Job satisfaction among foreign-born skilled nursing facility employees in Washington State

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Abstract

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The need for long-term care is growing, related in part to aging societies, military-related disability, and insurance reforms. This care depends upon a workforce that is reliable, one that cannot be outsourced or readily replaced by technology, and is increasingly foreign-born. Satisfaction among these workers has many implications, including effect on turnover rates and quality of care. This cross-sectional exploratory study sought to further define predictors of satisfaction among a sample of foreign-born nursing home workers in Seattle, Washington through combined quantitative and qualitative methodology. Questionnaire data indicated significant foreign-born representation among respondents. Cross-tabulations and regression analysis yielded strongest (negative) predictors of satisfaction in experiencing: language proficiency as barrier to work goals, feeling afraid about living in the US, and weight gain since coming to the US. Focus groups revealed further important satisfaction-related themes of respect, communication, interpersonal work environment, and expectations of life in the US and elder care. These findings are important to understanding the economic, societal and ethical ramifications of the care received by the world's elders, as well as general populations in health-worker-deprived low-and-middle-income countries from which many of these workers emigrate.

Introduction

The growing need for long-term care (LTC). Fifty-eight million retirement-age Americans now comprise about 17 percent of the population, but by the year 2040, more than one in five Americans will be considered old (Profile of Older Americans 2023). This mirrors an international trend, with more than 1.5 billion (16.4%) of the world's citizens expected to be older than age 65 by mid-century (Vollset et al 2020). The subset of elders over 85 will triple by then, with the implication that the fastest rate of growth is among those who will require the most support and care, and thus investment of health resources (Vollset et al 2020; Jaul and Barron 2017).

America's aging society, coupled with recent health insurance reform, sets the stage for a major expansion of long-term care and increased demand for a workforce to provide significantly more care for more elders in various care settings, including nursing homes. The Institute of Medicine anticipates need for 3.5 million additional health care workers by 2030 (Retooling for an aging America 2008), and immigrants commonly fill health care workforce shortages (Altorjai and Batalova 2017; Patel et al 2018). Four percent of Americans over age 65 live in skilled nursing facilities (SNFs), while this number grows to 17% among those older than 85. Some research suggests United States (US) nursing home utilization rates are low compared to other industrialized nations, implying that this number may not decline with the next generations of elderly (Eskildsen and Price 2009). Over the next two decades, almost half (46%) of Americans who live to age 65 will need a SNF at some point in their lives (Grabowski and Stevenson 2008). At the same time, forces of globalization and wealth distribution are driving vast numbers of working-age people to seek employment outside the pathways their aging parents might have predicted. The long-term care industry in wealthy countries, for one, is creating opportunities for migrants from low-income countries who seek entry-level employment. Predicted increases in long-term care utilization conservatively represent more than four million new jobs for nurse aides, home care personnel and personal care (The Long-Term Care Workforce: Can the Crisis Be Fixed? 2007).

Aging is not the only factor in generating demand for long-term care. The sustained deployment of more than 2.2 million Americans to combat zones over the last decade has also generated need for such services. Approximately 800,000 veterans have required care as a result of injuries sustained during the conflicts in Iraq and Afghanistan (Geiling et al 2012; Potential costs of veterans health care 2010). Though related data is scarce, "polytraumatic" injuries common to these conflicts are often associated with decades of rehabilitation involving institutional care (Geiling et al 2012).

Reforms to long-term care through the U.S. Affordable Care Act (ACA) also serve to increase demand for care. The ACA altered both Medicare and Medicaid, which since 1965 have been the predominant sources of health insurance for adults over age 65. Medicaid is the primary

payer for majority of patients in the country's 17,000 nursing homes (Culp et al 2008), while Medicare covers skilled short stays in these facilities (Eskildsen and Price 2009; Miller 2012). Long-term care recipients represent only 6% of the Medicaid population, however they account for almost half of overall Medicaid spending. These government programs now pay almost 60% of total nursing home costs (Weech-Maldonado et al 2012). Medicaid expansion under the ACA provides more coverage for long-term care, and elders no longer need to spend down as much of their savings before receiving payment assistance; however, the effects of this provision may be blunted by financial and legislative differences between states (Miller 2012; The Long-Term Care Workforce: Can the Crisis Be Fixed? 2007; Scala-Foley 2012). And while the ACA provides incentives for service delivery and payment models that may increase community-based care, that is not expected to dampen demand for nursing home services. The Act also provides enhanced dementia-care and abuse-prevention training for certified nurse assistants, and ensures the staff themselves will receive health insurance coverage (Miller 2012).

Nursing homes in the US are largely run for profit (68%), although one in four (26%) are non-profit and 6% are government owned (Kaiser 2010). The industry was conceived in the United States in the 1930s, when the Social Security cash assistance program for elders made long-term care a potentially profitable enterprise (Eskildsen and Price 2009). Nursing homes under chain-affiliated ownership rose from 39% to 52% between 1990 and 2004, most of them for-profit (Weech-Maldonado et al 2012). Multi-facility chain operations promise better financial performance through better capital access, service breadth and standardization of care (Weech-Maldonado et al 2012). US nursing homes employ 1.7 million people, with a growth of 11% expected over the next decade, according to Bureau of Labor Statistics projections (2010-2020 Industry-occupation matrix data, by industry 2012). Meanwhile, the proportion of nursing home workers covered by labor union contracts has steadily declined from 15% to 10% since 1985. Facilities with more residents, more Medicaid patients, hospital or chain affiliations and Northern or West Coast state locations are more likely to have union representation (Sojourner et al 2010). Institutional characteristics vary by geography: e.g. urban institutions, numbering about 11,000, experience challenges and benefits of employing and caring for more culturally diverse groups of people (Howe 2009; King 2006; Redfoot and Houser 2008), while the 6,000 rural entities are more affected by infrastructure- and resource-related limitations compared to their urban counterparts (The Long-Term Care Workforce: Can the Crisis Be Fixed? 2007; Bowblis et al 2013; Dalton and Harold Van Houtven 2002).

The long-term care workforce. The highly-regulated nursing home industry depends on a workforce that must reliably show up every day of the year, around the clock. Direct-care jobs cannot be outsourced or readily replaced with technology (Sojourner et al 2010). Worker satisfaction is established as pivotal to maintaining effective, stable health care services, in part because it affects turnover and retention rates, which influence nursing home care quality and quality ratings (Report of findings 2007 AHCA survey nursing staff and vacancy and turnover in nursing facilities 2008; 2011 Staffing Survey Report 2012; Spilsbury et al 2011; Castle and Engberg

2007; Blaauw et al 2013; McAuliffe et al 2013; Rahman et al 2010). Job satisfaction in health care settings is a complex phenomenon reflecting various dimensions of work environment, including relationships with patients and colleagues, remuneration and benefits, role definition and meaning, recognition for achievement, and overall feelings about one's job or its facets (Lu et al 2012; Lambrou et al 2010; Hagopian et al 2009; Scheurer et al 2009; Judge et al 2001; Coomber and Barriball 2007). Nurses who work in long-term care, which is often physically and emotionally difficult and garners relatively little respect or compensation, have demonstrated lower satisfaction than nurses in other sectors and workers generally (The Long-Term Care Workforce: Can the Crisis Be Fixed? 2007; Act now for your tomorrow: the final report of the National Commission on Nursing Workforce for Long-term Care 2005). The nature and structure of long-term care work has led to a 40-60% turnover rate or greater in some of these settings (Report of findings 2007 AHCA survey nursing staff and vacancy and turnover in nursing facilities 2008; Miller et al 2010), with turnover highest among direct care staff (2011 Staffing Survey Report 2012). Turnover itself may worsen satisfaction by increasing the workload for those who remain, creating a vicious cycle (Coomber and Barriball 2007; Hayes et al 2012; Bae et al 2010; O'Brien-Palla et al 2010; Thomas et al 2013; Goetz et al 2011; Kivimaki et al 2007; Rouleau et al 2012; Luboga et al 2011). Turnover among nurse aides alone is estimated to cost the industry $4 billion per year nationally, an average of $250,000 per facility (Act now for your tomorrow: the final report of the National Commission on Nursing Workforce for Long-term Care 2005).

These direct care workers are critical to long-term care, and in demand. Nursing assistant employment growth has outpaced the rate of other US occupations (2010-2020 Industry-occupation matrix data, by industry 2012), and a shortage of these workers poses an "impending healthcare crisis" according to the Institute of Medicine and the US Bureau of Labor Statistics (2010-2020 Industry-occupation matrix data, by industry 2012; Retooling for an Aging America: Building the Health Care Workforce 2008). Immigrants to the U.S. provide a pool of labor willing to take positions undesirable to native-born Americans, including nursing home work (Howe 2009; Redfoot and Houser 2008; Browne and Braun 2008). Though some have raised ethical concerns regarding immigrant worker vulnerability to exploitation, cited language differences as a barrier to quality care, or expressed disquiet about this industry potentially contributing to the "brain drain" of professionals from low-income home countries, there is no indication this workforce pool will evaporate anytime soon (Caspar and O'Rourke 2008; Stone 2001). The proportion of foreign-born workers in U.S. long-term care settings increased from 6% to 16% between 1980 and 2003, and in large cities more than 1 in 3 nursing aides are foreign-born (Redfoot and Houser 2008). The proportion of US long-term care nurses trained abroad is growing (Polsky et al 2007), compared to foreign-trained physicians that have represented 25% of their workforce for many years (Thompson et al 2009), and these nurses are three times more likely to work in nursing homes than their American-trained colleagues (Redfoot and Houser 2008; Schumacher 2011). Many foreign-trained direct-care workers can be professionally-trained health workers in their home countries, but US licensure requirements create barriers to filling jobs for which they may be more appropriately

trained. Licensed health professionals from low-income countries often experience "decredentialing," or working below their level of expertise (Redfoot and Houser 2008). Other wealthy nations report similarly increased demand for immigrant long term care employees (Howe 2009; Di Rosa et al 2012; Iecovich and Doron 2012; Jorens and Hajdu 2008).

Washington State. Nursing homes in Washington State face similar issues as those nationally. The proportion of for-profit nursing facilities (76%) is higher than the national figure however (Kaiser 2010), and (perhaps as a consequence) the workforce is more likely to be unionized compared to those of most other US regions (Sojourner et al 2010). Medicaid covers 60% of state's 18,000 nursing home patients, although compared to all other states Medicare covers the highest number of nursing home short-term stays at 17% (2012 Edition - Medicare and Medicaid Statistical Supplement 2012). Fewer than one in four (22%) nursing home patients are paying privately for their care (Providers and service use indicators: Nursing facilities 2010). Washington's over-65 population is expected to reach 1.7 million, or 20% of the state's population, by 2030. The state's expanding generation of elders is also increasingly diverse, with ethnic minorities comprising more than 20% of the population in 11 counties (Washington State Plan on Aging 2010-2014 2010).

More than 80,000 people are employed by the long-term care industry in Washington State's nursing home facilities (King 2006). Washington State was tagged with a worse-than-average nursing home employee retention rate (70%) in 2011; only 16 states had worse rates (2011 Staffing Survey Report 2012). The state ranks among the top ten for largest minority population percentages of Asians, Native Americans, Pacific Islanders, and those reporting two or more races (Washington State Plan on Aging 2010-2014 2010). Washington's workforce growth as a whole is fueled in large part by immigrant workers, but this is especially true for nursing homes. Seattle area nursing home administrators have said that without immigrant workers their facilities would "completely collapse" (King 2006).

Long-term care employee satisfaction. Researchers have analyzed satisfaction among nursing home aides and nurses generally (Culp et al 2008; Lu et al 2012; Lambrou et al 2010; Coomber and Barriball 2007; Ball et al 2009; Castle et al 2006), and a few have even explored the satisfaction of foreign-born nursing home workers. Khatutsky utilized 2004 data from a national survey of nursing assistants to compare non-immigrant and immigrant (particularly Hispanic) direct care employees with regards to personal characteristics, wages, benefits, and working conditions (Khattutsky et al 2010). Authors found immigrant nursing assistants to be older, better educated, more likely to find jobs through friends and family and experience communication difficulties and on-the-job discrimination, but also more likely to stay longer in one position. They found no evidence of difference in working conditions, earnings or motivation overall between the two groups. Immigrants tended to rate training, contentment with supervisor, and overall satisfaction more highly than non-immigrants, which may reflect cultural reluctance to formally complain. Findings among immigrant home care workers suggest that more formal education and experience,

as well as decisional authority and variety, confers greater satisfaction (Iecovich and Doron 2012). The satisfaction of health workers who have emigrated from lower-income countries may also be influenced by issues including language and cultural barriers, discrimination, and altered professional identity (Kawi and Xu 2009; Ea et al 2008; Hurtado et al 2012; Ertel et al 2011). Fisher (2008) corroborated the significance of both language difficulties and work relationships to satisfaction (Fisher and Wallhagen 2008). Survey data from long-term care health workers in a variety of settings suggested that job-related stressors and social support particularly affect satisfaction (Harrington et al 2012). Ball et. al (2009) found a strong connection between worker satisfaction and meaning appropriated through the emotional dimensions of work and workplace relationships (Ball et al 2009).

About our study. Given its increasing and far-reaching significance as discussed above, our study intended to further explore predictors of satisfaction among a sample of foreign-born nursing home workers in Seattle, Washington through a mixed methods approach. This study is undertaken to better understand factors specific to foreign-born nursing home employee satisfaction through combined quantitative and qualitative methodology among workers at all sub-management employment levels.

Methods

We conducted a mixed methods cross-sectional exploratory study of nursing home workers in a variety of job categories in four employment settings in and around Seattle, Washington during 2012. We used a 50- to 77-question instrument that generated quantitative measures and open text responses to questions about job satisfaction and in relation to various demographic and job-related correlates. We additionally ran focus groups of non-supervisory employees in three of these skilled nursing facilities.

Our sampling frame included the 67 Seattle skilled nursing facilities (hereafter, "SNFs," "nursing homes," or "facilities") that offered care to patients who regularly require 24-hour nursing care due to limited ability to perform their own activities of daily living. [65, 66] The nursing homes were all members of the statewide Washington Health Care Association (WHCA), a state organization representing both for-profit and non-profit facilities, as well as chain and stand-alone facilities, presenting a repository of engaged facilities in good standing. We selected six of these Seattle WHCA facilities for data collection, preferencing varied geographic distribution and large size to maximize chance of employee participation, and four of these agreed to participate. Three were non-profits, and none had union representation. The one for-profit facility was part of a national chain, while the others were stand-alone nursing homes. The facilities ranged in size from 120 to 211, for a total of 669 beds (average 167), and had between 225 and 365 employees each (average 288). We also conducted an on-line survey of the administrators of all the WHCA facilities in the state, the results of which are reported elsewhere (Acker et al 2015).

We obtained institutional review board approval from the University of Washington human subjects review board, and all participants consented to participate.

Questionnaire

Our anonymous 7-page 50-item paper questionnaire was distributed to non-management personnel in each home, offering a $10 gift card in exchange for participation. An additional 27-question foreign-born employee supplement on 5 pages was administered to those who answered initial queries indicating that they were 1) born outside the US, 2) spoke another language at home, 3) trained abroad, and/or 4) worked abroad. The entire questionnaire was piloted among a small group of foreign-born medical translators and graduate students to ensure coherency. In each facility, we obtained assistance from managers who provided time and space for anonymous questionnaire distribution and collection. Administrators in two of the homes were more engaged with the project, and our sample size from those facilities was therefore larger. Because of technical/logistical difficulties in administration, 28 immigrant employees did not receive the supplemental questionnaire that they should have.

Our questions to all workers asked about their personal characteristics, pre-service training, hours worked and second jobs, previous experience, earnings and benefits, aspects of job satisfaction and dissatisfaction, intent to stay on the job, and career aspirations beyond the current job. Twenty-one specific job satisfaction and morale questions utilized a 5-point Likert-type scale, 1 = strongly disagree to 5 = strongly agree. The immigrant worker questions related to their immigration experience and their work-related training and experience in the home country. Questions were largely drawn from questionnaires previously administered to hospital employees, home care workers and physician immigrants by researchers whose results were published in peer-reviewed literature (Hagopian et al 2009; Luboga et al 2011; Nguyen et al 2008; Hagopian et al 2003).

Focus groups

Employees at all four facilities were offered additional $15 gift cards to participate in focus group discussions, and were largely recruited on-location from among workers who were available when researchers appeared at shift change times, and with help from managers. We asked employees to tell us about what they liked and did not like about working in the nursing home, what they would like to change, and any special issues related to being immigrant workers.

Data analysis

Questionnaire data were entered into a computer using CSPro, and cleaned through rec-checks in Excel. We first analyzed data using frequencies on all questionnaire items. We created a "satisfaction score" by finding the mean from the 21 Likert-style satisfaction questions for each case, and conducted a Cronbach's alpha reliability analysis of the individual elements of the score. Using data from cases that answered at least 75% of the satisfaction questions, we conducted cross-

tabulations between demographic and job-related predictors of satisfaction, and selected those that appeared to be significant to create a regression model. All analyses were conducted using SPSS 19 for the Macintosh.

Qualitative data from focus group discussions and interviews were manually reviewed for recurring themes, agreed-upon by the authors. Similarly, answers to open-ended questions were systematically reviewed without aid of software.

Results

Thirty-five workers from the for-profit facility (20% of included participants), and 72 (42%), 54 (31%) and 11 (6%) workers from the three non-profit facilities completed a significant portion of the study questionnaire, for a total of 172 included participants. General characteristics and findings are summarized in Table 1, while characteristics specific to foreign-born respondents who answered supplemental questionnaire are summarized in Table 2. Eighty-eight percent of included surveyed employees were foreign-born from 41 different countries; they had emigrated on average 14 years before, and the vast majority were working age at the time of their emigration. Ethiopia (23%) and the Philippines (20%) were the most represented countries of origin; 44% were from African nations. Thirty-eight first languages were spoken among the foreign-born group, most commonly Amharic (19%); English was not the primary language for 86% of the total polled participants. The majority of participants (60% per available data) were female, and they ranged in age from 20 to 71 years old with a mean and median in the early fifth decade of life.

Most included respondents currently held a nursing-related position (i.e. nurse assistant, licensed practical nurse, registered nurse). One-quarter of those surveyed already had at least a university degree, and 43% desired to earn some kind of higher-education degree in the future to achieve positions in general nursing (53%), medicine (6%), or some other profession (13%) such as psychology, social work, physiotherapy, advanced nursing practice, or administration. However, only 19% were interested in taking classes currently when asked. The same number of people desired to be doctors as already had professional degrees. Most worked fulltime and earned $13/hour; 56% of these workers financially supported at least three people. Among 98 respondents to this question (57% of included questionnaire participants), an average of $314.54 was sent to family and friends abroad per month. Eighty-three percent had some employment benefits, but over half were without health insurance.

Satisfaction

Satisfaction analyses involved data from 163 cases after 9 cases were eliminated for answering fewer than 75% of satisfaction scale questions. See Table 3. Cronbach's alpha for the scale was 0.955. In total, the mean scores of all 21 items were greater than 3; overall mean and median score for all items and cases was 3.81. Forty-three percent of case mean scores fell between 3 and 4, and 41% between 4 and 5. Mode satisfaction score was 3. The mean score of the overview

satisfaction question ("Considering everything, I am satisfied with my job") was 3.92. Lowest average scores related to opportunities for promotion (3.13) and wages considered fair (3.27).

Cross-tabulations indicated significant associations between satisfaction score and several factors. Based on these analyses without controlling for age and gender, worker satisfaction was positively associated with possession of health insurance (p 0.035), total number of benefits (p 0.093), previous direct care work experience (p 0.045), working in LTC because it was familiar work (p 0.064), absence of trouble meeting work goals (0.001), and employing facility (p 0.020). Factors negatively affecting satisfaction included foreign-born status (p 0.034), trouble meeting work goals due to language (p 0.016) or poor financial support (p 0.011), working in a nursing home because it was the only available job (p 0.041), feeling afraid (p 0.039) or shocked (p 0.059) about living in the US, experiencing problems with acculturation (p 0.054) or weight gain (p 0.021) or increased substance use (p 0.025) since coming to the US, experience of discrimination in the US (p 0.056), and working >1 job (p 0.065).

After controlling for age and gender, regression modeling based on cross-tabulation analysis demonstrated significant negative association between satisfaction score and other variables (see Table 4): 1) language as a barrier to meeting work goals (R=.15), 2) feeling afraid about living in the U.S. (R=.145), 3) weight gain (R=.08), 4) experiencing discrimination (R=.06), 5) fear or shock about living in the US (R=.06) ; and 6)working in nursing home care because it was the only job available (R=.04) . Satisfaction was positively related to workers agreeing that they have found what they were seeking in coming to the US (R=.07). Language was correlated with other significant predictors including finding what was sought in US, acculturation, and experiencing other barriers and no barriers to work goals. Stepwise and standard regression analysis with appropriate variables yielded maximum predictive value from combined predictors of language proficiency as a barrier to reaching work goals (coefficient -0.537, p 0.005), feeling afraid about living in the US (coefficient -0.960, p 0.002), and experiencing weight gain since coming to the US (coefficient -0.257, p 0.091) based on model r squares, associated changes in coefficients and p values, and Akaike information criteria. This model accounted for 26.1% of observed satisfaction score variance in this sample population. See Table 5. Association between discrimination and job satisfaction was no longer significant after controlling for language and/or fear.

Qualitative

Fifteen workers participated in three focus group discussions at the three non-profit nursing homes – six (1 central supply worker, 3 CNAs, 2 nurses) from "Home A," five (1 food service worker, 3 CNAs, 1 nurse) from "Home B", and four (3 housekeepers, 1 environmental care/maintenance worker) from "Home C." All participants were adult immigrants to the US except for three effectively US-born workers in the last group. Many focus group recruitment attempts at the for-profit facility were unsuccessful. Important satisfaction-related subjects that arose consistently across all three locations included *respect* as a fundamental theme, which related

to additional themes of language use and *communication*, *interpersonal work environment*, and *expectations* of life in the US and appropriate elder care.

Feeling respected by fellow coworkers and employers was the central factor linked to turnover and retention among focus group participants. This concept was also expressed by terms such as "value" of and "care" for employees. Perception of interpersonal respect was clearly influenced by degree and style of communication among employees and with managers, as well as the ability to work "together" in a "friendly" manner as a "team." These quotes demonstrate some dimensions of the relationship between respect and language, and how these can affect interpersonal work environment and turnover:

> *"…first week I quit! The boss was so mean, and he didn't have any respect…I don't know if that's the way he talks to you, or that's the way he does his job, but that is very bad. Bad environment to work in. So, after [that] I started working here…And it is team work – team work is very nice."* – CNA from Home A

> *"…when you come the accent is different, and…nobody sees the potential that your background in. I mean I don't say nobody, but there's some places you will go and the first thing they hear is your accent. Some of us have very strong accents – not because of the education level, but because of different places where we are born. I can give you a very good example of my husband …. very wise, very smart – but then when we go both of us to a place they see him like he doesn't know what he is saying."* – RN from Home A

Comments suggested that good teamwork requires and indicates interpersonal respect among team members. Good, respectful teamwork, in contrast to individualistic focus and isolation, also seems to mitigate challenging aspects of the work, such as its physical demands, and experiencing disappointed expectations about appropriate elder care based on previous home country experience:

> *"…everyone come from scratch, from CNA, nursing…so I know…how hard it is their job, and then we all help with the patients – we try to give them best care, you know. So that's working as a team, at the same time trying to make them comfortable, make them feel they're home."* - RN from Home B

> *"…you know the ways we look at the elderly people [back home], and kind of the way we should handle them, so… [when I started working in nursing home care] I would go home and sit and stare at the walls…not knowing whether I met the expectations…But now I go to work and take care of ten people, and as much as I want to do the very same that I would do with one person, I cannot. So for awhile that becomes very stressful trying to make those standards because you're fighting with yourself, you're trying to do all this…"* RN from Home A

> *"So yeah I quit that place because like I said we have too much residents… [I care for] the same [number of patients now], but in the place that we work for…the job will get easily done…. I think our job is everyone work as a team, the job will get things easy."* CNA from Home B

Workers' sense of respect for themselves and from others also seemed to be influenced by their expectations of US emigration, of the quality of life and opportunities they would receive through this process. If these immigrants' career and livelihood goals are not met even in this nation proffered as one of limitless possibilities, it might seem to implicate a personal deficiency, and even lead to isolation and depression that could in turn hinder work performance.

> *… I think when we're coming from home we have only one painted picture: Everything's good. …coming from Africa the picture that is painted is you're going to the land of opportunity, and so what my head was I'm landing on opportunity and nothing else but opportunity. Which it is true, given time I can get, can be whatever I want to be in the United States – if I'm able to pursue it. Now the pursuing is the hard part, especially if you come in with children and family…It's all laid out for you, but then how to get there … it's the maneuvering around becomes a bit of hard. …Now jobs in Africa are rare. So just because I think my job is a teacher, I am not going to go get it back… So its like, "I can't go back." So no matter what, I'm stuck. … I believe everybody who comes to the United States as a migrant goes through this phase of depression – culture shock and the expectations. … first when I got here I thought, You know what, I am going to study until I get a PhD. Now that thought is kind-of slowly slipping away with time … It's only I think a picture you have when you are coming to the United States – it's completely different. And maybe if it were painted better to you and that this is exactly how it is, still you would have come but maybe with different expectations.* – RN from Home A

As suggested, the feeling of respect among these workers may have important global as well local implications, influencing not only movement of persons from one nursing home to another, but movement between countries as well:

> *"…there is one thing I really think about so hard is, the same respect we talked about…if all countries, their leaders, [were] like the United States…[where] the government takes care of them …if only [world governments] cared about the people, I believe it will be very different because now what happens is they don't care about the people, whatever little income they have to treat their own people is just wasted because after they get trained and they get their education they take off. … they get more exposed, and they are like, You know, I cannot take this anymore, they just go away… So if there's anything they should do it's coming up with ways of respecting their people more, be more transparent/accountable… Nobody doesn't like their own home, I'll tell you that. …But people will say, Okay, do I stay here and die, or end up being a nothing no matter how hard I work – with the thought that I cannot even say much because if I try to I'll have no head…there's so many things that go on. So if you have the security, if there is respect, I believe there would be a change."*

Notably the Home C focus group was unique in that it contained no direct patient-care workers, and effectively only one immigrant worker out of the four participants. This group focused the most explicitly on the importance of monetary compensation. Even so, when the solitary foreign worker was asked directly about how organizations can help foreign-born employees achieve their goals, he emphasized respect above everything else:

> *Facilitator:* …How does this place help foreign-born workers achieve their goals if at all?

Worker: …they respect us.

Facilitator: So it's about respect, so foreign workers are respected?

Worker: Well, that's my opinion…

The same worker, who was sending much support to impoverished family in Haiti, also noted later that he would feel more respected and supported if he was paid more money, implicating the importance of tangible, basic material provision as a measure of respect, as well as the influence of complex social needs that arise from individual circumstances and life stories.

Mirroring focus group findings, narrative elements of employee questionnaires also emphasized language, in addition to food and cultural community, as correlates with satisfaction in the US. Language, closely associated with culture and education, was offered as the single most important barrier to getting established in the US, independently mentioned by 26 people. Food, intimately intertwined with culture, community and family, was repeatedly mentioned when asked what was most missed about home, suggesting elements lacking from their US experience that might spur discontent:

"Traditional dish."

"Family. Being with my people. Food. Simplicity of living."

"Home-cooked meals."

"Hospitality and community life."

"no worries your neighbor can help you"

"The good food and people happy even they are poor."

Discussion

Understanding the characteristics of the US LTC worker population in urban settings, largely comprising foreign-born persons, and their predictors of satisfaction is an important precursor to improving employee satisfaction and retention. This kind of information carries implications for the health of the growing LTC industry, the quality of care for society's increasing population of elders, and the wellbeing of implicated immigrant communities and their countries of origin.

Our study sampled close to 200 workers in this field, from 41 countries and almost as many first languages, consistent with expected urban LTC worker demographics (Probst et al, 2009). Prior research included significant Hispanic-origin-worker representation; this study offers sampling of a non-Hispanic-dominant worker population, expanding upon characterizations

available in the current literature. The cultural and linguistic diversity of this crucial workforce presents rich opportunities and challenges.

This group was highly educated relative to job requirements and pay of these largely entry-level positions, also consistent with similar research findings (Altojai and Batalova 2017; Khatutsky et al 2010), with most workers supporting multiple dependents and many sending hundreds of their earned dollars abroad each month (Van Houtven et al 2020). And despite these workers being middle-aged on average, over 40% of respondents desired further education to serve in a professional role, also a trend seen in prior studies (Gao et al 2015; Huynh et al 2024). However, only half of those interested in additional education currently wanted to seek it, which may relate to existing language barriers to accomplishing work goals. This combination of findings helps contextualize themes relating to expectations of immigration experience including acculturation, as workers find themselves unable to utilize their prior education nor access desired additional education they thought abundantly accessible. It also has implications for brain drain and waste: these individuals who are exuberant, ambitious and educated no longer directly contribute to services in their home countries, and yet they encounter significant barriers to realizing their professional potential in the US.

Satisfaction findings relate to some of these themes. Only 9 of 172 surveys were discarded due to insufficient completion, suggesting high quality data, with a high reliability coefficient (0.955). Respondents registered high satisfaction ratings overall consistent with prior research showing reluctance among foreign-born workers to complain (Eskildsen et al 2010; Marsden et al 2020), The three strongest individual predictors of satisfaction were experiencing language as a barrier to achieving work goals, feeling afraid about living in the US, and experiencing weight gain since living in the US.

Language as a barrier to achieving work goals. As much of 15% of job dissatisfaction was explained in our regression analysis by "language as a barrier to achieving work goals." Language fluency bears implications for how one is viewed and how much one feels respected and heard, thus affecting a person's sense of identity, function, and capacity within society and specific contexts like place of employment. Our focus groups expressed a strong connection between language fluency and the dominant theme of respect, and the verbal and nonverbal communication thereof. Participants spoke of being judged by their English language fluency alone, often feeling dismissed and undervalued if English was limited or affected by a heavy accent. This applied directly to the work environment, but as this was given as a barrier to getting established in the US more generally it likely encroaches on multiple if not all spheres of life in the US, and thus satisfaction on multiple levels. More than 86% of participants, or 127 workers, reported English was not their primary language. The true percentage may be higher, since those for whom English is not primary may be less likely to respond to a sign inviting them to complete a questionnaire in English.

Language as a barrier to work goals was also correlated with the significant satisfaction items of finding what was sought in coming to the US, experiencing acculturation issues, and experiencing other barriers or no barriers to achieving work goals, all suggesting that language is a strong mediator of one's expectations for life after immigration. As echoed in other literature (Nichols and Campbell 2010; Xu et al 2008), our focus groups connected disappointed expectations (e.g. regarding the appropriate care of elders) with a loss of personal and professional identity and thus a sense of deep dissatisfaction at work and beyond.

Feeling afraid about living in the US. Abundant literature spanning a variety of contexts, including most recently liked to the COVID pandemic, has found correlation between fear and decreased job satisfaction (de Vries et al 2024; Abd-Ellatif et al 2021; Çağış and Yıldırım 2023; Raja et al 2022; Yavuz et al 2023; Baydin and Erenler 2014; Jimenez et al 2023). Lacking trust and a sense of safety in one's environment, has clear implications for job satisfaction. In controlling for fear and/or language, discrimination (perhaps unexpectedly) was no longer an independent predictor of satisfaction, suggesting the former elements are mediators of the latter. Focus group participants suggested that lack of job, educational, and physical security in home countries influenced their decision to emigrate; if then they still experience this fear and lack of security at their destination, disillusionment and dissatisfaction is natural. One commenter associated security and respect as serving a similar purpose: coming from source country governments these could protect against brain drain and waste, and coming from LTC management might similarly prevent worker turnover. The focus groups seemed to highlight healthy community and teamwork, each person recognized to play an important part that contributed to the whole and greater good, as palpable demonstrations of respect and yielding a sense of security, thus mitigating fear and other barriers.

Weight gain since living in the US. Though the significance of weight gain as a predictor of satisfaction was initially surprising, it becomes less so when considering its various implications. Weight gain has bearing upon a person's self-image and thus identity, as it can cause feelings of physical alienation from one's own body, so that one not only feels detached from their former identity psychologically, but also in how they physically look and feel (Hosseini and Padhy 2025; Knox-Kazimierczuk et al 2018; Magdaleno et al 2010). It can also be a visible representation of negative consequences associated with immigration, which also affects physical health, symptoms, and capacities. The significance of weight gain also lies in its multifaceted etiologies, including chronic stress, depression, poor sleep, overconsumption of low quality nourishment and processed products, lack of eating within healthy social contexts and timeframes, lack of regular healthy movement and interconnected increased media use (García-Cáceres et al 2010). Clearly connected to this was the qualitative recurrent theme of food as something missed from home countries, and related themes of hospitality and contentment in simplicity. Beyond physical nourishment, we see reiterated here that food represents culture and connection, that which is made and offered of one's skill and means and family/cultural identity and memory, both within

and between cultural groups, and can convey a sense of shared acceptance of these things when gladly received and enjoyed by others. This further bears upon the identified theme of interpersonal work environment, and being known not only as a worker serving a specific function but as a person.

Limitations. There are several considerations regarding the interpretation and generalizability of our results. Specific regional ethnic compositions may affect some results, but this is unlikely to be significant since our findings were similar to other studies of the immigrant worker experience generally rather than seeking information specific to places of origin. We lost some characterization data as 15% of foreign-born workers did not receive the appropriate supplemental questions. Our sampling may have preferenced older workers who have been in-country longer as more willing to help with this kind of project and one done in English. National turnover trends suggest that those sampled in this study were unusually inclined to remain in their current positions, which could suggest even less satisfaction score variation than normal for this kind of foreign-born worker population; further study would clarify whether this is a true regional trend or a feature of our relatively small sample.

The study would also benefit from higher representation among for-profit facility workers, as workers in this dominant sector likely have different experiences than those in non-profit facilities. Upon retrospective review, wording may have limited the effectiveness of several questions directed at foreign-born workers, perhaps due to the high level of education and English-speaking ability among our pilot population. These questions pertained to debt, timing of decision to emigrate, and earnings prior to emigration. Several narrative answers also incidentally suggested prior but now forsaken ambition to enter a medical profession; such stories were not captured well by the survey that focused on current professional desires.

Though not included in in this study's formal analyses, researchers also conducted stakeholder interviews in the Republic of the Philippines, which yielded some themes pertinent to discussions above. This nation has maintained worker export policies for many years and is considered a prominent source of immigrant health workforce worldwide. A consistent theme throughout the four interviews, two with top immigration researchers and two with political advocates and lobbyists in the area of health worker migration, highlighted the commodification and reduction of health workers as products for export. Terms like "export" were used in reference to these human workers, as the researchers discussed how remittances, upon which from their perspective the nation's economy has formed a dependence, stabilized the nation through an otherwise difficult financial climate worldwide. They noted nurses were included alongside bananas and cars in trade agreements between Japan and the Philippines. While the grassroots health worker advocate was critical of utilizing this perspective, researchers saw promise in the possibility of government further leveraging these prized workers in international agreements, to increase funding for their own domestic health infrastructure development. Our study findings above may

indicate that reducing workers to materially valuable trade products at the cost of human respect may ultimately be counterproductive in the pursuit of health worker retention.

Our study's findings can also be interpreted through the lens of respect as a dominant theme interwoven throughout. Respect can be seen as conveyed through and tightly associated with language and communication, as well as expectations of US life and elder care, and affecting critical interpersonal work environments. The perceived presence or absence of this pivotal underlying respect seems to have bearing on capacity for cultural adjustment on physical and emotional levels as suggested by weight gain (combined with the significance home country food) and fear (combined with importance of security as indication of respect) satisfaction correlates. Especially given workers' repeated reflections on missing the home-country joy that existed amidst simple living and few possessions, along with need for minimal security and provision, study findings seem to show that once basic material needs are met among this subpopulation, satisfaction is more dependent on higher-level signs of respect for human persons.

These data suggest predictors of job satisfaction and turnover for the LTC workforce in high-income nations, along with quality of life of these workers, and related reflections on social determinants of wellness that may be associated with rising rates of international health worker migration (Leitão et al 2024). The substantial challenge converges in this question: Within the bounds of capitalism's reliance on surplus value to return on investments how can health workers expect to be respected and valued for their work? And this tension has huge implications for an aging population, who utterly rely on these workers. If this challenge can be met, it has the potential for greater retention of health workers and subsequent quality in elder care facilities as well as in general health care systems around the world, and possibly subsequent improvement of population health in low-income nations and the US alike.

Though foreign-born status did not directly predict satisfaction after regression analysis, all three significant predictors of negative satisfaction were found only on the question set administered specifically to foreign workers. This finding emphasizes the unique benefit of this study that polled foreign-born workers with questions unique to those with immigrant backgrounds, versus previous studies that have explored results to general satisfaction and contextual questions aimed at both foreign- and domestic-born employees. The integration of qualitative approaches and findings greatly augmented this investigation into satisfaction, especially given foreign-born workers' documented general reluctance to directly criticize work environments.

Another unique aspect of this investigation was the inclusion of non-direct-care nursing home workers within the sample population, and subset of employees who are also integral to functional LTC and are increasingly foreign-born. Though a minority of those surveyed, their prominent representation and expression in one of the FGDs may indicate that while still critically concerned about employee respect, this subpopulation seemed more focused on monetary

provision than direct care workers, which may be related to lower baseline wages. Respect may thus be conveyed and received in more tangible terms. However, a single small focus group discussion alone is not sufficient to validate this observation.

Conclusions and Recommendations

The exploding long term care industry is increasingly reliant on foreign-born nursing home workers. Studies of the satisfaction, characterization, and wellbeing of this high-income country long-term care workforce are important to understanding the economic, societal and ethical ramifications of the care received by the world's elders, as well as general populations in health-worker-deprived low-and-middle-income countries from which many of these workers emigrate. We found the most significant individual predictor of workforce satisfaction was the level of respect perceived by workers in long term care facilities. Further research would be required to validate and more clearly characterize this finding. This small study points to themes and ideas that larger studies could explore. Implementation research could identify the promise of interventions aimed at increasing systemic respect (perceived and real) of foreign-born care workers. Pilot projects aimed at improving job satisfaction and retention of long term care workers could focus on language and culturally-inclusive communication and physical and emotional wellbeing. Findings suggest that effective interventions may go beyond "language classes," to include systemic efforts to enhance respectful intra- and intercultural communication and sharing. Subsequent investigations could benefit from supplementing worker surveys and more group discussions with focused questions about respect, and ideas for specific interventions as informed by our qualitative findings. The essential connection between job satisfaction and retention and workforce perception of true human respect may suggest avoiding policies that may commodify these workers and reduce them to the equivalent of an export product.

Table 1. Demographic and job-related characteristics of Seattle-area nursing home survey participants

Respondent characteristics (N=172, all participants)	**US compared to immigrant employees**		
	American Employees (N=19)	Immigrant employees	p-value
Age (N=140)			
Average age in years	39	42	0.269
Median age in years	35	40	
Range of ages	24 - 66	20 - 71	
Gender (N=159)			
male	1	49	0.000
female	18	85	
Race (N=151)			
Black	3	64	0.001
Asian	1	43	
Latino	2	6	
White	8	7	
Native Hawaiian/Pacific Islander	1	8	
American Indian/AN/First Nations	0	1	
Place of birth (N=162)			
U.S.	19	0	0.000
African nations	0	71	
Ethiopia	0	37	
Kenya	0	11	
Eritrea	0	7	
	0	4	
	0	32	
Philippines	0	0	
Latin America	0	4	
Peru	0	3	
Mexico	0	3	
American Samoa			

Primary Language (N=161)			
Amharic	0	31	0.000
English	18	5	
Tagalog	0	22	
Tigrigna	0	10	
Spanish	0	8	
Ilocano	0	6	
Samoan	1	5	
Highest Education (N=158)			
Primary	0	6	0.002
Secondary	1	45	
Some college/tech school	8	48	
University degree	7	25	
Graduate/Professional degree	1	6	
Current job (N=156)			
Nursing-related	4	100	0.000
Nurse assistant	2	73	
LPN	2	7	
RN	0	20	
Housekeeping	3	16	
Food service	1	11	
Other	10	10	
Facility profit-status (N=172)			0.000
For-profit	16	18	
Non-profit	3	125	
Wage (N=142)			0.335
Average wage in $/hour	17.06	16.48	
Median wage in $/hour	17.00	13.00	
Range of wages	7.00 – 32.00	9.00 – 45.00	
Work hours (N=158)			0.318
Works part-time	3	9	
Works close to full-time	14	102	
Regularly works over-time	2	19	
Number of current jobs (N=164)			0.000*
Works 1 job only	19	118	
Works > 1	0	18	
Prior nursing home patient-care experience (N=146)			0.116
Yes	2	36	
No	15	84	
Time at current facility (N=159)			0.044
3 years or less	13	79	
More than 3 years	5	80	
Benefits (N=162)			
Receive some benefits	15	111	0.677
Receive no benefits	4	23	
Have health insurance	9	77	0.407
Have no health insurance	10	57	

Intends to leave job within five years (N=161)			0.518
Yes	8	51	
No	10	71	
Have experienced discrimination in the US (N=145)	3	29	0.440
Motivation for working in a nursing home (N=162)			
Desire to work in healthcare			
Family/friends in field	6	58	0.333
Work is familiar	3	30	0.513
Work is rewarding	4	26	0.865
	7	23	0.043
Dependents (N=144)			
Support 0-1 person	11	30	0.006
Support 2-3 people	3	39	
Support 4 or more	4	53	
Average # of people supported	2	3.8	
Median # of people supported	1	3	0.010
Range	0 – 7	0 – 40	
Household income (N=114)			0.063
Average per month in USD	28,595.88	9,688.40	
Median per month in USD	5,250.00	3550.00	
Range in USD	384 – 100,000	900 – 75,000	
Interest in taking classes (N=164)	4	26	0.842
For medical assisting	1	3	0.253
For nursing	1	16	0.593
Currently enrolled	1	17	0.356
Future position desired (N=135)			0.116
Nurse	7	66	
Doctor	0	9	
Other professional	4	10	
Future degree desired (N=103)			0.864
Health-related BA or MA	6	30	
Health-related, less than BA	5	28	
None	2	16	
Place of birth, setting			0.063
Rural	4	57	
Urban	14	65	

Source of table data: Survey of 172 nursing home employees in four facilities in and around Seattle, Washington, in 2012

Table 2. Characteristics specific to foreign-born respondents who answered supplemental questionnaire

Respondent characteristics (N=115, all participants)	**Immigrant employees**	
	All participants	
Length of time in US (N=113)		
Average time in years	14.2	
Median time in years	12	
Range of years in US	1 – 42	
Age at emigration to US (N=103)		
Average age in years	28.2	
Median age in years	26	
Range of ages	1 – 62	
Percent >18 years (working age) at emigration	89.3%	
Home country health worker wage (N=27)		
Average wage in USD/month	402.26	
Median wage in USD/month	300.00	
Range of monthly wages	10.00 – 2000.00	
Visa-related costs (N=57)		
Average costs in USD	2,795.61	
Median costs in USD	2,000.00	
Cost range	250.00 – 22,000.00	
Remittances sent to home country (N=88)		
Average amount in USD per month	350.28	
Median amount in USD per month	300.00	
Range of USD sent per month	50.00 – 2,000.00	
Feelings about being in the US (N=102)		
Grateful	55 (47.8%)	
Content	37 (32.2%)	
Excited	24 (20.9%)	
Encouraged	24 (20.9%)	
Lonely	11 (9.6%)	
Disappointed	11 (9.6%)	
Afraid	6 (5.2%)	
Have you found what you were seeking in coming to the US?		
Yes	69 (60%)	
No	31 (27%)	
General level of worry		
Before coming to the US (N=107)		
Very high	23 (20%)	
High	23 (20%)	
Not high or low	37 (32.2%)	
Low or very low	24 (20.9%)	
Now (N=108)		

Very high	4 (3.5%)	
High	26 (22.6%)	
Not high or low	31 (27%)	
Low or very low	47 (40.9%)	
Difference (*p*-value)	0.012	
Sources of worry since arriving in US (N=115)		
Acculturation		
Family obligations	70 (60.9%)	
Finances	52 (45.2%)	
Unemployment	49 (42.6%)	
Loss of professional identity	32 (27.8%)	
	16 (13.9%)	
Problems since arrival in US (N=104)		
Weight gain	29 (25.2%)	
Sleep issues	24 (20.9%)	
Decreased self esteem	12 (10.4%)	
Benefits since coming to US (N=103)		
Financial	71 (61.7%)	
Family	43 (37.4%)	
Professional	39 (33.9%)	
Barriers to meeting work goals (N=102)		
Language	32 (27.8%)	
Family obligations	22 (19.1%)	
Poor financial support	18 (15.7%)	
Lack of US clinical experience	17 (14.8%)	
Had trouble finding work in home country (N=74)	13 (11.3%)	
Encouraged to emigrate by		
Family (N=104)	78 (67.8%)	
Friends (N=88)	53 (46.1%)	
Media (N=69)	25 (21.7%)	
Discouraged to emigrate by		
Government (N=69)	19 (60%)	
Church (N=68)	15 (13%)	

Source of table data: Survey of 115 nursing home employees in four facilities in and around Seattle, Washington, in 2012 who received questionnaire items specific to immigrant experience

Table 3. Job satisfaction score element frequencies, immigrant compared to American-born participants, including data from participants who answered 75% or more satisfaction questions

Job satisfaction score items (N=163, those who answered ≥75% of satisfaction items)	**US compared to immigrant employees**		
	American Employees (N=19)	Immigrant employees (N=134)	p-value
Considering everything, I am satisfied with my job.	4.0	3.9	0.765
The job is a good match for my skills and experience.	4.0	3.9	0.745
When I come to work, I know what is expected of me.	4.4	4.3	0.935
I receive recognition for doing good work.	4.2	3.7	0.150
My immediate supervisor cares about me as a person.	4.2	3.7	0.078
In the past six months, someone has talked to me to encourage my development.	3.5	3.3	0.464
Overall, the morale level at work is good.	3.7	3.8	0.833
My opinion seems to matter at work; I am respected.	4.0	3.8	0.416
I have a good friend at work.	4.1	4.1	0.823
I would encourage my friends and family to seek care here.	4.1	4.0	0.902
I have flexibility to balance the demands of my workplace and my personal life.	4.2	4.0	0.498
This is a fun place to work; the work I am doing is stimulating.	3.9	3.7	0.508
I have been given the training needed to succeed.	3.9	3.9	0.830
I consider myself a part of this community.	3.9	4.1	0.692

I am fairly evaluated on my work.	3.9	3.7	0.358
My supervisor is available when I need support.	4.1	3.9	0.455
The nursing home administrator here is competent and committed.	4.3	4.1	0.505
I am actively involved in helping to make this a great health care facility.	4.4	4.1	0.161
Work is manageable.	3.9	4.0	0.745
My wages are fair.	3.3	3.2	0.915
There are sufficient opportunities for promotion.	3.5	3.1	0.264

Data source: Survey of 172 nursing home employees in four facilities in and around Seattle, Washington, in 2012

Note: Satisfaction scores are on a scale of 1-5, with 5 = strongly agree, 3 = neutral, 1 = strongly disagree.

Table 4. Regression values associated with predictor variables that were significantly associated with nursing home worker satisfaction score via cross-tabulation, after controlling for age and gender.

Predictor	Correlation Coefficient	p-value	95% CI	R squared
Feels afraid about living in the US	-1.044	0.000	-1.610, -0.478	0.145
Feels shocked about living in the US	-0.726	0.035	-1.399, -0.053	0.063
Difficulty meeting work goals due to language proficiency issues	-0.500	0.001	-0.794, -0.205	0.152
Has experienced discrimination since coming to US	-0.388	0.010	-0.684, -0.093	0.038
Has found what was sought in coming to the US	0.375	0.026	0.045, 0.704	0.072
Has experienced weight gain since coming to US	-0.373	0.019	-0.684, -0.063	0.083
Works in LTC because it was the only job available	-0.369	0.030	-0.702, -0.036	0.045
Has experienced acculturation stress since coming to US	-0.226	0.104	-0.500, 0.047	0.057
Works in LTC because the work was familiar	0.204	0.362	-0.103, 0.512	0.002
Previous experience with direct patient care work	0.180	0.449	-0.120 0.480	0.022
Has health insurance	0.147	0.440	-0.111, 0.405	0.020
Not born in the US	-0.141	0.580	-0.516, 0.235	0.015

Source of table data: Survey of 172 nursing home employees in four facilities in and around Seattle, Washington, in 2012

Coefficients indicate change in a five-point satisfaction score associated with each factor; the R squared values indicate the proportion of satisfaction score variance accounted for by the model that includes the given variable. For example, the 32 immigrant nursing home employees who experienced difficulty meeting work goals due to language proficiency issues scored 0.5 points lower in satisfaction than did nursing home workers for whom language was not a barrier to meeting work goals. The model containing this factor in addition to age and gender controls accounted for 15.2% of the variance in satisfaction data.

Table 5. Summary of strongest multiple regression models, using forced entry ("enter") method, for predicting satisfaction among Seattle-area nursing home workers. Controlled for age and gender.

Predictor variables	B	SE	β	t	p	R square of model	AIC
Difficulty meeting work goals due to language proficiency issues	-0.500	0.148	-0.350	-3.370	0.001	0.152	-80.190 198.3
Feeling afraid about living in the US	-1.044	0.285	-0.366	-3.666	0.000	0.145	-83.567 194.4
Having experienced weight gain since coming to US	-0.373	0.156	-0.249	-2.390	0.019	0.083	-81.331 203.8
Having experienced discrimination since coming to the US	-0.388	0.149	-0.227	-2.600	0.010	0.061	323.3
Feeling like one has found what was sought in coming to the US	0.375	0.165	0.247	2.264	0.026	0.072	198.1
Working in a nursing home because it was the only job available	-0.369	0.168	-0.186	-2.193	0.030	0.045	355.7
Feeling shocked about living in the US	-0.726	0.339	-0.229	-2.143	0.035	0.063	199.8

Source of table data: Survey of 172 nursing home employees in four facilities in and around Seattle, Washington, in 2012

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