

“This is an Accepted Manuscript of an article published by Taylor & Francis in Journal of Gerontological Social Work on 14 Apr 2020, available online: <http://www.tandfonline.com/https://doi.org/10.1080/01634372.2020.1750524>.” All rights reserved. Access to this work was provided by the University of Maryland, Baltimore County (UMBC) ScholarWorks@UMBC digital repository on the Maryland Shared Open Access (MD-SOAR) platform.

Please provide feedback

Please support the ScholarWorks@UMBC repository by emailing scholarworks-group@umbc.edu and telling us

what having access to this work means to you and why it's important to you. Thank you.

The Role of Empowerment in Home Care Work

Nancy Kusmaul¹, Sandy Butler², and Sally Hageman³

1. University of Maryland Baltimore County, School of Social Work

2. University of Maine, School of Social Work

3. Idaho State University, Department of Sociology, Social Work, & Criminology

Corresponding Author:

Nancy Kusmaul, PhD, MSW

University of Maryland Baltimore County

1000 Hilltop Circle, Sherman Hall 322

Baltimore, MD 21250

nkusmaul@umbc.edu

Abstract

The home care industry experiences similar problems with the recruitment and retention of direct care workers (DCWs) as those faced by institutions, and it is important to identify strategies to help retain and grow this important workforce. The empowerment of DCWs has been shown to be an effective strategy for increasing job satisfaction and decreasing turnover in nursing homes, but has not been studied in home care. Using Kanter's organizational theory of empowerment, including structural empowerment (structure of opportunity, access to resources, access to information, and access to support) and psychological empowerment (meaning, competence, self-determination or autonomy, and impact) this study examined whether home care workers (HCWs) feel empowered in carrying out their jobs. An exploratory, qualitative study of 12 HCWs, recruited from two states in the United States, found high levels of both structural and psychological empowerment among research participants, as well as a number of disempowering aspects of their job. Findings suggest ways to support elements of the work that HCWs find empowering and decrease elements that contribute to job dissatisfaction and turnover.

Introduction

As the population ages, home and community based care is both supplementing and replacing care provided in long term care institutions. Reasons for this shift include care recipients' preference to remain in the community, policy changes in funding priorities, and more people in need of care. Yet there are many challenges to providing this care. Funding sources are inconsistent and inadequate, and the care is provided by direct care workers (DCWs) who labor under a variety of challenging conditions for low levels of pay.

The DCWs in nursing homes-- nursing assistants (NAs) and certified nursing assistants (CNAs)—provide comparable care and face similar challenges to home care workers (HCWs), but in structured settings. Traditionally, DCWs in nursing facilities operate on the lowest rungs of the organizational hierarchy and have the least power, making empowerment a potentially effective intervention for addressing worker challenges. Research on job satisfaction for NAs and CNAs in residential settings has suggested that empowerment can increase job satisfaction and improve retention (e.g., Berridge, Tyler & Miller, 2016).

Home care workers in agencies also occupy low positions in their organizations, but in a less supervised and less structured environment. To date, the impact of empowerment on HCWs has received less attention than for their equals in institutional settings (Johnson & Noel, 2017). This study used Kanter's organizational theory of empowerment (Kanter, 1993), which includes structural empowerment (structure of opportunity, access to resources, access to information, and access to support) along with psychological empowerment (meaning, competence, self-determination or autonomy, and impact; Laschinger, Finnegan, Shamian, & Wilk, 2001) to explore whether HCWs felt empowered and what impact that had on their work experience.

Literature Review

The Need for Home Care

Projected increases in the need for personal assistance will have profound consequences on long term services and supports (LTSS) (Marquand & York, 2016). About one-third of people 65 and older and two-thirds of those 85 and older experience functional limitations that require assistance (Marquand & York, 2016). Of the 80 million adults 65 and older anticipated by 2040, 29 million will have some sort of disability (Agbonifo, Hittle, Suarez & Davis, 2017), with the number of people needing LTSS expected to more than double between 2000 and 2050 (Spetz, Trupin, Bates, & Coffman, 2015). Many of these individuals will likely want to remain at home and will receive most of their assistance from informal—or family—caregivers (Seavey & Marquand, 2011). But the availability of unpaid family caregivers is decreasing with rising rates of employment among women, smaller family sizes, increased childlessness and higher divorce rates (Johnson & Wiener, 2006), leading to a dramatic increase in demand for paid HCWs.

Local, state and federal policies support the rights of individuals to receive care in the least restrictive environment (such as home) instead of more regulated settings like long term care facilities (Seavey & Marquand, 2011). In addition, public and private health insurers are calling for lower cost care options that align with patient goals (Seavey & Marquand, 2011). Thus, it is important to understand factors that contribute to better retention of HCWs to ensure an adequate supply of caregivers as home and community based services continue to expand.

Empowerment

Lack of control over one's work environment is often associated with low-wage work, and structural empowerment has been explored as a means for organizations to return control to workers (Laschinger, 1996). Home care workers may find their patient care activities limited by agency policies or the restrictions imposed by funding sources (Seavey & Marquand, 2011).

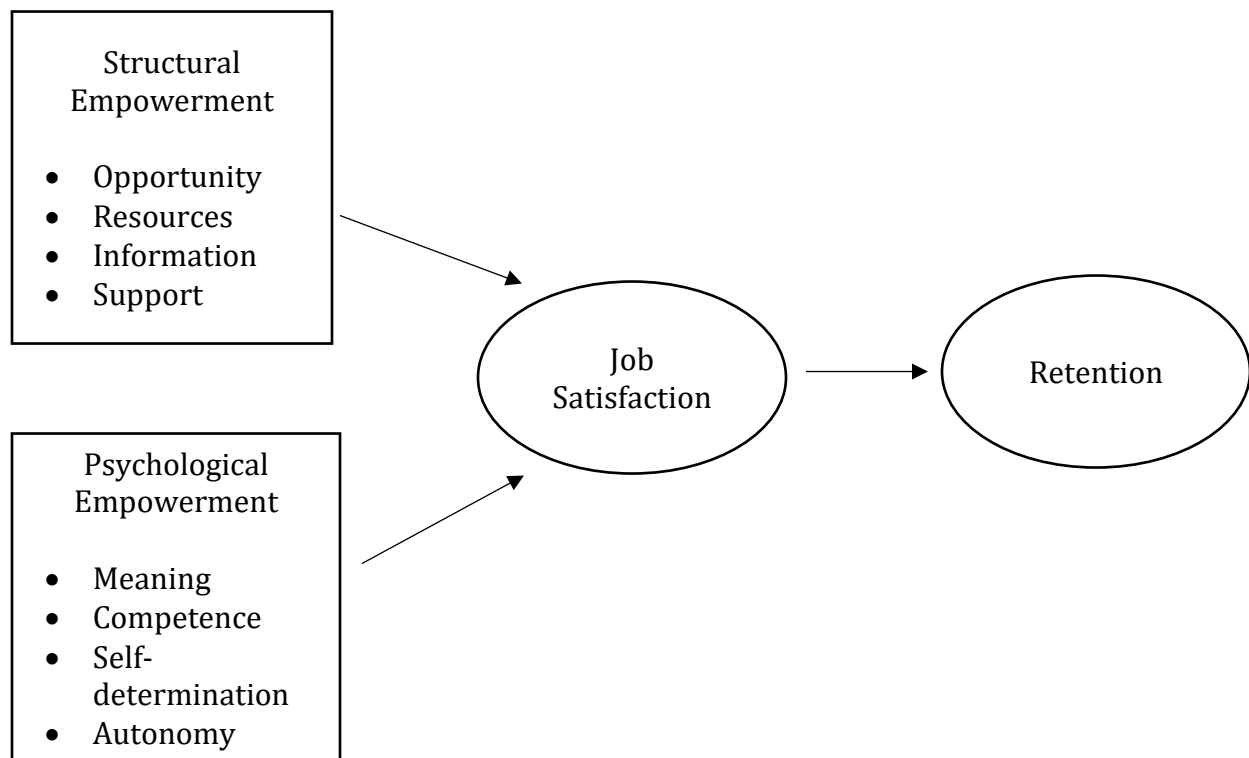
Empowering home care workers would allow them flexibility to meet complex client needs and give them more control.

This study uses the expansion of Kanter (1996)'s theory of empowerment introduced by Laschinger, Finegan, Shamian, and Wilk (2001). Kanter's (1996) theory included structural empowerment (structure of opportunity, access to resources, access to information, access to support); Laschinger et al (2001) added components of psychological empowerment (meaning, competence, autonomy, impact). Structural support might include responsiveness of supervisors or emotional support in difficult cases. Opportunity could include access to advancement or education. Psychological empowerment, which includes autonomy and the meaning one finds in one's work, has been linked to job satisfaction (Spreitzer, 1995). Job satisfaction is strongly related to intent to stay in one's job (or intent not to leave) (Stone et al., 2017), an important factor for reducing overall costs and improving quality, as workers with longer tenure are able to develop relationships with and knowledge of clients (Spetz, Stone, Chapman, & Bryant, 2019).

The factors in the Kanter/Laschinger model are similar to Delp, Wallace, Geiger-Brown, and Muntaner's (2010) use of the Job Demand Control/Support (JDC/S) model with home care workers. They used the JDC/S model to study job satisfaction and its connection to the relationships between the physical and emotional demands of clients, how much control workers had over daily tasks and larger policies, and the support they received from family, friends, clients, co-workers, and supervisors. Their model postulated that while job stressors and support/control are influenced by larger factors such as policies and societal expectations, it is the stressors/demands that directly influence job satisfaction. Yet they were surprised to find that physical demands and emotional suppression (i.e, workers hiding their own feelings while providing care) were associated with greater job satisfaction, which is counter to what the model

would have predicted. More importantly, they found that having more control over job tasks was not significantly associated with being highly satisfied with home care jobs but support was associated with satisfaction (Delp, Wallace, Geiger-Brown, & Muntaner, 2010). The Kanter/Laschinger theory and previous research on the role of empowerment and job satisfaction would appear to counter the lack of association between control and satisfaction, which is why more research like this is needed with the direct care workforce. As mentioned above, our framework by Laschinger et al. (2001), which includes structural empowerment (structure of opportunity, access to resources, access to information, access to support; Kanter, 1993), and psychological empowerment (meaning, competence, autonomy, impact) illustrates the expectation, based on the literature, that structural and psychological empowerment ultimately lead to job satisfaction which in turn increases retention. (Figure 1)

Figure 1: Conceptual model guiding inquiry (adapted from Laschinger et al., 2001).



Previous research on the role of empowerment in increasing retention and job satisfaction in health care has focused primarily on nursing (e.g., Laschinger et al., 2001; Williamson, 2007) and NAs in residential facilities (e.g., Berridge et al., 2016). Research on empowerment and direct care has focused on retention and job satisfaction of nursing home workers, with the idea that more empowered DCWs are more satisfied and remain longer in their jobs, thus improving care. For example, Berridge et al (2016) found that higher staff empowerment scores were associated with greater staff retention. In another study, Barry, Brannon and Mor (2005), using a version of Kanter's theory of structural power among organizations, found higher scores of aide influence on patients' care plans were related to higher scores on social engagement of residents and lower direct care staff turnover rates were associated with better care. Overall, Barry and colleagues (2005) reported specific management practices could empower aides, which could positively impact patient outcomes. Given this positive impact of empowerment for DCWs in nursing facilities, it is reasonable to believe that empowerment might have similar positive effects for HCWs and their clients.

While home care workers and nursing home workers perform similar care tasks, nursing home workers complete them in the context of hierarchical organizational structures with on-site supervision. Home care workers perform these tasks 1:1 with clients, with supervisors who are sometimes many miles away, accessible only by phone, and, little is known about the role of empowerment in the job experiences of HCWs (Johnson & Noel, 2017). Since empowerment is associated with greater retention in nursing home workers, we posit that it might also be related to retention in home care. Understanding factors associated with retention of HCWs is critical to meet our growing need for community-based care. Some of the key challenges faced by HCWs are low wages, lack of benefits, and erratic hours (Butler, Brennan-Ing, Wardamasky, & Ashley,

2014; Seavey & Marquand, 2011; Stacey, 2011). Home care work also involves physical and emotional hazards. Despite these challenges, many HCWs find satisfaction in caring for older adults and people with disabilities (*e.g.*, Butler, Brennan-Ing, Wardamasky, & Ashley, 2014; Faul et al., 2010; Stacey, 2011). Intrinsic rewards such as finding meaning in job tasks, having input into job tasks (empowerment) (Morgan, Dill, & Kalleberg, 2013), and organizational/supervisor support has been shown to reduce HCWs' intention to leave their jobs (Ahyoung & Jang, 2008; Morris, 2009, Morgan et al., 2013).

This exploratory, qualitative inquiry seeks to understand how HCWs experience and define empowerment in their jobs, and ways they could feel more empowered because empowerment has not been well studied in home care.

Methods

This study used qualitative semi-structured interviews to examine empowerment among home care workers in one rural area and one more urban area in the Eastern part of the U.S.

Interview Guide

The authors created the interview guide based on the conceptual framework, of structural empowerment (structure of opportunity, access to resources, access to information, access to support), and psychological empowerment (meaning, competence, autonomy, impact; Laschinger et al., 2001). We asked three or four questions under each component. For example for "structure of opportunity" we asked: 1) What sort of continuing education opportunities have you had since beginning work as a home care aide? Since beginning at your agency? 2) Please describe any opportunities for advancement in your organization. and 3) What would be your vision of ideal opportunities for advancement in your work? These questions guided the research participants in their responses, but we also allowed participants to define the components of the

conceptual framework for themselves. For example, under the questions about “access to support,” we specifically asked about support from their supervisors, which gleaned rather targeted responses. But we also asked “What would be your ideal in terms of support from your employer?” which led to a wide range of responses from increased pay to access to emotional support such as an in-house counselor for workers.

We also asked research participants how they defined empowerment and experienced, or did not experience, it in their employment. Additional questions focused on their job history in home care, including with the agency they currently worked for; and demographic questions on age, education, income, racial/ethnic identity, health insurance and receipt of public assistance.

Participant Recruitment

To be included in the study, participants needed merely to be working in home care and speak enough English to complete the interviews. Some were trained CNAs, while others worked as personal care workers and did not have CNA training. In the rural region, participants (n=8) were recruited via flyers at two home care agencies, contact with a worker advocacy organization, and word of mouth. Interested workers contacted the investigator and interviews were conducted at a public location of their choice (n=4) or by phone (n=4). There was no apparent difference in the quality of the in-person versus the telephone interviews. In the urban region (n=4), workers were recruited through one home care agency, which notified all workers about the study and provided them with the investigator’s contact information. Ultimately, all four interviews took place at a senior independent living apartment building where multiple HCWs worked. Institutional Review Boards at the authors’ universities approved all study procedures.

Analysis

Interviews were recorded and transcribed verbatim. All authors read all transcripts. The third author reviewed the transcripts for a general fit to the conceptual framework, selecting quotes that illustrated each component. The first and second author analyzed the transcripts line-by-line using a priori codes based on the structural and psychological empowerment framework (Boyatzis, 1998). Each component of the framework was examined for its presence on each end of a continuum (e.g., good support vs. poor support; meaningful work vs. work not meaningful). Additionally, we analyzed participants' definitions of empowerment and whether they felt empowered in their work. NVivo 12 qualitative data analysis software was utilized to assist in data management. Initial coding produced 90% or greater agreement on each component of the framework. Differences were reviewed and discussed until full consensus was achieved. From the first level of coding, more general themes were developed based on overlap among codes and the salience of some codes over others. The final themes were: *Well Supported*, *Satisfying Work*, *Downsides of the Job*, and *Definitions of Empowerment*. Observer triangulation (two interviewers) and peer debriefing throughout data collection and analysis (all three authors) increased the trustworthiness of the analysis (Padgett, 2008).

Findings

Sample Description

There were 12 total participants, eight from the rural region and four from the urban region. Participants' average age was 42.54 and ranged from 20 to 64. They averaged 12.88 years in home care suggesting significant experience, but it varied widely, from two weeks to 40 years. All participants were female, reflective of a workforce where 87% of all home care workers are female (Paraprofessional Health Institute, 2019). Table 1 provides a description of the sample, along with pseudonyms for the 12 research participants. All but one study

participant, Caitlyn, had health insurance; Helena and Mariama had Medicaid—a publicly-funded health insurance program for low-income individuals. In the United States, health insurance is often tied to full time employment. Nationally, two in five HCWs works part time, many due to circumstances beyond their control (PHI, 2019). Access to health insurance has been shown to increase job retention among HCWs (Butler, Wardamasky, & Brennan-Ing, 2012). Caitlyn received assistance from the Women, Infants and Children (WIC), a publicly-funded nutrition program, for her toddler. While our sample had three participants who received public assistance (25%); nationally, 53% of HCWs receive some sort of public assistance, including Medicaid (PHI, 2019). (Insert Table 1 here.)

Well Supported

Drawing from the responses to the questions regarding adequacy of resources to do their job, availability of information about their clients and agency policies, and the level of support from their employers, research participants, for the most part, described having what they needed for their work and being well supported by their supervisors. In the conceptual framework, these questions were all part of the structural aspects of empowerment.

Resources

Eleanor described having the resources she needed.

My company provides me all the basics. They provide my gloves, which are the most important....They provide us with a nice little calendar which is wonderful.

They provide us with the paperwork we need and we can request, you know, hand sanitizers, mask and gloves if we need them.

Caitlyn, interviewed during the winter, noted both the usual resources as well as seasonally specific items.

[The agency] gives us medical supply things. We get the gloves and the sanitizer, everything we need there. They provide, especially in this kind of weather, they supply ice grippers and stuff like that. Just so we can safely get through all this stuff.

Such resources were likely less important to the study participants who completed most of their work within one apartment complex, as was true for the four participants from the urban state.

Information

The questions in the interview guide about availability of information regarding their clients, asked research participants about the process of communication in their agencies. Helena, who was working privately at the time of the interview, described what it was like when she last worked for a home care agency.

If I ever had any problems when I went home and I was not in the patient's home, I would call the office. And I always got prompt, you know, I was able to hook up with the job coordinator, who knew a lot about the people. Either that or a visiting nurse would return my call. So it was a pretty good set up. I never had a problem with communication.

Eleanor also described her agency's quick response to workers' questions:

I have a problem, I call my supervisor and she is right on the ball...for those who work on the off hours, there is on-call and they get back to you within 15 minutes. And they will ring the appropriate person up at home and they will get in touch with you. Communication is good.

Mariama, whose clients were all in one building noted that she could access information right on-site if she wanted, "This company, I can call them any time. I can even walk to them, the

manager office, and tell them, look, this lady is a little problem...then they will train me more. They will tell me things to do that I can handle it.

Support

Research participants offered many examples of the support they received from their supervisors. Two research participants who worked at the same agency described how their supervisor supported them. Brianna who had just started at the agency said, “He always reassures you and always checks in to make sure you know what is going on. He is very on top of it to make sure you know what is happening.” Frieda, who had worked there for six months remarked, “If clients say something positive about me, he tells me immediately. They slipped in a raise and they didn’t tell me that; I noticed.”

Cases of good support seemed to be linked to responsive supervisors and workers not feeling alone when they encountered a difficult case or client. Helena described a male client who was inappropriate towards female workers and the support she received from her supervisor:

Well I had a client, he was a gentleman, he was inappropriate and I was no longer comfortable going into his home....and she [the supervisor] was very supportive and said “we will put it down on your chart that you don’t want to go to this gentleman’s house.

Satisfying Work

Research participants’ responses to the questions in the interview guide that were focused on psychological empowerment (i.e., feelings of competency, levels of autonomy, how meaningful they found the work, and whether they thought they had an impact on their clients’ lives and/or on their agencies) largely painted a picture of job satisfaction.

Competence

All the research participants expressed feelings of competence, as they carried out their work, as illustrated by Helena, who looked back on her 34 years of doing both institutional and home caregiving:

I've had a lot of experience.... I've always felt very confident. And I've worked with some older nurses that really took the time to teach... There was rarely anything that happened that made me think "oh I can't do this." No I really always felt very confident about the care I gave.

Gail also expressed this confidence in her skills, "I feel pretty confident every time I walk into a new house... I'm not in fear of not being confident. And I have had some difficult, difficult people."

Autonomy

Closely related to competence, all the research participants also reported feeling autonomous as they carried out their work. Dottie provides an example of this theme:

Every day, when I walk into a home I know exactly what I'm doing. I don't have to stop and ask anybody, anything except for what are they eating for dinner tonight. I mean I make my own decisions, because I know. This is how you roll somebody. I know this is how you change somebody. I know this is the order of how you do things. So I feel very self-sufficient.

Meaning

Each of the research participants described ways in which home care work was meaningful for them. Imani, said this very simply in her interview, "I love my job. I love taking

care of the elderly.” Brianna, who was about to complete her degree in nursing was motivated to be a caregiver through her life experience:

I want to help others. Because when I was younger I had cancer so I grew up in the hospital quite a bit. So I’m kind of in the mentality that I want to be a nurse so I can give back the way the other nurses helped me. Pretty much. I just want to make sure people have an easier and better quality life.

Eleanor described how her impact on client lives brought meaning to her job:

I’m not going to win a Nobel, I’m not going to make a splash, but I can go into a client, and whatever, I can usually move their feeling from, at least one step up the ladder, and usually several steps. And that is a good feeling. And there aren’t very many jobs where you can do that.

Impact

All the other study participants also described the positive impact they had on their clients’ lives. For example Frieda said, “Because we are there and we are seeing on a daily basis how somebody is, we can relay that information to the family and then make vital differences.” Many felt that their work and their ability to identify clients’ changing needs allowed clients to remain in their homes or the community. Helena voiced this sentiment in her interview:

Just having a client who is able to stay in their own home. You know working in nursing homes and working in home care, I can’t tell you the difference in the mentality.... I mean some people are still unhappy because they don’t feel well or having so many different faces in their home, but they know they need the care. They can’t stay in their home unless that happens. So yeah, big difference. You know people are just so much happier and eat better in their own surroundings.

Taken together, the feelings of competence and autonomy, and the knowledge that what they did positively impacted their clients' wellbeing, contributed to research participants' conception of meaningful work and overall job satisfaction. Nonetheless, despite the general feeling of being supported in their work—structural empowerment—the high level of job satisfaction—psychological empowerment—research participants also reported aspects of their employment that were less empowering.

Downsides of Job

Participants also reported aspects of their jobs that were less positive, including inadequate support and information, few opportunities for advancement, and ways in which the impact they had was constrained.

Inadequate Support

While all the research participants indicated receiving support from their employers, eight also indicated ways in which their employers did not provide enough, including both poor support from their supervisors and poor compensation for their work. The four research participants from the urban region who all worked within one senior independent living building where their supervisor was onsite and easily accessible in person did not report problems with supervisor support, while six from the rural region, who worked independently in private homes, expressed more isolation.

Abby, who learned about the study through an advocacy organization working to improve job conditions for home care workers, and thus had more experience than the other research participants in articulating the parts of the job that needed improvement, noted one of the difficulties of working independently in the community:

The person that I call and... rely on for emotional support and informational support, I have never met them. I've had three different ones for [agency] and I've never met them once. I've never seen their face and so it is weird to have a personal relationship with someone you never see, you never meet.

The isolation experienced in home care was also voiced by Gail:

Like I get stuck at a client's house and I really need help, there is no back up to come in and help me. If I just happen to hit it lucky, that the nurse is coming in, then maybe the nurse and I can go ahead and work with the client. But ...you know you are in there alone and that is the way it is.

Gail, who had worked in a hospital setting for many years before moving into home care, further noted that having someone at the agency to discuss the hard parts of the job would decrease her stress:

I think we need some kind of communication with somebody who is objective. We [could] call in or go in, kind of like counseling. You could go in, tell them all the negatives about this person or that situation and say "is it me or is that the way it is?" Because up at the hospital, we had that: we had sessions where you could go in and just talk, clear the air, and then you are not going home with that guilty feeling, or a feeling like "Jeez, I shouldn't have done that." I think every company should have that.

A few research participants from the rural region remarked upon the very low wages, another indication of inadequate support. At the time of data collection, minimum wage in the rural region was \$10, while in the urban region it was \$15, resulting in different wage experiences between the two samples; low wage work such as home care is often directly

affected by the local minimum wage. Abby describes how lack of adequate compensation has impacted her life:

I need a smart phone. I use my phone to take my notes. One of my companies gives me a 20% discount on the plan only, for being an employee. So it is only 20% off the \$40 part of the plan. Not the payment of the phone nor any of the other services. And I have to use my car, my own personal vehicle. And I get paid a pittance in mileage. So I've been through three cars in the last three years.

After years in the field, Helena, who left home care work soon after her interview due to her inability to move out of poverty and the physical toll the work took on your body, reflected, "it is a burnout job. It is not that people in it don't actually like it, but they get angry. You know, they are not making a living and it is hard."

Inadequate Information

Eleanor expressed concern about the lack of training some home care workers had as they started to see clients. She and several other research participants believed more attention should be devoted to training. In particular, Eleanor believed having experienced workers mentor younger workers would decrease turnover and increase client satisfaction. She said:

There is no funding. They cannot afford to pay two people to be in the same place. But what they don't understand, if you are going through all these people who are not working out, you would have prevented if you took a little extra time and money in the beginning and gave them training. Something as simple as how to walk in and greet your client for the first time.

Another structural problem identified by Eleanor had to do with barriers to communication regarding the needs of particular clients. She described how this played out:

Some of my clients have [agency] nurses. Some have them from another company and that is where it really gets difficult. I have one client who has physical therapy from one company, occupational from another company, a nurse from a third company, a senior nurse from the hospital, and they have my services. There isn't any central information. That is to the detriment to the client.

Mixed Views on Opportunity

Most, but not all, study participants did not see clear pathways to advancement in their jobs—the access to opportunity component of the conceptual framework. Not all study participants saw this as problematic as indicated by Eleanor:

This job doesn't really have advancement. The next step would be becoming a CNA or CRMA [Certified Residential Care Medication Aide]. That would be a personal choice if that is the direction you go. For me, this particular kind of job fits my requirement of having time off scheduled when I need it and the pay is not great.

Low Impact

Most of the instances of dissatisfaction with home care work for the research participants related to the components of structural empowerment. Research participants largely felt competent and autonomous in their work and found their jobs meaningful—components of psychological empowerment. And while they believed they positively impacted their clients' lives, their low status in the health care field constrained that impact, as noted by Helena.

In home care or staffing they are not going to listen to PCAs [personal care attendants] or CNAs. They've had the years of education and I don't feel they're

open to listening to what we have to...they may listen to us, but they don't actually hear us.

Definitions of Empowerment

After asking research participants about their experiences with the structural and psychological components of our conceptual framework, we asked them for their own definition of the word empowerment, and how they felt empowered and/or disempowered on the job. The participants' definitions overlapped with components of the conceptual framework. Autonomy and competence were reflected in several definitions. For example, Dottie defined empowerment as, "Empowerment means that I feel like...like I'm in charge of it. I do adequate work for my job." Helena also included these concepts along with how the job was meaningful and brought her satisfaction: "It means doing things that may be independently done that give you satisfaction that you are doing things right, the way you feel, or maybe a certain client, to be right." Fatmata's definition also included the concept of autonomy; she said, "...empowerment with patients, being in control of stuff...but it's like I let them make their own decisions."

Several other research participants included the meaning of the work as part of their definitions. For Mariama, empowerment included meaning, but also included feeling competent and having the opportunity to grow in the job: "It means a lot. I love, I mean it's something that's, it's like, if you have strength, or you have belief, that you're doing right, yes, and if every day I'm learning more and more and more things." In Caitlyn's definition competence and access to information supplemented meaningful work: "I guess the best way to describe that would be having the capabilities and knowledge to be able to do the meaningful work, whether that is just personally at home, whether that is in the job."

Eleanor's definition drew from the structural aspects of the conceptual framework, including resources, information and support: "Being given the resources and skills I need to do my job and a recourse to address the issues that are not resolved." Her definition includes the idea that she will be heard when problems arise. This is echoed in Frieda's definition, which includes aspects of autonomy and support, with an emphasis on respect: "It means I have the ability to think for myself and say and make suggestions and be heard with respect." Abby, the research participant who was the most critical of her employers, also emphasized being heard, as well as feeling safe to express opinions:

I guess it just means feeling valued and heard and some control. Like I feel I can speak up and say things should be different, or things are great, either way. I guess "safe" would be another good word to equate with that.

Brianna's definition underscored autonomy, but also knowing her work had an impact on clients' lives:

I think empowerment means to me, being able to do a lot of things on my own. According to this job, going in and helping someone out on my own and not having to watch them not do their best.

Three of the research participants were unable to come up with a definition, in part as the word was new to them. For example, Gail thought it meant having power over others, such as her clients, and she emphasized that she did not support that. Imani and Abina, for whom English was not their first language, were also unable to provide definitions of the word.

Discussion

The home care workers in our study reported both positive and negative aspects of their jobs. Specifically, our findings suggest that aides did not always feel structurally empowered, but

generally did feel psychologically empowered. Most felt supported by their supervisors and felt they received the information and resources they needed to do their jobs well. According to the literature, this feeling of support is unusual among care workers and suggests that our sample may be unique or we may have asked questions that better allowed participants to describe both the support they receive as well as the support that is lacking. Replicating the study with another sample would allow us to examine this further. The only component of the structural aspect of the empowerment framework for which study participants were more negative than positive was that of opportunity, specifically noting a lack of training and funding. Study participants also positively experienced all components of the psychological aspect of the empowerment framework. They found their work meaningful, felt competent, enjoyed the autonomy of the job, and believed they positively impacted their clients.

Moreover, the study participants' definitions of empowerment drew on both the structural and psychological components of the conceptual framework (Laschinger et al., 2001). Many of the things research participants reported as positive- finding meaning, having autonomy, and receiving the resources they needed – were empowering to them. Some chose home care work after having worked in institutional settings, preferring the one-on-one, the reduced stress of not having to rush, and the autonomy to create their own schedules and manage their own workflow, all aspects related to having time. The importance of having time to provide care reflects the recent findings of McDonald, Lolich, and Warters (2019), who found that time was essential to providing quality person-centered care. In our study, those who experienced disempowering aspects of the job identified mostly structural aspects of empowerment, including access to support, resources, information and opportunity.

For many, these challenging aspects of the work involved not feeling supported or valued. This lack of support played out in many different ways, such as not having back up when alone in a home with a client, or the inadequate compensation that made it challenging to meet their own needs while doing this important work, or the lack of opportunities for advancement. For years home care work has been devalued economically by perceptions of it as women's work, and that women are only in it for spare money (Howes, 2015). These perceptions have prevented the improvement of some aspects of home care work such as wages, yet some people choose home care for its flexibility and the ability to work home care in addition to another low wage job (Howes, 2008). But even though workers do find aspects of these types of jobs to be beneficial does not mean that they should not be adequately supported or compensated.

While the literature describes structural empowerment as a means for organizations to return control to workers (Laschinger, 1996), our respondents included both the psychological and structural components discussed in Laschinger et al (2001)'s model. Those who defined empowerment linked it to meaningful work, the ability to do things independently, and a desire to make suggestions and have them be heard. Therefore, these are things that can be improved to augment the positive and decrease what drives some to leave the work. Additionally, the results suggest that some of the elements of empowerment were dependent on others: for example, autonomy was valued, but workers did not want to feel like they were on their own without support. This seems to support the Job Demand Control/Support Model postulated by Delp et al (2010) in which they postulated both job stressors and demands, and support and control should be directly related to job satisfaction, and found that adequate support can transform job stressors into job satisfaction.

The implications for home care agencies and the home care workforce as a whole, is that there are structural changes that would improve the job experience for home care workers and potentially improve retention. Both this study and past research supports the idea that, specifically, agencies need to build systems that increase workers' connection with supervisors and peers to provide both the tangible and emotional support that workers need (Franzosa, Tsui, & Baron, 2019). Participants were interested in training on more advanced issues. One way to provide these advanced competencies and increase the value of more experienced workers would be to develop advanced roles, such as opportunities to mentor new workers. Advanced training has been documented to reduce turnover and increase job satisfaction among HCWs (PHI, 2017).

We need to increase the value we place on these workers. Agencies must build in structures that recognize and value the contributions of these workers to the well-being of the frail people for whom they provide care. Increased compensation is an essential piece of increasing the value of these workers. More of the rural workers mentioned compensation than urban workers, however, minimum wage was substantially higher in the urban area where the study took place than in the rural area (as of this writing \$15 vs \$11/hour).

The primary co-worker relationships mentioned by participants in our study were supervisors and nurses. We suspect that this was due to the types of home care some clients received- for example, those with the private pay agencies generally received only home support services. Other workers described clients who received a network of services through Medicaid or other waiver programs. For the workers who assist clients with multiple health care providers, the gerontological social workers on the health care teams can be leaders in valuing these important workers. They can advocate for improved job conditions, more training, and better compensation and benefits. The limitation would be that not all home care is provided to clients

also served by social workers, and other means of support would need to be available. Social workers might also serve as in-house counselors for HCWs—as suggested by study participant, Gail—to allow them a safe place to discuss stressful situations they encounter in their work

Limitations

As an exploratory, qualitative study with a small sample, we do not look to generalize our findings. Our findings are consistent with previous studies that show that home care workers find value in their work despite challenges, and are in need of more supervisor support. In our study we do note some differences between the workers from different areas, and the ways in which those differences could have impacted the findings. Not only were wages different between the two areas, all the urban workers worked for the same agency while the rural workers came from several different agencies. Those from the same agency had been referred by the agency, and might have tended to report more positively on their work experiences. We did note that they reported positive support from the agency but noted no differences in other reports related to challenges. There were race/ethnicity differences as well. All the urban workers were immigrants, who represent a significant part of the home care workforce in some parts of the country. This diversity allowed our sample to be more representative of the diversity in the HCW population nationally.

Conclusion

According to the Bureau of Labor Statistics (2019), the need for home care workers is projected to grow 36% in the next 10 years. Home care workers are essential in allowing older and disabled individuals to remain in their communities which is what many want, and many funders prefer. While the HCWs in our study felt empowered by the autonomy of their work and felt that their work had high impact on the clients they served, there were structural gaps that

could become barriers to their remaining employed in this field. These gaps must be closed to ensure an adequate workforce to meet future care needs.

References

- Agbonifo, N., Hittle, B. Suarez, R. & Davis K. (2017). Occupational exposures of home healthcare workers. *Home Healthcare Nurse*, 35, 50-159.
<http://doi.org/10.1097/NHH.0000000000000509>
- Ahyoung, AL & Jang Y. (2008). What makes home health workers think about leaving their job? The role of physical injury and organizational support. *Home Health Care Services Quarterly*, 35 (1), 1-10. <https://doi.org/10.1080/01621424.2016.1145165>
- Butler, S.S., Brennan-Ing, M., Wardamasky, S., & Ashley, A. (2014). Determinants of longer job tenure among home care aides: What makes some stay on the job while others leave? (2014). *Journal of Applied Gerontology*, 33(2), 164-188.
<https://doi.org/10.1177/0733464813495958>
- Butler, S.S., Wardamasky, S., & Brennan-Ing, M. (2012). Older women taking care of older women: The rewards and challenges of the home care aide job. *Journal of Women & Aging*, 24 (3), 194-215. <https://doi.org/10.1080/08952841.2012.639667>
- Barry, T. T., Brannon, D., & Mor, V. (2005). Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. *The Gerontologist*, 45(3), 309-317.
<https://doi.org/10.1093/geront/45.3.309>
- Berridge, C., Tyler, D.A., & Miller, S.C. (2016). Staff empowerment practices and CNA retention: Findings from a nationally representative nursing home culture change survey. *Journal of Applied Gerontology*, 35, 1-16. <https://doi.org/10.1177/0733464816665204>
- Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: SAGE.

Bureau of Labor Statistics, U.S. Department of Labor. (2019). *Occupational outlook handbook*.

Home health aides and personal care aides. Retrieved from

<https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm>

Delp, L., Wallace, S., Geiger-Brown, J., & Muntaner, C. (2010). Job stress and job satisfaction:

Home care workers in a consumer-directed model of care. *Health Services Research*,

45(4), 922-940. <https://doi.org/10.1111/j.1475-6773.2010.01112.x>

Faul, A.C., Schapmire, T.J., D'Ambrosio, J., Feaster, D., Oak, C.S. & Farley, A. (2010).

Promoting sustainability in frontline home care aides: Understanding factors affecting job

retention in the homecare workforce. *Home Health Care Management Practice*, 22, 408-

416. <https://doi.org/10.1177/1084822309348896>

Franzosa, E., Tsui, E., & Baron, S. (2019). "Who's caring for us?": Understanding and

addressing the effects of emotional labor on home health aides' well-being. *The*

Gerontologist, 59(6), 1055-1064. <https://doi.org/10.1093/geront/gny099>

Howes, C. (2008). Love, money, or flexibility: What motivates people to work in consumer-

directed home care? *The Gerontologist*, 48(Special Issue 1), 46-59.

https://doi.org/10.1093/geront/48.Supplement_1.46

Howes, C. (2015). Home care: The fastest growing low-wage industry. *New Labor Forum*,

24(2), 98-105. <https://doi.org/10.1177/1095796015579692>

Johnson, C. S., & Noel, M. (2007). Level of empowerment and health knowledge of home

support workers providing care for frail elderly. *Home Health Care Services*

Quarterly, 26(3), 61-80. https://doi.org/10.1300/J027v26n03_04

Johnson, R.W. & Wiener, J.M. (2006). *A profile of frail older Americans and their caregivers*.

Washington DC: The Urban Institute.

- Kanter, R.M. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.
- Laschinger, H.K.S. (1996). A theoretical approach to studying work empowerment in nursing: A review of studies testing Kanter's theory of structural power in organizations. *Nursing Administrative Quarterly*, 20, 25-41.
- Laschinger, H.K.S, Finegan, J., Shamian, J., Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings. *Journal of Nursing Administration*, 31, 260-272. <https://doi.org/10.1097/00005110-200105000-00006>
- Marquand, A. & York, A. (2016). Squaring to the challenge: Who will be tomorrow's caregivers? *Generations*, 40, 10-17.
- McDonald, A., Lolic, L., & Warters, A. (2019). "Time is more important than anything else": tensions of time in the home care of older adults in Ireland. *International Journal of Care and Caring*, 3(4), 501-515. <https://doi.org/10.1332/239788219X15622468259858>
- Morgan, J., Dill, M., & Kalleberg, A. (2013). The quality of healthcare jobs: can intrinsic rewards compensate for low extrinsic rewards? *Work, Employment, & Society*, 27(5), 802-822. <https://doi.org/10.1177/0950017012474707>
- Morris L. (2009). Quits and job changes among home care workers in Maine: The role of wages, hours, and benefits. *The Gerontologist*, 49, 635-650.
<https://doi.org/10.1093/geront/gnp071>
- Padgett, D.K. (2008). *Qualitative methods in social work research*. Los Angeles: SAGE
- Paraprofessional Healthcare Institute (PHI). (2019). *U.S. home care workers: Key facts*. (Issue Brief). Retrieved from the Paraprofessional Health Institute website:
<https://phinational.org/resource/u-s-home-care-workers-key-facts-2019/>

- Paraprofessional Healthcare Institute (PHI). (2017). *Federal policy priorities: Strengthening the direct care workforce*. Retrieved from: <https://phinational.org/resource/federal-policy-priorities-strengthening-the-direct-care-workforce/>
- Seavey, D. & Marquand A. (2011). *Caring in America: A comprehensive analysis of the nation's fastest-growing jobs: Home health and personal care aides*. New York City: PHI.
- Spetz, J., Stone, R., Chapman, S., & Bryant, N. (2019). Home And Community-Based Workforce For Patients With Serious Illness Requires Support To Meet Growing Needs. *Health Affairs*, 38(6), 902-909. <https://doi.org/10.1377/hlthaff.2019.00021>
- Spetz, J., Trupin, L., Bates, T. & Coffman, J.M. (2015). Future demand for long-term care workers will be influenced by demographic and utilization changes. *Health Affairs (Millwood)*, 34, 936-945. <https://doi.org/10.1377/hlthaff.2015.0005>
- Spreitzer, G.M. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of Management Journal*, 38, 1442-1465.
- Stacey, C.L. (2011) *The caring self: The work experience of home care aides*. Ithaca, NY: Cornell University Press.
- Stone, R., Wilhelm, J., Bishop, C., Bryant, N., Hermer, L., & Squillace, M. (2017). Predictors of Intent to Leave the Job Among Home Health Workers: Analysis of the National Home Health Aide Survey. *The Gerontologist*, 57(5), 890-899. <https://doi.org/10.1093/geront/gnw075>
- Williamson, K.M. (2007). Home health nurses' perceptions of empowerment. *Journal of Community Health Nursing*, 24, 133-153.

Table 1: Research participant pseudonyms and demographic information

Research Participant (pseudonyms)	Age	Education	Immigrant status/race	Income	Years in home health	Type of agency	State of residence
Abby	36	Some college	Born in US/White	\$40,000-50,000	16	For-profit home care-Medicaid	Rural state
Dottie	61	Some college	Born in US/White	\$40,000-50,000	10	For –profit home care-Private pay	Rural state
Helena	54	Some college	Born in US/White	\$10,000-20,000	34	Works independently	Rural state
Brianna	20	Some college	Born in US/White	<\$10,000	< 1	For –profit home care-Private pay	Rural state
Eleanor	58	Bachelor’s degree	Born in US/White	\$30,000-40,000	4	For-profit home care-Medicaid/Medicare	Rural state
Caitlyn	26	Bachelor’s degree	Born in US/White	\$20,000-30,000	3	For-profit home care-Medicaid	Rural state
Frieda	60	Associate’s degree	Born in US/White	Missing data	< 1	For –profit home care-Private pay	Rural state
Gail	64	Associate’s degree	Born in US/White	\$10,000-20,000	16	For-profit home care-Medicaid/Medicare	Rural state
Imani	63	High School	Immigrant/Black	\$30,000-40,000	40	For-profit home care-Private Pay	Urban state
Fatmata	Over 40	Associate’s degree	Immigrant/Black	\$30,000-40,000	20	For-profit home care-Private Pay	Urban state
Mariama	63	High School	Immigrant/Black	\$20,000-30,000	7	For-profit home care-Private Pay	Urban state
Abima	26	High School	Immigrant/Black	\$20,000-30,000	4	For-profit home care-Private Pay	Urban state