

A Dual-Driver Model of Retention and Turnover in the Direct Care Workforce

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Purpose: The purpose of this study was to understand the factors associated with turnover and retention of direct care workers. We hypothesize that a dual-driver model that includes individual factors, on-the-job factors, off-the-job factors, and contextual factors can be used to distinguish between reasons for direct care workforces (DCWs) staying on the job or leaving the job. **Design and Methods:** We conducted 7 focus groups with 47 participants. We identified key themes they used to describe their experiences focusing on differences between stayers (had been in the same job for at least 3 years) and leavers (had changed jobs within the past 3 years). **Results:** Five major themes associated with turnover were identified as follows: (a) lack of respect, (b) inadequate management, (c) work or family conflicts, (d) difficulty of the work, and (e) job openings. Themes associated with retention were as follows: (a) being “called” to service, (b) patient advocacy, (c) personal relationships with residents, (d) religion or spirituality, (e) haven from home problems, and (f) flexibility. Themes associated with turnover were different from those associated with retention. **Implications:** DCW turnover and retention are complex, multifactorial issues. Efforts to stabilize the DCW must address the issues associated with retention as well as those associated with turnover. Specifically, factors that promote retention may be qualitatively different than those that prevent turnover. Treating retention and turnover as simply the obverse of each other may be misleading in addressing the underlying problem of job stability among DCWs.

Key Words: Long-term care, Direct care workers, Workforce, Turnover, Retention

The Institute of Medicine Report, *Retooling for an Aging America: Building the Health Care Workforce* (Committee on the Future Health Care Workforce for Older Americans, Institute of Medicine, 2008) lists as a prime concern a shortage in the direct care workforce (DCW), which includes nursing assistants in nursing homes, personal care aides (PCAs) in assisted living or personal care settings, and home health aides. The problems of shortage are compounded by high DCW turnover in nursing facilities (40%–100% annually), which has been associated with (a) disruptions in care protocols, resulting in a decline in the overall quality of care and quality of life for consumers (Barry, Brannon, & Mor, 2005; Brannon, Barry, Angelelli, & Weech-Maldonado, 2005; Castle, 2003; Eaton, 2000; General Accounting Office, 2002; Leon, Marainen, & Marcotte, 2001; Proenca & Shewchuk, 1997; Schnelle, 2004; U.S. General Accounting Office, 2001); (b) heightened personal stress, job burnout, and other deleterious social consequences for workers and their families (Burgio & Burgio, 1990; Cohn, Horgas, & Marsiske, 1990; Mercer, Heacock, & Beck, 1993; Office of the Inspector General Report, 2002); (c) millions of dollars spent on site-specific recruitment and training as new workers enter a facility, only to be wasted when workers leave these jobs, often to move to new ones where the cycle of training begins again (Leon, Marainen, & Marcotte, 2001a; Proenca & Shewchuk); and (d) higher costs to the health care system as a whole due to all the above (Leon, Marainen, & Marcotte, 2001b). High turnover among DCWs also depletes the potential benefits of quality improvement processes, creating a vicious cycle where organizations

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spend significant resources on training and quality improvement, only to see little to no sustained improvements (Karsh, Booske, & Sainfort, 2005; Office of the Inspector General Report Report, 2003; Rahman & Schnelle, 2008; Rantz et al., 2001; Rosen et al., 2005).

The existing literature provides more information regarding worker turnover than worker retention and predominantly evaluates facility-level characteristics. Banaszak-Holl and Hines (1996) analyzed job design and other organizational factors as predictors of turnover in 250 facilities in 10 states. They found that turnover was higher in for-profit homes, lower in facilities in which certified nursing assistants (CNAs) participated in care conferences, and also affected by local market conditions. However, workload, payer mix, training, and facility size were not related to the rate of CNA turnover. In another study of 288 facilities in eight states, Brannon, Zinn, Mor, and Davis (2002) took a similar approach, examining structural differences between “high staff turnover” and “low turnover” nursing homes. High turnover facilities were more likely to have higher registered nurse turnover, be a training site, and owned by investors rather than being nonprofit. Again, factors associated with the actual job like supervision, training, workload, and integration into the care process did not differentiate high and low turnover facilities.

Contrasting with these facility-level studies are research approaches that examine the DCW’s job from the workers’ perspective. One group of studies relate survey-based perceptions of job satisfaction to turnover intentions (e.g., Bergman, Eckerling, Golander, Sharon, & Tomer, 1984; Castle, Engberg, Anderson, & Men, 2007; Karsh et al., 2005; Kiyak, Namazi, & Kahana, 1997). Another approach uses in-depth qualitative studies seeking to understand how DCWs make sense of their work environment. For example, Bowers, Esmond, and Jacobson (2003) found that perceptions of being underappreciated and undervalued were related to turnover. Tellis-Nayak and Tellis-Nayak (1989) and Pfefferle and Weinberg (2008) found that DCWs face considerable stress at work that may contribute to turnover through factors such as low job satisfaction. This latter set of studies is closer in spirit to the culture change movement in nursing homes, which generally assumes that the imbued meaning of the job should enhance the quality of care (Rahman & Schnelle, 2008).

Notably, facility-level studies and surveys of individual workers are focused on turnover reduction,

with the assumed premise that reduced turnover also increases job stability and retention. Moreover, they assume most of the turnover is related to facility-level factors or to organizational initiatives aimed at pay and satisfaction. But as illustrated by the empirical reality, despite all the resources directed at reducing turnover (Banaszak-Holl & Hines, 1996; Beck et al., 2005; Bergman et al., 1984; Castle, 2006; Castle & Engberg, 2006; Francis-Felsen et al., 1996; Kiyak et al., 1997; Robertshaw, 1999; Spector & Takada, 1991; Tai, Bame, & Robinson, 1998), there are virtually no programs that have resulted in improvements in actual retention rates and sustained quality improvements (Castle, 2006). The one exception is a recent study by Pillemer and colleagues (2008) that showed reduced turnover rates in facilities that had specially trained retention specialists who took a comprehensive approach to addressing the problem.

Conceptually, we believe that this is due to two untested assumptions in the prior facility-based and survey-based studies. First, it is assumed that worker turnover is simply the obverse of worker retention and, correspondingly, factors that reduce turnover will by default also promote retention. But what if this assumption is incorrect? What if worker retention and worker turnover are qualitatively different phenomena, each having a different set of antecedents? If so, this may explain the disappointing results of the numerous programs aimed at fostering workforce retention that have been designed on the basis of research studies aimed at understanding workforce turnover.

Second, studies examining turnover have taken a narrow approach focusing mostly on facility-level and/or job-related factors to the exclusion of spiritual, emotional, and other personal aspects of the DCW’s life. In particular, it is not well understood if this broader context affects retention and/or turnover in a similar or distinct fashion. We examine both these untested assumptions, seeking to uncover potential differences in the drivers of retention and turnover of direct care workers.

Turnover and Retention: A Dual-Driver Model

Many work attitudes and behaviors—ranging from job satisfaction and dissatisfaction to trust and distrust in management—are more accurately described as distinct phenomena rather than as opposite ends of a single continuum. Herzberg (Herzberg, Mausner, & Snyderman, 1959) was one of the first theorists to suggest such a difference. He posited that

the factors that drive job satisfaction may be quite different from those that drive job dissatisfaction. According to his motivation–hygiene theory, workers will be dissatisfied with their jobs if their lower order needs—“hygiene factors”—are not met because of inadequate salary levels, supervisory practices, and working conditions. In contrast, gratification and motivation result from fulfillment of higher order psychological needs—“motivational factors”—such as feelings of achievement, value, and significance at work. Thus, hygiene factors and motivation factors are not ends of a bipolar continuum where one increases as the other diminishes. Instead, they represent separate phenomena driven by different aspects of the work environment and job characteristics (Herzberg, 2003).

Similar arguments have been made about workplace culture, particularly with regard to trust among coworkers and between workers and management. Factors that promote trusting relations at work are qualitatively different from the factors that lead to distrust (Kramer, 1999). Trust is a more general attitude or expectancy than distrust and tends to be associated with factors like individual predisposition. Distrust, conversely, appears to be more closely related to factors such as workplace surveillance and status differences. Moreover, distrust has a “catastrophic” quality to it, whereas trust building tends to be a more leisurely and forgiving process.

Positive and negative affect (e.g., happiness vs. sadness) have been similarly differentiated in work settings and shown to be influenced by different factors. For example, Weiss, Suckow, and Cropanzano (1999) found that individual feelings of happiness were influenced by whether or not performance was rewarded, with little attention to procedural fairness, that is, fairness in how reward distributions were determined. Conversely, procedural fairness played a far larger role in inducing negative feelings such as guilt and anger. Shaw, Duffy, Jenkins, and Gupta (1999) similarly found differences in the paths by which positive and negative affect influence a particular aspect of job satisfaction: satisfaction with pay. Even beyond organizational contexts, this asymmetry between positive and negative drivers of particular attitudes and emotions has been widely supported (e.g., Mittal, Ross, & Baldasare, 1998).

Cumulatively, these studies led us to question whether employment stability—construed in terms of retention and turnover—of DCWs might be similarly differentiated. Are DCW retention and

turnover at opposite ends of the same continuum as prior research has implicitly assumed? Or is staying with a direct care job motivated by qualitatively different factors than is leaving such a job? The research described subsequently aims to address these fundamental questions.

Design and Methods

We use an exploratory-interpretive study aimed at understanding a phenomenon rather than testing a prespecified theory from a positivist stance (Miles & Huberman, 1994). We conducted focus groups to directly elicit their DCWs’ motivations, attitudes, and perceptions related to their job, workplace, employer, coworkers, clients and their families, and their personal situation. The research team extensively reviewed the existing literature on turnover and retention—not only in the context of DCWs but also in the broader context of organizational behavior and service organizations. We also interviewed nursing home administrators and patients and their families to get a richer sense of the work context facing the DCWs. This study was approved by the Institutional Review Board of the University of Pittsburgh.

We conducted a total of seven focus groups with 47 CNAs and PCAs in summer 2007. Each focus group lasted between 60 and 90 min. CNAs were recruited to participate in focus groups using the Pennsylvania Registry of Health Workers database, which was provided to us by the Pennsylvania Department of Health. To qualify for the study, respondents had to report working in the senior health care or mental retardation industry for at least 3 years. Respondents were screened to ensure that they matched the study inclusion criteria and represented a mix of gender, race, type of job performed, and both nonprofit and for-profit organizations. Each participant also completed a screening survey on demographic characteristics, job stability, and current employment. Thus, we were able to match individuals with similar job stability into three categories of focus groups: (a) stayers: those direct care workers who have been at their current jobs for the past 3 years, (b) intermittent leavers: those who have changed jobs once or twice in the past 3 years, and (c) chronic leavers: those who have changed jobs more than twice in the past 3 years. These criteria, while subjective, represent our effort to deliberately maximize heterogeneity in terms of job retention and job turnover within the context of the Pennsylvania DCW.

Table 1. Characteristics of Focus Groups

Group name	Number of focus groups	Number of participants	Work history
Chronic leavers	1	5	Switched jobs more than twice in the past 3 years
Intermittent leavers	2	15	Switched jobs once or twice in the past 3 years
Stayers	2	17	Worked for the same employer for more than 3 years
Rural health worker	1	3	Low to high turnover workers living in rural counties
Part-time health worker	1	7	Work part time and/or those who are employed by temp agencies
Total	7	47	

We included two additional groups of DCWs—rural and part-time health workers—to allow the possibility of uncovering insights that may be unique to these circumstances. For instance, turnover has been reported to be higher in urban versus rural settings (Castle & Engberg, 2006) and among those employed part time (Castle et al., 2007), although it is not known why this may be the case from the workers' perspective. For instance, we could not assume that rural workers have as many options as urban workers to switch jobs to an alternative health care site or could we assume that those working part time are motivated by the same factors as full-time CNAs. The details of the different groups, their organization, and the number of participants in each are summarized in Table 1.

Rather than working with a set of prespecified questions, the focus group moderator covered four broad areas allowing participants to inject new thoughts and provide input on each area. The moderator encouraged participants to build on each others' experiences seeking confirmation, refutation, and exemplars to more thickly capture data on these concepts. These topic areas included (a) situations that promote DCWs to stay in their job, (b) situations that foster leaving a job, (c) job and family interface and issues associated with it, and (d) their own work and what is good or bad about it.

Participant Profile

In terms of demographics, 87% of the participants were women. Further, 36% identified themselves as African American, 2% as Hispanic, and the remainder identified as Caucasian. Less than a third (31%) of respondents were married or partnered, whereas the majority were single, either never married (51%) or divorced, widowed, or separated (18%). Ten percent of the participants

were younger than 30 years, 59% were between the ages of 30 and 49 years, and 31% were older than 50 years. With the exception of age, the sample characteristics—predominantly women, a relatively large proportion of minorities, only a third being married or partnered—are similar to the characteristics of this workforce both in Pennsylvania and nationally (Center for Disease Control & National Center for Health Statistics, 2008).

Sixty percent of participants reported working in the field of direct care for more than 10 years. Thus, they were both older and more experienced than state and national averages. Nearly half (49%) reported switching jobs in the past 3 years, with 24% reported holding their current job for less than a year. Six in 10 participants (61%) currently worked for a nonprofit facility or employer and 20% were members of a labor union. Participants reported working in a variety of other industries and jobs in the past, including food services (27%), childcare (16%), cleaning and janitorial (16%), clerical (14%), and retail (11%).

Approach to Analysis

Taking an exploratory-interpretive (Lin, 1998; Miles & Huberman, 1994) or discovery-oriented (Glaser Straus, 1967) stance, we iterated between the data (focus group transcripts) and theory (our understanding of the turnover literature) to develop the main themes that inform our research questions. We followed Hirschman (1986) to ensure that the themes fulfill three objectives: (a) credibility (did the authors interpret the participants' respondents as the respondents intended?), (b) confirmability (what steps were taken to ensure that the themes are not biased?), and (c) dependability (to what extent is the phenomenon stable across multiple human beings?).

With these objectives in mind, we took several steps. First, the focus groups were conducted by an external moderator with more than 10 years of experience. She was cognizant of the research setting and the basic research question but blind to the a priori notions of the research team. This ensured that the data-gathering phase—that is, conducting the actual focus groups—was objective in that the researchers could not lead the respondents. Second, the focus groups were conducted in a phased manner as recommended by Miles and Huberman (1994). We conducted one focus group with intermittent leavers and one with stayers to surface the key issues. Then, in subsequent focus groups, the moderator gauged dependability and credibility of the data from the previous groups eliciting reactions and clarifying the meaning and intent of thoughts elicited in prior groups. The groups, to state differently, built on each other, with subsequent groups helping establish the face validity of the findings from previous groups (Agar & MacDonald, 1995; Rabiee, 2004; Reed & Payton, 1997).

Next, we analyzed the data, that is, focus group transcripts. To summarize the data using themes that were both descriptively accurate and had confirmability, credibility, and dependability (Hirschman, 1986), we took the following steps. Each researcher and the focus group moderator independently analyzed the transcripts and developed themes that could be used to describe the data. We then met to discuss the themes as they related to the researchers' theoretical stance (e.g., prior theories of job retention or turnover) and the moderator's understanding of the data collection context (e.g., the actual focus group dynamics). It is noteworthy that the research team included people with a diversity of theoretical orientations and disciplines, namely background in geriatrics or nursing home care, organizational behavior and human resources, and service quality and marketing. These meetings, which lasted several days, occurred until we resolved issues about coding consistency through negotiated reassessments of categorization rules. As a precaution, we took a random sampling of actual thought listings from the focus group transcripts and asked independent coders to categorize them in the themes we developed. They agreed in the majority of the cases (90%) with disagreements resolved through discussion. In developing the different themes or categories, we focused on descriptive accuracy. Here, two issues deserve to be highlighted. First, we

found many thoughts expressing multiple meanings. Rather than forcing them to represent only a single category, we chose to reflect the richness and pluralistic nature of the participants' experience by allowing thoughts to span multiple categories. This fluidity, while a problem from a strictly positivist stance, is a desirable in exploratory studies to capture the richness of the underlying phenomenon (Fournier, 1998; Lin, 1998). Second, the results from intermittent and chronic leavers were remarkably similar. To be parsimonious, we collapsed both subgroups into a single group entitled leavers. Thus, results compare stayers (job tenure of at least 3 years) with leavers (job tenure less than 3 years).

Results

We organized our themes around the two main questions: (a) Why do direct care workers leave their jobs? and (b) Why do direct care workers stay with their jobs? We discuss these factors in turn subsequently.

Drivers of Turnover

There were four major themes that emerged regarding why DCWs leave their jobs. Not surprisingly, low pay and inadequate benefits were mentioned as reasons for leaving, supporting prior empirical studies (e.g., Leon et al., 2001). However, other issues were at the forefront of the discussions among leavers. In addition, stayers cited similar reasons in explaining why others left these jobs even if they did not do so themselves.

Lack of Respect.—By far, the issue that was voiced most vociferously for leaving a direct care job was the perceived lack of respect for the work, primarily from management, and to some degree from the larger society as well. Following are some illustrative samples in the worker's own words:

[Administrators] were very rude to the aides. They treated everybody horribly.

It's like you're at the bottom of the pole.

I'd like it if there was more respect for aides. Doctors and nurses should treat us like a partner and rely upon our knowledge of the patients.

There's not really shame in it, but a lot of people—when you say what you do—they're like, 'Oh, you wipe butts for a living. You're a professional butt wiper.' . . . That's how people look at it.

There was a lot of animosity between the nurses and CNA's. Nurses treat aides poorly.

Poor Management.—Management refers to the facility administrators as well as nurse supervisors. Among leavers, management was consistently described as uncaring, uninvolved, and out of touch with the workforce and the workplace:

They [management] would hire anybody. And these people were not cut out for the job.

I worked in assisted living . . . that place was so chaotic . . . no one would come in and run it. One time we came in there was all workers, wasn't no [administrators] in there. I mean, it was really bad for the residents.

They jump on the good workers before they jump on the bad workers.

The administrators only care about you getting all your paperwork done.

Work or Family Conflicts.—DCWs who were not married but had children at home reported difficulty balancing the sometimes unpredictable needs of their children with the sometimes unpredictable demands of their work:

Aides [get] 'written up' when they must call off to care for a sick family member.

I feel like between my work life and my home life, I'm always trying to fit pieces together.

I think another problem in terms of high turnover is the low pay. Especially like with single moms and they have to pay all that money for childcare.

Difficulty of the Work.—Both leavers and stayers describe their work as physically and emotionally difficult. Among leavers, work demands that were seen as unreasonable were an impetus for leaving a job:

I feel like I'm doing two people's work.

I struggled to give good care to my patients. I was just given too many patients.

You've got to be able to deal with diarrhea; you've got to be able to deal with blood. You know, it's a very nasty aspect of our job. You've got to stomach it.

A lot of new aides don't expect that they'll have to change diapers. They don't expect to be slapped and bit by residents. They just don't understand 'total care.'

I think my most challenging is to say goodbye when someone dies.

Factors Promoting Retention

The themes described subsequently highlight the powerful positive aspects of direct care work that promote worker retention but may not be immediately obvious to administrators and families—although they are unlikely to be missed by those directly receiving care. Most interestingly, these factors are quite different from those associated with turnover and do not represent its opposite.

Being "Called" to Service.—Participants took pride in and got emotional satisfaction from their jobs when they felt needed and were able to provide good care to their patients. Although echoed in all groups, these findings were particularly dominant among stayers who expressed the wish to remain in the direct care role. Leavers were more likely to seek career advancement through job change.

Well, I've come out of the job actually very sad at times and wanting to leave and thinking it's too much. But then I go back because I have so much in common with them and I feel that I'm really good for the patients.

I don't know what else I would do, honestly. I couldn't even think of another job that I would rather do.

I get a lot of satisfaction from work and a lot of peace knowing that I'm doing good for others.

I really appreciate the 'thank you's', the 'I love you's' and the gratitude. I feel like I've really contributed and accomplished something.

Patient Advocacy.—DCWs perceived themselves as being patient advocates. Most stayers felt that they had the best "on the floor" patient knowledge and that they provided more hands-on patient care than nurses and doctors who were often described as "pill dispensers." In addition, DCWs felt that they cared more about the patients than did the nurses and doctors. Whereas a "calling" describes the internal satisfaction experienced by DCWs, advocacy describes their capacity to help the resident feel well or receive good care.

I want to be the one that's interacting with the residents and, you know, being able to come in their room and make them smile and make them happy.

Well, the reason why I've been at [my current job] so long is that . . . you're afraid to leave 'cause you're afraid somebody's not gonna give [the residents] good care like you were.

And pretty soon, you're part of [the residents'] lives, and you don't want to stay [overtime] when you're mandated, but you do because who's going to take care of them?

Personal Relationships With Patients or Residents and Their Families.—Many participants got a great deal of joy from their day-to-day interaction with patients, imbuing these transitory relationships with personal intimacy. Interestingly, stayers used terms of ownership when discussing residents or patient care (e.g., “my people”), treating them as a kind of extended family. In contrast, leavers described them in more impersonal terms (e.g., “the residents”). It was evident that personal relationships and patient advocacy commonly co-occur, although they can be quite distinct motivations for workers. Advocacy was typically described as something a DCW does because of her unique position, that is, providing day-to-day care—and the enhanced knowledge about each patient that such constant interaction provides. Personal relationships were described in terms of emotional connections with residents particularly in the role of surrogate or adopted family. Thus, advocacy was motivated primarily by professional knowledge—that is, enhanced knowledge of the patient's unique physical and psychological needs—whereas personal relationships were motivated by emotional attachments between patient and aide:

I enjoy taking care of elderly that doesn't have family, and you get involved in them. You do start—after a while, you start loving them.

They're just like your grandmother. They're really just like relatives.

So you just stick where you are because they become your family.

When someone dies, you're their last support. Patients shouldn't die alone—there should be better support.

Religion or Spirituality.—Along with the common feeling of a calling to do direct care work, many stayers indicated that their religious beliefs and/or spirituality were the foundation of that calling and also helped them deal with tough job demands. They also reported extending their role as caregiver by offering to pray with patients who need comforting and/or are dying.

I pray a lot. Through my job, as well as otherwise . . . it gets me through the night shift.

A strong faith and my Christian background is absolutely (essential).

You can go in and pray with these people and talk more openly about spiritual things . . . they're more open to it at that point, and I enjoy that.

Haven.—Many respondents described their home lives as quite challenging. As physically and emotionally difficult as direct care work is on a day-to-day basis, it was described by many stayers as a reprieve from some of the personal challenges at home.

When I go to work I'm actually in a better mood than I am at home because I have to be.

I'm humbled by my job when I see my patients go through very difficult things. It helps me deal with my own life.

I mean, there's days I don't want to go home.

Job Crafting and Flexibility.—One aspect of the work that many “stayers” cited as attractive was the discretion and flexibility it gave them. Although they had many responsibilities at work, they were not closely monitored as they carried out their tasks. Consequently, several reported crafting their jobs to better suit the circumstances on the floor—even if sometimes this involved bending or breaking the rules. Many respondents proudly described how they were able to modify their jobs to provide better care for their residents:

I've changed everything for myself. But when the person finds out that trained me, they frown upon it. But it's like, “Mine's more efficient,” but they're not willing to change.

When the state comes around—you know how you can't mix [food], but some residents won't eat unless some stuff's mixed. We have a woman who [won't eat her food without something sweet in it]. Yep, if there's no ice cream in that, like, pureed meat, she won't touch it. But you can't do that. That'd break the rules. So, but that's not the only thing that's modified usually, I'd imagine. I know I'm not the only one that does it.

Summary

DCWs reported leaving their jobs for a different set of reasons than those that motivated them to stay. Although nearly all the participants in our study described the inherent challenge of direct care

Table 2. Understanding Direct Care Workforce Retention and Turnover

Retention Enhancement Driver	Turnover Prevention Driver
Organizational or management factors	
Salary and benefits	Salary and benefits
Flexibility in carrying out the work (job crafting)	Poor management
	Difficulty of the work
Relational or esteem factors	
Relational factors	
Personal relationships with patients and their families	Work–family conflicts
Work as a haven	
Esteem factors	
Religiosity and spirituality	Lack of respect from others
Being called to service	
Patient advocacy	

work, leavers were more likely to focus on negative aspects of the job such as rude supervisory behavior, job challenges, and lack of flexibility. Conversely, stayers described many of the same experiences when queried directly about them, but they were far more focused on positive aspects of the job such as its relational aspects and the flexibility it afforded them in carrying out their tasks. Thus, the same basic job is experienced very differently by stayers and leavers. These are not just differences of degree but fundamental differences in kind. We conclude that stayers and leavers construct qualitatively different meanings from their experiences at work. These differences were echoed among rural and part-time workers as well. Thus, despite differences in the structural setting of the work—rural and/or part time—the underlying factors that constitute the meaning of work and the rewards and difficulties of staying in a job (or not) seem to be more universal rather than a particular themes across all workers.

A Dual-Driver Model of Retention Enhancement and Turnover Prevention

Based on these insights, we developed a conceptual typology for understanding factors that drive DCW turnover and retention. Although the workers did not describe their experiences in precisely this way, we believe that the emergent themes can be classified along two dimensions. The first dimension captures two distinct categories of work experience: (a) organizational or managerial factors such as the flexibility of the job and (b) social

or esteem factors such as relationships with others and the perceived significance of one’s work. As shown in Table 2, the second dimension is retention versus turnover. Note that although our participants did not focus on pay and benefits, these are obvious potential drivers of turnover and retention so we include them in the table.

Three novel and important insights emerge from this typology. First, drivers of turnover are different than drivers of retention, and strategies aimed at reducing turnover should not be assumed to enhance retention. Second, organizational and management initiatives designed to decrease turnover (e.g., a focus on salary and benefits), while important, underappreciate the complexity of a DCW as a person. Third, DCWs have important psychological needs based on factors like interpersonal relationships, spirituality, respect, and esteem; these needs remain unmet in a paradigm focused solely on instrumental factors such as pay and benefits.

Discussion

Factors that motivate DCWs to stay with a job are not simply the obverse of factors driving turnover, as assumed in previous research. As deceptively simple as this point is, the implications of this insight are potentially profound for future research and practice. Our findings question the wisdom of continuing to design worker retention programs on the basis of research aimed at understanding worker turnover. Instead, the motivations of job stayers and job “leavers” may be quite distinct.

Among the high retention group, many expressed a sense of calling. For many direct care workers, there is a powerful spiritual and religious connotation to their work. Some actually verbalized being called by God to perform these duties. Pfefferle and Weinberg (2008, p. 955) argue that the theme of doing God’s work “reflects CNAs’ struggle to create a positive identity by insisting on the inherent value of direct care work.” This relational aspect of work and its effect on self-identity is virtually unacknowledged and not formally studied in the current literature and management practices examining DCW retention and turnover. If borne out in quantitative analysis, it may be useful to develop processes and structures that can nurture and reinforce the spiritual aspects of work in a way that also nurtures a positive self-identity.

As noted by England, Budig, and Folbre (2002), such spiritual aspects can be thought of as intrinsic rewards that have been used by some economists to

justify the low pay of these jobs. However, such an economic model assumes that intangible and tangible rewards are tradable and interchangeable—an untested assumption that has been challenged by England and colleagues and others. Also, although broad constructs such as the quality of care or quality of life in nursing facilities may acknowledge spirituality among residents, job satisfaction scales for DCWs do not. This is a crucial oversight in the research paradigm and has implications for practice. For example, given the current worker shortage, recruitment through religious and/or faith-based affiliations might be a viable addition to current recruitment strategies. Such a spiritual perspective may complement and reinforce the culture change approaches that are currently being implemented to improve care in nursing homes (Rahman & Schnelle, 2008).

One of the most powerful negative forces described was the lack of respect from nurses and administrators. This finding confirms earlier work by Bowers and colleagues (2003) and others seeking to understand the DCWs' viewpoint (Monahan & McCarthy, 1992; Pfefferle & Weinberg, 2008). In our focus groups, a common theme was that DCWs are not trusted to make clinical decisions and they are treated as if they are incapable of working without close supervision. This perception is puzzling to these workers. From their perspective, they are making important decisions constantly regarding the methods, sequences, and priorities of the care they deliver to multiple people daily. They often work behind closed doors or in private homes, and especially at night, they work with very little oversight. They are constantly adjusting their approach to care to meet the needs of particular recipients or to prioritize the essential care tasks when the workload is unreasonably high. So from the perspective of the individual worker providing care, she (or he) is a unique and competent decision maker on a daily basis. When that same worker perceives that she is excluded from care planning conferences, this is interpreted both as a lack of respect and as a lack of understanding by administrators about the fundamentals of care. Of note, these perceptions were similar for the leavers and the stayers, suggesting that the feelings of disrespect are universal, but stayers likely counterbalance the positive aspects of their work against the negative.

All the DCWs acknowledge that their work is very demanding—physically, cognitively, emotionally, and spiritually (see also Tellis-Nayak & Tellis-Nayak, 1989; Monahan & McCarthy, 1992). The physical challenge of this work is confirmed by

Bureau of Labor Statistics data showing that DCWs are second only to “common laborer” in terms of work-related injuries (Bureau of Labor Statistics, 2008). The emotional challenge of the work includes the lack of appreciation from care recipients who are incapable of appreciating the care or are actually aggressive with caregivers. The turmoil caused by the death of care recipients cannot be overstated. A DCW may provide care for a recipient for extended time and develop a strong bond with that person and their family. When the recipient dies, the family goes off to mourn while the DCW is assigned another person to care for. There is typically no time to mourn and no process of support in place (Anderson & Gaugler, 2006).

What happens at home—the stability and complexity of relations at home—may affect workers' ability to cope with these multifaceted demands. Past studies have focused on job-related factors like adequate staffing and supervisor support (Bowers et al., 2003). In contrast, our data suggest that off-the-job needs experienced by DCWs must be understood as well. For instance, it appears that workers who have been in their job for long periods of time have more stable family environments. Clearly, the nature of our data precludes us from making any causal inferences, but several issues merit further empirical scrutiny. First, causally, how do workplace stability and family life stability reinforce each other? Second, how can family life stability moderate the effect of workforce factors like job satisfaction on actual turnover? Third, are there underlying characteristics such as spirituality that allow particular workers to become better at work and in their family contexts? These are intriguing ideas that we seek to explore in our future research.

Finally, affective commitment to a given job requires choice or at least the illusion of it (Salancik & Pfeffer, 1978). DCWs who stay in difficult and low-paying work may nonetheless feel a sense of personal efficacy if their job “choice” can be explained in terms like spirituality and calling. With the present research design, we cannot separate cause from effect in this regard—(i.e., do workers stay in the job because they are called or is the calling a post hoc rationalization for their long tenure?)—and future longitudinal studies will be needed to answer this question. In either case, however, it is clear that stayers imbue their work with far more meaning than previous studies of turnover have recognized. Such meaning can be a powerful motivator of their future work attachment and behavior regardless of its origin.

Limitations and Future Research

Although our research provides some insights into the motivations of DCW stayers and leavers, it is an incomplete treatment of complex phenomena. Regarding the sample, we included DCWs who despite turnover within organizations, stayed within the industry. Thus, we are unable to make claims about those who change organizations and industry, that is, leave the DCW. What drives people to change industries rather than just change jobs? This is an issue warranting further investigation. Moreover, if workers simply rotate in the same position from one organization to another—where the same factors influencing turnover are likely to be present—how can the industry as a whole organize to address this endemic problem? Clearly, more research comparing those who rotate in the same job at different organizations with those who left for other positions (perhaps in other industries) is needed to fully understand this issue. The current turnover research paradigm is organization focused, studying classifying workers as “turned over” when they leave a particular organization. This is limiting. Rather, turnover parameters need to be more flexibly and more comprehensively defined in terms of a job, organization, and industry. For instance, people may move to a different job within the same organization or same job with a different organization or leave the industry entirely. It is doubtful that all these moves are causally prompted by the same, or even similar, set of factors. Thus, the notion of turnover itself needs to be more clearly specified and investigated.

In our research, the multiplicity and duality of the experiences of the DCW’s that were captured in a cross-sectional manner. In particular, we did not observe how the various themes may have evolved over time. For instance, although themes like personal relationships, patient advocacy, and being called to service are conceptually different, they can be simultaneously echoed in the same experience on the part of a worker. A longitudinal approach is needed to reveal underlying evolutionary processes, that is, how all three come to be echoed in the same experience for a single worker. For instance, DCWs who feel a calling to their work over time may become patient advocates and also develop personal relationships with patients. Or, it may be that those who are patient advocates only engage in such advocacy on behalf of those residents with whom they develop personal rela-

tionships. Clearly, these issues can be addressed via longitudinal observational approaches.

We have made both relational and causal statements in imposing a framework on our data. Recognizing this limitation, we hope our research will provide fertile ground for empirical research, particularly longitudinal studies that develop measures of constructs like patient advocacy, spirituality, and job crafting and statistically measure the association with and impact on retention and turnover. Such intensive yet comprehensive research approaches can shed light on the complex issues that contribute to staff turnover and to staff retention. Concepts related to DCWs’ job and home present similar issues. For instance, for some DCWs, work is a haven from the stresses of their home life, whereas others may carry their work-related stresses home. There are still others who manage to compartmentalize their home and work lives. What role does a person’s spirituality or work calling play in these dynamics? These are issues that surfaced in our study but need careful scrutiny in future research.

The advancing nursing home “culture change” and “pioneer” movements focus on “person-centered” care. The implications of these movements on the DCW indicate that staff “empowerment” results in improvement in some elements of care, but as of yet, no definitive impact on retention or turnover (Yeatts & Cready, 2007). The importance of workforce stability in the culture change movement cannot be underestimated. Future interventions and studies within the culture change paradigm should address the role of DCW turnover and retention along the conceptual framework currently proposed. Finally, we note that the traditional conceptualization of DCW retention is powerfully rooted in an exchange paradigm—work for pay. Our research suggests that such a paradigm oversimplifies the underlying dynamics and needs to be broadened. Our work here is a first step in that direction.

Funding

The Jewish Healthcare Foundation, the Pennsylvania Department of Labor and Industry, the Heinz Endowments, and the University of Pittsburgh Research Council supported this work.

References

- Agar, M., & MacDonald, J. (1995). Focus groups and ethnography. *Human Organization, 54*(1), 78–86.
- Anderson, K. A., & Gaugler, J. E. (2006). The grief experiences of certified nursing assistants: Personal growth and complicated grief. *Omega (Westport), 54*, 301–318.

- Banaszak-Holl, J., & Hines, M. A. (1996). Factors associated with nursing home staff turnover. *The Gerontologist*, 36, 512–517.
- Barry, T. T., Brannon, D., & Mor, V. (2005). Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. *The Gerontologist*, 45, 309–317.
- Beck, C., Heacock, P., Mercer, S. O., Doan, R., O'Sullivan, P. S., Stevenson, J. G., et al. (2005). Sustaining a best-care practice in a nursing home. *Journal for Health Care Quality*, 27, 5–16.
- Bergman, R., Eckerling, S., Golander, H., Sharon, R., & Tomer, A. (1984). Staff composition, job perceptions, and work retention of nursing personnel in geriatric institutions. *International Journal of Nursing Studies*, 21, 279–293.
- Bowers, B. J., Esmond, S., & Jacobson, N. (2003). Turnover reinterpreted: CNAs talk about why they leave. *Journal of Gerontological Nursing*, 29(3), 36–43.
- Brannon, D., Barry, T. T., Angelelli, J., & Weech-Maldonado, R. (2005). *2004 Pennsylvania long-term care workforce surveys; A report to the Pennsylvania intra-governmental council on long-term care*. University Park: Pennsylvania State University.
- Brannon, D., Zinn, J. S., Mor, V., & Davis, J. (2002). An exploration of job, organizational, and environmental factors associated with high and low nursing assistant turnover. *The Gerontologist*, 42, 159–168.
- Bureau of Labor Statistics. (2008). *Occupational outlook handbook-2008*. Washington, DC: U.S. Department of Labor.
- Burgio, L. D., & Burgio, K. L. (1990). Institutional staff training and management: A review of the literature and a model for geriatric, long-term care facilities. *International Journal of Aging and Human Development*, 30, 287–302.
- Castle, N. G. (2003). Strategic groups and outcomes in nursing facilities. *Health Care Management Review*, 28, 217–227.
- Castle, N. G. (2006). Measuring staff turnover in nursing homes. *The Gerontologist*, 46, 210–219.
- Castle, N. G., & Engberg, J. (2006). Organizational characteristics associated with staff turnover in nursing homes. *The Gerontologist*, 46, 62–73.
- Castle, N. G., Engberg, J., Anderson, R., & Men, A. (2007). Job satisfaction of nurse aides in nursing homes: Intent to leave and turnover. *The Gerontologist*, 47, 193–204.
- Center for Disease Control & National Center for Health Statistics. (2008). *Nursing home and nursing assistants*. CDC Data (online) from <http://www.cdc.gov/nchs/>
- Cohn, M. D., Horgas, A. L., & Marsiske, M. (1990). Behavior management training for nurse aides: Is it effective? *Journal of Gerontological Nursing*, 16, 21–25.
- Committee on the Future Health Care Workforce for Older Americans, Institute of Medicine. (2008). *Retooling for an aging America: Building the health care workforce*. (Rep. No. ISBN: 0-309-11588-4). Washington, DC: National Academies Press.
- Eaton, S. C. (2000). Beyond 'unloving care': Linking human resource management and patient care quality in nursing homes. *International Journal of Human Resource Management*, 11, 591–616.
- England, P., Budig, M., & Folbre, N. (2002). Wages of virtue: The relative pay of care work. *Social Problems*, 49, 455–473.
- Fournier, S. (1998). Consumers and their brands: Developing relationship theory in consumer research. *Journal of Consumer Research*, 24, 343–373.
- Francis-Felsen, L. C., Coward, R. T., Hogan, T. L., Duncan, R. P., Hilker, M. A., & Horne, C. (1996). Factors influencing intentions of nursing personnel to leave employment in long-term care settings. *Journal of Applied Gerontology*, 15, 450–470.
- General Accounting Office. (2002). *Nursing homes: Quality of care more related to staffing*. Rep. No. GAO-02-431R. Washington, DC: Author.
- Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine Publishing Company.
- Herzberg, F. (2003). One more time: How do you motivate employees? *Harvard Business Review*, 81, 87–96.
- Herzberg, F., Mausner, B., & Snyderman, B. B. (1959). *The motivation to work*. New York: John Wiley.
- Hirschman, E. C. (1986). Humanistic inquiry in marketing research: Philosophy, method, and criteria. *Journal of Marketing Research*, 23, 237–249.
- Karsh, B., Booske, B. C., & Sainfort, F. (2005). Job and organizational determinants of nursing home employee commitment, job satisfaction and intent to turnover. *Ergonomics*, 48, 1260–1281.
- Kiyak, H. A., Namazi, K. H., & Kahana, E. F. (1997). Job commitment and turnover among women working in facilities serving older persons. *Research on Aging*, 19, 223–246.
- Kramer, R. M. (1999). Trust and distrust in organizations: Emerging perspectives, enduring questions. *Annual Review of Psychology*, 50, 569–598.
- Leon, J., Marainen, J., & Marcotte, J. (2001). *A report to the Pennsylvania intra-governmental council on long term care: Pennsylvania's frontline workers in long term care. The provider organization perspective*. Jenkintown, PA: Polisher Research Institute at the Philadelphia Geriatric Center.
- Leon, J., Marainen, J., & Marcotte, J. (2001a). *A Report to the Pennsylvania Intra-Governmental Council on Long Term Care: Pennsylvania's Frontline Workers in Long Term Care. The Provider Organization Perspective*. Jenkintown, PA: Polisher Research Institute at the Philadelphia Geriatric Center.
- Leon, J., Marainen, J., & Marcotte, J. (2001b). *In their own words: Pennsylvania's Frontline Workers in Long Term Care. A Report to the Pennsylvania Intra-Governmental Council on Long Term Care*. Jenkintown, PA: Polisher Research Institute at the Philadelphia Geriatric Center.
- Lin, A. C. (1998). Bridging positivist and interpretivist approaches to qualitative methods. *Policy Studies Journal*, 26, 162–180.
- Mercer, S. O., Heacock, P., & Beck, C. (1993). Nurse's aides in nursing homes: Perceptions of training, work loads, racism, and abuse issues. *Journal of Gerontological Social Work*, 21, 95–112.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Mittal, V., Ross, W. T., & Baldasare, P. (1998). The asymmetric impact of negative and positive attribute-level performance on overall satisfaction and repurchase intentions. *Journal of Marketing*, 62(1), 33–47.
- Monahan, R. S., & McCarthy, S. (1992). Nursing home employment: The nurse's aide's perspective. *Journal of Gerontological Nursing*, 18(2), 13–16.
- Office of the Inspector General Report. (2002). *Nurse aide training* Department of Health and Human Services; Office of the Inspector General. (Rep. No. OEI-05-01-00030). Washington, DC: Author.
- Office of the Inspector General Report. (2003). *Quality assurance committees in nursing homes*. Washington, DC: Department of Health and Human Services, Office of the Inspector General. (Rep. No. OEI-01-01-00090).
- Pfefferle, S. G., & Weinberg, D. B. (2008). Certified nurse assistants making meaning of direct care. *Qualitative Health Research*, 18, 952–961.
- Pillemer, K., Meador, R., Henderson, C., Jr., Robison, J., Hegeman, C., Graham, E., et al. (2008). A facility specialist model for improving retention of nursing home staff: Results from a randomized, controlled study. *The Gerontologist*, 48, 80–89.
- Proenca, E. J., & Shewchuk, R. M. (1997). Organizational tenure and the perceived importance of retention factors in nursing homes. *Health Care Management Review*, 22, 65–73.
- Rabiee, F. (2004). Focus group interviews and data analysis. *Proceedings of the Nutrition Society*, 63, 655–660.
- Rahman, A. N., & Schnelle, J. F. (2008). The nursing home culture-change movement: Recent past, present, and future directions for research. *The Gerontologist*, 48, 142–148.
- Rantz, M. J., Popejoy, L., Petroski, G. F., Madsen, R. W., Mehr, D. R., Zwygart-Stauffacher, M., et al. (2001). Randomized clinical trial of a quality improvement intervention in nursing homes. *The Gerontologist*, 41, 525–538.
- Reed, J., & Payton, V. R. (1997). Focus groups: Issues of analysis and interpretation. *Journal of Advanced Nursing*, 26, 765–771.
- Robertshaw, N. (1999). Understanding the needs of direct care staff. What it takes to attract and keep quality staff. *Provider*, 25, 38–53.
- Rosen, J., Mittal, V., Degenholtz, H., Castle, N., Mulsant, B., Rhee, Y., et al. (2005). Organizational change and quality improvement in nursing homes: Approaching success. *Journal for Healthcare Quality*, 27, 6–14.
- Salancik, G. R., & Pfeffer, J. (1978). A social information processing approach to job attitudes and task design. *Administrative Science Quarterly*, 23, 224–253.
- Schnelle, J. F. (2004). Determining the relationship between staffing and quality. *The Gerontologist*, 44, 10–12.
- Shaw, J. D., Duffy, M. K., Jenkins, G. D., Jr., & Gupta, N. (1999). Positive and negative affect, signal sensitivity, and pay satisfaction. *Journal of Management*, 25, 189–205.
- Spector, W. D., & Takada, H. A. (1991). Characteristics of nursing homes that affect resident outcomes. *Journal of Aging and Health*, 3, 427–454.

- Tai, T. W. C., Bame, S. I., & Robinson, C. D. (1998). Review of nursing turnover research, 1977-1996. *Social Science & Medicine*, 47, 1905-1924.
- Tellis-Nayak, V., & Tellis-Nayak, M. (1989). Quality of care and the burden of two cultures: When the world of the nurse's aide enters the world of nursing homes. *The Gerontologist*, 29, 307-313.
- U.S. General Accounting Office. (2001). *Nursing workforce: Recruitment and retention of nurses and nurse aides is a growing concern*. (Rep. No. GAO-01-750t). Washington, DC: Author.
- Weiss, H., Suckow, K., & Cropanzano, R. (1999). Effects of justice conditions on discrete emotions. *Journal of Applied Psychology*, 84, 786-794.
- Yeatts, D. E., & Cready, C. M. (2007). Consequences of empowered CNA teams in nursing home settings: A longitudinal assessment. *The Gerontologist*, 47, 323-339.

Received September 10, 2008

Accepted February 11, 2009

Decision Editor: Nancy Schoenberg, PhD