Voices from the Front:
Recruitment and Retention Of Direct Care Workers In Long Term Care Across Michigan

April 22, 2004

Maureen Mickus, PhD
Michigan State University

Clare C. Luz, PhD
Michigan State University

Andrew Hogan, PhD
Michigan State University

Acknowledgements

We wish to acknowledge the contribution of Jack Steiner, Executive Director of BEAM (Bringing the Eden Alternative™ to Michigan) who collaborated with the Michigan Office of Services to the Aging (OSA) on issues related to recruitment and retention of Michigan's direct care workers. Since 2002 he has provided invaluable guidance on the research, while promoting important reforms on behalf of workers in long term care across Michigan. We also recognize Harvey Zuckerberg, Executive Director of the Michigan Home Health Association (MHHA), for his assistance in facilitating participation from home health agencies for this study.

In addition to the primary sponsors of this research project, we wish to acknowledge the participants of the Michigan Direct Care Workforce Initiative (MDCWI) Coalition, comprised of advocates, consumers and government representatives, for their dedication and support of this project. We thank Lauren Swanson at OSA for her many contributions in completing this report.

Finally, our deepest gratitude to the many direct care workers across the state who took the time to complete this survey and share their experiences with us. We dedicate this final report and our continued efforts to them, in the hopes that their work will soon be recognized and rewarded with long term care and workforce policies that reflect a greater respect for them as well as the people in their care.

This research study was funded, in part, by a grant from the Michigan Office of Services to the Aging to BEAM (Bringing the Eden Alternative™ to Michigan).

Executive Summary

Current social conditions that include a burgeoning aging population and fewer available kin caregivers will soon strain a long term care system already beleaguered by severe labor shortages and the retention of frontline workers. Exorbitant worker vacancy and turnover rates within this sector not only affect the quantity and quality of care to consumers, they have serious ramifications for the local and state economy. Despite high unemployment rates within Michigan, many direct care jobs exist but often go unfilled. Furthermore, the demand for these workers is anticipated to sharply increase with the rapid aging of the population. The challenge lies in creating a stable, yet competent workforce.

In order to stop the flow of workers from this sector, it is crucial that we understand more about the specific factors that influence direct care workers' decisions about their work. Foremost, we need to understand what draws them to direct care work, and what motivates them to stay in or leave this field. Therefore, the purpose of this research was twofold: to examine factors associated with entry into direct care work, and to examine factors related to retention of workers including caseload, wages, supervisory style and job satisfaction in Michigan's long term care settings, particularly nursing homes and home health agencies.

Research Design

Over 1,100 direct care workers statewide completed an anonymous mail survey in the summer and fall of 2003. The population sample was based on both a random selection of workers from a nurse's aide registry obtained from the Michigan Department of Community Health (MDCH) and a convenience sample of direct care workers in home health settings obtained from twelve Michigan Home Health Association (MHHA) members. The sample provided unique insight into what conditions might best predict workforce losses because it included individuals who had completely left direct care work. In addition, respondents with a current direct care job were asked about their intentions to leave within six months, providing a glimpse at potential turnover.

Findings

In general, this research:

- Provides an empirical database of Michigan direct care workers that may be used as a basis for developing future interventions;
- Challenges opinions regarding why individuals enter or leave direct care work; and
- Identifies variations in motivations between long term care settings and between regions across Michigan, both of which have implications for how to best focus resources and reforms.

Key findings suggest that workers in this sample intentionally chose direct care work, not because they had no other options, but because they had a desire to help others, particularly older adults. Altruism and a vocational interest in health care reigned as the primary motivators in their decisions to enter this field.

While not the driving force for entering direct care, wages were the strongest predictors in motivating individuals to leave the field. Furthermore, workers from poorer households were more likely to quit direct care compared to those with higher incomes. In addition to wages and household income, perceived lack of respect and lack of control from supervisors were critical factors significantly related to turnover. Reasons for leaving varied when comparing nursing home and home health workers, as well as those in different regions. For example, low wages were a major catalyst for quitting direct care work among nursing home workers. Although problematic and substantially lower among home health workers, wages were not specifically a factor prompting home health workers to leave direct care. Instead, lower household income, as well as lack of control provided to the worker by the supervisor, served as catalysts to leave among home health workers.

A host of other job characteristics were cited by workers as being important and potentially influential but were not necessarily predictive of whether or not they left the field. In particular, nursing home workers cited a high caseload and not being valued by the employer as important, and home health workers reported issues related to insufficient hours.

Despite these adverse job conditions, three-fourths of the total sample reported overall job satisfaction. Yet, nearly half of the current workers cited intention to leave

their position within six months with, again, lack of respect and lack of control perceived as critically important. In fact, the findings suggest that if those intending to leave their current jobs within six months had been more satisfied with these two factors alone, they may not have considered leaving, irrespective of the pay rate. It should be noted that workers citing their intent to leave within six months might not have planned to leave direct care altogether, but may have simply planned to move to a different health care employer. Although wages played an important role among those who had left the field, this was not the case for the workers who were still working, yet contemplating a job change within the next six months. It appears that these two sets of workers had qualitative differences that require further exploration.

These findings underscore several important areas of interest in our understanding of direct care work. Retaining a stable workforce in long term care is undoubtedly complex and requires multi-faceted solutions. Low wages and poverty represent major issues that drive out committed, well-intentioned workers. Wages are especially troublesome among workers in nursing home settings. Clearly, low wages and poverty status are likely linked for all direct care workers. These factors play an important role given that roughly half the workers are near or below the U.S. poverty threshold. However, more than half of the direct care workforce reported having post-high school education. Beyond wages, the need to create a culture within long term care that demonstrates respect for these frontline workers is paramount. Given the critical labor shortage at hand, this may require changing organizational structures to allow direct care workers some measure of control over their jobs (scheduling, assignment and care decisions for example) and realistic caseloads.

This research lays the groundwork for targeted interventions attempting to stave off the exodus of caring, competent workers in long term care. These efforts are likely to be most effective if tailored to specific work settings and, in some cases, regions. The immediacy of this crisis, brought about by the fragility of this workforce, the multitude of adverse job conditions and rapid aging of the population, demands our serious attention.

Introduction

Current social conditions that include a burgeoning aging population and fewer available kin caregivers will soon strain a long term care system already beleaguered by severe labor shortages and problems with recruitment and retention of frontline direct care workers.[1] High worker vacancy and turnover rates within this sector not only affect the quantity and quality of care to consumers, they have serious ramifications for the local and state economy. Thousands of long term care jobs exist but often go unfilled, and demand for them is anticipated to sharply increase. The challenge lies in filling these positions with competent workers and then in retaining this workforce.

Given the critical need to build a stable, qualified workforce for the long term care needs of Michigan's citizens, it is imperative that we increase our understanding of the factors that influence direct care workers' decisions about their work. Foremost, we need to understand what draws individuals to direct care work, and what motivates them to stay in or leave direct care work. To date, no empirical statewide studies related to this issue have been undertaken.

Therefore, the purpose of this research was to examine worker and organizational characteristics that influence the recruitment and retention of direct care workers in Michigan's long term care settings, particularly in nursing homes and home health care. The findings are important for the future development of evidence-based public policy initiatives on long term care, workforce, and economic issues.

The study described in this report makes unique contributions to the understanding of direct care workers on several levels. First, it utilized a statewide randomly selected sample to conduct a survey that was completely anonymous so that workers would be

---

1 For purposes of this study, a direct care worker is defined as someone who performs certain functions related to the care of another that does not require a professional license. These include social tasks such as companionship, assistance with instrumental tasks of daily living such as light housekeeping and meal preparation, and intensive hands-on personal care. Direct care workers may supplement the care of other professionals or may be the only assistance an individual receives, depending on the needs and resources of the individual. They are known by many names including paraprofessional, home health aide, home care attendant, personal care attendant, homemaker, and so forth. For this study, the term "direct care worker" will be used. The term "frontline" denotes workers who actually provide the care as opposed to people who hold more administrative or supervisory positions.

more inclined to provide an honest appraisal of their work experiences and decisions about tenure. These responses provided empirical evidence to support intuitive and anecdotal knowledge specific to Michigan. Second, it included both individuals still working in direct care as well as those who had left and could provide insight into what conditions might best predict workforce losses. Finally, respondents with a current direct care job were asked about their intentions to leave within six months, providing a longitudinal glimpse at potential turnover.

Specific Aims

This project had two specific aims:

- To examine factors associated with entry into direct care work.
- To examine factors related to retention of direct care workers including caseload, wages, supervisory style and job satisfaction.

Background and Significance of the Research

Direct Care Worker Shortages: Crisis Projected

There is currently a shortage of direct care workers in all long term care arenas, and this shortage will soon reach crisis proportions as the population ages and the availability of kin caregivers declines.[1, 2, 3, 4, 5] Direct care workers provide the vast majority of paid long term care, second only to family and other informal caregivers.

To illustrate the extent of the current shortage, the American Health Care Association (AHCA) conducted a 2002 survey of over 6,100 nursing homes across the nation to examine vacancy and turnover rates among six nursing staff positions, including Certified Nurse Assistants (CNAs).[6] Nearly 52,000 CNA positions (approximately 8% compared to 11% in 2001) were estimated to be vacant and the average annual turnover rate among CNAs was 71% (compared to 78.1% in 2001), a stunning figure when compared with the national annual employee voluntary turnover rate for all industries of 19.2 percent.[7] Even the hotel and food service industry averages less than a 50% annual turnover rate. Some studies report turnover rates in nursing homes exceeding 100 percent.[4] In Michigan nursing homes, AHCA reported that the CNA vacancy rate for nursing homes approximated the national average of 8.3% (compared to 10.5% in 2001) and the turnover

rate reached nearly 66 % (compared to 72.2% in 2001). The Health Care Association of Michigan (HCAM), the statewide trade association for the state's for-profit nursing homes, has conducted its own studies on turnover and reports that among CNAs, the 2002 turnover rate was 48.5% (compared to 64% in 2001). [8] Their findings vary slightly from the AHCA studies may be due to differences in how calculations were estimated. Both report a decline in vacancy and turnover rates over the one-year period. HCAM attributes this decline to increased wages.

Several national and state studies indicate that shortages and turnover of direct care workers in home care settings are lower but also critical. According to one source, only 17% of turnover can be attributed to movement of workers within the healthcare sector versus leaving health care entirely.[3] A recent survey conducted nationwide reported that 42 states have experienced major problems with recruitment and retention of direct care workers across long term care settings.[9]

Exorbitant turnover rates among direct care workers exact both a high human and monetary toll. The cost of constant recruiting and training to replace short-term workers is staggering and represents resources that are desperately needed elsewhere to improve the quality of life and care for consumers. As an example, the cost of replacing a direct care worker in a nursing home has been estimated at between $2,341 and $3,840 and for replacing a home health care worker at $3,362.[2,10,11] These estimates include costs associated with recruitment, training, increased management expenses and lost productivity. With turnover rates in excess of 50% annually, such costs quickly add up to millions of dollars statewide. With high vacancies and such frequent staff changes, continuity of care is virtually impossible and reports suggest that quality is compromised.[1, 4, 12, 13, 14] A direct link between turnover and quality has just begun to be empirically established[15, 16] and is an area in which research is still much needed.

Vacancy and turnover rates among direct care workers are the result of multiple factors including demographic changes; an economic downturn; poor labor conditions due in part to the low social value placed on direct care work and caregiving in general; and rising health care costs.[3, 4, 17, 18,19, 20] Health care costs have led to staggering increases in Medicare and Medicaid expenditures, which have prompted changes in public financing of long term care and, in turn, pressured institutional/agency providers of care to focus on

cost containment. Reimbursement rates and methods play a critical role in the ability of nursing homes and home care agencies to attract and retain good workers with decent wages, benefits, and workloads. Since labor comprises the largest single expense category of most healthcare businesses, labor costs are inevitably targeted. [21, 22] One strategy for increasing the productivity of paid labor is to institute higher workloads.[21,23]

Primarily due to job dissatisfaction and continued changes in demographic factors, increased worker shortages are clearly expected in the future. It is estimated that the population of people aged 65 and older will double by the year 2030 (the year "baby boomers", those born between 1946-1964, will begin to reach age 85). People aged 85 and older who are most likely to require long term care, currently constitute the fastest growing age group in the U.S.[4,6,24] The number of direct care jobs in nursing homes and home health care is expected to increase by 36% and up to 58% respectively, in comparison to a 14% increase in all job sectors, during this period.[2,25, 26, 27] One report estimates the demand for direct care workers to grow 200-242% by the year 2050. [5]

Yet during this same time, the number of women between the ages of 20 and 54 who have traditionally occupied direct care positions will increase minimally. Consequently, the gap between available jobs based on increased demand, and the availability of direct care workers to fill these positions, will widen dramatically. The current shortages with all of the resulting costs to quality of care, life and productivity also have far-reaching economic consequences including the ability of communities to attract and keep residents and vital industries.

Characteristics of Direct Care Workers

The actual size of the direct care workforce is difficult to determine for a number of reasons. In home care for example, the job is poorly defined, often entails part-time episodic work, and workers with multiple jobs may not report home care work as their primary occupation. The Public Health Service and the Bureau of Labor Statistics collect only limited data on home care workers, none on independent providers. The Center for Medicare and Medicaid Service's annual figures on home care spending do not include reports from private agencies, independent providers, or agencies receiving public funds from sources other than Medicare and Medicaid.

Nevertheless, studies have been conducted to determine a typical demographic profile of direct care workers. It is consistently reported that the majority of workers in both nursing homes and home care are female, middle aged, disproportionately African American and Hispanic, unmarried, are the primary wage earner, and have a limited education, income, and little or no health insurance. [3, 17, 28] Still, researchers agree that there are notable differences between hospital, nursing home, and home care direct care workers. The profile of home care workers has changed somewhat in the last fifteen years: they are now younger, more educated and more likely to have children. However, they continue to be older than hospital and nursing home workers with an average age of 43 (compared to 36), slightly less likely to be married, and less likely to have a child at home, which reflects differences in the age distribution. Both nursing home and home care workers still tend to be less educated than hospital workers

There are significant differences in family incomes as well. Poverty rates for nursing home and home care workers average 16% and 22% respectively, exceeding the national average of 12-13%. This compares to 9% of hospital workers at poverty level. Moreover, an additional 29% of nursing home workers and 25% of home care workers live at near-poverty level. Adjusting for inflation, income and wages have increased slightly for home care workers, but have actually decreased for both nursing home and hospital direct care workers over the last fifteen years.[17]

In terms of benefits, nursing home and home care workers are also less apt to have any benefits than hospital direct care workers, most notably health insurance. Home care workers are more likely to have Medicare coverage, a reflection of age differentials, and Medicaid coverage, a reflection of low-income status. [17, 28]

Labor Conditions

Studies that report on the job conditions of direct care workers in both nursing homes and home care settings reveal similar findings. According to the workers themselves, the work is characterized by low wages, few if any benefits, lack of guaranteed hours (hence, lack of guaranteed income), inadequate training and supervision, lack of information about clients and responsibilities, isolation from peers, unclear lines of authority, minimal opportunity for advancement, possible unsafe working conditions, no

allowance for travel or training time, high work-related injury rates especially among nursing home workers, and little respect accorded the position. [3, 15, 16, 22,29,30,31, 32] National data from several sources indicate that home care workers receive lower wages than hospital and nursing home workers.[17,28]

Motivations for Entering Direct Care Work

It is notable that all of the labor conditions heretofore mentioned reflect a negative assessment of direct care work. If conditions are so poor and the public does not value the work by rewarding it in concrete ways, then why would anyone choose this type of work? One reason suggests that these workers have no other options. Another is that minimal skill and credentials are required, thus providing easy entry to the field.

Past research on worker motivations indicate far different reasons. For example, the majority of workers reportedly find direct care work intrinsically rewarding. They have intentionally chosen it because they enjoy helping others in need of care or assistance, enjoy the relationships with their clients, and possess a desire to engage in meaningful work. Further, a number of workers prefer part time hours, flexible hours that accommodate their needs, the job's variety, independence, feeling needed, and, particularly for home care workers, being able to provide individual attention and to work on their own. [29, 33, 34, 35, 36, 37] The research of Feldman, Sapienza, and Kane[32] suggests that, despite numerous difficulties, home care work offers significant rewards, which can motivate direct care workers to stay in the business. Similar to workers in any other field, direct care workers make trade-offs.[36] For example, if isolation is a drawback, the positive trade-off is independence and personal responsibility. Likewise, the negative job conditions or lure of better pay and benefits may ultimately outweigh what rewards of the work exist.

Motivations for Leaving Direct Care Work

As stated above, vacancy and turnover rates among direct care workers are the result of multiple factors including demographic changes, poor labor conditions, and rising health care costs. The negative conditions alone are all potential motivators for leaving direct care work. It is often said that raising wages would stabilize this workforce, although there has been little empirical evidence to support this claim. On the contrary,

studies indicate that the issue is far more complex. Direct care workers, as workers in most fields, are likely motivated by factors other than wages alone, weigh the pros and cons of each job taking into consideration multiple factors, and ultimately make trade-offs in order to achieve the conditions that are of most value to them.

Research suggests that there are some job conditions that drive workers' decisions to leave more than others. One job condition that has been repeatedly found to influence retention is supervisory style or the relationship between workers and their supervisors. Workers that are treated with respect by their supervisors and participate in decisions regarding client care and work schedules are more likely to stay on the job. [3, 15]

The Link between Direct Care Workers and Quality of Care

Within the formal long term care system, direct care workers provide eight out of every ten hours of nursing home care and *every* hour of unlicensed care in home care. [38, 18] Job quality and satisfaction are linked with quality of care because direct care workers spend more time with clients than any other provider, and this alone gives them tremendous insight.

Neil Henderson's [39] and Timothy Diamond's [40] ethnographic research as nursing assistants in nursing homes describe the "unofficial" work of the aides. Unofficial work includes ways to personalize care based on intimate knowledge of the client's needs and preferences. It derives from extensive contact with the client and renders the direct care workers able to identify even subtle but important changes. This places workers in a decision-making position from which they either go ahead and act on their own or report the change to a higher authority. Henderson frequently observed workers making what he calls "folk diagnoses" and providing "treatment" modeled after mother/child interactive patterns that were physically and emotionally nurturing.

Rosalie Kane [41] agrees. She states that the myriad of small issues that arise daily in contacts with clients require "everyday ethics" that include such concepts as autonomy, justice, dignity, communication, problem-solving, and choice, ultimately affecting the quality and safety of care. Direct care workers spend the greatest amount of time with clients in the most intimate of care.

There is growing empirical evidence that direct care worker satisfaction with job conditions has an impact on indicators of quality of care as well as client satisfaction with the care they receive. [14, 42, 43, 31, 32, 44, 45, 46, 47] One job condition alone may make a difference, such as in the effects of staffing levels. Harrington et al. [48] advised the US Congress in 2000 that minimum nurse staffing standards are required to improve quality of care in nursing homes. A 2000 Health Care Financing Administration (HCFA) Report to Congress on the appropriateness of mandating minimum nurse staffing ratios in nursing homes presented compelling evidence that, below a certain staffing level, residents are at risk for quality of care problems.[49] It noted that the nursing hours per resident day, particularly nurses' aide hours, were directly related to the number of quality care deficiencies reported by state inspectors. For example, nurse's aides play a critical role in the prevention of rates of infection (respiratory, urinary tract, or sepsis), which account for the majority of transfers to hospitals. A 2001 follow-up Report to Congress by HCFA[14] confirmed that staffing levels do indeed affect quality of care and indicated a strong relationship between nursing assistant retention and quality, as well as turnover and quality on certain outcomes including urinary tract infections and pressure ulcers.

Beyond staffing levels, other job conditions affect quality of care, particularly the relationships that develop between workers and clients which are highly valued by both parties.[33] This human interaction is of central importance to satisfaction and affects both social and physical outcomes. Brannon and Smyer[42] suggest that when nursing home aides are able to provide care with which they themselves are satisfied, they become committed caregivers and in turn, residents get good care. Other researchers posit that committed caregivers-those who are already motivated by altruistic feelings as opposed to economic need only-will attempt good care under any conditions and agonize when conditions force them to give less than desirable care.[46, 36] In other words, workers committed to giving good care are leaving the workforce.

Surpin, [44] founder of Cooperative Home Care Associates (CHCA), a home care company owned and run by the home health aides themselves, has closely monitored the relationship between the quality of workers' jobs and the quality of the work they provide. CHCA is based on two fundamental beliefs: the quality of care received by a client is directly related to the quality of the worker's job; and, good jobs must be supported by an

organization that can advocate for adequate wages and benefits and select and train workers not only in technical skills but also in caring, cooperation, problem-solving and communication. Yee [50] states that despite advanced medical technology, the key criteria for good care continues to be recruiting workers that are honest, reliable, compassionate, willing to learn, and committed as caregivers.

New Initiatives and Strategies for Recruiting and Retaining Direct Care Workers

There have been a number of new strategies initiated for recruiting and retaining direct care workers across the country within the last decade. Some have been implemented at the state level, most at the individual facility or agency level. The majority of these have not included a formal evaluation or research component, so any changes that have occurred seemingly in conjunction with new initiatives are largely anecdotal and lack the empirical authority to effect serious policy reforms or widespread practice changes. However, they do mark a movement toward increased consciousness of the need to reassess how long term care is delivered, and a potential groundswell developing of collaborative effort to implement fundamental changes.

In 2002, The Center for Health Workforce Studies of the State University of New York at Albany, reported the results of a 2002 survey of all 50 states on their responses to health worker shortages.[51] They concluded that 88% of the states have now convened task forces to study workforce shortages. The most common strategies that have already been implemented are scholarship and loan repayment programs directed at registered nurses and other licensed health professionals. Forty percent of states have begun programs to market health careers, again mainly directed at licensed nurses. Other initiatives include career ladder programs, health workforce training and education initiatives (some funded by Workforce Investment Act (WIA) and Temporary Assistance to Needy Families (TANF) funds), demonstration projects for exploring job redesign, legislative changes prohibiting or limiting mandatory overtime, mandating minimum nurse staff ratios, wage and benefit pass throughs, and transportation reimbursement. According to the report, states do not seem to be trying to change licensure requirements or practice regulations. At the national level, there are a number of programs designed to support workforce development including TANF, WIA, Welfare to Work grants, and Employer Tax Credits.

Many direct care workers qualify for the Federal Earned Income Tax Credit (EITC) and facilities and agencies are beginning to institute programs to help their employees claim this benefit. The Catholic Health Association of the United States and the Professional Health Care Institute have published a report outlining many of the strategies that can be used to become an "*employer of choice*."[52]

In Michigan, scholarship and loan repayment programs are under consideration for RNs, LPNs and CNAs. There are multiple grassroots coalitions developing including the statewide Michigan Direct Care Workforce Initiative (MDCWI), which was supportive of this research project. A wide range of strategies have been undertaken by individual organizations or communities including surveys, training programs for direct care workers, worker recognition awards, conferences, transportation assistance programs, and lobbying efforts for specific legislative changes. Michigan Governor Jennifer Granholm recently formed a long term care task force that will examine the link between the direct care workforce, economic development and many other issues.

In summary, the growing shortages and problems with vacancies and turnovers among direct care workers have been well documented along with the impact on long term care costs and ramifications for local and state economic health. Of interest are the key factors driving movement within Michigan's long term care system and what strategies might be employed to reduce the worrisome exodus of valuable workers. The following sections detail the methods and findings of the current study of direct care workers in Michigan.

Research Design

Measures

Outcome measures for the survey used in this study were drawn from previous research related to direct care workers as well as input sought from the recently formed Michigan Direct Care Worker Initiative (MDCWI) advisory panel. This panel was comprised of a statewide coalition of individuals from a wide range of backgrounds including academics, advocates, providers and policymakers, all of whom were involved or interested in the long term care workforce, the recruitment and retention of direct care

workers in particular. Several drafts of the survey instrument were reviewed by this group and revised based on their input.

The survey instrument (Appendix A) contained nominal (e.g. race/ethnicity), ordinal (e.g. satisfaction ratings) and continuous (e.g. wages) variables. Respondents were asked to indicate if they were currently working in direct care and then were categorized as "stayers" or "leavers" for the analysis. All but three sets of questions were directed at the entire sample. One of these sets was asked only of workers who had left direct care work and focused on their reasons for leaving. The other two sets of questions were asked of stayers and inquired about their intentions to leave the job within the next six months and their reasons why. It should be noted that intention to leave a position did not necessarily suggest that the worker would leave direct care work entirely, but rather just that particular job.

Respondents were asked to identify which setting best described their current (or in the case of leavers, last) employer. The vast majority of respondents reported nursing home or home health agencies while the rest reported a range of settings. In some cases, respondents reported employment in more than one setting such as both nursing home and home health. Since it was not possible to identify which setting was their primary employment, these individuals were coded as working in "multiple settings." Two new broad categories were created based on the settings most frequently reported by workers who responded "other"; hospital/rehabilitation and assisted living/retirement home/independent living settings. The remainder of choices were left as "other" and included such diverse settings as physician offices, group homes, and self-employed. Because the bulk of this study sample was comprised of workers in nursing home and home health settings, much of the analysis focuses on comparisons between these two groups.

The survey contained 10 items related to the respondent's immediate supervisor. This scale was drawn from previous work conducted in Michigan related to direct care workers in hospitals. Factor analysis of data from our study indicated that these 10 items clustered around two separate constructs: lack of respect and lack of control given by the supervisor to the direct care worker. Thus, lack of respect and lack of control indices were created and used throughout the analyses rather than the original 10 items.

Finally, while this survey primarily solicited close-ended responses, many additional comments were received including letters from workers about their experiences on the job. This qualitative data added depth to the findings and are included in the discussion section.

Methods

Two cross-sectional mail surveys of direct care workers were conducted in the summer and fall of 2003. First, a statewide registry dating back 18 months that included approximately 37,000 nurse aides with a current certified license (active) and 5,637 nurse aides with expired licenses (inactive), was obtained from the Bureau of Health Services, Michigan Department of Community Health (MDCH). A sample was randomly selected representing 5% of the actives and 20% of the inactives. These percentages were based on anticipated response rates relative to the size of the total sample populations. With a sufficient response rate, ample power to detect differences significant at .05 or less could be achieved. The first survey was mailed to a random sample of 3,079 individuals with roughly two thirds coming from the actives. The assumption was made that the majority of the workers from the total MDCH list held or had held a direct care job in a nursing home, since nursing homes require certification and most other long term care settings do not.

Second, a survey was mailed to a convenience sample of direct care workers in home health settings. No central registry of non-certified or home health workers exists either at the state level or with any other organization. Therefore, in order to examine direct care workers across settings, the assistance of the Michigan Home Health Association (MHHA) members were solicited. MHHA is the state trade association for home health and hospice agencies. Twelve affiliates agreed to participate by providing lists of both current and past direct care workers employed by them within the past year. All of the 809 workers identified by MHHA affiliates were included in the second sample.

Sample

The four-page survey included a cover letter informing respondents of the purpose of the survey, explaining their rights as research subjects, and assuring anonymity. The survey did not request their names and respondents were provided with pre-addressed,

stamped return envelopes. The surveys were mailed a second time to the same sample to maximize the response rate. As it was not possible to determine who had responded to the first mailing, the second mailing was sent to the entire sample with a cover letter asking them to disregard the survey if it had already been filled out.

Of the 3,079 surveys mailed to the MDCH list, 795 (nearly 26%) were returned due to undeliverable addresses, possibly an indication of a somewhat transient population. A total of 891 surveys were returned for a final response rate of 41%. Of the 809 surveys mailed to workers from participating home health agencies, 127 (16%) were returned as undeliverable. A total of 209 surveys were returned from this group for a final response rate of 30 percent.

The decision was made to combine the two samples (from MDCH and home health agencies) for several reasons. First, the surveys sent to each group were virtually identical. Secondly, distinctions between the two samples were not clearly drawn. Some workers from the MDCH list worked in home health care and likewise, there were workers from the home health list who identified nursing homes as their place of employment. Similarly, workers identified as "active" were actually no longer employed in direct care work, whereas there was a significant minority of "inactives" that were working in a direct care job. Therefore, the main criteria for dividing the sample (the original lists that respondents were sampled from) were no longer meaningful. Accordingly, workers who had a direct care job were considered "stayers" and workers without a direct care job as "leavers".

Combining the respondents from the MDCH sample with those from the home health agencies resulted in an overall sample of 1,109 respondents. Since the possibility existed that using two different sampling methods (random versus convenience sample from the home health agencies) could confound final results, sampling method was controlled for in most analyses.

Findings

Worker Characteristics

The worker sample was composed primarily of white, middle-aged women with a disproportionate percentage of African American workers (23%) compared to that of the general population (13%), (Table 1). Slightly more than half of the workers in this study

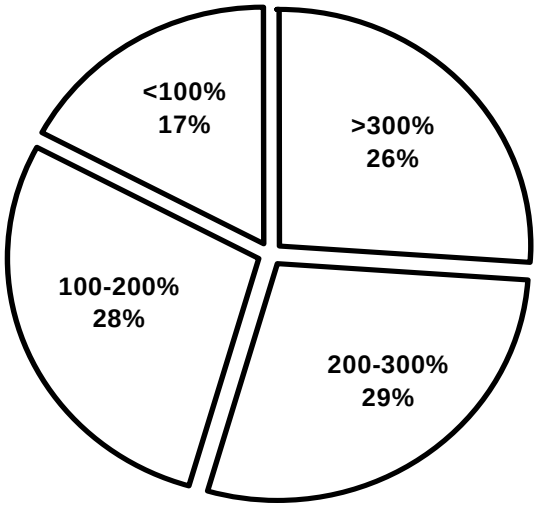
were married. Nearly half had children under age 18. All regions of the state were represented (See Appendix B for regional categories).

Table 1: Worker Characteristics (n=1,109)

		Mean (sd)
Age		42 years (13.3) Range: 18-79
		Percentage (n)
Female		95 (1030)
Households with children under age 18		49 (533)
Households with children under age 5		21 (212)
Caring for disabled/older family member		20 (214)
Race	Caucasian African American Other	68 (741) 23 (255) 9 (97)
Marital Status	Married Divorced Never Married Separated Widowed Unmarried Couple	51 (559) 17 (180) 18 (200) 4 (41) 5 (50) 6 (60)
Education	< High School High School Some College College LPN/RN	6 (67) 38 (421) 41 (451) 12 (126) 3 (34)
Annual Household Income	> 10,000 10,000-19,999 20,000-29,999 30,000-39,999 40,000-60,000 60,000 >	10 (109) 23 (240) 28 (291) 17 (183) 13 (141) 9 (92)
Region	Southeast Detroit South Central Southwest N. Lower Peninsula Upper Peninsula	20 (214) 14 (145) 14 (150) 33 (354) 9 (97) 9 (98)

Figure 1 depicts household income adjusted for family size as it relates to poverty rates. For example, poverty level for a family of four was $18,400 based on the 2003 Federal Register. As seen, roughly half of the workers were at or below100-200% of the poverty rate, considered poor and near poor.

Figure 1: Worker Household Income as % of Poverty Income



Job Characteristics

As seen in Table 2 listing specific job characteristics of the sample, nearly one third of all the respondents were no longer working in direct care. Slightly more than one half of the respondents were or had been employed in a nursing home setting as compared to approximately one-fifth in home health. These two groups differed significantly with respect to whether or not they held a second job (chi-square 12.08, p<.001), were certified (chi-square 65.58, p<001) or had union representation (chi-square 55.28, <.001). Home health workers were more likely to report a second job while nursing home workers were more likely to be certified and report union representation.

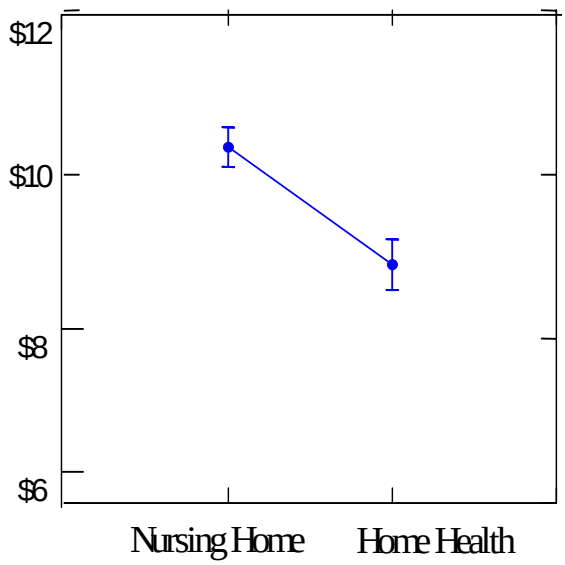
Table 2: Job Characteristics

		Percentage (n)
Work Setting	Nursing Home Home Health Hospice Other Multiple Settings Hospital/Rehab, Assisted Living/ Retirement Home	53 (573) 21 (231) 2 (16) 7 (80) 9 (96) 7 (72) 1 (14)
State certified	Total Nursing Home Home Health	85 (895) 91 (507) 68 (144)
Union representation	Total Nursing Home Home Health	30 (318) 38 (213) 11 (25)
Works second job	Total Nursing Home Home Health	26 (285) 19 (108) 31 (69)
Currently has a direct care job		63.6 (695)
		Mean (sd)
Average miles between home & direct care job	Total Nursing Home Home Health	13.5 (13.7) 12.3 (11.9) 17.4 (19.3)
Months since last direct care job among leavers		21.8 (20.1) Range: 0-120 months

Wages

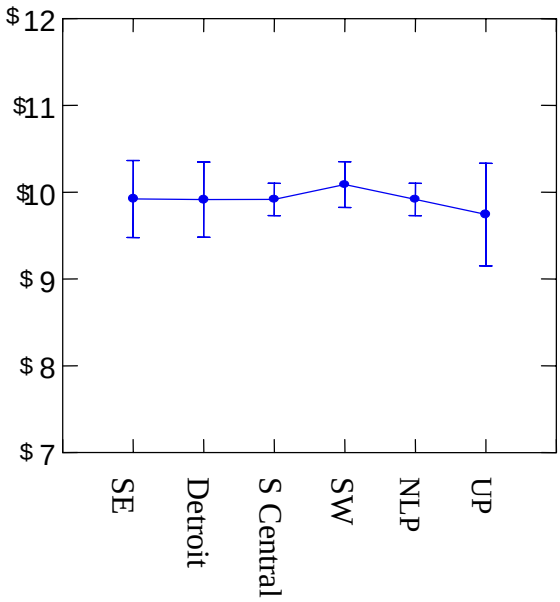
The total sample of workers in this study earned an average of $10.35 per hour (sd 2.47). Comparing nursing home and home health workers, wages differed significantly controlling for sampling method (namely random versus convenience)($F=28.52$, $p<.001$). On average, nursing home workers earned $10.73 per hour (sd=2.13) compared to the $9.78 per hour (sd=2.78) home health wage (Figure 2). Comparing regions, no significant difference on wages were found (F-ratio=.54, p=.74) (Figure 3 and Table 3).

Figure 2: Hourly Wages Comparing Nursing Home and Home Health Workers[1]



[1] Controlling for sampling method

Figure 3: Wages by Region[1]
(Nursing Home and Home Health Workers)



[1] Controlling for sampling method

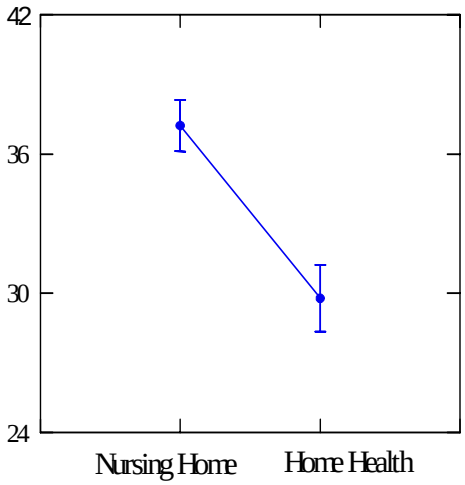
Table 3: Hourly Wages by Region (Nursing Home and Home Health Workers)

	Mean (sd)
Southeast	$9.92 (.44)
Detroit	$9.92 (.43)
South central	$9.92 (.19)
Southwest	$10.09 (.26)
Northern Lower Peninsula	$9.92 (.19)
Upper Peninsula	$9.74 (.59)

Work Hours

The average number of hours worked in direct care per week was 35.2 (sd 11.6) for all workers. Comparing work settings, stark differences were found after controlling for sampling method (F=20.6, p=<.001) (Figure 4). Again, home health workers logged far fewer hours per week (approximately 7 hours less) than nursing home workers. Hours for nursing home workers averaged 37.2 hours/week (sd 1.11) compared to those in home health 29.8 hours/week (sd=1.44). Work hours for nursing home and home health workers did not vary significantly by region, controlling for type of work setting and sampling method.

Figure 4: Work Hours Comparing Nursing Home and Home Health Workers[1]

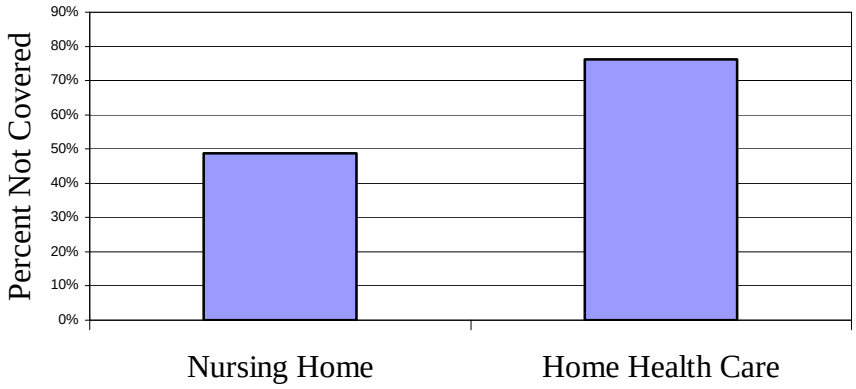


[1] Controlling for sampling method

Health Insurance

Of the total sample, 43.5% of workers were covered by health insurance through their employers. Coverage varied significantly by work setting (chi-square=51.263; p=<.001) as seen in Figure 5. Approximately three-fourths of home health workers (76.2%) compared with half (49.7%) of nursing home workers reported a lack of health coverage through their employer. It is possible however, that they received health insurance from another source such as a spouse.

**Figure 5- Lack of Health Insurance Coverage through Employer
Comparing Nursing Home and Home Health Workers**



Entry into Direct Care Work

Among the entire sample, the top reasons for entering direct care work included a desire to help people and work in health care, a belief that they had the skills to do the job well, a desire to use these skills, and enjoyment in working with older people (Figure 6). Also noteworthy is that availability of training was an important factor for 40% of workers. Reasons sometimes cited by the general public for why individuals go into direct care work, "the only job available" and "not qualified for other types of work", were ranked lowest. There were no significant differences comparing reasons for job entry comparing stayers and leavers, even after controlling for region and sampling method.

When comparing nursing home and home health workers, no differences were found among the top reasons for entering direct care work, namely altruism and vocational interests. The two groups differed significantly on several of the lower ranked reasons; pay rate, experience caring for a family member and schedule. Nursing home workers were more apt to be motivated by pay rate (p=.01) and marginally by benefits (p=.058) compared to home health workers who were more likely to cite scheduling (p=.016) and experience with caring for a family member (p=.002). Nearly half of the home health workers cited this past caregiving experience as a motivation for job entry.

Comparing regions, analysis revealed several differences among the total sample on reasons for entering direct care work, controlling for sampling method. Significant differences were found between Southeast (SE) Michigan and the Upper Peninsula (UP)

for pay rate (p=.031) and between SE Michigan and Detroit compared to the UP for closeness to home (SE vs. UP: p=.006 and Detroit versus UP: p=.001). Workers in the UP ranked pay rate higher than SE Michigan, perhaps indicative of a lack of other jobs with pay rates exceeding minimum wage. Closeness to home appeared to be more important for workers in the UP than other regions and may be due to a greater need to consider terrain and weather conditions when looking for work. The remaining regions did not differ significantly.

Figure 6: Reasons for Entering Direct Care Work[1]
Total Sample

[1]Survey provided respondents the opportunity to select as many reasons for job entry as applicable.

Job Satisfaction

All respondents, both stayers and leavers, were asked about their overall level of job satisfaction. Nearly three-fourths (73.3%) of the direct care workers reported satisfaction (combining "very satisfied" with "satisfied") with their jobs (See Figure 7).

Figure 7: Overall Job Satisfaction
Total Sample

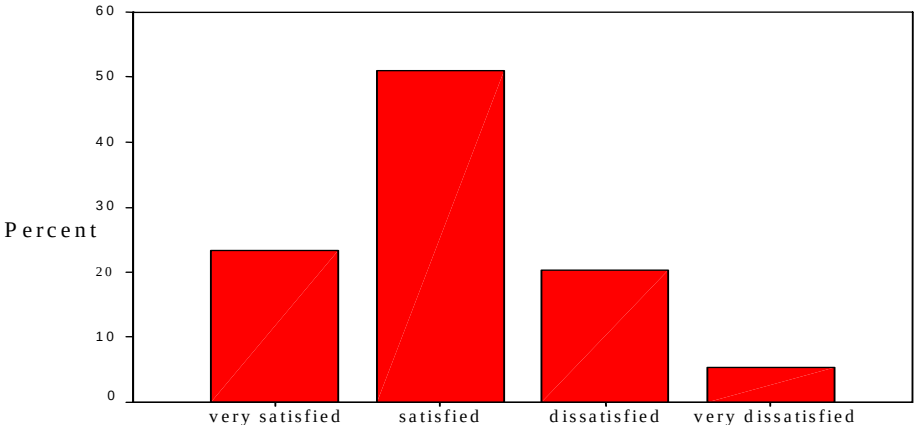


Table 4 displays results of the ordinal regression analysis related to job satisfaction after controlling for a number of key variables including sampling method. Job satisfaction was coded so that the higher the number, the greater the dissatisfaction. As an example, the negative coefficient for wages of -.075 suggests that as wages went down, job dissatisfaction increased. Lack of respect from supervisors and lack of control provided also increased dissatisfaction. College education was marginally significant, and also associated with increasing levels of dissatisfaction as well. No significant difference comparing nursing home workers to other workers was found.

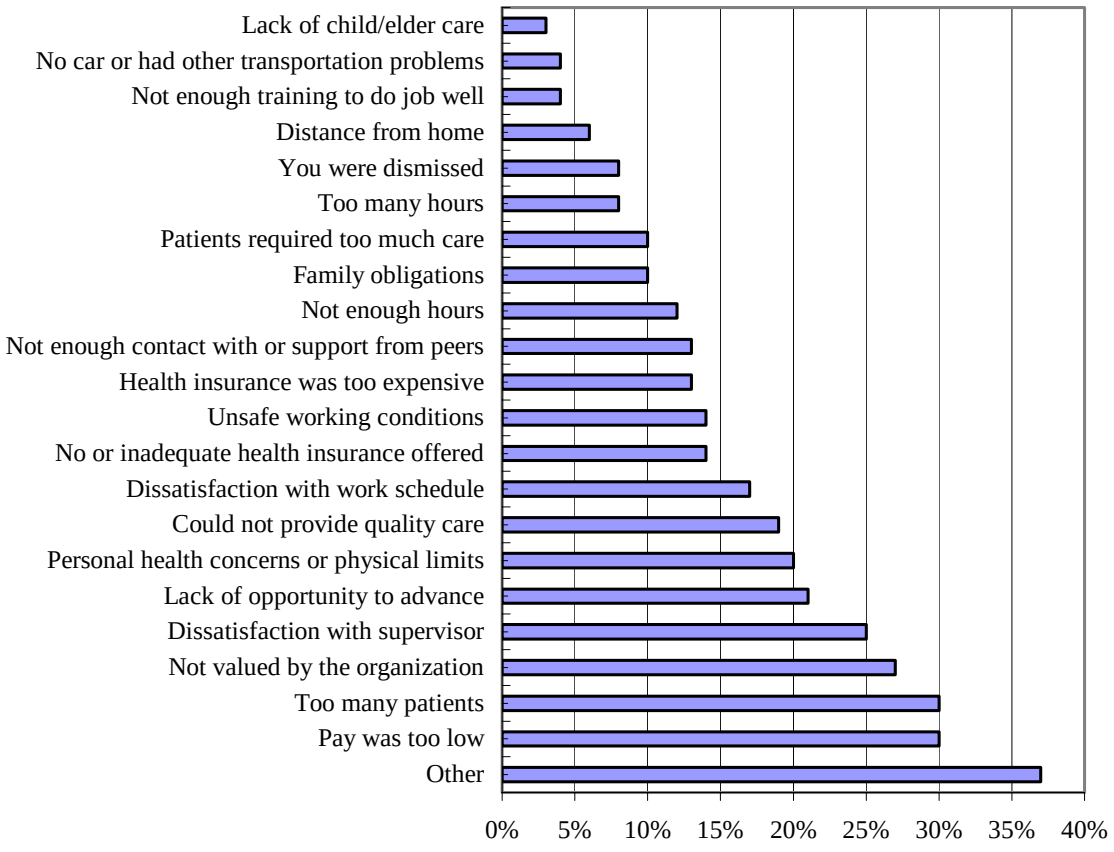
Table 4: Job Satisfaction Comparing Nursing Home and Home Health Workers

	Estimate	Std. Error	Sig.
Lack of Respect	.606	.079	.000
Lack of Control	.522	.081	.000
Family Size Adjusted Income	.011	.056	.844
Wage Rate	-.075	.036	.039
Nursing Home Worker	.384	.252	.128
College Graduate	.477	.254	.060

Reasons for Leaving Direct Care

Findings related to leaving direct care work are based on responses from those no longer employed in the field. The top reasons for leaving direct care work (omitting the category of "other") included low pay, too many patients, not feeling valued by the organization, dissatisfaction with supervisors and lack of opportunity to advance (Figure 8). Many of the workers who responded "other" to this question provided written explanations that were so similar to one of these five top reasons that they were classified as such. For example, a worker's statement that "caseloads were too high" was coded the same as "too many patients". While 40% of workers reported the availability of training as a draw to the field, this factor does not appear influential for retention. Similarly, "lack of child/elder care", and "transportation problems" were ranked last.

Figure 8: Reasons for Leaving Direct Care



Reasons for leaving direct care varied when comparing different groups. Workers from nursing homes ranked reasons for leaving differently than those from home health. Table 5 and Figure 9 both illustrate contrasts among workers in these two settings. Both groups included low pay, not feeling valued and personal health concerns in their top reasons for leaving. Percentages in Table 5 are displayed in descending order according to responses from nursing home workers.

Table 5: Reasons for Leaving Comparing Nursing Home and Home Health Workers[1,2]

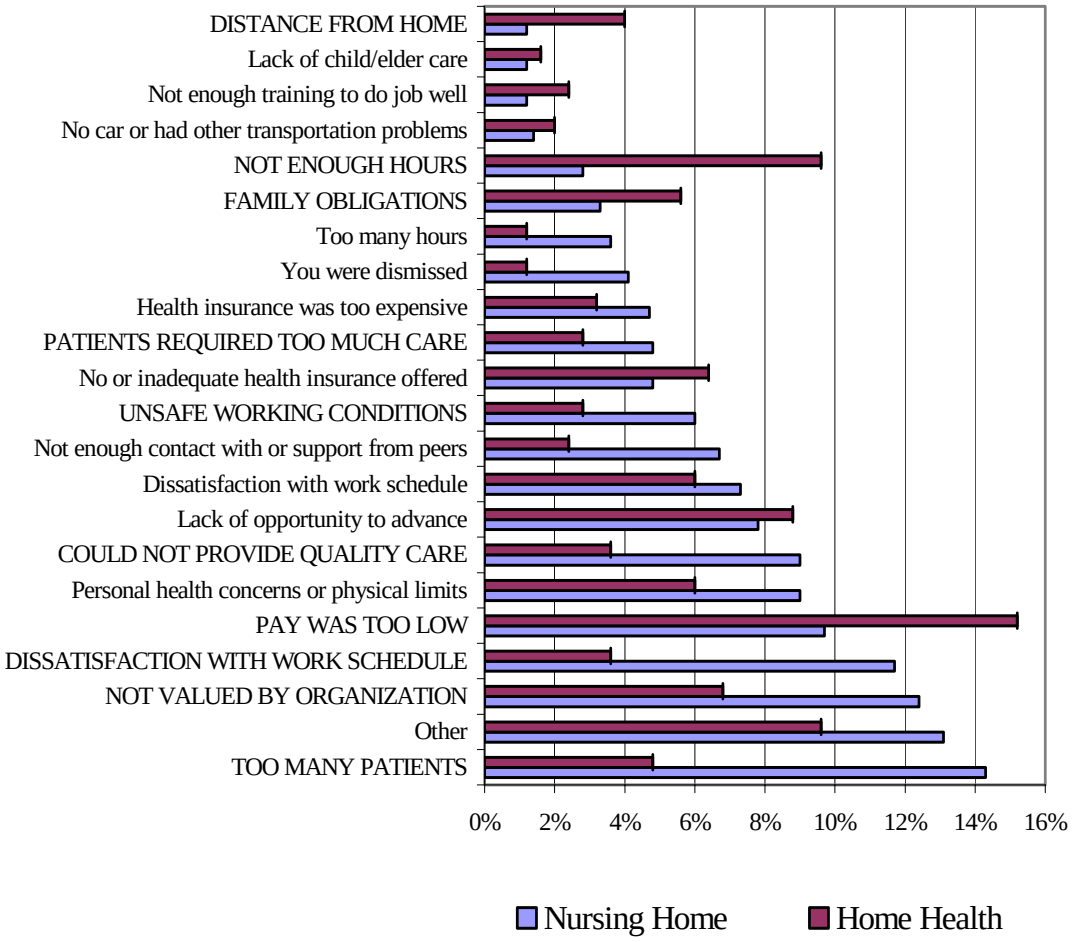
	Percentage			
	Nursing Home	Home Health	P value[1]	P value[2]
Too many patients	14.3	4.8	.00	.007
Other	13.1	9.6	.482	.799
Not valued by the organization	12.4	6.8	.00	.120
Dissatisfaction with supervisor	11.7	3.6	.00	.254
Pay was too low	9.7	15.2	.007	.004
Could not provide quality care	9.0	3.6	.024	.367
Personal health concerns or physical limits	9.0	6.0	.924	.640
Lack of opportunity to advance	7.8	8.8	.428	.079
Dissatisfaction with work schedule	7.3	6.0	.768	.294
Not enough contact with or support from peers	6.7	2.4	.058	.885
Unsafe working conditions	6.0	2.8	.012	.495
Patients required too much care	4.8	2.8	.013	.069
No or inadequate health insurance offered	4.8	6.4	.084	.946
Health insurance was too expensive	4.7	3.2	.005	.648
You were dismissed	4.1	1.2	.342	.232
Too many hours	3.6	1.2	.429	.175
Family obligations	3.3	5.6	.015	.021
Not enough hours	2.8	9.6	.035	.002
No car or had other transportation problems	1.4	2.0	.214	.005
Distance from home	1.2	4.0	.014	.001
Lack of child/elder care	1.2	1.6	.266	.428
Not enough training to do job well	1.2	2.4	.736	.086

[1] Controlling for both region and sampling method [2]Controlling for sampling method

However, nursing home workers who have left direct care work were significantly more likely to cite too many patients, the inability to provide quality care, as well as unsafe conditions, three factors that are presumably linked. In addition, nursing home workers

were more likely to report dissatisfaction with supervisors and not being valued by the organization. Overall, these workers cited a greater number of reasons for leaving than home health workers. Comparatively, home health workers were more likely to list low pay, "not enough hours" and dissatisfaction with work schedule as triggers for leaving, which again, may be interrelated factors. These findings are consistent with past research indicating nursing home workers often have caseloads that are too demanding and home health workers have caseloads that are too small to make a sufficient income. Other contrasts included home health workers as more likely to leave due to family obligations or distance to the job.

Figure 9: Reasons for Leaving Comparing Nursing Home and Home Health Workers[1, 2]



[1]Statistically significant differences in CAPS; $p < .05$
[2]Controlling for both sampling method and region

Significant regional differences were seen as well (Table 6). Respondents from Detroit were more likely to cite not enough hours as a problem than other regions. Similarly, Detroit, Northern Lower Peninsula and Upper Peninsula (UP) workers were most likely to report being undervalued by their organizations, prompting them to leave. In addition, workers from Detroit and Northern Lower Peninsula appeared to be more likely to leave direct care work because of lack of advancement opportunities. Job dismissal was cited more frequently by individuals from the UP where a full 20% noted this as a reason for leaving direct care work. Beyond these few variables, there were no significant differences across regions.

Table 6: Reasons for Leaving Direct Care Work by Region [1]

Percentage							
	South East	Detroit	South Central	South West	Northern LP	UP	P value[1]
Not enough hours	7.9	17.3	6.1	6.4	8.6	10.0	.018
No or inadequate health insurance offered	9.0	15.4	10.2	7.5	5.7	16.7	.104
Too many hours	4.5	5.8	4.1	3.5	17.1	10	.185
Health insurance was too expensive	2.2	11.5	12.2	8.1	8.	3.3	.104
Dissatisfaction with work schedule	11.2	17.3	8.2	11	22.9	10	.231
Not enough training to do job well	2.2	7.7	0	12	5.7	3.3	.212
Pay was too low	24.7	32.7	6.1	15.6	28.6	20	.070
Not enough contact with or support from peers	9.0	15.4	8.2	6.4	22.9	10	.348
Too many patients	16.9	25	24.5	19.1	25.7	16.7	.061
Family obligations	9.0	5.8	6.1	5.8	14.3	3.3	.398
Patients required too much care	7.9	9.6	6.1	8.1	2.9	6.7	.437
Lack of child/elder care	2.2	1.9	0	1.2	8.6	3.3	.061
Dissatisfaction with supervisor	13.5	17.3	28.6	10.4	28.6	36.7	.146
No car or had other transportation problems	2.2	3.8	0	1.7	5.7	3.3	.643
Not valued by the organization	13.5	26.9	18.4	15.0	31.4	33.3	.051
Personal health concerns or physical limits	18.0	13.5	22.4	8.7	17.1	30	.881
Lack of opportunity to advance	16.9	23.1	6.1	9.2	28.6	13.3	.022
Distance from home	7.9	3.8	4.1	1.2	5.7	3.3	.171
Could not provide quality are	12.4	13.5	12.2	13.9	20	16.7	342
You were dismissed	4.5	3.8	4.1	2.3	11.4	20.0	.028
Unsafe working conditions	6.7	15.4	8.2	8.1	14.3	6.7	.186
Other	15.7	25.0	36.7	15.0	31.4	30	.574

[1]Controlling for sampling method

Work setting and regional differences aside, of interest are what specific factors actually predict whether a worker leaves direct care work (stayers versus leavers). Work setting, sampling method, and a wide range of variables were included in a logistic regression analysis, such as age, race/ethnicity, education, martial status, and region. None of these factors were significant in predicting workers who had left. The remaining model displayed in Table 7 below includes the total sample and illustrates only those factors that were significant in predicting whether a worker had left the field.

Lower wage rate was the most significant factor in predicting turnover. For example, every increase of $1/hour in wage decreased the odds that a worker would leave by 15% (1-.85). Poverty status also played a role such that workers with lower household incomes (adjusted for family size) were more likely to leave the field. In addition, two other factors stood out as problematic among those who had left the field -- lack of respect and lack of control provided the worker by the supervisor. Finally, college graduates were more likely to leave direct care compared to those with lower education. As seen, workers with a college degree were more than two times as likely to leave direct care as those without.

Table 7: Factors Affecting the Likelihood of Leaving Direct Care[1]
Total Sample

	B	SE	Sig	Odds Ratio
Lack of Respect by supervisor	.223	.091	.014	1.250
Lack of Control by supervisor	.232	.096	.015	1.261
Family Size Adjusted Income	-.212	.077	.006	.809
Wage Rate	-.159	.052	.002	.853
College Graduate	.756	.303	.013	2.130

[1] controlling for sampling methods

The following two tables display factors predicting whether a worker left the field among nursing home workers (Table 7A) and home health workers (Table 7B). Wages were highly predictive of whether a nursing home worker left the field. A $1/hour increase in pay decreased the odds that a worker would leave by 27%. College graduates were 2.5

times more likely to have left than other workers. Finally, lack of respect by supervisors also proved significant in whether a nursing home worker left the job.

Table 7A: Factors Affecting the Likelihood of Leaving Direct Care Nursing Home Workers[1]

Independent Variables	B	S.E.	Sig.	Odds Ratio
Lack of Respect by supervisor	.209	.106	.048	1.233
Lack of Control by supervisor	.146	.106	.168	1.157
Family Size Adjusted Income	-.001	.001	.181	.999
Wage Rate	-.310	.069	.000	.734
College Graduate	.921	.397	.020	2.512

[1] controlling for sampling method

In contrast, wages were not significant in predicting the exodus of home health workers after controlling for the other factors, including sampling method. Instead, lack of control, but not lack of respect, was significantly related to leaving among this sub-sample. Similar to nursing home workers, higher levels of poverty among workers increased the odds that they would not remain on the job.

Table 7B: Factors Affecting the Likelihood of Leaving Direct Care Home Health Workers[1]

Independent Variables	B	S.E.	Sig.	Odds Ratio
Lack of Respect by supervisor	.304	.207	.143	1.355
Lack of Control by supervisor	.689	.269	.010	1.991
Family Size Adjusted Income	-.004	.002	.013	.996
Wage Rate	.075	.063	.235	1.078
College Graduate	.458	.498	.357	1.582

[1] controlling for sampling method

Intentions to Leave Current Job within Six Months

Approximately half (47%) of workers who were currently working reported that they intended to leave their current direct care position within six months. In Figure 10 illustrates that approximately one-third (36%) of these respondents would consider leaving

their position due to pay. It should be noted that the list of choices regarding intent to leave within six months was substantially less than the choices presented to workers who had already left. For example, among the items regarding intent to leave, the more general choice of "job dissatisfaction" may have included more specific reasons that this study did not tap into.

Figure 10: Reasons Cited for Intent to Leave Job within 6 Months

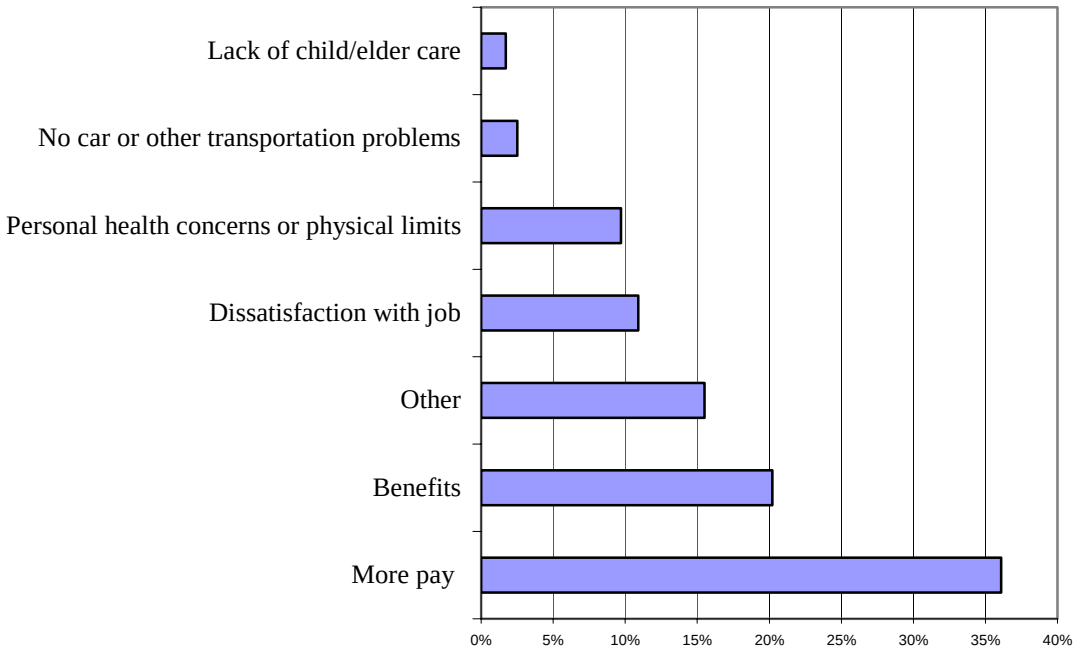
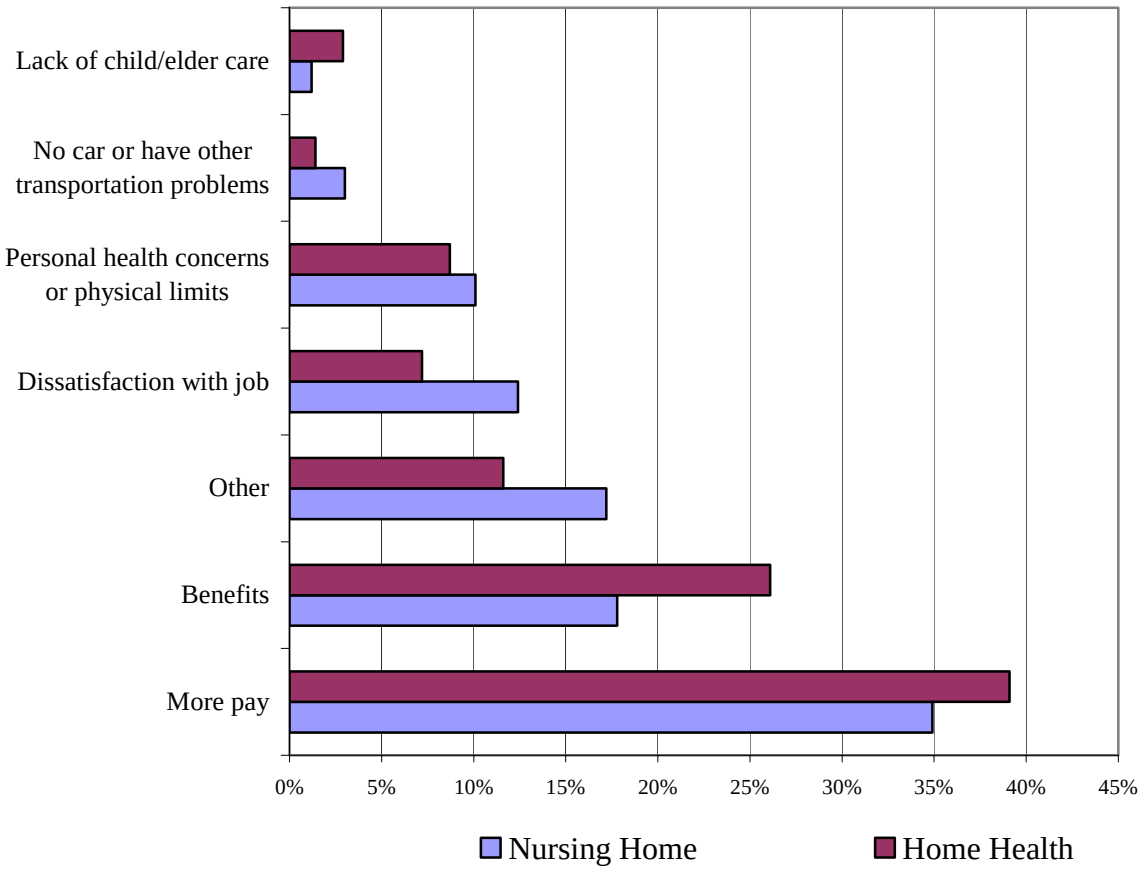


Figure 11 below indicates an overall lack of significant differences comparing nursing home and home health workers with regard to intent to leave within six months.

Figure 11: Intention to Leave Direct Care Job within 6 Months by Work Setting [1]



[1] Controlling for region and sample

Regional variations on intent to leave the current job in six months were indicated for overall job dissatisfaction. In an analysis that included only nursing home and home health workers, those in Detroit and the Northern Lower Peninsula were more likely to cite job dissatisfaction as prompting their intent to leave their current job compared with workers in other regions (Table 8). In the previous section, we reported that respondents who had already left the field from Detroit and Northern Lower Peninsula were more likely to cite lack of advancement opportunities and feeling valued by their organizations compared to other regions which is likely related to job satisfaction. Beyond job

satisfaction, workers in all regions struggled with similar challenges, particularly pay and benefits.

Table 8: Intention to Leave Direct Care Job within 6 Months by Region[1]
Nursing Home and Home Health Workers

	Percentage						
	South East	Detroit	South Central	South West	Northern LP	UP	P Value[1]
No car or have other transportation problems	2.6	13.8	0	1.2	0	0	.826
Dissatisfaction with job	13.2	20.7	3.1	4.8	21.7	5.0	.000
Personal health concerns or physical limits	13.2	10.3	6.3	8.3	8.7	15.0	.691
More pay	47.4	65.5	25.0	31.0	34.8	15.0	.228
Benefits	21.1	27.6	12.5	21.4	26.1	10	.092
Lack of child/elder care	0	6.9	0	2.4	0	0	.243
Other	15.8	17.2	9.4	19.0	13.0	10	.248

[1] Controlling for sampling method

Table 9 displays the results of the logistic regression predicting whether a worker intended to leave within six months. This model includes only nursing home and home health workers who are currently employed. Controlling for sampling method as well as the other independent variables listed in the model, the only significant variable was lack of control provided to the worker. Lack of respect by the supervisor was marginally significant (p=.08). As seen, wages, poverty level and being a nursing home (versus home health) worker did not play a role in determining intentions to leave the job. Although an effort was made to repeat this logistic regression model separately for nursing home and home health workers, there was not sufficient power (sample size too small) to detect changes within these two groups.

Considering the workers who had left direct care work and this sub-sample that is considering leaving suggests that there may be some qualitative differences between these two groups. While it is not clear whether they may leave or not, it would seem apparent that issues of respect and control would be influential in this decision.

Table 9: Factors Affecting Intention to Leave within 6 Months[1]

Independent Variables	B	S.E.	Sig.	Odds Ratio
Lack of Respect by supervisor	-.182	.104	.080	.834
Lack of Control by supervisor	-.209	.106	.049	.812
Family Size Adjusted Income	.111	.076	.143	1.118
Wage Rate	.063	.052	.226	1.065
Nursing Home (vs. Home Health Worker)	-.365	.390	.350	.622
College Graduate	-.475	.373	.204	.577

[1]Controlling for sampling method

Discussion

Overall, the findings of this study confirm much of the past research about direct care workers--their financial vulnerability, the challenging aspects of their job, and the triggers that characterize the exceedingly high turnover rate in this field. However, these data strongly indicate that direct care workers intentionally chose this field, not because they had no other options but because they had a desire to help others and an interest in health care as a vocation. These individuals wanted to work directly with people, especially with older adults. Nearly one-fifth of the sample was currently providing care to an older or disabled relative (perhaps more having provided care in the past) suggesting that many direct care workers entered the field with important caregiving skills.

Consider the following responses of workers in this study:

> *"I have been pursuing a career in nursing since I was six. I wanted to be a nurse and to help others."*
>
> *"I wanted to feel like my job mattered."*
>
> *"I don't like older people being forgotten about in a home. Elderly and disabled people are very special."*
>
> *"I love working with older people. They are great and if I could, I'd do it every day."*

In addition to their interest and skills in caregiving, more than half of the workers reported post-high school education. Furthermore, since the availability of training

opportunities was an important draw for entry into direct care, there is rationale to develop greater professionalism within this field, thus bringing needed credibility to these workers.

Although not the driving force for entering direct care, wages were the key factor in prompting individuals to leave the field. Given that workers enter this field with strong intentions for helping, leaving the job because of low wages is not always without regret. As voiced by one worker:

"It broke my heart to leave the residents but the pay was too low."

Interestingly, although home health workers received significantly less pay than workers in other venues, it was not necessarily a predictive factor in whether this group left direct care. Home health workers also struggled with insufficient hours as well as an apparently greater need to work a second job. Adjusting for family size, home health workers were also more likely to have lower annual household incomes averaging $12,964.37 (sd 285.95) compared to $14,194.54 (sd 186.92) for nursing home workers. It may be that despite low wages, insufficient hours, and household income, home health workers remained because of other benefits, such as flexibility and greater autonomy. Low wages for nursing home workers, by contrast, were a catalyst for leaving the field.

Poverty status plays a major role in the retention of direct care workers. Not only are half of direct care workers considered poor or near poor based on their household incomes, poverty rates are a major determinant of job turnover. Workers from poorer households were significantly more likely to leave direct care than those with higher incomes. It may be that these workers led less stable lives or needed to find work that was even marginally more lucrative compared to others. Providers who help link workers to important economic resources such as the Earned Income Tax Credits are likely to have a positive impact on the retention of these low-income workers.

In addition to poverty status, it appears that those with college degrees are also less likely to remain on the job. This sub-sample was relatively small, but does suggest that some workers may use long term care as a training ground before moving on to other jobs.

Two of the most consistent reasons for leaving direct care work were related to supervisory support, namely the lack of respect and lack of control supervisors provided to

workers. For example, supervisors' lack of respect toward nursing home workers was significant in predicting whether these workers left the job. Similarly, home health workers who perceived their supervisor as giving them little control were significantly more likely to quit direct care work compared to those who stayed. Lack of control may be related to the inability to work the hours they wished or needed, coupled with the fact that they had to accept fewer financial rewards than nursing home workers (due to lower hours and wages in home health). Perhaps more entrepreneurial by nature, it may be that they are more sensitive on issues of control. Authoritarian behavior by supervisors and restrictions on how they provide care may not be as tolerated and drive them away even if mild by comparison to conditions in the nursing home setting.

Worth noting is the finding that among both nursing home and home health workers who are currently employed, yet intend to leave the job within six months, supervisory support was likely to have retained these workers, irrespective of the pay rate. Direct care workers may possibly have several immediate supervisors however (e.g. scheduling, clinical), which the findings of this study do not distinguish.

Relationships with supervisors evoked strong emotional responses from workers:

> *"Nurses treat us like a piece of garbage."*

> *"There are too many telling you what to do instead of helping you with getting the job done."*

> *"The Administrator and Director of Nursing threaten all the workers with termination every day for the littlest things. That makes the job very stressful."*

> *"No one respects the position of CNAs. They want us to do more and more, some of the LPN work within the same amount of time, for the same pay."*

> *"There is no trust by management and no worker rights as far as management is concerned."*

And perhaps most poignantly, one worker bemoaned:

> *"I was scolded for showing emotion when one of our residents died."*

Worker respect and control are two factors that might be targeted for future reform without adding significant increases to operational costs. Strategies might include training supervisors in good management skills and encouraging employers to shift more power and control to workers.

Improved relationships with supervisors may also be tied to setting more realistic caseloads for workers. Heavy caseloads and the ability to provide good care posed a particular problem for nursing home workers. One nursing home worker reported having 22 residents for one CNA every day. Their frustration and sadness are evident in the following statements.

> *"I loved my job but the patients would have to lie in bed and get bedsores because there was no time to get them up and I couldn't meet the patients' needs."*

> *"There's too much responsibility placed on one person and not enough time to care for residents the way they should be or even to meet their basic needs. I was being forced to neglect those needs because one person can only do so much."*

Despite these adverse job conditions, three-fourths of the total sample reported overall job satisfaction. Similar to the triggers for leaving direct care work, dissatisfaction with the job was predicted by low wages as well as the supervisors lack of respect and control provided to workers. Attention to all of these factors is warranted especially since nearly half of current workers cited intention to leave their current direct care position within six months-- a proxy measure of actual job turnover. Whether they leave the direct care field altogether is unclear.

Within Michigan, transportation, training and child-care programs have been attempted as strategies that can help to stabilize the direct care workforce. Yet, the workers in this study did not rank these factors as pressing reasons for either entering or leaving the field. Regional differences were evident in a few cases, such as weekly hours, or workers in some areas such as the Detroit, Northern Lower Peninsula and the Upper Peninsula, reporting feeling the least valued and/or having the fewest opportunities for advancement. However, findings based on regions did not vary significantly on most items, including wages.

Overall, this study lays the groundwork for targeted interventions attempting to stave off the exodus of caring, competent workers in long term care as it underscores several areas. Retaining a stable workforce in long term care is undoubtedly complex and requires multi-faceted solutions. Low wages are, without question, a major issue that drives out committed, well-intentioned workers. Beyond wages, the need to create a culture within long term care that demonstrates respect for these frontline workers is paramount. Given the critical labor shortage at hand, this may require changing organizational structures to allow direct care workers some measure of control over their jobs (scheduling, assignments and care decisions for example) and realistic caseloads. Finally, reform efforts are likely to be most effective if tailored to specific work settings, and in some cases, regions.

Study Limitations

This study had a number of design limitations. While the MDCH sample was randomly selected, the sample provided by the home health agencies was not. The potential of bias related to two different sampling methods was controlled for in all analyses. With either sample, self-selection may have occurred. For example, the most disgruntled or the most satisfied of direct care workers may have responded because of their strong views on their job experiences. Since the surveys were anonymous, information about non-responders could not be obtained. Despite anonymity, workers may have been reluctant to share information about their supervisors or other issues which might be considered confidential or place their job in jeopardy.

Future Research

This research increases understanding of Michigan's direct care workers yet also emphasizes other research questions that need exploring. One of the fastest growing sectors within the long term care system in Michigan is assisted living facilities, both licensed and unlicensed. In addition, Michigan's Home Help and Medicaid Waiver programs provide long term care services in the community to thousands of individuals. Increasing understanding of the conditions and retention factors in these settings and how these compare to the workers in this study would be useful for tailoring future workforce

interventions within the broad long term care system. Since an estimated 40% of long term care recipients are under age 65, there is also a need to further explore what recruitment and retention exists within this worker population, and how their work experience might differ from those caring for older adults.

More information is needed about movement of workers within the direct care field. The frequency with which direct care workers move from one direct care job to another or their motivations for doing so is generally unknown. For example, longitudinal research is needed to understand whether a high-risk period for turnover exists or similarly, if specific factors might predict whether a worker leaves the field at six months, a year or longer.

Research is also needed on specific interventions. Training programs that are currently being developed need to include a rigorous evaluation component that links such training to worker, client, and cost outcomes. Demonstrating the effectiveness of projects related to training supervisors in management skills or providing workers with more decision-making power would be worthwhile. Comparisons should be examined between the recruitment and retention strategies used in long term care versus other job sectors such as in the manufacturing industries.

Conclusions

The immediacy of the direct care crisis described in this report is undoubtedly brought about by the fragility of this workforce, the multitude of their adverse job conditions and not the least, the rapid aging of the population. Direct care workers from a variety of settings and regions may enter the field with similar goals and then face conditions difficult to endure for a sustained period.

For many of the workers, however, the opportunity to serve others remains paramount despite adverse job conditions. Noted by one respondent, “I feel that I am making a difference in each resident’s life and that I’m helping.” Workers themselves can envision an environment where they can give care that they are proud of and in which they would want to remain. As one nursing home worker asked, “Can you imagine if we could advertise that we have a 5 resident to 1 worker ratio here? Come and enjoy “living” the rest of your life.” These profound voices from the front challenge us to listen and respond.

References

[1] Institute of Medicine (2000). Improving the Quality of Long-Term Care, Washington D.C.: National Academy Press.
[2] Stone, Robyn I. & Wiener, Joshua M. (2001). Who will care for us? Addressing the long-term care workforce crisis. The Urban Institute and the Institute for the Future of Aging Services, American Association of Homes and Services for the Aging.
[3] Leon, Joel & Marainen, Jonas (2002). Job careers of paraprofessional frontline workers in long term care, Edward and Esther Polisher Research Institute, North Wales, PA.
[4] Scanlon, William J. (2001). Nursing workforce: Recruitment and retention of nurses and nurses aides is a growing concern. U.S. General Accounting Office (GAO), GAO-01-750T.
[5] Department of Health and Human Services and the Department of Labor (2003). The future supply of long-term care workers in relation to the aging baby boom generation. Report to Congress, May 14, 2003.
[6] Decker FH, Gruhn P, Matthews-Martin L, Dollard KJ, Tucker AM & Bizette L (2003). Results of the 2002 AHCA survey of nursing staff vacancy and turnover in nursing homes. American Health Care Association.
[7] http://www.nobscot.com/survey/index.cfm. Retrieved: February 7, 2004.
[8] Health Care Association of Michigan (HCAM) (2003). 2002 Wage and Personnel Survey.
[9] North Carolina Division of Facility Services. (1999). Comparing state efforts to address the recruitment and retention of nurse aide and other paraprofessional aide workers. Retrieved January 7, 2004 from http://facility-services.state.nc.us/recruit.pdf.
[10] Johnston K. (1998). Developmental disabilities provider direct service worker study: Results and findings. Anchorage, Alaska. In Paraprofessional Health Institute (2003). Long-term care financing and the long-term care workforce crisis: Causes and solutions. Citizens for Long Term Care, Washington, D.C.
[11] Pillemer K. (1996). Solving the Frontline Crisis in Long-Term Care. Cambridge, MA: Frontline Publishing Company.
[12] Leon J, Marainen J & Marcotte J (2001). Pennsylvania's Frontline Workers in Long-Term Care: The Provider Organization Perspective. Jenkintown, PA: Polisher geriatric Institute at the Philadelphia Geriatric Center.
[13] Burger SG, Kayser-Jones J & Bell JP (2000). Malnutrition and dehydration in nursing homes: Key issues in prevention and treatment. Report to the Commonwealth Fund by the National Citizen's Coalition for Nursing Home Reform, Washington D.C.
[14] Abt Associates (2001). Appropriateness of nurse staffing ratios in nursing homes, Phase II Final Report. Prepared for the Centers for Medicare and Medicaid Services, Abt Associates, Cambridge, MA.
[15] Eaton SC (2000). Beyond 'Unloving Care': Linking human resources management and patient care quality in nursing homes. Journal of Human Resource Management.
[16] Stone RI, Reinhard SC, Bowers B, Zimmerman D, Phillips C, Hawes C, Fielding J & Jacobson N (2002). Evaluation of the Wellspring Model for improving nursing home quality. The Commonwealth Fund.
[17] Yamada, Yoshiko (2002). Profile of home care aides, nursing home aides, and hospital aides: Historical changes and data recommendations. The Gerontologist 42(2), 199-206.
[18] Stone RI, Dawson SL & Harahan M (2003). Why workforce development should be part of the long-term care quality debate. Institute for the Future of Aging Services, American Association of Homes and Services for the Aging, Washington D.C. and Paraprofessional Healthcare Institute
[19] Banazak-Holl J and Hines MA (1996). Factors associated with nursing home staff turnover. The Gerontologist 36(4): 512-17.
[20] Turnham, Hollis & Dawson, Steven (2003). Michigan's care gap: Our emerging direct care workforce crisis. Paraprofessional Healthcare Institute, Bronx, NY.
[21] Close L, Estes CL, Linkins KW & Binney EA (1994). A political economy perspective on frontline workers in long-term care. Generations, 18: 23-28.
[22] MacAdam, M. (1993). Home care reimbursement and effects on personnel. The Gerontologist, 33 (1), 55-63.
[23] Harrington, C. et al., (1993). Nursing homes under prospective payment. In C.L. Estes, J.H. Swan, & Associates (eds.), The Long Term Crisis: Elders Trapped in the No Care Zone. Newbury Park, CA: SAGE.
[24] US Census Bureau (2000). National projections. U.S. Census Bureau, Population Division, Populations Branch: Washington D.C.

[25] U.S. Bureau of Labor Statistics (2001). Employment projections by occupation, 2000 and projected 2010. Monthly Labor Review, Table 2.
[26] Harmouth, Susan (2002). The direct care workforce crisis in long-term care. NCMJ March/April 2002, 63(2): 87-103.
[27] Hecker DE (2001). Employment outlook: 2000-10, Monthly occupational employment projections to 2010. Labor Review, U.S. Bureau of Labor Statistics: Washington D.C.
[28] Crown, W.H. (1994). A national profile of home care, nursing home, and hospital aides. Generations, XVIII (3), 29-33.
[29] Cantor, M., and Chichin, E. (1990). Stress and Strain among Home Care Workers of the Frail Elderly. New York: Brookdale Research Institute on Aging, Third Age Center, Fordham University.
[30] Eustis, N., N., Fischer, L.R., & Kane, R.A. (1994). The home care worker: On the frontline of quality. Generations, XVIII (3), 43-49.
[31] Feldman, P.H., (1994). Dead end work or motivating job? Prospects for frontline paraprofessional workers in LTC. Generations, XVIII (3), 5-10.
[32] Feldman, P.H., Sapienza, A.M., & Kane, N.M. (1994). On the home front: The job of the home aide. Generations, XVIII (3), 16-19.
[33] Eustis, N.N. & Fischer, L.R. (1991). Relationships between home care clients and their workers: Implications for quality care. The Gerontologist, 31 (4), 447-456.
[34] Eustis, N., Kane, R., & Fischer, L. (1993). Home care quality and the home care worker: Beyond quality assurance as usual. The Gerontologist, 33 (1), 64-73.
[35] Keigher, S. M. & Luz, C. C. (1997). Common Stakes in Home Care: A Pilot Study of Milwaukee's Gray Market in Independent Care. Milwaukee: The Helen Bader Foundation and the University of Wisconsin-Milwaukee. School of Social Welfare.
[36] Luz, C (2001). Self-employed caregivers: Their motivations, labor conditions, and patterns of decision making related to work selection and tenure. Unpublished dissertation, University of Wisconsin – Milwaukee.
[37] Raphael, C., & Santamaria, J. (1994). Looking ahead at home care: An employer's perspective. Generations, XVIII (3), 50-53.
[38] McDonald CA (1994). Recruitment, retention, and recognition of frontline workers in long-term care. Generations 18(3).
[39] Henderson, JN (1994). Bed, body, and soul: The job of the nursing home aide. Generations, XVIII (3), 20-22.
[40] Diamond, T., (1992). Making Gray Gold: Narratives of Nursing Home Care. Chicago, IL: University of Chicago Press.
[41] Kane, R.A., (1994). Ethics and the frontline care worker: Mapping the subject. Generations, XVIII (3), 71-74.
[42] Brannon, D. & Smyer, M. (1994). Good work and good care in nursing homes. Generations, XVIII (3), 34-38.
[43] Caudhill, M., & Patrick, M., (1991). Turnover among nursing assistants: Why they leave and why they stay. Journal of Long Term Care Administration, 19 (4), 29-32.
[44] Surpin, R. (1994). CHCA's strategy for replication. Generations, XVIII (3), 57-58.
[45] Wilner MA & Wyatt A (1998). Paraprofessionals on the front lines: Improving their jobs, improving the quality of long-term care. A conference background paper prepared for the AARP Long-Term Care Initiative, September.
[46] Bowers BJ et al (2000). The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides. Journal of Nursing Care Quality 14(4).
[47] Wunderlich GS & Kohler PO (2001). Committee on improving quality in long-term care. National Academy Press. .
[48] Harrington C, Kovner C, Mezey M, Kayser-Jones J, Burger S, Mohler M, Burke R & Zimmerman D (2000). Experts recommend minimum nurse staffing standards for nursing facilities in the United States. The Gerontologist 40(1): 5-16.
[49] http://www.cms.hhs.gov/Medicaid/reports/rp700hmp.asp, Retrieved January 11, 2004.
[50] Yee, D.L. (1994). Will new settings offer better work environments for paraprofessionals? Generations, XVIII (3), 59-64.

[51] The Center for Health Workforce Studies (2002). State responses to health worker shortages: Results of 2002 Survey of States. School of Public Health, University at Albany, SUNY.

[52] The Catholic Health Association of the U.S. (2003). Finding and keeping direct care staff. The Catholic Health Association, St. Louis, MO and the Paraprofessional Healthcare Institute, Bronx, NY.

Appendix A

Health Care Worker Survey

Your Background

1. In what year were you born? _____
2. Male ___ Female ____
3. Are you currently
   - ❑ Married
   - ❑ Divorced
   - ❑ Separated
   - ❑ Widowed
   - ❑ Never Married
   - ❑ Member of an Unmarried Couple
4. How many children younger than 18 live in your household? _____
5. How many of these children are 5 years of age or under? _____
6. Do you provide care for an elderly/disabled family member (not for pay)? □Yes □ No
7. Which of the following describes your racial background?
   - ❑ African American or Black
   - ❑ Asian or Pacific Islander
   - ❑ Native American
   - ❑ Caucasian or White
   - ❑ Multi-racial or Bi-racial
   - ❑ Other
8. Are you of Hispanic, Latino, or Spanish origin? □Yes □ No
9. What is the highest level of education you have completed?
   - ❑ Less than High School
   - ❑ High School Graduate or GED
   - ❑ Some College
   - ❑ College/Professional Degree
   - ❑ LPN or RN
10. Which best describes your annual total household income (from all sources including a second earner, SSI, child support, retirement income, etc.)?
    - ❑ Less than $10,000
    - ❑ $10,000 – 19,999
    - ❑ $20,000 - 29,999
    - ❑ $30,000 - 39,999
    - ❑ $40,000 - 59,999
    - ❑ Over $60,000
11. What is your home zip code? 4/__/__/__/X

Your Work Experience

12. What was the reason you took a direct care work job in the first place? **Check all that apply.**

☐ It was the only job available	☐ I wanted to help people
☐ The pay rate	☐ I enjoy working directly with people
☐ The number of hours	☐ I had experience taking care of a family member
☐ The schedule	☐ I felt I could do the job well
☐ The benefits	☐ I was not qualified for other types of work
☐ It was close to home	☐ I felt it was my personal calling
☐ I wanted to work in health care	☐ Training was available
☐ I enjoy working with older people	☐ Other, Please explain

13. Are you currently employed as a health care worker directly assisting older or disabled persons?
- ❑ Yes – **Skip** to question 17
- ❑ No – **Continue** on with question 14

14. How long ago did you leave your last job as a direct care worker? (in months) _____

15. What was the reason you left your last job as a direct care worker? **Check all that apply.**

☐ Not enough hours	☐ No or inadequate health insurance offered
☐ Too many hours	☐ Health insurance was too expensive
☐ Dissatisfaction with work schedule	☐ Not enough training to do job well
☐ Pay was too low	☐ Not enough contact with or support from peers
☐ Too many patients	☐ Family obligations
☐ Patients required too much care	☐ Lack of child/elder care
☐ Dissatisfaction with supervisor	☐ No car or had other transportation problems
☐ Not valued by the organization	☐ Personal health concerns or physical limits
☐ Lack of opportunity to advance	☐ Distance from home
☐ Could not provide quality care	☐ You were dismissed
☐ Unsafe working conditions	☐ Other, Please explain

16. Where are you currently working? Continue on with question 17.

- ❑ Another type of health care job, not direct patient care.
- ❑ Retail
- ❑ Food Service
- ❑ Not Working
- ❑ Other - Please explain: _____

17. What type of health care setting best describes your current (last) direct care employer?
☐ Nursing home ☐ Home health care agency ☐ Hospice ☐ Other – Please explain: _____

18. Are/were you a union member or does/did a union represent you in the direct care job?

☐Yes ☐ No

19. Do/did you have another paid job in addition to your direct care position?

☐Yes ☐ No

20. If so, is/was the other job in health care?

☐Yes ☐ No

21. Are you a Certified Nursing Aide/Assistant (CNA)?

☐Yes ☐ No

22. How far from your home is/was your direct care job (in miles)? _____

23. How many hours *on average* do/did you work each week in your direct care job? _____

24. How many *total* hours do/did you work each week (direct care job plus any other jobs)? _____

25. What is/was your pay rate per hour for the primary direct care work job? _____

26. Do/did you have health insurance through your direct care work employer?

☐ Yes ☐ No -Not offered ☐ No -Too expensive ☐ No –Have health insurance from another source

27. For each statement, check the box that *best* describes your immediate supervisor in your current/last direct care job.

True	Mostly True	Mostly False	False	
				Values direct care workers
				Treats employees fairly
				Is responsive to workers' ideas & concerns
				Asks for workers' input
				Encourages teamwork
				Makes good use of workers' knowledge and skills
				Gives clear instructions
				Gives feedback to workers about performance
				Gives workers control over their daily schedule
				Gives workers control over how they do the work.

28. How often do/did you experience conflict with other workers in your direct care job?
☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always

29. On a typical day, how often do/did you have too many demands on your time in your direct care job?
☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always

30. Overall, how satisfied are/were you with your direct care job?
☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

31. What aspects, if any, of your direct care job are/were you dissatisfied with? **Check all that apply**.

☐ Not dissatisfied at all	☐ Lack of opportunity to advance
☐ Not enough hours	☐ Not valued by the organization
☐ Too many hours	☐ Can/Could not provide quality care
☐ Dissatisfaction with work schedule	☐ No or inadequate health insurance offered
☐ Pay is/was too low	☐ Health insurance is/was too expensive
☐ Too many patients	☐ Not enough training to do job well
☐ Patients require/required too much care	☐ Not enough contact with or support from peers
☐ Dissatisfaction with supervisor	☐ Other, Please explain

32. If you hold a direct care job and intend to **leave** it in the next 6 months, why? Check the **most important** reason.

☐ Not intending to leave	☐ No car or have other transportation problems
☐ Dissatisfaction with job	☐ Personal health concerns or physical limits
☐ More pay	☐ Benefits
☐ Lack of child/elder care	☐ Other, Please explain

33. If you intend to keep working at your direct care job more than 6 months, why? Check the **most important** reason**.**

☐ It is the only job available	☐ I feel valued
☐ The pay rate	☐ I enjoy the personal relationships with the clients
☐ The number of hours	☐ I like my supervisors
☐ A flexible schedule	☐ I feel I do the job well
☐ The benefits	☐ I am not qualified for other types of work
☐ It is close to home	☐ Other, Please explain

You have completed the survey. Please use the enclosed prepaid addressed envelope to return the survey to MSU. Once again, thank you very much for your generous contribution to improving direct care jobs and care for countless individuals.

Appendix B

Regional Categories by Zip Code*

Southeast: 4801 - 4819; 4830 - 4861

Detroit: 4820 - 4829

South Central: 4862 - 4899

Southwest: 4890 - 4959

Northern Lower Peninsula: 4960 - 4979

Upper Peninsula: 4980 - 4999

*Only the first four digits of respondents' zip codes were requested to assure anonymity.