
	Med./LTCP		4	1	4	1	20		4.07	.0985**
*Definitely Yes = sponsor oriented, Definitely No = patient oriented										
Case Three (Patient wants to go out for ice cream cone with person forbidden by sponsor)										
3a Call sponsor to get him to let pt. go	Pvt./TCP		28	6	2	2	3		1.683	
	Med./LTCP		17	6	4	1	3		1.935	(.17)
3b Cannot reach sponsor, let patient go	Pvt./TCP		9	7	3	5	17		3.341	
	Med./LTCP		9	5	7	3	7		2.806	.09**
3c Sponsor refused, still let pt. go	Pvt./TCP		5	5	5	6	20		3.756	
	Med./LTCP		9	4	3	7	8		3.032	.0256**
*Definitely Yes = patient oriented, Definitely No = sponsor oriented										
∞Total Commitment to Profit (TCP)--5a = 1; Less Than Total Commitment to Profit (LTCP)--5a >1										

TABLE 11 (cont'd.)

Alternative	Patient I.D./ Administrator Commitment to Profit∞	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Hypothesized Direction at Mann-Whitney Confidence Level of:
Case Five (Patient wants beauty shop money; sponsor refuses)										
5a Ask sponsor for enough for weekly visit	Pvt./TCP		24	8	3	3	2		1.775	
	Med./LTCP		17	10	-	2	2		1.774	(.4325)
5b Ask sponsor for enough for bi-weekly visit	Pvt./TCP		28	11	1	-	1		1.415	
	Med./LTCP		22	8	-	-	1		1.387	.4168
5c "Shame" sponsor into giving the money	Pvt./TCP		7	3	8	7	16		3.537	
	Med./LTCP		10	3	3	7	8		3.000	.09**

*Definitely Yes = patient oriented, Definitely No = sponsor oriented

∞ Total Commitment to Profit (TCP)--5a = 1; Less Than Total Commitment to Profit (LTCP)--5a >1

**Null hypothesis of "no difference" may be rejected at proposed confidence level of .10

> will be more oriented to behavior associated with this role when it conflicts with the needs of Medicaid patients and/or sponsors than will homes run by administrators with lesser commitments to this role when faced with similar private-pay patient and/or sponsor conflicts.

The findings pertaining to H_{2B} were presented in Table 12. This table confirmed the author's earlier apprehensions about combining administrative commitments to the health care professional role with patient revenue distinctions to produce the (supposedly) most extreme cases. Seven out of the nine comparisons were in the "wrong" direction and one of these was statistically significant. Accordingly, H_{2B} was not supported.

As discussed in the section evaluating questionnaire validity, the author did not put a great deal of faith in these findings. He did find it interesting that the unexpected (opposite) reactions to private-pay/Medicaid distinctions were so strong as to apparently "over-power" the responses paralleling administrative commitment to the health care professional role. (i.e., combining these two variables, one of which assumed the "right" direction, resulted in comparisons that were <u>still</u> in the "wrong" direction.) Although the author did think the unexpected reactions to private-pay/Medicaid distinctions were worth further study, discussion of his perceptions of their potential importance shall be delayed until the final chapter.

With these choice-mechanism issues disposed of, the next issue was assessing the apparent results of the orientation alternatives available to patient/sponsor conflicts. As discussed in Chapter II, the perceptions/satisfactions emanating from patient/sponsor orientations

TABLE 12

RESPONSE TO ADMINISTRATOR VS. PATIENT AND/OR SPONSOR CONFLICTS BY PATIENT IDENTIFICATION COMBINED WITH ADMINISTRATOR COMMITMENT TO HEALTH CARE PROFESSIONAL ROLE-- EXTREME CASES ONLY
(From Administrator Questionnaire)

Alternative	Patient I.D./ Administrator Commitment to Health Care∞	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Hypothesized Direction at Mann-Whitney Confidence Level of:
Case Two (Sponsor and patient want patient hand-fed; home refuses)										
2a Hand feed evening meal only	Pvt./LTACR		1	3	2	5	5		3.625	
	Med./TACR		7	15	13	6	8		2.857	(.03)**
2b Let sponsor hand feed patient when present	Pvt./LTACR		3	8	1	-	4		2.625	
	Med./TACR		11	13	8	9	8		2.796	.34
2c If above not acceptable, hand feed patient anyway	Pvt./LTACR		-	2	2	5	7		4.063	
	Med./TACR		4	6	3	9	27		4.00	(.39)
Case Four (Patient won't use cane, has been restrained; family and patient object)										
4a No restraints on night following use of cane	Pvt./LTACR		4	6	2	1	3		2.563	
	Med./TACR		19	14	4	4	8		2.347	(.24)
4b "Last chance" trial period without restraint	Pvt./LTACR		1	6	2	3	4		3.188	
	Med./TACR		5	11	13	5	15		3.286	.38
4c More inclined to the above if withdrawal	Pvt./LTACR		1	-	1	6	8		4.250	
	Med./TACR		4	2	8	4	31		4.143	(.41)

TABLE 12 (cont'd.)

Alternative	Patient I.D./ Administrator Commitment to Health Care∞	DY*	1	2	3	4	5	DN*	Mean	Response Pattern In/(Not In) Hypothesized Direction at Mann-Whitney Confidence Level of:
Case Six (Patient wants to use wheel chair she doesn't need in main dining room or be fed in her room)										
6a Let patient eat in room if walker used during day	Pvt./LTACR		2	8	2	2	2		2.625	
	Med./TACR		13	14	9	5	8		2.612	(.44)
6b Let patient take wheel chair in dining room if walker used during day	Pvt./LTACR		-	3	1	5	7		4.00	
	Med./TACR		-	4	4	13	21		3.755	(.35)
6c If above unacceptable, let patient use wheel chair in dining room	Pvt./LTACR		-	2	1	5	8		4.188	
	Med./TACR		5	4	4	9	27		4.000	(.25)

∞ Total Administrator Commitment to Health Care Professional Role (TACR)--5e = 1; Less Than Total Administrator Commitment to Health Care Professional Role (LTACR)--5e >1

* Definitely Yes = patient/sponsor oriented, Definitely No = administrator oriented

**Null hypothesis of "no difference" may be rejected at proposed confidence level of .10

were to be evaluated by conducting interviews with patients and sponsors involved with homes representing the extremes of patient or sponsor orientation. Identifying homes belonging to the two categories was not difficult, but obtaining cooperation from the two types of homes chosen was so markedly different from one type to the other as to constitute an unexpected finding.

Comparative co-operation of patient-oriented and sponsor-oriented homes

Table 13 portrayed the comparative response of patient oriented and sponsor oriented homes to the HCAM request for co-operation in this research project. Remembering that the homes were asked to send HCAM a list of six lucid patients and ten co-operative sponsors, the two groups of homes actually co-operating appeared about equal in their compliance with the requests made. For the most part patient-oriented homes forwarded more than the requisite number of patient names while sponsor-oriented homes only provided the six requested. However, the sponsor-oriented homes provided more than the ten sponsor names requested, while such over-compliance was less uniform for the patient-oriented homes.

The real differences were to be found in both the proportion of homes within the two categories who submitted lists at all, as well as the degree of co-operation actually extended once the subject homes agreed to participate. As can be seen, all of the patient-oriented homes co-operated fully, while only five of the seven sponsor-oriented homes actually participated. Furthermore, of the sponsor-oriented homes

TABLE 13

COMPARATIVE RESPONSE OF PATIENT-ORIENTED AND SPONSOR-ORIENTED HOMES TO HCAM REQUEST FOR CO-OPERATION IN RESEARCH PROJECT

Home	Patients		Sponsors		Comments
	Received	Interviewed	Received	Interviewed	
Patient-Oriented Homes					
A	8	6	13	6	
B	6	6	6	4	
C	7	6	11	6	
D	6	6	9	3	
E	10	6	10	6	
F	6	6	10	6	
Total	43	36	59	31	
Sponsor-Oriented Homes					
1	6	6	12	6	
2	6	6	10	6	Sent list for wrong home first time
3	6	5	12	6	
4	6	6	10	6	
5	6	6	10	6	Sent wrong list (Medicaid instead of private-pay) first time, corrected with second
6	0	0	0	0	Said lists were sent (never received), said sent a copy (never received)
7	0	0	0	0	Administrator "never in", did not return HCAM calls
Total	30	29	54	30	

who agreed to participate, only three of the homes actually forwarded the requested material in the manner desired the first time.

To the author these differences hinted at an unexpected behavior differential which was manifested along orientation choice lines. Seemingly, the sponsor-oriented homes were much less anxious to admit outside researchers than were the patient-oriented homes. As shall be discussed in Chapter IV, the author does believe these indications of behavioral differentials should be investigated further. Given their apparent intensity (and the attendant reluctance of some homes to participate at all), he was grateful that enough homes were secured to enable him to test his hypotheses regarding the perceptions/satisfactions produced by varying orientations.

Detailed findings regarding patient/sponsor perception of nursing home orientation H_{3A} and H_{3B}

The author's evaluation of the perception of nursing home orientation was meant to test the following:

H_{3A} Patients in patient-oriented homes will perceive more attention to their needs (vs. those of their sponsors) than patients in sponsor-oriented homes.

H_{3B} Sponsors of patients in sponsor-oriented homes will perceive more attention to their needs (vs. those of their patients) than will sponsors of patients in patient-oriented homes.

The findings reflecting patient/sponsor perception of nursing home orientation were included in Table 14. As might have been expected, the majority of both the patients and sponsors perceived no difference between the nursing homes' attention to their needs and those of their

TABLE 14

PATIENT/SPONSOR PERCEPTION OF NURSING HOME ORIENTATION
(From Patient Interviews and Sponsor Telephone Interviews)

Response Difference	Question (10-5)	-3	-2	-1	0	+1	+2	+3			
New Code	Relatively more attention to sponsor needs	1	2	3	No Perceived Difference 4	5	6	7	Relatively more attention to patient needs	Average	Response Pattern In/ (Not In) Hypothesized Direction at Mann-Whitney Confidence Level of:
Patients											
Patient-oriented homes		0	0	1	31	4	0	0		4.08	
Sponsor-oriented homes		0	0	0	21	7	2	0		3.86	.16
Sponsors											
	Question (4-11)										
Patient-oriented homes		0	0	6	25	0	0	0		3.81	
Sponsor-oriented homes		0	2	7	21	0	0	0		3.63	.22

counterparts. However, the differences that were manifested (though not statistically significant) were in conformity with the directions proposed by H_{3A} and H_{3B}. Patients in patient-oriented homes did indicate that they perceived slightly more attention to patient needs (vs. sponsor needs) than did patients in sponsor-oriented homes. Likewise, sponsors of patients in sponsor-oriented homes did indicate perception of slightly more attention to sponsor needs (vs. those of patients) than did sponsors of patients in patient-oriented homes.

Because the Mann-Whitney test pertaining to the above two comparisons did not reject the null hypothesis of "no difference" at the chosen level of .10, the best the author could claim for H_{3A} and H_{3B} was that the findings were promising, but inconclusive. He thought part of the problem keeping his findings from statistical significance might be some sort of response set to the perception questions (which were, after all, related in meaning and wording). Such a set could keep the majority of respondents from indicating any difference at all in their replies to the paired questions producing the data tested. Accordingly, he hoped for somewhat better results in analyzing the satisfaction related findings which were the product of many inputs of a varied nature.

Detailed findings regarding patient satisfaction produced by nursing home orientation

H_{4A}

H_{4A} proposed the following:

H_{4A} Patients in sponsor-oriented homes are more dissatisfied with the nursing care provided than are patients in patient-oriented homes.

Table 15 arrayed the data gathered to test H_{4A}. Table 15 strengthened the author's earlier suspicions that nursing home administrators had probably chosen the most favorable patients for interviewing purposes as most of the ratings assigned were in the favorable portion of the rating scale. Still, some ratings were at the bottom end of satisfaction and, promisingly enough, these were only to be found among patients in sponsor-oriented homes. However, these were counterbalanced by a large number of other sponsor-oriented homes at the top end of the scale which produced averages indicating only very slight directional conformity with H_{4A}. Because the Mann-Whitney does not evaluate comparative means (which were included only to assist the reader in determining direction), but rather rankings, the author thought it might indicate greater significance than would otherwise be expected. As can be seen, such was the case, but the level of significance still did not meet the .10 confidence level proposed. Therefore, once again the best that could be said was that the findings relative to H_{4A} were promising but inconclusive.

The author thought the problem with H_{4A} might be conceptually similar to that of H_{3A} and H_{3B} in that the Pincus rating scale used to test H_{4A} produced just one solitary variable. Though based on many inputs, this variable could assume only one of five values. Because the sample was probably skewed toward the favorable end of the scale to begin with, the differentials needed to support the author's hypotheses could be present, but not indicated due to the limited sensitivity of the single application of the Pincus rating. Accordingly, he thought

TABLE 15

PATIENT SATISFACTION BY NURSING HOME ORIENTATION
(From Patient Interviews)

Patients in:	Satisfaction With the Home Rating							Mean	Response Pattern In/(Not in Hypothesized Direction at Mann-Whitney Confidence Level of:
	Very Dissatisfied	1	2	3	4	5	Very Satisfied		
Patient-Oriented Homes		0	0	5	18	13		4.22	
Sponsor-Oriented Homes		2	1	2	8	16		4.21	.19

better results might be available from the multi-faceted approach used to measure sponsor satisfaction with nursing home care.

Detailed findings regarding sponsor satisfaction produced by nursing home orientation (H_{4B})

H_{4B} Sponsors of patients in patient-oriented homes are more dissatisfied with the nursing care provided than are sponsors of patients in sponsor-oriented homes.

An examination of the data relevant to H_{4B} (Table 16) indicated that probing several issues related to nursing care did produce more striking differentials in the perceived quality/satisfaction attendant to that care. This time all but one of the comparisons manifested the hypothesized directions of greater sponsor dissatisfaction with the nursing care provided by patient oriented homes. Furthermore, two of the six "correct" differentials were statistically significant. Unfortunately, this was not enough to meet the decision rule (requiring four out of six "correct" comparisons) that was developed in Chapter II to assess H_{4B}. Disappointingly, the same "promising, but inconclusive" adjectives were appropriate for the data pertaining to H_{4B}.

As shall be discussed in the final chapter, this recurring theme of "promising, but inconclusive" results need not indicate that this study was a total failure. Rather, it may hint at the existence of a very real phenomenon (both inside and outside of nursing homes) that could be worthy of further research.

TABLE 16

ELEMENTS OF SPONSOR SATISFACTION WITH NURSING CARE BY NURSING HOME ORIENTATION
(From Sponsor Telephone Interviews)

Variable	Nursing Home Orientation	Response						Mean	Response Pattern In/(Not In) Hypothesized Direction at Mann-Whitney Confidence Level of:
		Very Satisfied	1	2	3	4	Very Dissatisfied		
Adequate number of staff	Patient		9	21	0	1		1.774	
	Sponsor		14	13	2	1		1.667	.20
Outside groups coming in to entertain	Patient		10	20	1	0		1.710	
	Sponsor		8	18	2	0		1.786	(.34)
General cleanliness of resident	Patient		13	16	2	0		1.645	
	Sponsor		23	6	1	0		1.267	.01**
Good food	Patient		12	15	3	1		1.774	
	Sponsor		15	12	3	0		1.60	.21
Cheerful atmosphere	Patient		9	21	1	0		1.742	
	Sponsor		12	17	1	0		1.633	.24
Kindly treatment of relative	Patient		13	16	2	0		1.645	
	Sponsor		20	10	0	0		1.333	.04**
Diversionary activities	Patient		8	22	1	0		1.774	
	Sponsor		11	14	2	0		1.667	.23

**Null hypothesis of "no difference" may be rejected at proposed confidence level of .10

CHAPTER IV

CONCLUSIONS, INSIGHTS, AND RECOMMENDATIONS

Introduction

Because of its exploratory nature, this research was intended to produce insights in three different areas. Its primary objective was to probe the suspected origins of dissatisfaction with nursing homes. However, the parallels between such homes and other surrogate situations suggested a potential for attaining a second objective by generalizing the findings of this project to those other surrogate relationships. Finally, in the process of conducting such an exploratory study, the author sought to test a number of different research techniques and so provide guidance for subsequent research (and researchers). This chapter shall discuss the implications of the findings (already detailed in chapter III) to each of these three topics. For the reader's convenience a verbal summary and graphic depiction (Figure 4.1) of the most relevant conclusions will first be introduced. This will be followed by a detailed presentation of the analysis that produced these conclusions. The limitations of these conclusions will also be introduced where appropriate. The final section shall detail the directions the author believes subsequent research should take.

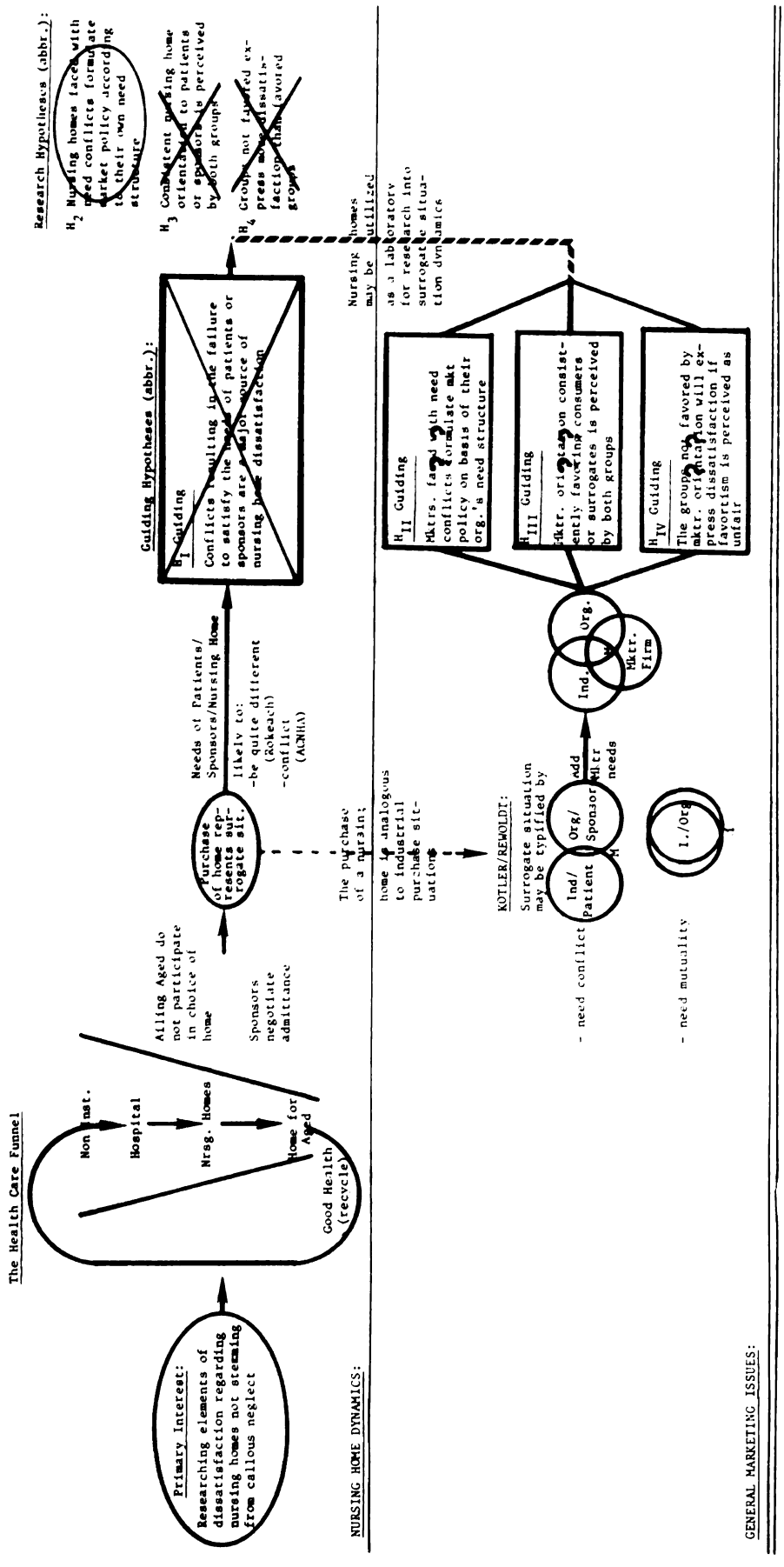


Figure 4.1--Summary of Conclusions

Summary of conclusions

The strong indications of "side-taking" (on both sides of surrogate disputes) evidenced by this study pointed to a good likelihood of even greater variation in orientation choice for less emotion laden situations.

The author's most positive conclusion was that H_2 relating nursing home orientation and nursing home need structures was tenable. In spite of some contradictory indications (of suspect validity) the evidence supporting this finding was powerful enough to warrant acceptance of H_2. Moreover, there was at least some indication that further research might permit generalization of the hypothesis.

No conclusion indicating patient/sponsor perception of nursing home orientation (H_3) could be reached. However, the directional emphasis of the data (which did take the hypothesized directions without attaining statistical significance) argued for a position that such perception might be present in other surrogate situations, and research in these areas might be fruitful.

It was not possible to conclude that nursing home orientation choice was linked to patient/sponsor dissatisfaction (H_4). The directional emphasis of the data (which supported H_4 without attaining statistical significance), indicated further analysis of the general relationship between marketer orientation and surrogate/consumer satisfaction might be promising. However, the complexity of surrogate/consumer relationships external to nursing homes made predictions about such research very difficult to formulate.

The failure of H_3 and H_4 mandated that H_I be rejected. The findings indicated that nursing home orientation in patient vs. sponsor conflicts was not a major source of dissatisfaction with nursing homes. However, the over-all directional emphasis of the author's data (which conformed to the predictions of the conflict model) pointed to other non-neglect related variables which could be the source of dissatisfaction with nursing homes, and should be studied further.

With regard to research techniques the author felt the surprisingly high response to his questionnaire indicated that securing association assistance was a good way to research the otherwise antagonistic individuals involved with nursing homes. He found the case approach to be a good mechanism for research orientation choice. The Pincus interview format was judged to be too subjective in application to provide a sensitive indicator of variation in

the perceived quality of nursing homes. Similar (though less intense) feelings were produced by usage of the Tomlinson interview instrument.

Variation in nursing home orientation choice

As discussed in Chapter III, before reaching any conclusions about nursing home/surrogate market behavior, the author first had to assume that variations in orientation choice existed. Given the environment facing the nursing home industry, such differences could have been lacking, but were shown to be present. The fact that side-taking was shown not to be uniform for nursing homes has powerful ramifications for marketing science.

Orientation variation in non-nursing home surrogate situations

If orientation choice can vary for nursing homes (despite apparently strong social pressures to the contrary), the amount of variation in other surrogate situations seems likely to be still greater, and worthy of further research. In the author's opinion, the best potential for further studies of similar orientation variation would probably be found in the industrial arena. In this lucrative market studies of whether or not industrial marketers faced with surrogate conflict situations also varied in their orientation seem likely to produce intriguing findings. This is doubly true in light of the author's conclusions linking orientation choice and need structure.

Conclusions about orientation choice and nursing home need structure

Originally, the author proposed the following hypothesis linking orientation choice and nursing home need structure:

> H_2 A nursing home confronted with conflicting needs of patients and sponsors will tend to satisfy the group whose satisfactions will best serve the nursing home's need structure.

The strongest findings of this research were produced by the author's exploration of the relationship proposed by H_2. The power of his findings linking strong commitment to the profit motive to greater sponsor orientation (in patient vs. sponsor conflicts) for private-pay (vs. Medicaid) patients produced a conclusion that H_2 was tenable. This position was taken despite unexpected indications that administrators were not similarly more oriented to patient/sponsor concerns (in administrator vs. patient and/or sponsor conflicts) when private-pay patients were involved (vs. Medicaid patients). The importance of the administrator vs. patient and/or sponsor findings was thought to be diminished by the somewhat shaky validity of the questionnaire on this point and the possibility that the original assumptions about Medicaid/private-pay behavioral distinctions might actually be opposite to those proposed for such conflicts.

The author realized that the power of his conclusion regarding H_2 was severely limited by the single operational hypothesis utilized to produce it. He felt much additional research would be necessary before it could ever be considered very powerful. Subsequent studies of this issue in nursing homes would need to determine whether

duplications of this project with other nursing home samples chosen on a more random basis would evidence similar results. Further, before much confidence could be placed in H_2 the factors producing the contradictory findings in the area of administrator vs. patient and/or sponsor conflicts would have to be explored. Studies in this area would have to conclusively determine whether the problem was with the author's instrument or his assumptions about private-pay vs. Medicaid revenue distinctions in such cases. An equal number of unanswered questions were felt to be present in non-nursing home areas.

Orientation choice in non-nursing home surrogate situations

By testing H_2, the author hoped to gain insights about the following:

H_{II} Guiding — A marketer confronted with a surrogate purchase situation containing conflicting needs of consumers and surrogates will formulate actions that best satisfy the need structure of the marketing organization.

In general, the author saw no reason why the conclusions of H_2 could not be extended to non-nursing home areas. This position clearly indicated that further research into the relationship between orientation choice and marketer need structure could be very promising.

Once again, the author felt the industrial area offered a particularly interesting area for such research. If variations in industrial marketer orientation were shown to be present by the research already recommended, linking that orientation to marketer need structure could have powerful strategic implications. In the author's opinion, some of the main problems facing such research would be the definition

and classification of marketer need structures, as well as determination of the impact produced by "outside" variables (the state of the economy, the competitive nature of the market, etc.). Similar difficulties with outside variables might attend the study of orientation choice in consumer settings.

Duplicating the author's study of orientation choice in the consumer surrogate situations proposed by Hollander might produce interesting findings. But, before these could ever be considered very conclusive, research into external imposition of orientation choice would be in order. (i.e., in situations, such as the doctor-patient relationship where one party is known to be all powerful, do marketer need structures cause any differences in the degree of side-taking, or is it uniform?)

Conclusions about patient/ sponsor perception of orientation choice

In regard to the perception of nursing home orientation choice, the author had proposed the following:

> H_3 Nursing home orientation consistently favoring the needs of patients or sponsors in situations involving need conflicts between these two groups is eventually perceived by both groups indigenous to the situation.

Because neither sponsors nor patients indicated the perception of nursing home orientation at statistically significant levels, H_3 could not be supported. However, the directional emphasis of the author's data (which had been in conformity with his operational

hypotheses) hinted that such perception just might be present in other surrogate settings, as discussed in the following section.

Perception of orientation choice in non-nursing home settings

H_{III} Guiding Market orientation favoring the needs of either consumers or surrogates in a surrogate market situation is eventually perceived by both groups indigenous to that situation.

Although the failure to find definitive support for H_3 within nursing homes precluded the possibility of acceptance of H_{III} Guiding, the author felt his findings might possibly indicate that such perception of marketer orientation could very well be present in other "typical" surrogate situations. Whether or not such perceptions of marketer orientation might be present at levels sufficient to support H_{III} Guiding could depend upon the surrogate situation involved.

Certainly, for the interior decorators or "professional shoppers" studied by Hollander the whole issue of perceived marketer orientation appears to be a moot point. Because such surrogate relations would be entered into (and maintained) at the sole discretion of the consumer, the author is unable to imagine any reason why such a consumer would long tolerate any situation distinctly unfavorable to him. Therefore, for such "shoppers" all of the related consumer/surrogate conflict issues would seem to be irrelevant. Similar conclusions can be reached for most other surrogate situations (even those involving recommenders and diagnosticians). Presumably, if a consumer knew so little about an area that he had to rely upon a professional, the

chances of his perceiving marketer orientation to surrogate needs he did not understand seems somewhat unlikely.

However, for the industrial surrogate situations discussed by Kotler, et al., just the opposite would appear to be true. Industrial surrogate situations are distinguished by the fact that they are somewhat non-voluntary and comparatively continuing in nature. Under such conditions the likelihood of industrial perception of marketer orientation appears good. Whether or not the chances of orientation perception would be greater for industrial surrogate situations than for nursing homes is certainly debatable. Although industrial and nursing home surrogate situations are analogous, a strong argument was made in the first chapter for a position that the concentrated nature of the nursing home purchase (i.e., all elements are present within the nursing home at one time) would lead to a relatively greater likelihood of nursing home orientation perception. However, an equally convincing argument in the opposite direction does exist. As already discussed, sponsors were expected to (at least consciously) place patient needs somewhat superior to their own. This could lead to suppression of indications that nursing homes were paying more attention to their own needs than those of patients (although, in retrospect, the author found little to indicate this was true). Furthermore, patients and sponsors would have relatively little knowledge about "typical" nursing home operations and so would have no comparative basis to use in assessing orientation. Such would not be the case for industrial surrogate situations. The greater market knowledge available to industrial surrogates and consumers, the continuing nature of the industrial market

(with its attendant "grape vines," etc.), and the presumed sophistication of those involved could all mandate a greater likelihood of industrial marketer orientation being perceived than was the case for nursing homes.

The author was in no position to determine which of the preceding arguments might be true. He did feel that the encouraging results of his own experiment did argue for research into these issues. However, as shall be discussed in the following section, the likelihood (and importance) of industrial perception of marketer orientation could be submerged or amplified by a number of other variables related to satisfaction. Accordingly, suggestions for research into the perception of industrial marketer orientation will not be discussed here until after the complete research problem has been outlined.

Conclusions regarding patient/sponsor satisfaction resulting from orientation choice

The author had proposed the following hypothesis relating patient/sponsor satisfaction to orientation choice:

> H_4 Marketers of long term nursing care faced with conflicting needs of patients and sponsors create dissatisfaction on the part of one of these groups when the needs of the other are favored as this favoritism is perceived as unfair.

As was the case with perception, the satisfaction related data assumed directional emphasis that would have supported H_4 but statistical significance was lacking, so the results were, at best, inconclusive. Nevertheless extension of the findings to broader areas might be possible.

Satisfaction emanating from orientation choice in non-nursing home settings

Hoping to be able to generalize from the findings of his research, the author had proposed the following:

> H_{IV} Guiding In a surrogate purchase situation containing conflicting needs, the group not favored by marketer orientation will express greater dissatisfaction with the purchase involved than the favored groups if the favoritism is perceived as unfair.

The failure to obtain clear support for H_4 does not necessarily mean that H_{IV} Guiding should be totally rejected. As discussed earlier, the relative insensitivity of the Pincus instrument could have been responsible for the failure to attain statistical significance with the patient dimensions considered. Furthermore, depending upon the surrogate situations involved, the promising nature of the directional differences that were exhibited could hint at stronger satisfaction related findings that might be available in other surrogate areas.

Any future attempt to research satisfaction related dimensions of conflict in surrogate market situations might properly exclude the Hollander surrogates for the reasons already discussed. Whether or not the promising indications contributed by nursing homes would likely be duplicated by more powerful findings in industrial surrogate situations would probably depend upon three issues--perception of orientation, the importance of the orientation manifested to those involved, and the alternatives available to those affected by the orientation chosen.

Though not previously researched, a logical assumption would be that clearly perceived marketer orientations would be more powerful

in influencing satisfaction than those which were not. If industrial surrogates and consumers perceived marketer orientation more clearly than those involved with nursing homes, more powerful results could be expected from industrial surrogate situations than had been the case for nursing homes. Thus, the further research suggested by the previous section appears doubly important.

Should industrial surrogate "actors" be found to perceive marketer orientation more distinctly, the satisfaction related effects of such perception might hinge upon how important the identified orientation was to those who were affected by it. Nursing homes constitute virtually the entire life of the residents they serve. Therefore the importance of their actions to the patient-consumers involved must be considered at least as great or greater than the significance of the gifts/entertainment/etc. produced by industrial marketer orientation are to the purchasing agents and the firms they represent. Accordingly, whether or not the satisfaction opinions influenced by industrial marketer orientation would be more intense than those encountered within nursing homes could depend upon the combination of these perceptions and importance-of-orientation variables. But, even if the indications of dissatisfaction produced by unfavorable industrial marketer orientation were found to be less intense, their importance to industrial markets might conceivably <u>be greater</u> than was the case for the marketers of long term nursing care. This seemingly inconsistent premise is based upon the responses available to the surrogates/consumers involved.

Within broad limitations the patients and sponsors affected by nursing home orientation have little alternative but to disparage

the home serving them when it doesn't cater to their needs. True, in unbearable situations the patient could switch homes or complaints be made to the health authorities, but the nursing homes contacted indicated that the former action was seldom taken and the latter occurred only in extreme cases.[1] The options available to industrial situations are much more numerous and (from the marketer's viewpoint) more powerful.

Because industrial surrogates choose from apparent equals, even small differences in their personal feelings toward a supplier could produce large differences in the relative amount of business allocated. Of course, the ability of the surrogate to exercise this power to force orientation favorable to himself would be constrained by his relationship with the consuming firm he represents. Unlike the patient/sponsor situation, industrial consumers can terminate their attachment to any unsatisfactory surrogate with relatively little difficulty. On the other hand, they might be reluctant to do so because of the time and expense involved with training a replacement (who might do the same thing).

Just how all of the preceding influences might "sort out" is not clear. In the author's opinion, the findings of his operational hypotheses (though not statistically powerful enough to support his research hypotheses) suggest that further research into the dynamics

---

[1] It is virtually impossible for a patient to check himself out and sponsors are reluctant to make such a move as it involves considerable effort on their part. In regard to complaints, the author wonders how effective patients (who are often considered to be a senile lot, anyway) would be in effecting action from the proper authorities. Furthermore, both patients and sponsors could be constrained from registering formal complaints for fear of retaliation.

of industrial surrogate behavior might be rewarding. Such research would have to investigate the various combinations and permutations of the following:

-Do industrial surrogates and industrial consumers perceive marketer orientation? (And, if so, how strongly?)
-If perceived, how important is this orientation to the consumers/surrogates involved. (Is it resented, considered a fact of life, etc.)
-What consumer/surrogate actions stem from orientation choice? (i.e., sale implications, policy restrictions, etc.)

Hopefully, research into these issues might produce more conclusive evidence than the author could obtain about the origins of dissatisfaction with nursing homes.

Conclusions about the true source of dissatisfaction with nursing care

In the beginning the author hypothesized the following:

H_I Guiding Marketers of long term nursing care seeking to provide services to patients who have interested sponsors are faced with a surrogate purchase situation containing conflicting sets of needs. Among these needs are those of the sponsor, those of the patient, and those of the marketing organization. Conflicts resulting in the failure to serve the needs of the patient, his sponsor, or both are a major contributor of dissatisfaction among patients and sponsors that is more or less inevitable.

In light of the failure to support the hypotheses leading up to H_I Guiding, this hypothesis was rejected. Although the long term nursing care market did appear to represent a surrogate situation with conflicting needs, the available evidence, though in conformity with the spirit of H_I Guiding, did not indicate that patient vs. sponsor conflict was ". . . a major contributor of dissatisfaction among patients and sponsors. . . ." The author's feelings about this

conclusion (and the facts used to reach it) were somewhat mixed. Because the directional emphasis of his data was in accordance with the hypothesis (even though not at a level of statistical validity), he examined several simple explanations for the failure to attain statistical significance.

The author thought one methodological explanation for his disappointing results in the area of satisfaction might rest on the relatively small size of his sample of patients and sponsors. Possibly, had more patients and sponsors been contacted, they would have responded in the same proportions as his smaller sample and produced stronger findings. However, the indicated significance of his findings was so low that an extremely large sample (responding in approximately the same proportions) would be required before the data could be regarded as conclusive at the .10 level.

The author believed that the problems introduced by the small size of his sample of patients and sponsors were probably compounded by the instruments he used. As discussed in earlier chapters, the author had real apprehensions about utilizing the Pincus instrument with a small sample that was probably skewed towards the favorable side from the beginning. Apparently, these fears were well founded. Though the non-random nature of the sample was unavoidable, the subjective nature of the Pincus instrument made fine distinctions in satisfaction difficult to obtain. The fact that this instrument produced such disappointing results, even when applied by professional interviewers, argues for a position that any subsequent researchers might well view its use with caution. This position is strengthened by the fact that some

distinctions of the type posited by the author were produced by the somewhat less subjective Tomlinson interview. However, the author was not totally pleased even with the Tomlinson instrument. It, too, required very subjective opinions and observations. Doubtless, it could be improved by tying evaluations to more quantitative measurements of the same variables (e.g., what percent of the patients you have interacted with would probably rate the food as satisfactory, etc.).

If this research project were duplicated with a random sample (in itself a real problem due to illness of patients, etc.) and more sensitive instruments, the author believes that support for his initial guiding hypothesis might possibly be found. However, in comparing the expense involved to the honest probability of success, it appears that further research effort would better be directed at some associated areas. Because of this project, a number of insights into what shape such subsequent research should take are apparent.

Insights/recommendations for further research

The insights generated which would be of interest to subsequent research were centered in two main areas, research techniques, and promising indications for further research. In regard to research techniques, the author thought his case-centered questionnaire approach represented a useful contribution to anyone researching the area of surrogate market orientation. The author's experience suggested that the thorniest problem associated with such an instrument was the assessment of its validity. His only advice to others who might wish to use similar techniques would be to make sure the case materials chosen are

as true to life as possible. Not only does this contribute to the face validity of the instrument, but also it probably increases the response rate.

The favorable quantitative and qualitative response to the author's questionnaire by a population difficult to research (at best) implied that the interest generated by "real-life" problems could be an effective motivator to combat sample non-response. Of course, as previously discussed, evaluating the power of this interest factor was complicated by the presence of another contributor to questionnaire response, the assistance of HCAM.

In the author's opinion anyone wishing to research the nursing home industry should seriously consider first securing the cooperation of the local professional associations. Because of the pressures threatening the industry such associations appear to have become particularly powerful. These same pressures seem to contribute to the industry's antagonism to outside research. So, the best way to research issues requiring a reasonably representative sample of homes would probably be to involve the relevant associations. In the author's case, the Michigan associations proved most cooperative (even before the issues to be researched were fully formulated). The only precondition insisted upon was a genuinely unbiased approach to the issues being investigated. For most scientific research such a requirement should not be much of a problem. (If it is, the researcher should probably question his motives for doing the research.)[2]

As discussed in the preceding section, the author was less than pleased with the Pincus and Tomlinson instruments. Their subjective nature makes determination of finite distinctions difficult. Given the lack of prior research into nursing homes, expediency may dictate using these available tools instead of developing new ones. However, future researchers should be forewarned of their deficiencies.

Beyond development of the tools necessary for conducting research, the next issue becomes what direction such research should take. The findings of this project suggested further research into two different areas might be promising. The most general of these was in the area of industrial surrogate market dynamics. As discussed more fully in the preceding sections, the following areas appear promising:

- -Study of whether variation in marketer orientation is present in industrial surrogate/consumer conflict situations,
- -Further analysis of the relationship between industrial marketer orientation and organizational need structure,
- -Research into whether or not industrial marketer orientation is perceived by the consumers and surrogates involved,
- -Further study of the market implications of industrial marketer orientation choice.

Turning the focus back toward nursing homes, the author believes the reason greater patient/sponsor orientation (for administrator vs. patient and/or sponsor conflicts) was unexpectedly indicated for Medicaid patients should be probed further. The problem could have been the validity of the questionnaire on these issues, but the author is not certain that such was the case. Had validity been the problem,

he would have expected a more indeterminate pattern to emerge. The fact that the pattern indicated administrators were more willing to give up their perogatives with Medicaid patients could have ominous implications. Because administrator perogatives could be equated with medical imperatives, the findings generated could imply that Medicaid patients actually receive care that is worse for them in a medical sense (despite the fact that it probably keeps them and their families happy) than private-pay patients. The possibility that one of the factors responsible for this strange situation could be over-zealous scrutiny of the industry is ironic. At any rate, the true reasons for this unexpected behavior should be studied.

Another unexpected finding apparently worthy of further research was that obtained from comparing the cooperation extended by patient-oriented and sponsor-oriented homes. The sponsor-oriented homes seemed so defensive as to cause the author to wonder whether their activities should be monitored further.

The author did believe that one element (the satisfaction related dynamics of conflict) leading to his original guiding hypothesis could and should be studied further. Although the satisfaction differences manifested by this project were not statistically significant, their directions were in accordance with those hypothesized by the Miller analysis of conflict. During the course of this project, the author has come to suspect that patient vs. sponsor and administrator vs. patient and/or sponsor conflicts may not be the most powerful ones present within the nursing home. In his opinion, the most troublesome conflict within nursing homes may be that involving the servicing of

patients (and their attendant sponsors) who really didn't want to come there in the first place. Certainly, the negative implications of aged institutionalization (discussed in Chapter I) indicate that most patients would prefer not to be admitted. Furthermore, the power of sponsor guilt produced by placing a patient in a home would support a strong argument that sponsor involvement with nursing homes is involuntary.

As such, the foundation for a powerful patient/sponsor conflict regarding nursing homes appears to be laid. This conflict is not between patients and sponsors or even patients/sponsors against the home. The real conflict is between the patients/sponsors and the circumstances that forced the admission to this "dreaded" institution. Because of the powerful emotions involved, striking out at the only available target, the nursing home, appears logical (particularly when criticism of nursing homes seems so socially acceptable). In light of these considerations the author is convinced that a study comparing the relative satisfactions of patient/sponsors who wanted to come to the home with those of patients/sponsors who didn't want to should be made. Although such a study would have more than a few methodological problems (patients who didn't want to come would probably be more sickly, etc.), the indications are that it would be feasible. The fact that approximately one-third of the patients admit themselves indicates that enough of the "wanted to come" (or at least "didn't not want to come") variety would be available to conduct an experiment. The fact that two-thirds of the patients were admitted by others (and so might belong to the "didn't want to come" category) indicates that enough situations to

test the other side would be available. It also implies that this source of dissatisfaction, if shown to be present, could be a non-neglect related variable powerful enough to be responsible for much of the dissatisfaction with nursing homes.

Should this "conflict effect" be shown to be present in nursing homes, investigation of its impact could be shifted to other areas of marketing where consumers are overruled by circumstances they cannot control. Indeed, this variable might be found to explain some of the dissatisfaction seemingly inherent to such non-consumer controlled markets as hospitals, utilities, the oil companies, and (biggest of all) government services. If so, such a finding would make a real contribution not only to the marketing literature, but also to other social sciences which have been borrowed from (without return exchange) for much too long. As such it is certainly worth pursuing.

APPENDIX A

INTERVIEWS WITH OFFICERS OF MICHIGAN CHAPTER OF AMERICAN COLLEGE OF NURSING HOME ADMINISTRATORS (ACNHA)

APPENDIX A

INTERVIEWS WITH OFFICERS OF MICHIGAN CHAPTER OF AMERICAN COLLEGE OF NURSING HOME ADMINISTRATORS (ACNHA)

Date of Interview	Location	Name	Title (ACNHA)
March 13, 1974	Grandville, MI	Mr. Robert Dreyer	President
Feb. 5, 1974	Coldwater, MI	Mr. Harold Creal	President-elect
March 14, 1975	Benton Harbor, MI	Mrs. Ranee Clayton	Vice President
March 7, 1975	Grand Blanc, MI	Mr. Dale Pelton	Treasurer

APPENDIX B

PRETEST ADMINISTRATOR QUESTIONNAIRE

ADMINISTRATOR QUESTIONNAIRE

NOTICE: All information which would permit identification of the individual or his place of employment will be held in strict confidence, will be used only by persons engaged in and for the purposes of this survey, and will not be disclosed or related to others for any purposes.

The Health Care Association of Michigan is conducting a statewide survey of its members to develop information about how administrators perceive the best ways to do their job. Your answers will be given confidential treatment, the information will be used for statistical purposes only, and will be presented in such a manner that no individual person or establishment can be identified.

Thank you for your cooperation

---

1. How long have you been the administrator:

   a. in this facility? (no. of years) _____

   b. in other nursing homes, homes for the aged, or similar facilities? (no. of years) _____

   c. in hospitals? (no. of years) _____

2. Which of the following professional degrees, licenses, or association registrations do you have? (Mark all that apply)

   _____ Physician (M.D.)
   _____ Physician (D.O.)
   _____ Bachelor's or master's in business administration (BS/BBA/MBA)
   _____ Registered Nurse (R.N.)
   _____ Licensed Practical or Vocational Nurse (L.P.N. or L.V.N.)
   _____ Registered Physical Therapist (R.P.T.)
   _____ Registered Occupational Therapist (O.T.R.)
   _____ Other professional degree, license, or association registration (specify) _____
   _____ None of the above

3. What type of facility are you now managing: (check the appropriate box)

   _____ Proprietary
   _____ Non-profit/charitable
   _____ County health care facility

4. If you are administering a proprietary nursing home, are you the full or partial owner? (check one)

   _____ Yes _____ No

Administrator Opinions:

Instructions: The following questions are based on a scale of (1) to (5). These numbers match a semantic scale spanning two extreme opinions, such as "Very Important" and "Very Unimportant." Assume that a question were to ask:

_____ How important is being well liked by local businessmen to your activities as an administrator?

Very Important _____ Very Unimportant
1 2 3 4 5

Referring to the above scale you would place a "1" in the blank if you thought this factor very important, "5" if you thought it very unimportant, "3" if you felt neutral about it, "2" if you thought it somewhat important, and "4" if you thought it almost unimportant.

5. In the operation of your nursing home, how important are the following goals? Very Important _____ Very Unimportant
1 2 3 4 5

____ a. The generation of profit (or financial solvency for non-profit homes).
____ b. Being well liked by patients.
____ c. Being thought of as an able health care professional by colleagues.
____ d. Being well liked by staff.
____ e. Being professionally satisfied by all actions taken by myself or my staff.

Administrative Dilemmas:

Introduction:

Frequently, nursing home administrators may be faced with situations in which their actions are bound to displease someone no matter what they do. As our industry is relatively new, there often seem to be no clear-cut guidelines as to what actions should be taken. A number of such dilemmas are described below, and we are interested in how you would resolve them.

Although these may or may not be situations which you have personally encountered, please lend us your expertise by reporting your feelings about the various solutions posed.

Instructions: A number of administrative dilemmas are briefly outlined in the remainder of this questionnaire. After each dilemma a number of alternative actions which an administrator might take are suggested. You are to report whether or not you think you would take the action suggested by utilizing a semantic scale of Definitely Yes/Definitely No in much the same fashion as the previous questions.

EXAMPLE:

Myrna L. is an 81 year old private pay patient of the "B" nursing home. She is white, and spent most of her life in Alabama. Recently Becky W., a black 85 year old from Chicago, became Myrna's new roommate. The two did not get along from the start and Myrna has demanded that she be assigned a new room herself, or be given a new roommate.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ a. Would you try to "stall" Myrna, hoping time might resolve the differences?
_____ b. Would you move Myrna into a new room?
_____ c. Would you move Becky into another room and get Myrna a new roommate?

Referring to the above scale, you would place a "1" in the blank opposite the question if you definitely would, "5" if you definitely would not, "3" if you were undecided, "2" if you probably would, and "4" if you probably would not.

PLEASE RESPOND TO THE FOLLOWING CASES IN THE SAME MANNER AS THE PRECEDING.

Memo: For many of the following cases, both sponsors and patients are mentioned. For the purposes of this questionnaire, sponsors are those responsible parties who negotiate a patient's admittance and are designated as the first to be called should an emergency arise. For all the situations mentioned below it is to be assumed that the sponsor is interested enough that he calls on the patient at least twice a month. All patients discussed are to be assumed to be long-term residents who will stay in the home until their condition becomes terminal. Any additional information needed is contained in the body of the cases.

Case One

Sara M. is a 68-year-old resident of the X nursing home. She is mentally alert and in good physical condition for her age. Lately, James L. a 71-year-old widower who was admitted to the home as a private pay patient after a mild stroke which left him only minimally impaired physically, has developed an interest in Sara. Sara and James have been seen visiting each other's rooms and holding hands. Mr. L's sponsor observed this and became very upset. He has repeatedly demanded that the home "break-up" this budding romance, and your attempt to disuade him has failed.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 1a. Would you "passively" try to keep Sara and James apart by arranging activities for them at different times and/or places.

_____ 1b. Would you "actively" try to break up this romance by instructing your staff not to allow Sara and James to hold hands or be alone together, etc.

_____ 1c. If Mr. L. threatened to withdraw James from your home if you did not "do something," would your answers to either of the above change?

Case Two

Jenny P. was admitted to the home as a private pay patient after a mild stroke which left her unable to live in her old apartment. Her sponsor (who is her daughter) is extremely guilty about her inability to take Jenny into her own home. Jenny, who has some mild tremor in her hands, has decided that she cannot feed herself (and, in fact, usually does spill some food on her clothes when she tries). However, she can get the job done with some prodding.

Jenny's sponsor has demanded that you hand feed Jenny even though in your opinion she does not need it. You have explained this to Jenny and her sponsor, but both remain adamant.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 2a. Would you be willing to propose a compromise in which Jenny was hand fed one of her meals (perhaps evening) so that she would look better for visitors?

_____ 2b. Would you be willing to propose a compromise in which Jenny was hand fed by her sponsor whenever she had the time and had to go it her own at all other times?

_____ 2c. If none of the above were acceptable, would you go ahead and hand feed Jenny?

Case Three

Georgia X is a widow who was admitted to the nursing home as a private pay patient when it was found she could no longer live by herself. Her physical condition is not bad for her age (seventy-nine), and her mental condition is fairly alert. Her sponsor is her eldest son (one of two) who resides in an adjoining town. Her sponsor detests his younger brother, Tom, who is a merchant seaman and is only infrequently in the area. For whatever reasons (no good ones you know of) Georgia's sponsor has left explicit orders that she is not to leave the nursing home with anyone other than himself. He has explicitly stated that under no circumstances is she to be allowed to go out with Tom. Suddenly, Tom shows up and wants to take his mother out for an ice cream cone. She states that she would like to go with him.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 3a. Would you call Georgia's sponsor and try to get him to let Georgia go?

_____ 3b. If you did call and you could not reach the sponsor, would you let Georgia go?

_____ 3c. If you did call, did reach the sponsor, and he still refused to allow her to go, would you let Georgia go (assuming you saw no reasons not to let her)?

Case Four

Ed L. is an eighty-one-year-old private pay patient who was admitted to the home after a hip fracture. The operation to repair this fracture left his walking somewhat shaky unless he uses a cane (which he detests). His mental condition is sometimes confused, but the one thing he is always sure of is that he does not want to use that cane. The nursing home staff is able to make Ed use his cane during the day, but at night he will frequently get up to go to the bathroom and "forget" it. He has been told to either use his cane or call for assistance, but he frequently does not do this. The staff has tried raising the rails on his bed, but he just climbs over them. Twice he has fallen at night and not been hurt. Finally, it is decided to put a restraint on him at night to keep him in bed. He objects violently to this and his sponsors demand that you not leave it on him even though its purpose has been made clear to them. Doctor's orders are to use restraints as required.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 4a. Would you be willing to propose a compromise in which Ed was allowed to remain without restraints following any night in which he used his cane or asked assistance?

_____ 4b. Would you be willing to agree to one short trial period without the restraint to give Ed "one last chance" (if he ever failed to use the cane, he would have to be restrained for good)?

_____ 4c. If Ed's sponsors were willing to sign a document absolving the nursing home of all responsibility for any injury arising from his not being restrained, would you agree to not restrain him?

Case Five

Vicky M. is a seventy-six-year-old private pay patient of the "Y" nursing home. Her physical and mental condition are generally good. She receives a small allowance from her sponsor to pay for personal items. The "Y" nursing home has just secured the services of a professional beautician who comes in once a week to serve the patients. Her fees, though modest, are not included in the patients' normal rates and must be charged to them or their sponsors as additional. Vicky's rommate has her hair done by the beautician and now Vicky wants it, too. She has asked her sponsor (her nephew) for the additional money, but he has steadfastly refused to give it to her. Vicky has asked the administrator of the "Y" home to try to "force" her sponsor to give her this extra money.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 5a. Would you talk to Vicky's sponsor in an attempt to persuade him to let Vicky have the extra money to see the beautician once a week?

_____ 5b. If the above were tried and failed, would you try to work out a compromise with her sponsor in which Vicky got enough extra money from him to see the beautician at least once every other week?

_____ 5c. If none of the above worked, and Vicky thought this issue important enough to be very unhappy about it, would you be willing to "force" Vicky's sponsor by telling him to either give her the money or remove her from your institution?

Case Six

Shirley O. was admitted to the "Z" nursing home as a private pay patient after an operation to repair a hip fracture (her second). Her mental condition is borderline senile. After her second operation Shirley decided she could not get around without a wheel chair even though her doctor says that she probably could (and should) walk with a walker. The "Z" nursing home has two dining rooms. In the main dining area no wheel chairs are ever allowed, as this is where the ablest patients dine. Upon her arrival Shirley wheeled herself to this area (where her friends were) and was told she could not go in except with her walker. She then demanded to be fed in her room, but was told she did not need this and it was the main area or nothing. She then got out of the wheel chair and sat on the door to the main area crying piteously. Her sponsors came in at this very moment and were enraged. Even after they were told the reasons behind the nursing home's actions they demanded that Shirley be allowed to eat in the main area with her wheel chair or be fed in her room.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 6a. Would you be willing to propose a compromise that would allow Shirley to eat in her room if she had used her walker at some other times during the day?

_____ 6b. Would you be willing to propose a compromise that would allow Shirley to take her wheel chair into the main dining room if she had used her walker at some other times during the day?

_____ 6c. If for some reason the above were unacceptable to Shirley, her sponsors, or yourself, would you agree to allow Shirley to take her wheel chair into the main dining area?

APPENDIX D

FINAL ADMINISTRATOR QUESTIONNAIRE
(Private-Pay Version)

ADMINISTRATOR QUESTIONNAIRE

NOTICE: All information which would permit identification of the individual or his place of employment will be held in strict confidence, will be used only by persons engaged in and for the purposes of this survey, and will not be disclosed or related to others for any purposes.

The Health Care Association of Michigan is conducting a statewide survey of its members to develop information about how administrators perceive the best ways to do their job. Your answers will be given confidential treatment; the information will be used for statistical purposes only and will be presented in such a manner that no individual person or establishment can be identified.

Thank you for your cooperation.

---

1. How long have you been the administrator:

   a. in this facility? (no. of years) _____

   b. in other nursing homes, homes for the aged, or similar facilities? (no. of years) _____

   c. in hospitals? (no. of years) _____

2. Which of the following professional degrees, licenses, or association registrations do you have? (Mark all that apply)

   _____ Physician (M.D.)
   _____ Physician (D.O.)
   _____ Bachelor's or Master's in business administration (BS/BBA/MBA)
   _____ Registered Nurse (R.N.)
   _____ Licensed Practical or Vocational Nurse (L.P.N. or L.V.N.)
   _____ Registered Physical Therapist (R.P.T.)
   _____ Registered Occupational Therapist (O.T.R.)
   _____ Other professional degree, license, or association registration (Specify) _____
   _____ None of the above

3. What type of facility are you now managing? (Check the appropriate box)

   _____ Proprietary
   _____ Non-profit/charitable
   _____ County health care facility

4. If you are administering a proprietary nursing home, are you the full or partial owner? (Check one)

   _____ Yes _____ No

Administrator Opinions:

Instructions: The following questions are based on a scale of (1) to (5). These numbers match a semantic scale spanning two extreme opinions, such as "Very Important" and "Very Unimportant." Assume that a question were to ask:

_____ How important is being well liked by local businessmen to your activities as an administrator?

Very Important _____ Very Unimportant
1 2 3 4 5

Referring to the above scale you would place a "1" in the blank if you thought this factor very important, "5" if you thought it very unimportant, "3" if you felt neutral about it, "2" if you thought it somewhat important, and "4" if you thought it almost unimportant.

5. In the operation of your nursing home, how important are the following goals?
Very Important _____ Very Unimportant
1 2 3 4 5

_____ a. The generation of profit (or financial solvency for non-profit homes).

_____ b. Being well liked by patients.

_____ c. Being thought of as an able health care professional by colleagues.

_____ d. Being well liked by staff.

_____ e. Being professionally satisfied by all actions taken by myself or my staff.

Administrative Dilemmas:

Introduction:

Frequently, nursing home administrators may be faced with situations in which their actions are bound to displease someone no matter what they do. As our industry is relatively new, there often seem to be no clear-cut guidelines as to what actions should be taken. A number of such dilemmas are described below, and we are interested in how you would resolve them.

Although these may or may not be situations which you have personally encountered, please lend us your expertise by reporting your feelings about the various solutions posed.

Instructions: A number of administrative dilemmas are briefly outlined in the remainder of this questionnaire. After each dilemma a number of alternative actions which an administrator might take are suggested. You are to report whether or not you think you would take each action suggested by utilizing a semantic scale of Definitely Yes/Definitely No in much the same fashion as the previous questions.

EXAMPLE:

Myrna L. is an 81 year old private pay patient of the "B" nursing home. She is white, and spent most of her life in Alabama. Recently Becky W., a black 85 year old from Chicago, became Myrna's new roommate. The two did not get along from the start and Myrna has demanded that she be assigned a new room herself or be given a new roommate.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ a. Would you try to "stall" Myrna, hoping time might resolve the differences?

_____ b. Would you move Myrna into a new room?

_____ c. Would you move Becky into another room and get Myrna a new roommate?

Referring to the above scale, you would place a "1" in the blank opposite the question if you definitely would, "5" if you definitely would not, "3" if you were undecided, "2" if you probably would, and "4" if you probably would not. Although you would probably need more facts to reach an actual decision than those available, please give us your feelings on the basis of the information presented.

PLEASE RESPOND TO THE FOLLOWING CASES IN THE SAME MANNER AS THE PRECEDING, BEING SURE TO RESPOND TO EACH ALTERNATIVE ACTION PRESENTED.

Memo: For many of the following cases, both sponsors and patients are mentioned. For the purposes of this questionnaire, sponsors are those responsible parties who negotiate a patient's admittance and are designated as the first to be called should an emergency arise. For all the situations mentioned below it is to be assumed that the sponsor is interested enough that he calls on the patient at least twice a month. All patients discussed are to be assumed to be long-term residents who will stay in the home until their condition becomes terminal. Any additional information needed is contained in the body of the cases.

Case One

Sara M. is a 68-year-old resident of the X nursing home. She is mentally alert and in good physical condition for her age. Lately, James L., a 71-year-old widower who was admitted to the home as a private pay patient after a mild stroke which left him only minimally impaired physically, has

developed an interest in Sara. Sara and James have been seen visiting each other's rooms and holding hands. Mr. L's sponsor observed this and became very upset. He has repeatedly demanded that the home "break-up" this budding romance, and your attempt to dissuade him has failed.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 1a. Would you "passively" try to keep Sara and James apart by arranging activities for them at different times and/or places?
_____ 1b. Would you "actively" try to break up this romance by instructing your staff not to allow Sara and James to hold hands or be alone together, etc?
_____ 1c. Would you have been more likely to do either a or b had Mr. L's sponsor threatened to withdraw James from your home if you did not "do something"?

Case Two

Jenny P. was admitted to the home as a Medicaid patient after a mild stroke which left her unable to live in her old apartment. Her sponsor (who is her daughter) is extremely guilty about her inability to take Jenny into her own home. Jenny, who has some mild tremor in her hands, has decided that she cannot feed herself (and, in fact, usually does spill some food on her clothes when she tries). However, she can get the job done with some prodding.

Jenny's sponsor has demanded that you have Jenny hand fed even though in your opinion she does not need it. You have explained this to Jenny and her sponsor, but both remain adamant.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 2a. Would you be willing to agree to a compromise in which Jenny was hand fed one of her meals (perhaps evening) so that she would look better for visitors?
_____ 2b. Would you be willing to agree to a compromise in which Jenny was hand fed by her sponsor whenever she had the time and had to go it her own at all other times?
_____ 2c. If none of the above were acceptable, would you go ahead and have Jenny hand fed?

Case Three

Georgia X is a widow who was admitted to the nursing home as a Medicaid patient when it was found she could no longer live by herself. Her physical condition is not bad for her age (seventy-nine), and her mental condition is fairly alert. Her sponsor is her eldest son (one of two) who resides in an adjoining town. Her sponsor detests his younger brother, Tom, who is a merchant seaman and is only infrequently in the area. For whatever reasons (no good ones you know of) Georgia's sponsor has left explicit orders that she is not to leave the nursing home with anyone other than himself. He has explicitly stated that under no circumstances is she to be allowed to go out with Tom and has indicated he does not wish to discuss the matter further. Suddenly, Tom shows up and wants to take his mother out for an ice cream cone. She states that she would like to go with him.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 3a. Would you be willing to call Georgia's sponsor in an attempt to get him to let Georgia go even if you thought this might be highly irritating to him?
_____ 3b. If you did call and you could not reach the sponsor, would you let Georgia go?
_____ 3c. If you did call, did reach the sponsor, and he still refused to allow her to go, would you let Georgia go (assuming you saw no reasons not to let her)?

Case Four

Ed L. is an eighty-one-year-old Medicaid patient who was admitted to the home after a hip fracture. The operation to repair this fracture left his walking somewhat shaky unless he uses a cane (which he detests). His mental condition is sometimes confused, but the one thing he is always sure of is that he does not want to use that cane. The nursing home staff is able to make Ed use his cane during the day, but at night he will frequently get up to go to the bathroom and "forget" it. He has been told to either use his cane or call for assistance,

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 4a. Would you be willing to agree to a compromise in which Ed was allowed to remain without restraints following any night in which he used his cane or asked assistance?

_____ 4b. Would you be willing to agree to one short trial period without the restraint to give Ed "one last chance" (if he ever failed to use the cane, he would have to be restrained for good)?

_____ 4c. Would you be more inclined to agree to either of the preceding if you thought failure to do so would result in Ed's sponsors moving him to another nursing home?

Case Five

Vicky M. is a seventy-six-year-old private pay patient of the "Y" nursing home. Her physical and mental condition are generally good. She receives a small allowance from her sponsor to pay for personal items. The "Y" nursing home has just secured the services of a professional beautician who comes in once a week to serve the patients. Her fees, though modest, are not included in the patients' normal rates and must be charged to them or their sponsors as additional. Vicky's roommate has her hair done by the beautician and now Vicky wants it, too. She has asked her sponsor (her nephew) for the additional money, but he has steadfastly refused to give it to her, and he seems to be becoming very hostile to the entire issue. Vicky has asked the administrator of the "Y" home to try to "force" her sponsor to give her this extra money.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 5a. Would you be willing to risk irritating Vicky's sponsor by attempting to persuade him to let Vicky have the extra money to see the beautician once a week?

_____ 5b. If the above were tried and failed, would you be willing to try to work out a compromise with her sponsor in which Vicky got enough extra money from him to see the beautician at least once every other week?

_____ 5c. If none of the above worked, and Vicky thought this issue important enough to be very unhappy about it, would you be willing to try still stronger measures ("shaming" the sponsor, etc.) to "force" him to give Vicky the money?

Case Six

Shirley O. was admitted to the "Z" nursing home as a private pay patient after an operation to repair a hip fracture (her second). Her mental condition is borderline senile. After her second operation Shirley decided she could not get around without a wheel chair even though her doctor says that she probably could (and should) walk with a walker. The "Z" nursing home has two dining rooms. In the main dining area no wheel chairs are ever allowed, as this is where the ablest patients dine. Upon her arrival Shirley wheeled herself to this area (where her friends were) and was told she could not go in except with her walker. She then demanded to be fed in her room but was told she did not need this; it was the main area or nothing. She then got out of the wheel chair and sat at the door to the main area crying piteously. Her sponsors came in at this very moment and were enraged. Even after they were told the reasons behind the nursing home's actions they demanded that Shirley be allowed to eat in the main area with her wheel chair or be fed in her room.

Definitely Yes _____ Definitely No
1 2 3 4 5

_____ 6a. Would you be willing to agree to a compromise that would allow Shirley to eat in her room if she had used her walker at some other times during the day?

_____ 6b. Would you be willing to agree to a compromise that would allow Shirley to take her wheel chair into the main dining room if she had used her walker at some other times during the day?

_____ 6c. If for some reason the above were unacceptable to Shirley, her sponsors, or yourself, would you agree to allow Shirley to take her wheel chair into the main dining area?

APPENDIX E

INITIAL COVER LETTER

FOUNDED 1948

HEALTH CARE ASSOCIATION OF MICHIGAN

Michigan Nursing Home Association

1320 Commerce Center Building ' 300 South Capitol Avenue ' Lansing, Michigan 48933 ' Phone (517) 371-1700

August 22, 1974

Dear HCAM Member:

The Health Care Association of Michigan, through its Education Committee, is cooperating in a statewide member survey to develop information about how administrators perceive the best ways to do their job.

Administrators are urged to complete the enclosed questionnaire and return it in the envelope provided for that purpose. It will take only a few minutes of your time. Please complete it and return it now.

We emphasize that this is an association sponsored project. Its success is up to you.

Sincerely,

Charles E. Harmon

Charles E. Harmon,
Executive Director

CEH:lb

Enclosure

APPENDIX F

REMINDER LETTER

FOUNDED 1948
HEALTH CARE ASSOCIATION OF MICHIGAN
Michigan Nursing Home Association
1320 Commerce Center Building / 300 South Capitol Avenue / Lansing, Michigan 48933 / Phone (517) 371-1700

September 20, 1974

Dear HCAM Member:

On August 22, 1974, we forwarded to you a questionnaire designed to develop information about how administrators perceive the best ways to do their job.

Many members have already responded to this Association sponsored survey. We regret that we have not heard from you.

Would you please take the few minutes required to complete the questionnaire and return it to us? Your participation is vital to the success of the project.

Thank you for your consideration.

Sincerely,

Charles E. Harmon

Charles E. Harmon,
Executive Director

CEH:lb

Encl.

APPENDIX G

PATIENT INTERVIEW FORMAT*

*Questions 1-4, 6-9, 11-12 by Allen Pincus, Ph.D., University of Wisconsin.

Nursing Home _____

PATIENT INTERVIEW FORMAT

Introduce yourself and explain what you are doing.

Name _____ Age _____

To be answered by nursing home personnel:

Is patient receiving any public funds to help defray the costs of his stay at this nursing home? Yes _____ No _____

To be answered by patient (read it to him):

1. If I were planning to come into _____ Home, what would you say to me? (*Get R to "play a game" with you saying something like: "Make believe I'm your age and am thinking of coming to _____ Home and I come to you for advice. Help me decide." Act as if you are taking notes.*)

2. What would I need to know to do OK here? (*Continue with role playing game, as if you are their age and they are advising you.*)

3. In what ways did you have to change in order to adjust to the Home? (*Probe: things have to do differently, getting up, going to sleep, eating pattern, being alone, etc.*)

4. What were some things you had to learn in order to adjust?

5. How would you respond to this statement?

   "Within reason, the staff at this nursing home usually tries to do what I want."

   Would you (*Check one*) _____ Strongly Agree _____ Agree _____ Disagree _____ Strongly Disagree

6. What kind of person your own age would you advise to come to _____ Home? (*Probe: traits of person, illness, etc.*)

7. In what ways is life the same for you as it was before you came into the Home?

8. In what ways is it different?

9. If you were being asked to advise a government inspector about how a Home like this should be changed to make it a better place, what would you tell him?

10. How would you respond to this statement?

"Within reason, the staff at this nursing home usually tries to do what the relatives of residents want."

Would you (*Check one*) _____ Strongly Agree _____ Agree _____ Disagree _____ Strongly Disagree

11. If you had to do it all over again, would you apply to _____ Home? (*Probe why*)

12. Are you glad you came to _____ Home?

Thank the patient

Overall satisfaction with the home rating _____
(*See accompanying rating scale.*)

APPENDIX H

RATING SCALE FOR GRATIFICATION FROM THE HOME ENVIRONMENT (GH)*

*By Allen Pincus, Ph.D., University of Wisconsin, 1968.

RATING SCALE FOR GRATIFICATION FROM THE HOME ENVIRONMENT (GH)

(Questions 1-4, 6-9, and 11-12)

1 - S is sorry he came to the Home. If he had to do it over again he would try to find some alternative to his current living arrangements. The Home is no good and has nothing to offer S. Life is miserable there and he would like to get out.

2 - S would come again, but only as a last resort, if there were no place else to go. He is resigned to living in the Home and at best "enduring" the environment, but sees it as more tolerable than someone with a rating of 1. S might mention some positive things about the Home but might also frequently refer to the fact that if a person has money or children he shouldn't be in the Home. "Nobody comes here for pleasure," is a frequently expressed sentiment.

3 - S would probably come again as a last resort, but is ambivalent about whether he is glad he came. S may enjoy the security or sustaining services the Home offers, but feels he is getting this at the expense of his privacy and/or freedom which is important to him. S may be satisfied with the Home, but not really happy there. It will never be "home" for S.

4 - S is glad he came and would come again. He seems to be generally satisfied with the Home, but makes some statements which would place him a step below those with a rating of 5. For example, S might mention that he is glad he came to the Home because he is no longer a burden on the family, as opposed to saying that he is glad he came because of some positive aspect of the Home itself. Or perhaps there are some aspects of the Home which mar S's enjoyment of it, but not to the extent of someone with a rating of 3.

5 - S is definitely glad he came and would definitely come again. The emphasis is on "this is the best place for me" rather than on "this is a last resort." The environment meets most of S's needs. There may be some aspect of the environment which S does not like, but he has learned to accommodate himself to them and it does not bother him very much. The institution is a satisfactory and satisfying home for S.

APPENDIX I

SPONSOR TELEPHONE INTERVIEW

Nursing Home _____

SPONSOR TELEPHONE INTERVIEW

Introduce yourself and explain what you are doing.

Name _____ Age _____

1. How long has your relative been in _____ nursing home? _____
   (If relative is no longer in home, record how long he was there) _____

2. How frequently do you visit (did you visit) your relative in the home?
   _____/month *(If less than once per month, continue interview, but do not record data and be sure to do an additional phone interview in order to achieve your quota of six interviews.)*

Please indicate how satisfied you have been with each of the following aspects of the _____ nursing home. *(Check one)*

		Very Satis.	Satis.	Dissat.	Very Dissat.
3.	adequate number of staff	____	____	____	____
4.	co-operation of staff with you	____	____	____	____
5.	outside groups frequently coming in to entertain the residents	____	____	____	____
6.	general cleanliness of resident maintained	____	____	____	____
7.	good food	____	____	____	____
8.	cheerful atmosphere	____	____	____	____
9.	kindly treatment of relative	____	____	____	____
10.	diversionary activities, i.e., TV, crafts, library, hobby center, music room, discussion groups, Bible study, games available, movies	____	____	____	____
11.	co-operation of staff with resident	____	____	____	____

Thank the respondent.

APPENDIX J

PATRON LETTER

Dear Patron:

Our nursing home is participating in a research project being conducted jointly by the education committee of the Health Care Association of Michigan and Michigan State University. This study is attempting to determine some of the factors which produce satisfaction with nursing homes.

Within the next few days you may be contacted over the phone by an interviewer involved with this project. We feel that this study represents needed research into an important area, and urge your co-operation. Please be assured that your answers will be held in strictest confidence and no individual responses will ever be identified or divulged (even to us).

Thank You for Your Co-operation.

APPENDIX K

INTERVIEWER INSTRUCTIONS

Name of nursing home _____

INTERVIEWER INSTRUCTIONS

NOTE: Please read all materials prior to initiating any contacts. Should you have any questions call me (Richard Buchanan) at 616-664-4627 or 616-383-1925.

Introduction

This project involves two research instruments which are to be applied to two populations associated with nursing homes. One population, patients, are to be personally interviewed while the other, the relatives or "responsible parties," are to be interviewed over the telephone. Because nursing homes are generally wary of participating in research of any kind (they have been badly misused in the past) EXTRA CARE SHOULD BE USED IN DEALING WITH THEM. However, your objectives will be easy to accomplish if the following steps are taken.

Before Hand Upon receipt of these materials call the nursing home listed on the cover of this packet and make arrangements (usually with the administrator) to come into his home and interview patients. Be sure to identify yourself as part of the project being conducted by the Health Care Association of Michigan. The administrator has already agreed to participate with this project, but may need reminding. Should there be any problems or questions suggest the home re-contact the Health Care Association. Ask for enough time for you to conduct six interviews and do a few additional jobs (to be explained later). Familiarize yourself with all materials prior to the interview.

The Day of the Interview On the agreed-upon date go to the home and identify yourself via the letter from the Health Care Association provided in the packet. Also in the packet are ten letters and envelopes addressed to the relatives you will be contacting later. These are to reassure the relatives that it is all right to participate in the study. Have the letters signed by the nursing home in the space provided (a rubber stamp would do nicely) and take these with you to be mailed later. Return addresses may be affixed by the nursing home if desired.

IMPORTANT NOTE The sample respondents to be interviewed by this project have to be very carefully chosen. Each nursing home serves two different kinds of patients/relatives, private-pay and Medicaid. It is very important that the patients/sponsors chosen from this home be of the type. Supposedly, this has already been taken care of in the list of respondents provided. However, it is so important that you should double check this information anyway. If your list of respondents does not conform to the desired characteristics, ask for others. Should the home be unable to come up with enough patients/sponsors of the desired type, it is permissible to fill in with the other type (but be sure to identify their responses as such).

The Patient Interview

Let the nursing home personnel steer you around to the proper patients. Should any of the patients on your list be unwilling or unable to participate on the date of your visit it is permissible to substitute (try to get six interviews). Just be certain that the patient interviewed is of the desired type (private pay vs. Medicaid), has been at the home long enough to judge it, and is mentally competent to interview (some may be a trifle on the senile side, but that is all right). Use the "patient interview format" with the patients. It should be read to them and you should act according to any instructions supplied with each question. Only questions "5" and "10" require you to mark down a specific response. The responses to all the others are to be aggregated in one single "Satisfaction with the home" rating. Use the rating scale provided to reach this rating.

Next

Mail the letters to the relatives. Allow enough time for them to be delivered.

Relative Interview

The relative interviews are to be conducted over the phone. Where possible the telephone numbers have been provided for you. If you do not have the telephone numbers, you might request them from the nursing home or just call information. Be sure to remind the relative of the letter he received. If he is very reluctant to participate you could refer him back to the nursing home (or just go on to the next). Read him the sponsor telephone interview and fill in the desired information. Once you have six interviews with the desired (private-pay vs. Medicaid) orientation who visit their relative at least once per month your job is complete.

Miscellaneous

If anyone wants to know what this information is for, you may explain that it is part of a research project trying to uncover what is the best way for a nursing home to satisfy the people it serves.

GOOD LUCK

APPENDIX L

LETTER OF INTRODUCTION

Health Care Association of Michigan
1320 Commerce Center Building
Lansing, Michigan 48933
Phone 517 371-7700

January 13, 1975

To Whom It May Concern:

This will identify the interviewer for the research project sponsored by Health Care Association of Michigan and Michigan State University. Ralph Schmuckal of our staff discussed it with you recently.

If you have any questions, please call us. Thanks as always for your cooperation.

Sincerely,

Charles E. Harmon

Charles E. Harmon,
Executive Vice President

CEH:lb

APPENDIX M

STATISTICAL TECHNIQUES EMPLOYED

STATISTICAL TECHNIQUES EMPLOYED

Introduction

The purpose of this section shall be to illustrate one example of the Mann-Whitney test employed for research purposes. The majority of the techniques contained herein were drawn from Nonparametric Statistics for the Behavioral Sciences (McGraw-Hill, New York, 1956) by Sidney Siegel. The interested reader is referred to this work for greater detail.

Assumptions of test

The Mann-Whitney U test assumes at least ordinal data obtained from independent random samples. As discussed in the "Analytical techniques employed" section, the data definitely did not constitute a random sample. Therefore, the "significance" of any application of the test should be understood to represent only an indicator of the relative importance of the findings.

Subject of test

The items chosen for demonstration purposes were the total responses to the questionnaire alternative "1a." As shown in Table 7, these were as follows:

DY	1	2	3	4	5	DN
Private	13	28	11	9	18	
Medicaid	9	21	11	23	18	

Test procedure

The above response patterns were analyzed via the following procedural steps from Siegel.

1. "Determine the values of n_1 and n_2. n_1 = the number of cases in the smaller group; n_2 = the number of cases in the larger group."

$$n_1 = 71 \qquad n_2 = 79$$

2. "Rank together the scores for both groups assigning the rank of 1 to the score which is algebraically lowest. Ranks range from 1 to $N = n_1 + n_2$. Assign tied observations the average of the tied ranks."

	Private			Medicaid		
Value	Average Value Rank	No.	No. x Value Rank	Value Rank	No.	No. x Value Rank
1	11.5	13	149.5	11.5	9	103.5
2	47	28	1316	47	21	987
3	82.5	11	907.5	82.5	11	907.5
4	104	9	936	104	12	1248
5	132.5	18	2385	132.5	18	2385

3. "Determine the value of U. . .

$$U = n_1 n_2 + \frac{n_2(n_2 + 1)}{2} - R_2$$

R_2 = sum of the assigned ranks for n_2"

$$R_2 = 149.5 + 1{,}316 + 907.5 + 936 + 2385$$

$$R_2 = 5694$$

$$U = (79)\ (71) + \frac{79(79 + 1)}{2} - 5694$$

$$U = 3075$$

4. "The method for determining the significance of the observed value of U depends on the size of n_2:

   If n_2 is larger than 20, the probability associated with a value as extreme as the observed value of U may be determined by computing the value of z as given by formula and testing this value by referring to Table A.

$$Z = \frac{U - \frac{n_1\ n_2}{2}}{\sqrt{\frac{(n_1)\ (n_2)\ (n_1 + n_2 + 1)}{12}}}$$

$$Z = \frac{3075 - \frac{(79)\ (71)}{2}}{\sqrt{\frac{(79)\ (71)\ (151)}{12}}}$$

$$Z = 1.02$$

   The observed value of Z is .1539

5. "If the observed value of U has an associated probability equal to or less than α reject H_0 in favor of h_1."

   Since the associated probability of .1539 is greater than the chosen α of .10, the null hypothesis of no difference cannot be rejected.

Correction for ties

As noted by Siegel:

> The Mann-Whitney test assumes that the scores represent a distribution which has underlying continuity. With very precise measurements of a variable which has underlying continuity, the probability of a tie is zero. However, with the relatively crude measures which we typically employ in behavioral scientific research, ties may well occur . . .
>
> The effect of tied ranks is to change the variability of the set of ranks. Thus the correction for ties must be applied to the standard deviation of the sampling distribution of U. Corrected for ties, the standard deviation becomes:

$$\sigma_{\sim} = \sqrt{\left(\frac{(n_1\ n_2)}{N\ (N-1)}\right)\ \left(\frac{N^3 - N}{12}\right) - \Sigma\tau}$$

where $N = n_1 + n_2$

$$T = \frac{T^3 - t}{12}$$ (where t is the number of observations tied for a given rank)

T is found by summing the T's over all groups of tied observations. With the correction for ties we find z by

$$z = \frac{U - \frac{n_1\ n_2}{2}}{\sqrt{\frac{n_1\ n_2}{N(N-1)}\quad \frac{N^3 - N}{12} - \Sigma\tau}}$$

The Western Michigan University Computer Center which was used to process the author's data employed a program which did not include a correction for ties. The author was assured that the effect of ties was nominal, but for his own edification he ran one test of his data through with a correction for ties in order to see what effect might be produced. Accordingly, he made the following calculations:

$$\Sigma\tau = \frac{(22)^3 - 22}{12} + \frac{(49)^3 - 49}{12} + \frac{(22)^3 - 22}{12} + \frac{(21)^3 - 21}{12} + \frac{(36)^3 - 36}{12}$$

$$\Sigma\tau = 16226$$

$$Z = 3075 - \frac{(79)(71)}{2}$$

$$\sqrt{\frac{(79)(71)}{150(149)} \quad \frac{(150)^3 - 150}{12} - 16{,}226}$$

$$Z = 1.05$$

The probability associated with a value of z as extreme as 1.95 is .1469.

Because the difference between the probability of z with the correction factor and the probability of z without the correction factor was so small (.007), the author decided that the advantages of utilizing the existing program far outweighed the possible disadvantages, especially in light of the fact (as noted by Siegel) that " . . . when we do not correct for ties our test is 'conservative' in that the value of p will be slightly inflated."

BIBLIOGRAPHY

BIBLIOGRAPHY

Books

Alexander, George and Lewin, Travis. The Aged and the Need for Surrogate Management. Syracuse, N.Y.: Syracuse University, 1972.

Barney, Jane. Patients in Michigan's Nursing Homes. Ann Arbor: Institute of Gerontology, 1973.

Baumgarten, Harold. Concepts of Nursing Home Administration. New York: Macmillan, 1965.

Braverman, Jordan. Nursing Home Standards . . . A Tragic Dilemma in American Health. Washington, D.C.: American Pharmaceutical Association, 1970.

Brotman, Herman B. Who Are the Aged: A Demographic View. Ann Arbor: Institute of Gerontology, 1968.

Kogan, Nathan, and Wallach, Michael. Risk Taking, A Study in Cognition and Personality. New York: Holt Rinehart and Winston, 1964.

Kotler, Philip. Marketing Management. Englewood Cliffs: Prentice-Hall, 1972.

Margolis, Sidney. "The Older Consumer as a Force in the Marketplace," The Aging Consumer. Papers from the 22nd Annual Conference on Aging. Ann Arbor: Institute of Gerontology, 1969.

Mendelson, Mary. Tender Loving Greed. New York: Alfred A. Knopf, 1974.

Meyers, Robert J. Medicare. Homewood, Ill.: Richard D. Irwin, 1970.

Miller, Gerald, and Steinberg, Mark. Between People: A New Analysis of Interpersonal Communication. Palo Alto: Science Research Associates, 1975.

Rewoldt, Stewart H., et al. Introduction to Marketing Management. Homewood: Richard D. Irwin, Inc., 1969.

Rokeach, Milton. The Nature of Human Values. New York: The Free Press, 1973.

Siegel, Sidney. Non-Parametric Statistics for the Behavioral Sciences. New York: McGraw-Hill, 1956.

Stanton, William J. Fundamentals of Marketing. New York: McGraw-Hill, 1971.

Townsend, Claire. Old Age: The Last Segregation, Ralph Nader's Study Group Report on Nursing Homes. New York: Grossman Publishers, 1971.

Webster's Seventh Collegiate Dictionary. Springfield, Mass.: S. and C. Merriam Company, 1963.

Periodicals, Journals, and Articles

Busse, Ewald. "The Modern Challenge of Threescore and Ten." Journal of the American Geriatrics Society, XVII (September, 1969), 887-93.

Fenelon, Stephani. "Patients' Families Need Information." Modern Nursing Home, January, 1974, pp. 8-9.

Gallagher, Jim. "Family Faces Guilt Feelings--Easing Parent's Move to Nursing Home." Detroit Free Press, November 10, 1974, pp. 1C, 9C.

Hollander, Stanley. "Buyer Helping Businesses . . . and Some Not-So-Helpful Ones." MSU Business Topics, Summer, 1974, pp. 52-68.

Hollander, Stanley C. "She Shops for You or with You." New Essays in Marketing Theory. Edited by George Fisk. Boston: Allyn and Bacon, Inc., 1971, pp. 218-40.

Hyatt, Jim. "Medicare Woes, Nursing Home Benefits Grow Harder to Collect." The Wall Street Journal, April 8, 1970, pp. 1, 28.

Jacoby, Susan. "Waiting for the End: On Nursing Homes." New York Times, March 31, 1974, p. 13.

Kotler, Philip. "Behavioral Models for Analyzing Buyers." Journal of Marketing, XXIX (October, 1965), pp. 37-45.

Lieberman, Morton A., and Lakin, Martin. "On Becoming an Institutionalized Aged Person." Processes of Aging. Edited by Richard A. Williams. New York: Atherton Press, 1963, pp. 475-503.

Loehwing, David A. "Recovery in Nursing Homes." Barron's, March 26, 1973, p. 3.

Luck, David J. "Broadening the Concept of Marketing--Too Far." Journal of Marketing, XXXIII (July, 1969), 53-55.

Raven, Bertram H., and Kruglanski, Ariel W. "Conflict and Power," The Structure of Conflict. Edited by Paul Swingle. New York: Academic Press, 1970, pp. 69-109.

Sheldon, Henry. "The Changing Demographic Profile." Handbook of Social Gerontology. Edited by Clark Tibbitts. Chicago: University of Chicago Press, 1960, pp. 27-61.

Simos, Bertha. "Adult Children and Their Aging Parents." Social Work, XVIII (May, 1973), 78-85.

Spivak, Jonathan. "HEW Plans to Issue Regulations to Improve Safety and Medical Care at Nursing Homes." Wall Street Journal, January 14, 1974, p. 7.

Wallach, Michael, et al. "Group Influence on Risk Taking." Journal of Abnormal and Social Psychology, LXV, No. 2 (1962), pp. 75-86.

Yawney, B. A., and Slover, D. L. "Relocation of the Elderly." Social Work (May, 1973), pp. 87-95.

Association Materials

American College of Nursing Home Administrators. Membership Information. Silver Springs, Md.: ACNHA, 1974.

American Nursing Home Association. Facts in Brief. Washington, D.C.: ANHA, 1972.

American Nursing Home Association. "Proposed Position Paper," ANHA Governing Council Report. Chicago: ANHA, August 19, 1973.

Michigan Nursing Home Association. Application for Membership. Lansing: MNHA, 1974.

Michigan Nursing Home Association. Michigan Nursing Home Association Operational Code. Lansing: MNHA, 1972.

Government Publications--Federal

Brotman, Herman. The Older Population: Some Facts We Should Know. Washington, D.C.: Government Printing Office, 1970.

U.S. Bureau of the Census. Current Population Reports. Series P-23, No. 43, "Some Demographic Aspects of Aging in the United States." Washington, D.C.: Government Printing Office, 1973.

U.S. Bureau of the Census. We the American Elderly. Washington, D.C.: Government Printing Office, 1973.

U.S. Comptroller General of the United States. Report to the Congress, Continuing Problems in Providing Nursing Home Care and Prescribed Drugs Under the Medicaid Program in California. Washington, D.C.: Government Printing Office, 1970.

U.S. Department of Health, Education, and Welfare. Characteristics of Residents in Nursing and Personal Care Homes. Rockville, Md.: National Center for Health Statistics, 1973.

U.S. Department of Health, Education, and Welfare. Charges for Care and Sources of Payment for Residents in Nursing Homes. Rockville, Md.: National Center for Health Statistics, 1973.

U.S. Department of Health, Education, and Welfare. Chronic Conditions and Impairments of Nursing Home Residents. Rockville, Md.: National Center for Health Statistics, 1973.

U.S. Department of Health, Education, and Welfare. Health Resources Statistics, 1972-73. Rockville, Md.: National Center for Health Statistics, 1973.

U.S. Department of Health, Education, and Welfare. Nursing Home Care, Consumer Information Series #2. Washington, D.C.: Government Printing Office, 1972.

U.S. Congress. Senate. Committee on Finance and U.S., House of Representatives, Committee on Ways and Means. Summary of Social Security Amendments of 1972, Public Law 92-603. Washington, D.C.: Government Printing Office, 1972.

U.S. Congress. Senate. Special Committee on Aging. Hearings Before the Subcommittee on Long Term Care of the Special Committee on Aging, parts 1-15. Washington, D.C.: Government Printing Office, 1971.

U.S. Office of Human Development. Administration on Aging. New Facts About Older Americans. Washington, D.C.: DHEW, 1973.

Government Publications--State

Michigan. Bureau of Health Facilities. February 1974 Directory of Hospitals, Nursing Care Facilities, and Homes for the Aged. Lansing: Michigan Department of Public Health, 1974.

Michigan. Division of Health Facilities Standards and Licensing. Rules and Regulations for Nursing Homes and Homes for the Aged. Lansing: Department of Public Health, 1974.

Michigan. Medical Assistance Program Bulletin No. B-3 (Revised Reimbursement Rates). Lansing: Department of Social Services, 1974.

Unpublished Works

Bair, L. A. "The Effect of the Introduction of Medical Assistance and Medicare on the Structure of the Michigan Nursing Home Industry." Unpublished Ph.D. dissertation, Michigan State University, 1973.

Henry, L. H. "The Effect of Medicare and Medicaid on the Supply and Demand Conditions of Nursing Homes." Unpublished Ph.D. dissertation, Notre Dame, 1970.

Miller, Frederick. "An Analysis of the Marketing Strategy of Florida Nursing Homes." Unpublished Ph.D. dissertation, Louisiana State University, 1970.

Pincus, Allen. "Toward a Conceptual Framework for Studying Institutional Environments in Homes for the Aged." Unpublished Ph.D. dissertation, University of Wisconsin, 1968.

Saul, Sidney. "A Study of Family Factors Relating to Application to a Home for the Aged." Unpublished Ed.D. dissertation, Columbia University, 1968.

Silverstone, B. M. "Expert vs. Consumer Viewpoints: An Organizational Analysis of the Contrast in Descriptions of Homes for the Aged by Administrators and Indigenous Residents." Unpublished Ph.D. dissertation, Columbia University, 1973.

Tomlinson, Barbara. "The Nursing Home Research Project and the Relative Sub-Study." Unpublished paper, Institute of Gerontology, 1971.

Trainor, John. "The Nursing Home Industry in Washington State." Unpublished Ph.D. dissertation, Washington State University, 1970.

Miscellaneous

Baumgarten, Harold. Letter to R. W. Buchanan, March 18, 1974.

Baumgarten, Harold. The First Kuttnauer Seminar on Nursing Homes and Extended Care Facilities (December 8-9, 1967) as related by Harold Creal, Past President of the Michigan Nursing Home Association in a personal interview February 5, 1973.

Typed and Printed in the U.S.A.
Professional Thesis Preparation
Cliff and Paula Haughey
144 Maplewood Drive
East Lansing, Michigan 48823
Telephone (517) 337-1527