Received: 12 July 2022 | Revised: 5 January 2023 | Accepted: 13 March 2023

DOI: 10.1111/1748-8583.12502

Human Resource Management Journal WILEY

RESEARCH ARTICLE

Getting to what works: How frontline HRM relationality facilitates high-performance work practice implementation

Nick Krachler

Human Resource Management & Employment Relations Group, King's Business School, King's College London, London, UK

Correspondence
Nick Krachler.
Email: nick.krachler@kcl.ac.uk

Abstract

The lack of an efficient support system for people with multiple, long-term health conditions has increased costs, worsened health outcomes, and prompted policymakers to implement a boundary-spanning role within healthcare settings. While scholars have demonstrated the benefits of coordination roles and other such high-performance work practices (HPWPs) in this sector, the actual implementation of these practices is less clear. Based on a comparative case study approach, 153 interviews, and other qualitative data, this article explores frontline managers' HR philosophies and practices ('frontline HRM relationality') to explain possible variation in efforts to implement the boundary-spanning role of care coordinators (CCs). Despite strong policy support for the role, coordination has improved unevenly because of varying degrees of HRM relationality: findings show that higher frontline HRM relationality was associated with lower inter-occupational professionalization differences and higher boundary-spanning coordination. The article contributes to a nascent literature on HPWP implementation by theorizing frontline HRM relationality as a

Abbreviations: Acronyms of terms: CCs, care coordinators; HPWPs, high-performance work practices; HR, Human Resources; HRM, Human Resource Management; RC, relational coordination. Acronyms of cases: HRC_1, HighlyRelationalCare_1; HRC_2, HighlyRelationalCare_2; HTC_1, HighlyTransactionalCare_1; MC_1, MixedCare_1; MC_2, MixedCare_2; MC_3, MixedCare_3; RC_1, RelationalCare_1; TC_1, TransactionalCare_1.

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continuum that moderates professionalization-related coordination problems and highlights the importance of frontline HRM relationality for implementing HPWPs in professionalized settings.

KEYWORDS
healthcare, HPWP implementation, relational HRM, workforce innovation

Practitioner notes

What is currently known?

- HPWPs are positively associated with organizational performance.
- In inter-dependent work contexts, relational coordination mediates this HR-performance link.

What this paper adds?

- Explains variation in HPWP implementation in the case of a boundary-spanning role's task performance in health and social care.
- Shows how the relationality of frontline managers' HR philosophies and practices conditions boundary-spanners' task performance by moderating coordination problems related to professionalization.
- Theorizes frontline HRM relationality as a continuum, associating higher relationality with lower inter-occupational professionalization differences and higher boundary-spanning coordination.

Implications for practitioners

- Policymakers aiming to improve boundary-spanning must ensure high levels of frontline HRM relationality.
- Employees in boundary-spanning roles, as well as those working with them, should highlight frontline HRM relationality problems to secure more managerial support.
- Frontline HRM relationality may also shape implementation of HPWPs in other professionalized settings.

1 | INTRODUCTION

In the health and social care sectors, policymakers have aimed to improve performance by increasing coordination between sectors. One mechanism for this has been a boundary-spanning role called 'care coordinators', tasked with enhancing 'care coordination', that is, the exchange of information between patients and different care providers. In a context of increasing health and social care costs, driven especially by people with multiple long-term health conditions (Jackson et al., 2013; NHS England, 2014), much hope for productivity gains and care improvements rests on the ability of CCs to manage long-term conditions.

Accordingly, this article's main research questions are as follows: Which HR philosophies and practices can facilitate the implementation of an HPWP like the boundary-spanning CC role? And what is the role of frontline managers in this regard? As yet, however, there have been few studies on the necessary HRM conditions that facilitate HPWP implementation (Kirkpatrick & Hoque, 2022; Monks et al., 2013; Wu et al., 2015). It is important to understand the HRM conditions of HPWP implementation because any link between HPWPs and performance is predicated on effective implementation. Based on 153 interviews, this article investigates how the relationality of HR philosophy

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and practices enacted by 'frontline managers'—i.e., managers with great influence over operations like supervisors and middle managers—facilitates HPWP implementation.

Furthermore, while there is much evidence associating HPWPs with increased coordination (Bolton et al., 2021), the processes behind this coordination have been less studied. Building on recent studies of HRM complications in professionalized settings (Chen et al., 2022; Kessler et al., 2017), this article also investigates how frontline HRM relationality can help overcome professionalization problems to facilitate the implementation of boundary-spanners.

This article contributes to the HPWP literature by highlighting one important condition for effective HPWP implementation in the case of roles that span multiple occupational boundaries: the degree of relationality enacted by frontline managers. This condition is conceptualized as a continuum between a highly relational, facilitative pole and a highly transactional, hampering one, whereby a higher degree of relationality is associated with better implementation of boundary-spanners. The article further argues that implementation improves by lowering professionalization differences between the occupations involved.

The following sections first discuss the relative inattention towards conditions of HPWP implementation; subsequently, the methodology and research findings are presented and their conceptual and practical implications discussed.

2 | CONDITIONS OF HPWP IMPLEMENTATION

This section first discusses how the HPWP literature has predominantly focused on establishing the 'HR-performance link', while paying less attention to conditions of HPWP implementation. Second, it discusses several relevant factors that could condition HPWP implementation.

2.1 | The focus on the HR-performance link

High-performance work practices refer to the ways in which managers dispose of an employee's labour to improve organizational performance (Combs et al., 2006). While there is some ambiguity around these practices, common HPWPs have included: recruiting for job-specific attributes and skills; induction and initial job training; ongoing training, developmental performance management, and career development; above-average pay, benefits, and job security; and consultation and teamworking (Appelbaum et al., 2000; Guest, 1997; MacDuffie, 1995). Stemming from the literature's origins in manufacturing, 'performance' has often meant profitability and sales (Batt & Banerjee, 2012); more recently, though, HPWP studies of the services industry have expanded notions of performance to health outcomes such as hospital readmissions (Gittell, 2009).

More broadly, the HR-performance link is based on an understanding of business strategy in which human resources are viewed as adding value to organizational competitiveness. While the strategy can rely on enhanced quality or innovation (Guest, 1997), HPWPs are often associated with the resource-based view, in which resources add sustained value through their rarity, inimitability, resistance to substitution, and contribution to operations (Wright et al., 1994, 2003). However, HPWP studies have shown that various HPWPs must be implemented in a coherent way (MacDuffie, 1995). If they work against one another, performance enhancements may not occur.

A sub-set of the broader HPWP literature is relational coordination (RC) theory, which conceptualizes boundary-spanners like care coordinators as an HPWP. A central proposition of RC theory is that coordination-specific HPWPs are associated with performance outcomes via 'relational coordination'—the timely, frequent, accurate, and problem-solving communication between different roles. RC studies have validated the theory in diverse sectors including civil aviation (Gittell, 2003), banking (Siddique et al., 2019), education, social services (Bolton et al., 2021), and health services (Gittell, 2009): all contexts in which different roles' work is interdependent in a non-trivial way. For example, in a study of 12 US hospitals, Gittell et al. (2009) found that significantly improved relational coor-

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dination led to decreased patient lengths of stay and enhanced patient-perceived care quality. The HPWPs relevant for this article were: problem-solving meetings between different roles and 'boundary-spanners' who tracked a patient's treatment across various service providers and exchanged relevant information at all stages and with all relevant health professionals—like this article's case of 'care coordinators'.

Altogether, the HR-performance link approach suggests a linear model: a business strategy supports HPWPs, which then improve HR outcomes, which then leads to better operational outcomes and organizational performance (Jiang et al., 2012). HPWP studies, however, have rarely investigated the link between strategy and HPWP implementation (Paauwe & Boselie, 2005). Additionally under-investigated (and the focus of this article) is how lower-level managers might play an important role in implementing HPWPs at the workplace level, even where business strategy is supportive.

2.2 | Nascent research on HPWP implementation conditions

Recent notable studies have expanded beyond the traditional focus on the link between HR practices and performance to the HPWP implementation conditions of firm size, professionalization issues, and HR philosophy. For example, Wu et al. (2015) found that the link between HPWPs and performance was contingent on firm size; the link held for large firms but only for labour productivity in small-sized firms and not at all in medium-sized firms. Additionally, Kirkpatrick and Hoque (2022) found that formal HR qualifications for senior managers responsible for HR conditioned effective HPWP implementation.

While the preceding studies focused less on the mechanisms explaining these associations, Monks et al. (2013: 391) have argued for the interconnection between HR practices and 'HR philosophy'. The latter are general principles that assign value to human resources in an organization, and HR practices "uphold and reinforce the particular HR philosophy of the firm and the configuration of HR practices chosen to deliver this philosophy". Specifically, they differentiated between a 'commitment-based' HR philosophy—maximizing social capital, innovation, problem-solving, and creativity—and a 'productivity-based' HR philosophy—stressing productivity and efficiency over knowledge-sharing and problem-solving.

Like HPWP studies more generally, RC theory studies have predominantly examined the HR-RC performance-link but rarely HPWP implementation conditions. RC theory scholars have, however, also considered or called for more research on certain managerial conditions (Gittell et al., 2008). These conditions include the workloads of boundary-spanners (with lower workloads facilitating coordination) (Gittell & Weiss, 2004) and the physical proximity of services, also known as 'co-location' (Gittell, 2009). Additionally, while scholars have noted how professionalization processes can inhibit the link between HPWPs and relational coordination, they have not studied how to overcome this barrier (Gittell, 2009).

More recent workforce innovation scholarship on the employment of new roles in highly professionalized settings has argued that for HPWPs to be effective, complementarity must develop between established and new roles, with managers playing some role in this process. Common problems with new roles include a lack of trust in their competencies (Kessler et al., 2017) and the perception that they might threaten the power and identities of established professionals (Chen et al., 2022; Krachler & Kessler, 2022). By working together, however, these problems can resolve over time as established professionals come to recognize a new role's complementary competencies. As opposed to 'substitution', where the new role performs tasks that are traditionally in the established professionals' domain for a lower cost, 'complementarity' develops when new roles assume tasks that were not previously performed or are considered 'lower-status', thus 'freeing up' professionals to perform higher-status tasks (Bach et al., 2008; Kessler et al., 2015, 2017). While these processes could occur without managerial intervention, these studies found that HR practices such as training, mentorship, autonomy (Chen et al., 2022), multi-disciplinary teamworking, and assigning manageable workloads (Procter et al., 2018) could facilitate cross-occupational working.

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Overall, while much HPWP literature has focused on the HR-performance link, some nascent research has shifted the focus to understanding the conditions for implementing HPWPs and therefore, from knowing what works to *getting to* what works. These conditions include: firm size, professionalization of HR responsibility, HR philosophy, workload management, co-location, and work complementarity between established and new roles. To advance our understanding of HPWP implementation conditions, this article theorizes—in an empirically grounded way—the relationships between some of these conditions and explores new relationships, focusing on the following questions: how do HR practices influence the implementation of an HPWP like boundary-spanners and what is the role of frontline managers in this context?

3 | METHODOLOGY

3.1 | Research context

Emerging from policymakers' drive to integrate care services since the early 2010s, the care coordinator role spans boundaries across different health services (primary, secondary, community care, and mental health) and across health and social services. To do so, the role performs the following work process: CCs first assess a care-receiving person's health and social needs, then develop a care plan with prioritized goals. Subsequently, CCs support the person to implement the care plan, either *administratively* by organizing required services, such as scheduling follow-up appointments, or through *more complex* activities, like talking to other care providers to clarify treatments or help solve people's problems in following treatments. Moreover, the CC is a *newly emergent* role that is not professionally registered or licensed. Consequently, there are no statutory skill requirements to assume the role, which means that CCs have varied titles and qualification backgrounds.

More complex activities are considered to be more impactful than administrative activities (Wells et al., 2018) because they require exchanging information with a range of other care providers ('care coordination'). These providers include primary and secondary care nurses and physicians, mental health professionals, and social services professionals (for issues like inadequate housing or low income). Furthermore, while administrative tasks require persistence and a familiarity with bureaucratic workings, complex coordination tasks require unique competencies such as building long-term relationships and engaging in problem-solving with time-constrained care providers.

Policymakers running CC programs are waging that these complex coordination activities can contain the disproportionately high costs of people with two or more long-term conditions, predominantly by improving people's health and/or avoiding a deterioration of health that can lead to hospitalizations. For example, one calculation associated around 75% of Medicaid costs with this population in the US (Jackson et al., 2013), and in the UK, NHS England (2014: 6) arrived at a similar estimate: "Long term health conditions - rather than illnesses susceptible to a one-off cure – now take 70% of the health service budget".

The implementation of the CC role has, however, faced managerial barriers, such as time and resource constraints, and professional barriers, such as the role's emergent status and inter-professional differences (Wells et al., 2018). These obstacles have arisen because healthcare systems have predominantly been organized around acute physical health issues instead of prevention and/or long-term management of chronic conditions. Traditionally, the system has emphasized physician-driven services, a strict separation within medical specialties and between different occupations, and a status hierarchy of care services. Additionally, human resource shortages and more onerous reporting and documentation requirements (Krachler & Kessler, 2022) have increased time constraints for care providers.

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3.2 | Research approach, data collection and data analysis

To study the little-explored role of frontline managers in implementing boundary-spanners, an inductive, iterative approach based on purposive sampling was chosen (Corbin & Strauss, 1998). Moreover, a case study design was selected in which eight workplace studies were understood as nested cases (Yin, 2003) of the larger case of CC role implementation.

Regarding case selection, cases with a CC program that had been running for at least 2 years and had at least five CC team members were chosen. Furthermore, cases were selected to minimize variation (Table 1) by examining the role in a similar care setting (care coordination in outpatient, instead of inpatient, settings), serving a comparable patient population (people with two or more long-term health conditions). It also involved selecting cases with similar organizational characteristics: medium- to large-sized, hospital-based organizations instead of small clinics; senior management expressing support for care coordination and pursuing a progressive strategy of population health

TABLE 1 Nested cases' sample characteristics (without frontline management or coordination).

Workplace case	Care setting	Organization and financial status	Senior management support	Union status	Policy program	Country
Highly transactional Care_1	Pulmonary and diabetes outpatient clinic	Mid-sized hospital, deficit	Yes	Same union contract	New York State Health Home Program	US
MixedCare_1	Behavioural health outpatient clinic					
Transactional Care_1	General chronic conditions call center	Large-sized hospital, surplus	Yes			
MixedCare_2	Behavioural health call center			Grievance and disciplinary procedures, pay, benefits like union contract		
MixedCare_3	General respiratory outpatient clinic	Large-sized hospital, deficit	Yes	Agenda for Change	Local Community Health Services Block Contract	UK
HighlyRelational Care_1	General neurology outpatient clinic					
RelationalCare_1	General chronic conditions outpatient clinic	Mid-sized hospital, surplus	Yes			
HighlyRelational Care_2	Behavioural health outpatient clinic					

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through outpatient care (as opposed to the traditional focus on inpatient admissions and emergency visits); and 'good' employment through collectively bargained or equivalent working conditions. Finally, the cases were chosen if their policy program standards were minimal, permitting much frontline management discretion. The policy programs also did not vary within country contexts, and a public US program was chosen to ensure comparability with the UK's public program.

Guided by the general concepts of HPWPs, relational coordination, inter-professional differences, and complementarity/substitution, data collection and analysis occurred in two stages. In the first stage, four workplace cases were studied in New York City between February 2016 and October 2017. Subsequently, these were analysed to generate a first coding scheme. In the second stage, four cases were studied in London between January and May 2019, which permitted a refinement and validation of the framework. While cross-national variation was also explored in this project, this article's focus is limited to the commonalities of HR management that facilitated high levels of coordination across country settings.

This article draws on 153 semi-structured interviews (see Table 2); 26.5 (US) and 24 (UK) hours of non-participant observation of team meetings, care coordination trainings, and governance and policy meetings; and 53 (US) and 58 (UK) documents, such as CC policy program standards, policy reports, and training documents, which were triangulated for higher internal validity (Patton, 1999). While interview guides were tailored to each work role, common questions involved the frequency, communication quality, and breadth of CCs' information exchanges with other care providers; the aims of care coordination programs; and the character of frontline HR management practices and/or regulations that might pertain to frontline HR management. Additionally, CCs were asked about their educational background, prior work experience, work motivations, as well as the pay, benefits, and training they received. Managers were additionally asked about relevant broader dynamics within their organizations (such as the level of organizational support for CC programs). Furthermore, policymakers provided information about the standards, financial incentives, and monitoring arrangements of their policy programs, as well as about the CC programs' broader community context and the targeted patient population. All interviews were audio-recorded and transcribed, except for two interviews during which notes were taken; moreover, close, hand-written observations were taken. The interviews lasted between 35 and 180 min, averaging 63 min.

TABLE 2 Overview of research participants.

Country	Type of participant	Number of participants
USA	Care Coordinators	20
	Other Occupations Working with CCs	12
	Frontline Managers	16
	Senior Managers, Employee Representatives	15
	Regional Policymakers, CC Educators	18
	USA Total	*81*
UK	Care Coordinators	11
	Other Occupations Working with CCs	12
	Frontline Managers	8
	Senior Managers, Employee Representatives	12
	Regional Policymakers, CC Educators	29
	UK Total	*72*
	Overall Total	153

Note: The significance of italics value demonstrates a balanced sample between the countries and an overall comprehensive sample for the research.

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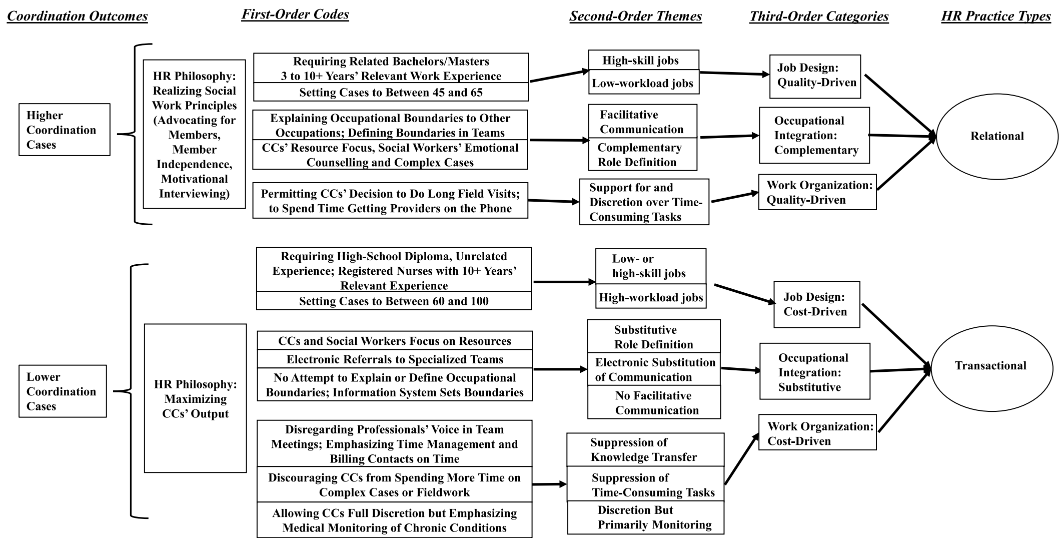

FIGURE 1 Detailed stage 1 coding structure (US cases).

The data were analysed through iterative, line-by-line coding (Corbin & Strauss, 1998). Following the first stage of data collection, the workplace cases were categorized by degree of relational coordination (Gittell et al., 2008), where 'high coordination' consisted of more frequent information exchanges, was more oriented towards joint problem-solving, and involved a broader set of care providers. Levels of relational coordination for each case were differentiated by triangulating CCs' descriptions of how frequent, complex, and broad their regular information exchanges with other care providers were in a typical work week with CCs' descriptions of their daily work routines. Moreover, these interview data were further triangulated with frontline managers' and other occupations' descriptions and evaluations of CCs' relational coordination. Subsequently, HRM differences between high- and low- coordination cases and how other care providers constructed the CC role were analysed, abstracting these first-order codes into second-order themes and then into third-order categories. This yielded a framework in which frontline HR practices were dichotomized into 'relational' or 'transactional' (Figure 1).

After the second stage of data collection, this framework was applied to the next four workplace cases. Next, all eight workplace cases were theorized (Figure 2). This second stage yielded two conceptual developments: first, coordination outcomes were differentiated into low, moderate, and high; and second, managerial practices were differentiated into 'highly transactional', 'transactional', 'mixed', 'relational' and 'highly relational'. It was therefore concluded that frontline HRM relationality constituted a continuum (from a highly relational pole to a highly transactional one) instead of a dichotomy.

4 | FINDINGS

This section first introduces the conceptual framework that was empirically developed and then provides an in-depth discussion of the nested workplace cases around which the framework was developed.

To understand the HRM conditions of implementing CCs, the framework's first proposition is that frontline HR practices and their underlying HR philosophy can be categorized along a continuum between two poles: a highly

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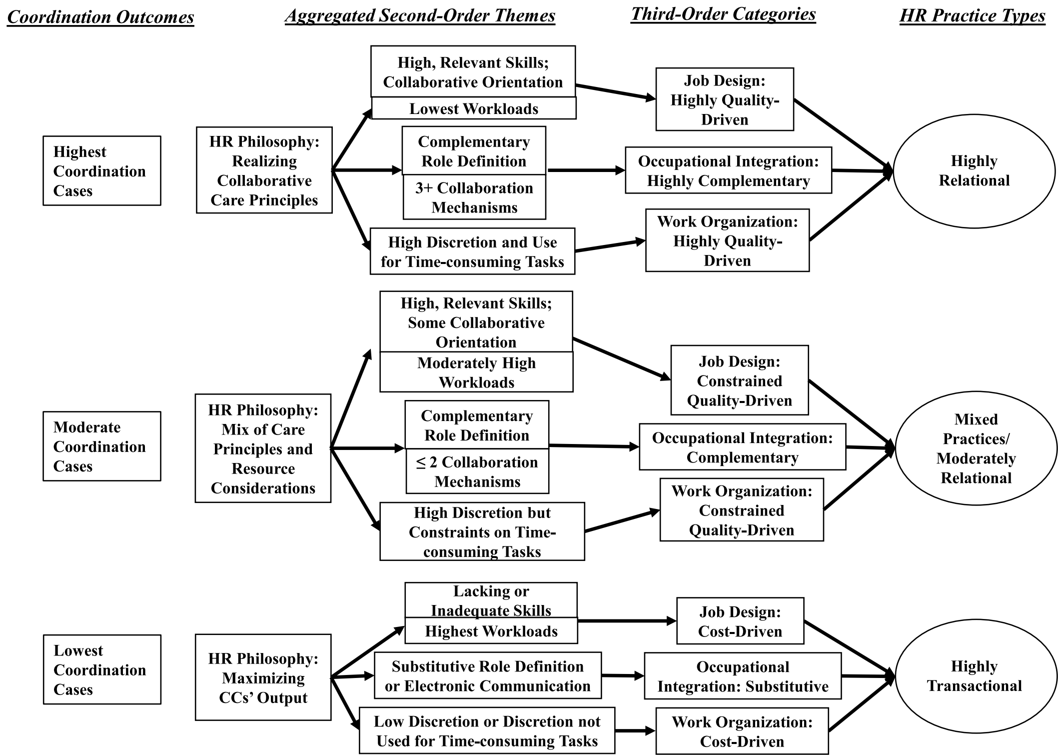

FIGURE 2 Stage 2 coding structure (all cases).

transactional one and a highly relational one, which are associated with low and high levels of coordination, respectively. High relationality was underpinned by an HR philosophy that aimed at realizing collaborative care through the HR practices of ensuring unique competencies or expertise and manageable workloads (‘quality-driven job design’). Highly relational contexts also featured a complementary relationship between CCs and other care providers, which was established through the HR practices of formal collaborative mechanisms and/or facilitative, informal communication. They also featured a quality-driven work organization that granted CCs a high degree of discretion and the time to collect and exchange relevant and unique information. High transactionality, by contrast, was underpinned by an HR philosophy aimed at maximizing CCs' output. It consisted of a cost-driven job design, a substitutive relationship between the CC role and other care providers' role, and a cost-driven work organization. Between these two poles were cases in which a partly relational, partly transactional HR philosophy produced a mixed form of HRM relationality (Figure 2).

The framework's second proposition is that professionalization differences co-vary with frontline HRM relationality, thus moderating the relationship between HRM relationality and CCs' coordination. Highly relational practices decreased professionalization gaps between the CC role and other care providers, and a quality-driven job design enabled unique competencies or expertise, collaborative work orientations, and the time required to coordinate. Moreover, complementarity reinforced the CC role as valuable and avoided perceptions of occupational substitution. Finally, granting CCs discretion enabled CCs to generate and/or share relevant, unique information with other care providers. Conversely, transactional practices increased professionalization differences. Figure 3 summarizes the overall framework.

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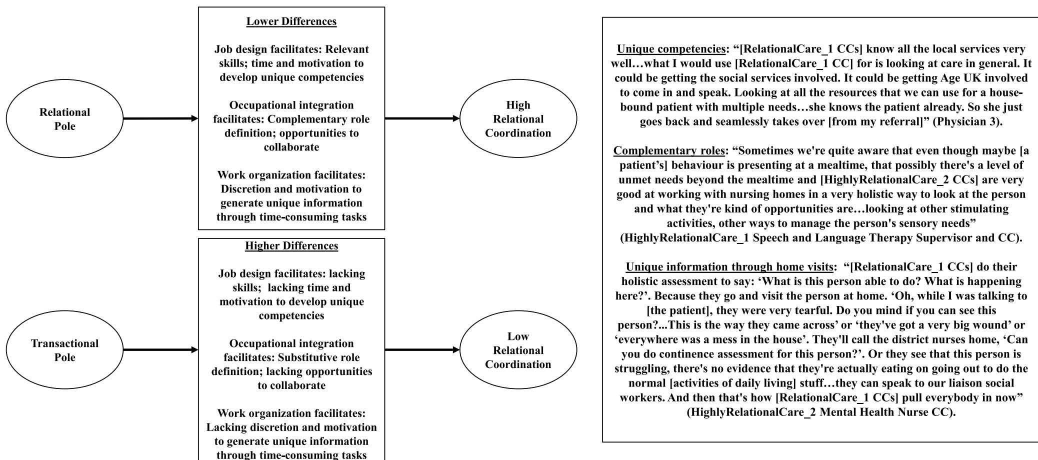

FIGURE 3 Professionalization difference's role between relationality and coordination.

The following discusses the workplace cases grouped by degree of frontline HRM relationality and coordination: first, two predominantly transactional cases with low coordination; second, three cases of moderate coordination where relational practices were scarce or constrained by cost concerns ('mixed' cases); finally, three cases with predominantly relational HRM and high coordination (Table 3 summarizes these findings).

4.1 | Transactional frontline HR practices

Two workplace cases embodied the 'transactional' type with the lowest level of RC. At HighlyTransactionalCare_1 (HTC_1), CCs stated that they provided administrative coordination (e.g., scheduling appointments) and did not have regular problem-solving meetings (i.e., 'case conferences') with other care providers. Several times a week, CCs joined a physician consultation, primarily to provide translation services: "Say it's a Spanish-speaking patient, I go just to make sure they understand" (HTC_1 CC_1). There was similarly low RC at TransactionalCare_1 (TC_1), where CCs case-conferenced only when they suspected a care-receiving person (called a 'program member') was missing due to a mental health emergency; otherwise, they referred members electronically to other care providers.

An HR philosophy aimed at maximizing CC output, primarily by increasing the number of monthly contacts with members, embedded this transactional type. For example, while the payment mechanism was the same for all US workplace cases, HTC_1's Director emphasized revenue generation most explicitly:

> "The strategic thinking [behind the program set-up] was money-driven. We get paid for every patient per month every time we meet the rules. We're bringing a lot of money into the hospital now…We've more than tripled the amount of cash that we're bringing in, and that's because we keep increasing our population".

The TC_1 Medical Director characterized the case as "more of a contracting organization", and the Operations Director similarly focused on revenue generation by enrolling members into other CC programs but servicing them with only one CC:

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TABLE 3 Overview of frontline HRM relationality.

Case name, HR philosophy, and coordination outcomes	Job definition	Occupational integration	Work organization
HighlyTransactionalCare_1: Output-oriented HR philosophy Low Relational Coordination (RC)	• Non-professionals; little relevant experience; High School diploma • 60 cases (per month)	• No facilitative communication or collaboration mechanisms • Instrumental relationship to physicians; substitutive relationship to social workers	• Concerted manager pressure to minimize time spent on clients in weekly team meetings • Conflict with professionals encouraging time-consuming tasks
TransactionalCare_1: Output-oriented HR philosophy Low RC	• Registered nurses; 10+ years' relevant experience • 90–100 cases	• No facilitative communication or collaboration mechanisms • Electronic referrals to specialized teams obviating coordination; CCs' focus on medical monitoring	• Day-to-day autonomy • Neither active support nor discouragement of time-consuming tasks
MixedCare_1: Mixed (Care Principles and Cost Considerations) HR Philosophy Moderate RC	• Non-professionals; 5+years' relevant experience; relevant Bachelors degree • 55 cases	• Facilitative communication • Complementary relationship to therapists; CCs' focus on resource management	• Extensive day-to-day autonomy and normative support of time-consuming tasks • High caseloads limiting available time for fieldwork
MixedCare_2: Mixed HR Philosophy Moderate RC	• Non-professionals; 3+years' relevant experience; relevant Bachelors degree • 65–75 cases	• 2 mechanisms: Regular training and monthly multi-disciplinary team meetings within CC team • Complementary relationship to supervisors who were licensed clinical social workers; CCs' focus on routine cases and resource management	• Day-to-day autonomy, though close monitoring by supervisors; support for telephonic coordination with other care providers • Call center model impeding fieldwork
MixedCare_3: Mixed HR Philosophy Moderate to High RC	• Nurses, physiotherapists; 5+ years' relevant experience • 35 cases • 5 team vacancies	• 2 mechanisms: Multi-disciplinary team meetings within CC team, and triage system for PCP referrals • Complementary relationship to primary care, acute secondary care; CCs' respiratory medicine expertise	• Extensive day-to-day autonomy and normative support for time-consuming tasks • Vacancies and caseloads inhibiting multi-disciplinary meetings beyond CC team

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TABLE 3 (Continued)

Case name, HR philosophy, and coordination outcomes	Job definition	Occupational integration	Work organization
RelationalCare_1: Collaboration-oriented HR Philosophy High RC	• Non-professionals; 1 to 10+ years' relevant experience, High School Diploma • 15 to 35 cases	• 3 mechanisms: Extensive multi-disciplinary teamworking; multi-disciplinary triage system with other CC services; co-location with HighlyRelationalCare 2 and other CC and primary care services • Complementary relationship to other CC services, primary care, voluntary services, social services; CCs' focus on relationship building and resource management	• Day-to-day autonomy; monthly supervision meetings with developmental focus (i.e., about solving complex cases) • Strong normative support for all time-consuming tasks (e.g., comprehensive assessments in the home; fieldwork)
HighlyRelationalCare_1: Collaboration-oriented HR Philosophy Very High RC	• Physiotherapists, occupational therapists, speech and language therapists; 5+ years' relevant experience • 12 to 30 cases	• 4 mechanisms: Extensive multi-disciplinary teamworking within and beyond CC team; regular training sessions; multi-disciplinary triage system within team • Complementary relationship to other CC services, primary care, secondary care, social services; CCs' physical/occupational/speech and language therapy expertise	• Extensive day-to-day autonomy; monthly or bi-monthly developmental supervision meetings • Strong normative support for all time-consuming tasks
HighlyRelationalCare_2: Collaboration-oriented HR Philosophy Very High RC	• Mental health nurses, occupational therapists; minimum 2 years', predominantly 10+ years' relevant experience • 8 to 15 cases	• 5 mechanisms: Extensive multi-disciplinary teamworking within and beyond CC team; training provision to other services; multi-disciplinary triage system with behavioral health services; co-location with MixedCare 2 and other CC and primary care services • Complementary relationship other CC services, primary care, psychiatric secondary care, social services; CCs' focus on mental health expertise	• Extensive day-to-day autonomy; monthly developmental supervision meetings • Strong normative support for all time-consuming tasks

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> "We can have a patient that is in [a risk program], in [managed long-term care], in our [CC program], and in another risk arrangement. So, they're in four programs. Technically, they're supposed to have four [CCs], four regulatory requirements, four different assessments…but I don't want to manage to the program".

This output-oriented HR philosophy was associated with a high-caseload job design (ranging between 60 and 100 cases per month), a lack of complementary integration between CC roles and other care providers, and work organization that deprioritized time-consuming tasks often considered to be highly beneficial for patient care (e.g., visiting program members in their home to assess their living conditions).

At HTC_1, managers hired non-professionals with little relevant prior experience and assigned the CC role a lower-paying job classification than available at the organization. Managers did not communicate the value of the CC roles to other professionals or establish collaboration mechanisms to achieve complementary occupational integration. Instead, CCs performed the same tasks as other roles, but for lower pay ('substitution'): "We're doing what a lot of case managers and even social workers do. And of course, they're getting a way bigger salary than we are" (HTC_1 CC_2). Furthermore, in weekly team meetings, managers actively discouraged CCs from performing time-consuming tasks advised by nurses and social workers (who clinically supervised the team), thus inhibiting knowledge transfers. For example, one social worker argued that CCs should be "agents of change in someone's life", for example, by conducting home visits, but that this issue led to regular "head-butting" with managers. Overall, this transactional model meant that CCs primarily filled an administrative role rather than providing unique expertise. Consequently, one physician characterized the role as derivative rather than transformative:

> "[CCs are] a second person to explain [what the doctor is saying] …[CCs] will say: 'Just listen to Doctor [surname]' (Physician 1).

At TC_1, the CC role had higher skills requirements—with managers employing registered nurses—yet all CCs had 90-100 monthly cases and sat in a call centre far removed from the patient population. Due to CCs' medical orientation, they primarily monitored clinical indicators of member conditions and explained medications. Furthermore, despite having task discretion, CCs did not liaise telephonically with other care providers, instead using electronic referral processes, some of which were automated, thus minimizing the time spent on coordination and reducing the CC role to a limited medical scope:

> "We try to prevent hospitalizations and re-hospitalizations… [We do this by asking] members for their health goals that they want to work on, such as normalizing their blood sugar levels…If patients get a mental health score of 10 or more, the system triggers a physician to reassess the treatment and referrals of the patient, but we can also send a referral to our behavioural health team". (TC_1 CC_1).

Overall, TC_1's model generated low RC due to managers' allocation of high workloads, electronic substitution of problem-solving communication with other care providers, and the failure to emphasize the value of performing time-consuming tasks. Furthermore, employing CCs with a medical orientation reduced the scope of coordination, which a physician connected to the model's output-driven aims: "[TC_1 CCs] do a whole bunch of things to try to keep [patients] out of the hospital [and engage in] clinical practice…because that's how we fund ourselves" (Physician 2).

4.2 | Moderately relational frontline HR practices

Moving along the spectrum from the transactional type, three cases exemplified a 'moderately relational' type of frontline HRM relationality wherein relational practices mixed with transactional ones or resource constraints led to transactional practices. This type was associated with moderate RC levels.

Additional to administrative coordination, CCs in this context case-conferenced moderately frequently with other care providers: 2–3 times weekly [MixedCare_1; (MC_1)]; 4–6 times weekly [MixedCare_2; (MC_2)]; and 6–15 times weekly [MixedCare_3; (MC_3)]. These conferences were less focused on translation services than on seeking advice from or jointly solving problems with other providers. For example, an MC_2 CC connected conferencing with preventing a deterioration of health:

> "[Our aim is] making sure that you get to the problem before it's a problem…One member could have issues with housing, one…with health…You're talking with a doctor here, but on the other end of it, you're talking with a housing lawyer and…a housing company".

In this moderately relational type, the HR philosophy emphasized the importance of realizing relevant care principles while also acknowledging resource constraints. For example, the Directors of MC_1 and MC_2 expressed support for social work principles such as helping members gain independence and advocating for their rights. Simultaneously, however, they assigned moderately high caseloads that pushed the limits of care quality: "If you want to keep quality, I think 65 [monthly cases] is doable" (MC_2 Director). Similarly, the MC_3 Director supported collaborative, community-based care while also recounting how her program was affected by restructurings and managerial downsizing:

> Through the transformation, those three teams merged, which made a lot of sense for the patients because it all became more seamless. But [consequently], the line management, etc., all changed. So actually, four posts went down to one, and that is a part-time post. So that's me [laughter].

The moderately relational type's job design accorded with this mixed philosophy, hiring people with 5+ years' relevant coordination experience (non-professionals at MC_1 and MC_2; occupational therapists and specialist nurses at MC_3) while assigning moderately high caseloads (around 55, 65–75 and 35, respectively). Some managers set these moderately high caseloads consciously, but on the MC_3 team, they resulted from various staff vacancies (a clinical psychologist, an occupational therapist, and three senior CCs) that increased caseloads and persisted due to recruitment challenges:

> "We've got huge turnover…those aren't the easiest of posts to recruit to in terms of what skills you're really looking for. Community doesn't appeal to everyone" (MC_3 Director).

Regarding occupational integration, the moderately relational type somewhat facilitated complementarity through two mechanisms. At MC_1, CCs claimed unique competencies in building relationships and managing members' resources (e.g., knowing how to apply for welfare benefits); the Director supported the role by differentiating these competencies from the counselling competencies of psychotherapists and clinical social workers:

> "[MC_1 Director] made it her business to introduce [CCs], speak with the units, speak with the therapists…explaining what role we play. What is it that we can do, what we're not able to do…She just made it [clear]: 'They're case management and case management means this'…basically helping [members access] their resources" (MC_1 CC_1).

At MC_2, the Director established a team structure in which a group of non-professional CCs sat next to a supervisor, a licensed clinical social worker, so that CCs could easily consult them when, for example, a member was having an emotional crisis CCs could not handle. The supervisors also provided weekly training sessions to facilitate knowledge transfer:

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> "This isn't clinical staff. So if any [person] mentions anything that is alarming to them or they feel uncomfortable with, we're available to kind of take over. And then process that with [CCs]…just teaching [CCs] about motivational interviewing and communicating with this population" (MC_2 Supervisor_1).

At MC_3, in addition to care coordination CCs claimed professional expertise around respiratory care, advising primary care physicians, and performing acute care tasks in secondary care settings. Managers facilitated complementary relationships through multi-disciplinary team meetings—including with a physiologist and respiratory consultant who advised on clinical issues—and by establishing a triage phone system so that primary care physicians could seek advice on potential referrals to the CC program.

Work organization in the moderately relational type granted CCs the discretion to engage in time-consuming tasks, though resource constraints could hamper their ability to do so. For example, MC_1 CCs accompanied patients to important benefits or court appointments when possible, but their high caseload limited how often they could. Furthermore, in MC_2, CCs working in a call centre did not have the ability to perform home visits. And finally, MC_3 CCs regularly did home visits but could not attend meetings across multiple primary care practices because such attendance "[would] undoubtedly have some sort of business case attached to it…It's not possible within existing resources" (MC_3 Director).

Overall, based on a mixed HR philosophy, the moderately relational type incorporated several relational HR practices, but transactional practices and/or resource constraints hampered coordination, keeping RC at a moderate level.

4.3 | Relational frontline HR practices

Three workplace cases represented the predominantly relational type of HR practice, which featured few or no transactional elements and was associated with the highest RC levels.

Additional to administrative coordination, relational type CCs case conferenced most frequently with other care providers: 10 to 15 times weekly [RelationalCare_1; (RC_1)]; and 15+ times weekly [HighlyRelationalCare_1, (HRC_1); and HighlyRelationalCare_2 (HRC_2)]. Furthermore, these CCs regularly sought and gave advice, engaged in complex problem-solving, and, more uniquely, coordinated with social services on a regular basis. For example, RC_1 CCs routinely interacted with the voluntary sector and housing providers; HRC_1 had a local government social worker who attended fortnightly team meetings; and HRC_2 regularly liaised with specialist mental health social workers and nursing homes. Finally, the HRC cases had privileged access to community and mental health systems, sharing information with others who lacked access.

An HR philosophy emphasising collaborative, holistic, and community-based care principles embedded the relational type, providing strong normative support for RC. The HRC_1 Director, for example, stressed the aim of helping people gain independence while managing a condition:

> "[We look] at impairments, but in a way that's meaningful to the person and what they're doing, even their activities, their sport, all of that, hobbies…There's a big sort of self-management ethos within the service as well, so [people] can be working on things and then we can go back in…to review".

The HRC_2 Director expressed the importance of addressing long-term issues through psychosocial interventions and collaborative care to address all of a patient's interlinked issues:

> "Services need to work together better. Because we should be all singing the same tune. It's not like your flipping head's being chopped off. Your body, your mind, brain, soul, they all work together".

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The RC_1 Supervisor explained that while there were some cost-focused pressures emerging— like senior managers' demand for more transparency around meeting performance targets—the main aims were to manage social determinants of health and further patient advocacy, independence, and safety due to a "duty of care":

> "Obviously for some people [gaining independence] just isn't going to work at all, if they're dementia patients…But with [them], it's around…as long as we can put something in place to make sure that, however quickly they deteriorate, they're safe".

The relational type's job design facilitated these collaborative care principles. The CCs hired were people with 10+ years' relevant coordination experience (non-professionals at RC_1; physiotherapists, occupational therapists, and speech and language therapists at HRC_1; and occupational therapists and specialist mental health nurses at HRC_2), and they were assigned purposefully low caseloads (15–35, 12–30, and 8–15, respectively). In one instance, an HRC_1 supervisor had begun to weight cases by acuity to facilitate optimal workloads:

> "You may well have a list of a lot of names on your caseload, but that doesn't necessarily mean that you're at capacity, and vice versa…So rather than thinking about numbers of patients on our caseload, I'm trying to get my team to think about the complexity and checking in on that [regularly] so that they can more attentively think about their capacity".

Regarding occupational integration, the relational type facilitated complementarity through three or more collaborative mechanisms. At RC_1, non-professionals claimed the unique competencies of building relationships with people and care providers and helping people manage resources (e.g., home care services). For one social services manager, RC_1 CCs' value lay in knowing "who's who within the health services" and sustaining relationships with care-receiving people: "[Social workers are] relatively new into [a person's] life, whereas the [RC_1 CCs] might, on and off, have been involved with them for a long time". Also facilitating coordination was managerial support for CCs' multi-disciplinary teamworking (e.g., attending primary care practices' team meetings); a system of triaging people across different CC services; and co-location of RC_1 CCs with other CC services. One CC emphasized the collaborative benefits of co-location in particular:

> "We're sitting in an office with physiotherapists, occupational therapists, nurses, [healthcare assistants]…we tend to pull from one another. We get information. We get advice. We'll look at things that…if we weren't sitting in the room together we might have not thought: 'Okay. Well, actually that doesn't look right. Maybe we could refer them to so-and-so".

At the HRC cases, CCs claimed professional expertise based on physical, occupational, or speech and language therapy and mental health. HRC_1 managers had a nurse and a psychologist regularly advise the CC team; operated a multi-disciplinary system to triage patients within the team; organized weekly training sessions; and supported multi-disciplinary working with providers outside of the team, for example, joint home visits with dieticians, attending patient consultations with primary care physicians, and bi-weekly or weekly interactions with a social services worker:

> "We have a bi-weekly…case conference discussion, but if I have cases that require urgent assessment, what I do is I can call [the HRC_1 team] and find out who is involved in the care of the person, and we arrange a date as quickly as possible…If there are any anxiety issues and they require psychology input, they have a psychologist…They have the [primary care electronic health records] which I don't have access to…So it's like a one-stop shop where we can have all the necessary support from social services and then health to make sure [people] become independent" (Social Worker_1).

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Similarly, HRC_2 managers had a psychiatrist and pharmacist regularly advise the CC team; operated a multi-disciplinary system to triage patients with another mental health-focused CC team; co-located CCs with other CC services, enabling regular joint home visits and mental health support; encouraged extensive multi-disciplinary teamworking with mental health, primary care, and long-term care services; and had occupational therapy CCs aid care homes by providing advice and running a 10-week, dementia-focused training program:

> "[HRC_2 CC_1] is fantastic...she sometimes does dementia mapping, and an analysis of how she thinks that we should manage the care. And that's a great help to have that kind of support and expertise because it just helps us to manage that person better than we would normally do it" (Nursing Home Manager).

Regarding work organization, the relational type provided CCs with extensive day-to-day autonomy and developmental support through monthly, one-to-one supervision meetings focused on complex cases. For example, RC_1 CCs estimated that they spent between 50% and 80% of their time 'out in the field,' and said that their supervisors stressed the importance of home visits in making holistic assessments and ensuring that patients felt free to discuss sensitive issues they might not bring up over the phone and counter with: "I'm absolutely fine, dear. No problems. Thank you very much for calling" (RC_1 Supervisor). An HRC_2 physiotherapy supervisor and CC highlighted the combination of discretion and developmental supervision for the new role:

> "I feel like I've got a lot of discretion. But I also feel that I can ask any questions or be quite open about any difficulties or issues that I'm having. And basically, when we have supervision, it's documented supervision so the first part of the supervision session is going back on the last supervision and following up on actions".

Overall, the relational type involved an HR philosophy based on collaborative care principles and complementarity with a broad range of other care providers. It combined the practices of high skill requirements, low workloads, more than three collaboration mechanisms, discretion, and developmental supervision to facilitate high levels of RC.

5 | DISCUSSION

HPWP scholars have placed much attention on establishing the HR-performance link. More recently, though, HR scholars have shifted their attention from *what works* to *how to get to what works* by focusing on the conditions for implementing HPWPs. This article builds on this nascent literature by examining the role of frontline HR practices as a condition of implementing an HPWP. More specifically, this article highlights how HPWP implementation was influenced by the extent to which frontline managers enacted varying degrees of relationality.

To explore the role of frontline HRM relationality for HPWP implementation, this article studied the 'care coordinator' role, intended to span the boundaries of health and social services. The CC role is a vital element of policymakers' efforts to improve health and wellbeing. On the one hand, the policy programs promoting the role reflect a recognition of what HR practices work best; on the other, the role's implementation has faced several barriers, suggesting a limited understanding of effective implementation.

This article's framework (Figure 3) emphasizes the importance of frontline managers in implementing HPWPs. In doing so, it shifts attention from the HPWP literature's traditional focus on the HR-performance link (Paauwe & Boselie, 2005; Wright et al., 2003) to frontline, HRM conditions of HPWP implementation. The findings confirmed the HPWP literature's traditional emphasis on consistency (MacDuffie, 1995) insofar as the boundary-spanning CC role achieved higher coordination if supported by relational frontline HR practices that were based on collaborative care rather than inhibited by transactional practices based on output maximization. Moreover, as in Monks and

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colleagues' (2013) study, findings showed that an HR philosophy promoting collaborative work principles and knowledge sharing over output maximization embedded more relational practices, though with less of an emphasis on innovation than the firms in Monks et al.'s study. This difference could be due to professional services firms requiring a greater regularity and frequency of innovation than health and care organizations, where better coordination is itself an innovation. Nonetheless, this suggests the fruitfulness of studying frontline HRM relationality in professional services.

This article also strongly resonates with Kirkpatrick and Hoque's (2022) study in stressing the importance of professionalization processes for HPWP implementation. However, those scholars emphasized senior managers' professionalization level, while this article stressed lower-level managers' role in minimizing professionalization differences between CCs and other care providers. This focus was primarily due to research design whereby all nested workplace cases enjoyed senior manager support for care coordination; consequently, future research could study how senior managers' relationality shapes HPWP implementation. Furthermore, while Wu et al. (2015) found firm size determined HPWP adoption, this article's nested workplace cases were located within medium- and large-sized hospital organizations. Another future research avenue could therefore involve examining frontline HRM relationality in small organizations.

This study also contributes to RC theory by suggesting that frontline HRM relationality increases RC by reducing professionalization problems in the context of a boundary-spanning role. RC scholarship has suggested that professionalization acts as a barrier for coordination (Gittell, 2009), and this article has provided empirical evidence for this proposition. Furthermore, in theorizing the continuum between highly relational and transactional frontline HRM relationality and their relationship to professionalization differences, this study has examined the conditions of frontline HRM relationality, as well as how such relationality can overcome professionalization differences.

The article's framework also resonates with the workforce innovation literature's emphasis on complementarity, and indeed advances this field by putting a stronger emphasis on managerial facilitation. Workforce innovation studies often examine managerial interventions that allocate some of an established profession's tasks to a lower-skilled role such as, for example, healthcare assistants (Chen et al., 2022; Kessler et al., 2015; Krachler & Kessler, 2022; Procter et al., 2018). While these studies acknowledge the role of managerial facilitation, they emphasize the autonomous regulation of occupational relations over time. In contrast, this article has highlighted several HR practices that frontline managers can enact to actively facilitate a new boundary-spanning role, perhaps partly because coordination is wider-ranging and thus requires more managerial intervention: coordination interventions do not reallocate existing tasks but add a new set of tasks into an existing system; moreover, while the aforementioned studies referred primarily either to health or social care settings, CCs aim to integrate *both* sectors. Future studies could therefore examine whether the attempted workforce innovation (task reallocation vs. new task creation) influences the impact of managerial intervention.

6 | CONCLUSION

This article contributes to our knowledge of HPWP implementation in several ways. First, building on a nascent literature, it refocuses the study of HPWPs from performance outcomes to implementation conditions. Second, the article develops a theoretical framework that centres one important condition: the degree of relationality enacted by frontline managers' HR philosophy and practices ('frontline HRM relationality'). In drawing from discussions around professionalization and complementarity, this article also integrates insights from workforce innovation studies and proposes that HPWPs—in addition to other relational HR practices—can facilitate relational coordination by reducing problems related to professional status between new and existing roles.

This research has several practical implications. For policymakers aiming to improve coordination through a new boundary-spanning role, it is vital that they diffuse knowledge around the nature and importance of frontline HRM

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relationality. Similarly, senior managers overseeing coordination programs should ensure frontline HRM relationality, for example, through training programs. Furthermore, frontline managers should provide—and where absent, employees should highlight the need for—managerial support through relational HR practices such as assuring manageable workloads, establishing collaboration mechanisms, and granting task discretion to enable effective coordination between CCs and other care providers.

This research has several limitations. First, the nested workplace cases did not vary in terms of potentially influential managerial conditions. It may be fruitful to study how the lack of senior management support or small organizational size might condition frontline HRM relationality. Second, participants from transactional, nested workplace cases reported that they performed some degree of administrative coordination. This suggests that the article might underestimate the importance of relationality as the framework suggests that CCs' inability to provide any coordination at all would derive from even more transactional HRM than was found in the workplace cases. Third, the qualitative case-study methodology employed here was suitable for conceptually exploring and developing HPWP implementation conditions. Going forward, quantitative methodologies, such as surveys or econometric analyses, would be suitable for testing the broad applicability of the theoretical framework and for providing a more rigorous test of the causal relationships it suggests. Finally, this research focused on an inter-dependent work context—the highly professionalized health and care sectors—highlighting relevant frontline HR management practices and professionalization problems. Future research could investigate the importance of frontline HRM relationality in similar sectors, such as professional services or education, where the work context is also interdependent but where policy aims and professionalization issues might differ.

ACKNOWLEDGEMENTS

I would like to thank the policymakers and respondents who gave their valuable time and knowledge. I would also like to thank the editors Geoffrey Wood and Anders Dysvik for their invaluable guidance and the reviewers for their constructive comments. Many thanks also go to Rose Batt, Graeme Currie, Ginny Doellgast, Louise Fitzgerald, Kate Kellogg, Adam Seth Litwin, Pam Tolbert and Kim Weeden for their constructive comments on the research and earlier versions of this article. Moreover, I would like to thank Jody Hoffer Gittell, Ian Kessler and Dimitrios Spyridonidis for their equally constructive and generous comments on a recent draft of this article. This research benefited from a Cornell Engaged research grant.

DATA AVAILABILITY STATEMENT

The data that support the findings of this article are not shared to protect the anonymity and confidentiality of participants.

ORCID

Nick Krachler https://orcid.org/0000-0001-8424-9863

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How to cite this article: Krachler, N. (2023). Getting to what works: How frontline HRM relationality facilitates high-performance work practice implementation. *Human Resource Management Journal*, 1–21. https://doi.org/10.1111/1748-8583.12502

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