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Care Workers' Motivations for Employment in Long-Term Care, Assisted Living, and Particular Facilities: Reconciling Inconsistent Values

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CARE WORKERS' MOTIVATIONS FOR EMPLOYMENT IN
LONG-TERM CARE, ASSISTED LIVING, AND PARTICULAR FACILITIES:
RECONCILING INCONSISTENT VALUES

by

MICHAEL JAMES LEPORE

Under the Direction of Dr. Frank J. Whittington

ABSTRACT

Direct care worker turnover and shortages plague long-term care, weakening its quality, heightening costs for governments and employers, and cyclically breeding further turnover and shortages of workers. To address these issues, I investigate why direct care workers chose employment in long-term care (LTC), assisted living (AL) and specific AL facilities. Data come from a mixed-methods study of 45 AL facilities in Georgia, including interviews with 400 direct care workers. Findings include qualitative data analyzed using a grounded theory approach and descriptive quantitative data.

Care workers' motivations for employment in LTC, AL, and specific AL facilities reflect a split between moral and material values for care work, and care workers' motivations illustrate a process of reconciling moral and material values. Individuals become care workers for reasons that are both materialistic, like earning a living wage, and moralistic, like the desire to care for others. They take employment expecting it to be consistent with their moral ideals *and* to satisfy

their economic needs. Various individual, facility, industry, and community level factors influence workers' motivations, and these factors reinforce the inconsistency between moral and material values for care work.

Considering the heightening demand for LTC and short supply of care workers, as well as the deindustrialization of the economy, several recommendations are made for policies and practices that would support workers' motivations for employment in LTC. Areas for future research also are highlighted.

INDEX WORDS: Assisted living, Long-term care, Moral values, Material values

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iv
LIST OF TABLES	viii
LIST OF FIGURES	ix
CHAPTER	
1 INTRODUCTION	1
Statement of the Problem	1
Purpose of the Research	6
Background and Significance	7
Summary	16
2 CONCEPTUAL FRAMEWORK	19
Understanding Motivation	19
Challenges of Studying Motivations	28
3 RESEARCH METHODS	30
Background for the Study	30
Selection of Participants	37
Data Analysis	41
Grounded Theory	44
4 FINDINGS: DCW SAMPLE AND CASE EXAMPLES	54
Personal Characteristics	54
Job Characteristics	56

DCWs' Employment Histories	58
Case Examples	59
5 MOTIVATIONS FOR LTC EMPLOYMENT	77
Material Motivations for LTC Employment	80
Moral Motivations for LTC Employment	90
Professional Motivations for LTC Employment	101
Social Networks Support Motivations for LTC Employment	109
Relationships between Motivations for LTC Employment	114
Summary of Motivation for LTC Employment	116
6 MOTIVATIONS FOR AL EMPLOYMENT	121
Care-Centric Motivations for AL Employment	123
Work-Centric Motivations for AL Employment	134
Environmental Motivations for AL Employment	140
Social Networks Guide DCWs to AL	144
Summary of Motivations for AL	146
7 DCWs' MOTIVATIONS FOR PARTICULAR FACILITIES	149
Location	151
Hiring Strategies	155
Social Networks	161
Summary of Motivations for Particular Facilities	163
8. DISCUSSION	165
Summary and Discussion of DCWs' Motivations	165
Moral and Material Values of Care Work	169

Care Work Entails Both Care and Work	175
The Nature of Motivations	177
Implications for Policy and Practice	181
Research Directions and Limitations	194
Conclusion	197
REFERENCES	203
APPENDICES	
A TYPE 1 INTERVIEW ITEMS	222
B TYPE 2 INTERVIEW GUIDE	235
C ADMINISTRATOR INTERVIEW GUIDE	253
D OBSERVATION GUIDE	266

LIST OF TABLES

Table 1: [Population of Facilities by Geographic Area and Size]	33
Table 2: [Sample of Facilities by Geographic Area and Size]	36
Table 3: [Type 1 Interview Participants by Area and Facility Size]	40
Table 4: [Distribution of Staff for Interviews by Facility Size]	40
Table 5: [DCWs' Personal Characteristics]	56
Table 6: [DCWs' Job Characteristics]	58
Table 7: [DCWs' Employment Histories]	59
Table 8: [Overview of DCWs' Motivations for LTC Employment]	79
Table 9: [DCWs' Motivations for AL Employment]	122
Table 10: [DCWs' Motivations for Particular AL Facilities]	150

LIST OF FIGURES

Figure 1: [Material Motivations for LTC Employment]	82
Figure 2: [Moral Motivations for LTC Employment]	91
Figure 3: [Professional Motivations for LTC Employment]	102
Figure 4: [Social Networks Support Motivations for LTC Employment]	109
Figure 5: [Mutually Supportive Motivations for LTC Employment]	114
Figure 6: [Inconsistent Moral and Material Values for Care Work]	117
Figure 7: [Relationship between Motivations for LTC Employment]	118
Figure 8: [DCWs' Motivations for LTC Employment]	120
Figure 9: [Care-Centric Motivations for AL vs. Nursing Home Employment]	124
Figure 10: [Work-Centric Motivations for AL Employment]	136
Figure 11: [Environmental Motivations for AL Employment]	142
Figure 12: [Motivations for AL vs. Nursing Home Employment]	147
Figure 13: [Motivations for AL vs. In-Home Care Employment]	148
Figure 14: [Influence of Location on Facility Choice]	154
Figure 15: [Influence of Hiring Strategies on Facility Choice]	161
Figure 16: [Motivations for Employment in Particular Facilities]	164

CHAPTER 1

INTRODUCTION

Statement of the Problem

A man dies. His wife, children, grandchildren, extended family, and paid caregivers grieve by his bedside in the assisted living facility where he lived for two years. A week later, family and paid caregivers gather in the facility to memorialize the deceased man, whom they all had grown to love. Scenes like this one, drawn from my personal experience, grow more common every year as increasing numbers of older adults move to assisted living, which promises elders an opportunity to age in place. However, paid caregivers who take care of older adults in assisted living facilities, and across long-term care settings, may not always be available. The demand for these direct care workers is increasing exponentially, but their supply is dwindling. In the following pages I describe the care crisis that our society is facing and point to the importance of understanding why people enter care work for alleviating this crisis.

The aging of the United States' population is a primary demographic feature of the early 21st century. In 2000 there were over 35 million older adults in the U.S., and with the aging of the baby boom generation the older adult population is projected to grow rapidly over the next 30 years (Grantmakers in Health [GIH] 2000). By 2030, the number of older adults and younger adults will be nearly equal. In years past, younger adults far outnumbered older adults (GIH 2000). Further, longevity is increasing, making the 85-plus age group the fastest growing segment of our society (Hetzl and Smith 2001). Among the 85 and older group, care needs are highest (GIH 2000; Stone 2000).

However, as a result of the shift in age demographics, fewer young individuals will be available to care for older adults. In a presentation to the Institute of Medicine, Steven Dawson, president of the Paraprofessional Healthcare Institute, warned that this “tectonic demographic change” threatens the ability of our long-term care system to meet the increasing demand for care: “...as the demand for paraprofessionals grows by 35 percent from 2004 to 2014, the tradition labor pool from which these workers are drawn—women aged 25-54—will barely hold its own, increasing during this period by less than 2 percent” (2007:3). In conjunction with current long-term care trends, like care worker shortages and high rates of turnover, these demographic trends are fueling the care crisis that our society is facing.

Currently, there are more than two-and-a-half million paraprofessionals in the direct care workforce (Institute for the Future of Aging Services 2007). Because of population aging, these occupations are expected to increase by about 30 percent by 2012—more than all other health occupations (United States Bureau of Labor Statistics [USBLS] 2004). Overall, USBLS (2004) projects 1.2 million direct care workers (DCWs) will need to enter long-term care by 2012 to fill new positions and replace workers who leave their jobs. Turnover and shortages of these workers plague the long-term care system: A recent study found an annual turnover rate of between 70 and 100 percent among nursing home DCWs (Wilner and Wyatt 1999).

Care worker shortages have serious implications for care quality. Direct care vacancies and turnover have been found to result in inadequate and unsafe care, non-continuous care, and denial of care (Dawson and Surpin 2001). National organizations representing consumers also have indicated that staffing issues seriously worsen care

quality: 13 state chapters of the Alzheimer's Association selected staffing issues as their top priority in the year 2000, and The Commonwealth Fund reported that staffing issues result in a lack of individualized care, malnutrition, and dehydration of LTC residents (Dawson and Surpin 2001).

In addition to jeopardizing health care quality and availability (Dawson and Surpin 2001), care worker shortages and turnover cost governments billions of dollars (Seavey 2004). The General Accounting Office (2000) estimates that turnover costs providers \$3,840 per certified nursing assistant. These costs result from providers spending money on advertising to fill vacated positions, offering hiring incentives, and implementing training and orientation programs (Dawson 2003). At the governmental level, Seavey (2004) reports that DCW turnover costs federal, state and local governments \$2.5 billion annually, resulting in high and hidden taxes. Long-term care worker shortages and turnover are particularly costly to governments because neither the long-term care system (hereafter referred to as LTC) nor our health care policies were designed with current age or market demographics in mind. The National Commission for Quality Long-Term Care, a non-partisan organization of medical professionals, academics, nurses, and other interested parties, summarizes the overarching problems that LTC is facing: "Today's long-term care system strains to accomplish tasks for which it was never designed for a population whose magnitude was never envisioned" (2006:5).

Unlike any other time in history, caring labor is now a global phenomenon driven by the long-term care needs of older people. In addition to becoming an increasingly important employment field, direct care work has become occupied by a progressively marginal workforce. The heightening demand for care workers has been met by

increasing numbers of poor women, with disproportionately high reliance on black women, immigrant women, poor women, and women with little training or education (Smith and Baughman 2007). According to data from the National Clearinghouse on the Direct Care Workforce (2006), nine out of ten direct care workers in all LTC facilities are female, slightly more than half are white and non-Hispanic, and about one-third are African American. The Institute for the Future of Aging Services (2007) similarly reports that about 90 percent of DCWs are women and about 50 percent are racial and ethnic minorities. The average age of DCWs is 37 in nursing homes and 41 in home care, and about 45% of DCWs completed their formal educations with a high school degree (National Clearinghouse on the Direct Care Workforce 2006). In comparison to the general workforce, DCWs are more likely to be unmarried African American or Hispanic women with children under the age of 18 at home (Harris-Kojetin et al. 2004). Overall, women dominate care work and minority racial and ethnic group women dominate the direct care workforce in some regions.

Immigration adds further complexity and diversity to the characteristics of DCWs. Redfoot and Houser found more than one in four LTC nurses and nurse aides in central U.S. cities was foreign born, and “the proportion of foreign-born workers in long-term care settings rose from 6 percent in 1980 to 16 percent in 2003” (2005:xii). Foreign-born DCWs differ from native-born DCWs in multiple ways. Overall, foreign-born DCWs have more formal education but less ability to speak English (Redfoot and Houser 2005). Furthermore, non-Western cultures are often deemed to honor elders more highly, leading many to believe that “immigrant caregivers make up with caring behavior what they may lack in technical and language skills” (Redfoot and Houser 2005:39). Now,

individuals who have migrated from poorer countries, like those in sub-Saharan Africa and the Caribbean, are providing more and more of the care for older people in developed countries (Redfoot and Houser 2005).

The marginal status of DCWs has raised alarm about social justice (MacDonald and Merrill 2002) and spurred the development of concepts like ‘care penalty’ (England and Folbre 1999; Nelson 1999), which depicts the suppression of extrinsic rewards for work that involves care. Generally, concerns with social justice highlight the striking inconsistencies between the high moral meanings and low financial meanings of care, but also expose more specific dilemmas, like the failure of LTC to provide health care benefits to care workers (Dawson 2007). Concerns about social justice extend to care recipients as well, as low pay and minimal benefits may not motivate quality job performance—in this case, the provision of quality care. Furthermore, low extrinsic rewards attract few people. The Institute for the Future of Aging Services (IFAS) explains that people who have other job options may be less likely to choose LTC work: “When the economy is strong... and unemployment is low, the pool of personnel—particularly women who may have in the past chosen long-term care—have more options. The tighter the labor market, the more difficult it may be to attract personnel to long-term care jobs” (2007:7).

The gender, race, class, and education characteristics of the direct care workforce suggest that DCWs’ motivations for employment may be influenced by discriminatory societal factors, like sexism and racism. Otherwise, the distribution of DCWs across gender, race, class, and educational status would be less strongly skewed toward poor minority women with limited educations. Taking these sociologically significant factors

into account, I have been alert to the influence of coercive societal forces, like sexism, on DCWs' motivations. Coercive forces contribute to social reproduction, like women's persistent dominance of care work, and demand attention when studying work worlds and workforces that are so strongly skewed in terms of gender, or other categories of difference.

Within LTC, multiple studies have been conducted, and numerous policies and practices have been implemented to address the shortage of LTC workers; most address increasing retention (Barry et al. 2005; Bishop et al. 2008; Bond and Galinsky 2006; Brannon and Barry 2006; Howes 2005; Pillemer and Meador 2006; Sikorska-Simmons 2005) or decreasing turnover (Anderson et al. 2004; Banaszak-Holl and Hines 1996; Castle and Engberg 2005; Castle 2005; Castle et al. 2007; Hatton and Dresser 2003; Parsons et al. 2003). Through this work, several core strategies have been identified that support retention and decrease turnover: (1) increasing compensation, including wages and health insurance, and offering full-time employment; (2) enhancing professional opportunities, with strong training and the possibility of career advancement, and incorporating care workers into decision-making; and (3) providing support through various organizations and public benefits, as well as "in-house" supervisors, management, and owners (Dawson 2007).

Fewer studies have addressed individuals' motivations for employment in LTC; as Moody and Pesut explain: "To date there has been little investigation or theory development that specifically addresses the motivation to care" (2006:16). However, some researchers have examined institutional practices that support recruitment: Rodin (2006) determined that offering health insurance benefits is crucial for increasing the

supply of care workers and Leon and colleagues (2001) found that more staff training decreased recruitment problems. In general, it has also been found that greater staff satisfaction leads to more successful recruitment (National Clearinghouse for the Direct Care Workforce). The present study is grounded in the idea that understanding care workers' underlying motivations for employment in LTC and in specific settings will help guide strategies for enhancing the supply of care workers.

Purpose of the Research

This dissertation consists of a state-wide study of individuals' motivations to work in long-term care. The overall purpose of this research is to contribute knowledge of care workers' motivations to guide policies and practices to close the emerging care gap and alleviate the care crisis. The focus on motivations fills the current gap in research on this topic. Drawing primarily on interview data collected with 400 assisted living care workers in Georgia—this sample was assembled through study of a stratified random sample of 45 assisted living facilities—I examined DCWs' motivations for employment. I also linked my basic research aim of developing knowledge of DCWs' motivations with two practical goals: (1) suggesting strategies that employers could use to improve recruitment and retention and (2) suggesting policies that governments and LTC-organizations could implement to support providers' recruitment and retention efforts. Ultimately, the research questions I answer fall into two groups: questions about care workers' motivations and questions seeking understanding of how DCWs' motivations are influenced by individual-, institutional-, and community-level factors. The first set of questions addresses DCWs' motivations for employment at three levels of long-term care:

- (1) What are DCWs' motivations for working in long-term care?
- (2) What are DCWs' motivations for working in AL?
- (3) What are DCWs' motivations for working for their current employer?

The second set of questions link DCWs' motivations to other factors:

- (1) How are DCWs' motivations at each level influenced by their personal characteristics (race, gender, age, national origin, education, life history, employment history, caregiving experience)?
- (2) How are DCWs' motivations at each level influenced by characteristics of their current jobs (workload, level of resident disability, pay and benefits, physical and social environment of facility)?
- (3) How are DCWs' motivations at each level influenced by characteristics of their communities (employment opportunities in area, urbanicity)?

By understanding the influence of individual-, institutional-, and community-level factors on DCWs' motivations, employers and governments will be better able to develop strategies and policies that are sensitive to care workers' particular experiences and grounded in the reality of current care settings and communities.

Background and Significance

Understanding the Direct Care Workforce

Care workers providing direct assistance to elderly residents have been identified as the most essential component of formal long-term care (Dawson 2003; Stone 2000). Overall, direct care jobs in LTC are low-wage positions involving housekeeping duties and care of often incontinent older adults who may have little cognitive awareness (Stone 2001). The labor performed by direct care workers—who provide the hands-on support to

long-term care residents (Kiefer, Harris-Kojetin, Brannon, Barry, Vasey, Lepore 2005), is physically taxing and includes assisting residents with activities of daily living, like dressing and bathing; emotionally demanding, including interacting with and supporting residents who may be physically or mentally impaired; spiritually depleting, especially in the inevitable situation where residents die; and mentally demeaning, as indicated by the large number of low-grade tasks DCWs perform, such as changing residents' soiled diapers, serving and clearing residents' meals, washing dishes, and doing laundry.

Because care work is intensively demanding on multiple levels, individuals' motivations to perform this work have been discussed by researchers. Abel and Nelson (1990), for instance, argue that material forces, like the need for stable income, are critical motivators for care work. Pay is widely acknowledged as a critical component of employment for workers, but national wage and employment data reveal that care work pays little. Nurse aides on average receive lower wages and fewer benefits than workers in general: In 1999, the national average hourly wage for nursing home aides was \$8.29 and for home health care aides was \$8.67, compared to \$9.22 for all service workers and \$15.29 for all workers (Scanlon 2001). The limited data available for assisted living workers indicate that their pay is similarly low. Hawes and Phillips (2000) reported that more than 75% of DCWs in their study of assisted living earned between \$5.00 and \$9.00 per hour, and Ball and colleagues found that all DCWs in small African American facilities earned between \$5.00 and \$7.00 per hour (Ball et al. 2000a). More recently, the National Clearinghouse on the Direct Care Workforce (2006), which is the research compilation arm of the Paraprofessional Healthcare Institute, reported that the median hourly wage for DCWs (\$9.56) is still significantly less than the median wage of U.S.

workers (\$14.15). Though LTC is facing unprecedented shortages of DCWs, trends indicate that the DCWs' pay is not increasing. Rather, Yamada (2002) found that nursing home and hospital DCWs' wages *decreased* from the late 1980s to the late 1990s, from \$7.29 to \$7.00 and \$9.81 to \$7.99, respectively. Yamada (2002) also found that both nursing home and home care aides were more likely to be in poverty than the general population. The National Clearinghouse on the Direct Care Workforce (2006) also found high levels of poverty among DCWs: 19% of home care aides and 16% of nursing home aides are poor, and over 30% of DCWs receive food stamps. Perhaps most poignantly, many DCWs lack health insurance coverage. Compared to approximately two-thirds of all Americans, less than half of nursing home aides and only about one-third of home care aides are provided with health insurance by their LTC employers (The National Clearinghouse on the Direct Care Workforce 2006). Furthermore, a recent Supreme Court decision permits home care employers to pay home care workers less than the minimum wage (Boris and Klein 2007).

However, in addition to performing arduous tasks for little pay, DCWs' jobs also entail establishing personal relationships with care recipients, and assisted living work worlds are typically described as attractive home-like environments. Care work requires the development and maintenance of emotionally and physically intimate relationships. In assisted living, these intimate relationships take place in home-like settings. Motivations for care work have been conceptualized as intrinsic when they have been geared toward these relational aspects of care work and extrinsic when geared toward concerns like pay and benefits.

The limited extrinsic rewards provided for care work suggests that individuals who perform this essential activity may be motivated by intrinsic factors. However, the high rates of poverty among DCWs and the increasing representation of marginal social groups, including black women, immigrant women, poor women, and women with little training or education among the direct care workforce (Smith and Baughman 2007), suggests that DCWs are, indeed, motivated by economic need. Because the demand for caring labor is growing, understanding these motivational factors has become increasingly necessary.

Given the demanding workload and low pay of direct care work, it is not surprising that DCW turnover plagues long-term care, and DCW shortages exist throughout LTC (Wilner and Wyatt 1999). However, the combination of a demanding workload and low pay makes DCWs' motivations to perform this work very enigmatic. This study sheds light on workers' motivations for employment in LTC.

The Landscape of Long-Term Care

Across LTC settings staffing is problematic. DCW turnover is high in every LTC setting, and many facilities across these settings suffer from staff shortages. The National Clearinghouse on the Direct Care Workforce reports:

By 2014, the number of home health aide positions is expected to grow by 56 percent, making this occupation the fastest growing in America. Personal and home care aide positions are expected to increase by more than two-fifths (41 percent), making it one of the economy's fastest-growing and largest growth occupations. By contrast, nurse aide, orderly, and attendant positions are predicted to increase by only 22 percent, but the sheer number added will be enough to place nursing assistants in the top ten occupations with the largest job growth between 2004 and 2014 (2006:2).

Nursing homes, home-based health care, and continuing care retirement communities are some of the major alternatives to AL. In addition to DCW positions, these various LTC

settings, including AL, often include administrative positions, like facility management, marketing, and finance; housekeeping and maintenance positions; social leadership positions, like activity and volunteer coordinators; and cooks and kitchen staff. The number and variety of positions in a given setting varies according to each facility's size and resources, and large facilities with the most resources generally include more positions.

Nursing homes are fairly hospital-like settings, in that generally they have an institutional feel and provide skilled nursing services, so care work in nursing homes usually involves substantial bed-and-body care. In contrast, home-based health care services range widely from the provision of minimal assistance with instrumental activities of daily living, like cooking and cleaning, to total care, like that performed in nursing homes (National Clearinghouse on the Direct Care Workforce 2006). However, home-based health care services are performed in care recipients' private homes. Continuing care retirement communities (CCRCs) promise housing and a full-range of care until death, so care work in these settings also varies extensively. CCRCs often include large campuses with many amenities, including swimming pools and workout-rooms. However, CCRCs are mostly available only to relatively affluent individuals due to their entrance fees, which are sometimes as high as \$400,000 (Sanders 1997).

Assisted Living: A Critical Component of Long-Term Care

Within LTC, assisted living—a type of mid-range supportive housing intended to prevent or delay nursing home placement—has become one of the most attractive residential care options for older adults (Zimmerman et al. 2003). Tumlinson and Woods (2007) report that nursing homes are becoming less popular among older adults and

assisted living (hereafter referred to as AL) is becoming more popular: “the percent of people over age 85 residing in nursing homes has dropped from 21.1 percent in 1985 to 13.9 percent in 2004” (2007:3). In contrast, “assisted living has grown rapidly over the past decade with approximately 36,451 assisted living facilities with 937,631 units/beds now existing in the United States” (Tumlinson and Woods 2007:4).

Hawes and Phillips (2000) have reported the most comprehensive data about AL staff. These data come from a national sample of 569 staff members and represent 41% of all licensed AL facilities nationwide that met the researchers’ criteria for high-service or high-privacy facilities. Only 61% of staff worked full-time and half had worked in the facility for two or more years. Slightly over half (51%) were DCWs, and 20% were licensed professionals. The median ratio of DCWs to residents was 1:14. A national survey of 178 AL facilities found the mean number of staff to be 7.7 for facilities with 25 or fewer beds; 7.8 for facilities with 26-40 beds; 14.2 for facilities with 41-60 beds; and 14.3 for facilities with 61 or more beds (National Investment Conference for Senior Living and Long-Term Care Industries 1998).

Though AL is an increasingly important component of LTC, it has escaped clear definition. Robert Mollica’s report for the U.S. Department of Health and Human Services highlights the confusion around what, exactly, “assisted living” means:

Despite widespread use of the term, assisted living has evolved as a generic term that describes services in licensed residential settings. Some States have separate licensing categories and requirements for assisted living and residential care facilities; others use the terms interchangeably. Definitions of assisted living include references to the licensed entity, the type of building, the relationship of the residents to the owner, the purpose for which a license is sought, the philosophy of the regulations, the needs that may be addressed or not addressed, the services that may or may not be provided, and the minimum size required for license (2005:4).

Differences between AL facilities are inevitable, and broad categorization of AL facilities necessarily generalizes their characteristics. However, defining AL within more specific parameters than permitted by our current indefinite concepts of AL has important implications for government licensing and funding policies. Currently, AL is state-licensed, which lends it to categorical variations. Mollica and Johnson-Lamarche explain the extent of state-level variations in defining AL:

Forty-one states and the District of Columbia now use the term assisted living in their residential care regulations. In some states, assisted living is a specific model with a consumer-centered service philosophy, private apartments or units, and a broad array of services which support aging-in-place. In others states, residential care licensing categories have been consolidated under a new general set of "assisted living" rules that might cover the new model of assisted living, as well as board and care, multi-unit elderly housing, congregate housing and sometimes even adult family or foster care (e.g., Maine, Maryland, and North Carolina).

Assisted living may be *a licensed setting* in which services are delivered or *a licensed agency* that delivers services in a range of settings. Four states (Connecticut, Maine, Minnesota, and New Jersey) describe assisted living *services* that may be provided in two or more settings. Connecticut and Minnesota see assisted living as *a service*, and license the service provider (which may be a separate entity from the organization that owns or operates the building). Other states see assisted living as *a building* in which supportive and health related services are provided. The operator of the building is licensed, and services may be provided by the operator's staff or contracted to an outside agency (2005:8).

In recognition of these state licensing variations, I use "AL" when referring to "assisted living," rather than the commonplace "ALF," because AL licenses are not restricted to *facilities*, but also are granted for *services*.

Because multiple variations exist across concepts of AL, the federal government has called upon multiple stakeholders to develop a unifying definition. This group of stakeholders—the Assisted Living Workgroup—developed the following definition of AL:

Assisted living is a state regulated and monitored residential long term care option. Assisted living provides or coordinates oversight and services to meet the residents' individualized scheduled needs, based on the residents' assessments and service plans and their unscheduled needs as they arise. Services that are required by state law and regulation to be provided or coordinated must include but are not limited to:

- 24-hour awake staff to provide oversight and meet scheduled and unscheduled needs
- Provision and oversight of personal care and supportive services
- Health related services (e.g., medication management services)
- Meals, housekeeping, and laundry
- Recreational activities
- Transportation and social services

These services are disclosed and agreed to in the contract between the provider and resident. Assisted living does not generally provide ongoing, 24-hour skilled nursing. It is distinguished from other residential long-term care options by the types of services that it is licensed to perform in accordance with a philosophy of service delivery that is designed to maximize individual choice, dignity, autonomy, independence, and quality of life (2003).

Because staffing is a central problem for AL, and for LTC more generally, developing a definition of AL from the perspective of DCWs may be an effective strategy for both resolving the ambiguity of what “assisted living” means and for making AL more attractive to DCWs. By attending to DCWs’ motivations to work in AL, rather than to work in a nursing home or to provide home-care services, this dissertation elucidates key features of AL that attract workers. By highlighting these features when defining AL, more workers may be attracted to AL.

Comparing Assisted Living to Nursing Homes

Establishing a definition of AL is very important for consumers and governments. However, on a daily basis, AL DCWs experience this phenomenon that has eluded definition. DCWs in AL facilities most frequently offer assistance with bathing (87%), dressing (85%), and medications (80%), and 52% of AL facilities provide care or monitoring by RNs or LPNs (Hawes, Rose, and Phillips 1999; Mollica 2002). AL

facilities should be qualitatively different from nursing homes. Differences between AL and nursing homes include the physical environment, residents' financial resources and care needs, and staff training requirements. The physical environment of AL should be less institutional and more homelike than nursing homes, with an emphasis on privacy, including private rooms (Mollica and Johnson-Lamarche 2005). AL facilities are mostly private-pay and serve older people with sufficient personal resources, as opposed to nursing homes, where Medicaid reimbursements are primary (Tumlinson and Woods 2007). However, illustrating the dynamism of AL, the National Commission for Quality Long –Term Care (2006) reports that in recent years more Medicaid assistance has been provided to AL residents. Additionally, training requirements for AL staff are less strict than nursing home training requirements. Mollica and Johnson-Lamarche report:

Three-quarters of unlicensed personnel [in AL] were required to attend some type of pre-service training or orientation, most commonly lasting between 1 and 16 hours. Only 11 percent of the staff who received required training completed it prior to the start of work; the remainder received on-the-job training or a combination of pre-service and on-the-job training. In contrast, nursing homes aides are required to have a minimum of 75 hours of training (10 days) and to pass an exam before they can work on a unit providing direct resident care (2005:33).

Furthermore, many states do not allow persons with continuous skilled care needs to reside in AL, resulting in residents who are less frail and have less cognitive impairment and fewer care needs than those living in nursing homes. However, each state has different criteria for residents' suitability to live in AL. Mollica and Johnson-Lamarche (2005) describe these criteria as fitting into three categories, full continuum, discharge triggers, and levels of licensure: *Full Continuum* criteria are used in states that allow facilities to serve people with a wide range of needs; *Discharge Trigger* criteria are used in states with a list of medical needs or treatments that cannot be provided in AL and

result in a resident's discharge; and *Levels of Licensure* criteria are used in states that license facilities based on the needs of residents or the services that may be provided in a specific kind of facility.

In addition to the multiple variations *across* states, criteria for admission to AL change over time *within* states. Mollica and Johnson-Lamarche report: "Since 2002, Arkansas, Delaware, South Carolina, South Dakota, Vermont, and Washington have modified their admission criteria" (2005:20). Further illustrating the dynamism of AL, The National Center for Assisted Living (1997) report that AL residents are, on average, much less impaired than nursing home residents, but are increasingly older, more functionally impaired, and have greater physical care needs. By illustrating the influence of residents' care needs on DCWs' motivations to work in AL, this dissertation offers guidelines for the establishment of admission and discharge criteria for residents that will encourage successful recruitment and retention of DCWs.

Though AL facilities share many characteristics in their comparison to nursing homes, AL facilities also vary in multiple ways. Data from a ten-state survey found that facilities ranged in size from two to more than 1,400 beds (Hawes et al. 1995). While the majority of facilities were small (2-10 beds), most residents lived in medium-sized (11-50) or large (51+) facilities. Recent data estimate 36,451 licensed residential care facilities with 937,601 units/beds (Mollica, Johnson-Lamarche 2005). By comparing these figures to those of nursing homes, of which there are approximately 18,000 facilities with 1.9 million beds (Jones 2002), the significance of assisted living as a long-term care option becomes clear.

Summary

Considering emerging demographic and employment trends, it is crucial to find ways to bolster the direct care workforce. The increasing demand for assisted living suggests that care workers are particularly needed in this residential care venue, but the diminishing supply of care workers and the low material rewards for care work offer little hope for meeting this demand. In addition, recent research indicates that care workers are marginal in society, with increasing representation of minority groups across categories of gender, race, ethnicity, and class. Together, these demographic and workforce trends suggest that LTC is a critical site of sociological research. More information is needed about what brings workers into LTC to ensure a continuing supply of care. This qualitative study fills important knowledge gaps in the literature of workers' motivations for LTC and provides valuable insights for researchers, policymakers, and service providers.

The following chapter reviews recent research on motivations for work, particularly care work, and presents the specific research questions that will be addressed. As a whole, it provides a conceptual framework for the sociological problems investigated in this dissertation.

Chapter 2

CONCEPTUAL FRAMEWORK

Understanding Motivation

In general, motivation is having the desire and willingness to do something. Ryan and Deci explain: “To be motivated means *to be moved* to do something” (2000:54). Markus and Kitayama more explicitly suggest: “The study of motivation centers on the question of why people initiate, terminate, and persist in specific actions in particular circumstances” (1991:231). As articulated above, the intention of this dissertation is to develop understanding of DCWs’ motivations to work in long-term care, assisted living, and specific facilities. These motivations are the focus of study because they are not understood and they are important to the existence of LTC and thus the lives of increasing numbers of older adults. Because various funding sources, both private and public, intersect in the provision of care for older adults, studying motivations for elder care is particularly important for economic, political, and demographic reasons (Kendall 2001). Kendall argues: “One of the most pressing contexts in which examination of the motivations at stake is a priority is the case of social welfare for older people” (2001:360). Though motivation has been a topic of interest for some time among sociologists, psychologists, anthropologists, and employers, debate about the nature of motivations has recently exploded in a flurry of studies and opinions. In the following paragraphs, I describe current debates regarding workers’ motivations and outline my approach toward care workers’ motivations in the context of these debates.

Abraham Maslow developed the first widely-known theory of motivation. Maslow's (1943) theory is grounded in his belief that humans have an innate drive to satisfy a hierarchy of needs, from basic, fundamental needs, such as food and water, to more complex, psychological needs, with self-actualization as the pinnacle. According to Maslow, humans advance linearly from one level of needs to the next, achieving individuality, humanness, and psychological health as their higher needs are met. In other words, Maslow posits that humans possess a natural tendency for growth and development, and motivations derive from this natural tendency.

Since the 1970s, Edward Deci and Richard Ryan (Deci 1976; Deci and Ryan 1980; Gagne and Deci 2005; Ryan and Deci 2000) have pioneered the development of self-determination theory (SDT). Like Maslow's theory of motivation, SDT builds on the assumption that humans have a natural tendency for growth. However, unlike Maslow's theory, SDT holds that an encouraging environment is often a necessary precursor to activate human motivation. That is, SDT distinguishes between intrinsic motivation—an innate tendency for growth, and extrinsic motivation, which is environmental.

When applied to work settings and organizations, dichotomized motivational theories, like those that posit a binary extrinsic-intrinsic system of motivations, have important implications. According to economist Bruno Frey (1997), workers' motivations are either extrinsic or intrinsic, and these two types of motivations preclude one another through a "crowding-out" dynamic. Consequently, for Frey, either extrinsic or intrinsic rewards should be used to motivate workers, but not both, because they will cancel each other out. Similarly, Kreps, an economist, argues: "Providing extrinsic incentives for workers can be counterproductive, because it may destroy the workers' intrinsic

motivation” (1997:360). However, Kreps also acknowledges problems with the assumption of dichotomous intrinsic and extrinsic motivations and suggests that, because workers differ in what they value, many motivators are “fuzzy” and neither clearly intrinsic or extrinsic (1997:361).

Recently, dichotomous notions of motivations as distinct and separate have been attacked on several fronts, particularly with regards to care work. Markus and Kitayama (1991) and Scheuer (2000) infuse motivation theory with the concepts of culture and group social norms, thereby bridging intrinsic-extrinsic, micro-macro dichotomies. Markus and Kitayama (1991) specifically differentiate between Western (European and American) and Eastern notions of “self” to illustrate that cultural differences result in entirely different self-systems and etiologies, or sources, of motivations. They describe Eastern self-systems as conceptually *interdependent* and claim: “Those with interdependent selves should express, and perhaps experience, more of those motives that are social or that have the other as referent” (Markus and Kitayama 1991:130). In contrast, they describe Western self-systems as conceptually *independent* and claim that motivations rooted in Western self-systems focus on the self, rather than others, and often include factors like “the motive to enhance one’s self-esteem, the motive to achieve, the motive to affiliate, the motive to avoid conflict, or the motive to self-actualize” (Markus and Kitayama 1991:130). The cultural construal of motivations debunks monolithic, universal conceptions of motivations and the self. As such, Markus and Kitayama’s (1991) work helped sensitize my research to cultural influences on care workers’ motivations.

Furthermore, during his meta-analysis of motivation research, Scheuer explains that each worker is “simultaneously an individual actor and a participant in a number of collective connections” (2000:205). He claims that human motivation is driven by self-reflexivity and that “this reflexivity is based on both rational action and on social-normative agency” (2000:206). This emphasis on reflexivity and the influence of societal norms also supports the practice of attending to cultural influences on motivations and further debunks monolithic conceptions of motivations. Ultimately, Scheuer’s argument reflects the symbolic interactionist assumptions that individuals actively choose their motivational orientations within cultural parameters and that their motivations are not innate.

Social ideals shape people’s values, but some societal practices are not consistent with its ideals. Many societies express a high ethical, but low economic value for care work. These inconsistencies have serious consequences, as suggested by the dire condition of the LTC workforce, and reflected in the everyday experiences of care workers. Within LTC facilities, care workers commonly experience incongruence between managerial rhetoric that asserts their importance and managerial practices that symbolize their unimportance (Bowers, Esmond, and Jacobson 2003). In other words, DCWs are led by societal values and managerial rhetoric to believe that care work is highly important, but the low compensation for care work expresses, in contrast, the very low value of this work. In a survey of approximately 600 nursing home workers, Karl Pillemer (1996) found the primary reasons for entering care work were its intrinsic worth and the sense that it is socially valuable and personally fulfilling. Pillemer’s (1996) findings suggest that the most important reasons DCWs come to LTC are to help others,

to feel meaningful, and to serve society, and research also shows that relationships with residents are a central component of job satisfaction and retention among care workers (Ball et al. forthcoming; Berdes and Eckert 2001; Foner 1994). However, high care worker turnover rates suggest that these intrinsic rewards do not suffice to keep people in the field. Rather, intrinsic and extrinsic factors seem to interact, and the lack of extrinsic rewards seems to override the value of the intrinsic rewards for keeping care workers in their jobs. Bowers, Esmond, and Jacobson argue that the interconnection between intrinsic and extrinsic factors is so thorough that it “dissolves the distinction between intrinsic and extrinsic factors” (2003:42).

Recent studies informed by feminist philosophies also show that individuals who provide care to older adults enter this work for a variety of reasons and suggest that dichotomous notions of motivation as extrinsic *or* intrinsic fail to match individuals’ experiences of entering care work (Folbre 2006; Meagher 2006). Folbre (2006) and Meagher (2006) also argue that conceptualizing motivations for care work as dichotomous supports current market dynamics that limit care workers’ pay. Bruno Frey’s (1997) economic notion of *crowding out*, which asserts that intrinsic and extrinsic motivations preclude one another, illustrates how dichotomous concepts of motivation can limit pay for care work. By relying on survey data in which respondents rated predetermined reasons for entering care work, Pillemer’s (1996) study conserved the dichotomous notion that people enter care work for either intrinsic or extrinsic reasons and illustrated that, when forced, care workers are prone to choosing intrinsic over extrinsic motives. In contrast, Folbre and Nelson deconstruct the dichotomous idea that

care workers' motivations are for either intrinsic *or* extrinsic rewards, like love *or* money, and re-envision the market as capable of providing both intrinsic *and* extrinsic rewards:

What are the motivations of paid caregivers? In some discussions it seems as if a dichotomy is posed: one works either for love or for money—that is, out of spiritual values, affection, and altruism, or out of crass materialism, self-interest, and greed. Such a dichotomy implicitly assumes, however, first, that market agents' actions spring from their own unquenchable wants, and second, that agents are autonomous and unconnected self-sufficient beings. Neither assumption is useful in this context (2000: 131).

While debates about the nature of motivations for care work and the potential of markets to support these motivations already suggest that examining individuals' motivations for care work is a complex endeavor, recent expansion and specialization of LTC settings offers further complications. Long-term care settings vary and research has not yet addressed DCWs' motivations for entering particular care venues. However, these specific motivations are important for policy-makers to consider because each DCW comes to LTC by getting a job in a particular setting, and policy differences across care settings can influence DCWs' choices.

Requirements for employment as a care worker vary in each state and setting, but training requirements for DCWs are minimal across settings (IFAS 2007). Overall, federal regulations require nursing home DCWs to be certified nursing assistants, but no federal training or education requirements exist for assisted living or home care work. Because training requirements are minimal across long-term care, many DCWs can “job hop” between care venues, gaining experience and knowledge that is valuable to consecutive employers and care recipients. Consequently, DCWs' initial and subsequent choices of work setting (e.g., nursing home, assisted living, or home-care) deserve close attention by policymakers attempting to understand and expand the direct care workforce.

DCWs' specific choices of work setting have particularly important implications for certification and training policies, and the Institute for the Future of Aging Services argues that "facilitating movement between health-related occupations" is necessary for resolving the "emerging care gap" (2007:11).

Furthermore, mandated staff-to-resident ratios, and admission and discharge criteria for residents vary across settings. These differences likely have a significant influence on DCWs' experiences. Differences in staff-to-resident ratios likely result in very different workloads, and variations in admission and discharge criteria for residents likely influence DCWs' abilities to establish relationships with residents. As a result of the differences between LTC settings, DCWs' motivations for particular settings are likely far more complex than suggested by studies of motivations for LTC in general.

Previous Studies

While this dissertation builds on previous literature about DCWs and their motivations, it also builds on my previous research and work experiences. Prior to collecting the data on which this dissertation is based, I worked with the core members of the research team, including the primary investigators (Drs. Mary Ball and Molly Perkins), on a smaller study of AL. This smaller, ethnographic study, "Relationships of Care Staff in Assisted Living," was funded by the National Institute on Aging (R03 AG022611-01). Findings from this study were based on interviews with 38 DCWs and five administrators as well as approximately 250 hours of participant observation performed at two AL facilities in the metropolitan Atlanta, Georgia area. We studied the facilities sequentially, starting at the smaller facility, Blue Castle, and ending at the larger facility, Forest Manor. Blue Castle was a 36-bed non-profit facility with 23 DCWs.

Eighteen (78%) of the 23 DCWs at Blue Castle were African American women. Forest Manor was a corporately-owned, for-profit facility, with 90 beds. At Forest Manor there were 38 DCWs, 36 (95%) of whom were African American women. Across both facilities, there was only one African American resident, and she lived at Forest Manor. After the conclusion of the study, I returned to both facilities and performed life history interviews with long-tenure staff—DCWs who had worked in their current facility for over ten consecutive years. Thirteen women, four of whom worked at Blue Castle and the other nine at Forest Manor, constituted the sample pool of long-tenure DCWs. Twelve were African American and one was white. I performed life history interviews with six of these DCWs (three from each facility), including the one white DCW.

By performing life history analyses in my Master's thesis, I found long-tenure DCWs were motivated by societal racism and gender discrimination to become formal caregivers, often after first having been informal family caregivers (Lepore 2005). For these long-tenure DCWs, *turning points* (Crosnoe and Elder 2002) during their life histories were important life-course predictors of their later tenure as DCWs. For several DCWs, the turning point that led them into the process of retention was realizing that they would never achieve their professional goals, like becoming registered nurses. These DCWs ultimately redefined their professional goals so that they were embodied by direct care work, which was the highest position they were able to attain in the health care field. Achieving personal goals, like raising a family and fulfilling the obligations that were consistent with being a “good wife,” also was a turning point that led to long-tenure employment as a DCW. Overall, I found DCWs' life histories and personal characteristics served as the stepping-stones to their current lives and identities.

In addition to the understanding of DCWs I gained through previous research, particularly the influence of DCWs' life histories on their motivations to enter and stay in LTC, my dissertation is informed by *my* life history experiences, especially the years of 1998 through 2002, when I worked in childcare (1998-2000) and assisted living (2000-2002). While working in these settings, I considered my motivations to do care work as grounded in my education, specifically my bachelor's degree in psychology, which I considered myself to be putting-to-use by taking care of vulnerable populations. However, I also considered taking care of others inherently good, so questioning of my motivations was minimal. When I left childcare and started work in AL, I recognized that I had grown tired of working with children, whose emotional, mental, and physical demands I found too great, and considered the comparative peacefulness of AL as a component of my employment motivations as well. However, upon starting research on the topic of workers' motivations, I also recognized that during my job search, after I had left childcare and before I started in AL, I applied for jobs in childcare and in a university academic office. Upon reflection, I recognized that my motivations were not entirely based on my belief in the inherent goodness of care work or the relatively comfortable social environment of AL. I needed income, and neither the childcare job nor the university job that I applied for offered me a position. Furthermore, by reflecting on my job hunt, I recognized that my application for employment as a DCW in AL largely stemmed from the fact that the AL facility where I worked was located less than five minutes from where I lived. Ultimately, my employment as a DCW originated because the AL facility where I was hired was the only employer to offer me a job. Through further reflection, I have also recognized that, as a male, my queer identity was

supportive of my work in childcare and in AL, because these were gender non-conformative roles.

In contrast to my experiences and perceived motivations, DCWs with experience caring for loved ones who have died or who work with their family members in LTC would likely understand their motivations differently. They may believe “it runs in the family” or “it is in my blood.” They may find it has great moral value. However, like me, their motivations also may stem from lack of employment options, simple logistics like distance from home, or societal gender norms, any of which DCWs may fail to recognize as motivations for their entry into direct care work.

Challenges of Studying Motivations

Adding further complexity to the topic of motivations, social-psychologists, especially symbolic interactionists, draw attention to the tendency for individuals to manage the impressions of themselves that they expose to others (Goffman 1963, 1967). Impression management could distort the results of research that relies heavily on interviews. Racial minorities, and marginalized people in general, are especially prone to perform impression management because of stigmas associated with their identities (Goffman 1963). Because care workers are mostly women, many are racial minorities, and almost all are very low paid, their tendencies for impression management are likely to be active. Accordingly, poor African American women, like many care workers in Georgia, may be less likely to express extrinsic motivations for care work. Their intersecting racial, gender, and class identity is already stigmatized, but, as dichotomous categorizations of care motivations indicate, extrinsic motivations preclude the presence of intrinsic motivations (Frey 1997). Because poor black women often are stereotyped as

being lazy and greedy, as in the stereotypical portrayal of welfare mothers (Davis and Hagen 1996), they can counteract that stigma by expressing intrinsic motivations for work and minimal concern with workload. I address the issue of impression management by foregrounding DCWs' life histories, including their employment histories and educations, and their personal characteristics, like race and gender. Because DCWs are unlikely to distort their entire life histories even if exercising impression management, their background information helps illustrate their *motivational courses* or *pathways*, that is, the dynamic unfolding of their life events.

Because interview and survey data are prone to bias by impression management. DCWs' behaviors, like their interactions with residents, can help verify the accuracy of interview data. When DCWs report during an interview that they were motivated to provide care because they love spending time with older adults, the validity of this data can be assessed by comparing it with ethnographic field notes that describe their interactions with residents. Participant observation provides data to address the influence of impression management on interview data. Furthermore, examining workers' employment histories helps contextualize their motivations for employment in long-term care, assisted living, and their specific facilities, and thus also helps address the influence of impression management.

CHAPTER 3

RESEARCH METHODS

Background for the Study

Data for this dissertation come from a study funded by the National Institute of Aging: *Job Satisfaction and Retention of Direct-Care Staff in Assisted Living* (Mary Ball, PI). Data include ethnographic field notes, interviews with administrators, and interviews with DCWs. Two types of interviews were performed with DCWs: Type 1 mixed-method interviews (N = 370) and Type 2 qualitative interviews (N = 42). Data collection included attention to workers' employment motivations. However, the primary goals of this study were to: (1) understand what job satisfaction means to AL DCWs; (2) understand how individual, sociocultural, and environmental factors influence AL DCWs' job satisfaction and retention, and understand how these variables relate to one another; and (3) identify strategies that support AL DCWs' job satisfaction and retention. Much of the data pertaining to satisfaction and retention reinforce the findings about workers' motivation and are drawn on in the Findings chapters.

Selection of Research Sites

During the past three years (2004-2007), data for this study were collected at 45 AL facilities in Georgia. Only AL facilities with 16 or more beds, located within 150 miles of metropolitan Atlanta, and serving a primarily elderly population were included in the facility sample pool. No facilities with 15 or fewer residents were selected because previous studies indicate that smaller and larger AL facilities are substantially different in multiple ways, including experiences of DCWs (Ball et al. 2000; 2005). In many facilities

with 15 or fewer residents, the owner or a full-time manager provides all or most resident care and performs most other duties such as housekeeping, laundry, and meal preparation, with other staff being hired only on an intermittent and part-time basis. Furthermore, DCWs in facilities with fewer than 15 residents may have closer relationships with residents and greater autonomy in their work, but also lower pay and fewer benefits.

To minimize travel time and expense, the sample facilities were drawn from counties within 150 miles of Atlanta. We defined our geographic strata according to Georgia's 12 planning and service areas (PSAs), nine (1-9) of which are located within the target radius. To increase the number of sample facilities in rural areas, we combined the 9 PSAs into 3 strata. We based the PSA combinations on their geographic contiguity, the number of facilities in each PSA, and the cultural characteristics of residents that we expected to find in each area. Area 1 was comprised only of PSA 3, which includes the 10-county Atlanta region and is the most populous PSA. Area 1 has 135 AL facilities in the sample pool. Area 2 contains the 5 PSAs (4, 6, 7, 8, and 9) south, southwest, southeast, and east of Atlanta, which contains 69 counties and the medium-sized cities of Augusta (pop. 477,441), Macon (pop. 322,549) and Columbus (pop. 274,624). Eighty-one AL facilities are located in the Area 2 sample pool. Area 3 (PSAs 1, 2, and 5) contains 39 counties located northeast, northwest, and north of Atlanta and includes the mountain areas of Georgia and two small cities, Gainesville (pop. 139, 277) and Athens (pop. 153,444). Area 3 has 85 AL facilities in the sample pool. These 3 areas vary in racial composition (ranging from 10% black in Area 3 to 32% black in Area 1) and population density (ranging from 2,484 persons per square mile in one Area 1 county to

11 persons per square mile in one county of Area 2) (U.S. Census Bureau 2000).

To select the facility sample, the research team first created a comprehensive list of appropriately-sized facilities in the defined geographic area of Georgia. Facilities were then stratified according to size and geographic area, using three size categories—small (16-25 beds), medium (26-50 beds), and large (51+ beds). Stratifying the sample by facility size was important because previous studies show that closer social relationships are likely to occur in smaller facilities (Ball et al. 2000), and workplace relationships have been found to influence DCW employment outcomes (Sherman 1991; Wilner 1994). Furthermore, facility size influences DCWs' workloads, as suggested by DCW-resident ratios across facilities of various sizes. For example, in Georgia, both a facility with 20 residents and one with 30 residents are required to have only two DCWs on duty during residents' waking hours. As a result, each DCW in the larger facility would need to care for five additional residents with no additional help. Because of the influence of facility size on relationships and workloads in LTC, DCWs' feelings about their work, and their reported motivations, may be strongly influenced by facility size (Ball et al. 2000).

We stratified the sample by geographic area to increase the probability of selecting a sample of facilities with DCWs and residents who are diverse in terms of socioeconomic status, culture, race, and ethnicity. Geographic stratification also increased the probability of selecting a sample of facilities located in communities that vary by size and local economy. We expected these components of stratification would be important because previous studies by the research team (Ball and Whittington 1997; Perkins, Whittington, and Ball 1998) have shown that facilities in diverse settings, like

small-towns, rural mountain communities, and urban areas, each have unique characteristics that may influence DCWs' motivations to enter LTC. For instance, community variables such as unemployment rates, the number of LTC facilities, and the availability of public transportation may strongly influence DCWs' motivations.

Table 1 shows the complete population of licensed AL facilities stratified by size categories and geographic areas. Placement of facilities into size and geographic strata was based on information from the state long-term care regulatory agency and Georgia's Long-Term Care Ombudsman Program (LTCOP). These data indicate that approximately 45% of facilities in the sample pool are located in the Atlanta metropolitan area (pop. 4.5 million), 9% are located in metropolitan areas with populations of 250,000-999,999; 2% are located in metropolitan areas with populations of 100,000-249,000, 20% are located in metropolitan areas with populations of less than 100,000, and 29% are located in rural areas.

Table 1. Population of Facilities by Geographic Area and Size

Area/Size	16-25 Beds	26-50 Beds	51+ Beds	Total	%
Area 1	26	38	71	135	44.9
Area 2	35	27	19	81	26.9
Area 3	29	33	23	85	28.2
Total	90	98	113	301	
%	29.9	32.6	37.5		100.0

Sample facilities were selected by systematic random sampling within strata. First, the appropriate number of facilities for each area was calculated by creating a ratio for the sample that reflected the characteristics of the sample pool. For instance, because 28% of the facilities in the sample pool are in Area 3, we determined that approximately 28% of the sample facilities also should be in Area 3. In the same way, the number of facilities per size category was selected in proportion to the total population in that size category. By dividing the number of facilities in each stratum of the sample pool by the number of facilities desired for each stratum in the sample, a number (n) was calculated for each stratum. Facilities then were arranged alphabetically within strata, and each n th facility was selected for the sample, beginning with a blindly-selected starting point. For each stratum, up to ten facilities were selected beyond the number determined appropriate for the sample size. The extra facilities were selected by returning to the beginning of the list after the target number of facilities had been selected and continuing to count each n th facility in the list. These additional facilities served as replacements when other facilities refused to participate in the study.

To request facility participation, researchers sent a letter to the owner or executive director explaining the project. Researchers followed the letters with a phone call and/or a visit to allow the facility representative to ask questions and address concerns about the study prior to deciding whether or not to participate. Each facility that refused to participate was replaced by the next facility on the list within the appropriate size category and geographic area.

Originally, the plan for data collection included studying 36 facilities, and with this plan the final number of sample facilities would have reflected the total number of

facilities in each size category and geographic area. However, during the study, the facility sample increased to 45 facilities to improve the robustness of quantitative measures. When researchers designed this study, no known studies of staff satisfaction and retention in assisted living existed. Because no data were available that could be used to calculate power for this multilevel study, researchers calculated an *a priori* power analysis assuming no aggregate-level data and adjusted this estimate to take aggregate data into account once approximately two-thirds of the data were collected. Researchers used Cohen's (1988) general guidelines to conduct the *a priori* power analysis and they used the Optimal Design program (Spybrook et al. 2006), a software program for estimating power for longitudinal and multilevel research designs, to conduct the post hoc analyses. Intent to leave, a continuous outcome variable in the conceptual model, was used as the dependent variable in these analyses. Based on an alpha level of .05, 26 predictor variables, and an estimated medium population effect size, an *a priori* power analysis showed that a minimum of 226 participants were needed to insure statistical power of .90. The proposed sample of 308 staff participants, which substantially exceeded the required number needed for statistical power, was determined based on the anticipated sample pool in each size facility, the number of facilities in each size category, and the three geographic strata.

After interviewing 207 DCWs (approximately two-thirds of the original proposed participant sample of 308) in 27 facilities, researchers conducted an ad hoc power analysis, which was based on an alpha of .05, the harmonic mean of the within-group sample size equal to 6, and an intraclass correlation (ICC) of .13. This analysis showed

that at least 45 facilities were needed for statistical power of .80 to detect an effect size of .30, a value that falls within the moderate range according to Cohen (1998).

To select the additional nine facilities required to increase the sample from 36 to 45 facilities, researchers assessed the original sample and determined that facilities in rural areas were underrepresented. In the sample pool, most facilities located in rural areas are small and located in Area 3. Consequently, when selecting the additional nine facilities, researchers oversampled small facilities in Area 3 to augment the sample's representation of rural facilities. Researchers ultimately selected six small facilities in Area 3, one medium-sized facility in Area 1, one large facility in Area 1, and one large facility in Area 3 to increase the sample to 45. The final sample of 45 facilities represents about 15% of the sample pool (N = 301). Table 2 shows the number of sample facilities by size and geographic area.

Once data collection was complete, researchers conducted a second ad hoc power analysis to determine the power for the conceptual model. With an alpha of .05, the number of facilities equal to 45, the harmonic mean of the within-group sample size equal to 6, and an ICC of .09, analysis showed that researchers had power of .80 to detect a moderate effect size of .42 (Cohen 1988).

Table 2. Sample of Facilities by Geographic Area and Size

Area/Size	16-25 Beds	26-50 Beds	51+ Beds	Total	%
Area 1	2	4	8	14	31%
Area 2	5	4	4	13	31%
Area 3	11	5	2	18	38%
Total	18	13	14	45	
%	40%	29%	31%		100

Selection of Participants

In each of the 45 facilities, at least one administrator was interviewed. Because two pairs of facilities were located on the same campus and shared administrative staff, we interviewed only one administrator at each pair of facilities, resulting in a total of 43 administrator interviews. We selected to interview the administrator with responsibility for hiring and managing direct-care staff at each facility. In the smaller facilities (16-25 beds), this person usually was the owner or executive director. In other size categories, we regularly found an administrator whose primary responsibility is staffing. We expected that administrators who manage direct-care staff would have the best knowledge of their characteristics and experiences and of policies and procedures related to staffing and would be able to provide valuable insights into issues of staff satisfaction and retention. Administrators often were very helpful to the research process, providing richly detailed interviews as well as lists of staff and their schedules and work statuses.

The strategy for sampling direct-care staff was guided by our research questions and by how the data from each type of interview would be analyzed. Type 1 interviews contained both open- and closed-ended questions and job satisfaction scales. These data are being analyzed both quantitatively and qualitatively. Type 2 interviews, in contrast, are in-depth and are being analyzed only qualitatively. Type 2 interviews contained primarily open-ended questions intended to elicit detailed responses and rich data from care workers about their experiences, thoughts and attitudes. In both Type 1 and Type 2 interviews, DCWs were asked how they came to work in (1) long-term care, (2) assisted living, and (3) their specific facilities. DCWs' responses to these questions serve as the primary data for this study.

Stratified random sampling was used to select 370 participants for Type 1 interviews. Table 3 shows the distribution of Type 1 interviewees across facilities categorized by size and area. Within each facility, DCWs were stratified by shift and employment status—full-time vs. part-time. Within these strata, DCWs were selected by systematic random sampling. We stratified the sample according to these criteria for several reasons. First, the information necessary to divide the staff population in this way was readily available. Second, job content and workload vary by shift: DCWs who work the morning shift typically have more ADL care responsibilities, and DCWs who work overnight have fewer care tasks and no dining room service, but may have greater housekeeping or laundry tasks. Third, employment status affects potentially relevant variables such as benefits, income, and flexibility of scheduling. Whereas part-time DCWs may have been motivated to take their current positions for the flexible schedule it offers, full-time DCWs may have been motivated by the availability of health care insurance to full-time employees. Overall, we interviewed DCWs from every shift at every facility, including full-time and part-time workers. The number of staff who participated in Type 1 interviews ranged from two in a small facility to 17 in a large facility.

Our final sample includes 370 DCWs from 45 AL facilities across central and northern Georgia and represents large metropolitan areas, small towns, and rural communities within 150 miles of Atlanta. Our stratification criteria resulted in a sample of AL facilities located in communities with diverse local economies and a broad range of DCWs in terms of age, race, ethnicity, education, and employment histories.

Type 2 interview participants were selected through *purposive sampling* in that

we selected “*information rich cases* for study in depth.” (Patton 1990: 169).

Consequently, we selected participants who were receptive to researchers and at least somewhat forthcoming with us during participant observation, as well as DCWs whose personal characteristics were theoretically relevant. For instance, DCWs with long tenure, immigrants, men, and older adult DCWs were all selected for Type 2 interviews. We attempted to perform Type 2 interviews with care staff who did not participate in Type 1 interviews, because the Type 1 interviews captured substantial data that overlapped with Type 2 interviews. However, five care staff participated in both Type 1 and Type 2 interviews. Either these individuals were extraordinarily open with a researcher, or the researcher who performed their Type 1 interview determined that the participant would contribute additional and rich data in a Type 2 interview. In most facilities, one staff person participated in a Type 2 interview. However, in eight facilities, no Type 2 interviews were performed, and in six facilities two or three Type 2 interviews were performed. Because we visited more small facilities (18) than medium or large facilities (13, 14), we also performed more Type 2 interviews in small facilities (18) than in medium or large facilities (12, 12). Table 4 shows the distribution of staff for Type 1 and Type 2 interviews by facility size.

The final data set includes 370 mixed-method standardized DCW interviews with quantitative and qualitative responses, 41 in-depth, open-ended, tape-recorded, qualitative DCW interviews, 43 in-depth, semi-structured, tape-recorded, qualitative administrator interviews, fieldnotes from over 650 hours of participant observation, and review of each facility’s policies and procedures.

Table 3. Type 1 Interview Respondents by Area and Facility Size

Area	16-25 Beds	26-50 Beds	51+ Beds	Total	%
Area 1	12	32	106	150	41%
Area 2	18	31	54	103	28%
Area 3	49	40	28	117	31%
Total	79	103	188	370	
%	21%	28%	51%		100.0

Table 4. Distribution of Staff for Interviews by Facility Size

Facility Size/ Interview Type	Type 1	Type 2
Small	83	17
Medium	99	12
Large	188	12
Total	370	41

Data Analysis

Analysis for this dissertation centered on my two major research aims: (1) understanding DCWs' motivations for long-term care, assisted living, and specific facilities; and (2) understanding how DCWs' motivations relate to individual-, facility- and community-factors. I utilize descriptive quantitative data to broadly illustrate my sample of (i) DCWs' individual characteristics (race, gender, age, etc), (ii) facility characteristics (pay scales and benefits, levels of resident disability), and (iii) community characteristics (unemployment in area, local economy). Quantitative findings serve as a reference point for qualitative analysis and most findings derive from qualitative data. Qualitative data collected during Type 1 and Type 2 interviews serve as the primary focus of analysis. Because I only use descriptive statistics to describe broad trends in the data rather than perform explicit quantitative analysis, this dissertation should be considered qualitative in nature.

Because an aim of this study is to suggest strategies that providers could use and policies that governments could implement to support the recruitment and retention of DCWs, I develop multiple categories of motivations. Dichotomous conceptualizations of workers' motivations fail to capture the complexity of motivations for care work and also would likely fail to provide either providers or governments with adequate guidance for the development of nuanced and sensitive recruitment and retention strategies. Consequently, I categorize DCWs' motivations for long-term care, assisted living, and their specific facilities without partiality for dichotomous modeling.

Analytical Themes

For this study, I primarily attend to DCWs' motivations for their work. I specifically focus on DCWs' motivations as reported during Type 1 and Type 2 interviews and participant observation. I contextualize DCWs' reports of their motivations by also attending to their educational and employment histories and their life histories more broadly. This contextualization includes attention to individual-, facility-, and community-level factors.

Individual-level factors, or themes, of analysis include DCWs' specific cultural backgrounds, including their racial, ethnic, and national identities; their family lives across time; their reported values; their economic situations; and their social relationships, including their connections to other individuals in LTC, in AL, and in their particular facilities. These factors were identified in DCWs' responses to Type 1 and Type 2 interview items about their personal identities, their life histories, their family histories and religions, and their employment histories. Individual-level questions, like *What do you consider your race?* and *What was life like where you grew up?* were asked in the beginning of Type 1 and Type 2 interviews (see Appendices A and B).

Facility-level factors and themes, like facility-size, pay, and workload, are addressed through the middle and toward the end of Type 1 and Type 2 interviews, as well as during administrator interviews (see Appendix C). Items of facility-level analysis include the number of residents the facility is licensed for and the facility's actual resident census at the time of study; residents' levels of impairment, including the number of activities of daily living they need assistance with; the number and nature of

tasks DCWs' are responsible to perform; DCWs' minimum, maximum and current hourly pay rates and benefits; the criteria for hiring DCWs and the methods of DCW recruitment; and the overall social environment in the facility, identified during interviews on a continuum ranging from family-like to business-like.

Community-level factors, like employment opportunities in the areas where DCWs live, are addressed toward the end of Type 1, Type 2 and administrator interviews (see Appendices A, B and C). Specific items of analysis include employment history questions as well as questions about other industries *and* other care facilities in the area. To bolster the accuracy of findings, community-level data from interviews were compared with interview data from other facilities in the community and from city-, county-, and state-government reports. Government reports also will be utilized to identify the population, urbanicity, and unemployment characteristics of each community.

In addition to analyzing these multiple levels of data, I attend to multiple types of data, primarily including qualitative interview transcripts and participant observation fieldnotes, but also to archival documents, like employee handbooks and marketing materials collected by the research team, as well as quantitative responses to standardized interview items. Combining various forms of data in this way is often referred to as *triangulation* (Berg 1989), or *crystallization* (Richardson 2000), and is regularly practiced by researchers to ensure the accuracy of findings. Ethnographic studies, for example, often employ both observation and interviewing in order to benefit from the advantages of each method, as well as counteract each method's shortcomings. Together, these methods can address thoughts, feelings, meanings, and process, but separately, each

method is limited. By analyzing multiple forms of data, I have developed a complex and nuanced picture of DCWs' motivations.

Analytical Procedures

My specific analysis procedures include simple quantitative analysis and more detailed qualitative analysis. Quantitatively, I identified the numbers and percentages of DCWs to report types of motivations (which were identified qualitatively). Using quantitative data, I also examined the influence of individual-, facility-, and community-level factors on DCWs' motivations. Individual-level factors examined include gender, race, nativity, age, education, employment history, and marital status; facility-level factors include criteria for employment, pay, and benefits; and community-level factors include urbanicity, unemployment rates, and the number of LTC beds.

Qualitative analysis aimed to uncover the multiple and dynamic social realities recorded in the data with reflexive recognition of the researchers' role in creating the data. This inductive approach toward analysis, which is "often employed from a grounded theory perspective" (Leavy 2007), and researcher reflexivity, are strongly emphasized in the feminist paradigm with which I approach the data (Hesse-Biber, Leavy, Yaiser 2004). Consequently, I employ grounded theory within a feminist framework. In the following pages, I describe the grounded theory methods with which I approach the data, the feminist framework that guides my data analysis, and the reflexivity that I employed throughout the research process.

Grounded Theory

I used the grounded theory method (Strauss 1987; Strauss and Corbin 1990) to analyze all types of qualitative data—open-ended responses from Type 1 interviews,

Type 2 interview transcripts, and field notes from participant observation. A major advantage of grounded theory analysis is its flexibility to address new findings, which stems from its inductive approach toward the data. That is, using the grounded theory method (GTM) involves developing categories *from the data*, rather than from previous literature, theory, or the researcher's preconceived beliefs (Hesse-Biber and Leavy 2007). As a result, GTM inherently is as flexible as the data are varied.

The process of grounded theory involves three steps of coding (open, axial, and selective), beginning with close reading of data (Hesse-Biber and Leavy 2007). Open coding, regularly the first step in grounded theory analysis, involves examination of data for important categories. According to Strauss and Corbin (1990), open coding is a process of breaking down and categorizing data into codes. First, I read and reread and marked the various topics in the interview transcripts and field notes to develop an initial list of codes. Codes are akin to subject areas, and represent areas or topics on which the study participants elaborate. I developed codes after reading at least 10 in-depth (Type 2) interviews several times. These preliminary readings helped me be acquainted with themes of importance to participants, as well as the terms they use to describe these themes. In this first stage of coding, I examined data for themes or concepts that were based on questions asked by the investigators or issues raised by the informants. Consistent with the grounded theory of Strauss and Corbin (1990), I first analyzed data into separate parts, then closely scrutinized and evaluated the data to determine similarities and distinctions. Conceptually similar data were grouped in categories or codes. I then developed codes according to their specific characteristics and dimensions, making each code increasingly more precise and differentiating it from other codes.

When examining data related to DCWs' motivations for employment in assisted living, for instance, codes that emerged included *workload*, *social environment*, and *training requirements*. As the process of coding continued and new themes emerged, I modified, collapsed, or dropped codes to fit the data. For example, I initially found that *limited opportunities for employment* was a main reason for working in assisted living. However, when examining subsequent data, I learned that DCWs' motivations for AL do not only stem from their lack of employment options but also from AL's *minimal training requirements* in comparison to nursing homes. As a result, I broke down the initial code, *limited opportunities for employment*, into two codes: *limited opportunities for employment* and *minimal training requirements*. The codes that were developed during open coding were applied to all data.

To reassemble the data that were broken down and separated during open coding, I related categories and subcategories in a process called *axial coding* (Strauss and Corbin 1990). During axial coding, the analyst links the initial categories to other categories, or subcategories, through a *paradigm model* (Strauss and Corbin 1990). The paradigm is the perspective taken toward the data that helps integrate the structure and process of the phenomena being studied (Strauss and Corbin 1990). Through the paradigm model, categories are linked in a set of relationships that denote causal conditions, contexts, intervening conditions, action/interaction strategies, and consequences. When examining DCWs' motivations for employment in AL, for example, the category of motivation, *time to socialize with residents*, was related to the *workload* category. That is, *workload* negatively influenced *time to socialize with residents*, so that as workload increased, social time with residents decreased. The relationship between

these categories was then examined in relation to individual-level factors, such as family caregiving experiences, which were expected to influence DCWs' desire for social time with residents, and facility-level factors, such as staff-resident ratios, which were expected to influence workload.

As part of axial coding and development of the paradigmatic model, I compared predicted patterns, like the influence of workload on the availability of social time with residents, with empirically-based patterns. While performing this process of pattern-matching, I also engaged in explanation building (Yin 1994). Pattern-matching allowed me to compare the results of my analysis with predicted patterns, and explanation building entailed the comparison of different case studies, like the comparison between specific DCWs and between clusters of DCWs, like native-born or young DCWs. This process of explanation building has been identified as the most appropriate technique for theory building (Yin 1994; Strauss and Corbin 1990).

In the final stage of coding—*selective coding*—major categories were organized around a central explanatory concept or *core category* (Strauss and Corbin 1990). The core category was chosen for its ability to pull the other categories together. Analysis was considered to be complete when *theoretical saturation* occurred, that is, when no new or relevant data emerged regarding a category, when category development was dense, and when the relationships between categories was well established and validated.

Life Course Perspective

My application of GTM was guided by a life course perspective (Giele and Elder 1998). The four central elements of Giele and Elder's life course perspective, employed in this study, address the importance of location in time and place, or cultural

background; the linkages between individual lives, or social integration; the importance of human agency, or individual goal orientation; and the timing of lives, or strategic adaptation, which specifically addresses questions like “How and why a person. . . takes a job. . .” (Giele and Elder 1998: 10). Because this study examines life course factors that influence entry to care work careers, particular attention is paid to *turning points*, or events that provide starting or termination points to pathways or trajectories (Crosnoe and Elder 2002). Specifically, because workers’ entries to LTC are the central phenomenon driving this study, turning points related to work trajectories are highlighted.

Feminist Analytic Framework

My application of GTM is also guided by a feminist framework, consisting of close attention to (1) the words of DCWs, (2) the influence of gender and gendered norms on DCWs’ motivations, and (3) the practice of care work. This feminist framework draws on postmodern and poststructural thinking.

Many feminists, like most symbolic interactionists and postmodernists, recognize the importance of language for understanding the meanings of social life. The influence of language and discourse on social life has been a dominant interest of postmodern and poststructural thinkers, including Michel Foucault (1978), Jacques Derrida (1976), Jean Baudrillard (1981, 1988), and Jean-Francois Lyotard (1984). Postmodern and poststructural thinking about language has merged with feminist interests in women and gender. Illustrating the centrality of language for feminism, Shulamit Reinharz explains that many names, definitions, and concepts do not fit women’s experiences:

Feminist researchers have also identified problems in conventional frameworks without being able to rectify them. Some examples are the problem of defining a woman’s social class independent of her husband’s, if she is married, naming relations to children for the purpose of studying

lesbian family life, naming women's community activity as a form of political participation... , defining historical period to reflect women's lives, and developing a concept of career that fit women's work experience (2004: 248).

Building on Reinharz's observation that language often does not match women's experiences, Marjorie Devault argues that language makes women deviant: "language itself reflects male experiences . . . its categories are often incongruent with women's lives. . . . linguistic forms . . . exclude women. . . . vocabulary and syntax make women deviant. The names of experiences often do not fit for women" (2004: 227). The failure of language to match women's experiences has direct implications for this study, as illustrated by Ruth Ray's incorporation of feminist, postmodernist and gerontological perspectives in the meaning of the word *caregiving*:

["Caregiving"] includes at least two assumptions: that the activity involves intimacy and connection ("care"), in addition to the meeting of physical needs, and that this care is offered freely ("given"). Simultaneously, the term excludes a view of care as hard work performed, in the case of service workers, for pay or, in the case of some family members, out of a sense of duty and responsibility (1999: 677).

Ray's observations plainly indicate both the need for a postmodern feminist gerontology that questions linguistic assumptions and the relevance of *caregiving* in this endeavor. To limit the influence of assumptions about linguistic meanings on my interpretation of care workers' words, I heeded Reinharz's (1984) suggestion that we move texts beyond standard vocabularies, commenting on the vocabularies along the way. Specifically, I developed codes and categories from DCWs' words according to the meanings they report and compare and contrast these terms with traditional terms and meanings. Emphasizing DCWs' words grounded analysis and interpretation in the data. Dana Crowley Jack explains the importance of this process and succinctly depicts the feminist-framed grounded theory analysis I performed:

According to grounded theory, the researcher is led by the data—that is, categories and theories emerge from the data. Even though it is impossible to approach interviews without any preexisting paradigms, this method works well to correct a

researcher's misconceptions, particularly when the data force us to notice any implicit frameworks we may unconsciously hold (Hesse-Biber and Leavy 2007: 337).

Moderating the influence of unquestioned assumptions on the process of interpreting DCWs' words (about their motivations) required being aware of the influence of gender and gendered norms (on their motivations). This is because our linguistic and conceptual frameworks, especially those related to care, are gendered. Ray (1999: 674-7) explains the gendered quality of care and its relevance for gerontology:

The study of aging, by sheer force of demographics, is necessarily a women's issue. . . . The primary caregivers of this growing number of elderly are, and will continue to be, predominantly female—either wives and daughters (Dwyer & Coward, 1992) or paid service workers (Abel & Nelson, 1990). . . . Feminists argue that the predominance of female caregivers is not the result of “natural” tendencies in women toward nurturing, but the result of socialization processes and social policies which reify gendered patterns of caregiving by depending for their efficiency and cost-effectiveness on the unpaid labor of women (Hooyman, 1992; Stoller, 1993; Walker, 1992).

Our practices and concepts of care are gendered. We experience such a great extent of life through gendered terms and as gendered beings that moderating the influence of gender on interpretative frameworks and data analysis is a significant challenge. Describing the ubiquity of gender, Barrie Thorne illustrates its colonization of social life: “Gender is deeply embedded in institutional structures, ideological frameworks, discursive and interactional practices, and . . . in the processes through which selves and persons are constituted” (2006: 476).

Gender is pervasive, but I attempted to limit the influence of gender on my interpretation of the data. To do this, I emphasized the practice of care work over the

identity of “woman” which is possessed by so many of its practitioners. Similarly, I emphasized DCWs’ motivations to practice or perform care work rather than emphasize DCWs’ motivations to be care workers. Emphasizing the gendered practice of doing care rather than the category of being a care worker opened analysis, in Raka Ray’s words, “to more processual and complex strategies” (2006: 473). Ray describes this shift in attention, “from conceptualizing men and women as categories and focusing on the category ‘women’ to questioning the content of that category and shifting to the exploration of gendered practices” (2006: 460), as one of the most significant shifts that have occurred within sociology as a result of feminist theory.

Reflexivity

Performing GTM within a postmodern feminist framework demands reflexivity on the part of the researcher. Researchers do not agree on one definition of reflexivity, but Marcus provides a foundation: “The baseline form of reflexivity is associated with the self-critique and personal quest, playing on the subjective, the experiential, and the idea of empathy” (1998). Consequently, reflexive data analysis affords an opportunity for researchers to explore themselves, and imposes an obligation that they recognize the impact of their subjectivity on the data. Reflexive practice also requires that researchers attend to their changing positions in relation to the research process, the specific social and historical contexts of the study, and the changing power dynamics experienced by the research participants during the study (Hesse-Biber, Leavy, and Yaiser 2004).

As a member of the research team for this study, I participated in all aspects of data collection—including DCW and administrator interviews and participant observation, and analysis. Throughout these processes, I have regularly reflected on my

role as a researcher, my relationship to the study participants and the data, and on my own life story. For instance, early in the study I reflected on the process of building relationships with study participants:

We established a very comfortable rapport through performing the interview, and I had not been certain that doing an interview before doing observations would work out well. I think doing the interview first in [one of the study homes] helped make the research relationship more comfortable both for the workers and the researchers. Perhaps in smaller homes, where there are so few workers, doing interviews early on will be a good strategy for establishing rapport.

In addition to participating in every aspect of this study's data collection procedures and reflexively attending to my role as a researcher during these processes, my life history further aided my ability to reflexively approach data analysis. Specifically, having worked as a DCW in assisted living for two years prior to this study, I approached questions about DCWs' motivations with a distinctly relevant and deeply personal understanding of how becoming a DCW in assisted living can happen. As described above, I understand my motivation to become a DCW in assisted living as multi-layered and complex, involving my education, employment history, and values, in addition to the employment opportunities available to me where I was living, societal norms for gender roles, and the proximity of an AL facility to my home. By reflexively performing the study, I have come to understand my own life history more fully. I approached data analysis with these reflexive insights and they enabled me to identify the rich and complex stories that were necessary to accurately portray how DCWs come to LTC, assisted living, and specific facilities. A researcher who did not practice reflexivity could accurately categorize DCWs' reported motivations, but as the above discussions of

the complexity of motivations and impression management indicate, DCWs' reported motivations may not, themselves, be complete or accurate.

CHAPTER 4

FINDINGS: DCW SAMPLE AND CASE EXAMPLES

In this chapter, I first describe the sample of 400 DCWs, illustrating their personal characteristics, for example, gender, race, nativity, age, and education; and their job characteristics, such as pay and benefits. These characteristics broadly depict DCWs as a group and set the stage for understanding their motivations for employment.

The description of the overall sample is followed by six detailed case examples of DCWs, including their various pathways to assisted living employment. These case examples offer a rich description of how individuals come to work as DCWs and illustrate many ways that personal characteristics influence employment outcomes. Each case illustrates at least one of four ideal types of primary motivations for employment: *moral, material, professional, and environmental motivations*; or the secondary motivation—*social networks*. In the following three chapters (5, 6, and 7) I describe how these motivations lead DCWs to LTC, AL, and their particular facilities and draw on the case examples and additional cases to illustrate how personal-, facility-, and community-level factors influence individuals' motivations for care work employment.

Personal Characteristics

Ninety-nine percent of the 400 DCWs were female. Only 4% (n=14) were Latina or Hispanic. In contrast to the overwhelming dominance of women in the sample of DCWs, they varied by race: 57% were black (including DCWs who were African-born or Caribbean-born), and 1% of black DCWs were Latina; 39% were white, and 5% of white DCWs were Latina; 4% of DCWs were Asian-American, American-Indian, or multiple

or mixed races, and 1% of these DCWs were Latina. Most DCWs (82%) were born in the US; but 10% were born in Africa; 4% on a Caribbean island, such as Haiti, Trinidad, or the U.S. Virgin Islands; and the remaining 4% came from a variety of other countries, including El Salvador, Honduras, Guyana, Paraguay, Peru, Mexico, Germany, India, Pakistan, and the Philippines.

DCWs also varied by age: 17% were aged 18 to 25 years; 32% were aged 26 to 40 years; 38% were aged 41 to 55 years; and 13% were 56 or older. DCWs' levels of educational attainment also varied: 16% had not completed high school; 47% had a high school education with no further formal education; 32% had completed some college, including those who completed a two-year degree; 5% had completed a four-year college degree; 55% were certified nursing assistants (CNAs).

DCWs' family lives also vary. Overall, 39% were married, but many had never married, many were divorced or separated, and some were widowed. More than half of the DCWs had dependent children at home and 81% supported individuals *outside* their households, either giving physical care, financial support, or both. Many DCWs provided care for older relatives, mostly parents and grandparents, and many of the foreign-born workers sent money to relatives in their countries of origin. Overall, 31% of single DCWs (never married, separated, divorced, or widowed) have dependent children living with them at home; and 31% of single DCWs support individuals outside their households. DCWs' personal and job characteristics are summarized in Table 5.

Table 5. DCWs' Personal Characteristics

Variables	Characteristics	Percent
Sex	Female	99
	Male	1
Race	Black	57
	White	39
	Hispanic	3
Age	18-25	17
	26-40	32
	41-55	38
	56+	13
Education	< High School	16
	High School	47
	Some College or 2-year Degree	32
	College Degree	5
Specialized Training	CNA	55
Marital Status	Married	39
	Never Married	29
	Divorced or Separated	28
	Widowed	4
Dependents	Children at Home	54
	Support Others	81

N = 400

Job Characteristics

DCWs' job characteristics are summarized in Table 6. Their median hourly pay was \$8.00. Across all 400 DCWs, the median number of hours worked per week was 36. These hourly rates and weekly work hours result in an average annual net pay of approximately \$16,000. During the year prior to interviewing for this study, approximately 85% of DCWs who had over two years facility-tenure earned less than \$24,999; 70% earned less than \$19,999; 41% earned less than \$14,999; and 9% earned less than \$9,999. Limiting this analysis to DCWs with two or more years of facility tenure assures that their annual income reflects pay from their current AL employer, and not income from another field or from a period of unemployment.

Table 6. DCWs' Job Characteristics

Variable	Characteristics	Percent
Hourly Pay	< \$7.50	35
	\$7.51 - \$9.00	37
	\$9.00+	28
Annual Income (2+ years tenure)	< \$14,999	41
	\$15,000 - \$24,999	44
	> \$25,000	15
Benefits	Employer Offers Health Insurance	62
	DCWs Use Employer's Health Insurance	28
Job Status	Full Time	82
	Part Time	18
Other Employment	Has a Second Job	25
	Second Job in LTC	13
N=400		

Almost half (46%) of DCWs wanted to work more hours than offered at their facilities, and 24% worked one or two additional jobs. Of the DCWs who had two or three jobs, over half (52%) had two positions caring for older adults. DCWs' second long-term care jobs are split fairly evenly between assisted living, nursing homes, and in-home care. DCWs with a second job *outside* of long-term care held positions in a variety of fields, including childcare, food service, domestic labor, secretarial work, and retail.

Additionally, 72% of DCWs did not have health care coverage through their jobs. *Overall, 42% had no health care benefits at all.* The other 30% of workers were most commonly insured by a family member's health care plan and some by Medicaid or Medicare.

DCWs' Employment Histories

The employment histories of DCWs in our sample varied, but 65% had worked in long-term care prior to their current jobs. Ten percent had previously worked in both nursing homes and in-home care settings; 25% had previously worked in a nursing home, but not in-home care; 20% had provided in-home care, but not worked in a nursing home; and 10% had previously worked in AL, but no other care settings. Thirty-five percent of DCWs had no prior LTC experience; 15% had worked only in other care settings, for instance providing child care or working as a hospital aide; and 20% had no prior care work experience. DCWs with no care work experience included individuals who were currently working for their first employer, as well as DCWs who previously worked in housekeeping and food service positions, and in factories and mills.

Overall, 60% of DCWs in the sample had been employed in LTC for over four years. The *median* length of LTC-tenure was about five years. In contrast, as the high worker turnover rates in LTC would have us predict, tenure in specific facilities was much shorter: 80% of DCWs had been employed in their facilities for four years or less, and the median length of facility-tenure was just 18 months. DCWs' employment histories are summarized in Table 7.

Table 7. DCWs' Employment Histories

Variables	Characteristics	Percent
Care Work History	Nursing home, not in-home care	25
	In-home care, not nursing home	20
	Nursing home and in-home care	10
	Other assisted living facility	10
	Other: childcare, hospital aide	15
	No care work experience	20
Facility Tenure	Less than 1 year	40
	1 - 4 years	40
	4 – 10 years	18
	10 - 20 years	2
Long-Term Care Tenure	Less than 1 year	15
	1 - 4 years	25
	4 – 10 years	25
	10 - 51 years	35

Case Examples

The six case examples illustrate our sample and the long-term care workforce in terms of their personal and job characteristics and their employment histories. They also represent multiple important intersections of DCWs' characteristics, including an African American woman with extensive care work experience, a female college student of African birth, an elderly white woman who works part-time, and a white man who has provided live-in care to his grandmother. Each case depicts a type of care worker, including an impoverished care worker, an older care worker, and a male care worker, and illustrates the complexity of decision-making regarding motivations for LTC employment. The specific experiences of these individuals are unique, but they each also represent an important substratum of the direct care workforce. To provide a rich understanding of how individuals come to work in LTC, AL, and their particular

facilities, I draw on these case examples throughout the discussion of DCWs' motivations. The six cases were selected from the DCWs who participated in a Type 2, in-depth qualitative interview because these data provided rich and detailed accounts of DCWs' experiences in, and motivations for, care work.

Five of the cases are women and thus representative of a large subset of DCWs in the sample. The one male is an outlier, both in the sample and the wider direct care workforce. Another case—a homeless DCW, represents the large subset of DCWs who live in poverty, but is a marginal example that was chosen to vividly depict the extreme poverty that some DCWs confront and strive to avoid. And another case, an older worker, represents workers over 56-years-of-age, but as the sample's oldest DCW at 75-years-of-age, she illustrates the extent of age variation within the LTC workforce. Highlighting marginal cases is intended to increase understanding of two distinct subsets of the direct care workforce—men and individuals who are in extreme poverty.

Entering LTC as a Professional Stepping Stone: Jonee's Story

Jonee, like 18% of the sample, is an immigrant care worker. She was born in Nigeria 25 years ago and has been in the US for five years. Currently, Jonee is in college studying nursing and health care management, and her long-term goal is to be a nurse. Jonee considers direct care work an important component of her professional training that provides her with a grounded understanding of health care: "It gives you a better view of things. If you are on top, you can see everything, but you can't see what is going on *really*. You can only see so far."

By examining Jonee's life history, the sources of her motivations are identified. She first moved to the US, and Georgia when she was 20 years old. The first year she had

no automobile, and for six months, she worked in a restaurant that was within walking distance of her home. Then she entered long-term care employment in AL. For three months, until she got her own car, she relied on others for rides to work. She spent nine months as a DCW in this first AL facility and got her CNA during this time because her employer increased pay for DCWs with a CNA. While getting her CNA, she had an internship in a nursing home. Overall, Jonee did not like working in the nursing home, and the internship strengthened her appreciation for assisted living: “When I got my CNA we had to go to a nursing home to do an internship; it was not a good site. I didn’t want to work in a nursing home. It was too much for me. This place makes it feel more like a home. I like this better; it is more calm and more like a home.” Jonee’s motivations to work in AL rather than another LTC setting were primarily environmental.

Jonee left her first AL employer because new management came in and made changes in the social environment: “She fired the wrong people and it was not a happy place to work. I gave them my two-weeks notice.” Ultimately, leaving that AL facility led her to her current employer: “They had someone, as I was leaving the job, [who] told me about this place so I applied and they called me.” When Jonee started working at her current facility, she was paid \$8.00 per hour. After three years employed in this facility working approximately 32 hours per week, she earns \$9.00 per hour. Jonee also attends college and has completed two years of a four-year program in pre-nursing and health care management. Although class schedules change every semester, she has been able to stay with her current employer and achieve three years of tenure because the administrators have permitted her flexibility with her schedule:

They will work with your schedule here. That is one thing; that is why I have been here that long. People are like, “Why have you been here so long?” I try

to tell them it is not easy to find a job that you tell them when you can work and they work with that. If I tell them, “I can’t get here,” they let me work that. They work with your schedule.

This semester, Jonee is for the first time taking advantage of her employer’s educational support program. Her employer will reimburse 50% of her tuition and book costs if she successfully passes the courses. One of Jonee’s coworker-friends is also a student and received tuition reimbursement from their employer the prior semester. Jonee’s choice of employment setting after completing her degree is unclear, but she is considering assisted living: “I will work in the hospital, [but] probably something like this—assisted living.”

At home, Jonee lives with her younger brother. He came to the US with Jonee and also works (for the telephone company) and goes to school. Though neither earns a great deal of money, they occasionally send money to their family in Nigeria. Jonee explains that her family mistakenly believes coming to the US guarantees substantial income, as if the streets are indeed paved with gold, but she recognizes that she too had this misconception when her father was living in the US and she was in Nigeria:

I have a younger sister and younger brother and from time to time you have to send money home. Regardless of how much you try to explain to them, “It is not what you think”—everybody thinks you come to America and you grab the money anyhow, and you are paid thousands of dollars. . . . I try so hard to explain to them, but no matter how much you explain to them. There was a time when my dad tells me he doesn’t have the money and I am like, “Yeah, yeah, there he goes again.” But now I know how it is and what I am going through. I try to spread the money out and send it to them.

Jonee’s story depicts two important subsets of DCWs: immigrant workers and those aspiring to health care professions. Her story also illustrates multiple motivations for care work employment.

Entering LTC as a Second Career: Ethel's Story

Ethel, like 13% of the sample, is older than 56 years. She was born in a rural area of Georgia in 1932. She is white and, at 75, the oldest DCW in our sample. A researcher describes her as having “a sweet and kind looking face.” When she was 13 years old, Ethel’s mother took Ethel and her siblings away from their alcoholic father and brought them to another rural county, where her family lived. Ethel has lived in this area ever since: “My dad was an alcoholic and we came to Bolton County when my mother left my daddy. She took as much of it as she could and came to Bolton County where her people lived. I’ve been in this area ever since.” Living on a farm in a rural area of the South in the 1940s, one of Ethel’s chores was picking cotton. However, Ethel strategized to avoid this laborious task: “I *chopped* cotton till they found out. I figured out that all I chopped up I wouldn’t have to pick. [Laughter]. Then they made me quit. I hated, I hated cotton . . . It was back-breaking.” A nearby cotton mill employed Ethel’s mother, who worked nights to support her children. When Ethel was 16 years old, she took a job in a dime store for spending money. After graduating high school, she worked for 26 years at a clothing manufacturing company. During this long period of stable employment, Ethel married a man who worked for a large power equipment company. Together, Ethel and her husband lived a comfortable life and raised several children and grandchildren.

In addition to performing paid factory work, Ethel cared for several of her brothers, who were all bachelors, and her mother, who had a stroke. When Ethel’s husband had a major stroke, his home health caregivers showed her how to perform care-related tasks that she never thought she could do: “They did a feeding tube and I learned to do that. I didn’t think I could, but I found out I could. . . . I learned so much from

home health, from them coming into the house And it's just always been a field I thought I would enjoy." Though Ethel acknowledges the importance of her informal training with the home health caregivers, she also thinks of her caregiving abilities as a divine gift: "It just seems like the Lord gives us talents and He gave me that one [for caregiving]."

After Ethel's husband died, she provided in-home care to her son-in-law's grandmother for about six months. At this time, Ethel was already over 70 years old. At age 74, she took a DCW position in her current AL facility, where she had a friend working, because she had grown bored with being home alone. At the time of the interview she had been working there for over one year: "I have a friend that worked here and I came in. I wanted some part-time work; I was bored doing nothing. So, I came in and put in an application and they hired me. And I've been here a year and really enjoy it."

Now 75 years old, drawing on Social Security, and living in government-subsidized housing, Ethel is in the unique situation where, due to her housing subsidy, she desires no additional pay:

I can only make so much money. So I don't worry about a raise. I'm satisfied with the \$7. . . . I draw my Social Security and that's my living. This is just something I pick up to do things extra. Like if I want to take a cruise or I want to buy something for my grandchildren, this money does that. . . . I don't even want a raise. . . . When my husband died, I sold my house. I gave myself a year to see what I wanted to do. But I had a 4-bedroom house and I didn't need all that room. I didn't want to have too much house and then my kids would want to move back home. But anyway, I moved into a government subsidized, and you know, we can only make so much money.

Ethel's story illustrates an important subset of LTC workers—those who are older and who enter the field after careers in other low-wage jobs.

Maximizing Employment Options: Vera's Story

Vera, like 20% of the sample, is a first-time care worker. She is 50 years old, African American, and she attended school up to the 12th grade, but did not graduate high school. As a child, Vera lived in a small town in Georgia with her parents and six older siblings. For over 25 years, her mother worked in a poultry plant and her father worked in a mill.

Vera's first job was also in a mill, and she stayed employed there for 29 years. Getting to and from the mill was a challenge because she did not own a car, but her employer's flexibility (like Jonee's AL employer), and the assistance of her social network, allowed Vera to keep the mill job. During these years of steady employment, Vera married and had two children, one who is now 29 years old and one who is 19. Now a grandmother, Vera helps her children by picking up her grandchildren from school.

After 29 years, Vera left the mill because the social environment had deteriorated to one of constant bickering: "There were a lot of clashes and you kind of get burnt out on stuff like that. You get tired of the bickering." Vera thought long and hard about leaving the mill job and consulted with her husband on the matter:

I talked it over with my husband before I did it. I said, "I think it is time for me to move on to something else, I am getting kind of worn out." He didn't want to say anything because he wanted it to be my decision because he knew it was me who had to go out and find a job. At first I was kind of like, am I doing the right thing? I said, "There are other jobs but I will wait until I find the right job and feel like it is the right job for me." So that is what I did.

Some of Vera's coworkers at the mill had already come to work part-time in AL, but Vera did not come to AL directly from the mill. She first took a job driving people to dialysis appointments for about three months but grew disenchanted with the job and the danger she faced driving: "I did it for three or four months, but I realized going up and

down the road at 4:00 in the morning by myself, and sometimes the van would break down. A couple of mornings there were trees across the road and I was like, this is not for me.” At this point, Vera found a newspaper ad for a care worker position with her current AL employer.

Because Vera had no experience as a care worker, she did not expect to get the AL job. However, she talked to the administrator and explained that she liked older people: “I thought I wasn’t going to get it so I came up here and I talked to Laynee. . . I told her I hadn’t ever did anything like this, but I like talking to older people and I like being around them.” Though Vera had no care work experience, she, like Ethel, had provided family and thereby gained some skills and confidence in caregiving: “My mom, when she got sick, I had to care for her, so I was kind of used to it and knew some of the things I had to do.” Ultimately, the administrator hired Vera on a trial basis: “I came here and she told me she was going to try me out for about two weeks to see if I was going to like it.”

After the challenges Vera faced with transportation and driving in her prior two jobs, it is not surprising that the proximity of the AL facility to her home was a strong point of attraction: “I realized the first day I was going to like it. I wanted to. It was a job and it was close to home.” Vera’s coworkers from the mill who were now working in the facility also supported her liking the job: “When I came up here I saw one of them and asked how was it, and they said it was a pretty good job.” The facility’s convenient location and Vera’s social network supported her desire to like the job, and ultimately she has been satisfied with her choice of AL employment, especially establishing relationships with the residents: “It is a good job. I like it. I like the residents.”

When Vera was hired at the AL facility, she earned \$6.00 per hour. Now that she has been in her position for four years, she earns \$8.10 per hour, approximately the pay she had earned at the mill. For Vera and the other former factory workers, the transition from industrial to service work has been a significant financial setback. However, by taking work in AL, Vera has sidestepped the shortcomings of her previous jobs, including the poor social environment in the mill and the danger of the driving job. Furthermore, demonstrating the tendency for retention that LTC employers desire, Vera intends to stay in this job until her work-life ends. She views her aptitude for retention as a family trait exhibited by her parents' employment histories, which also included factory work, as well as her own employment history: "I am not a person to go from job to job. If I am on a job I like to try and stay on that job. My mom stayed on her job a long time and my dad did too. I am not a person to go from job to job. I am here and I hope to be here until I retire."

Valuing High Quality Care: Kim's Story

Kim, like 35% of the sample, has been employed in LTC for over 10 years. She is a 40-year-old, African American woman with an associate degree and a CNA. She is single and has a 21-year-old son who lives with her. She grew up in a rural area of Georgia and still lives in the general area. Her parents worked together at an electric company where they both retired from, and now both her parents have other jobs. Kim's mother now provides in-home care to older adults: "She deals with the elderly also, and she has been with her client now for 15 years, and basically that is all I have known of her doing."

Like Vera, Kim's first job was in a factory. She was 18 when she took the position and she held it for three years. After three years, she grew disenchanted with the lack of autonomy she felt in her job and decided to leave: "Industrial work is just something I can't do; I have to have the freedom to move around. With industrial work you come to work, you stay in one place and that is where you are for eight hours. I couldn't stand it, but I hung in there for three years. After that, I just had to go."

After her first job, Kim got her CNA. "I wanted to be a nurse all of my life," she explained. However, Kim's finances did not permit her to continue to pursue education in nursing: "Things happened where I couldn't afford school." She tried many jobs in a variety of fields, and eventually came to work in LTC, which she considers "the closest thing" to nursing:

I did a little bit of everything. I worked at another plant. It was different because you couldn't sit down there; you had to move around, but it was still boring. I couldn't stand it, so I worked maybe a year there and then I worked in food. I worked for the vending company, but I couldn't stand that. I don't like the kitchen, I don't like the cook, I don't want to do that, so... I worked at Burger King. I went back to industrial work; I worked at a sewing plant. I worked at Wyatt Industry, Thurgood Textile, and it was cool, it was fun. They couldn't pay enough money so it kind of died out. Let me see, then I got into the health care field. I have worked everywhere. I think I have been in the health care field for 18 years.

Kim's 18 years in "the health care field" consists of approximately ten years working in nursing homes, a year-and-a-half of childcare, several years providing in-home care, and seven years working in AL. Overall, Kim strives to provide high quality care, and this passion for care quality has propelled her along her LTC career pathway. Unfortunately, Kim has felt obliged to leave both nursing home jobs and her childcare and in-home care positions because she came to view the quality of care disappointing in

each position. In general, Kim experienced tension between her value for providing quality care and her employer's value for making profit.

Kim truly enjoyed her first nursing home job for several interrelated reasons; there was strong teamwork among the staff, the workload was manageable, and the care quality was high:

I liked it because the staffing was great; we really worked well together. A lot of people look at it as being hard work. We were able to break the work down between us, and it worked out, and everyone had great attitudes about caregiving, and this was like in 1980-something. It was really nice; I really enjoyed it so I stayed there until management changed.

When the management changed, a concomitant change in values occurred. That is, the value for care quality was supplanted by a value for profit. As a result of this change, the care quality declined and Kim was no longer satisfied with her job:

When management changed, some of the care went out the window with the change of management, and I just couldn't stand it anymore, couldn't do it. What we had been used to doing as far as taking care of the residents, all that had changed and it was those people that came that didn't care. It was all about money instead of health care and people. I just couldn't do that.

Though Kim's first nursing home experience was, ultimately, unsatisfying, she took another nursing home job, and many of her coworkers at the previous nursing home came to work in this next facility too. Again, they worked well together and made the workloads manageable: "We did the same thing up there because a lot of the people that left [the first nursing home] went there. It was the same way: we worked together and we divided the work up so that nobody was exhausted." However, a change in management again resulted in a de-emphasis of care quality and an overemphasis on profit, eventually driving Kim from this facility as well:

Again, change in management. A lot of times we got to the point where we were really taking care of people well and had someone we were working

with. The change in management, they didn't care. It was about money, revenue. It wasn't about health care and I had to go. You get to the point where your focus is to take care of elderly people, and it goes out the door, and you don't care, and it is just about money. I couldn't stay there.

Having twice confronted incompatibility between her value for caring for older adults and her employers' value for profit, Kim left elder care and took a position providing care to children with special needs. She was satisfied with this job primarily because the care quality was high and the value for care quality was consistent across the organization: "I worked with them maybe a-year-and-a-half and it was great; we had a great supervisor. I had the kind of supervisor that if something went wrong with a resident during the night he would get up and see what we could do to help that resident." Though care quality had been high at this venue, a change in management yet again resulted in poor care quality and an overall change in organizational culture away from values for care, leading Kim to leave this job as well: "Again, change in management. It got to the point where the staff didn't care, they would rather sit outside, smoke, do whatever they wanted to do, but they didn't want to take care of these people, so I just couldn't stand it anymore."

During these years of nursing home and childcare work, Kim established an extensive social network in the long-term care field. This social network led her to provide in-home care: "A couple of people I knew that were trying to start their own agencies, they would call me and have people that they needed to care give and I went." Kim enjoyed some aspects of in-home care work, like helping care-recipients in their homes, but ultimately found it too depressing. Specifically, Kim was bothered by her inability to ensure quality care for her care-recipients after she left their homes:

We went to 20 counties and helped people in their homes and I liked that, but still it is hard on the mind, especially when you go in and people have dialysis, you name it, they are just laying there in their own juices. Once I do everything I can do, it does no good because once I leave they are going to be sitting there another how many hours. It is depressing because you can't really see your progress.

After leaving her in-home care job, Kim reflected on her job history and considered her job options. She then came to work in AL, which she expected would be better than nursing home work: "I sat down at home and I thought about everything that I had done and when I saw this place I said, 'assisted living,' and I was like, 'Well, it has got to be a step up from nursing homes.' And that is what made me come in and apply for the job. When I got here I said, 'I can live with this.' It is a big step up from nursing homes." Kim has held her position in her current AL facility for seven years and wishes she had come to work in AL sooner:

I came here and I have been here almost going on seven years and it has been great here. I like assisted living. If I had to do it over again I would have gotten into this from the beginning. . . . You can give the right care and give these people what they want without a bunch of problems and overhead and I really like it.

The consistency between Kim's value for providing high quality care and her employers' support for high care quality, without interference by economic concerns, is a welcome relief for Kim, contributing to her retention.

Now Kim has 18 years' experience caring for older adults and has worked in nursing homes and AL, and provided in-home care and childcare. She plans to return to school to become an RN. Kim's story depicts an important subset of AL employees—experienced long-term care workers, and illustrates the driving influence of moral motives, particularly the value for providing high quality care, on individuals' career pathways.

Entering LTC through Family Care: James's Story

James, a male DCW, who represents only 1% of our sample, illustrates a common pathway to LTC, through family care. He has lived his entire life in Georgia. As a child in the 1970s, he did farming work under his father's guidance. James's mother was a housewife. When he was about eight years old, his nuclear family moved next-door to his grandmother. One of James's uncles lived with his grandmother, but eventually married and moved out. James moved in with his grandmother and later, after she suffered injury due to a fall, he became her primary caregiver.

After graduating from high school, James's first job was in a nursing home kitchen. He stayed in that job for only three months, because he did not like doing dishes, and then worked at a large retail store where he stocked shelves for \$17 per hour. He stayed there for 11 years.

James left his relatively lucrative retail job to care for his grandmother after she broke her hip and needed total care. During the four years he cared for her, he first recognized his strengths as a caregiver and began to consider long-term care as a viable employment option: "At that time I was real young; I said I will never work in this kind of field. But when I began to take care of my grandmother, that is when I had the patience to do what I do now."

While unemployed and caring for his grandmother, James was recruited to his current AL facility by a friend who worked there: "I was at home minding my own business and I received a phone call from Deirdre. She is the activities director now, and she called me and asked me would I come over—they wanted to interview me for the activities position. So I came over." James came to work at this AL facility, and a paid

sitter stayed with his grandmother while he worked. However, his grandmother's in-home care aide was unsatisfactory to James—the quality of care she provided was poor—so James quit his job and took care of his grandmother until she died: “I didn't really like the care that lady was doing. So, I quit and stayed with her [grandmother] until she passed away and then I came to work here.” James returned to work for his AL employer and has been there for two years.

James is now 34 years old, single (never married), lives alone, and is an active member of his church. He provides instrumental care to two frail, elderly aunts and two cousins who have health problems. He checks on them, runs errands for them and cleans their houses. Professionally, James intends to continue working with older adults: “I don't really see myself doing anything else but working with the elderly. . . . If it is not here, then working with the elderly in some way is what I see myself doing.”

James's story depicts an important, but rare subset of LTC workers—men, and illustrates the strong influence of social networks on individuals' entry to LTC: James's friend Deirdre guided him into LTC. His story also illustrates the influence of family caregiving experiences on individuals' pathways to care work.

Entering LTC as a Last Resort: Debbie's Story

Debbie is one of the nation's working poor. Debbie's pathway to LTC and the recruitment strategies employed by her facility are unique in our facility- and DCW-samples, but her case is particularly valuable because it vividly illustrates the marginal position of some workers and facilities.

Debbie was raised in a poor African American household in Buffalo, NY. Her single mother raised her and her two brothers while working as a baker. “Family life was

Mama working all the time to make ends meet,” she explained. After graduating high school, Debbie married and moved to Atlanta where her brother-in-law lived. In Atlanta, she held a secretarial job and her husband worked as a security guard. She left her clerical job and began temporary work, she explained, “Because they noticed I was pregnant.” (Her daughter is now 18 years old and they have minimal contact.)

After leaving her first job in Atlanta, Debbie went to work as an administrative assistant with the Division of Aging. She left her administrative job to care for her mother. After her mother died, Debbie returned to paid work, but this time as a live-in care worker and administrative assistant at a male personal care home. Though unreported, Debbie’s choice of live-in employment, when considered in the context of later employment choices, suggests that her mother’s death left her homeless. The personal care home where she first took live-in employment served disadvantaged residents who were mainly recruited from a homeless service organization. Unable to successfully recruit and retain residents, Debbie’s employer was eventually forced to close, leaving her jobless and homeless. Ultimately, Debbie sought assistance from the homeless service organization where her previous employer had recruited residents.

Homeless and suffering from mental health problems, including “panic disorders,” Debbie’s story vividly illustrates the dire conditions that some DCWs emerge from, or strive to avoid, by working in LTC. At the homeless shelter, Debbie met her current employer who was recruiting workers. Desperate for work and a place to live, Debbie took the live-in job and started working even before gathering her belongings:

She basically hired me on the spot. Nonetheless, I worked on the spot. I wasn’t ready to start work on the spot. I didn’t have any clothes; my clothes were based out of the shelter I was staying at, and I couldn’t go get them

because she wanted me to start working right away. She said, “You will get them.” Four or five days later I got my clothes. That is how that happened.

Debbie’s employer, a small, low-income, AL facility with 18 residents, commonly recruits disadvantaged care workers from homeless shelters and provides live-in positions. All three DCWs at the facility were previously homeless. In addition to Debbie, another woman who was also in her 40s worked and lived at the facility. They work 12-hour shifts. In addition to room and board, Debbie earns \$25 a day. No health care benefits are offered. At this small facility, which is a large house in an urban area, Debbie has a private room with a bed. The other DCW sleeps on a sofa in the administrator’s office. Both DCWs share bathrooms with the residents. Debbie’s boss, the owner of the facility, provides minimal training. When asked about training for her job, which she had had for two weeks at the time of her interview, Debbie explained: “Girl, I ain’t had no training. I like training.”

Debbie’s interview was somewhat restricted in length, because she intermittently fell into an apparent drug-induced sleep. The interviewer noted: “Debbie kept nodding off during the interview. She said she was on medication that makes her drowsy. It seemed to me like she was high on something.” Debbie explained that her fatigue was due to poor health, medications, and the peacefulness of the interview environment:

They worry about me, but, you know, the blood work I am supposed to take, I don’t take it as much as I am supposed to. I have to have something in my system because, you know. . . . Yeah, the medications they prescribe for me, it is three times a day, but I try to only take it at night, but it overlaps into the morning. And another thing too, I am sitting here too and it is peaceful.

Ultimately, Debbie’s story illustrates a last-resort pathway to LTC.

Case Example Summary

Jonee, Ethel, Vera, Kim, James, and Debbie were motivated to work in LTC, AL, and their particular facilities by a variety of multi-level factors, including their own financial need, moral values, social networks, and professional goals. In the following three chapters, workers' pathways to employment in LTC, AL, and particular facilities are explained in detail. Major motivational themes are depicted by drawing on the case examples and on the reports of many other DCWs. The multiple factors influencing their motivations are discussed.

CHAPTER 5

MOTIVATIONS FOR LTC EMPLOYMENT

Overview of Motivations for LTC: Reconciling Conflicting Values

The six case examples demonstrate several different pathways to and motivations for employment in LTC. They show that DCWs' motivations to work in LTC are influenced by various personal characteristics, including their educations and employment histories; major cultural factors, such as moral and market values; important job characteristics, including pay and criteria for employment; and social factors, such as DCWs' networks of friends and family and their religious backgrounds. These factors interactively guide DCWs' employment decisions, steering them into LTC. In general, DCWs' personal characteristics limit their job options to positions that require minimal training, and cultural factors make direct care work attractive by attributing it with high moral value.

Direct-care work fits a unique employment niche that has elevated moral value and limited educational or experience requirements. Although other careers, such as being a nurse or a doctor, are also consistent with cultural values for helping others, the minimal employment criteria for low-level LTC jobs make them uniquely suitable to DCWs, who typically have limited education. Other low-wage jobs, including food service and retail, also have minimal criteria, but these jobs are morally meaningless. That is, they bear no resemblance to the moral values taught by families and religions and are not emotionally or spiritually meaningful.

Overall, DCWs come to work in LTC to satisfy their economic needs and to do work that is consistent with their moral values. The motivation to meet one's economic needs however, conflicts with the desire to enact one's moral values: morally valuable work, like caregiving, reaps minimal economic rewards. Moral and market values for care work are inconsistent. As a result, DCWs' motivations for employment in LTC depict a dynamic of *reconciling conflicting values*. DCWs enter LTC to satisfy their material need to make a living but also to do something they believe is ethically good.

DCWs report three primary categories of motivation for LTC employment: *material motivations*, *moral motivations*, and *professional motivations*. DCWs who are motivated by material concerns commonly identify financial need as their motivation for LTC employment. DCWs who are morally motivated tend to identify values for helping others, particularly older adults, as their motivation for LTC employment. In contrast, DCWs who are motivated by professional goals emphasize meeting their career aspirations and commonly identify LTC as a stepping-stone to achieving their professional goals. DCWs who are motivated by professional goals aim for careers which meet *both* their moral values and material needs, but require greater training and education, and offer greater economic rewards than direct care work. As a result, DCWs with professional motivations for employment in LTC are striving to reconcile conflicting (moral and material) values.

How do DCWs know LTC employment could satisfy their moral, material, or professional desires or needs? Their *social networks* serve as informants and employment advisers. Consequently, social networks act as a conduit to LTC employment as they support moral, material, and professional motivations.

Material needs, moral values, professional goals, and social networks are not independent motivators. Rather, each of these motivators is influenced by multiple factors, including personal factors, for example workers' educations and religious and family backgrounds; community-factors, such as gender norms about caregiving and employment options; and institutional-factors, including the educational and other criteria for employment in LTC. Additionally, more than a third (35%) of DCWs express a combination of motivations for LTC. For instance, one DCW may be morally *and* professionally motivated to work in LTC, and her social networks may also provide encouragement. The percent of DCWs to report each type of motivations is depicted in Table 8.

In the following pages, I describe each of these motivations and how they are influenced by various factors and illustrate, using quotes from DCWs, each motivation both separately and in combination with other motivators.

Table 8: Overview of DCWs' Motivations for LTC Employment

Motivation	Percent
Material	33
Moral	67
Professional	7
Social Networks	33

Material Motivations for LTC Employment

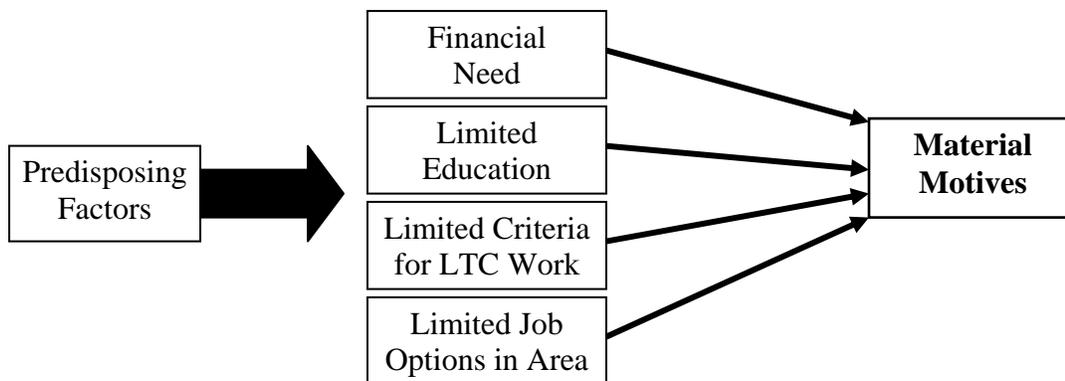
Overall, DCWs have limited educations, few employment options, and scarce economic resources. Because their options for employment are limited and their need for income is urgent, many DCWs come to work in LTC simply to meet their economic needs. In fact, for 29% of DCWs, job availability was the *primary* motivation for LTC employment. That is, when asked why they chose LTC work, job availability was the *first* motivation expressed. Altogether, 33% of workers cited job availability or financial need as their primary, secondary, or tertiary motivation for employment in LTC. Material motivations reflect the basic need for income, not a specific desire to do care work. Furthermore, for 34% of DCWs, *job availability* was the primary motivation for AL employment, and for 26% of DCWs, *job availability* was the primary motivation for employment in their current facility. These consistent and high percentages, and the increasing prevalence of poor non-white women in the direct care workforce, indicate that socioeconomic factors, particularly a lack of education and training, are a central factor contributing to employment in LTC. Debbie's story, like that of other impoverished care workers, vividly illustrates material motivations for care work.

These DCWs come to LTC, AL, and specific facilities due to material motivations. Black, white, Hispanic, U.S.-born, immigrant, old and young DCWs were all motivated by economic need. Neither gender, race, nativity, nor age *cause* DCWs to take LTC employment, but their socioeconomic conditions, especially their educations and employment histories, which *are* likely influenced by these personal factors (gender, race, nativity, age) have substantial influence on DCWs' motivations for these jobs. Additionally, turning points (Crosnoe and Elder 2002) in DCWs' family lives often spur

material motivations and entry to LTC. In the following pages I discuss how material motivations are influenced by: (1) individual-level socioeconomic factors; (2) industry-level educational criteria for employment; (3) community-level employment options; (4) family life; and (5) individual health.

The influence of these factors on material motivations is depicted in Figure 1. Predisposing factors that lead to financial need, and thus material motivations, include gender and racial discrimination, which exacerbate financial need and limit education among women, particularly black women in the South. And the cultural view that care work is natural for women, which is a component of gender discrimination, contributes to the limited criteria for LTC employment, as there is no need to train individuals for jobs which they were born prepared to do. In turn, workers with pressing financial needs and limited education commonly come to LTC because they need income and have few job options. And material motivations are enhanced in communities where job options are slim for individuals with limited education. The influence of these factors on material motivations for LTC employment is discussed in detail in the following pages.

Figure 1: Material Motivations for LTC Employment



Socio-Economic Factors Influence Material Motivations

DCWs' socioeconomic conditions—their financial need—were the primary factor to influence material motivations for employment in LTC. Generally, financial need spurs material motivations, and material motivations often originate, or become activated, at a turning point characterized by increase in financial need. For 9% of DCWs, the material motivation for LTC employment was activated by the loss of their previous jobs. For instance, Dana, who lost her previous housekeeping job, came to work in LTC for \$5.75 per hour to meet her economic needs: “I got laid off. I did cleaning for school. I heard about this job.” Likewise for Glory, the loss of her previous job also led her to LTC, where she earns \$6.50 per hour: “My other job closed down. I looked in the paper and saw this job. I came down and they hired me.” Similarly, Sherry, a 35-year-old

African American woman who has worked in LTC for four years, explains: “I came to long-term care only because I lost my other job. . . . I did not have plans to do elder care.”

Overall, financial need is a central cause of DCWs taking employment in LTC.

DCWs’ personal socioeconomic conditions also interact with community policies and practices. For instance, two DCWs who are now coworkers were directed to their current employer, a large AL facility, by “the unemployment office” or “the labor department.” Additionally, industry-wide standards, such as the minimal education and training required to perform care work, especially in AL, also attract DCWs to LTC.

Employment Criteria Influence Material Motivations

The low employment criteria for direct-care work were a critical factor influencing material motivations. Jobs with similarly low criteria that compete with LTC for employees include food service, housekeeping, and retail. Echoing the experience of many DCWs, Denise came to work in LTC over 13 years ago because she needed paid employment but her job options were limited: “Just a way to keep getting paid. My job opportunities are limited.”

DCWs’ limited education and employment histories are particularly salient reasons for taking employment in LTC. Choosing among low-level job options was a common experience of our DCW sample. A researcher explains how one DCW weighed her job options and decided LTC was her optimal choice: “When I asked her why she decided to work at the facility in the first place she said that she knew she did not want to work at a fast food place or in retail and at the time she felt like they made her the best offer.” LTC administrators are also aware of DCWs’ low-level job options. In one community, an administrator considers fast food the only other job option for many

DCWs. Illustrating one of the central challenges of AL staffing LTC, this administrator considers working in the fast food industry preferable to direct care work: “If I were looking at making \$7.00, \$7.25 an hour and I could either be in here changing diapers or go flip burgers at Wendy’s, I’d say, ‘bring on the burgers.’ I really would, I wouldn’t do it. I wouldn’t do it for what they make. It is a hard, hard job.” In other words, given their equally low pay, the prospect of flipping burgers seems less challenging, and thus more attractive, than direct care work.

The minimal criteria for employment in LTC attract some DCWs to the field. These workers are not motivated by any particular value or plan for caregiving, but by the material need for income. For example, Betty, a 52-year-old immigrant, came to work in LTC reluctantly and without any plan to be a caregiver. She had moved to New York from Africa and had difficulty finding a job but eventually was hired into LTC: “When I first moved to New York it was very hard for me to get a job—it wasn’t like I wanted it [a LTC job].” The low criteria for LTC employment may attract DCWs, but DCWs attracted to LTC due to its low criteria for employment are not necessarily dedicated to LTC or to the aim—shared by LTC employers and desired by LTC consumers—of providing high quality care.

LTC competes for these workers with the fast food industry and retail, which also demand little or no training or experience. However, the personal values associated with care work, which are discussed in the section *Moral Motivations for Employment in LTC*, make care work stand apart from these other job options.

Community Features Influence Material Motivations

Personal socioeconomic factors also interact with community-level factors, especially the economy and aging demographics, in directing individuals to care work. Because many DCWs come to work in LTC primarily for material reasons, broad economic phenomena, like deindustrialization and welfare reform, have an important influence on the direct care workforce. For instance, Vera is a first-time care worker who had only a 12th-grade education when hired by her AL employer. But Vera's personal characteristics fit a broader societal pattern: her pathway to LTC leads from a closing factory to a growing LTC system. In fact, 4% of the DCWs in our sample came directly to LTC from factory work. Vera's employer, located in a rural county, relied heavily on displaced factory workers: "Just about all of us worked at the mill," Vera explained. And all but one of Vera's DCW-coworkers who were former factory workers had a high school education or less. Illustrating this theme, Peggy, a DCW with a high school education, came to work in LTC because the mill where she had worked was downsizing: "I was laid off at the mill and there was a job available at a nursing home; I applied to Carlson Nursing Home and they hired me."

Communities with limited job options for individuals with little education and growing older populations support material motivations for LTC. In a lakeside community where two large mills recently closed and the population of retirement migrants has expanded, a DCW explained her motivation for employment in LTC: "There's not too many fields you can go in around here." Bolstering this view, her boss similarly said:

We had a big poultry mill in the county; for over 100 years and it closed about four years ago, and there were a lot of people out of a job. You will notice

most of the people that work here are not young; they are in their 40s and up. A number of those people had worked there for 20 or 30 years and have wonderful work habits.

In conjunction with the decline of industrial work in this community, LTC has faced increasing demand due to the migration of older adults. The administrator explains:

We have a tremendous influx to the Lake Horton area and I have worlds of people trying to get their mothers and fathers here. They are from everywhere; I have people who came from Washington state, Chicago, a bunch from Florida, just all over the U.S. I have people on the waiting list, and it was amazing how many people were from different states up north trying to get in here because the families were here. They say it is just going to continue to grow.

Beyond changes in local markets and demographics, which represent community-level turning points, no other community characteristics influenced material motivations for LTC employment. Material motives were reported in communities with high and low unemployment rates; in communities with thousands of LTC beds and in those with just a couple hundred; and in urban and rural areas.

Family Lives Influence Material Motivations

Like Debbie, whose need for housing appears to stem from changes in her family life, particularly her mother's death, other DCWs also find their economic needs heightened after a major change, or turning point, in their families. Divorce, birth, death, or a family member's job loss or entry into college were common turning points.

For instance, Joan, a single mother who needed income to support her family, came to work in LTC without training or knowledge of what LTC employment would entail: "I didn't know what I was getting into. I didn't want to go back to school. I'm a single mom and I needed a job." Though her entry to LTC was not well-informed, Joan has remained employed in LTC for over ten years. Prior to taking her current AL job four

months earlier, she worked for over ten years in nursing homes. When she came to work in AL, her hourly pay was \$7.25.

Likewise, Terri, a 63 year-old American Indian woman, first took employment in LTC 40 years ago, after her divorce left her needing income. She explains her motivations to work in LTC: “I got married and was out of a job. Then my husband and I got a divorce and I couldn’t find anything in the field I’d been in (doctors’ offices). I saw an ad and came in.” In contrast, Gayle came to work in LTC 20 years earlier because her husband lost his job: “I got into it by accident. My husband lost his job and I had to get the first job, which was at a nursing home.” For Gayle, her husband’s loss of employment forced her to take the first job she could get. Four years earlier, after 16 years working in LTC, she came to her current ALF, where she started at an hourly rate of \$7.00.

In addition to changes in spousal relations, turning points in DCWs’ children’s lives activate material motivations. One middle-aged woman came to work in LTC to pay for her daughter’s college education, but likely will leave if she gets a position in a school cafeteria that offers benefits. Since only 28% of the sample received health care benefits from their LTC employers, it is possible that this pathway out of LTC will be, to the detriment of LTC, heavily tread.

Overall, individuals’ family responsibilities are a common influence on their employment decisions. The DCWs’ stories presented in this subsection depicted how family lives reinforced *material* motivations for LTC work. The influence of family lives on *moral* motivations for employment in LTC is discussed in the following section.

Health Influences DCWs' Material Motivations

DCWs' entry to LTC is also influenced by their health. For instance, though Debbie's homelessness was the primary factor leading her to take employment in LTC, her poor mental health and her drug use likely contributed both to her homelessness and to her limited job options. In fact, Debbie would prefer a secretarial job, but explains it is "hard to get them." Debbie's prescription drug use, which is intended to address her panic disorders, also could impede her ability to find clerical work.

In addition to mental health problems, physical health concerns also influence pathways to LTC. For example, Ginny, a 63-year-old woman who is overweight and a smoker, came to work in LTC because she expected it would be easy physically: "I thought this was something I could do without too much wear and tear on the body." Ginny had been working in LTC for just three months at the time of her interview. Her husband died one year earlier and she sought employment for "something to do."

Though direct care work can be physically and mentally grueling, poor mental and physical health lead some DCWs to LTC. Some DCWs even consider their jobs beneficial to their health. They view the physical demands of care work as exercise. For example, a DCW who is over 70 years old, retired, and works full time in AL reports that staying busy and working allow her to stay healthier. Though Dottie became interested in care work after caring for her now-deceased mother, the physical and mental health benefits of care work and exercise may also attract other retirees with time on their hands and the need for extra cash.

Long-Term Care Employment Fails to Satisfy DCWs' Material Needs

One-third of DCWs are motivated for LTC employment by their material needs, and these needs are stimulated by various socioeconomic factors, the loss of prior employment, their career goals, changes in their family lives, their overall health and well-being, and the employment options in the area. However, few DCWs are satisfied with the material rewards gained from LTC employment. For example, Carole, a 50-year-old African American woman, came to LTC less than two years prior to her interview because she lost her previous job and needed income. She started at an hourly rate of \$8.00 and is dissatisfied with her pay: "I got laid off from my job when I was going to school. So when the checks stopped, I went looking for a job. . . . The only thing I don't like about this job is the pay. They don't pay enough." Carole had received a pay increase, and was earning \$8.60 per hour at the time of her interview. This is the average pay for DCWs at her facility, and similar to the pay of the rest of the sample. Overall, DCWs are alike both in pay and in their attitudes about pay. Among all DCWs, including those who came to LTC to meet their material needs, 42% consider their pay "bad." Additionally, for 31% of DCWs the pay or the quality of benefits is the primary reason they would leave their jobs. DCWs with material, moral, professional, or social motivations for employment in LTC all reported dissatisfaction with pay and considered pay the most likely reason they would leave their jobs. This attitude cut across all types of motivations.

Among those DCWs who have not yet been driven from LTC by its low economic rewards, some translate the material need that brought them to LTC into moral meaning. For example, Molly, a 42-year-old African American woman, recognizes that

she did not like working in LTC at first, but over time she has come to embrace caring values and to have familial feelings for the residents, which makes her job meaningful and enjoyable: “I didn’t like it at first. I got used to it. I enjoy being around them [residents], like they’re my grandmother and granddad, they make me laugh. I like to help them, it makes me feel good.” The material need that draws many DCWs to LTC employment often is not met through care work jobs, but moral values are affirmed through care work, and these values are also an important motivation for LTC employment.

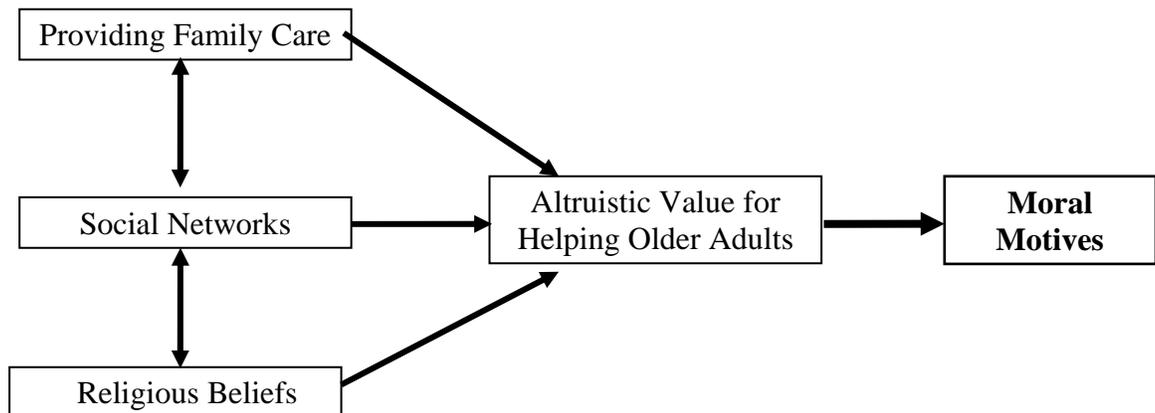
Moral Motivations for LTC Employment

Many DCWs (67%) come to work in LTC because care work is consistent with their *moral values*, including their love of older adults, their attitudes about family, and their religious notions of caregiving. For half of the sample, moral values were the primary motivation for employment in LTC—the one they reported first; for one-third, moral values were a secondary or tertiary motivation.

DCWs’ values draw them not only to LTC employment but, more specifically, to AL. Moral values also motivate DCWs across numerous categories of personal difference (including sex, race, age, nativity, education, and employment history). Many DCWs are motivated to enter LTC both by their personal values and by their need for income, their career goals, or their social networks; and the affinity between DCWs’ values and care work is influenced by multiple factors, especially their family caregiving experiences and their religious beliefs. Families and religious organizations provide education that establishes the groundwork for moral values, and many DCWs specifically attribute religious or familial meanings to care work.

In Figure 2, moral motivations are modeled as stemming from altruistic values for helping, and these values are supported by workers' religious beliefs and their experiences providing family care. Workers' social networks, returned to in a later section, also support altruistic values for helping, and are mutually reinforcing of workers' religious beliefs and family care.

Figure 2: Moral Motivations for LTC Employment



In addition to attracting workers to LTC, the consistency between care work and DCWs' moral values provide meaning to care work: "I feel like I am doing something meaningful when I help," revealed one DCW. Having a sense of meaning in their work also provides DCWs with a sense of consistency in their identities as caregivers or helpers, as opposed to a sense of alienation. Anita, a 56-year-old African American woman who has worked in LTC for eight years, describes this sense of meaning and identity: "I feel like I was meant to do this kind of work and it stems from within; I just like helping anybody who needs help; I am a helper." The administrator of a large AL facility compares material and moral motivations and argues that DCWs with moral motivations are unlikely to be dissatisfied with their jobs on account of unsatisfactory material rewards:

Most people feel they deserve more [pay] than what they are getting. What we find is that [pay] is not the primary motivation for the staff that work for us. Because of that, even the people who feel like they should get paid a little more, it doesn't affect the way they look at the company or the way they do their job, because they are here because they believe in what they do and have the heart for it.

Care work fits DCWs' moral values for caring for others, especially caring for older adults and in this way contrasts with other low-wage, unskilled jobs, such as food service and housekeeping jobs. However, moral values and associations between these values and various industries fluctuate; over time more industries may compete for morally motivated, little-educated workers.

Love for Older Adults Influences Moral Motivations

More than half (59%) of DCWs with moral motivations for caregiving specifically value taking care of older adults. Some come to LTC because they care *about*

older adults and some particularly value caring *for* older people. Of course, DCWs who value caring *for* older adults likely also care *about* them.

Janice, a 48-year-old African American woman who has worked in LTC for five years, chose LTC because she cares *about* older people: “I think it is a good work to work with elderly. I care about them.” Similarly, Katie, a 23-year-old woman with five years’ LTC experience expressed a similar motivation: “I love working with older adults. I love to communicate with elderly and be with them. I like the elderly in general.” In contrast, an Asian American woman who had worked in LTC for just five months and who had prior worked in retail valued caring *for* older people: “I love this type of work. I want to take good care of the elderly.” Similarly, Zoey, a 25-year-old African American woman with three-and-a-half years’ experience in LTC, explained: “I like taking care of elderly ones; make them feel at home.”

Caring about older people and valuing caring for older adults are common motivations for employment in LTC. As a community, DCWs represent a caring culture. Because the LTC industry provides DCWs with jobs that are fundamentally intended to promote the well-being of older adults, DCWs perceive consistency between their values and the LTC industry and are attracted to this consistency. However, the LTC industry is a diverse field, with non-profit, for-profit, independently-owned, and corporately-owned facilities which may have different values and cultures. For instance, some LTC employers value profit more highly than do other employers and some LTC companies are organizationally structured more hierarchically than are others. As a result, the consistency of DCWs’ values with LTC employers’ values likely vary as well, and this variation may influence workers’ outcomes (e.g.; satisfaction, turnover, retention). In

fact, 33% of workers in corporately-owned facilities, in comparison to just 17% in independently-owned facilities, report that *pay* would be the reason they would leave their jobs, were they to leave within one year.

Though cultural variations exist within LTC, and organizational culture change is possible, workers' motivations for employment in LTC basically reflect a uniform and static view of LTC employment as consistent with moral values for care. To better understand the source of DCWs' values requires understanding their religious beliefs and their notions of family.

Religious Beliefs Influence Moral Motivations

DCWs' religious beliefs were not a component of the interview guides, but religious attitudes toward care work emerged as an important factor motivating DCWs to enter LTC. Seven percent of DCWs indicated that their religious doctrine influenced their attitudes toward the value of care work. Because this finding was largely unprompted by researchers, religious attitudes may have a stronger influence on DCWs' motivations than findings suggest. DCWs reporting religious attitudes toward care work vary by age, race and nativity. However, data about DCWs' religious backgrounds are limited, and only DCWs with Christian backgrounds have been identified.

Overall, DCWs' religious beliefs influence their motivations for LTC employment by providing them with an understanding of care work as a divinely inspired duty. An African American woman who considered caregiving a mission explained: "I am a Christian and I live for help. This is like a mission for me. I help with my heart." Mary, a white woman, considered caregiving a blessing: "This is just something God sent for me to do. I was one of the blessed ones. Not everyone can do this type of job." Some

DCWs consider care work a calling. “I feel like I am called to do it,” explained Patricia, a 47-year-old white woman. Similarly, Virginia, a 30-year-old African American woman explained: “I just think it was my calling, something I was supposed to do.” Another DCW who considered care work her calling thought of herself as a “guardian angel.” Considering care work a mission, a blessing, or a calling illustrates how DCWs’ religious beliefs shape their personal values and provide care work with meaning. Some LTC employers share the religious view of LTC. One administrator explains:

I always wanted to be a nurse and take care of people. So I had this dream of having this big place to take care of people that weren’t able to take care of themselves and taking care of them and that just always stayed with me. And so I feel like it was a vision from God. So I call this a ministry, not a business I’m not a business-minded person; I’m a religious person.

In addition to providing care work with meaning, DCWs’ religious beliefs support job retention. The influence of religious beliefs on job retention is depicted by Sheila’s story. A white, 46-year-old DCW with a 10th grade education and a CNA, Sheila has worked in LTC, including nursing homes and in-home care, for over 25 years. She considers her aptitude for care work a divine gift. However, she has little education and her employment history is largely limited to LTC, with a short stint in factory work, which surely limits the availability of other jobs. Albeit, viewing her ability to provide care as a divine gift gives her work meaning and justifies her retention:

Researcher: Why have you stayed in long-term care?
Sheila: It is the only thing I know how to do. I reckon God gives us gifts and this is what he gave me.

In contrast to staying in LTC due to lack of other job options, which is not entirely consistent with the value for helping others, she understands her job retention as divinely derived. Lynn, a 57-year-old woman with over 13 years’ experience in LTC and 5 years’

tenure in her current facility, also intends to stay in her job for religious reasons: “That is what the Lord put me here for; to intervene in their lives. I will be here, good and bad.”

Some DCWs believe that their care work will reciprocally translate into receiving care, either for themselves or their loved ones, at some later time. This notion of delayed reciprocity motivated one DCW to do care work because she believed that older people need someone to care for them, and she hopes someone will care for her when she grows old.

Some workers’ notions of reciprocity operate in the opposite direction. For example, Allison, a young female DCW, came to work in LTC due to a belief in generalized reciprocity (Sahlins 1972). She wants to *repay* the help that older adults, in general, give to younger people. She said, “I love helping people. The elderly have helped you. It is giving back what they gave you.” Overall, DCWs’ notions of reciprocity with regards to their relationships with older adult care recipients support their entry to, and satisfaction with, LTC jobs.

Familial Beliefs Influence Moral Motivations

In contrast to religious meanings, 16% of DCWs who report moral motivations attribute familial meanings to their work. Many consider care work valuable, or consistent with their personal values, because their relationships with the residents resemble family relations: “I like to work with older adults,” explained one DCW, “the residents are like my family.” Similarly, Vera thinks of relations between residents and DCWs as familial:

I know they are not my family, but I still kind of look at them as family. They are older people and they have children and when their children aren’t here we have to be children to them. When you have to see about them you have to be a caregiver also. I look at it as friend and family. You have to be there for

them, but it is like you are their family because you be in here with them all the time. They know you are not their children, but you still have to be a person to them like a child, like they are your mama or grandmama, in a sense.

In addition to thinking of residents as family, many DCWs come to work in LTC because they have experience providing care to older family members. For example, Mandi, a 33-year-old African American woman who has been employed in LTC since she was 18, originally came to work in LTC because she had enjoyed caring for her grandmother: “I used to help my grandmother, which made me feel good since I was helping.” Naima, a 54-year-old African American woman who has been employed in LTC for over 23 years, similarly explains why she came to work in LTC: “My grandmother was sick. I took care of her. I like working with older people. This is where I am supposed to be.” Additionally, for some DCWs, an ethic of care permeated their family lives and prompted them to seek caregiving careers. One DCW attributed her motivation for LTC work to growing up in a family where caregiving was valued. Her mother always “took care of people” and often kept her grandparents in their home. Her grandfather and an aunt lived with them for years in their old age, and it was a family ethic to take care of people who were sick and needed help. This worker said she knew “from a child” that she wanted to be a nurse. Similarly, a 33-year-old African American woman said: “I took care of family members and thought this is what I would like doing.” James, a male DCW, also attributes familial meanings to care work: “When I began to take care of my grandmother, that is when I had the patience to do what I do now.” James was not the only male to be motivated by his personal values for LTC. Frank, a 50-year-old white man, was similarly motivated for LTC employment by his family-caregiving experiences and his value for helping: “I wanted to help people. I had

experience with my grandparents.” These examples illustrate interconnections between family caregiving experiences and later work choices. For many DCWs, care work is attractive because it resembles their family relations.

In contrast to those DCWs who come to LTC having enjoyed caring for an older family member, others come to LTC specifically because they have not had that experience. For example, Sheryl, a 22-year-old African American woman, came to work in LTC because she wants to help older adults enjoy their final years, but is unable to help her own grandmother: “I have a grandmother and I can’t really take care of her. I like working with the elderly. Help them, the last few years they have, to live peacefully.”

The influence of family relations on motivations for care work crosses cultural boundaries. Like domestic-born DCWs, foreign-born workers view care work as a connection to their past family caregiving experiences. One worker said: “In my country I cared for my grandmother and I liked doing that,” explained Rala, a 28-year-old DCW who was born in Ethiopia and has been working in LTC for just over one year. For some DCWs, caring relationships with residents serve as a replacement for family relations, similar to some residents for whom relationships with DCWs take on family-like features.

Both male and female DCWs are motivated for LTC employment by the consistency between their personal values for caring for older adults, which are supported by their experiences of family caregiving, and the nature of LTC work. The association between paid care work and family care may minimize the importance of its material rewards, which are inconsistent with unpaid, family care. James, for instance, left a retail

job where he was making \$17 per hour to care for his grandmother, and though the economic rewards of care work are much lower than his retail job (he started in LTC at \$8 per hour and almost three years later makes \$12 per hour as the coordinator of the dementia care unit in his facility), he finds the intrinsic value of relating to residents a worthy substitute for dollars per hour: “My job that I am doing now is rewarding because of the benefits I get from the residents.”

Furthermore, both young and old DCWs are motivated for LTC employment because it affirmed their personal values. Ethel’s story shows that she came to work in LTC because she viewed the job as consistent with her family caregiving experiences. She had cared for many brothers as well as her husband and considered care work an extension of these experiences, with the added bonus of pay: “I’ve been a caregiver for a long time at home. This is the first time I’ve gotten paid for it.” Ethel also sees religious meaning in her work: “It just seems like the Lord gives us talents and He gave me that one [for caregiving].”

Whereas many DCWs’ family caregiving experiences make care work resemble family life, other DCWs actually care for family in LTC. Kim, for instance, prefers working in the Alzheimer’s unit of her AL facility because her aunt lives there: “I think the Alzheimer’s unit is good. My aunt lives here, so I think it is good.” Similarly, Shelly, a 23-year-old white woman, came to work in LTC, in her current ALF, to develop her relationship with her grandmother, who was living there: “My grandmother lived here for four years and passed away here—so I could get closer to her.”

Consistency between Care Work and Moral Values Heightens Job Satisfaction

Though LTC work barely meets DCWs' basic material needs, the consistency between DCWs' moral beliefs and the nature of LTC work suggests that LTC actually does satisfy DCWs' emotional or spiritual needs (higher level needs, according to Maslow (1943)). In addition to providing care work with meaning, the consistency between LTC work and DCWs' morals provides DCWs satisfaction with and dedication to their jobs. For most DCWs, establishing caring relationships with LTC residents, their care recipients, is the most important component of their jobs. In fact, 67% of workers find relationships with residents to be the most satisfying aspect of their jobs and 53% say these relationships are the primary reason they stay in their jobs.

For Jonee, an immigrant care worker, the consistency between her moral belief that caring for older adults is important and the very nature of LTC work is the most satisfying aspect of her job: "You get to take care of the residents and go home knowing you did all of your work." Similarly, Vera, a first-time care worker, finds satisfying the residents' needs is the most satisfying aspect of her job: "To see people smile and be happy. Satisfying their needs." Siena, who has provided private, in-home care for 18 months and worked in assisted living for three years, explains how helping residents brings her satisfaction: "I like working with older adults; helping them and taking care of them. It makes me happy. I feel satisfied." When asked what keeps him on the job, James explains that his love for the residents is the primary reason why he stays: "I love working with the elderly, I love working with the elderly." Similarly, Vera stays on the job because she finds helping others intrinsically rewarding: "It is a rewarding job. It is a job that is giving back, it is helping." Overall, the prominence and deep significance (in

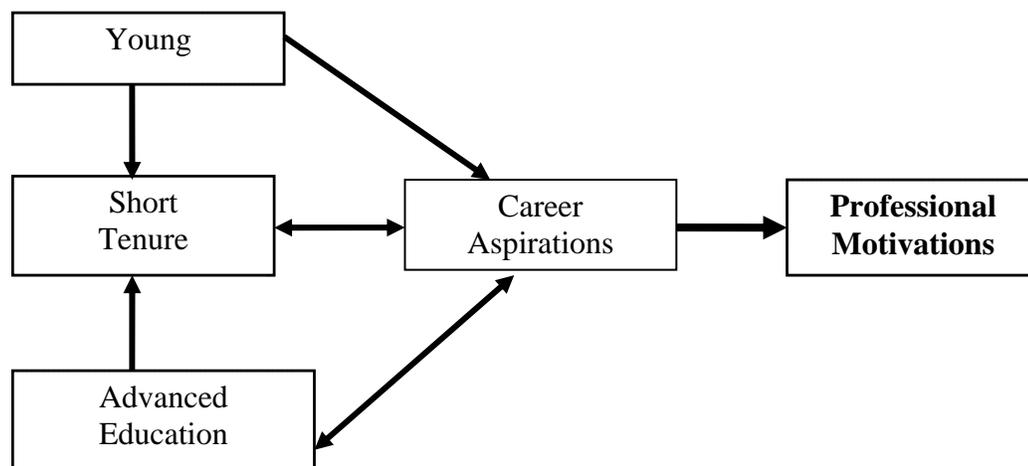
terms of identity, job satisfaction, and retention) of care work's moral meanings highlights the importance of supporting worker-resident relationships in LTC.

Professional Motivations for LTC Employment

Just 7% of the DCWs in our study came to direct care work in LTC because they viewed it as a stepping-stone to more professional health care employment, particularly nursing. Dena is representative of the workers' who had professional motivations. She was 27, a CNA, had a Bachelor's degree, and was in a nursing program. She had been employed in LTC for about one year and was hopeful the experience would be useful in seeking future work. She left her first AL facility to come to her current employer for its tuition reimbursement benefits.

Like Dena, the other workers' with professional motivations are young and have advanced levels of education. Their median age is 24, much younger than the overall sample, with a median age of 40. Most (79%) have at least two years' college education, compared to only 29% of the overall sample. Their median facility-tenure is just seven months, compared to 28 months in the overall sample; and their median LTC tenure is just 15 months, compared to 60 months (5 years) in the overall sample. They are all women. As the model in Figure 3 depicts, aspiring for a nursing career supports professional motivations, but such career aspirations are themselves associated with being educated, young, and relatively inexperienced as a care worker.

Figure 3: Professional Motivations for LTC Employment



Jonee’s story, an immigrant care worker and one of the case examples, also illustrates professional motivations for LTC employment. She aims to be a nurse or an LTC administrator and is enrolled in a four-year collegiate program in pre-nursing and health care management while working as a DCW in AL. She has completed her CNA and two years of her college program. During her CNA training she had an internship in a nursing home, her entry into LTC.

Other DCWs, across racial and nativity backgrounds, have similar stories. Another African-born DCW explains her pathway to LTC: “I wanted to go into the nursing field.” Likewise, a young white woman working on her undergraduate degree in nursing chose direct care work for professional experience. Though DCWs may view this

job as an avenue to careers in nursing, some LTC employers express concern that DCWs have misconceptions of what both care work and nursing entail and thus may shy away from aspects of hands-on care that they consider beneath the duties of a nurse. One administrator explains:

I think a lot of people get into this field thinking they are going to be a nurse and making a lot more money than they are going to be making. . . . I think they don't realize that a CNA is a CNA and a nurse is a nurse. My step-daughter went back to school and got her GED; she is 25. She said, "I am going to be a CNA." I asked did she know what is involved. She said it is kind of like nursing. I said, "No, you need to come up here to my office for about three days and you will find out it is not a nurse." I will also have CNAs that come to work here and they are going to school for nursing. We have a lot of that. We have a lot of people who come here part-time while they are going to nursing school. They are like, "I don't need to know how to give baths because I am going to be a nurse." They have a misconception about what even a nurse has to do.

Direct Care Work and the Continuum of Caring Careers

Conceptual linkages between direct care work, nursing, and the medical field support the stepping-stone motivation. That is, direct care jobs are broadly viewed as low-level positions on a career continuum. This perceived career continuum leads upward from direct care jobs to nursing jobs and medical positions (e.g., medical assistant) that require substantially more training and entail considerably less hands-on contact than direct care jobs. Amber, 20 years old, white, employed in AL for only five months, and in college studying nursing illustrates the belief that direct care work lies on a career continuum: "I am going into nursing and I thought long-term care work would have a medical aspect." Julie, one of Amber's coworkers, expressed similar motives: "I want to be a physician's assistant, so this is what I want to do for the experience."

Other DCWs chose their jobs as way of helping them decide whether nursing was an appropriate career for them. This was true for one worker who left her retail job to work in AL to “try on” the helping profession.

Entering Direct Care Work through Training

Because criteria for LTC employment are minimal, many DCWs enter LTC while training for a more professional care career. For example, Emily, a 27-year-old white woman, describes her pathway: “I was going to school for my CNA and it fit with schooling.” Her CNA training program was integrated with her high school curriculum. Similarly, Christa, a 60-year-old woman who had emigrated from India and trained as a CNA, had a similar avenue: “I worked in the health field in India and I was also interested in working here in the health field. I trained to be a CNA. My internship was with Robbins Assisted Living—they hired me and I have been with them.” As these examples indicate, affiliating with training programs may be an important strategy for LTC facilities seeking a trained workforce. An administrator at a large, corporately-owned AL facility finds most of his staff in these training programs: “The CNA schools; we get a lot of employees hired from there because they will come here to do their training sometimes. They do their clinical here. . . . Students who are going to school for nursing or health care and decide to come here.”

However, many people enter CNA training programs without desire to become DCWs in LTC. They enter these programs aiming to fulfill more prestigious health care career aspirations and view LTC as a stepping-stone to these higher-paying, more professional health care jobs. When Kim, a veteran care worker, took her first job

working with elders, she was making a career move. She had grown disenchanted with factory work and decided to try care work, on her way to a career in nursing:

I was bored with the plant scene... I decided to try CNA work, so I went to school and got my CNA and I started from there. I worked at Samson Nursing Home and I was just interested; basically, I wanted to be a nurse all of my life. But things happened where I couldn't afford school, so I just did the closest thing to that, but that is how I decided to get into it.

Like Kim, DCWs' career aspirations generally imply a desire to care for or help others, indicating that DCWs' values also influence their career aims and pathways. Because of this consistency between DCWs' values and the nature of care work (caring for or helping others), some DCWs who come to LTC as a professional stepping stone feel satisfied in direct care positions and no longer view LTC as a stepping stone. They come, instead, to view direct care as fulfilling their career aspirations, perhaps partly because their former goals required more rigorous training, education and experience.

People who are training for careers in nursing are sometimes rerouted to LTC. Training-industry practices, like internships, or personal social networks steer DCWs to LTC, where their values may be satisfied. Sometimes DCWs stay in these positions even when direct care jobs are not entirely consistent with the career aspirations that originally led them to seek training. Barbara, who has over 20 years of LTC experience, was training to be a nurse when she originally came to LTC. Along the way she replaced her career goal with the satisfaction of fulfilling the values for care that were a basis of her career goals: "Well, once I went to school and wanted to do patient care. I always wanted to be an LPN, but I did not finish. But I still do patient care." Similarly, Alicia, who is just 20 years old, was training for a career in medicine when she ended up working in LTC, "Because of the school I was taking. I wanted to go into the medicine, the health

field.” These DCWs came to view care work as a replacement for their original career goals of nursing or the medical field. This change of course illustrates an important pathway to LTC employment, as well as an interesting redefinition of one’s career goals in terms that are consistent with moral, rather than material motivations. Another worker who tried to go to nursing school in California could not keep up with the tuition and had to work two jobs to support her family. Even though she is not able to give the “higher level” of care, she is still “giving care” and “loves” it. Additional discussion of the consistency between moral values and professional goals for nursing are discussed below in the section *Moral and Professional Motivations are Mutually Supportive*.

This pattern of DCWs entering LTC employment while aiming for a more professional career also illustrates how the minimal criteria for DCW employment supports the stepping-stone motive—individuals who are untrained can come to LTC as a stepping-stone to a more professional career. For example, Kristen, a 25-year-old white woman who previously delivered pizza and had no care experience, came to work in LTC because she did not qualify for hospital employment: “I wanted to get into the medical field, but hospitals don’t hire CNAs, so I’m getting experience for hospital employment.”

LTC employers who wish to retain workers that strive for upward career movement would likely find developing in-house career ladders a helpful strategy. Jonee’s employer does not regularly provide DCWs with an opportunity for upward career movement, but she believes this practice would support retention: “I think the last time they had a care manager move to an administrative position has been a long time. I feel like people would feel more encouraged to stay and move their way up. I have had care managers become directors but not here.” Overall, the stepping-stone motive

highlights the importance of implementing policies and practices that actually situate direct care work on a professional continuum, or career ladder, from positions that require minimal training to positions that require more training and even direct care experience.

Material and Professional Motivations are Mutually Supportive

DCWs' professional motivations for employment in LTC are mutually supportive of their material motivations. DCWs who enter LTC because they have career aspirations in nursing or in the medical field are also motivated for LTC employment because the educational criteria for direct care work are minimal and they need income. Jenni, a 20-year-old white woman with two years college education and 10 months tenure in LTC, describes how both her material and professional motivations supported her entry to LTC: "I have always been interested in nursing, and this is the first place that hired me and might lead to other nursing-type jobs." Similarly, Barbara, a 46-year-old African American woman with one year of college education, came to LTC with goals of caring for patients as a licensed nurse, but has come to view her direct care position, with its lower educational requirements, as satisfying her career goal: "Well, once I went to school and wanted to do patient care. I always wanted to be an LPN, but I did not finish. But I still do patient care." Barbara has worked in LTC for over 21 years. Likewise, a 26-year-old white woman who had wanted to become a doctor explains that care work fulfills her career goal, which, more basically, is to take care of people: "What did I want to be? I could say a doctor—any doctor. I just thought it was neat seeing doctors take care of people. That was my goal to be in some kind of line of taking care of people. So, I can kind of seem to do that." Too few male DCWs are available in our sample for

comparison by sex, but men who aim to be nurses or doctors, but who do not have the necessary education, may also find LTC a satisfying career option.

Moral and Professional Motivations are Mutually Supportive

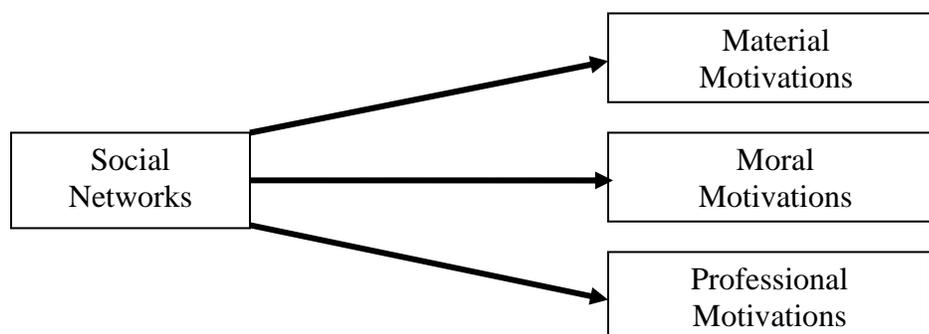
For some DCWs, care work fits both as relevant professional experience in pursuit of their career goals and as fulfillment of their personal values. Overall, among those DCWs who came to LTC primarily because they viewed it as a stepping-stone, 45% also reported that LTC work was consistent with their value for helping others. In this way, moral and professional motivations for employment in LTC are mutually supportive. Aiming for a nursing career is completely consistent with values for helping others, whereas, in contrast, few other careers reflect these moral values as strongly. Orna, a 43-year-old African American woman, explains how her values, her career aspirations, and direct care work are intertwined: “I like it, working with elderly. Even in high school, I said I would become a nurse... In this position I know more about the residents, I can spend one-on-one time with them.” Though Orna originally came to LTC aiming to be a nurse, she has stayed in LTC for 23 years. Likewise, Candy, an 18-year-old white woman, came to LTC both because it fit her values for care and because she believed the experience would help her determine if nursing is truly the career she desires. She explains the interconnection of her moral and professional motivations for LTC employment: “I wanted to be an RN. Working here will let me know if this is what I really want to do and can do. I love helping people. I plan to be a pediatric nurse.” Similarly, Shanetta, a 24-year-old African American woman with over three years’ AL experience, came to work in LTC both as a stepping stone to a career in nursing and because she values helping others: “I have always wanted to be a nurse and needed to

work in something similar with a CNA while working on a nursing degree, and I like helping others.” Overall, many DCWs enter care work as a professional stepping-stone that is consistent with their moral values.

Social Networks Support Motivations for LTC Employment

Many DCWs come to LTC, AL, and their particular facilities due to recommendations made by others. These social networks include friends, family members, casual acquaintances, and professional colleagues. Overall, 33% of DCWs were motivated to work in LTC by their social networks, 8% came to AL based on suggestions made by their social networks, and 35% came to their particular facilities based on such recommendations. In this way, social networks are conduits to LTC that channel the three primary (moral, material, and professional) motivations, as depicted in Figure 4.

Figure 4: Social Networks Support Motivations for LTC Employment



For example, Cora, a 41-year-old African American woman, came to work in LTC because her social network bolstered her moral motivation for care work: “My sister was in elder care. I fell in love with the elders. I was in nursing homes for ten years.” Cora’s sister’s experience in elder care led Cora herself to love elders and to work in nursing homes for 10 years and in AL for another 11 years. Similarly, Faye, a 52-year-old African American woman came to work in LTC because of her social network and her value for helping older adults, which she relates to her religiosity: “Mother was in it [LTC] and I got in it and stayed. I like dealing with elderly, helping them—I’m a minister on the side too.” Faye has worked in LTC for over 20 years.

In contrast, Vette, a 24-year-old African American woman, came to work in LTC because her social network supported her material motivations. She explains: “At the time, I had no job. My mama started here and they needed someone else. I really needed a job and Mama put me on to it.” Finally, Trina, a 43-year-old African American woman, came to work in LTC because her social network supported her professional motivations. She explains: “I always wanted to be a nurse. Most of my family is in the nursing field.”

Most DCWs’ social networks are comprised of female friends or family members who were themselves working in LTC. “I had a friend who was working here—she told me about this job,” reports Miss Gene, a 54-year-old African American woman who has worked in LTC for just two years. Likewise, Dawn, a 39-year-old white woman explains: “I had a friend who was the manager at another facility—she asked me to work for her.” Frannie, a 46-year-old African American woman describes how one of her girlfriends motivated her to leave food service and enter AL work:

At first I was in food service and a girlfriend told me about assisted living—I used to sit, volunteer at a hospital, and a girlfriend knew someone needed someone to sit with her. I started from food service in assisted living and stayed in that direction. They didn't care about experience. They saw that I stayed a long time and was dependable and didn't mind working.

This particular report further highlights how the low level of criteria needed to garner a direct care job supports DCWs' entry to LTC. Additionally, Frannie has worked in LTC for eight years, illustrating the potential for long-tenure care workers to emerge from non-care positions.

Family Networks Influence DCWs' Motivations for Employment in LTC

A broad range of female family members who worked in LTC, including grandmothers, mothers, daughters in-law, cousins, sisters, and sisters in-law, also motivate DCWs to enter LTC. Illustrating some of the breadth of family relations that motivate individuals to enter LTC and the variation of employment histories from which DCWs come, Michele, a 61-year-old white woman, first came to work in LTC based on the recommendation of her ex-husband's new wife. Michele previously owned a hotel in another state but moved to Georgia and has for almost four years worked in AL. She explains why she initially came to work in LTC: "I don't really know. My ex-husband's wife works here. I decided to try it. I didn't think I could do this kind of work."

Some DCWs, on the other hand, were led to LTC by family members who were also LTC residents or by family members for whom they provided informal care, including their mothers and grandmothers. For example, James's case example illustrates this pathway. Likewise, June, a 20-year-old woman who had worked in AL for only two months, understands her motivation to work in LTC to be influenced both by her experience caring for her grandmother and by her grandmother's experience as a DCW:

“I took care of my grandmother for two and a half years and liked caregiving. Plus, my grandmother worked in nursing homes, so I guess it runs in the family.” Hollis, aged 54 and white, worked in childcare for 25 years and became interested in elder-care when her mother-in-law moved into a nursing home attached to the AL facility where she works: “We had to put my mother-in-law in the other building, and it got me thinking about working with older adults.” Hollis left childcare and has been working in AL for five years.

Though social networks commonly guide DCWs to LTC, some social networks steer prospective care workers away. For example, Ebony, a 37-year-old African American, was warned by her mother, a CNA, to stay away from LTC because of staff shortages: “She was like, ‘Don’t do it because they are always short of help.’”

Professional Networks and Casual Acquaintances Guide DCWs to LTC

Some DCWs were encouraged to enter LTC work by professional colleagues, including other employees and previous and future employers. A DCW who never considered LTC work until she was recruited by her current employer has come to love her job: “It wasn’t something I had thought of—the owner told me about it and I didn’t think I’d like it, but honey, I loved it from the moment I walked over here. She kind of talked me into it, which was a good thing.”

Some DCWs were motivated by casual acquaintances. Chloe, a 25-year-old African American who has worked in LTC for six years, was encouraged by a stranger: “One day in a store, a lady said, ‘You’re patient. You’re nice. You should be a nurse.’” This particular report also highlights how DCWs conceptually link direct care work with nursing careers. Rose, a 41-year-old American Indian with a seventh grade education,

had worked in a fast-food restaurant for 13 years when she came to LTC, where she has worked for over 10 years. She first worked in food service at a nursing home but has since moved into a DCW position in AL. Rose's history shows that rudimentary career ladders in LTC already exist; hers led from food service to caregiving. Rose found her original nursing home job through an acquaintance: "I heard about the job opening from a man where I was working. He said they needed a cook at Warner's. I was trained at a nursing home."

DCWs' Social Networks Overlap

DCWs' social network sub-categories (friends, family members, casual acquaintances, and professional colleagues) are not exclusive; they often overlap. For instance, DCWs' professional colleagues are also frequently family members or friends. Claudia, a 57-year-old white woman with 34 years' experience in LTC, came to her current facility over five years ago because of a family member who was employed at the facility: "My sister was activities director at the time." Likewise, Faith, aged 56, white, with a 10th grade education, found her job through extended family connections to the administrator: "Because I know Jan. My sister-in-law and Jan are kin. She asked me to apply as they were looking for people." Faith has worked at her current facility for four years, and she has 25 years' experience in LTC.

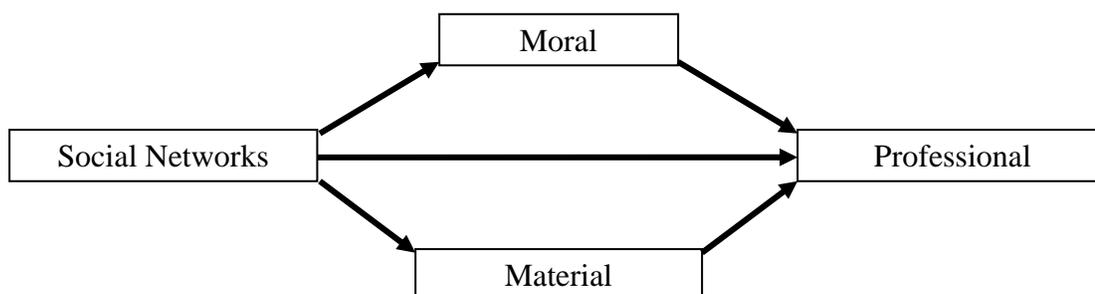
The overlapping of *social network* categories exposes the arbitrariness of separating professional from personal, or familial, networks for DCWs. For many DCWs, these boundaries are blurred, and they consider the same individuals friends, family members, *and* colleagues. Such boundary-crossing of social networks mirrors the venue-crossing influence of social networks on DCWs' motivations. That is, DCWs are

motivated for LTC work by social networks that cross social categories, and these social networks lead DCWs to LTC, AL, *and* their particular facilities. In contrast, other motivators, like the professional stepping-stone motive, are particular to just one level of LTC employment. Workers aiming for careers in nursing come to LTC for professional reasons, but these reasons do not guide them to seek employment specifically in AL or particular facilities.

Relationships between Motivations for Employment in LTC

Cultural values and motivations for employment in LTC are split between moral and material meanings, with social networks supporting both. Friends and family members reinforce moral values, including the importance of taking care of each other, and they also support material motivations by guiding workers to jobs when they need income. In turn, both moral and material values support professional aspirations for nursing careers, the achievement of which would entail *both* helping others and meeting one's financial needs. These supportive relationships between motivations are depicted in Figure 5.

Figure 5: Mutually Supportive Motivations for LTC Employment



Inconsistency between Moral and Material Motivations

In contrast to those motivations that support one another, moral and material motivations are not mutually supportive. For Ethel, minimal economic compensation was acceptable because she had an income cap that allowed her to qualify for subsidized housing. However, many DCWs are led to LTC by both moral values *and* financial needs. Though moral and material motivations commonly coexist, some consider these goals to be inconsistent. For example, a woman with over five years' experience in LTC initially explains her path LTC in moral terms, but ultimately acknowledges that her primary motivations were material: "I just like taking care of people—I have that helping. We don't make a lot of money. *Really* to get some extra money." Similarly, an administrator acknowledges the inconsistency between moral and material motivations when describing what she looks for in a worker: "The toughest part is finding someone with the commitment, who is willing to work for the wage, and *not* someone who is working for a paycheck."

When evaluated, moral motives are considered a legitimate reason for choosing care work, and material motives are not. A woman with over 15 years' experience explains her view: "When you are caring for people, you do it right. People are not a commodity, and you have to really *give* yourself. I look at *all the people* as my mother or my father and I think about the type of care I would want them to have. But everybody is not like that. For some people, it is just a job." Similarly, a DCW who has been working in LTC for 17 years acknowledges both the coexistence and inconsistency between moral and material motivations for employment in LTC: "People get into this stuff for different

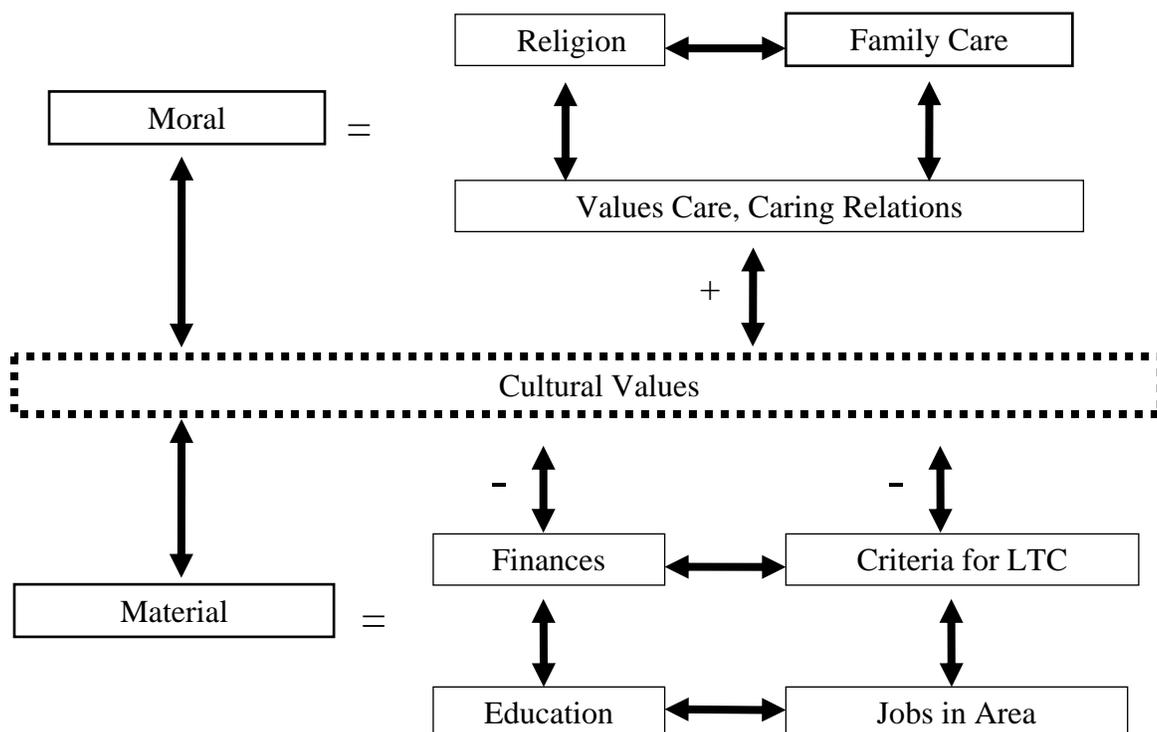
reasons. . . I don't know if they think it is money or what, but nursing has never been about money... I used to say people were in it to help people, but that is not always true.”

Summary of Motivations for LTC Employment

The four ideal types of motivations for LTC (moral, material, professional, and social networks) derive from moral and material values and reflect how these values work; they either support one another or are inconsistent. A conduit to LTC, DCWs' social networks support moral, material and professional motivations for direct care employment as well as the values that underlie these motivations. Moral and material motivations and values are *also* mutually supportive of professional motivations. In contrast, moral and material values are not consistent. The moral value of direct care work is high, but the material value of direct care work is low. DCWs' motivations for LTC employment, as a result, depict a reconciliation of these inconsistent values.

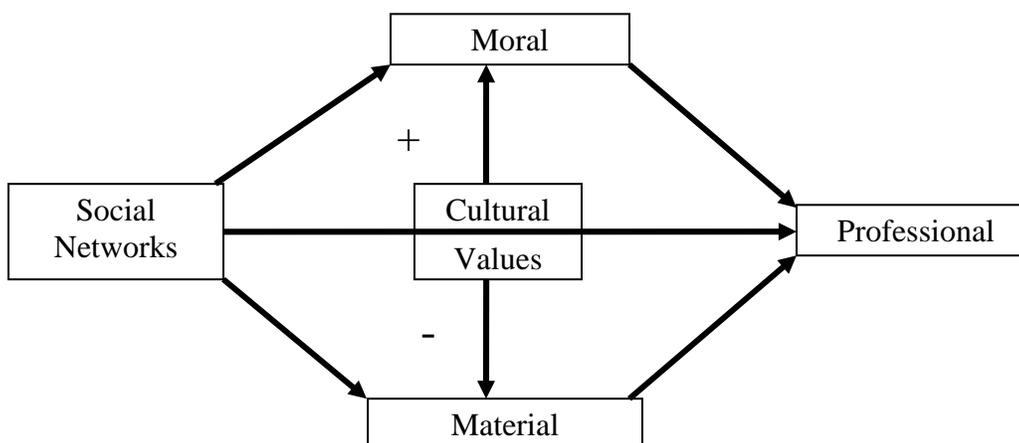
The inconsistency between moral and material values, or meanings of care work, is depicted in Figure 6. Cultural values support the moral value of, and moral motivations for, care work, but downgrade its material value, and material motivations. Specifically, families and religions *support* moral values for care and caregiving relationships, in general, the value for taking care of others. But market values drive down the criteria and pay for LTC employment, the material value of care work.

Figure 6: Inconsistent Moral and Material Values for Care Work



Cultural values and motivations for employment in LTC are split between moral and material meanings. But, as Figure 7 depicts, workers' social networks support both moral values and motives and material values and motives. Friends and family members reinforce moral values, like the importance of taking care of each other; but they also support material motivations by guiding workers to jobs when they need income. In turn, both moral and material values support professional aspirations for nursing careers, the achievement of which would entail both helping others and meeting one's financial needs.

Figure 7: Relationships between Motivations for LTC Employment



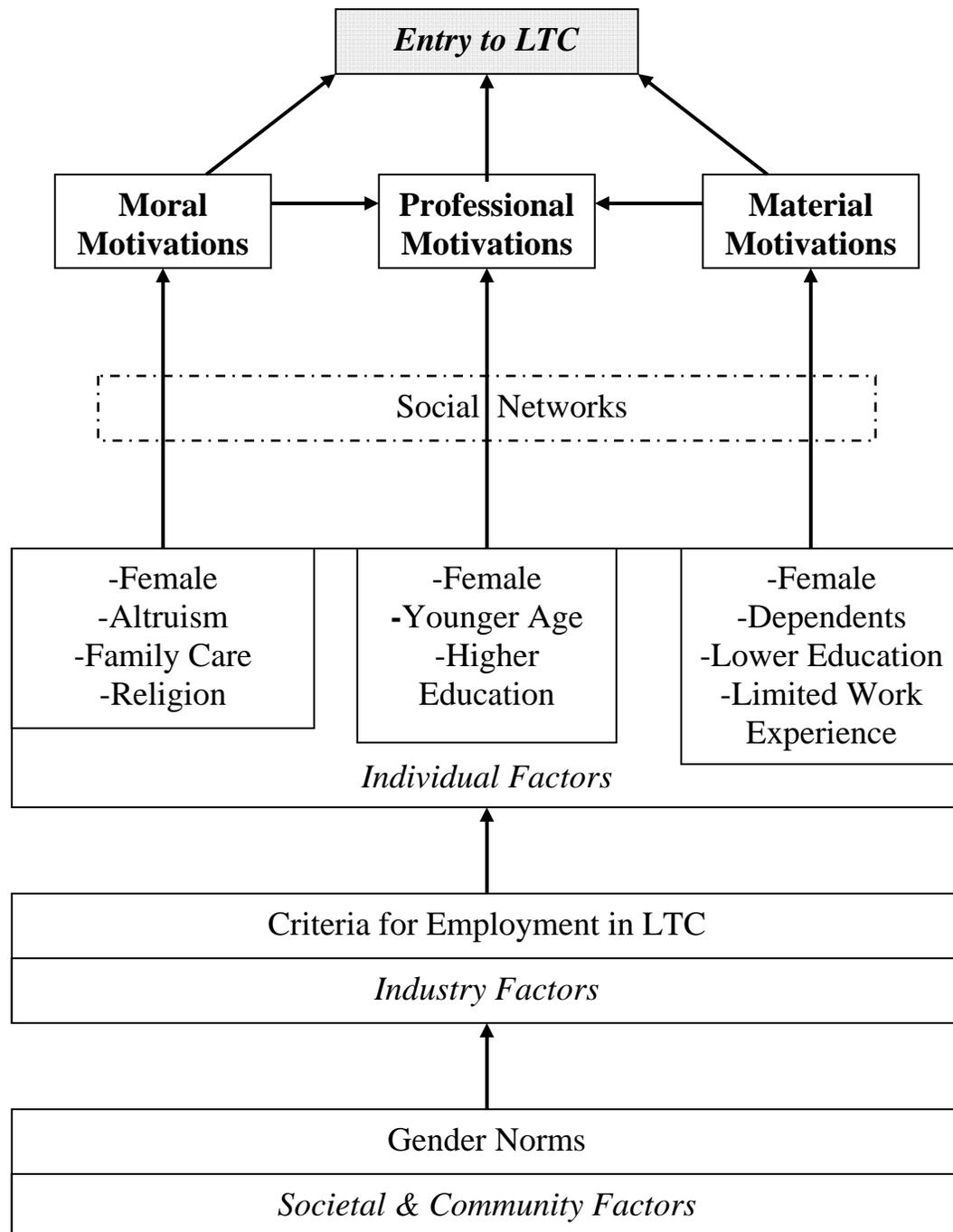
Individuals come to work in LTC for material and moral reasons; they need income and want work that is consistent with their values. Due to DCWs' socio-economic characteristics, such as their limited educations and employment histories, they have few employment options; only a sliver of their job options would fulfill both their economic and ethical needs. Care work fits a unique niche of entry-level employment; it both exemplifies cultural values of caring for others, which families and religions socialize people to embrace, and offers some economic security.

Both care work's ethical and economic meanings are apparent to DCWs, and many report being motivated to work in LTC by both moral and material considerations. Other DCWs expressly report being motivated for care work by either economic or ethical reasons; many admit that they are actually concerned with both, though one is more urgent or prominent in their minds. Additionally, of those DCWs motivated by both

moral values and material needs, some enter direct care work as a stepping-stone to a more professional and better paying health care career. These DCWs generally believe that a career in nursing or LTC administration would both meet their material needs and match their moral values. As such, these careers represent the promise of holistically satisfying, unalienated work, where employees enact meaningful labor *and* meet their material needs. However, becoming a nurse or acquiring some other professional caregiving job is a *goal* for DCWs, not a current reality: DCWs view LTC employment as a stepping-stone to these satisfying careers. As a stepping-stone, LTC has few requirements for direct care jobs, making them available to low-skill workers. However, opportunities for advancement are limited in LTC. As a result, workers who are professionally motivated leave LTC or redefine their motivations in moral terms. Moral redefinition of motivations for LTC employment follows from characteristics of direct care jobs. Though care work integrates ethical and economic meanings, it fails to provide a balance between these disparate spheres. The high moral value for caregiving that draws so many workers to LTC is not matched with a high economic value.

The inconsistency of care work's ethical and economic values is a strain for DCWs. They labor in poverty, caring for others, but most receive no health care benefits through their work. They do their god's will, but are marginalized in the world of men. DCWs are an at-risk, poverty-laden workforce, at the core of an at-risk long-term health care system. Their motivations for LTC employment reflect an influence of multiple factors which result in entry to LTC and thus have important implications for addressing the care crisis. DCWs' motivations for employment in LTC are summarized in model-form in Figure 8.

Figure 8: DCWs' Motivations for LTC Employment



CHAPTER 6

MOTIVATIONS FOR AL EMPLOYMENT

Overview of Motivations for AL: Maximizing Employment Options

LTC fits a unique employment niche that attracts minimally educated workers for moral, material, professional and social reasons, but within the field of LTC are several employment options, including nursing homes, in-home care, and assisted living.

Understanding DCWs' motivations to work in a particular setting provides an important perspective on how long-term care workforces develop. Because assisted living is the most rapidly growing long-term care venue, understanding DCWs' motivations to work in AL is particularly important.

Care workers enter LTC to satisfy their disparate economic and moral needs, but their motivations for AL illustrate a dynamic of *maximizing employment options*.

Choosing to work in LTC, or to do any work that merges economic and moral meanings, can limit one's job options. However, care workers choose to work in AL to maximize their options in the context of LTC. That is, many DCWs choose AL because they believe working in AL is superior, in terms of both *care* and *work*, to nursing home employment or providing in-home care.

Care workers choose AL over other LTC settings, for three primary reasons: (1) care-centric, moral motivations; (2) work-centric, material motivations; and (3) environmental reasons. Like DCWs' motivations for employment in LTC, these three primary motivations for AL are supported by DCWs' social networks.

Distinguishing motivations that are care-centric from those that are work-centric highlights some of the discrepancies that are experienced by care workers and implied by the conceptual conjunction of *care* and *work*. The discrepancy between care-centric and work-centric motivations for AL also further elucidates the distinction between DCWs' moral and material motivations for LTC employment. In general, care-centric motivations follow from moral values and work-centric motivations follow from material considerations.

DCWs' environmental motives for AL employment include, primarily, the attractiveness and cleanliness of AL environments in comparison to nursing homes. DCWs' social networks inform them about care-, work-, and environmental-features of AL, and ultimately guide them to AL employment. The percentages of DCWs to report each type of motivation are summarized in Table 9.

Table 9: DCWs' Motivations for AL Employment

Motivation	% of DCWs
Care-Centric Motivations	46
Work-Centric Motivations	36
Environmental Motivations	7
Social Networks	11

N = 400

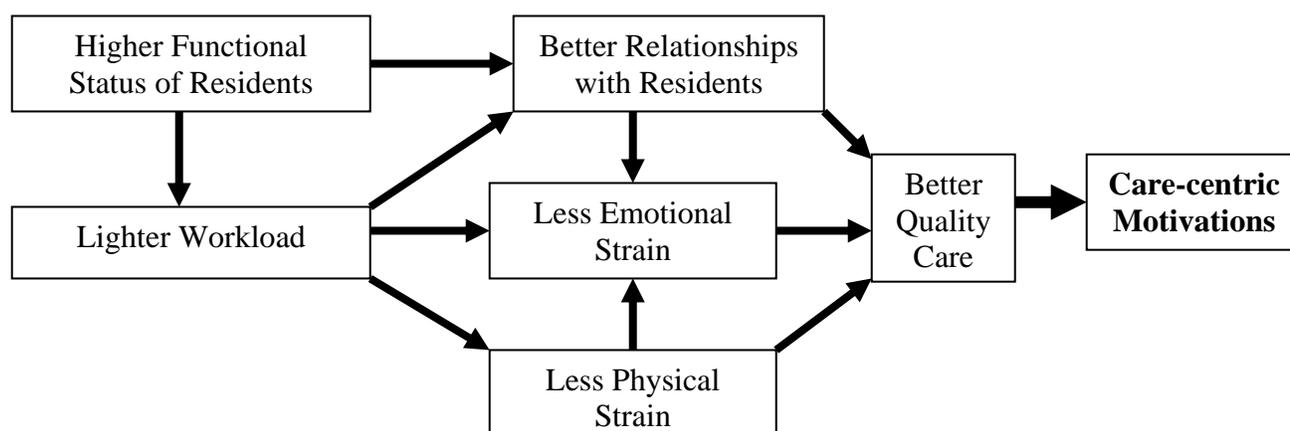
Care-Centric Motivations for AL Employment

Care-centric motives for AL reflect the moral values that draw DCWs to LTC, particularly the principle of caring for others, and show the consistent influence of moral principles on DCWs' employment decisions. Almost half (46%) of the sample expressed care-centric motivations for choosing AL. DCWs' primary care-centric motivation is the desire to provide high quality care. That is, DCWs expect to be able to provide higher quality care in AL than would be possible in a nursing home. This expectation is grounded in their beliefs that compared to nursing homes; AL serves more functional residents (mental and physical functioning) and entails lighter workloads. DCWs believe these factors will contribute to better relationships with residents and less physical and emotional strain. Neither exclusive nor independent, these factors often interact and guide workers to AL. For example, one DCW, who had previously worked in a nursing home, preferred AL because there are fewer residents per staff person, the residents are not as frail, and due to these factors, she was able to spend more time with the AL residents, and she enjoyed "being involved in what they do."

Overall, AL employment is more attractive to DCWs than nursing home work because the higher functional status of AL residents lightens workloads, which supports relationships with residents and, in turn, benefits care quality and reduces emotional strain. Residents who function at a high *physical* level require less assistance, which lightens workloads and lessens physical strain. Lighter workloads also give DCWs time to develop closer relationships with residents and to provide high quality care, both of which reduce the emotional strain of care work; establishing relationships with residents is, in turn, emotionally rewarding for DCWs. Residents' higher *mental* function supports

the development of relationships with DCWs and enhances care quality primarily because of increased opportunities for communication. Dementia also heightens physical care needs, which increases workloads and the physical strain of care work, in turn decreasing care quality *unless* staffing is increased accordingly. Illustrating the dynamism of AL and the linkage between facilities' resident populations and DCWs' experiences, many DCWs report their workloads have increased over time as residents' functional statuses have deteriorated. Additionally, DCWs who work primarily with residents in specialized dementia care units are more likely to report that their work is as strenuous as nursing home work. Summarily, DCWs are attracted to AL by its promise of higher care quality, but many factors influence actual care quality outcomes. Care-centric motivations are modeled in Figure 9.

Figure 9: Care-centric Motivations for AL vs. Nursing Home Employment



Case Examples' Care-Centric Motivations

Ethel and James express care-centric motivations for AL. The story of Ethel—the older care worker, illustrates consistency between the moral values for employment in LTC and care-centric motives for employment in AL (as opposed to material values and work-centric motives). Overall, 45% of DCWs who came to LTC due to moral motives came to AL with care-centric motives. Ethel explains how her attraction to AL rather than to nursing home work was rooted in expectations for higher care quality:

What really impresses me about the whole thing (AL) is that if we tell them (administrators) we need something in helping to care for the residents, they're not very long getting it for us, and I had been to the nursing home with my mother, which I wouldn't name, but I tell you I didn't have much respect for them, that nursing home. . . .When I came here I was just amazed at the difference.

Unlike most DCWs, Ethel is in the unique situation where she needs low income. Consequently, her motivations, in contrast to other DCWs, are very clearly care-centric and value-laden rather than work-centric or economic: “I can only make so much money. . . . I draw my Social Security and that's my living.”

Similarly, James chose AL because he expected the residents would be more independent than in a nursing home: “I like assisted living because there is still a lot of stuff that they can do, and they still have a lot more freedom than a nursing home. In a nursing home there is more skilled nursing, in assisted living it is not.” Additionally, James expected the AL environment, compared to “overcrowded” nursing homes, to be more conducive to building relationships with the residents: “In assisted living you can do more one-on-one with them than you can in a nursing home, because the nursing home is overcrowded.”

DCWs' concerns about residents' functional statuses, care quality, relationships with residents, workloads, and emotional and physical strain are tightly interconnected, and all represent care-centric motivations. The following descriptions of each factor illustrate how they influence DCWs' entry to AL, both separately and in combination with other factors.

Workload and Physical Strain

About 25% of the DCW sample said they chose AL over nursing homes because they expected workloads would be “lighter” or “easier.” Workloads are the most popular reason DCWs give for coming to work in AL rather than another LTC setting. DCWs' attraction to AL workloads is influenced by numerous factors, including (1) personal characteristics, especially DCWs' employment histories, values for care quality, and age and physical health; (2) job characteristics, including the availability of employer-provided benefits, staffing ratios, and residents' functional statuses; and (3) community characteristics, especially long-term care staffing regulations and health care policies.

For some DCWs, the expectation that AL will be easier than nursing home work derives from their experiences working in nursing homes. For example, Dena, who had 10 years of nursing home tenure, came to AL because: “There is too much work in a nursing home—no time to give attention to residents.” Another DCW expressed similar care-centric motivations: “Nursing homes are so rigorous, a lot of work, low level of care. At assisted living; it's just assisting, you have more quality time with the residents.” Yolanda, who worked in a nursing home for just one year, had a similar viewpoint: “It's easier to work in assisted living. I worked in a nursing home for one year, and it was

terrible: hard work, overworked, because there was only one resident aide assigned to 12 to 15 helpless people.”

In contrast, other DCWs drew on the experiences friends when making job decisions. Gina explains how her friends’ attitudes about nursing home workloads guided her to AL: “It’s not as hard as nursing home. I have some other friends who have worked in nursing homes and complain about the work there.” DCWs who are older or who have health problems are particularly drawn to the lighter workloads of AL. As Christa explains, “I like assisted living. I heard nursing home work is very hard. I am old myself (60) and it would be difficult for me.”

Age was a contributing factor in some decisions to choose AL. Beatrice, a 61-year-old woman explains: “With my age, my health wouldn’t hold out with heavy lifting.” Laurette—one of the oldest DCWs in the sample—said: “I’m not as able to do as much work now as I’m seventy-five.” Physical health concerns also were influential. “I have back problems and I can’t lift,” explains Kerry, age 36. Likewise, Ebony, a 25-year-old, reports that fear of injury influenced her choice of AL: “In the nursing home, the work is more difficult and easier to get injured.” Similarly, Jana, a 46-year-old woman explains, “Nursing homes are too much with my bad knees.”

The workload motivation also is supported by job characteristics, particularly the availability of employer-provided health insurance. A woman who has been a CNA for over 20 years and has 18 years’ experience working in nursing homes describes her aversion to nursing home work and relates it to an awareness she gained through her social network: “I am older now and cannot lift—hurt my back. My mother worked in a nursing home and hurt her back. There are 18 to 19 people to care for in a nursing home.”

Since this DCW, like many (over 40% in this study), has no health insurance, concerns about workload-related injuries are an understandable motivational factor. The numerous reports of DCWs who come to AL rather than nursing homes because they fear injury attest to the influence of both staffing ratios and employer-provided health insurance on care workers' motivations.

Despite the attraction to AL, some DCWs have been disappointed to find workloads in AL as demanding as in nursing homes. A DCW with over eight years of experience in nursing homes and over four years in AL explains: "I thought it would be easier on my back, but it is not easier. It is nursing home work." A DCW who has found her AL job negatively affects her health similarly reports, "I figured assisted living wouldn't be as much care, pulling and lifting people, but it is; I was fooled." Another DCW, one who had worked in a nursing home for six years, explains the process whereby her AL workload has become increasingly heavy: "I figured it would not be as hard, that there would be less residents to work with. As years went by, this facility came to be like a nursing home." Similarly, another DCW explains: "I thought it would be a little bit easier, but some days I think I am still in the nursing home. . . . I think all facilities start that way. Start out saying assisted living, but once you get in there it is a totally different story."

Relationships with Residents

Five percent of workers report taking employment in AL rather than another LTC setting due to their expectations that relationships with residents will be better. As noted, this expectation is integrally linked to job characteristics in these settings, especially the number of residents DCWs care for and the residents' functional statuses. DCWs'

employment experiences and their social networks inform them about developing relationships with residents. Sally, a 42-year-old woman with 17 years' tenure in LTC and three years' in her current facility, explains her decision: "I got tired of the nursing home—running too short on help. Somebody told me about assisted living, and you get to do more one-on-one, and it's not as stressful as the nursing home." Similarly, Molly, who has worked in nursing homes and assisted living, explains how her employment history informed her decision to work in AL: "I've worked in both assisted living and nursing homes; it's a challenge in both. Here there are people [residents] you can communicate with, can listen to their stories more efficiently than in nursing homes." In addition to paid employment experience, DCWs' volunteer experiences support their expectation that relationships with residents will be superior in AL compared to nursing homes. Julie explains: "I volunteered at a nursing home and didn't like it. . . . At least here they can talk to you."

DCWs expect opportunities for closer relationships in AL, as Anita, who had worked in nursing homes for four years and in assisted living for two, explains: "The residents in assisted living become our friends." Others note the ability of residents to offer them rewards. One DCW explains: "This is better because they can do more on their own—it's not just wiping butt. And they can give more back too." This ambiguous reference to residents "giving something back" refers to AL residents' ability to contribute to relationship-development, particularly through communication. This view is expressed by another DCW: "I feel assisted living is more suitable for me because in the nursing home there is an illness difference. Some may talk and some may not talk. In

assisted living you help them, but they can mostly do for themselves, and they will talk more with you.”

The promise of developing relationships with residents is an attractive feature of AL, especially in contrast to nursing homes. DCWs recognize that lighter workloads enhance the ability to establish relationships with residents. However, the expectation that AL workloads will be light and AL residents’ functional statuses will be high is often unmet. When this happens, DCWs’ ability to develop relationships with residents is jeopardized.

Emotional Strain

DCWs’ expectations about their relationships with AL residents were influenced by their ideas of workloads in this setting: They perceived the development of meaningful relationships with residents as more likely in situations where workloads are lighter or more manageable. These expectations also shaped their notions of the emotional strain that work in either setting would entail. The high dependency of nursing home patients repelled many DCWs, thereby attracting them to AL. For many, nursing home work seemed far too depressing. Overall, nine percent of DCWs (n=37) chose employment in AL because they expected it would be easier emotionally, with less likelihood to cause depression or stress.

Both experienced and new DCWs chose AL over nursing homes due to the lighter emotional strain in AL. When asked why she came to work in AL rather than in a nursing home or a home-care setting, a DCW who previously worked in both settings simply explained: “Nursing homes are very stressful, more so than assisted living.” For some DCWs, the emotional stress of nursing home work derived from the quality of residents’

health. A DCW who has worked in nursing homes and in a total of six different AL facilities explains: “I never want to go back to nursing home work. It is too much mentally—dealing with a lot of sick people. I had nightmares about the residents. Assisted living is easier.” Similarly, Vera, a first-time care worker, experiences emotional strain when she must care for people who are in very poor health; this has prevented her from working in nursing homes:

I will go to the nursing home but it kind of affects me when I see them, I hate to see anybody really sick. . . . With them I feel like I just couldn’t help them enough, even though I would like to help them. . . . That is always how I have looked at it when I was growing up. I had some people I would go visit in the nursing home, and I didn’t think I would be able to handle it. I don’t know, I might could.

For other DCWs, the emotional strain of nursing home work derived from the deaths of residents. A researcher describes why a DCW who had previously worked in a nursing home came to work in AL: “She feels assisted living work is less physically and emotionally demanding than a nursing home. She said when you ‘care for someone, you begin to care about them.’ It was hard for her at the nursing home when residents died.”

In sum, the expectation that AL residents are more lucid and have higher abilities to communicate in comparison to nursing home residents is important because it supports the notions that relationships with residents are possible and that emotional strain is minimal in AL, both of which attract workers. However, like DCWs’ expectations of AL workloads, their expectations of emotional strain are not always met. For instance, one DCW explained that her attraction to AL was based on the false notion that few residents would die: “I didn’t really want to get into a situation where I knew people were going to die soon. But it still happens here.”

Quality of Care

The confluence of concerns about workload, relationships with residents, and emotional strain attracting DCWs to AL suggests that, as a whole, DCWs are genuinely concerned about the quality of care they provide. After all, quality care is difficult to provide if workloads are too heavy or relationships are non-existent. Twenty-eight DCWs (7%) report coming to work in AL rather than in a nursing home because they believed the quality of care in AL would be superior. A few of these DCWs particularly expressed concern that nursing home residents are neglected or abused.

DCWs' employment histories and social networks support their belief that care quality is better in AL. Drawing on her nursing home experience, Chandra, a 40-year-old African American with five years LTC experience and about 10 months' tenure in her current facility, explains how her concerns about care quality led her to work in AL: "I left the nursing home because I did not like the way they treat the elderly. I feel guilty if you do not say anything about it. They do not get the care and attention they need." Likewise, another DCW who had previously worked in a nursing home explains how her employment history contributed to her decision to work in AL: "I did not like the nursing home; the residents were not treated right. They were being abused and I did not like that." Another DCW similarly reports that she came to AL because her experience working in a nursing home led her to believe the quality of care in AL would be superior: "The CNAs were abusive—physically and verbally—at the nursing home. I saw too much. Assisted living is a better environment."

In addition to active abuse, more passive neglect in nursing homes repelled many DCWs and attracted them to AL. Thus, *lack of attention* was a prominent theme in

DCWs' descriptions of nursing home care. One DCW contrasted the neglect in nursing homes to the personal care of AL: "People don't get the attention they need in nursing homes. You can give more of yourself, be more personal, in assisted living." Similarly, Cora, a 41-year-old woman with over 20 years LTC experience, came to AL because nursing home workloads are too heavy, which prevents DCWs from giving patients the attention they need: "There's too much work in the nursing home; no time. You cannot give attention to the residents."

In addition to DCWs' employment histories, their family experiences support the belief that AL care is superior to that of nursing homes. Some care workers' family members received poor care, or were even abused, in nursing homes. One DCW related how her grandfather had been abused in the nursing home. Her family did not believe him when he told them he was being beaten, because he had dementia, but they found it was true. This report highlights a serious concern about long-term care: residents with dementia may be abused but have little hope of stopping the abuse. Another DCW removed her father from a nursing home because of poor care. As these examples indicate, family members' experiences in LTC influence DCWs' employment decisions, including their choice of AL employment.

Job characteristics, like staffing ratios, also bolster the belief that AL care is superior to nursing home care. Several DCWs specifically claim that low staff to resident ratios in nursing homes prevent quality care and intensify workloads. For example, an immigrant care worker from El Salvador came to AL because she felt nursing home staffing ratios limit care quality and cause emotional strain: "The assisted living care is more for the people. In nursing homes, there are too many residents, you can't help them,

you don't have time to really help people, make sure they're clean, they eat, are feeling well. In nursing homes, it's a broken heart." Like moral values for caring for others, care-centric motivations and concerns about care quality transcend ethnic and cultural boundaries, as well as age differences.

Concerns about nursing home care quality stem not only from personal experiences. Rather, word-of-mouth alerts some DCWs to care quality issues in nursing homes and motivate their entry to AL. As one DCW explains why she came to work in AL: "The nursing homes – I have heard horrible things about their care." The influence of DCWs' social networks on their motivations for AL employment is discussed in detail below, in the section *Social Networks Guide DCWs to AL*.

Work-Centric Motivations for AL Employment

In contrast to care-centric motives, some motives may be described as *work-centric*. Work-centric motivations are those that emphasize employment itself rather than the content of direct care jobs. Work-centric motives for AL reflect the material motivations that bring DCWs to LTC. Over one-third (36%) of DCWs report work-centric motivations for AL employment. These motivations are depicted by DCWs who take AL employment because AL jobs are more stable than in-home care positions, as well as DCWs who come to AL because the pay and benefits are superior to those in nursing homes or in-home care. Additionally, DCWs who come to AL simply because an AL employer is the first to offer them a job are categorized as having had work-centric motivations. Work-centric motivations are modeled in Figure 10.

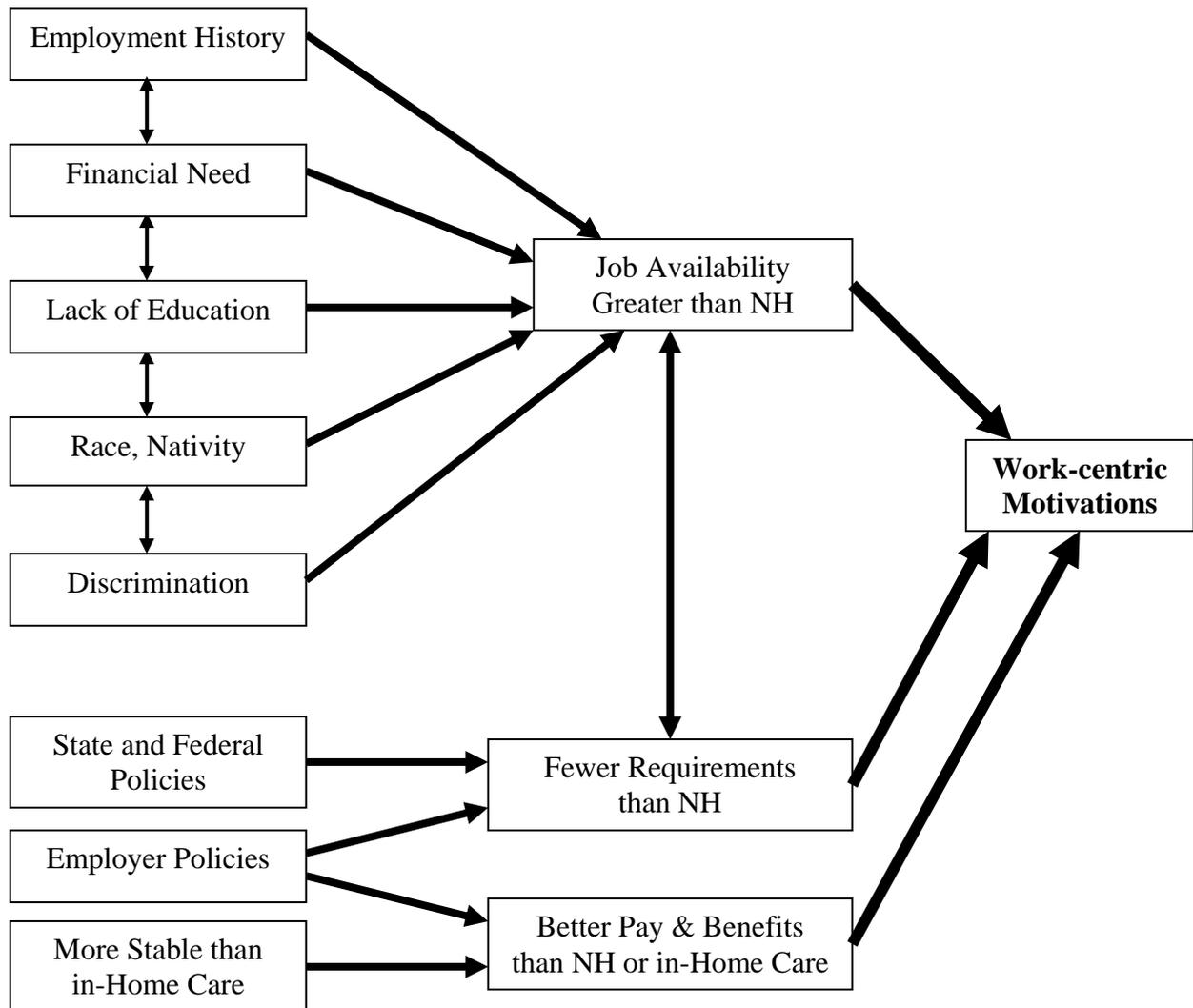
In contrast to James and Ethel, who came to AL expecting the care quality would be superior to that of nursing homes, Debbie did not consider issues of care quality when she took a job in AL. Debbie's motives for AL employment were work-centric rather than care-centric. She was homeless and unemployed and specifically came to work in AL because an AL employer recruited her, at a homeless shelter, for a live-in position. Most DCWs more simply need steady income, but both Debbie and these other DCWs come to AL for reasons that may be considered work-, rather than care-centric.

The primary work-centric motive is job availability. For DCWs, job availability is supported most strongly by the minimal amount of training required for AL employment. The lack of required training for AL leads many DCWs, especially those who are not CNAs, to choose AL over nursing homes. Additional work-centric motives for AL employment include the relative stability of AL jobs, pay and benefits. The relative stability of AL work leads many DCWs to choose AL over in-home care.

Job Availability

About 28% of DCWs took employment in AL because of job availability, including those who specifically came to AL because the training requirements are less stringent compared to nursing homes. DCWs' socio-economic characteristics and educations, as well as their race, nativity, and employment histories, influence the extent to which job availability attracts them to AL. Job characteristics, especially criteria for employment, also are influential, and are themselves dependent on state and federal policies, as well as individual employer preferences.

Figure 10: Work-centric Motivations for AL Employment



Because DCWs are relatively poor and poorly educated, they commonly confront financial and employment needs. As a result, the prevalence with which DCWs report coming to AL simply due to job availability is not unexpected; their poverty and lack of training make almost any available job important to consider. Debbie's story illustrates the economic desperation experienced by some DCWs. Further illustrating DCWs' economic need and lack of employment options, many DCWs did not particularly choose to work in AL but applied for employment in multiple care settings and took the first job they were offered, which in some cases was AL. Some DCWs were not even aware that they were applying to AL facilities, but ended up working in one simply because it was their first employment opportunity: "I didn't know it was assisted living until after I got hired. I needed a job and was applying everywhere, trying for two months."

For some DCWs, race and nativity support the influence of job availability on their motivations for AL employment. Some DCWs specifically cite workplace discrimination as limiting their employment opportunities and leading them to AL. In the words of one DCW, AL is "a place you could work with an accent. Georgia does not want people with accents in office work." However, discrimination on the basis of applicant's accents occurs in AL as well. The administrator and part-owner of a small AL facility explains: "I hate to say it, but one lady I turned down was of Indian heritage and I had a difficult time understanding her." Immigrant workers are becoming more prevalent in LTC (Redfoot and Houser 2005), making race, nativity, and language particularly relevant factors to care workforces.

Requirements for employment, especially training and experience, greatly influence the extent to which job availability attracts DCWs to AL. Almost half (n=40) of

the DCWs who came to AL because it was their first employment option had never before provided formal care to an older adult. Twenty-three had never worked in any care setting, and 17 had never worked in a nursing home or in home care; five had cared for a family member. Federal law requires DCWs to have a CNA for nursing home employment, and this requirement motivated many DCWs to work in AL instead. In Georgia, there are no training or educational requirements, except first aid and CPR, to gain employment in AL. As a result, the costs associated with completing and maintaining CNA status made AL a more viable option for many DCWs. Overall, seven percent of DCWs were specifically attracted to AL because the training requirements were minimal. As one DCW explained: “Nursing homes require a license, and I do not have a license, and I get on-the-job training here.” Similarly, another DCW reported: “The nursing home, you really had to have a CNA license to work there, unless you worked in housekeeping and I didn’t want to do that. Over here we don’t have to have a CNA to work.” Another DCW compared the level of experience desired by nursing home and AL employers: “The nursing home wants you to have experience with the elderly. They tried me here right away.”

Among those DCWs who come to AL without long-term care experience or knowledge, eight specifically chose AL employment as an entry-point to long-term care. Illustrating the greenness of some AL DCWs, one explained: “I never worked in a nursing home before. I don’t know what a nursing home is. I just got this job here.” Another reported similar lack of knowledge of AL: “I didn’t know it was assisted living. I didn’t really know what assisted living was.” Ultimately, the mere availability of a job

has a strong influence on DCWs' employment decisions; workers with little education find AL an attractive employment option.

Employment Stability, Pay, and Benefits

Overall, eight percent of DCWs came to AL due to the stability of employment in AL, the pay, or the benefits. Some came to AL because it offers more steady and predictable employment than in-home, private care. In-home care jobs often end when the care recipient dies. A 57-year-old DCW who has provided private care for multiple clients explained: "When you work one-on-one, it only lasts for so long." Similarly, another DCW explained how she transitioned from private care to AL work: "I started sitting with this little man and this little woman. I stayed with them until I came to work here. Off and on I still stayed with them on my two days off until they both passed away."

Scheduling stability, or consistent scheduling with clearly-assigned days off, also attracts DCWs to AL rather than in-home care. A DCW who had worked as a private sitter for 11 years and in AL for four provides an example: "I needed a break from the responsibility of home health—private duty. I'm now on an actual schedule with time off." In sum, employment stability was the primary factor guiding the decision to work in AL for several workers.

A few DCWs were attracted to AL by the availability of benefits. Their health, employment histories, and lack of health care benefits contributed to their motivations for AL employment. For example, when Grace, a 48-year-old African American woman with employment experience in nursing homes and in-home care, was asked why she came to work in AL, she explained: "I needed health insurance due to my health (heart

condition).” Another provided a similar reason: “Private home doesn’t have benefits and Clayton [current AL employer] is a good place to work.”

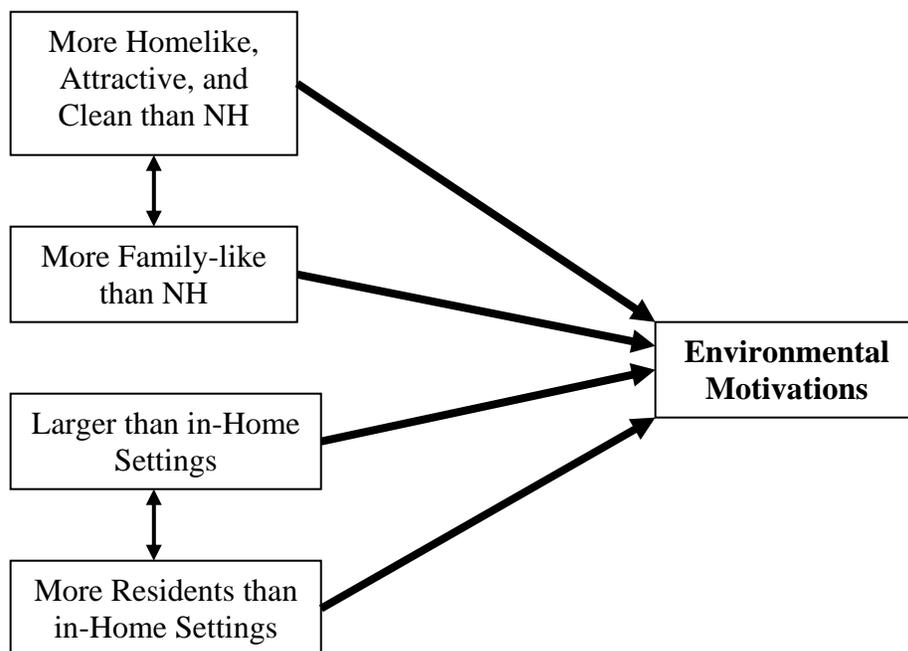
Several DCWs chose AL rather than nursing home work because they expected the pay would be more commensurate with the workload. Katrina, a 50-year-old woman with 15 years LTC experience, explains: “Nursing homes did not pay much; less work at assisted living than a nursing home.” Similarly, Veronica, a 47-year-old woman with over 12 years in LTC had a similar reason: “Nursing homes are too hard—underpaid.” Neither of these DCWs had actually worked in a nursing home. A DCW who *had* worked in a nursing home, and now in AL for four years, left the nursing home because she was “*overworked and underpaid.*”

Environmental Motivations for AL Employment

In addition to care- and work-centric motives for AL employment, many DCWs are attracted to AL by the environment, especially the home-likeness, cleanliness and size of AL facilities. DCWs find these environmental factors attractive for care- and work-centric reasons—because they support the development of relationships with residents and the provision of high quality care and because they make AL work more agreeable than nursing home employment or in-home care work. Compared to in-home care, DCWs generally expect AL’s larger physical environment and greater number of care recipients will make the social environment more enjoyable. And compared to nursing homes, DCWs generally expect the physical environment in AL will be more clean and homelike. Overall, 29 DCWs (7%) report coming to work in AL because of the environment. Several personal characteristics and job characteristics contribute to DCWs’ environmental motivations, including their employment histories, particularly their

experiences working in nursing homes or providing in-home care; their social networks; and the location of AL facilities. Environmental motives are modeled in Figure 11.

Figure 11: Environmental Motivations for AL employment



The physical environment of AL facilities, especially homelike characteristics, is particularly attractive to some DCWs. For example, one DCW describes coming to AL because it is “more homey—the setting, the people.” Another DCW similarly describes coming to work in AL because it is a “more homey, home-atmosphere.” Some DCWs believe homelike environments benefit the residents, which in turn increases their job satisfaction. For example, a DCW who had previously worked in a nursing home said: “Most of the people here consider this as home, and working for them makes me happy.” Some DCWs are attracted to the cleanliness of AL. Many particularly report wanting to avoid the “smell” or “odor” of nursing homes. As one DCW explains: “The smell of nursing homes is too much. I can’t handle it. Many residents are left up in the dirty facility in diapers and it smells bad.” As the two preceding examples illustrate, concerns about the physical environment are sometimes interwoven with concerns about care quality.

Additionally, two DCWs chose AL because they wanted to work with multiple residents. Compared to the solitude and limited physical boundaries of providing in-home care, AL provides many opportunities for interaction in a comparatively large venue. For example, a DCW who provided in-home care for eight years describes her switch to AL: “I really don’t care to privately sit; it is more confining. I like to be up and about and be around people.”

Compared to nursing homes, AL is a young institution. This newness attracted 14 DCWs to AL; they considered AL’s novelty an attractive feature within long-term care. DCWs’ employment histories were the primary factor to influence this attraction to AL. A DCW with both nursing home and hospital work experience reports why she came to

work in AL: “I didn’t want to work in the hospital anymore, and I didn’t want to work in the nursing home. Assisted living was [pause]; I wanted to try it to see if I liked it. And I do.” Similarly, another DCW explains why she came to work in AL: “I wanted to try something different.”

DCWs’ attraction to the physical environment of AL is sometimes interwoven with multiple factors. For Erin, her employment history and social network, as well as the location of the facility, all contributed to her environmental motivation to work in AL. She had worked in multiple nursing homes as well as in home health, her mother was a private sitter, and she was familiar with the AL facility where she came to work because of its proximity to her walking path:

I wanted to work here so bad. I love this house. I always walk on the trail down there, and I always tell myself I am going to work there one day. I came in and pleaded every day. Is there an opening? Can I come to work? So they finally hired me and I have been here for five years.

Not only did DCWs come to AL because, within LTC, it was a physically attractive employment option, six DCWs viewed AL as a unique setting that specifically excluded the worst aspects of nursing homes and home health. These DCWs considered AL their optimal LTC employment choice in terms of workload, emotional strain, employment stability, scheduling and pay. In general, the constellation of features that attract DCWs to AL depicts its social environment or culture.

For some DCWs, the social environment of AL is attractive because it is less depressing than nursing homes and offers more stable employment than home care. As one DCW explains: “Nursing home work is too depressing; private home work is unstable; this is the best of both.” A 35-year-old, African American DCW provides a similar explanation: “I don’t like nursing home work—I did clinical training in a nursing

home. And I don't like being one-on-one in a private home. This was the best choice if I had to work with elderly.”

Overall, the physical and social environment of assisted living is considered by many DCWs to be superior to the environments of nursing homes or in-home care. By excluding some of the unattractive aspects of other LTC settings, like the smell of nursing homes and the solitude of home health, these DCWs find assisted living offers the *best of both* settings.

Social Networks Guide DCWs' to AL

Finally, 45 DCWs, 11% of the sample, chose to work in AL because of their social connections. People who encourage DCWs to work in AL include friends, family members, casual acquaintances, and professional colleagues. Some DCWs are motivated to work in AL by family members who are residents in AL, including mothers and grandmothers. DCWs who previously worked as home-care aides or personal sitters, in contrast, often are led to AL by their care recipients. Overall, social networks guide DCWs to AL by presenting it as an attractive alternative to nursing home or in-home work.

Some DCWs who enter AL are not actively motivated to work in AL but are simply led to AL employment based on a recommendation. For instance, one DCW reports that *she was chosen by AL*: “It chose me! Just by accident. From private duty led to assisted living. I came to take care of one resident and it led to this.” Likewise, a DCW who had provided childcare in her home started working with older adults because her sister-in-law, who was a nurse, told her about CNA training, and she decided to take it. She described a subsequent visit to her current facility, in which she was “forced” to

accept her job, as “the point-of-no-return.” She has been in the job for over five years. As these two examples illustrate, DCWs’ motivations for employment are sometimes more passive than active.

Many DCWs were motivated to enter AL by friends or family who were working in AL. A DCW who lost her previous manufacturing job when the textile mill where she worked closed, reports why she came to work in AL: “I had a friend who was working here—she told me about this job.” Many women who previously worked together in factories have come, through their social networks, to work together again in LTC.

Similarly, many women who have worked in LTC for many years rely on their social networks to lead them into different LTC settings. For example, Frankie, a 59-year-old DCW with 20 years’ LTC experience, was led by her social network to the AL facility where she has worked for the past five years: “There was a position available in an assisted living facility that my friend told me about. I applied and got the job.” A broad range of female family members who worked in AL, including grandmothers, mothers, daughters in-law, cousins, sisters, and sisters in-law also encouraged DCWs to enter AL.

Overall, the influence of DCWs’ social networks on their motivations for AL employment amplifies the importance of bringing the reality of AL into line with DCWs’ expectations. DCWs who have been disappointed by the workload, their relationships with residents, or the emotional strain in AL also may dissuade prospective DCWs from entering long-term care.

Summary of Motivations for AL

Maximizing Employment Options

DCWs' motivations for AL employment are similar to their motivations for employment in LTC; moral motives for LTC resemble care-centric motivations for AL, and material motives for LTC resemble work-centric motivations for AL. Care workers tend to believe AL is superior, in terms of both *care* and *work*, that is, morally and materially, and in terms of the environment, to nursing home employment. DCWs' motivations for employment in AL rather than nursing homes, factors that influence these motivations, and the outcome, entry to AL, are depicted in Figure 12. Care workers also tend to believe AL is superior, in terms of employment or work, that is, materially, to in-home care. DCWs' motivations for employment in AL rather than in-home care, factors that influence these motivations, and the outcome, entry to AL, are depicted in Figure 13. For many DCWs, assisted living is the best LTC employment option. As a result, LTC workers maximize their employment options by coming to work in AL.

Figure 12: DCWs' Motivations for Employment in AL vs. Nursing Homes

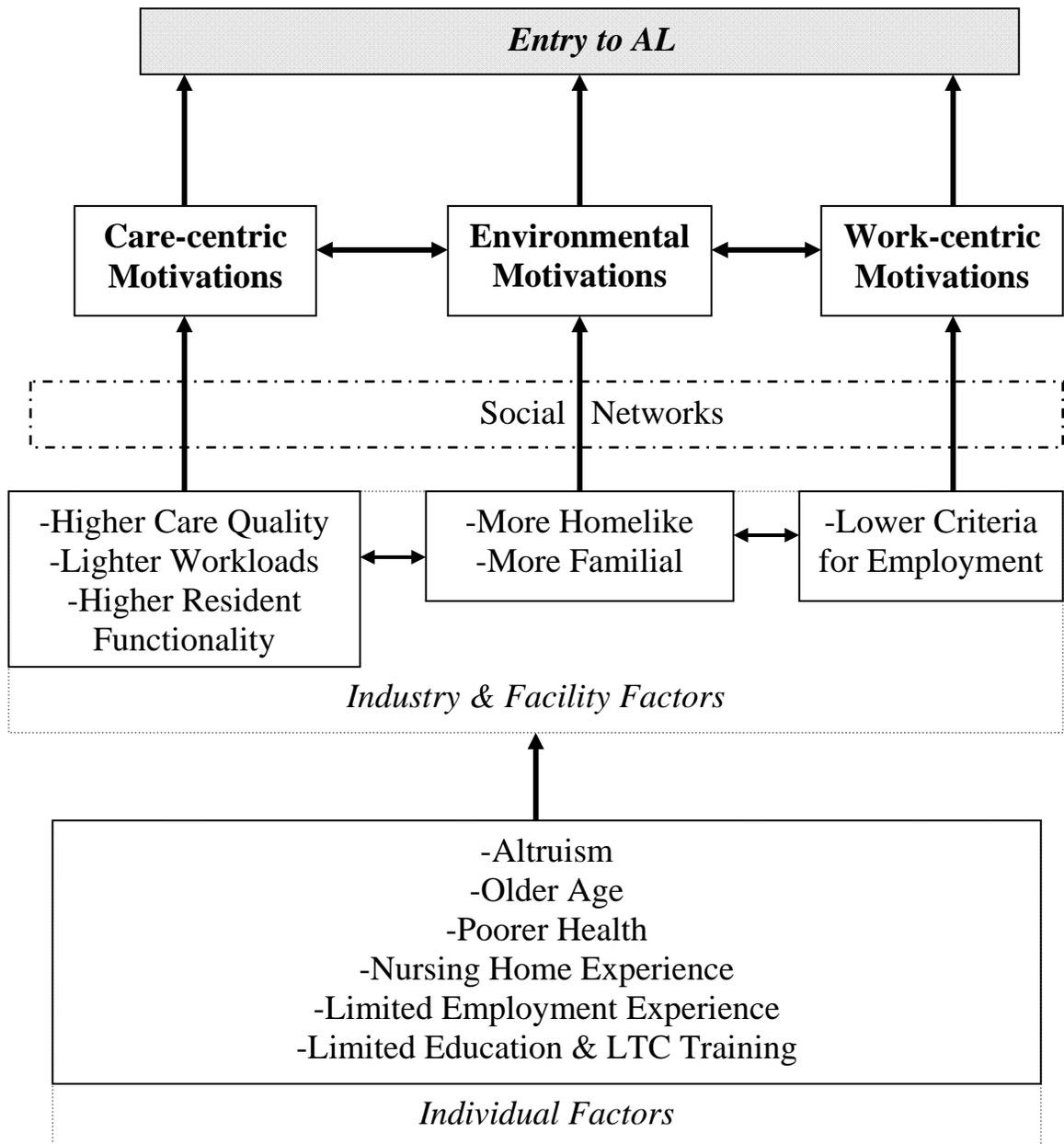
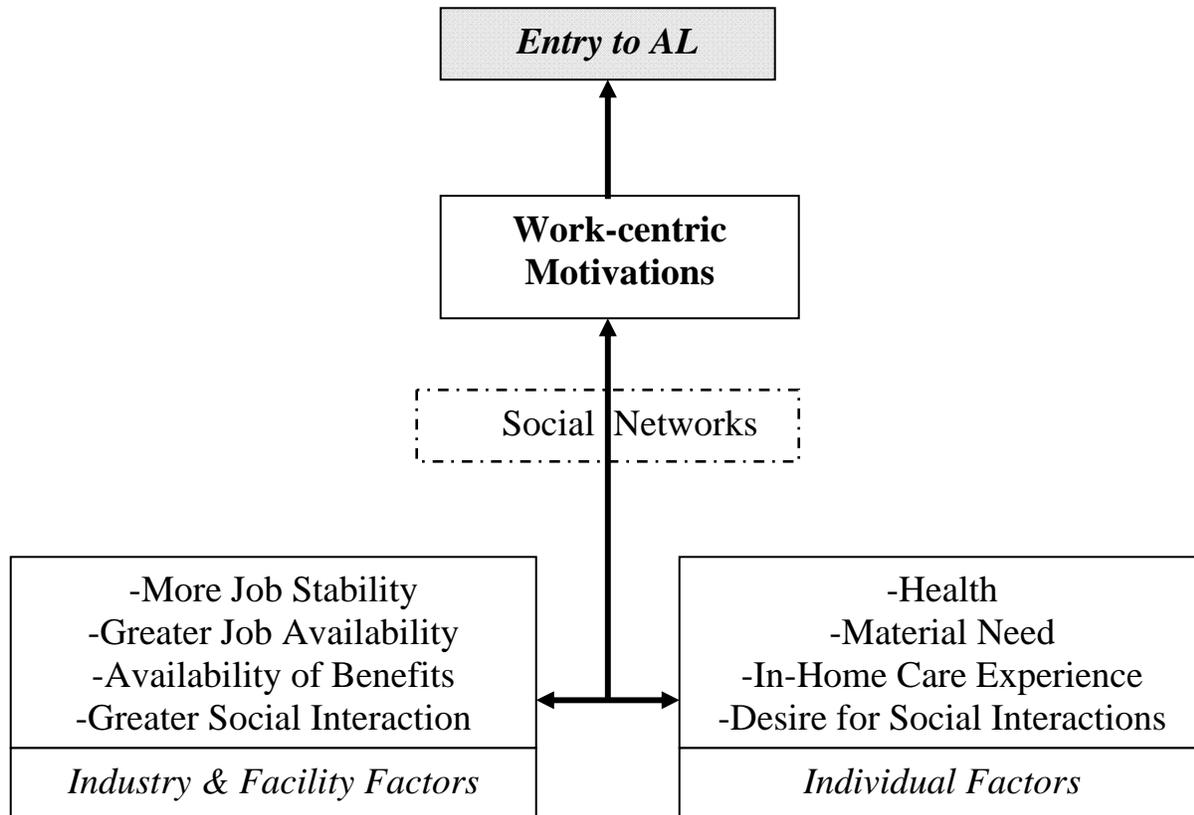


Figure 13: DCWs' Motivations for Employment in AL vs. In-Home Care



CHAPTER 7

MOTIVATIONS FOR PARTICULAR FACILITIES

Overview of DCWs' Motivations for Particular Facilities: Locating a Job

DCWs chose to work in their particular AL facilities for three primary reasons: the location of the facility, the facility's hiring strategies, and their social networks. Approximately 15% of DCWs came to work in their current facilities primarily because of its location, most often its proximity to their homes. Elaine, a 58-year-old woman with over 10 years' LTC experience, but just six months in her current facility, succinctly explained that location motivated her facility choice: "It was close to home." About 45% of DCWs came to their facilities primarily due to the facilities' hiring strategies. Della, a 27-year-old woman with three years' LTC experience, all but three months of which were in her current facility, explains why she came to the facility: "It was where I got hired." And about 40% of DCWs came to work in their facilities primarily due to recommendations made by their social networks. Nicola, a 27-year-old woman with five years' LTC experience and over three years' in her current facility, came to her facility due to a recommendation from her social network: "I met someone at my CNA course that recommended this facility." DCWs' motivations for employment in particular AL facilities are summarized in Table 10.

Table 10: DCWs Motivations for Employment in Particular AL Facilities

Motivation	Percent
Hiring Strategies	45
Social Networks	40
Location	15

Hiring strategies, location, and DCWs' social networks are interrelated in numerous ways, as illustrated by some of the case examples. James, for instance, came to his facility because of his social network, but the facility's hiring strategies were also a determining factor. When asked how he chose his facility, he explained: "I was at home minding my own business, and I received a phone call from Dayle. She is the activities director now, and she called me and asked me would I, um, come over. They wanted to interview me for the activities position. So I came over." Such active recruitment attracted other workers as well. Rosie, aged 70 and working in LTC, in her current facility, for 11 years, suggests that her employers' active recruitment strategies initially led her to the facility: "They needed a person and I got drafted."

Jonee acknowledges that her social network guided her facility choice, but her facility's hiring strategies were evidently also a factor. She had given her two-week notice at the LTC facility where she had been working (because changes in management had ruined the social environment), and she met a nurse who had already applied at the facility where Jonee (and the nurse) would come to work: "I gave them my two weeks'

notice. Then they had someone as I was leaving the job told me about this place so I applied and they called me. . . . She had just put in an application too. She is a nurse.”

Though some workers report only one motivation, hiring strategies, facility location, and social networks interact with one another. These motivations also are influenced by a variety of individual-, facility-, and community-level factors. For example, at the facility-level, employers’ affiliations with schools and training programs influence DCWs’ facility choices. Because many DCWs view their LTC jobs as a stepping-stone to a career in nursing, AL facilities that are affiliated with schools and training programs often gain professionally motivated DCWs from these programs.

Addressing how she came to work in her facility, Christa, a 60-year-old Asian American woman and rookie DCW—with three months’ LTC experience, all in her current facility, explains: “I did my internship here. I was offered the job. I have been working since.”

Even if formal links, like internships, do not exist between AL providers and schools, facilities that are located close to DCWs’ schools gain DCWs as a result of this proximity. For example, Amber, a 20-year-old woman who is also a student came to work in her facility because of its location in relation to both her school and her home: “It’s halfway between home and school.”

Location

For all DCWs, the median distance between their homes and their AL facilities was 15 minutes. For DCWs who came to their facilities because of the location, the median distance between their homes and their AL facilities was 10 minutes. Proximity to DCWs’ homes was a primary component of location to attract DCWs to particular facilities.

Though DCWs' attraction to facilities which are close to their homes could logically relate to car ownership, the availability of transportation had no effect on DCWs' facility choices. In fact, most DCWs (90%) have a car and drive themselves to work; 10% rely on rides from others, carpools, public transportation, or taxis. For one DCW, her facility furnishes transportation between home and work. Car ownership is a component of DCWs' socio-economic conditions, and this broader set of features influences DCWs' motives for employment in LTC and AL, but car ownership does not influence DCWs' attraction to facilities' locations. Rather, 15% of the sample came to their facilities due to location, but only 11% of DCWs who do *not* drive themselves to work were motivated by their facilities' locations.

Though, overall, car ownership did not influence DCWs' attraction to particular facilities, facility location and DCWs' access to transportation did interact with managerial hiring practices in determining where some DCWs would come to work. One DCW, Pat, a 37 year-old woman living in an urban area, specifically came to work in her facility because it is close to her home and she had no car. That is, facility location and access to transportation were primary reasons why Pat *sought* employment at the facility, but the administrator's practice of promptly contacting applicants was critical to her ultimate choice of facility. She explains: "It was just the first response when I applied. It was no choice, and I have no car now, but the facility is conveniently close by to home." The interaction of these multiple factors—location, transportation, and hiring practices—illustrates some of the complexity around DCWs' choices of facilities.

Facilities' physical environments also interact with location, making job availability at particular facilities a more or less attractive option. The physical

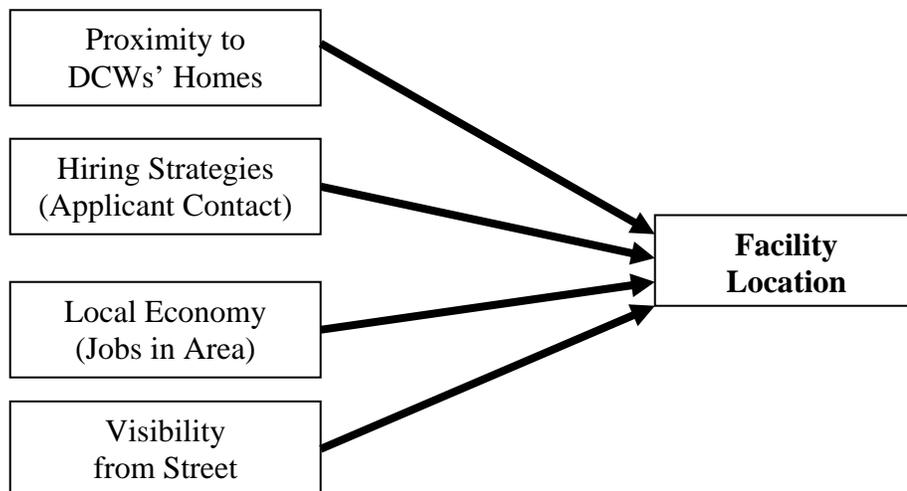
environment of an AL facility is sometimes a particularly strong motivator. One DCW, for instance, came to work in her current facility due to both the physical environment and the location: “I like it because the facility is beautiful; the view is so beautiful. It is close to home; I used to work down the road. I am glad I applied here; it is very beautiful.”

In addition to the physical environment, the social environment of a facility and the local economy in which it is embedded also influence workers’ choices. Solace, aged 47 and working in LTC, in her facility, for three years, came to work in her AL facility partially because the job options in the area where she lives are limited: “I like this facility. There’s not too many fields you can go in around here. There’s not too many jobs you can choose around here.” However, Solace’s facility choice was also influenced by the social environment of the facility: “The people are friendly here.” Similarly, Felicia, aged 25 and working in LTC for three years, came to her current AL facility three months earlier because she needed a job but knew of no other options in the area: “Just filled out application. It was the only place hiring.” Few workers acknowledge the influence of the local economy on their facility choices, but many (60%) come to their facilities in need of a job near where they live, indicating that the availability of low skill-level jobs influences workers’ employment pathways within specific communities.

Proximity to DCWs’ homes was the primary component of location to attract workers, but facility visibility also attracted DCWs. For example, Bea, a 55-year-old white woman, first came to work in LTC, in her current AL facility, because she noticed a sign beside the road: “I just stopped in to see if they were hiring; I saw the sign on the road.”

Overall, the proximity of facilities to DCWs' homes was a primary factor to influence facility choice. However, multiple factors interact with facilities' locations, including facility characteristics, like hiring practices; and community-level factors, especially local economies. The influence of these factors on workers' motivations for employment in specific facilities is modeled in Figure 14.

Figure 14: Influence of Location on Facility Choice



Hiring Strategies

Long-term care employers utilize various methods of hiring DCWs, and these strategies ultimately influence workers' facility-choices. Three employer strategies had the strongest influence: (1) the criteria for DCW employment; (2) advertising available positions; and (3) contacting applicants.

DCWs' educations and employment histories interact with facilities' requirements for employment, making certain facilities more viable employment options. Because most DCWs have limited educations and employment histories, facilities' criteria for employment have a strong influence on DCW job availability. In the same way, low employment criteria lead many individuals to become DCWs rather than nurses (see Chapter 5) and many DCWs to work in AL rather than in nursing homes (see Chapter 6).

Overall, only 11% of facilities (5 of 45) implemented a policy requiring DCWs to have a high school education. Anita, a 56-year-old African American woman with a 10th grade education, came to work in her particular facility because the administrator permitted her to work there with no care experience: "Marlene is the main reason I chose to work here. She took a big chance on me because I didn't have caregiving experience."

The professional criteria for AL employment, like education and work experience, are very low. However, such professional criteria are not the only measures used by employers to determine the suitability of applicants. Many AL administrators look for personal rather than professional qualities in DCWs; they consider applicants' physical features, attitudes, and values when making hiring decisions.

Carina, a 32-year-old African American woman with some college education and over seven years' LTC experience, believed her physical appearance (not her education

or employment experience) got her hired at her facility: “I was looking for work. I had to go some other place to drop off my application. I came in and asked if they have jobs. They liked the way I was dressed. They offered me the job.” Several administrators corroborate that an applicant’s physical appearance affects their decisions. For example, when asked what she looks for when hiring staff, one administrator explained: “We look for, of course, their appearance.” Similarly, another administrator explained: “First, appearances are number one. I mean, I’m sorry, I don’t care what the job is that you are going after, and I’m not looking for them to wear nylons and high heels; but to walk in clean, hair combed, presentable. We’re going to sit down and talk to them.”

Administrators’ appearance criteria include neatness and cleanliness. The administrator of a large facility simply explains: “We look for neatness.” Sometimes neatness and cleanliness are associated with age, class, or race. An administrator who prefers older applicants explains: “I guess I am prejudiced, but I am going to say I like the older worker in this area. . . . I have had the younger ones that come in here and they have something stuck in their nose, their clothes are horrible and they are dirty. They have on short shorts and you can see everything they got.”

A researcher describes how an administrator at a large facility evaluates applicants: “She seems to be class prejudiced. She spent time telling me how ‘they look when they come for a job interview—wearing flip-flops, tight shorts and cut down tops.’ She said she does not even consider applicants if they are that inconsiderate and dumb about how to apply for a job.”

Dana, a white woman in her thirties who was the administrator of a medium-sized facility, explains how she evaluates applicants: “When you are interviewing anybody,

their dress; if they come in in flip-flops and their belly hanging out, I just take their application and I don't even call them back." She continues: "If they come in demanding, 'I need to talk to you today; can we schedule an interview?' And they are like, 'I really want to know what you have open.' When they are like that with me; when they are making me do something; I don't even call them back. I get a lot of that here because of the location." (The facility is located in a residential area near a prison, a large discount retail store, and many gas stations.) Dana continues to explain the appearance of these undesirable applicants: "They walk in the door and they have do-rags on their head and say, 'I need a job.' They got soap all in their mouths and you can't understand them. You can look at me and tell I am not going to talk to you. [Laughs]. I am very careful." Dana's hiring criteria, while not explicitly racist, may be part of the reason some of her staff perceived her as racist. However, Dana did not understand why the staff "stereotyped" her in this way, because, she explained, some of her "best friends" were African American.

In addition to assessing an applicant's physical appearance, AL employers appraise applicants' morals when making hiring choices. Expressing a common opinion among the administrators in our study, the executive director of a large, corporately-owned facility looks for "heart" when considering DCW applicants. Identifying who has "heart" is a tricky task with no standard measure; this administrator relies on a variety of factors to determine which applicants have heart, including applicants' behaviors while visiting the facility and other workers' reports:

We look for the heart. Since you can't see the heart we look for the smile on the face and the interaction when they are sitting and waiting for the interview. Our concierge plays a huge role; they watch how they interact with the residents who come by, how they interact with the staff that come by, how

they interact with anybody they brought with them. We see heart through volunteerism, giving of their time to causes, whatever they may be. We see heart in the interview process by the way they answer certain questions. We have a list of questions we can pull from to try to gauge where they are in that process. Where their heart is leaning. Honesty, dependability, loyalty, genuine care for senior adults. We are looking for people who can be trusted. We are looking for people who can take initiative. We are looking for people who are coachable and have the kind of attitude that they don't know it all and they can learn everyday. Those are our primary things.

In other words, this administrator and many like her look for DCWs who personify the moral values and care-centric concerns that bring many DCWs to LTC and AL. They are not looking for materially motivated DCWs. As this quote shows, moral values are more important to AL administrators than traditional professional qualifications, like education or employment experience, because moral values (*caring about* others) form over the life course, whereas practical direct care job skills (*caring for* others) are taught relatively quickly. The administrator quoted above explains why, when hiring DCWs, moral qualities are more important to her than professional characteristics: “Experience is not required because we believe our training program is really effective and if an individual comes to us with the right attitude and heart and motivation, they can be trained to do what we want them to do.” What cannot be trained, it is implied, is “the right attitude and heart and motivation.”

The administrator of a small, privately-owned facility acknowledges consequences of relying on moral criteria to choose DCWs, including developing a workforce with little education: “I look for religious qualities and kindness, gentleness. . . . So most of my people are uneducated, but they are good working people and they listen and they are willing to learn.” This connection between kindness and lack of education implies that moral values, or religious qualities, are squandered through education

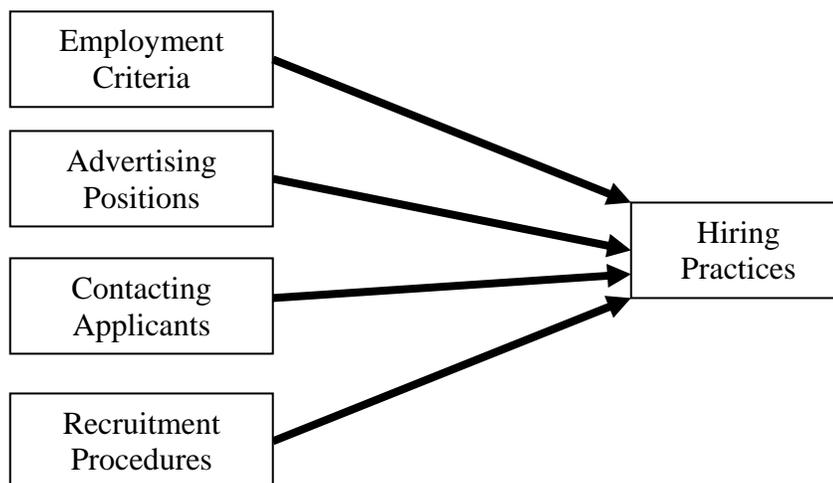
(wherein professional values may take hold). Overall, employment criteria for DCWs are minimal and those that exist tend to emphasize ethical, rather than professional qualities, and care-centric, rather than work-centric concerns.

In addition to the limited criteria for employment, employee recruitment strategies, including advertisements and call-back practices, also contribute to DCWs' motivations to work in particular facilities. Shayla, aged 35 and working in her current AL facility for seven years, was drawn to the facility by an advertisement: "There was a position here advertised. I interviewed and was hired." Advertisement methods varied and included newspapers and online notices. Advertisements in newspapers attracted some DCWs. Terri, a 63-year-old woman with four years' tenure in her facility, was drawn to her facility by a newspaper ad: "They had an ad in the paper, and I had to go to work fast." DCWs also are attracted to facilities by online job advertisements. In our sample, only DCWs at large corporately-owned facilities found their jobs online. Smaller and independently-owned facilities may also benefit from postings online. However, large, corporately-owned facilities are more likely to have websites with job postings. These websites sometimes attract DCWs both with descriptions of jobs available and with additional details about employment in the corporation. One DCW explains: "I found it online. [The corporation] has a website and offers tuition reimbursement." Online advertisements are useful for attracting DCWs from outside the immediate community. A DCW who was relocating explains how an online job advertisement led her to work in her facility: "I knew I was moving; I looked online, faxed my resume, and I got a call the next day. It is the only place I applied to." Large AL corporations are also sometimes able to retain workers by allowing them to transfer from a facility in one state

to a facility in another state. A young woman who worked for a multi-state corporation and was moving to Georgia explains how she found her facility: “The company in [the previous state] treated me well, and the corporate office people asked me to come here when I moved. They helped me get a job here and keep my benefits.” After moving to Georgia, this woman’s young husband also came to work as a DCW in the facility with his wife.

Finally, employers’ practices of contacting applicants also influence DCWs’ facility choices. That is, DCWs often choose to work in facilities where administrators contact job applicants quickly. Coco, a 24-year-old woman with two years’ experience in LTC—all of this time working in her current facility, explains: “I was filling out applications and this facility was my first call back.” Similarly, a 49-year-old woman with two years’ experience in LTC, but just 10 months in her current facility, explains: “They called me first after I sent my application.” Contacting applicants quickly is particularly important because many DCWs urgently need income. The factors that influence employers’ hiring strategies, which attract workers to specific facilities, are modeled in Figure 15.

Figure 15: Influence of Hiring Strategies on Facility Choice



Social Networks

DCWs' relationships and interaction with friends, family, and previous coworkers are also important factors that influence facility choice. Overall, 40% of DCWs came to work in their current facilities due to their social networks. In general, social networks guide DCWs to available jobs. For example, Quanda, a 53-year-old woman who has been working in her facility for six years, initially came to work in the facility due to her social network: "This is the one that needed help. My ex-daughter-in-law worked here and let me know." The influence of social networks on DCWs' motivations for employment, more generally, in LTC and AL, often overlap with their motivations for employment in particular facilities: 45% of DCWs who came to LTC due to their social networks, and 74% who came to AL because of their social networks, also came to their specific facilities due to their social networks.

Furthermore, DCWs' social networks contribute to their motivations for particular facilities based on the same criteria that they contribute to their motivations for LTC and AL. That is, in addition to simply alerting DCWs to available jobs, social networks sometimes more specifically inform DCWs of facilities' reputations for care, thereby contributing to moral and care-centric motives. But social networks also inform DCWs of facilities' reputations as employers, and thus contribute to DCWs' material and work-centric motives. Siena, a woman with over four years' experience in LTC, and three in her current facility, came to the facility for work-centric reasons, based on the reports of her social network: "Co-workers. I knew them before. They told me about this place. They like working here. I came and I liked it." In contrast, Nicola, a 27-year-old woman who has been working in her facility for over three years, initially came to the facility because her social network informed her of the facility's good reputation for care: "I knew two people who worked here; I heard good things." However, as with many workers' disappointment with AL in general, Nicola has come to see the care-centric advantages that AL traditionally has over nursing homes wane in her facility: "It was more like AL in the beginning, now it's a nursing home."

Several facility level factors influence the role of DCWs' social networks on their facility choices. Employers who permit family members to work together often benefit from DCWs recruiting family members. Beverly, a 63-year-old woman with over eight years' experience in LTC, came to work in her facility four years earlier because her sister worked there: "My sister was a nurse here and she talked me into coming here and I knew the people already." Most administrators acknowledge the benefits of allowing DCWs to recruit and work with friends and family, though they tend to disallow family

members to serve in supervisory positions over one another. The administrator of a large, corporately-owned facility explains that social networks, including family, are her facility's greatest worker-recruitment resource:

At this community we don't advertise a lot. Our main recruiting tool is word-of-mouth. We have a philosophy that we like to hire friends and acquaintances of good employees. Most of the people we hire have been referred to us by the staff. I believe that if one of our good care managers refers someone to me, they are probably going to be pretty good too. A good care manager doesn't want to work with someone who is not good. They know if they are working with someone who is not pulling their weight they will have to do it for them. . . . We will hire family members, even in the same community. The only policy we have is family members cannot serve in a supervisory capacity to their family member. So they can work together and even in the same department.

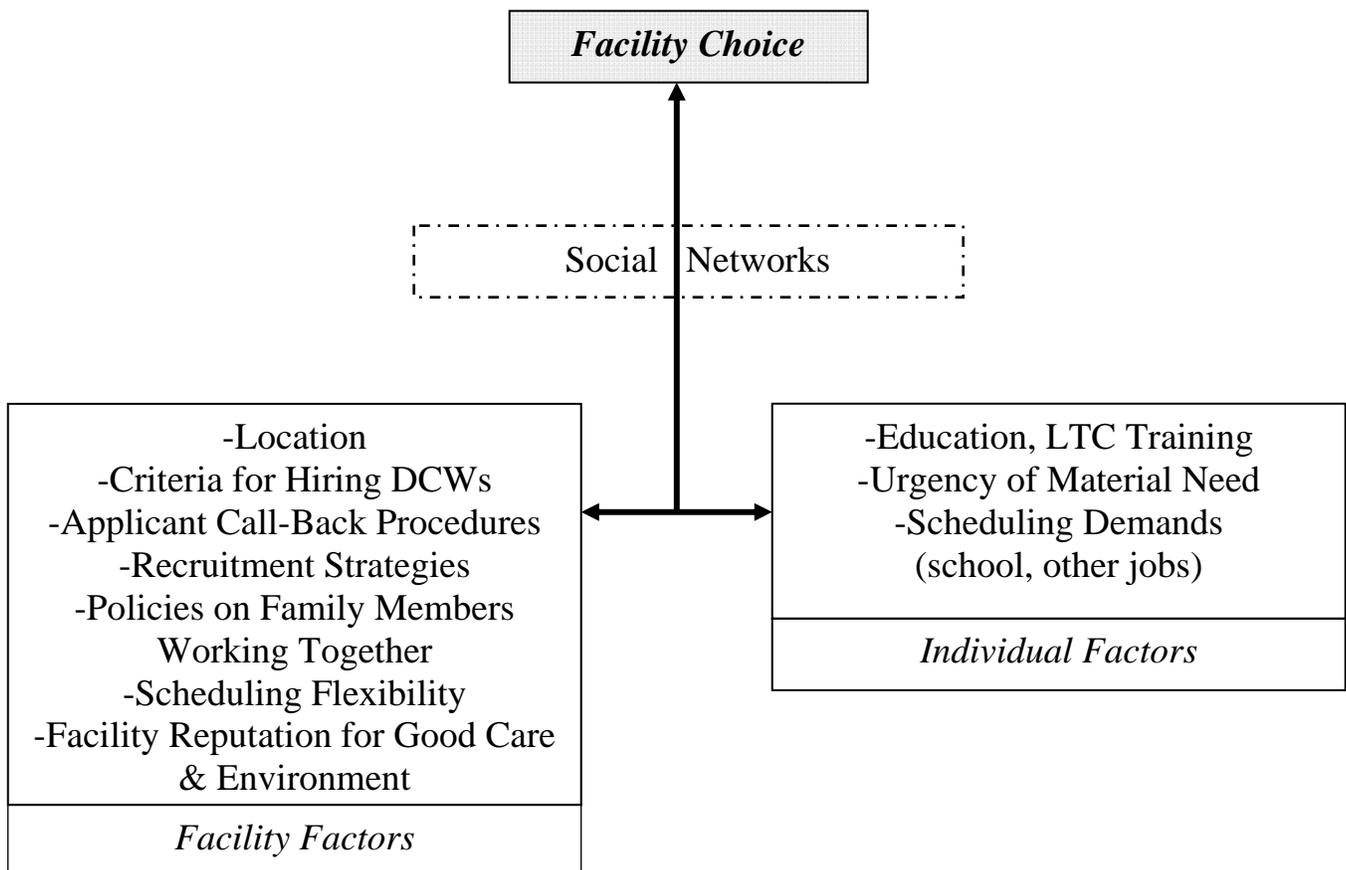
Several administrators have similar policies, but some others do not allow friends or family members to work together. For instance, the owner of a small, privately-owned facility does not hire friends or family of DCWs because she believes such practices leave employers at risk of a mass staff exodus. "Lose one, you lose two," she explains. Because social networks are a primary motivator for DCW employment at each level of analysis (LTC, AL, and facility), policies about family and friends working together are critically important to the direct care workforce.

Summary of Motivations for Particular Facilities

Locating a Job

DCWs come to particular facilities to find a job in a location convenient to them. Often, DCWs' social networks or employer job advertisements guide DCWs to available jobs in accessible locations. Employers' strategies of contacting applicants then often determine DCWs' facility-choices. DCWs' motivations for particular facilities, factors that influence them, and the outcome, facility choice, are depicted in Figure 16.

Figure 16: Motivations for Employment in Particular Facilities



CHAPTER 8

DISCUSSION

The examination of workers' motivations for employment in LTC, AL, and particular AL facilities presented in the preceding pages was spurred by an ethically important social problem: As a society, we care *about* the well-being of older adults, but are increasingly less able to care *for* them. A care crisis has emerged because the demands for LTC are growing beyond the available supply of care workers. By examining care workers' motivations for employment, this study reveals several opportunities for the implementation of policies and practices that could help alleviate the care crisis. Findings also include theoretical implications regarding the nature of motivation and value and provide guidance for future research.

Summary and Discussion of DCWs' Motivations

DCWs' employment motivations illustrate a process of reconciling material and moral values. Individuals, almost all women (99%), become care workers for reasons that are both materialistic, like earning a living wage, and moralistic, like the desire to care for others. They take employment in LTC expecting it to be consistent with their moral ideals *and* to satisfy their economic needs. Gender, as the percentage of female DCWs suggests, has a fundamental influence on motivations for care work.

Moral and Environmental Motivations

Care workers' low levels of education and limited employment histories, discussed in Chapter 4, show that their job options are largely limited to low skill-level positions, including service work, like housekeeping, food service, factory work, and care work. However, two-thirds of workers are morally motivated for LTC employment;

altruistic and benevolent values (which are fundamentally related to caring for others) are primary motivators.

The moral value of *care work*—its association with altruism and benevolence— attracts most DCWs. Findings indicate that these values are grounded in familial and religious beliefs. Overall, DCWs’ experiences with their families and teachings from their religions support the view that altruism and benevolence are *good*, thereby making care work morally meaningful and an attractive employment option. These findings provide empirical support for Moody and Pesut’s theory, which asserts: “Goals emerge from values” (2006:16).

The environmental factors that attract DCWs to AL (home-likeness and family-likeness) also reflect the influence of familial beliefs on motivations for care work. Research shows that relationships between LTC residents and DCWs are often identified as familial. For example, Gubrium and Buckholdt found that care recipients in multiple different care settings label caregivers “kin”: “Family status is assigned in the care, treatment, and informal relations of institutionalized persons” (1982: 878). Similarly, Moss and colleagues (2003) described nursing home care workers’ thoughts, feelings, and behaviors toward LTC residents as “family-like.” DCWs’ attraction to the “home-like” environment of AL and the potential for “family-like” relationships with AL residents, especially in comparison to nursing homes, reflects the influence of moral values on workers’ employment motivations.

Describing relationships between LTC workers and residents in familial terms, especially in the case of AL, may seem unproblematic. However, the negative influence of identifying care work as a familial task on its material rewards extenuates the care

crisis. Religious and familial beliefs about care work lead DCWs and LTC administrators to think of care work in moral, rather than material or professional, terms, and thus to justify the low pay and the low criteria of care work. Findings show that LTC employees' religious and familial beliefs about care generally negate the importance of DCWs' economic needs. Many DCWs and administrators consider care work in metaphysical terms of love, reciprocity, or divinity, and consider more concrete LTC job characteristics, like training and pay, superfluous to DCWs' experiences. Findings provide numerous examples of DCWs subordinating material connotations of care work to moral connotations. Rather than being rewarded monetarily, some DCWs believe they will be rewarded at an obscure time in the future, for instance, in heaven, for doing care work.

In addition to heightening the moral value of care work and justifying its low material value, familial and religious socialization reifies "gendered patterns of caregiving" (Ray 1999: 677; Brewer 2001). Peggy Dilworth-Anderson and colleagues explain how familial notions of care work and life course experiences of family caregiving reflect gendered cultural values: "caregiving is a 'gendered' experience whereby American cultural values, as well as those of specific cultural groups, socialize male and female children into defined roles that prevail today and are evident in who cares for elders in this society" (2005: S261). The dearth of male care workers reflects familial patterns of caregiving, as well as the gendered nature and low material value of care work.

Material Motivations

In contrast to moral motivations, one-third of workers report material motivations for LTC employment. The primary material motivation is financial need. The limited job options available to individuals with little education and employment experience contribute to DCWs' material motivations. Among many women, life course experiences of family caregiving detract from other educational and employment pursuits and heighten material need.

DCWs' facility choices are primarily motivated by material concerns. They seek specific jobs in the context of LTC and AL—that is, in a field and in a setting that are consistent with their moral values—to meet their material needs. Many DCWs identify available jobs at specific AL facilities through their social networks and some are attracted to particular facilities by the proximity of facilities to their homes. Employers' hiring strategies, especially the speed of making hiring decisions, also strongly contribute to DCWs' facility choices. The influence of employers' hiring speed on DCWs' facility choices reflects the urgency of their material need.

Professional Motivations

Professional motivations lead DCWs to LTC, but not to AL or particular facilities, and are not common. Only 7% of workers are professionally motivated for LTC employment. Young, educated workers who are aiming for careers in nursing, including DCWs who are currently in school, are most likely to enter LTC with professional motivations. Overall, these DCWs consider LTC employment a stepping stone to a more professional—better paying, more highly respected—career in nursing. Attracting more

professionally motivated workers to LTC is a core component of the policy implications discussed below.

Social Networks

Whether workers' employment motivations are moral, material, professional, or environmental, their social networks guide them to LTC (33%), AL (11%), and specific facilities (40%). Family members, friends, past and present coworkers, and passing acquaintances all support DCWs' employment motivations. Some social networks support moral motivations by reinforcing the importance and enjoyment of developing relationships with LTC residents; some support material motivations by alerting DCWs to available jobs; environmental motivations are supported by social networks who inform DCWs about the quality of social relations in AL; and professional motivations are supported by social networks that encourage DCWs to take LTC employment while training for a career in nursing. The influence of social networks on workers' motivations informs policy implications as well.

Moral and Material Values of Care Work

The moral value of care work is grounded in contemporary familial and religious beliefs and the material value of care work is rooted in market dynamics, whereby efficiency and productivity are honored (Held 2002). Market values and family values intersect in LTC as a result of caregiving's historical transition from being performed by wives, mothers, and daughters in private homes, to care work being provided by paid carers in the market. Philosopher Virginia Held explains: "The paid work that women go into is often an ill-paid version of the unpaid caring work they do at home" (2002: 21).

DCWs come to LTC because they seek both material and moral rewards, but the material value and moral value of care work are inconsistent. The inconsistency between care work's moral and material value is reflected by the imbalance of moral (67%) and material (33%) motivations for employment in LTC. This inconsistency is also reflected by DCWs who believe their job is a divine calling, a holy blessing, or an innate gift, but do not fully consider it a career. DCWs who consider their care careers as God-given blessings or inherent familial traits tend to also perceive more material, concrete aspects of their jobs, like pay and training, superfluous.

The different moral and material 'modes of valuation' (Anderson 1990: 8) applied to care work have been conceptualized by feminist economist Susan Donath (2000) as stemming from two distinct economies: the *market* economy and the *other* economy. In contrast to "mainstream economics," which Donath views as consisting of "a single central story of competitive production and exchange," she argues that at least two economies operate in society. According to Donath, the monolithic, mainstream model of economics, "is too simple a theory to provide an adequate explanation of the economy, especially as it affects, and is affected by, women's caring work" (2000:117). In the market economy, productivity and competition are valued. In contrast, Donath explains: "The other economy is concerned with the direct production and maintenance of human beings. This production and maintenance of human beings is an end in itself, not a means to producing commodities" (2000:117). As such, Donath describes LTC and other health care settings as "particularly important nonhousehold sites of the other economy" (2000:117).

Findings show that the market economy and the other economy, and material and moral ‘modes of valuation’ are not only distinct, but also *inconsistent*. Overall, the moral value of care work is high and its material/socio-economic value is low. DCWs achieve a high sense of moral value through care work, but are impoverished materially. DCWs’ employment motivations reflect the inconsistency between these values: moral motivations reflect the high moral value of care work and liken it to a holy task; material motivations reflect the low material value of care work and liken it to other jobs with low educational and professional criteria, like food service, housekeeping, or industrial labor.

Inconsistency between moral and material values for care work results in multiple problems, including poor pay, job dissatisfaction, and uncertain care quality: 42% of DCWs considered their pay “bad” and one-third (33%) claimed their pay or the quality of their benefits was the primary reason why they would leave their jobs. The low material value of care work heightens job dissatisfaction and is grounds for turnover. The high moral value of care, in contrast, is exemplified by DCWs with religious and familial beliefs about care work as well as by LTC administrators who use moral criteria for hiring DCWs, like having “heart,” rather than professional hiring criteria, like training, education, or employment experience.

Though clearly *different*, moral and material modes of valuation need not necessarily entail *inconsistent* valuation. Rather, caring work can, and I will argue should, be highly valued both materially and morally. In addition to easing the care crisis by making care work more attractive, a balanced valuation of care work would address social justice concerns about the exploitation of workers, particularly female workers. Because poor pay and lack of benefits detract from workers’ satisfaction, contribute to

turnover, and thus jeopardize care quality, social justice concerns related to the economic penalization of care work (England and Folbre 1999; Folbre and Nelson 2000; MacDonald and Merrill 2002) extend to care recipients as well. Denoting the links between familial ideals of care, caring motivations, and care quality, Meagher explains: “Familial ideals can foster an emphasis on spontaneous affection as the basis of caring relationships, and if this emphasis prevails, caring motivations may be harder to sustain and care recipients may be at greater risk of poor quality care” (2006:48).

The care crisis—the shortage and turnover of DCWs—is exacerbated by the inconsistency between moral and market values for care. Aligning these values may help resolve the care crisis, but the inconsistency between moral and material values for care work is self-extenuating. DCWs morally rationalize and justify the exploitative material conditions under which they work. Political philosopher Antonio Gramsci (1971) recognized when ruling ideals, like understanding caregiving as a familial, religious, or female task, are accepted as common sense, arguments to support these ideas are developed. Findings show that DCWs attribute to care work moral value and associate care work with unpaid family work. As a result of such associative logic, Gramsci (1971) explains, the exploited are passive toward political action. Accordingly, DCWs’ demands for systemic change in LTC are deficient. Who, in the case of a care worker strike, would care for LTC residents? This moral conundrum, layered as it is with DCWs’ financial need, has not been unraveled.

Due to their prominent motivational force, moral values are critical to the very existence of LTC—an industry that, at its core, is run by DCWs. However, motivating workers to enter LTC must be just one component of strategies aimed at alleviating the

care crisis. Keeping workers in LTC is also necessary. Because one-third of workers intend to leave their jobs as a result of dissatisfaction with their pay, increasing material rewards for care work is also necessary.

Identifying the imbalance between moral and material motivations for LTC employment also shows that care work, and perhaps women's work in general, is more morally than materially meaningful. Mostly women work in LTC, and most LTC workers are motivated for LTC employment by moral values. The shortage of DCWs with professional motivations for LTC employment, in contrast to the high percentage of DCWs with moral motivations, reflects the greater moral, rather than material, meaning of care work.

The moral salience of care work and its partial-, or para-professionalism, is supported by institutional practices which diminish care work's material and professional value, including the low educational criteria for LTC employment, care workers' poor pay and benefits, and the limitation of career ladders throughout LTC. Care work's greater moral, than material or professional value, highlights the centrality of "care" and the marginalization of "work" in the meaning of "care work." As a result of care work's prominent moral value, moral motivations for care work are predominant. Findings show that DCWs' moral motivations for LTC employment and related care-centric motivations for AL employment reflect the importance of virtues, like altruism and benevolence, and the importance of DCWs' relationships with LTC residents, on the meaning of care work.

Societal gender norms also support the moral salience of care work, as well as the dominance of care work by women. Nel Noddings (1999) describes, "two meanings of caring—one referring to a virtue, one to a special attribute of relations." She also

recognizes a basic distinction between “caring for” and “caring about,” and argues that moral virtues and relational concerns motivate women to care *for* dependents, but motivate men to care *about* them. Core findings of this study, including the dominance of female workers in LTC and the prominence of moral motivations for LTC employment, support Noddings’ claims.

The identity of care work as morally meaningful women’s work, rather than professionally meaningful and gender-neutral, is an outcome of historical processes. Care, which had been limited to performance by women, in homes, for no pay (care-giving), has entered the market; but its gendered, familial, and unpaid characteristics have not been left behind. These gendered, institutional, and economic remnants of care’s past are reflected in the dominance of care work by women; the high level of care work’s moral value; the prominence of moral motivations for care work; the low material and professional value of care work; and the marginalization of material and professional motivations for LTC employment. Care work’s minimal material value suggests that the “other economy” (Donath 2000) whereby it is valued may fairly be recognized as a “shadow economy” as well.

Many young, educated DCWs with professional motivations for LTC employment reveal that moral and material values can be integrated through educational and training programs. Before working in LTC for too long, these DCWs believe that they both can earn a good wage and do work that resonates with their moral values. This expectation is not altogether unrealistic, as depicted by the integration of moral and material values in the work of nurses and doctors, but such integration in LTC is currently prevented by the dead-end nature of direct care work. Professional motivations

bring educated DCWs to LTC as a stepping-stone to a nursing or medical career; DCWs want career ladders when they enter LTC work for professional reasons. But within LTC, few steps are available for advancement, leading professionally motivated DCWs to either leave LTC or give up their career aspirations. By limiting professional opportunities and material rewards, but endorsing the view of care work as a familial or religious activity, the LTC industry dissuades harmony between moral and material values, resulting in a poor, uneducated workforce with God-like notions of moral value.

Care Work Entails Both Care and Work

In contrast to the dominant influence of moral virtues and care work's relational relevance on motivations for LTC employment, financial need and career aspirations are less common motivations. The negligibility of care work's professional and material value limits professional and material motivations for employment in LTC. Because care is relatively new to the market, having prior been performed informally in private family homes, notions of care work as *care* overshadow notions of care work as *work*. German philosopher Sabine Gurtler explains:

Traditionally female activities that take place primarily in the private sector (so-called informal care) have. . . engendered neither economic independence nor social recognition. But it is exactly these two motives that have up to now been directly at the center of the philosophical concept of work: each of them is considered to be an appropriate criterion for whether an activity—whether performed formally or informally—is actually regarded as work (2005:129).

Within our gendered history, the linguistic conjunction *care-work* denotes a para-profession; an informal undertaking. Our understanding of care, societally and personally, originates in family life, and care, even in the market, retains its familial meaning. The familial notions entrenched within our understandings of care limit recognition of care work as work, and thus limit material and professional motivation for

LTC employment. The almost complete dearth of men in care work and the concomitantly near-complete reliance on women to provide paid care resembles traditional gender dynamics in families. Gurtler describes the relationship between familial notions of care and care work's paraprofessional identity within our gendered history:

Family work is not validated as work. . . its function with regards to the socio-economic exchange of services, is not made evident. This “shading” is primarily due to the terminological convolution of family work with. . . care-related forms of employment (as they result from the sexual division of labor) (2005:129).

Though eclipsed by its moral salience, care work's identity as *work*, and not (just) as a family-task, is evident and reflected by the consistent influence of financial need on DCWs' motivations: material need drives workers to LTC, AL, and specific facilities, and material motives may be even more common than findings indicate.

The mis-understanding of values and motivations as dichotomous—as either intrinsic or extrinsic—paired with the dominance of care work' moral values, over its material value, act as barriers to recognition of material motivations for care work. Upon entering LTC employment myself, I failed to recognize that financial need drove me to seek employment. I also failed to recognize that the mere proximity to my home of the AL facility where I worked, nor its visibility from the street between my home and the main thoroughfare, influenced my choice of LTC employment. My belief in the value of altruism—that caring for others was inherently good—accounts for my restricted insight into why I was doing care work. Like most DCWs in this study, while doing morally valued work, I recognized my own moral motivations. However, by recognizing care work's identity as actual employment, which has formed as a result of the market

expanding to include activities of care—in other words, as a result of the convergence of the market economy and the other economy—I recognize the necessity of redefining work, in general, to include care work. I also recognize the influence of financial concerns on my entry to LTC and the identity of work as having both moral and material relevance. As an increasingly important and morally valuable type of work, care work expands the meaning of work to include morally-motivated labor. Gurtler encourages redefining work with alertness to its ethical attributes, as well as recognition of family work as an economically meaningful activity: “What needs to be established here is a more precise specification and economic evaluation of family work as well as a bolstering and mediation of the third (ethical) motive as an important and crucial criterion for the definition of work” (2005:129).

The Nature of Motivations

The nature of human motivations has long been debated. Maslow (1943) developed one of the first widely acknowledged motivational theories, which envisions motivations as stemming from a hierarchy of innate needs. Other theorists (Deci and Ryan 1980; Gagne and Deci 2005) argue that innate motivations are activated by external stimuli. They differentiate and dichotomize intrinsic and extrinsic motivations. Bridging intrinsic-extrinsic dichotomies and debunking monolithic, universal conceptions of motivations, Markus and Kitayama (1991) and Scheuer (2000) infuse motivation theory with the concepts of culture and group social norms. Markus and Kitayama (1991) develop a theory of motivations as grounded in Eastern or Western cultural concepts of self. Scheuer (2000) emphasizes reflexivity and the influence of societal norms on motivations, indicating that individuals actively choose their motivational orientations

within cultural parameters and that their motivations are not innate.

Findings presented here indicate that workers' motivations are multifaceted, including moral, material, professional, environmental, and social components. Dichotomous notions of motivations as intrinsic or extrinsic are too simplistic to accurately depict motivations for care work. The prominence of moral values leading workers to LTC provides support for Markus and Kitayama's (1991) theory that motivations are grounded in culture, as morals are cultural products. Likewise, these findings support Scheuer's (2000) contention that motivational orientations are chosen within cultural parameters. The financial need that is common among DCWs may motivate employment-seeking behaviors, but entry to LTC and AL is more specifically motivated by a combination of material and moral concerns.

Findings support Folbre and Nelson's (2000) assertion that motivations for care work are for both love and money, and contrast with dichotomous arguments that extrinsic rewards *crowd out* intrinsic motivation (Deci et al. 1999). Findings presented here also reflect Pillemer's (1996) findings that care workers are more likely to report intrinsic, rather than extrinsic, motivations, as well as Bowers and colleagues' (2003) conclusion that the distinction between intrinsic and extrinsic factors is obscured in the context of care work. Ultimately, the inconsistency between moral and material values for care work and the influence of this inconsistency on caring motivations, job satisfaction, and the make-up of the LTC workforce, especially its dominance by poorly educated, low-pay women, support Bowers and colleagues' call for "a logical articulation between compensation and value" (2003: 42). Incongruence between societal and institutional rhetoric that care work is (morally) valuable, and societal and institutional

practices that grant, in contrast, very little (material) value to care work, heightens dissatisfaction and turnover and exacerbates the care crisis (Bowers et al. 2003). Material and moral motivations do not seem to be innate and hierarchically related, as Maslow (1943) suggested, but grounded in cultural (moral and material) values, which are inconsistent.

The almost total dominance of care work by women, and the prominence of moral motivations for care work, suggests that moral values, themselves, are gendered. Noddings (1999) argues that values for care are likely to lead women to care *for* dependents and men to care *about* them. The social problem at the root of this study—the fact that, as a society, we care about the well-being of older adults, but are increasingly less able to care for them—denotes the importance of understanding how cultural norms influence caring values and motivations. Findings help show the *gendered* nature of the social problem at hand: as a society, women and men care about the well-being of older adults, but almost no men care for them.

Markus and Kitayama (1991) depict motivations as stemming from Eastern or Western notions of self, but findings presented here indicate that motivations are influenced by gender. Care work is morally valuable for women as well as men, as depicted in Chapter 4 and highlighted in James' story, but the overall influence of moral values on workers' motivations clearly varies by gender. Specifically, the overwhelming dominance of female care workers and the dominance of moral motivations for care work indicate that moral values guide women's employment motivations more than men's. Noddings (1999) argues that moral values lead women, not men, to care for others.

DCWs' attribution of familial meanings to care work, and the positive influence of life course experiences of family caregiving on motivations for care work, show how families contribute to the gendered nature of care. Because women have been the primary family caregivers, the conceptual connection between family and LTC contributes to the replication of these gendered dynamics. However, as paid employment, both moral and material motivations influence entry to LTC, and care work is subject to both moral and material valuation.

Though moral values and other cultural artifacts have been construed as justifications or rationalizations for individual choices, rather than as motivations (Boltanski and Thevenot 1999; Swidler 2001), DCWs' selection of LTC employment, over their other employment options, supports the argument that moral values and cultural beliefs have motivational force and shape behaviors (Lakoff 2002). At least some DCWs consider care work more morally valuable than some of their other employment options—in comparison, for instance, to fast food work—and choose employment in LTC specifically for moral, often altruistic, reasons. The motivational force of moral values, rather than their justificatory role, is reflected in such morally grounded decisions.

Among care workers, however, moral values *also* appear to play a justificatory, or rationalizing, role. That is, few workers would take employment without need for income, but only one third of DCWs report entering LTC for material reasons; two-thirds of DCWs, in contrast, report moral motivations. This imbalance between reported moral and material motivations shows how moral values are utilized to rationalize and justify decisions that are likely, first and foremost, materially motivated. In this case, the high

moral value of care work acts as a justification for choosing employment that has low material value. In short, findings indicate that moral values motivate *and* justify action.

Furthermore, DCWs' motivations for employment in AL, rather than another LTC setting, reflects dual, moral and material, motivations. DCWs specifically come to AL rather than nursing homes or in-home care because they expect AL will (1) *more fully* reflect their moral values and (2) *better* satisfy their material needs. Environmental factors, including the "family-likeness" and "home-likeness" of AL, also attract workers. Overall, DCWs consider the physical and social environment of AL superior to that of nursing homes or in-home settings. These environmental factors, though conceptually distinct from care-centric concerns, reaffirm the *home*-source of moral values and motives.

Implications for Policy and Practice

Federal and State Policies and Practices

LTC research shows that strategies which enhance professionalization, like increased training and the development of career ladders, contribute to both the moral and material value of care work, thus supporting recruitment and retention (Coogle 2007; Richardson and Graf 2002). Robyn Stone explains: "Sustaining a quality workforce requires better compensation packages, benefits for direct care workers and incentives for providers to create better workforce cultures" (2007:24). However, due to their limited resources (Lopez 2006), providers are restricted in their allocation, resulting, for instance, in competition between raising residents' fees and raising salaries.

A large proportion (over 60%) of LTC funding comes from federally funded programs (Health Policy Institute 2003). Data on federal spending for AL is not collected

or tracked in the same way as nursing home care spending (Tumlinson and Woods 2007), so direct comparisons between spending for each setting are not possible, but federal spending on AL in 2002 was estimated to be about \$23 million (AAHSA 2006), whereas federal spending on nursing homes was closer to \$75 billion in 2004 (Burwell et al. 2006). Because of the high rate of federal funding for LTC, federal policy adjustments are particularly suitable strategies for increasing providers' resources and DCWs' wages without concomitantly raising residents' fees. To this end, policies could shift a greater amount of resources to LTC workers. Wage pass-through programs in several states serves as models for such a strategy (Seavey and Salter 2006).

More fundamental policy changes, like integrating Medicare and Medicaid, and thus discontinuing their current cross-purposive funding operation and the "misaligned incentives of the state and federal government" (Miller and Mor 2006:27), could also raise the proportion of federal health care spending that reaches workers. Currently, "Medicare reimburses for 'post-acute' care provided in nursing homes and by home health agencies," and Medicaid provides LTC support for individuals, including assisted living residents, who have spent down their assets (Miller and Mor 2006:26-27). However, LTC residents who are funded by Medicaid pay lower fees than private pay residents, resulting in lower resources and lower care quality in facilities where a greater proportion of residents have spent down their assets. The two-tiered LTC system that results from current funding strategies (Mor et al. 2004) contributes to AL's stronger attraction to workers as more AL residents pay for AL privately and private-pay resources are greater in AL. But this paradigm ultimately jeopardizes the quality of care for residents who must rely on federal assistance.

Though fundamental changes to Medicare and Medicaid may be necessary to steer greater federal and state resources to LTC, the Better Jobs Better Care research initiative provides guidance for implementing more easily achievable policy change. These efforts, which reflect collaboration between providers and governments, are noted for having “far reaching effects on the state of the workforce” (Stone 2007:20). For example, demonstration programs in North Carolina, Oregon, and Pennsylvania have shown success in heightening pay and benefits and limiting turnover:

Innovations include: a new state license program that rewards providers who meet higher standards for workplace culture; development of an occupational profile and core standards for direct care workers; working with state workforce investment boards to create new recruitment and retention programs for providers; and educating legislators on the need for direct care worker training and health insurance coverage (Stone 2007:20).

Establishing federal LTC policy guidelines in light of such tested demonstration programs likely would help heighten the professional stature of LTC employment.

Several policy strategies are at the fore of public debate. Miller and Mor recognize: “The nation must engage in a serious discussion about how to pay for long-term care in both the near and long term,” and detail the benefits “*universal* coverage for long-term care” (2006: 31-33). In addition to proposals for universal healthcare and long-term care, serious discussion of LTC funding must also recognize the alternative uses of federal funds. Because, by far, the largest proportion of federal funds are spent on Defense (Executive Office of the President 2008), gradual transition from this war-centric economy to a care-centric paradigm may be necessary, and desired, in the long run. Such a paradigm shift, in addition to transferring funds, could entail transferring personnel from the frontlines of war to the frontlines of care. Mandatory registration of young men for military service could be supplemented with alternative registration for care service.

In addition to supplementing LTC workforces, such a strategy, by encouraging the entry of men to LTC, could contribute to degendering care work. Model policies are already employed in Sweden, where citizens who object to war are permitted to register for a substitute service, including elder care, rather than military service (Swedish Ministry of Defence 1996).

In *Moral Politics*, linguist and political scientist George Lakoff (2002) shows that policies, including funding policies, reflect moral values, and achieving policy changes often requires moral support. Consequently, policy initiatives aimed at improving care, including LTC funding, may benefit from linking to other issues of moral and economic importance, like war. For instance, while *war* is commonly opposed, conceptually, to *peace*, a more appropriate and politically useful comparison to war may be *care*. Like peace, care possesses great moral value; but unlike care, peace exists in an economic vacuum with no direction for action. Unlike peace, which retains an idealistic and utopian sense of passivity that provides little guidance for economic activity, (health) care is an active pursuit with increasing market relevance and opportunities for the implementation of technology (IFAS 2007). Furthermore, environmentalism and emerging Green industries share basic philosophical tenets with LTC, particularly the fundamentally benevolent attitude of caring about and caring for others. Held explains:

In practices such as those involves in childcare, education, healthcare, culture, and protecting the environment, market norms limited only by rights should not prevail, even if the market is fair and efficient, because market are unable to express and promote values important to these practices, such s mutually shared caring concern (2002:32).

Green industries are emerging in response to a crisis of environmental care whereby the physical world has been exploited by industrial, market forces; the LTC

crisis similarly results from the exploitation of care at the hands of the market. The merging of environmental care and elder care has already been initiated in certain research and demonstration projects, including “Sustainable Communities for All Ages: A Viable Futures Toolkit” (Dressel and Walker 2008), which offers guidance to community planners, policymakers, service providers, funders, and families about crafting solutions to social problems that are beneficial for all generations and their communities. Establishing interconnections between LTC and other fields of interest could contribute to recognition of the LTC crisis, especially among younger people who may have greater interest in issues of war and the environment than elder care. Heightened awareness of LTC likely would help pull it out of the shadow economy and into the mainstream economy.

Long-Term Care Policies and Practices

Systematic restructuring, in the form of broad policy changes, may be necessary to balance the moral and material values of care work and thus avert the impending disaster of an old country where help for the needy is poor or unavailable. Taking a feminist gerontological perspective, Nancy Hooyman and colleagues concur: “Fundamental structural changes in social institutions and values are needed to accord greater societal recognition to the work of caring” (2002:12). Ultimately, the failure of LTC to meet DCWs’ moral and material needs hurts consumers, employers, and governments by resulting in turnover, poor care quality, and high re-staffing costs. Because of these consequences, LTC stakeholders should direct considerable effort to establishing jobs that both meet DCWs’ material needs and are consistent with values for providing quality care.

Policies that would counteract inconsistency between care work's moral and material value and support professionalization of care work include increasing training, pay, and career ladders within LTC. Training and education requirements for DCWs may need to be heightened. However, to prevent heightened criteria from further limiting the LTC workforce, training and education for incoming DCWs may need to be provided. Employers' practices which impede identification of care work as a profession and contribute to identification of care work as a familial task that is undeserving of pay, like basing hiring decisions on moral values rather than training or experience, should be discontinued. By selecting workers according to their moral values rather than training, experience, or other widely accepted indicators of job aptitude, employers reinforce the importance of family and religious moral socialization for LTC employment and thereby enhance care work's identification as a familial or religious task, and as women's work. Overall, policies and practices that counteract, or reverse, the inconsistency between moral and material values for care work are needed. Because of deeply embedded beliefs about the nature of care as family work that is undeserving of pay, policies may be required to mandate increased pay, training, and career ladders. Furthermore, policies may be needed to counteract deeply embedded beliefs about the gendered nature of care; attracting greater numbers of male workers to LTC would both help quell the care crisis and support the professionalization of care.

A successful reconciliation of morality and materialism would be characterized by a LTC system that espouses values for caring for others and *equivalently* rewards the act of caring for others. Until values for care work are reconciled, the LTC staffing crisis will

likely continue and the direct care workforce will continue to be occupied by poor, racial and ethnic minority women who have little training or education.

Assisted Living Policies and Practices

Within LTC, DCWs come to AL to maximize their employment options: for many DCWs, nursing home work does not have the moral connotation of AL care work; for some, in-home care lacks the stability of AL employment. To support DCWs' attraction to AL, its care-centric and work-centric advantages over these other low skill-level LTC employment options should be maintained.

Findings show that compared to AL employment, nursing home work is most viscerally *not* consistent with DCWs' moral values to the extent that abuse or neglect (of care recipients by caregivers) results. DCWs take employment in AL rather than nursing homes primarily because they believe the quality of care in AL is superior and supported by lower workloads, higher functioning residents, and better relationships with residents. In short, one DCW explains, "In nursing homes, it's a broken heart." In any LTC setting, overcrowding, understaffing, devaluing, and mis-training counteract care. In these conditions, DCWs explain, the best care they can provide is quick bed-and-body care. Relationship development (between caregivers and care recipients) is unfeasible. For DCWs, poor care results in emotional strain. For LTC residents, poor care can result in death. Overall, findings show that DCWs take employment in AL rather than nursing homes because they expect AL will be superior to nursing homes across this broad range of factors.

Assisted living attracts workers away from nursing homes with its *promise* of higher care quality, but many workers indicate that the *actual* quality of care in assisted

living has come to resemble that of nursing homes. In order to fill beds and comply with residents' and family preferences, some AL facilities keep residents after their functionality declines below the point that DCWs expect of AL residents. This phenomenon is supported by the aging-in-place philosophy of AL (Chapin and Dobbs-Kepper 2001), which attracts consumers. However, the decline of resident functionality heightens workloads, infringes on relationship development between DCWs and residents, and ultimately weakens care quality and counteracts DCW satisfaction and retention. To support the recruitment of morally motivated workers, the largest subset of DCWs, to AL, employers should revisit the aging-in-place philosophy and the policies and practices associated with it. Employers may consider halting the gradual enfeeblement of resident populations, or they may prepare care workers for the increasing workloads that result when residents' functionality declines. Due to the centrality of relationships between carers and care recipients to care, AL providers could also support care quality by permitting DCWs more time to spend with each resident. For instance, employers could lighten DCWs' workloads implement tighter staff-resident ratio requirements. Training DCWs to connect with residents, including those with dementia and those with different cultural backgrounds, would also support care quality, and thus the moral meaningfulness of care work. Chapin and Dobbs-Kepper similarly argue: "Facilities that decide to increase flexibility in admitting and retaining the more severely cognitively impaired population will need specialized training and resources for staff to help them deal with older adults who have severe cognitive impairments" (2001: 49).

Because the aging-in-place philosophy of AL results in declining resident functionality and increasing workloads, policies or practices related to aging-in-place

need to be revisited. While discharging residents whose functionality decline seems antithetical to care quality, as few individuals want to relocate while their health is deteriorating (U.S. General Accounting Office 1999), retaining these residents, but allowing care quality to suffer as a result of increasing workloads and the lack of training that DCWs receive for providing this higher level of care, is also antithetical to care quality. Rather, AL employers could provide greater training to DCWs, especially for providing care to residents who are growing increasingly impaired as they age in place. Employers could also prepare DCW-applicants for this higher level of care during the hiring process, thereby counteracting the disappointment that many DCWs report as a result of their dashed expectations for highly functioning residents. Ultimately, LTC, AL, and perhaps all other organizations and industries, may find the surest way of limiting worker disappointment, dissatisfaction, and turnover is to implement practices and policies that are consistently integrated with their guiding philosophies. Aligning the moral and material value of care work would support such integration.

Recognition of AL residents' inevitable decline is also a guidepost to opportunities for alleviating the crisis in care. Increasing care demands resulting from declining resident health can be integrated with training programs and career ladders that prepare DCWs for higher levels of care. AL employers can also coordinate advanced training with career ladders that include higher levels of pay for greater care responsibilities. Such an integrated approach to care work would not only be intended to improve care quality and care work jobs, but also to attract more professionally motivated workers to LTC. Assisted living, nursing homes, and in-home care settings, though commonly traversed by many DCWs, are currently distinct fields of employment.

Integrating and streamlining LTC into an actual system with graduated training and reward programs may be necessary for meeting the increasing demand for LTC. For example, career ladders through LTC could entail AL work, nursing home employment, and in-home care, with training modules linked to each setting. In a report prepared for the National Commission for Quality Long-Term Care, Edward Miller and Vincent Mor suggest a national model from which the disintegrated system of LTC can learn to coalesce:

The U.S. Department of Veteran Affairs (VA) operates the largest health care network in the country, both financing and providing medical care that is increasingly viewed as second-to-none in the U.S. The VA integrates patients' acute and long-term care needs, and providers are held accountable for all care. We can learn from the VA's experiences (2006:29).

Facility Policies and Practices

At the facility-level, hiring strategies and locations are the primary motivations for employment. Ultimately, AL facilities situated nearby DCWs' homes and schools are optimal employment settings. Findings show that facilities located nearby colleges and training programs are attractive to professionally motivated workers, particularly those who are currently studying nursing and seeking experience to further their careers. However, findings show that several hiring strategies also influence DCWs' facility choices, including advertisement, recruitment, and applicant callback procedures. Additionally, employers' policies on family members and friends working together also influence DCWs' employment options, particularly because DCWs' social networks have a consistent influence on their motivations employment, from the particular facility to the field in general.

As with most careers, newspaper and online advertisements are useful recruitment strategies for LTC. However, the care crisis suggests that additional recruitment strategies are needed. Due to the prominence of moral motivations for care work, advertising available positions where potential applicants—especially individuals with caring values—congregate could be an important component of DCW recruitment. For many DCWs, altruistic values and moral motivations are linked to their religious beliefs. However, no employers report recruiting through religious organizations; such a strategy may supplement current LTC workforces.

In contrast to newspaper and online advertisements, Debbie's boss recruited her and her sole DCW-coworker at a homeless shelter. Because individuals residing in homeless shelters have extremely high material need, recruiting in these settings may yield a high return of materially motivated workers. However, this recruitment strategy is ethically questionable for several reasons: homeless workers may feel coerced to take live-in positions, even if the pay and the conditions of work and care are unacceptable; and reliance on homeless workers can result in dependence on DCWs, like Debbie and previous DCWs recruited to her facility from homeless shelters, who suffer from mental, emotional, or substance abuse problems.

The strategy of recruiting at homeless shelters reflects the lower level of resources available to Debbie's employer. Facility resources influence workers' pay levels and working conditions, and as a small facility with minimal resources, Debbie's employer attracted few workers. Potter and colleagues, bemoaning the poor working conditions in LTC, note the degradation of worker characteristics that results from the unattractiveness of care work: "As poor working conditions continue to make many direct-care jobs

‘unfillable,’ employers confront the prospect of hiring workers with questionable work histories” (2006: 370).

Facilities with greater resources, including larger facilities, pay DCWs better. In this study, DCWs’ median hourly pay was \$8.93 in large facilities, \$8.12 in medium-sized facilities, and \$7.34 in small facilities. Benefits were also better in large facilities, where 37% of DCWs were provided medical insurance through their employers, compared to just 11% of DCWs in small facilities (32% in medium-sized facilities). Larger facilities have greater resources and pay workers more.

Though the strategy of hiring at homeless shelters is wrought with practical and ethical problems, and may be inherently exploitative, its ingenuity provides an example of how employers negotiate their limited resources. This strategy also shows that traditional newspaper, on-line, and word-of-mouth recruitment techniques may fail to reach under-tapped workforce pools.

In addition to choosing the *method* of advertising DCW positions, employers must consider the *content* of job postings. Inaccurate job advertisements risk attracting individuals who are not prepared for AL work, which can exacerbate worker dissatisfaction and turnover. Consequently, LTC employers should be careful to inform applicants about the duties of direct care work very early in the recruitment and application processes.

When DCWs apply for jobs, they are subject to scrutiny by employers, who examine their values and behaviors, as well as their professional skills and experience. However, possessing caring values is the central qualification that employers seek among DCW applicants. Employers’ selection of DCWs on the basis of these values is at least

partially intended to weed out applicants who would provide poor care, or even abuse LTC residents.

Employers' selection of DCWs on account of their "heart," or the genuineness of their moral motivations, rather than on their care training, skills, or professional motivations, supports familial notions of care work, the minimization of care work's material value, and the gendered state of LTC. As such, morally-based hiring strategies contribute to the inconsistency between the high moral and low material and professional values of care work. Furthermore, by emphasizing moral values over professional skills when hiring, employers contribute to the *disjuncture* (Meagher 2006) between societal and institutional *rhetoric* that care work is important and societal and institutional *practices* that denigrate care work, including low pay, limited training, and minimal opportunities for professional development. In contrast to employers' current hiring strategies, Meagher presents an alternative strategy of conceptualizing appropriate motivations for care work that would help balance its moral and material values, and thus support the entry of professionally motivated workers to LTC:

I want to argue for the conceptual separation of caring motivations from feelings of affection in paid care, and for the privileging of cognitive understandings of caring motivations in the place of feelings-based understandings. This has the benefit of bringing caring motivations squarely into the domain of skills that paid carers can learn. Linking caring motivations as well as caring practices to skills also provides additional arguments in the struggle for proper recognition of care work (2006: 48).

Finally, as a result of social network's consistent support of motivations for care work, facility policies that permit friends and family members to work together and encourage workers to recruit friends and family likely will support employers' worker-recruitment efforts.

Research Directions and Limitations

Findings indicate that moral and material values of care are split, and this split reflects inconsistency between the high moral value of care, associated with families and religions, and the low material value of care in the market. Since women dominate activities of care, this split in moral and material values also appears gendered. To bring more workers, including male workers, into LTC, and to keep them in the field, which is a core component of this study's objectives, moral and material values for care should be reintegrated and degendered so that they reinforce, rather than oppose, one another. To this end, research is needed that compares the influence of health care policies on moral and material values of care, and on the gendered composition of LTC. In states or other nations where moral and material values of care are more balanced—for instance, in states with similar moral values of care but higher pay—I hypothesize that more workers, and even more male workers, would take employment in LTC. Such a balance between moral and material values may not *yet* exist in any state, but the public health demands of our aging population may require such a major shift in values.

Numerous policies that increase care workers' wages provide groundwork for establishing a more equitable balance between the moral and material values of care work and represent opportunities for future study. Smith and Baugham report: "The recently passed legislation to raise the federal minimum wage from \$5.15 per hour to \$7.25 per hour will effectively increase the wages of many paid caregivers—32 percent of direct care workers' . . . wages will increase by a hike in the minimum wage" (2007: 8).

Longitudinal study comparing workers' motivations for care work before and after the

minimum wage increase could help identify the influence of pay on motivations for care work.

In addition to broad workforce-oriented federal legislation, the minimum-wage hike provides guidance for state-level initiatives aimed more particularly at the LTC workforce: “Some states have legislation that sets their minimum wage higher than the federal minimum wage, and it is also possible for states to establish a wage floor for a specific occupation through legislation” (Smith and Baugham 2007: 8). Comparison of care workers’ motivations for employment across states with different minimum-wage levels for care workers would also help identify the influence of pay on motivations for care work. Study of states with different minimum wage levels may be particularly useful if conducted in bordering states, like Georgia and Alabama or Georgia and Tennessee, as such close proximity would help researchers control for regional factors in their samples, like immigrant populations and unemployment rates.

Wage pass-throughs, which are currently implemented in 23 states, are another strategy intended to increase care workers’ wages, increase the direct care workforce, and decrease turnover. These policies direct Medicaid funding to care worker reimbursement rather than to other LTC spending. The success of these programs, however, is debatable. Smith and Baugham explain: “As many of these policies have only recently been implemented, it is not clear whether or not they have achieved the intended effect” (2007: 8). Continued research on the influence of wage-pass throughs on care workers’ pay, and on the LTC workforce, is advised. Longitudinal comparison of LTC staffing—between states that utilize wage pass-through mechanisms and states that do not—could be particularly useful.

Findings also show that providing family care supports the moral values that motivate many workers, and these workers tend to think of LTC residents as family. Because of the importance of staff-resident relationships for job satisfaction and care quality (Ball et al. forthcoming), and the diversity of LTC, including a growing workforce of foreign-born caregivers (Redfoot and Houser 2005), strategies are needed to support staff-resident relationships in a multicultural context. To this end, research is needed that examines the influence of policies and practices on staff-resident relationships and on worker satisfaction and retention. I expect that educating workers *and* residents to communicate with each other, and maintaining manageable workloads, would support worker-resident relationships, and, in turn, support worker recruitment, satisfaction and retention.

To support professional motivations, researchers should continue to examine the effectiveness of career ladders in LTC. Career ladders that entail higher pay, more training, and greater responsibility may ultimately support the entry of professionally motivated workers to LTC. But our findings suggest that future studies should also examine pathways between LTC and other employment and educational settings; like the pathways from factories and mills to LTC. Understanding employment pathways *between* sectors may be particularly useful for helping LTC meet the increasing demand for care.

Additional directions for future research are intended to overcome the limitations of this study. For example, the study was limited to AL facilities in the state of Georgia. As a state-licensed entity, AL varies from state to state. Consequently, it is important for researchers to examine DCWs' motivations in other states as well. Studies of DCWs' motivations for employment in other states, but using similar methodologies to those

used in this study, would permit researchers to compare the influence of state-level policies on DCWs' employment motivations, and thus would support the development of policies that are most supportive of entry to LTC. Additionally, future studies could examine DCWs on regional, national and transnational levels, especially in the interest of doing comparative analysis of national policies and regional trends, and their influence on care work.

Another limitation of this study is its reliance on retrospective data collected at one point in time. These data collection methods risk oversimplification of motivations as well as bias by impression management. For instance, DCWs may downplay the influence of financial concerns when reporting their motivations for care work because idealistic notions of caregiving paint it as an activity that should only be *intrinsically* motivated (Kendall 2001). As a result, pay and benefits may be a much stronger motivator for AL employment than suggested by the findings in this study. To overcome these limitations, researchers could examine workers' motivations upon entering the field, and could longitudinally examine workers' motivations to determine if the motives they report, or their values, change over time.

Conclusion

The material devaluation of care work may be not only inconsistent with its currently high moral evaluation, but may also be a danger to the maintenance of care work's moral value altogether. Virginia Held warns: "Many people are not yet indifferent to values other than market ones, but it is unclear how long this will last" (2002:26). Altruistic values motivate caring, but these values are not inherently or universally good, as familial and religious connotations of care have many DCWs believe. Noddings

explains: “Caring may not be universal.” Rather, moral values are cultural products introduced to DCWs by various agents of socialization, and cultural changes will likely alter the moral value of altruism and caring. Tracing, in *The Genealogy of Morals*, how the moral value of altruism changed in the past, Nietzsche depicts the attribution of moral goodness to altruism, and its opposition to egotism, as a result of historical changes in power:

The origin of the opposites *good* and *bad* is to be found in the pathos of nobility and distance, representing the dominant temper of a higher, ruling class in relation to a lower, dependent one. . . . Such an origin would suggest that there is no *a priori* necessity for associating the word *good* with altruistic deeds. . . . In fact, it is only after aristocratic values have begun to decline that the egotism-altruism dichotomy takes possession of the human conscience. . . as is currently happening throughout Europe, where the prejudice equating the terms *moral*, *altruistic*, and *disinterested* has assumed the obsessive force of an *idée fixe* (1956: 161).

By continuing to materially devalue care, society risks also morally devaluing care, and altruism, and thus extenuating the care crisis. The material value of care is currently *inconsistent* with its moral value, but a tipping point may be reached at which the material value of care actually undermines, or obliterates, its moral value. Such a change of moral values for care work is already occurring in LTC; AL DCWs have come to view nursing home care work as less morally sound than AL care work. Like AL, nursing homes rely on materially devalued DCWs. However, for many DCWs, the moral value of nursing home work has largely been obliterated by the poor quality of care in those settings. They believe AL is superior to nursing homes across the axis of moral, care-centric concerns, and this moral advantage of AL over nursing homes is the most prominent attraction to AL employment. However, the gradual deterioration of AL residents’ functional statuses and DCWs’ relationships with AL residents, and the

concomitant increases in workloads, downgrades the care in many AL facilities. As a result, for some DCWs AL care quality becomes comparable to the poor quality of care in nursing homes. Resident abuse and neglect, which are inconsistent with altruistic values for care, have become common characteristics of nursing homes, as depicted by DCWs as well as popular media. Though AL employment *has been* superior to nursing home employment in terms of care and work, findings suggest that AL's moral advantages over nursing homes are deteriorating.

Perhaps institutionalization is simply incompatible with care and will necessarily result in the erosion of care quality regardless of setting. Maybe in-home, familial care is the only option for quality LTC. After all, DCWs view AL employment superior to in-home care for material, work-centric reasons, but not for moral, care-centric reasons. If current LTC institutions are unable to provide quality care and quality jobs, their dissolution may be the best solution to the care crisis. Smaller-scale community-based care settings may meet the demands for quality care and quality jobs better than the burgeoning AL industry.

Or perhaps the inconsistency between moral and material values of care work is endemic of a much deeper social problem; namely, the exploitation of morality by the market. Capitalism may necessarily result in the alienation of moral and material values, like that depicted by the inconsistency between these values of care work. Such a linkage between the economy and morality has been recognized in previous eras when socio-economics underwent a major change, like the current deindustrialization of society. In fact, two broad socioeconomic changes that have occurred in history, including the transition from hunting and gathering societies to agricultural societies (the beginning of

human civilization with agriculture), and the transition from agricultural societies to industrial societies, have been identified as the origin of changes in morality (Durant 1929). American social philosopher Will Durant depicts how the first of these socioeconomic turning points—the emergence of civilization—entailed changes in morals:

We do not know just when or how men passed from hunting to tillage; but we may be sure that the great transition created a demand for new virtues, and that many old virtues became vices in the settled and quiet routine of the farm. Industriousness was now more vital than bravery, thrift more desirable than violence, peace more profitable than war (Durant 1929: 115-116).

Industrialization brought upon another change in morals:

The rise of the factory system has put back marriage by rendering the individual insecure; it has multiplied promiscuity by this incontinent postponement, and by throwing millions of people together amid the stimulating contacts and protective anonymity of city life; it has brought the emancipation (industrialization) of women, with pre-marital experiments as an incidental result; it has weakened the moral influence of the family; and it has led to the replacement of Puritan asceticism and restraint by an Epicurean efflorescence of every pleasure and every perversion (Durant 1929: 127).

Today, industrialization is declining and a postindustrial service economy is taking hold of society. At the heart, and the base, of this economy are low skill-level workers, including DCWs, who provide direct services to consumers. Many DCWs previously worked in factories, which have now closed. Deindustrialization drives workers from factories to LTC, but also drives employers' values, and thus workers' values, from material emphases on production, quantity, and standardization to moral concerns of maintenance, quality, and personalization. As traditionally home- and family-based services, like childcare and eldercare, enter the market, moral values that had historically been restricted to the private family home collide with the material values of the market. This collision has exposed inconsistency between moral and material values, with moral

values generally being exploited for material interests. Paying DCWs minimal wages but assigning care work high moral value is a fundamental component of this exploitation.

Moral and market values for care work are inconsistent, and this inconsistency has proven detrimental to the demands of the service economy. By supporting high moral values and low pay for care work, current policies and practices exacerbate the care crisis our society is facing. In a service economy, with its emphases on, and responsibilities for maintenance, quality, and personalization, moral values like altruism deserve greater influence (than material values) on individuals' actions and market dynamics. However, Virginia Held explains that market values obscure all other modes of valuation: "The ideal of the market teaches that everyone is always motivated by self-interest, that firms seek to maximize profits, that economic value is the only kind of value that matters" (2002:25).

Paired with aging demographics, the discordance between moral and material values for LTC is making for a precarious, life-or-death situation for ever-greater numbers of people. According to the American Association of Homes and Services for the Aging Commission on Ethics in Aging Services (2007), it is a "moral imperative" that the quality of care work jobs are improved, and that this improvement include an increase in the material value of care work and an enhancement of the work-centric features of LTC.

Rather than continue to impede the integration of morality and money in care work, societies and employers could acknowledge care work as a fully professional career deserving of material rewards that are consistent with its moral value. Such

integration of economics and ethics, or extrinsic and intrinsic rewards, would fulfill DCWs' motivations and likely attract exponentially more individuals to care work.

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APPENDIX A

TYPE 1 INTERVIEW ITEMS

STAFF CHARACTERISTICS

First, I'd like to collect some general background information about you:

1. Please record the gender of the participant:
2. Are you of Hispanic or Latino origin?
3. What do you consider your race?
4. What is your country of origin?
5. What is your primary language?
6. What was your age on your last birthday?

OR

- 6A. I have a list of age ranges. Can you tell me what age range you fall into?

	1	18-25
_____ [14]	2	26-35
	3	36-45
	4	46-55
	5	56-65
	6	66 and over

 998 Refused
 999 Don't know

7. What is your highest educational level?

- 7A. Are you currently in school?

7B. **If yes:** Where do you go to school?

7C. What are you studying? (**Please record verbatim.**)

8. Have you received specialized training or obtained a degree in resident care, nursing, or the medical field, such as a CNA or nursing degree?

- 8A. **If yes:** What is that training? (**please record verbatim.**)

8B. **If requires a license or certification:** Is your license (or certification) current?

9. Are you married, separated, divorced, widowed, or have you never been married?

10. Do you live alone or with others?

- 10A. **If others are present:** Who are the people you live with?

10B. **If others are present,** how many of these people rely on you for care or financial support?

11. If any, how many people living outside of your household rely on you for care or financial support?

11A. **If yes:** Who are these people?

12. How would you rate your current health?

13. Has your job affected your health in any way? 1

13A. **If yes:** Could you tell me how?

JOB STATUS

Next, I'd like to collect some general information about your work status and schedule.

14. What is your job title?

15. Have you held the same job the entire time you have worked here?

15A. **If no:** Is your current job the result of a promotion?

16. **FOR HOMES THAT HAVE A DEMENTIA UNIT:**

Do you usually work with AL residents or residents in the dementia unit? (**Please probe for the primary job assignment.**)

17. Are you full-time or part-time?

18. How many hours do you usually work on each shift? (**Please record verbatim.**)

19. When are you *usually* scheduled to work?
(**Please record verbatim and probe for whether the schedule is “fixed” or “variable.” Remember to ask what shift and if the schedule includes any weekend work.**)

20. On a scale of 1-10 where 1 is “very satisfied” and 10 is “very dissatisfied,” how satisfied are you with your schedule?
(**Please present the response card to the participant and record the number they choose.**)

21. What is the average number of hours you regularly work per week in this job?

22. Do you ever work overtime where you are paid time and a half?

22A. **If yes:** Approximately how many overtime hours do you work per month?

23. If possible, would you like to work more hours than you do?

23A. **If no:** Would you prefer to work fewer hours than you do?

24. In addition to this job, how many other jobs do you have?

24A. **If yes:** What are these job(s)?

How many hours per week do work and what is your rate of pay?

(Please record verbatim and probe for: the type of job, work setting, and pay.)

EMPLOYMENT HISTORY

25. How long have you worked here? _____ Year (s) and _____ Month(s)

OR What was your start date?

26. Did you leave another job to come here?

26A. Where did you work?

IF PARTICIPANT HAD MORE THAN ONE JOB, PROBE FOR PRIMARY JOB/SOURCE OF INCOME.

(please record verbatim and probe for type of job and work setting.)

26B. What is the main reason you left your last job? **(Please record verbatim.)**

27. Thinking back over your employment history, how long have you been employed in caregiving jobs working with older adults?

(Please record verbatim and probe for the number of years/ months in each job.)

28. Why did you decide to do this kind of work?

(Please record verbatim. Please ask the participant to rank more than one choice in order of importance.)

29. Why did you choose assisted living as a place to work instead of another long-term care setting, such as a nursing home or a private home?

(Please record verbatim and probe for the *most* important reason.)

30. Why did you decide to work at (name of facility)?

(Please record verbatim and probe for the *most* important reason.)

31. Have you ever thought about leaving this job?

31A. **If yes:** What was your reason for thinking about leaving?
(Please record verbatim and probe for the *most* important reason.)

31B. When was the last time you thought about leaving? **(Please record verbatim.)**

JOB CONTENT

Next, I'm interested in learning about your daily tasks and responsibilities.
(When asking the next set of questions, please confirm that the participant usually performs these tasks.)

During your regular shift, do you *usually* help with:

32. Hands on care (i.e., provide ADL care for residents)?

33. Preparing food?

34. Setting up the dining room?

35. Serving food?

36. Washing dishes?

37. Doing laundry?

38. Light housekeeping, such as emptying residents' trash and making their beds?

39. Heavy cleaning, such as vacuuming, dusting, and mopping floors?

40. Do you *usually* help with transportation?

41. Are you *usually* responsible for any paperwork or record-keeping?

42. Do you *usually* help with resident activities?

43. Do you *usually* help with medications?

43A. **If yes:** When you help with medications, what do you do?
(Please record verbatim and probe for how medication is packaged, dispensed, how it is documented, and what the participant's role is. Please provide as much detail as possible.)

44. Is supervising staff one of your normal tasks?
45. Are there any other tasks that you usually do that I have not asked you about (“Other”)?
(Please confirm that this “other” task is something that the participant *usually* does each shift.)
Please record verbatim.
46. On a scale from 1-10 where 1 is “often” and 10 is “never,” how often do you feel pushed to get all of your work done?
(Please present the response card to the participant and record the number they choose.)
47. To get the job done, do you prefer to work by yourself or together with other staff members?

TRAINING

Now, I have a few questions about training.

48. The state requires that you receive 16 hours of training to do your job. Who provides most of your in-service training? **(Please record verbatim and probe for one answer.)**
49. On a scale of 1-10 where 1 is “very useful” and 10 is “not at all useful,” how useful do you think this training has been?
(Please present the response card to the participant and record the number they choose.)
50. Have you had difficulty getting your required 16 hours of training?
- 50A. **If yes:** What kind of difficulty have you had?
(Please record verbatim and probe for what has been *most* difficult.)
51. Have you ever had a situation, such as an emergency, where you felt that you lacked the skills you needed?
52. Could you tell me an area or areas where you might like to have additional training?
(Please record verbatim. Please ask the participant to rank more than one choice in order of importance.)

RELATIONSHIP WITH CO-WORKERS

Next, I’d like to ask you some questions about your relationship with your co-workers.

53. On a scale of 1-10 where 1 is “friendly” and 10 is “unfriendly,” what best describes your relationship with your co-workers?

(Please present the response card to the participant and record the number they choose.)

54. Now, thinking about relationships in a different way, on a scale of 1-10 where 1 is “family-like” and 10 is “business-like,” how would you describe your relationship with your co-workers?
(Please present the response card to the participant and record the number they choose.)

55. What kind of relationship do you most value with your co-workers?
(Please record verbatim.)

56. Whom do you *usually* confide in about problems or difficulties at work?
(Please record verbatim and probe for one answer.)

RELATIONSHIPS WITH SUPERVISORS AND OTHER MANAGEMENT STAFF

Next I'd like to ask you about your relationship with your supervisors.

57. On a scale of 1-10 where 1 is “friendly” and 10 is “unfriendly,” what best describes your relationship with
 (use name of direct supervisor)?
(Please present the response card to the participant and record the number they choose.)

58. Now, thinking about relationships in a different way, on a scale of 1-10 where 1 is “family-like” and 10 is “business-like,” how would you describe your relationship with
 _____ (use name of direct supervisor)?
(Please present the response card to the participant and record the number they choose.)

59. What kind of relationship do you most value with a direct supervisor?
(Please record verbatim.)

60. On a scale of 1-10 where 1 is “friendly” and 10 is “unfriendly,” what best describes your relationship with
 (use name of owner or facility director)?
(Please present the response card to the participant and record the number they choose.)

61. Now, thinking about relationships in a different way, on a scale of 1-10 where 1 is “family-like” and 10 is “business-like,” how would you describe your relationship with
 _____ (use name of owner or facility

director)?

(Please present the response card to the participant and record the number they choose.)

62. What kind of relationship do you most value with a facility owner or director?

(Please record verbatim.)

AUTONOMY/CONTROL

The next set of questions asks about personal control and decision-making. First, I want to ask about residents.

63. On a scale of 1-10 where 1 is “often” and 10 is “never,” how often do you think residents make their own decisions about the care they receive?
(Please present the response card to the participant and record the number they choose.)

64. On a scale of 1-10 where 1 is “very important” and 10 is “very unimportant,” how important do you think it is for residents to have some choices, appropriate to their abilities, about their daily routines and care (e.g., when they get up in the morning or when they eat breakfast) ?
(Please present the response card to the participant and record the number they choose.)

65. Now thinking about your own control, on a scale of 1-10 where 1 is “often” and 10 is “never,” how often do you make decisions about how you do your job, such as deciding when and how certain tasks are done?
(Please present the response card to the participant and record the number they choose.)

66. On a scale of 1-10 where 1 is “very important” and 10 is “very unimportant,” how important is it for you to have some control over how you do your job?
(Please present the response card to the participant and record the number they choose.)

SALARY AND BENEFITS

The next set of questions asks about salary and benefits.

67. First, do you have health insurance?

- 67A. **If yes:** Who provides it? **(Skip to Question 69)**

(PLEASE PROBE FOR ANY SOURCE, INCLUDING PUBLIC ASSISTANCE.)

68. **FOR HOMES THAT OFFER HEALTH INSURANCE** (If “NA,” skip to question # 69)

Why don't you take advantage of the health benefits offered here?

69. **FOR HOMES THAT OFFER DENTAL INSURANCE** (If “NA,” skip to question # 70)

Do you receive dental benefits with this job?

- 69A. **If no:** Why not?

70. On a scale of 1-10 where 1 is “very satisfied” and 10 is “very dissatisfied,” how satisfied are you with this facility's leave policy?

71. What was your starting hourly rate here at (use facility name)?
(If the participant is salaried, please indicate the pay rate and specify whether it is weekly, monthly, or annual.)

72. Now, how much do you make?

73. Facilities have different ways of recognizing employees for good work.

What type of recognition would be most meaningful to you?

(Please record verbatim and probe for what would be *most* meaningful.)

74. Overall, how would you rate (use facility name) as a place to work? (Please read the following list to the participant and ask them to choose the best answer):

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor

- 998 Refused
- 999 Don't know

75. Now, how would you rate _____ (use facility name) as a place for residents to live?

Please read the following list to the participant and ask them to choose the best answer:

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor

 998 Refused
 999 Don't know

76.If one of your elderly family members needed to move to assisted living, would you recommend (use facility name)?

(If the participant indicates that cost is an issue, ask them to pretend that cost is not an issue.)

77.On a scale of 1-10 where 1 is “friendly” and 10 is “unfriendly,” how would you describe the overall feeling or atmosphere at (use facility name) as a place to work?

(Please present the response card to the participant and record the number they choose.)

78.Now, thinking of the home in a different way, on a scale of 1-10 where 1 is “family-like” and 10 is “business-like,” how would you describe the feeling or overall atmosphere at _____ (use facility name)?

(Please present the response card to the participant and record the number they choose.)

79. In your opinion, is there a feeling of teamwork among the staff at (use facility name)?

80.What do you like best about working at (use facility name)?

(Please record verbatim. Please ask the participant to rank more than one choice in order of importance.)

81.What do you like least about working at

(use facility name)? **(Please record verbatim. Please ask the participant to rank more than one choice in order of importance.)**

82.On a scale of 1-10 where 1 is “extremely valued” and 10 is “not at all valued,” how valued or appreciated do you feel as a worker at (use facility name)?

(Please present the response card to the participant and record the number they choose.)

83. Now, thinking about your daily responsibilities, do you feel that you get enough time for breaks during a regular shift?

84.On a scale of 1-10 where 1 is “very important” and 10 is “very unimportant,” how important is it to you to have a room or area at a facility that is just for staff to use?

(Please present the response card to the participant and record the number they choose.)

85. On a scale of 1-10 where 1 is “very important” and 10 is “very unimportant,” how important is it to you to have a free or discounted employee meal?

(Please present the response card to the participant and record the number they choose.)

RELATIONSHIPS WITH RESIDENTS AND RESIDENTS’ FAMILY MEMBERS

Next I’d like to ask you about your relationships with residents and their family members.

86. On a scale of 1-10 where 1 is “friendly” and 10 is “unfriendly,” what best describes the relationship that you have with residents?

(Please present the response card to the participant and record the number they choose.)

87. Now, thinking about relationships with residents in a different way, on a scale of 1-10 where 1 is “family-like” and 10 is “business-like,” how would you describe your relationship with residents?

(Please present the response card to the participant and record the number they choose.)

88. What kind of relationship do you most like to have with residents?
(Please record verbatim.)

89. In this facility, what type of resident do you find most stressful to care for?

(Please record verbatim and probe to find out what is *most* difficult.)

90. On a scale of 1-10, where 1 is “very difficult” and 10 is “not at all difficult,” how difficult is it for you when a resident dies or moves away to a hospital or nursing home?

(Please present the response card to the participant and record the number they choose.)

91. In these situations, would it be helpful to you to receive counseling or training from the facility?

92. On a scale of 1-10 where 1 is “friendly” and 10 is “unfriendly,” what best describes the relationship that you have with residents’ family members?
(Please present the response card to the participant and record the

number they choose.)

93. Now, thinking about relationships with family members in a different way, on a scale of 1-10 where 1 is “family-like” and 10 is “business-like,” how would you describe your relationship with residents’ family members?

(Please present the response card to the participant and record the number they choose.)

94. What kind of relationship do you most value with residents’ family members?

(Please record verbatim.)

RACE

In learning about relationships, we are interested in race relations.

95. First, thinking about your *co-workers*, have you ever had an experience on your job where a *co-worker* treated you badly because of your race. For example, have you ever been called a name or been excluded from a social situation because of your race?

- 95A. On a scale of 1-10 where 1 is “often” and 10 is “never,” how often have you found yourself in this situation? **(Please present the response card to the participant and record the number they choose.)**

96. Now, have you ever had an experience on your job where *a supervisor* or *other management staff* treated you badly because of your race?

- 96A. On a scale of 1-10 where 1 is “often” and 10 is “never,” how often have you found yourself in this situation? **(Please present the response card to the participant and record the number they choose.)**

97. Now, thinking about *residents*, have you ever had an experience on your job where *a resident* treated you badly because of your race?

- 97A. On a scale of 1-10 where 1 is “often” and 10 is “never,” how often have you found yourself in this situation? **(Please present the response card to the participant and record the number they choose.)**

98. Next, have you ever had an experience on your job where *a resident’s family member* treated you badly because of your race?

- 98A. On a scale of 1-10 where 1 is “often” and 10 is “never,” how often have you found yourself in this situation? **(Please present the response card to**

the participant and record the number they choose.)

99. Have you ever thought about leaving this job because of race-related issues?
100. Have you ever thought about leaving another job because of race-related issues?

Now, I have a few miscellaneous questions.

101. Approximately, how many minutes does it take you to get here from home?

102. How do you usually get to work? **(Please record verbatim.)**

103. On a scale of 1-10 where 1 is “often” and 10 is “never,” how often do you have difficulty balancing this job with your other responsibilities?

(Please present the response card to the participant and record the number they choose.)

104. Are you currently a home owner or do you rent?

105. Now, I am going to show you a list of income categories. Thinking about your income from this job and any other jobs, what was your approximate annual income last year?

APPENDIX B
TYPE 2 INTERVIEW GUIDE

DIRECT CARE STAFF TYPE 2 INTERVIEW- NIA R01- 05/09/05
(For Staff without Type 1 Interview)

Staff Code _____ Facility Code _____ Interviewer _____ Date _____

Quantitative responses can be recorded after the transcript is returned if necessary.

Staff Characteristics

1. Record gender. Male _____ Female _____
2. Are you of Hispanic or Latino origin? Yes _____ No _____
3. What do you consider your race?
 Black /African American _____ White _____ Hispanic _____ Asian _____
 Other _____ Indicate what is meant by “other” (e.g., Jamaican).
4. What is your country of origin?
5. When did you come to the USA? Date of Entry _____
6. What is your primary language?
 English _____ Spanish _____ Other (list) _____
7. What was your age on your last birthday? _____ Or ask age range
 18-24 _____ 25-34 _____ 35-44 _____ 45-54 _____ 55-64 _____ 65-74 _____ 75+
8. What is your highest education level?
 _____ Less than high school diploma
 _____ GED
 _____ High school diploma
 _____ Trade school or vocational certificate
 _____ Some college or associate degree (2-year program)
 _____ Bachelor’s degree
 _____ Some post-graduate work
 _____ Graduate degree
 _____ Other _____
 Total number of years _____
9. Do you have a degree or specialized training in resident care, nursing, or the

medical field?

Is certification current?

Current?

CNA _____
 LPN _____
 RN _____
 Nursing training (no degree) _____
 Certified Medical Assistant _____
 Medication Certification _____
 Other _____

10. Are you currently in school? Yes _____ No

If yes, where do you go to school?

Probe for:

goals of school

how school paid for

difficulties managing school, work, and other responsibilities

11. Are you married, separated, divorced, widowed, or have you never been married?

Married _____ Widowed _____ Single _____ Divorced _____ Separated

12. Do you have children? Yes _____ No

(If children) How many? _____ What are their ages?

13. How many people live with you now?

Who are the people who live with you?: (Record # in each category)

Spouse _____ Partner _____ Child _____ Grandchild _____ Sibling _____ Parents

Grandparents _____ Friend _____ Other

Probe for details:

How long lived together

Reasons for sharing household

If children don't live in home, where they live

If older children, what are they doing? Jobs? Education?

14. How many of the people who live with you rely on you for care or financial support?

Who are these people? Record # in each category:

Spouse _____ Partner _____ Child _____ Grandchild _____ Sibling _____ Parents
 Grandparents _____ Friend _____ Other

Probe for:

Type and level of support
 Time frame of support
 Reasons for support
 Who else in the household works and what they do?

15. How many people outside of your household rely on you for care or financial support?
 Who are these people? Record # in each category:

Spouse _____ Partner _____ Child _____ Grandchild _____ Sibling _____ Parents
 Grandparents _____ Friend _____ Other

Probe for:

Type and level of support
 Time frame of support
 Reasons for support

16. Does anyone outside of your household help you out financially?

Probe for:

Who
 Type and level of support
 Time frame of support
 Reasons for support

17. How would you rate your health? Excellent _____ Good _____ Fair _____ Poor

What kind of health problems do you have?

Probe for:

Impact of health problems
 How health affects work / How work affects health

Life History

Now I'd like to ask you a few questions about your past life experiences.

18. Could you tell me about where you lived as a child and what life was like growing up?

Probe for:

Financial situation-whether family had enough money for everything it needed
 Kind of work mother and father did
 Number of siblings
 Whether grandparents or other relatives lived in the home

19. Where have you lived most of your life?

Probe for:

Time line of moves- duration of stays in places
 Factors contributing to moves, if any
If immigrant, situation leading to coming to US

Employment History

Let's talk a little about your employment history.

19. Could you tell me about your very first job?

Probe for:

How old when started working
 Kind of job hoped to have as a child

20. What kinds of work have you done most of your life?

Probe for:

All kinds of jobs and how long worked in each, getting details about positions in long-term care- type of job and setting and approximate time frame
 How and why aspirations changed throughout life

Record long-term care positions:

LTC Position _____ Length of time in that position

LTC Position _____ Length of time in that position

LTC Position _____ Length of time in that position

LTC Position _____ Length of time in that position

Approximate time in the field of long-term care

22. Looking back over your past jobs, which have you found most satisfying?

Probe for:

Details of what aspects of jobs were satisfying and why

23. Could you tell me why you left your earlier jobs? (**Ask specifically about the last few jobs.**)
23. What kind of jobs do you think you might like to have in the future?
23. During your life, how do you think your race has affected work opportunities for you?

Probe for:

Other **barriers** to employment opportunities

How has your **age** affected work opportunities for you?

How has your **education** affected work opportunities for you?

23. Now could you tell me how you got started in the field of long-term care and what led you to do this kind of work?

Probe for:

Personal qualities- What about you made you go into this field?

Presence of grandparents in life

Relationships with other elderly persons

Other caregiving experiences

Relationships with others in the field

Serendipitous events

Best job available

24. How did you choose assisted living over other care settings?

Probe for:

How AL work experience compares to other long-term care settings

Workload, job design, pay, time for relationships, type of residents

28. How long have you worked in this facility? _____ or start date

29. How did you choose this facility?

Probe for:

How and why facility chosen

Whether knew anyone in facility before applying

Whether knew anything about reputation of facility before applying

30. What is your current position?
31. What other positions have you held here?

Probe for:

Details about work history within facility
When changes made and why

32. What is your usual work schedule?

Probe for:

What shift worked
Number of hours
Whether fixed or variable
Whether part-time, full-time, PRN
Whether works overtime, how often

Record later:

Shift usually worked: Morning/afternoon ____ Afternoon/evening ____ Night

Combination

All weekends ____ All weekdays ____ Combination ____ Variable ____ Other

Part-Time ____ Full-Time ____ PRN ____

hours per shift ____ # hours per week ____ # hours per month **paid** overtime

33. How much control do you have over your schedule?

Probe for:

Who determines
How determined

34. How happy are you with the schedule you are working now?

Probe for attitude toward:

Shift worked
hours worked- enough, too few, too many

35. What area of the facility do you usually work in?

Probe for:

AL or dementia
particular floor
Whether varies
How decided

Record: AL ____ Dementia Care ____ Both

36. Do you have any other jobs now? Yes ____ No

If yes, could you tell me about these jobs?

Probe for:

Type of job , # of hours, income

How long had job

How long has worked more than one job

How working in more than one job affect this job and life in general

Job #1 _____ # of hours _____ Pay

Job #2 _____ # of hours _____ Pay

Job Design/Performance

Now, let's talk about your work here.

37. Tell me about a typical work day, beginning with when you get to work?

Probe for:

Tasks performed on a regular basis

Schedule for carrying them out- when, how often

Amount of time spent performing each

Record Later- Duties Usually Performed: # of daily tasks

_____ Paper work, record keeping

_____ Supervisory

_____ Training

_____ Preparing food

_____ Set up/clean up dining area

_____ Serving food

_____ Dish washing

_____ Light housekeeping

_____ Heavy cleaning

_____ Laundry

_____ Medication assistance

_____ Planned Activities

_____ Transportation (e.g., to the doctor, activities outside the home)

_____ Hands on care

_____ Other

38. Which of your assigned jobs do you like the best?

What do you like about doing X?

39. Which do you like the least?

What don't you like about doing X?

Probe for: How person feels about **overall** assignment, doing a **variety** of tasks

40. Could you tell me a little about **how** you like to work, your work style?

Probe for:

How they plan their work to complete tasks, i.e. work strategies
 Whether they like to work alone or with other staff
 How duties are shared

41. What does *teamwork* mean to you?
42. Do you think there is teamwork here at _____?
Probe for:
 Why or why not
 Differences/ conflicts between shifts
 Other variables that influence teamwork

I would like to ask you a few more questions about resident care. (Use to fill in gaps.)

43. How many residents do you usually care for each day?
Probe for:
 Whether number varies
 Whether has the same residents each day
 How assignments are made
44. Could you tell me about the resident who needs the most care?
Probe for:
 What care is needed and how provided
 # of residents who require “heavy care” (need help with 2 or more ADLs)
45. Now, could you tell me about the resident you find most difficult to care for?
Probe for:
 What is difficult and why
 How behaviors are managed
43. What do you enjoy most about caring for residents?
44. And what is most difficult or frustrating?
45. Overall, how much control or say so do you have over what you do and how you do your job? **Probe for:**
 What kinds of decisions they make
 Whether they would like more or less control and why

Now let’s talk about your overall workload- the amount of work you have to do during a typical shift.

46. Do you usually have enough time to finish all of your work?
Probe for:
 Any problems encountered
 How often pressed to complete work If pressed, why

47. Now tell me about your break time.

Probe for:

Where they go

What they do

Who they do it with

How long they take

Whether time is adequate

Training

Now I'd like to ask about training

51. When a person first comes to work here, how are they trained?

Probe for:

Who does it

How it is done

What they think about the initial training

52. What kind of ongoing training does the state of Georgia require you to have?

Probe for: Whether they are familiar with the state regs for # and type of training

51. How do you get your annual training?

Probe for:

Kinds of training received

Where they receive it

Any problems getting it

Who keeps up with the required hours

52. How does this training affect your ability to do your job

Probe for:

How useful they think training has been

What kinds most useful

Whether they feel training is adequate

Any problems related to inadequacies

53. What are some areas you might like additional training?

Workplace Relationships with management/supervisor

We are interested in how your work relationships influence your overall job experience. I'd like to begin by asking you about your relationship with each of your supervisors and other management staff. (when asking these questions please refer to **each** supervisor by name, including staff's shift supervisor, unit and facility director)

51. First, tell what kind of relationship you have with _____ (Direct supervisor)?

Probe for:

Type, quality of relationship

Degree of closeness- friends, family-like, professional
 Any problems
 How well know each other

52. Why do you think you have this kind of relationship with _____?
Probe for:
 Own attitudes
 affect of race
 affect of other factors- personality, longevity, facility policies
 favoritism- whether certain staff are treated differently and why
53. When do you usually see _____?
Probe for:
 Kinds of interactions- How often? When? Where?
 Whether available when needed
54. How does your relationship with _____ (Direct supervisor) affect your job?
 What is most satisfying about relationship
 Most frustrating
 How relationship affects how job carried out
 How relationship affects attitude toward job

Repeat above questions for each level of supervisor that is applicable.

55. Now, tell what kind of relationship you have with _____ (Unit manager)?
Probe for:
 Type, quality of relationship
 Degree of closeness, friends, family-like, professional
 Any problems
 How well know each other
56. Why do you think you have this kind of relationship with _____(Unit manager)?
Probe for:
 Own attitudes
 affect of race
 affect of other factors- personality, longevity, facility policies
 favoritism- whether certain staff are treated differently and why
57. When do you usually see _____(Unit manager)?
Probe for:
 Kinds of interactions- How often? When? Where?
 Whether available when needed

58. How does your relationship with _____ (Unit manager) affect your job?
 What is most satisfying about relationship
 Most frustrating
 How relationship affects how job carried out
 How affects attitude toward job
59. Now, tell what kind of relationship you have with _____ (Director)?
Probe for:
 Type, quality of relationship
 Degree of closeness, friends, family-like, professional
 Any problems
 How well know each other
60. Why do you think you have this kind of relationship with
 (Director)?
Probe for:
 Own attitudes
 affect of race
 affect of other factors- personality, longevity, facility policies
 favoritism- whether certain staff are treated differently and why
61. When do you usually see _____ (Director)?
Probe for:
 Kinds of interactions- How often? When? Where?
 Whether available when needed
62. How does your relationship with _____ (Director) affect your job?
 What is most satisfying about relationship
 Most frustrating
 How relationship affects how job carried out
 How affects attitude toward job

Now let's talk about your relationship with residents

68. Overall, what kind of relationship do you have with residents?
69. Could you tell me about a resident you feel close to?
Probe for: why staff person feels close to this resident
70. How do you get to know residents?
Probe for: how they develop relationships
71. Could you tell me about a resident you have problems with?
Probe for:
 Why relationship is problematic
 Other kinds of problems with residents

72. What do you do when you have a problem with a resident?
Probe for:
 Strategies for managing different kinds of problem behaviors
 Any facility policies or intervention
73. When do you usually spend time with residents?
Probe for:
 Type and frequency of interactions- whether times outside of caregiving
 Whether they have adequate time to spend with residents, to get to know them
74. How do you think race influences your relationship with residents?
75. What kind of relationship does management want you to have with residents?
Probe for: How policies discourage or promote good or close relationships
76. How does your relationship with a resident affects how you care for them?
Probe for:
 Time spent?
 Special care provided?
77. How does your relationship with residents affect your overall satisfaction with your job?
Probe for:
 How relationships with residents make job better and worse
78. Have you ever had to deal with the death of a resident?
Probe for:
 How they coped
 Kind of supports that would be useful
 How loss affected work experience and attitudes
79. In general, what kind of relationship do you have with **residents' with families?**
80. Could you tell me about a family member you feel close to?
Probe for: why staff person feels close to family member
81. How do you get to know residents' families?
Probe for: how they develop relationships
82. Could you tell me about a family member you have problems with?
Probe for: Why relationship is problematic
 Other kinds of problems with families
83. What do you do when you have a problem with a family member?
Probe for: Strategies for managing different kinds of problem behaviors
 Any facility policies

84. When do you usually see families?
Probe for: Type and frequency of interactions
85. How do you think race influences your relationship with families?
86. How does your relationship with a family member affect how you feel about the resident?
Probe for: Time spent? Special care provided?
87. How does your relationship with families affect your overall satisfaction with your job?
Probe for: How makes relationships with families make job better and worse
88. What might improve relationships between care staff and family members?
89. Are there any outside people who visit this facility who interact with you in some way? (Give examples if needed– **sitters**, regulators, ombudsmen, home health care workers)
Probe for: How they affect the work experience and attitudes

Now I would like to talk about your relationships with other care staff.

90. In general, what kind of relationships do you have with your co-workers?
Probe for:
 Quality of relationship
 How well they know other staff
 How they feel about staff on their own shift
 How they feel about staff on other shifts
 Presence of cliques
 Degree of trust
91. Could you tell me about a staff person you feel close to?
Probe for:
 Why staff person feels close to other staff/ what led to close relationship
 personal traits
 work experience
92. Could you tell me about a staff person you have problems with?
Probe for:
 Why relationship is problematic
 What led to relationship
 Other kinds of problems with co-workers
93. What do you do when you have a problem with a co-worker?
Probe for:
 Strategies for managing different kinds of problem behaviors

- Any facility policies
94. Could you tell me when you usually interact with other staff.
Probe for:
 What they do together
 Where? In and outside of workplace
 When? How often? How much time?
 Who they usually interact with
 Same shift, age, race etc.
95. What do you do if you have a problem with a co-worker?
Probe for:
 Whether problems dealt with on own or through management
 How management affects relationships
96. What do you think might improve relationships between co-workers?
97. How does your relationships with other staff affect how you feel about your job?
Probe for: Whether relationships make the work more or less pleasant
98. How does race affect relationships among staff?
Probe for: Whether race has affected own relationships
 Examples of other staff who have had problems
99. Now, can you tell me about your life outside of work?
Probe for:
 Caregiving responsibilities (e.g., childcare, elder care)
 Household responsibilities
 How spends leisure time
 Problems you have balancing work with family responsibilities
 How work affects home life
 How home life affects work
100. How far (in minutes) is the facility from your home?
 How do you typically get here? (bus, drive, get dropped off)
101. Do you have health insurance? _____ Dental insurance?
 If yes, where from?
 If no, probe for why not.
102. How do you feel about the benefits here?
 Probe for:
 Attitudes toward health insurance, vacation, sick leave, other
 Importance of having each type of benefits

What was your starting hourly rate?

Current hourly rate?

103. How do you feel about your salary?

Probe for: Whether it is fair

How compares with other facilities

How compares with income from other jobs

104. What kind of opportunities do you think you have to move up in your job here?

Probe for: Whether they think they have opportunity for raise, change in position

105. What kind of changes would you like to make in your present job?

Probe for: Whether would like to have to have a position with more responsibility?

106. Could you describe the employee recognition program here?

Probe for: How important this kind of recognition is

Attitude toward current program

107. What kinds of recognition would **you** most like to have?

108. Now, thinking about your job as a whole, how do you feel about it?

Probe for: What is most satisfying, what do you like most

What likes least or is most frustrating; what is the hardest thing about it

How do you feel about (facility name) as a place to work?

Probe for: Some things liked, disliked

Changes would like to make

Whether would place relative there

Would recommend to someone looking for a job

109. Do you see yourself working here a year from now?

110. What about your job makes you want to stay?

Probe for relative importance of: Job content, workload, people, pay, policies, environment etc.

What else would help

111. Have you ever considered quitting?

If yes, probe for: Why thought about leaving

Why stayed

112. What do you think is most important to most people to stay on this kind of job?

Probe for relative importance of: Job content, workload, people, pay, policies, environment etc.

113. What would be most likely to make you leave?

Probe for relative importance of: Job content, workload, people, pay, policies, environment etc.

I just have a few more questions.

114. Are you currently a homeowner? **Probe for:** If yes, how long
If no, whether believes a possibility

115. What county do you live in now?

116. Counting your income from all of your jobs, what is your typical monthly income?

117. Now, what was the approximate total household income for the past year?

Or choose from income categories:

Less than \$5,000

\$5,000 - \$9,999

\$10,000 - \$14,999

\$15,000 - \$19,999

\$20,000 - \$24,999

\$25,000 - \$29,999

\$30,000 - \$34,999

\$35,000 - \$39,999

\$40,000 - \$44,999

\$45,000 - \$49,000

\$50,000 and higher

120. What do you find *most satisfying*? (**Please record verbatim. Please ask the participant to rank more than one choice in order of importance.**)

121. What do you find *most frustrating* about your job? (**Please record verbatim. Please ask the participant to rank more than one choice in order of importance.**)

PLANS FOR THE FUTURE

I'd like to end this interview by asking you about your plans for the future.

122. On a scale of 1-10 where 1 is "very likely" and 10 is "very unlikely," how likely is it that you will leave this job within a year? (**Please present the response card to the participant and record the number they choose.**)

123. What most about this job keeps you here? (**please record verbatim. Please ask the participant to rank more than one choice in order of importance.**)

124. What about this job would be most likely to make you leave? (**Please record verbatim. Please ask the participant to rank more than one choice in order of importance.**)

125. If you left here for another job, what type of a job do you think you would look for?

(Please record verbatim and probe for one answer, including type of job and setting.)

126. I just have one last question. We are interested in where people live. What county do you live in?

APPENDIX C
ADMINISTRATOR INTERVIEW GUIDE

ADMINISTRATOR INTERVIEW GUIDE

Facility Code # _____

Administrator Code # _____

Tell administrator that before you leave today you will need to get a list of all staff and their schedules and job status (part-time vs. full-time. Also tell them that next week you will be giving them some forms to fill out to get more details about staff and residents.

First, I'd like to get some general information about your home.

General Information about Home

1. What year did (name of facility) _____ begin operating as an assisted living facility?
How long has it been under the present ownership?
2. Are there other homes operating under the same ownership? ____ Yes ____ No
Name of Corporation or owner
3. Is this facility:
For Profit _____ Not-for-Profit _____
County Operated _____ State Operated _____ Other _____
4. Is this facility part of :
Nursing Home _____ Retirement Community _____
Other (Specify) _____
or Free Standing _____

Information about Administrator's Job

5. What best describes your current position?
Manager _____ Owner _____ Executive Director _____
Other (Specify) _____
6. How long have you held that position?
7. Could you describe your responsibilities?

Information about Direct-Care Staff

Now, I would like a little information about direct-care staff.

Staffing Patterns

First I would like to ask about how you organize your staffing? (We need to get complete information here about how the home staffs the facility)

8. How do you **organize your shifts**? (Typical shifts of workers- i.e., 8 or 12 hour, weekday or weekend or mixed)
 Length of Shift: 8-hour _____ 12-hour _____ Both _____ Other _____
 All weekday _____ All weekend _____ Combination or alternating _____
Record any differences:

9. Could you tell me why you use this staffing pattern?

10. What **different staff positions** do you have? e.g., care asst., med tech etc.
List each position:

[Tell administrator you will give him/her form to fill out to list number of each type of staff per shift.]

11. Now could you describe the typical **job responsibilities** for each of these positions?

Probe for details **[will give check list later.]**

[If home has a DCU, how does staffing vary?]

12. What is the typical workload for care staff? # of residents
 Does this number ever vary?
[If home has a DCU, how is staffing different in the two areas?]

13. How are staff workloads determined?
 Probe for whether based on care needs of residents? Shift?

14. Do staff always care for the same residents? Yes _____ No _____
 Why or why not?

15. Do staff have any choice over which residents they care for? Yes _____ No _____
 Why or why not?

16. How are daily work assignments and schedules communicated to staff?
 Verbally? _____ Written? _____
[ask for copy of any work assignment form]

17. Could you tell me how you determine your staffing needs, i.e., the number of people for each shift?

18. What is your policy on overtime?
 Allowed? _____ Who sets policy?- administrator or corporate _____
 Average # of hours per staff person? _____
 Who eligible? _____
 Who determines who gets? _____
 How do think staff feel about this policy?

19. Do you use PRN staff? Yes _____ No
 Why or why not?
 How often and when?
18. Do your staffing levels or patterns ever change (e.g., related to changes in the resident census)?
 What determines these changes?
If DCU, how different?
19. What do you do when staff don't show or call out?

Other Staff Policies

20. What is your policy on staff dress?
 Uniforms? Other guidelines for dress? Nametags?
 Penalties for non-compliance?
21. What about policies on staff being late? Calling out? Penalties?
22. What are your biggest problems related to staff job performance?
23. How do you address these problems?

Staff Control

26. How much control do care staff have over which shift they work?
 Could you tell me how you get their input?
 Probe for policy rationale
27. How much control do care staff have over the number of hours they work?
 Could you tell me how you get their input.
 Probe for policy rationale
28. How much control do staff have over their work assignments?
[If facility has a DCU, do staff have control over what section of facility they work in?]
 Probe for policy rationale
29. How much leeway or say so do staff have about how they do their job?
 Probe for policy rationale
30. How important do you think it is to staff to have control over their work?

Retention

Now I am going to ask some questions about staff retention. **[I will give you a form later to fill in specific numbers.]**

31. How many care staff left of their own accord during the last year? _____ (Can be filled in later)

32. To the best of your knowledge, why did they leave?
Ask for each, if they remember, or just what in their experience are the most common reasons.
33. What are your criteria for termination of care staff?
34. How are these decisions made?
35. Who makes them?
36. How many care staff were terminated over the past year? ____ (Can be filled in later)
37. Could you tell me the reasons for termination? (Ask for each, if they remember. Otherwise, typical)

Hiring

Next I want to ask about hiring staff.

38. What personal qualities do you look for when hiring new staff?
Probe for the ideal type of person, importance of “fitting in.”
39. What minimum qualifications are required for the different staff positions? e.g., education, training, job experience
Probe for how they differ from the ideal.
[Ask about each position above.]
[If home has a DCU, are qualifications different for staff who work there?]
40. What are the biggest barriers to finding staff with the qualifications you are looking for?
41. How do you recruit staff? **[Probe for where and how they find staff]**
Advertise in newspaper? Internet? Word of mouth?
42. Could you describe your hiring procedures?
How do staff apply?
References?
Background check? Drug Test?
Interviews?
43. How are hiring decisions made?
Who is involved?
Do staff have any input?
How many people have you hired during the past year? _____ **[Can fill in form later]**

Pay Scale

44. Could you describe your pay scale for care staff?

[Use pay scale form or give to them to fill out later.]

46. How are starting salaries determined? Who determines salaries?

Probe for differential pay for same position.

[If home has a DCU, any differences for staff who work in DCU?]

Awareness of staff about other salaries

47. What opportunity do staff have for raises?
What are the criteria for raises?

48. What opportunity do staff have for advancement in position?
What are the criteria for advancement in position?

49. How do your salaries compare to other facilities in the area?

50. In general, how satisfied do you think staff are with their pay?

51. How satisfied are you with the level of pay for staff here?

Benefits

52. What health benefits do you offer to direct-care staff? **[Can fill out form later]**

Medical insurance _____ employee cost share _____ # employees enrolled

Dental insurance _____ employee cost share _____ # employees enrolled

53. How are these benefits determined?
Who makes decisions about these benefits?
How do you think staff feel about these benefits?
What do you think are the barriers to staff participation?

54. Could you describe your leave policy?
Personal or vacation leave? Sick leave?
_____ # vacation/ personal days per year _____ # sick days per year
_____ # combined days per year
Who determines this policy?
How do you think staff feel about this policy?

55. Do you have any other benefits?

Employee Reward/ Recognition

55. Do you have ways you recognize employees in special ways or show appreciation for good work?
 Could you describe them?
 Opportunities for bonuses?
56. How did you decide to use these types of recognition?
57. How are recipients selected?
58. In general, how do you think staff feel about these types of recognition?
 How much do you think they affect staff satisfaction?
 How much do you think they affect staff retention?
59. Can you think of other types of rewards or recognition that might work better?
60. What is your policy on staff accepting gifts from residents or family members?
 Do you have a special time for such contributions?
61. Could you describe any special events or parties you have for staff?
 How well attended are these events?
 How do staff feel about them?
 How do you think they affect their job satisfaction?
62. How are care staff included in general facility events?
 How do you think staff feel about being included (or not included) in such events?
63. Could you describe your policy regarding staff break time?
 How much time do staff have for breaks each day?
 How much time do you think they usually take?
 How do you monitor break time?
 How satisfied do you think staff are with the amount of break time they have?
64. What special areas in the facility do staff have to use for breaks? For smoking?
 [If home has a DCU, any differences?]
 How well is it utilized?
 How important do you think it is for staff to have a special place for breaks?
 What should it be like?
 What are some barriers to having a place just for staff?

Staff Training

65. How do you train staff when they first begin work?
66. Do you provide any ongoing training for staff to fulfill their required hours?
 _____ Yes _____ No
 How often? ___Monthly ___ Bi-monthly ___ Semi-annually ___Annually

67. How do you encourage attendance?
Penalties for non-attendance?
68. Could you describe some of the training you have had over the past year?
69. Do any staff receive training from other organizations? ____ Yes ____ No
LTCO ____ ORS ____ Alz. Assc. ____ Other
What kind?
70. How valuable do you think the 16 hours of annual training are to staff's job performance?
Satisfaction with their job?
71. What kind of training do you think is most important for direct-care staff to have?
[For staff working in DCU?]
72. To your knowledge, has your facility ever had training related to building relationships:
Between staff and residents? ____ Yes ____ No
Between staff and residents' families? ____ Yes ____ No
Between staff and their co-workers? ____ Yes ____ No
Between staff and management? ____ Yes ____ No
73. Do you think that kind of training in relationships would be helpful in improving staff satisfaction and retention? ____ Yes ____ No
Why or why not?

Meetings

74. Do you have regular staff meetings? ____ Yes ____ No
How often are they held?
Monthly ____ Quarterly ____ Annually ____ Other
75. What is the purpose of the meetings?
76. How well-attended are these meetings?
Do you offer any incentives for attendance? Penalties for non-attendance?
77. Who attends these meetings beside staff? Who runs them?
78. How do you think staff feel about these meetings?
How open and honest do you think they are they in voicing their opinions or complaints at meetings?

General Staff Attitudes

79. In your opinion, what do you think staff find most satisfying about their work?
80. What do you think they find most frustrating?
81. **If home has DCU**, how do you think attitudes differ for staff who work in AL and those who work in the DCU?
What area do staff prefer to work in?
Why?

Staff Relationships

We have just finished a study on the importance of relationships to staff satisfaction and retention and I want to ask about relationships here. First, staff relationships with residents-

Relationships with Residents

82. What kind of relationships do you think your staff have with the residents? Probe as to quality, differences among staff.
If DCU, how do relationships differ in the two areas?
83. What kind of relationship do you think they should have? Why?
84. Overall, how important do you think staff relationships with residents are to their job satisfaction? Why?
If DCU, how do attitudes differ in the two areas?
85. Do you know of any staff who have left because of problems related to relationships with residents?
_____ Yes _____ No Can you describe the situation?
86. What do you think are the biggest barriers to positive relationships between residents and staff?
87. Could you describe any problems related to race you are aware of between residents and staff?
If DCU, how do attitudes differ in the two areas?
How do you deal with these?
88. How does your facility promote relationships between residents and direct-care staff? e.g., any formal or informal policies that specifically address relationships between care staff and residents.
Any ways you help staff learn about residents?
89. On the whole, do you think staff have enough time during their shift to develop relationships with residents?
_____ Yes _____ No

90. Overall, how important do you think staff relationships with residents are to residents' quality of life?

Relationships with Residents' Families

Now families-

91. When do staff usually interact with family members?
Time of day? Reasons?
92. What kind of relationships do you think your staff have with the residents' families? Probe as to quality, differences among staff.
93. What kind of relationship do you think they should have?
94. Overall, how important do you think staff relationships with residents' families are to their job satisfaction? Why?
95. Do you know of any staff who have left because of reasons related to relationships with residents' families?
Can you describe the situation?
96. Are you aware of any race-related problems between staff and residents' families?

If yes, ask to describe.
97. Do you have any formal or informal policies that specifically address relationships between care staff and residents' family members.
That promote or discourage?
98. How do you address problems between staff and family members?

Relationships of Direct-Care Staff with their Co-workers

Now I am going to ask about relationships of care staff with each other:

99. When do staff usually interact with each other?
100. What kind of relationships do you think staff have with their co-workers?
Probe as to quality, differences among staff.
Any family members? Friends?
101. What kind of relationship do you think staff should have with their co-workers?
Why?
Any policies about hiring family members?
102. Overall, how important do you think staff relationships with co-workers are to their job satisfaction? Why?

103. How are new employees treated by other staff here?
104. Are you aware of any race-related problems between staff?
If yes, ask to describe.
105. Do you know of any staff who have left because of problems related to co-workers?
Can you describe the situation?
106. How do staff usually communicate with each other about resident care or other job tasks?
During shifts? Formal? Informal?
From one shift to another? Formal? Informal?
107. How does your facility promote relationships among direct-care staff?
Any special team-building events?
108. How do you solve any disputes you have with staff?
109. What do you think are the biggest barriers to positive relationships among staff?

Relationships of Staff with Supervisors and other Managerial/Administrative Staff

Next I want to ask about relationships between care staff and their supervisors and other managerial staff:

110. When do care staff usually interact with their supervisors?
With other administrative staff?
With you?
How do they get access to you if they need you?
111. Could you describe your own relationship with direct-care staff?
112. What kind of relationship do you think management should have with care staff?
Why?
113. Are you aware of any race-related problems between care staff and managerial staff?
If yes, ask to describe.
114. How does your facility promote relationships between managerial and care staff?
115. How important do you think relationships with managerial staff are to the job satisfaction of care staff?

116. How well do you think you know the care staff in this facility?
 Personal life?
 Knowledge and abilities?
 Quality of care they provide?
117. How well do you think direct supervisors know the care staff in this facility?
 Personal life?
 Knowledge and abilities?
 Quality of care they provide?

Miscellaneous

118. What is your policy on care staff working as sitters for residents?
 Why do you have that policy?
119. What kinds of social support do you provide to care staff? Support groups?
 Counseling?
120. From your overall experience, what do you think are your biggest barriers to keeping staff?

Personal questions about administrator

Now, before we end I'd like to ask a few more questions about you.

121. Could you tell me what motivated you to get into this field?
122. I'd like to know about your educational background?
 Probe for educational level and type of degrees.
124. What about long-term care training?
 Probe for any long-term care training or certification, time frame. LPN, RN, CNA
125. Do you have any managerial or administrative training?
 Probe for type of administrative, managerial training.
 Nursing home administrator license? assisted living administrator license?
126. Now could you tell me about your employment history before working here.
 Where were you before you came here?
 What other jobs have you had?
 Probe for how long in assisted living, other AL jobs
 Probe for other long-term care jobs, how long in long-term care
 Probe for managerial and administrative experience.
127. Now, could you tell me your age on your last birthday?
128. Is there anything else you would like to tell me about staffing policies and procedures in your facility?
 About the experiences and attitudes of direct-care staff?

Remind again about list of current staff.

Also ask for any marketing materials, facility policies and procedures.

Discuss how administrator would like to handle:

Observation visits- Set times? Notify them? Best times to come?

Requesting staff interviews- they or we ask?

Scheduling of staff interviews- during or after shifts?

Give \$25 and get reimbursement form signed.

APPENDIX D

OBSERVATION GUIDE

OBSERVATION GUIDE

SUMMARY OF TOPICS (A detailed guide for each topic follows the summary)

- I. Staff Meeting:**
 - Scheduled weekly/monthly meeting
 - Special meeting (e.g., to discuss specific issue)
 - Meeting with supervisor (e.g., to get shift assignment)
 - Meeting with coworker(s) (e.g., giving instructions to the next shift)

- II. Caregiving Activities Observed in Common Areas**
 - ADL/IADL care
 - Medication management
 - Incontinence management (e.g., prompting residents when it is time to go the bathroom)

- III. Other Shift Tasks (besides caregiving)**
 - Dining room service
 - Housekeeping
 - Conducting planned activities (e.g., leading exercise group)
 - Transportation

- IV. Informal Activities with Residents**
 - Playing cards/putting together a puzzle
 - Reading to a resident
 - Chatting with residents/smoking with residents

- V. Planned Group Activities with Residents**
 - Participating with residents in a planned facility (e.g., Bingo)
 - Special event (e.g., holiday party, birthday)

- VI. Interactions with Visitors to the Facility**
 - Residents' family members, friends
 - Regulators, ombudsman, social worker, home health workers
 - Volunteers, community groups

- VII. Informal Interactions with Coworkers and/or Supervisors**
 - Talking in break room
 - Gossiping during a shift
 - Smoking together

- VIII. Unexpected Occurrences**
 - Medical emergencies
 - Other crises

OBSERVATION GUIDE

I. Staff Meeting

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

Where was the meeting held?

What were the sequence of events ? (timing of events)

How was the meeting started?

Who was present at the beginning?

How long did specific events last (e.g., how long did it take for staff to assemble for the meeting?)

What signaled the end of the meeting?

Who was involved in the activity?

Who stayed for the entire meeting?

Who left?

Who joined late?

Who led the meeting?

Who talked ?(e.g., was the meeting interactive or did staff just listen?)

How were things done?

What topics were discussed?

How was the meeting organized/or unorganized?

Describe the social environment:

How did people organize into groups?

What were the groupings like (e.g., all white staff, all Latino staff)?

How did the participants relate to each other (e.g., how did males relate to females)?

How did participants arrange themselves in the social space? (diagram if necessary)

Describe the decision-making patterns

Who decides when meetings end?

How are decisions communicated?

How did participants react to what was said/done? What do people say?

Describe the frequency of interactions?

Describe body language (gestures, people's expressions, etc.)

Reflective Notes:

Interpretations/Questions Researcher Has

Who seemed bored/thoughts on why they might have been bored?

How did the meeting today compare to another meeting that was observed?

Thoughts about the activity (e.g., whether or not you think the meeting was productive)

II. Caregiving Activities Observed in Common Areas

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

What activities were observed?

Where did the activities occur?

What were the sequence of events ? (timing of events)

What events led up to the activity? (e.g., was it routine or did resident have an urgent need?)

Who was present at the beginning/end?

How long did specific events last? (e.g., administering medication took 20 minutes)

What signaled the end of the activity?

What signaled the end of the activity?

Who was involved in the activity?

Who was present during the activity? (were others present besides the resident and staff)

Who initiated the activity? (e.g., resident or staff)

How were things done?

How much help did the resident get?

Did staff allow the resident to perform certain tasks her (him) self (self-care)

Describe procedure giving detail (e.g., how were meds dispersed—handed to resident in a cup, etc.)

Describe the social environment:

How did the participants relate to each other (e.g., resident to staff)?

How did participants arrange themselves in the social space? (diagram if necessary)

How did participants react to what was said/done?

Describe body language (gestures, people's expressions, etc.)

What do people say?

Reflective Notes:

Interpretations/Questions Researcher Has

Feelings about the activity (e.g., staff encouraged/didn't encourage self-care, staff had time/didn't have time to adequately meet the residents' needs)

Feelings about the staff-resident interaction (e.g., staff was respectful/not respectful)

III. Other Shift Tasks

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

What tasks were observed?**Where did tasks take place?****What were the sequence of events? (timing of events)**

When did the task start

How long did each task take?

How were things done?

Were staff involved in more than one task at the same time? (e.g., serving meals and handing out medication)

Describe the social environment?

Were staff helping each other?

Did residents help?

Describe the environment (room, social climate)

If helpful, diagram the setting

Reflective Notes:**Interpretations/Questions Researcher Has**

Did staff seem overworked?

How did today's activities compare to activities observed on the last visit(s)?

IV. Informal Activities with Residents

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

Where did the activity occur?

What were the sequence of events? (timing of events)

What events led up to the activity (e.g., resident invited staff to participate, asked for help from staff)

What signaled the end of the activity? (e.g., resident was tired, meal started, activity was interrupted)

How were things done?

Due to their disabilities, did residents have to get special help from staff?

Describe the social environment?

Who was present during the activity?

Describe the environment (room, social climate)

If helpful, diagram the setting

Was anything said?

Reflective Notes:

Interpretations/Questions Researcher Has

What was the relationship like between staff and residents? (friendly, distant)

Did residents treat staff with respect?

Did staff treat residents with respect?

V. Planned Group Activities with Residents

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

Where did the activity occur?

What were the sequence of events ? (timing of events)

How was the activity introduced/ how did it begin?

How long did specific events last (e.g., how long did it take for residents to assemble?)

Did staff spend time reminding residents to attend/recruiting residents for the activity?

What signaled the end of the activity?

Who was involved in the activity?

How many staff participated?

How many residents participated?

How were things done?

What was said during the activity?

Did staff help residents? (e.g., help residents do the activity, remind residents to attend)

How was the activity organized/or unorganized?

Describe the social environment:

How did people organize into groups?

What were the groupings like (e.g., all male groupings, all female)?

How did the participants relate to each other (e.g., how did males relate to females)?

How did participants arrange themselves in the social space? (diagram if necessary)

Describe the decision-making patterns

Who makes the decisions about the activities that take place?

Who decides when activities end?

How are decisions communicated?

How did participants react to what was said/done?

Describe the frequency of interactions?

Describe body language (gestures, people's expressions, etc.)

What do people say?

Reflective Notes:

Interpretations/Questions Researcher Has

Who seemed bored/thoughts on why they might have been bored?

How did the activity today compare to the activity yesterday?

Thoughts about why certain people didn't participate?

Thoughts about the activity (e.g., whether or not you think people were having fun)

VI. Interactions with Visitors to the Facility

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

Where did visit take place? (e.g., in a resident's room, picnic area outside, activity room)

What were the sequence of events?

Was the activity planned/spur of the moment/daily or weekly regular activity?

Did participants do more than one activity? (How long was each activity?)

What was done? (e.g., talking, a planned activity, a meeting)

Describe any social interactions observed:

Were interactions friendly?

Did visitor(s) treat staff with respect?

How did staff react to visitor(s)

Reflective Notes:

Interpretations/Questions Researcher Has

Did staff and the visitor(s) seem to recognize/ know each other?

Did staff seem happy to see the visitor(s)?

Did the visitor(s) seem happy to see staff?

VII. Informal Interactions with Coworkers/or Supervisors

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

Where did the interaction occur?

What were the sequence of events? (timing of events)

What events led up to the interaction (e.g., scheduled break time)

What signaled the end of the interaction? (e.g., resident asked for help, supervisor instructed staff to return to work)

Describe the social environment?

Who was present during the interaction?

Describe the environment (room, social climate)

If helpful, diagram the setting

Was anything said?

Reflective Notes:

Interpretations/Questions Researcher Has

What was the interaction like? (friendly, distant)

Did participants treat each other with respect?

VIII. Unexpected Occurrences

Researcher: _____

Date (include day of week): _____

Time: _____

Length of Observation: _____

Descriptive Notes:

Where did the event occur?**What were the sequence of events? (timing of events)****Who was involved in the activity?****How were things done?****Describe the social environment:**Reflective Notes: **Interpretations/Questions Researcher Has**