RESEARCH ARTICLE

The relationship between transformational leadership and organizational commitment in nonprofit long term care organizations: The direct care worker perspective

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Abstract. The United States population is rapidly aging, and retaining direct care workers (DCWs) will continue to be a workforce concern for the industry in addressing the demand for long term care services. To date, scant literature exists that addresses the DCW perspective of leadership behaviors and their influence on organizational commitment. To respond to this deficiency, this research studied leadership behaviors of direct importance for DCWs at the immediate supervisor level, and provided empirical insight into organizational commitment among workers closest to patient care. Research on leader behaviors has focused on managerial and executive levels, with scant consideration in long term care at the lower hierarchical levels. Transformational leadership was hypothesized to have a significant positive relationship with organizational commitment, specifically affective and normative commitments, and a significant inverse relationship with continuance commitment. The quantitative correlational study explored the relationship between transformational leadership and organizational commitment among 322 direct care workers employed by nonprofit, multi-level long term care organizations located in the Midwest. Results revealed a statistically significant relationship between overall transformational leadership and organizational commitment as well as affective and normative commitment dimensions, with no significant relationship found between transformational leadership and continuance commitment. The study results are beneficial to industry leaders, researchers, and policymakers for addressing operational policies, leadership training, human resource practices, and workforce policy development. Operational policies should reflect the values of the organization and follow from a compelling, collective vision and mission. Human resources practices warrant review if not aligned with the vision, mission, and values. Leadership development training should be considered for continuing education for supervisors at all levels as well as for potential policy alternatives.

Keywords: Transformational leadership, organizational commitment, direct care worker, long term care, leadership practices

Introduction

The failure to attract and retain direct care workers (DCWs) in long term care has been described as the worst challenge facing the long term care industry (Stone, 2011), remaining a major issue for providers and policymakers for three decades (Stone, 2004, 2011). Projected Bureau of Labor Statistics demand indicates an additional 1.6 million DCW positions in the labor market by 2020 (Paraprofessional Health Institute [PHI], 2013b) due to Census Bureau (n.d.) projections that the 65 years of age and older demographic will grow 45% by 2025; the fastest growing segment of the population are those 85 years of age and older (Robnett & Chop, 2010). Three occupations, nursing assistants, home health aides, and personal care aides, are the primary focus for the Bureau of Labor Statistics, despite the additional 800,000 DCWs working as independent providers for consumers and state or county agencies (PHI, 2013b). The data also did not include the thousands of individuals working in front-line capacities to assist older persons with activities such as cooking, cleaning, and laundry assistance. Median hourly wages for DCWs ($10.63) are below the

national median wage for all U.S. workers ($16.71), with inflation-adjusted hourly wages having declined over the last 10 years (PHI, 2013b). Many DCWs work part-time and lack health coverage; many also earn below 200% of the federal poverty income level and rely on some level of public assistance, such as food stamps (PHI, 2013b; Stone, 2004). As a result, other factors such as leadership behaviors and practices become more prominent management considerations in determining organizational commitment for DCWs.

Interdependent factors such as regulations, wage levels, challenging work environments, targeted government workforce resources, organizational management, and society's value of caregiving all influence DCW recruitment and retention (Culp, Ramey, & Karlman, 2008; Decker, Harris-Kojetin, & Bercovitz, 2009; Lee, Coustasse, & Sikula, 2011; Stearns & D'Arcy, 2008; Stone, 2004, 2011). Of the organizational management elements, studies have found that compensation, work environments, interpersonal relationships, and supervisor qualities directly affect DCWs (Culp et al., 2008; Stearns & D'Arcy, 2008; Stone, 2004, 2011). In the traditional hierarchy in long term care, the locus of control remains with those furthest from patient care (Caspar & O'Rourke, 2008). DCWs provide over 80% of all patient care, have the least amount of education, receive the lowest pay, and exercise the least amount of decision-making authority and autonomy (Caspar & O'Rourke, 2008; Liu, Liu, & Wang, 2011; PHI, 2013a, 2013b; Stone, 2011). DCWs have stated that what they desire most is respect, recognition, and rewards, as well as inclusion in decision-making and empowerment (Bowers, Esmond, & Jacobson, 2003; Casper & O'Rourke, 2008; Leutz, Bishop & Dodson, 2009; Secrest, Iorio & Martz, 2005; Stone, 2004, 2011), manifested through transformational leader behaviors and informing turnover (Donoghue & Castle, 2009; Eaton, 2001). Liou (2008) asserted that organizational commitment is also related to employee retention. Low organizational commitment contributes to turnover (Liou, 2008), which is costly to long term care employers (Smith & Baughman, 2007), most recently estimated at over $3,300 for each turnover (Stone, 2004). From a policy view, retention is a concern due to the reforming healthcare environment, including changes in existing long term care regulations and effects of the Patient Protection and Affordable Care Act. Understanding the degree to which transformational leadership is associated with organizational commitment, or the intent to stay on the job, is integral to the formation of long term care policy that maintains the current DCW supply.

To date, scant literature exists that addresses the DCW perspective of leadership behaviors and their relationship to organizational commitment. Specifically, the correlation between transformational leadership practices and organizational commitment among DCWs in long term care organizations has not been empirically tested. The existent literature primarily explored the leadership qualities of higher hierarchical levels, despite evidence that transformational leadership behaviors have been shown to cascade downward to other managerial, leader positions, benefitting organizational performance as a whole (Bass, Waldman, & Avolio, 1987; Eaton, 2001; Godwin & Neck, 1998). To respond to this deficiency, this research studied transformational leadership practices of direct importance for DCWs, at the immediate supervisor level, and their association to organizational commitment among these workers closest to patient care. This research study considers the practical application of the research for leaders in the long term care industry and others striving to address DCW workforce issues, advances understanding of transformational leader practices associated with DCW organizational commitment, and assists in clarifying the degree to which the dimensions of organizational commitment are a factor to overall organizational commitment.

Literature review

The review of the literature occurred manually and electronically via libraries, library databases, and the Internet. The literature search primarily included the two variables, transformational leadership and organizational commitment, in the initial broad search and

subsequently narrowed to the health care industry, the long term care industry, and finally, the nonprofit sector in order to isolate specific health care related studies on transformational leadership and organizational commitment.

Transformational Leadership

Transformational leadership is generally understood as a process whereby leaders take conscious action to develop followers into leaders, exhibit behaviors that elicit trust, display self-sacrificial perspectives to build commitment and influence, and demonstrate a moral compass towards mission and purpose (Avolio, 2011; Bass, 1985; Kouzes & Posner, 1988, 2012). The term transformational leadership originated by Downton in his early writings on charismatic leadership and leader follower relations in mass social movements (Downton, 1973; Northouse, 2007). However, the term went unnoticed until it evolved from Burns' (1978) theoretical perspective of transform*ing* [emphasis added] leadership, whereby leaders seek to identify the higher need motives of followers and convert followers into leaders and ideally, moral agents, thus creating social change. Burns discussed transforming and transactional leadership within a political context, evaluating the behaviors and actions of leaders that led to political actions and social change. In his seminal efforts in leadership research, Burns expressed a sincere curiosity about leadership as a component of causation. He contended that leadership could be further refined by definition and variety in order to deconstruct its multiple variables as causal factors. The application of transform*ing* leadership within the corporate context was suggested (Burns, 1978) and, as a result, transformation*al* [emphasis added] leadership was identified by Bass (1985).

Bass (1985) distinguished leadership behavior via transformational (idealized influence, inspirational motivation, intellectual stimulation, individualized consideration) and transactional (contingent reward, management by exception) characteristics. Bass incorporated concepts of Burns' (1978) theory with elements of the path-goal theory, which House and colleagues expanded with regard to leadership and the pursuit of employee performance and motivation (Northouse, 2007). Over time and in concerted effort with colleagues Riggio and Avolio, the Full Range Leadership Theory (FRLT) was developed, utilizing the aforementioned leadership behaviors to distinguish between transformational, transactional, and laissez-faire leadership (Bass & Riggio, 2010). During the same time, Bass and colleagues were developing the FRLT, Kouzes and Posner (1988, 2012) were exploring transformational leadership from a different perspective. Kouzes and Posner (1988, 2012) suggested that leadership impact was best understood by everyday leadership practices, or causal mechanisms (Gerring, 2012), that occurred within a dynamic process. Leadership practice constructs were identified through early qualitative research with organizational executives striving to understand and learn what key attributes existed when leaders were performing at their personal best; themes revealed qualities such as involvement, persistence, vision, and encouragement (Kouzes & Posner, 1988). The Kouzes and Posner (2012) theory is referred to as *The Leadership Challenge* and reflects Burns' notion that the ultimate effects of leadership are only understood by way of evaluating leader and follower interactions. Adaptations of transformational leadership theories have occurred over time as transformational leadership studies have accumulated.

In the mid-80s, Bennis and Nanus (1985) identified four common strategies of transformational leaders: presenting a clear vision, acting as social architects, creating trust, and using creative deployment of leader strengths. Bennis (1997) described the differences between a manager and leader, noting that managing is more about conducting and controlling whereas leading is about influencing and guiding. Additionally, Podsakoff, MacKenzie, Moorman, and Fetter (1990) conceptualized transformational leadership based on six behavior-oriented dimensions: articulating a vision, providing an appropriate model, fostering the acceptance of group goals, setting high performance expectations, providing individualized support, and offering intellectual stimulation. Yukl (as cited in Bass & Bass,

2008) also organized a taxonomy of leadership and management practices based on extensive literature review, resulting in the origination of a managerial practices survey instrument, which he later reported validation findings with colleagues. More recently, Chandler and Chandler (2013) introduced a new transformational leadership framework which addresses leaders' use of followers to influence and disseminate their ideas. Illustrated as a Greek temple, the authors introduce four variables as the core skills of leadership: a compelling, well-conceived vision; persuasive communication; a capable, supporting organization; and finally, the foundational skill of selflessness (Chandler & Chandler, 2013). The authors assert that a capable, supporting organization must be effectively managed for leaders to be successful in achieving the vision; this core variable is one that Chandler and Chandler believe receives little attention by both historians and scholars.

Despite these adaptations, by far, the vast majority of empirical research exists with the FRLT utilizing the Multifactor Leadership Questionnaire (Avolio, 2011; Yukl, 2006) as a quantitative method for measuring transformational leadership and its associations, influences, and impacts.

Organizational commitment

Organizational commitment is a job attitude defined as the degree to which an employee identifies with an organization and its goals and desires to remain with the organization (Robbins & Judge, 2012), considered along three dimensions: affective, continuance, and normative (Meyer & Allen, 1997). Liou (2008) argued that organizational commitment must be given more priority in health care organizations, particularly as it relates to addressing workforce shortages in the United States. In prioritizing an emphasis on organizational commitment, health care leaders can focus their efforts on antecedents that foster increased organizational commitment and, as a result, increase retention and performance. As a construct, commitment addresses empowerment and its effect on behavior; empowerment reflects the psychological and social attachments to people, places or things, such as career professions or organizations (Liou, 2008; Meyer & Allen, 1997), which in turn can be affected by leadership behaviors (Avolio, 2011).

As a job attitude, Liou (2008) discussed the variance in theoretical definitions of organizational commitment. Despite its complexity, Morrow and McElroy (1993) asserted that "organizational commitment is the most maturely developed of the work commitment family of constructs" (p. 1). The evolution of the concept of organizational commitment has resulted in commonalities among the many theoretical definitions: psychological bond to the organization, a belief in the organization, an acceptance of the organization's goals and values, sacrifice for the good of the organization, and a willingness to remain with the organization (Allen & Meyer, 2000; Liou, 2008; Meyer & Allen, 1997). Early in its research history, organizational commitment was studied as unidimensional relative to attitudinal commitment, calculative commitment, and behavioral commitment, where distinctions were derived from observing the different processes in which employees became attached to organizations and their ensuing outcomes, such as absenteeism and turnover (Allen & Meyer, 2000; Becker, 1960; Mowday, Porter, & Steers, 1982). These distinctions were important to the further development of research about organizational commitment as a construct. Over time, an empirical understanding of organizational commitment resulted in three broad themes around commitment: (a) commitment toward an organization involves the affective domain; (b) employees recognize that there are costs associated with leaving an organization; and (c) commitment towards an organization reflects a level of obligation from employees (Allen & Meyer, 2000; Meyer & Allen, 1997). Following their systematic review of the literature, Meyer and Allen (1997) chose to address these three broad themes within three primary dimensions: affective, continuance, and normative (Liou, 2008; Meyer & Allen, 1997). In clarifying the distinctions previously observed in the literature, Meyer and Allen (1997) likened attitudinal commitment (Mowday et al., 1982) to affective commitment,

compared calculative commitment (Becker, 1960) to continuance commitment, and paralleled behavioral commitment (Mowday et al., 1982) with both continuance and normative commitment. Meyer and Allen's (1991) work resulted in the introduction of the multidimensional model of organizational commitment called the *Three-Component Model*.

Affective commitment represents the emotional component of organizational commitment, or the degree to which employees are emotionally attached to the organization and its beliefs and values (Liou, 2008; Meyer & Allen, 1997; Robbins & Judge, 2012). Continuance commitment considers the employees' perceptions of value in staying with the organization, including socioeconomic factors such as wages and benefits (Liou, 2008; Meyer & Allen, 1997; Robbins & Judge, 2012). Normative commitment occurs as a result of the employees' sense of obligation to remain with the organization; a level of conformity exists between the employees' beliefs and values and organizational norms (Liou, 2008; Meyer & Allen, 1997; Robbins & Judge, 2012). Because of the depth and breadth of organizational commitment as a concept, it is important to empirically study it along these commitment dimensions in order to further evaluate its relationship in the workplace. Accordingly, Meyer and Allen (1997) have cautioned that organizational commitment should not be analyzed without considering these dimensions independently because of the existential variation in employees' relationships with their organizations. Employees will experience the affective, continuance, and normative commitment dimensions in varying degrees, with each contributing to overall organizational commitment; thus, each can be hypothesized independently of each other when considered in relationship to antecedents and intervening processes (Allen & Meyer, 2000; Meyer, Stanley, Herscovitch, & Topolnytsky, 2002).

Leadership and commitment in long term care

In some organizations, turnover is used as a measurable outcome of organizational commitment. While Meyer and Allen (1997) cautioned against this as a sole focus, turnover is one of many key quality indicators within the long term care industry, specifically within nursing facilities where regulators seek to understand the influence of turnover on the quality of care for residents. Turnover is costly to long term care employers (Smith & Baughman, 2007), most recently estimated at over $3,300 in direct cost for each turnover (Stone, 2004). In a study of Pennsylvania long term care providers, the estimated cost of training due to turnover was over $35 million (Stone, 2004). In Iowa, direct cost of turnover in the direct care workforce was estimated at $189 million in 2011, an individual cost of $3,839, representing the time and expenses in addressing separation issues and replacing workers (Iowa Direct Care Worker Advisory Council, 2012). Mukamel et al. (2009) revealed a net savings of $167,063 for every 10% increase in turnover for California nursing facilities, as calculated using reported revenues and expenses on submitted cost reports; they suggested this savings offered an explanation for persistent turnover in the industry. However, not included in reported numbers for these studies are the indirect costs associated with turnover, such as lost productivity, reduced service quality, lost patient revenue, and declines in organizational reputation (Seavey, 2004), all of which contribute to a complete understanding of turnover in long term care.

High quality leadership and management, including the offering of recognition, feedback, and a culture of value and respect for DCWs has been associated with low turnover (Eaton, 2001). Low turnover is generally positively perceived, but if employees have low levels of organizational commitment, then other factors such as quality, customer satisfaction, and resident well-being can suffer (Bowers et al., 2003; Stone, 2004; Teal, 2002). High turnover can have the same effects. To develop and sustain a quality workforce, leaders must have a broader understanding of what other factors affect organizational commitment. It behooves leaders to consider other factors, not just retention and turnover rates (Meyer & Allen, 1997). A stable workforce is a necessary condition for quality, but it should not be exercised as a strategy at the expense of poor performers with low organizational commitment (Meyer &

Allen, 1997). Organizational goals should include a highly committed workforce and low levels of turnover among its measures of organizational performance.

High commitment levels have been demonstrated to enhance dyadic patient-caregiver relationships and quality of life in long term care, as primarily influenced by effective supervision and illustrated by supervisory support, autonomy, and respect (Bishop et al., 2008; McGillis-Hall et al., 2005). Supportive nursing practice environments in nonprofit long term care settings have been shown to positively impact nursing home patient outcomes, evidenced by higher quality ratings (Lutfiyya, Gessert, & Lipsky, 2013). However, study of nursing home administrators and directors of nursing found that transformational leadership qualities have no statistically significant relationship on quality of resident care (Marotta, 2010). This suggests that transactional leadership qualities are necessary in highly regulated environments, such as nursing facilities. Nursing facility providers have long touted the extreme level of regulations in the industry (Forbes-Thompson & Gessert, 2006). Because the long term care industry is highly regulated, transactional leadership behaviors may be necessary to assure compliance. Crawford (2005) found that nursing home administrators rate high in both transformational and transactional leadership behaviors, reinforcing the assertion by Avolio, Bass and Jung (1999) that transformational leadership augments transactional leadership. Administrators with consensus-based leadership styles, evidenced by transformational leadership qualities (Bass, 1985), have been shown to influence turnover at its lowest levels (Donoghue & Castle, 2009).

Long term care leaders must balance the need for transactional leadership qualities that benefit quality of care and regulatory compliance and transformational leadership qualities that enhance innovation, change orientation, and consumer/employee focus (Berndt, 2012; Dana & Olson, 2007). Leaders that insist on micromanaging DCWs risk decreased employee engagement and subpar continuous improvement efforts, negatively affecting employee commitment over time whereas implementation of employee participation in decision-making has been shown to positively influence employee behaviors at work (Heldenbrand & Simms, 2012). Transformational leadership behaviors have been shown to cascade downward to other managerial, leader positions, benefitting organizational performance as a whole (Bass et al., 1987; Eaton, 2001; Godwin & Neck, 1998). The leader behaviors of immediate supervisors, as perceived by employees, have been shown to motivate employee attitudes, both positively and negatively (Culp et al., 2008; Emery & Barker, 2007). Thus, negative employee attitudes cascade to customers, which has been illustrated in the industry by residents' reports of negative views of care and negative experiences with DCWs or reports of stories reminiscent of employees complaining while providing care (Eaton, 2001). Conversely, transformational leader behaviors such as empowerment have shown to positively relate to organizational commitment (Avolio, Zhu, Koh, & Puja, 2004).

Transformational leadership theories have advanced the notion that certain behavioral characteristics (such as visioning, caring, and empowering) will transcend organizational activities and employees toward higher goals, efficiencies, and productivity. For decades, theorists have studied leadership in an attempt to identify, understand, and develop optimal leader behavioral characteristics. Despite the positive advancement of leadership theories, scholars continue to further study leadership in a variety of contexts. Additionally, organizational commitment has been advanced over time as a multi-dimensional construct for understanding the reasons employees stay or leave organizations. Transformational leadership has been studied in a limited fashion as an antecedent to organizational commitment, and results have generally provided consistent results, although recent studies in the nonprofit sector have been contradictory (Freeborough, 2013). This research study responds to a need for additional empirical evidence about transformational leadership and organizational commitment within the long term care industry relative to the dynamics of leadership practices as they pertain to DCWs' desire to remain with their organizations.

Methods

The purpose of the quantitative correlational study was to explore the relationship between transformational leadership practices and organizational commitment among DCWs in nonprofit, long term care organizations. For the study, transformational leadership was the predictor variable, and organizational commitment was the criterion, or dependent, variable. Specifically, the objective of the correlational study was to examine the extent to which the variables co-vary to assist in predicting the relationship of transformational leadership and organizational commitment (Creswell, 2012) to understand the leader behaviors that are of greatest influence to DCWs, their immediate supervisors. DCWs were broadly defined as individuals providing either direct care (e.g. nursing assistant) or other services (e.g. dietary assistant) to persons requiring long term care services in a broad set of long term care settings. The goal was to be inclusionary of those long term care workers in front-line positions providing valuable holistic assistance. The research question and specific hypotheses tested in this study included:

> RQ: What is the relationship between transformational leadership and organizational commitment (affective, continuance, and normative) among direct care workers in nonprofit long term care organizations?
> H1: There is a significant positive relationship between transformational leadership and DCW affective commitment.
> H2: There is a significant inverse relationship between transformational leadership and DCW continuance commitment.
> H3: There is a significant positive relationship between transformational leadership and DCW normative commitment.

Method Overview

The theories of transformational leadership and organizational commitment formed the theoretical framework of the study. For purposes of this theoretical framework, the study addressed the transformational leadership theory of Kouzes and Posner (1988, 2012), focusing on its five leadership practices: model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. The long term care industry, specifically nonprofit organizations, prefers research applications that support its capacity to communicate in terminology easily understood by all levels of an organization, suggesting the industry would respond more favorably to a study utilizing the Kouzes and Posner (2012) theory. The study population consisted of DCWs employed by nine Midwestern long term care organizations meeting specific criteria: (a) nonprofit status, (b) provision of multiple lines of service, or types of long term care settings, and (c) willingness to participate. Approval for the research study was obtained by the Creighton University Institutional Review Board (IRB). Each organization was required to formally address permissive rights for the researcher to engage in research activities as a part of the study.

Two instruments were used for the study: (a) Leadership Practice Inventory (LPI) Observer which measures transformational leadership (Kouzes & Posner, 2013), and (b) Three-Component Model Employee Commitment Survey (TCM) which measures organizational commitment (Meyer & Allen, 2004). Permission to use each instrument was obtained from the respective authors. Demographic information including gender, age, ethnicity, education, and length of employment was also obtained by participants during survey completion in order to provide descriptive statistics of the participants.

Participants responded to 30 items in the LPI using a 10-point Likert-type scale with responses ranging from 1 = *almost never* to 10 = *almost always*. A higher value represents behaviors used more frequently (Kouzes & Posner, 2002). The LPI measured the five practices of exemplary leaders as described in Kouzes and Posner's (1988, 2012) theoretical leadership challenge framework of core leadership competencies. The LPI utilizes 30

descriptive, behavioral statements in which the respondent is asked to assess leader behaviors. For this study, survey participants assessed leader behaviors based on the supervisor to whom they directly report, as they perceive the supervisor's leader behaviors. Organizational commitment was measured using the academic version of the TCM Employee Commitment Survey developed and modified by Meyer and Allen (2004). The TCM consisted of 18 statements among three subscales (affective, continuance, normative) that represent employees' mindsets toward their organization. Study participants were asked to indicate the degree of agreement with each statement based on their feelings about their respective organizations. The statements required respondents to rate the degree of agreement on a 7-point Likert-type scale, ranging from 1 = *strongly disagree* to 7 = *strongly agree*.

The demographic questions were developed to describe the characteristics of the study participants as well as information about the organizations in general. Participants were asked about gender, age, ethnicity, length of employment, service in the military, wages, yearly income, benefits, relationship status, living arrangements, education, government assistance, availability of transportation, type of long term care setting they work in, and whether they are considering an employment change. These questions were chosen based on the potential influence they have to the organizational commitment subscales addressing affective, normative, and continuance commitment. Organizational demographics were obtained by the administrators on site at the time of data collection and included total employees, number of DCWs, year-to-date turnover, wage ranges, availability of benefits, types of services provided, premium costs of health insurance, and consideration of increasing wages.

Data Collection and Analysis

Utilizing both conference calls and electronic mail communication, on site visits were scheduled and data collection occurred between May and July 2014. In advance of onsite visits, 1,127 DCWs (number of DCWs employed at the time of data collection) were provided with an invitation to participate in the study utilizing flyers and change of shift reminders. Once onsite, DCWs were provided multiple opportunities to participate in the study and complete a paper survey. Multiple opportunities were intended to accommodate the varied work schedules of DCWs and provide ample occasions to participate in the study. Survey completion time was estimated to be 15 minutes. Prior to completing the survey, participants were provided the informed consent/assent information, followed by the two survey instruments and the demographic information. Because no identifying information was collected from the participants, informed consent/assent was implied through completion of the survey, as approved by the IRB. Following survey completion, the surveys were transferred to a secure container to ensure confidentiality. To thank participants, snacks were provided. The data collection process resulted in a sample of 322 surveys, constituting a 28.6% response rate.

SPSS 22 was used to calculate statistics and test the hypotheses. Internal reliability testing was conducted using coefficient alpha to determine if the survey scales were reliable (Creswell, 2012). Nonparametric statistical tests were used due to the nonprobability sampling approach for the study; however, normality was tested using the Shapiro-Wilk test for confirmation of non-normal distribution (Creswell, 2012). Q-Q plots were also used to graphically review for normality and confirmed non-normally distributed data. The LPI and TCM instruments utilized Likert-type measurement scales that were treated as interval scales. Correlational analysis was used to measure the relationship between the interval variables and to assist in making predictions about the variable associations (Creswell, 2012). When investigating linear-related variables, the Spearman's rank order correlation (Spearman's rho) can be used for nonparametric testing and is recommended especially when normality is questioned (Kowalski, 1972; Onwuegbuzie & Daniel, 2002). A significant relationship was defined using a 95% confidence interval for statistical testing of the hypotheses.

Ethical Considerations

Ethical considerations were present for this study. Participation in the study was voluntary, and there were no consequences for not participating. It was possible that DCWs under the age of majority would participate in the study due to data collection occurring in the summer. For this reason, the researcher reviewed the inclusion of children as important to the study due to the additional risk considerations for IRB review. This segment of the DCW population completes the same DCW tasks as their colleagues, regardless of age. Likewise, those under the age of majority have completed the same training to perform DCW tasks. No more than minimal risk was expected for DCWs under the age of majority because they were not being treated any differently than any of their corresponding colleagues. It would have been difficult to obtain parental permission for these DCWs to participate in the study because by doing so, identifying information would be collected, thus creating an imbalance to the commitment of anonymity and confidentiality. As a result, a waiver of assent was required and approved by the IRB. Participants received an informed consent/assent form prior to participation. To ensure anonymity and confidentiality of participation, no signatures were obtained to indicate consent or non-consent to participate. Completion of the survey constituted consent/assent to participate. Snacks were provided to participants as an incentive to participate in the study. Not completing a survey did not preclude DCWs from receiving the incentive, assisting the researcher in alleviating any appearance of coercion. Participating organizations received a copy of the research as a benefit to participating. However, to preserve anonymity and confidentiality of participating DCWs, data were analyzed and reported in the aggregate.

Descriptive Summary and Results

Participants represented DCWs employed at nonprofit long term care organizations offering multiple service settings (nursing facilities, assisted living, home health, hospice, senior housing, and adult day services). Participant characteristics were identified based on service setting and several demographic considerations, including age, gender, ethnicity, hourly wage, annual income, education level, and years of employment at the respective organization and in long term care in general. Of participants responding ($n = 314$), 79.3% worked in nursing facilities, 15.2% in assisted living facilities, 11.8% in independent living senior housing, 4.5% in home health, 2.9% in hospice, 1.3% in affordable senior housing, and 0.6% in adult day services.

Female participants dominated the study sample at 82.7% ($n = 317$). Participants ranged in age from 17 to 77 years old, with a mean of 39.05 years ($n = 303$). Regarding ethnicity, White/Caucasian participants constituted a majority at 76.7%, with Black/African participants following at 11.8%. The remaining participants were Hispanic (5.6%), Asian (2.2%), American Indian (1.2%), and other (0.6%). Of the participants responding, 9.3% indicated that English was their second language. The median hourly range of participants was $12.00 ($n = 295$, $SD = 2.69$), with a range of $7.35 to $30.00 per hour, with 88.5% of participants reporting an annual income less than $30,000 ($n = 304$). Of those responding ($n = 313$), 20.4% stated they had more than one job, and 50.5% ($n = 317$) indicated a dissatisfaction with their pay. Of 314 responding participants, 11.5% reported receiving government assistance, such as Medicaid, food assistance, and utilities assistance. Participants reported a range of formal education ($n = 314$); 52.5% reported having a high school diploma or GED, 38.2% having an undergraduate college degree, 8% having a graduate college degree, and 1.3% having less than a high school education.

Length of employment was also evaluated, both from an organizational standpoint as well as from an industry context. Organizationally, 21.2% of participants reported being newly hired less than one year in their employment ($n = 316$). Other tenure was reported as follows: one to three years (32.3%), four to six years (15.8%), seven to nine years (10.4%), and more than 10 years (20.3%). Based on survey coding, the average length of employment was 2.76

years, representing employment between one and six years. Industry employment tenure exceeds organizational tenure, with 32.3% of participants working in the industry for over 10 years (*n* = 315). Just under 10% (9.8%) of participants reported less than one year of employment in the industry. Average employment tenure in the industry was 3.11 years, representing employment between six and 10 years. When asked whether participants were considering a job change, 26.3% indicated affirmatively and 25.7% stated "not sure, maybe" (*n* = 315).

Site administrators at participating organizations reported employing 1,127 DCWs, accounting for 54.6% of total employees. A mean turnover rate of 33.4% was reported. The wage range for DCWs was $7.50 to $20.63 depending on position and experience. National median hourly wage ranges between $9.57 and $11.74, depending on the type of DCW position (PHI, 2013b). All organizations reported providing health insurance benefits in addition to benefits such as paid vacation, paid sick time, paid holiday time, and retirement plans. However, study participants reported differently; a range of participants reported that either their employer did not offer the aforementioned benefits, or they did not know if their employer offered the aforementioned benefits (health insurance, 11.1%; paid vacation, 13.2%; paid sick time, 32.6%; paid holiday time, 9.8%; and retirement plans, 27.9%). Site administrators were asked about the cost of monthly family health insurance premiums, which were reported to cost over $500 per month for 71.4% of the organizations. Only 1.9% of study participants reported paying over $500 in monthly health insurance premiums (*n* = 309); 12.3% reported having no health insurance, and 29.4% reported having health insurance coverage through other avenues. When asked if DCWs are paid a sufficient wage, 41.9% of site administrators indicated affirmatively.

Survey Instrument Descriptive Statistics and Reliability Levels

The LPI and TCM survey instruments both included statements requiring respondents to rate the degree of agreement on a Likert-type scale. The mean and standard deviations, by total score and by subscales, were calculated for the survey instruments and are illustrated in Table 1. Possible total scores for the LPI and TCM surveys are 300 and 126, respectively; each subscale has a possible total score of 30 for the LPI subscales and 42 for the TCM subscales. Reviewing the standard deviations provides insight as to the dispersion around the means for all of the scores, reflecting the extent to which the survey participants agreed or disagreed with one another. Variability exists with the total LPI score (SD = 63.92), indicating that in totality, participants are not in close agreement regarding their immediate supervisors' behaviors. Dispersion is noticeable with the total TCM score mean (SD = 18.96) with notable consistency in the standard deviations in the TCM subscale means.

Table 1: *LPI and TCM Means and Standard Deviations*

	Mean	Standard Deviation
LPI Total Score	188.07	63.92
LPI Model the Way	39.24	12.67
LPI Inspire a Shared Vision	35.26	13.69
LPI Challenge the Process	35.12	13.53
LPI Enable Others to Act	41.22	13.46
LPI Encourage the Heart	37.22	14.77
TCM Total Score	79.68	18.96
TCM Affective Commitment	27.31	8.73
TCM Continuance Commitment	25.93	8.73
TCM Normative Commitment	26.44	8.65

Note: After exclusion of missing data, n=289

Internal reliability refers to the level of precision and consistency of the survey relative to measurement errors that can result in differing scores for reasons unrelated to the participants (Gerring, 2012). For instruments with items scored as continuous variables, the coefficient

alpha is generally used to test for internal consistency (Creswell, 2012). For the LPI, internal reliability has been consistent in revealing reliability coefficients above the 0.75 level as measured by coefficient alpha (Kouzes & Posner, 2000). Reliability coefficients for the five subscales meet acceptable levels as illustrated in Table 2. Test-retest reliability procedures are used to examine the extent that the instrument is stable over time, with 0.6 as an acceptable level (Creswell, 2012). Kouzes and Posner (2002) have reported similar test-retest reliability for the LPI. Internal reliability is also within acceptable rates (above 0.70) for the TCM (Allen & Meyer, 2000; Meyer & Allen, 1997; Meyer et al., 2002).

Table 2: *Study Reliability Levels for LPI and TCM Survey Instruments, by Subscales*

LPI		TCM	
Model the Way	.883	Affective Commitment	.817
Inspire a Shared Vision	.916	Continuance Commitment	.739
Challenge the Process	.897	Normative Commitment	.835
Enable Others to Act	.911	TCM Overall Scale	.856
Encourage the Heart	.935		
LPI Overall Scale	.978		

Research Question and Related Hypotheses

As previously noted, an examination of the Shapiro Wilks test and Q-Q plots suggested non-normal distribution, thus warranting the use of the Spearman's rank order correlation coefficient (Spearman's rho) as a nonparametric statistical test to address the research question and hypotheses. The correlation coefficient is used to identify the degree of association between transformational leadership and organizational commitment, ranging from -1.00 (nonlinear association) to +1.00 (linear association); a 0.00 correlation coefficient indicates no correlation (Creswell, 2012). Spearman's rho revealed a statistically significant relationship between transformational leadership and overall organizational commitment as illustrated in Table 3. The correlation coefficient falls within the 0.35-0.65 range, indicating limited prediction (Cohen, 1988), although meta-analysis has shown this similar range to be beneficial for prediction in the relationship of two variables (Hemphill, 2003). The presence of transformational leadership explains a 14.3% variance in overall organizational commitment. The Spearman's rho was utilized for the related hypotheses on organizational commitment dimensions.

The first hypothesis stated that there would be a significant positive relationship between transformational leadership and organizational commitment. The Spearman's rho revealed a statistically significant relationship between transformational leadership and affective commitment. Variance (15.8%) in affective commitment was explained by the presence of transformational leadership. The second hypothesis stated that there would be a significant inverse relationship between transformational leadership and continuance commitment. This means that as transformational leadership increases, continuance commitment decreases. The Spearman's rho revealed no significant relationship between transformational leadership and continuance commitment, with the correlation coefficient falling below 0.20, indicating there is little usefulness or value in predicting the relationship between transformational leadership and continuance commitment (Cohen, 1988; Hemphill, 2003). The third hypothesis stated that there would be a significant positive relationship between transformational leadership and normative commitment. The Spearman's rho revealed a statistically significant relationship between transformational leadership and normative commitment. While the correlation coefficient indicated limited prediction (Cohen, 1988), the level has been described as beneficial for prediction in the relationship of two variables (Hemphill, 2003). Similar variance, 15.6%, in normative commitment was explained by the presence of transformational leadership.

Additional strengths of association between the transformational leadership subscales and organizational commitment and the corresponding subscales are also noted in Table 3. While not specifically addressed within the hypotheses of this study, the correlations demonstrated a consistently positive relationship between all five transformational leader behaviors and both affective and normative commitment. Of the five leader behaviors, "Model the Way" had the most association with normative commitment; modeling as a leader practice involves setting a personal example for others, clarifying values, following through on commitments, and holding people accountable (Kouzes & Posner, 2012). The relationship between "Inspire a Shared Vision" and continuance commitment indicated a negative association with no significance, while the remaining transformational leader practices indicated positive, yet insignificant, relationships with continuance commitment.

Table 3: *Spearman's rho Correlations between Transformational Leadership and Organizational Commitment, Overall and by Subscales*

	Affective Commitment	Continuance Commitment	Normative Commitment	Organizational Commitment (Overall)
Model the Way	.396**	.012	.407**	.376**
Inspire a Shared Vision	.334**	-.014	.354**	.334**
Challenge the Process	.366**	.054	.364**	.361**
Enable Others to Act	.377**	.023	.354**	.356**
Encourage the Heart	.366**	.041	.386**	.366**
Transformational Leadership (Overall)	.398**	.021	.395**	.378**

Note: Missing data excluded, n=289
*** Correlation is significant at the .01 level (2-tailed)*

Discussion

This study furnished additional information about how transformational leadership practices are associated with organizational commitment among DCWs in the nonprofit long term care industry by providing DCWs an opportunity to voice their perspective about immediate supervisor leadership practices. Transformational leadership was found to significantly correlate with organizational commitment among DCWs. This finding supports the existing literature that organizational characteristics such as leader practices contribute to organizational commitment (Kouzes & Posner, 2012; Meyer & Allen, 1997) and fills a research gap in the literature by providing empirical evidence for the long term care industry.

In reviewing the demographic characteristics, it is noteworthy that participants were predominantly female. This is typical of the long term care industry in front-line positions closest to patient care, which was the target population for this study. The majority White/Caucasian participant population is representative of the Midwest and the cities in which the research was conducted; English as the primary language is indicative of the racial characteristic. Likewise, the vast majority of the participants reported working in a nursing facility as compared to other long term care settings; this reflects the fact that nursing facilities require significantly more DCWs than other settings like assisted living or home health, which accounts for the large percentage (79.3%) of participants. Further research is warranted to better understand any potential relationships between demographic characteristics and transformational leadership or organizational commitment. Gender and race may play a role in the perceptions of leader behaviors and intent to stay with organizations. This study was limited to evaluating the degree to which the variables transformational leadership and organizational commitment co-vary.

The study hypotheses addressed organizational commitment within its three dimensions of affective, continuance, and normative commitment. This is an imperative component of the analysis because organizational commitment as a job attitude is complex (Liou, 2008; Meyer & Allen, 1997; Morrow & McElroy, 1993). If organizational commitment is analyzed only in

its totality, it ignores the variation of employee relationships with their leaders and organizations (Meyer & Allen, 1997). Thus, a dimensional view takes this complexity into consideration when considering the impact of transformational leadership on organizational commitment. In this study, transformational leader behaviors were significantly positively related to both affective commitment and normative commitment. In a previous meta-analysis of correlations between transformational leadership and affective and normative commitment, affective commitment was shown to have a stronger relationship (Meyer et al., 2002). In this study, affective and normative commitments were similar in their correlation strengths (0.398 and 0.395, respectively), although the variances attributable to transformational leader behaviors was not high (15.8% and 15.6%, respectively). This may be related to the strength of DCW conformity between personal and organizational beliefs and the emotional attachment this lends to nonprofit missions. It is possible that DCWs who already have a desire to help others and work in a nonprofit setting feel compelled to remain in nonprofit settings, and while transformational leader behaviors assist in increasing affective and normative commitments, they may not be as compelling as the nonprofit mission itself. Additionally, the standard deviations for the LPI scores revealed noticeable dispersion around the means, indicating a variety in DCW perceptions of their immediate supervisors' leadership behaviors, which in turn can affect DCW views in staying with organizations as it pertains to the organizational commitment dimensions. Research has shown that certain leader behaviors are influences for DCWs.

Supervisory support, autonomy, and respect were found to support high commitment levels in long term care (Bishop et al., 2008), and DCWs have expressed that they most desire recognition, respect, rewards, empowerment, and inclusion in decision-making (Bowers et al., 2003; Caspar & O'Rourke, 2008; Leutz et al., 2009; Secrest et al., 2005; Stone, 2004, 2011). All such leader behaviors are reflected in the five transformational leadership subscales in some fashion, and the study results illustrated the statistically significant relationship between the transformational leadership subscales and overall organizational commitment, affective commitment, and normative commitment. For example, "model the way" exhibits qualities that show respect for others, "inspire a shared vision" appeals to empowerment by building goals to achieve a shared vision, "challenge the process" assures that support exists for DCWs wanting to test new approaches to care, "enable others to act" ensures that collaborative cultures are created for shared decision-making, and "encourage the heart" recognizes and rewards DCWs for accomplishments and makes people feel valued. In total, transformational leadership practices, described by Kouzes and Posner (2012) as the five practices of exemplary leadership, are based on "mobilizing others to want to struggle for shared aspirations" (p. 30). In this view, the leader/follower relationship is integral to organizational commitment along the affective and normative commitment dimensions. The relationship to continuance commitment, however, remains inconsistent.

Contrary to initial expectations for this study, there was no significant relationship between transformational leader behaviors and continuance commitment. Results showed that the relationship was in fact a slight positive relationship (0.021) despite the hypothesized inverse relationship. However, when looking at the transformational leadership subscales, a negative relationship existed between "inspire a shared vision" and continuance commitment. This is contrary to previous research (Dunn, Dastoor, & Sims, 2012). This reveals a potential linkage as to what hierarchy levels DCWs expect to communicate the vision. Continuance commitment also takes into account both the sacrifices involved in leaving an organization as well as the awareness of available job alternatives (Hackett, Bycio, & Hausdorf, 1994; Meyer & Allen, 1997). Rather than leader behaviors affecting continuance commitment, other personal (age, length of employment) or organizational factors (autonomy, pay) may be more attributable to an understanding of continuance commitment (Hackett et al., 1994; Meyer & Allen, 1997). While the study revealed that the median hourly wage of DCWs ($12.00) was higher than the most recent national report ($10.63), median hourly wage remains lower than the median wage for all U.S. workers ($16.71) (PHI, 2013b). It is also worth considering that

DCWs may feel their skills in long term care are less transferrable to another organization or industry, or they perceive limited employment alternatives, thus increasing continuance commitment levels (Meyer et al., 2002). Furthermore, the nonprofit mission may contribute to a lessening of economic considerations with DCWs, thus reducing their desire to leave for higher pay. For example, if a nonprofit organization provides desired support for work-family balance, thus reducing stress for the DCW, higher pay may become less valuable to the DCW. Each of these considerations are worthy of further exploration and research.

Limitations and Delimitations

The study provided evidence for correlational understanding between leader behaviors and organizational commitment but should not be construed as inferring causality (Gerring, 2012; Onwuegbuzie & Daniel, 2002). Limitations of the study included the purposeful sampling approach with data collection occurring at limited points in time for each participating site. Furthermore, participants were primarily limited to those working at the time of data collection. Findings provide validity for the population studied and may be valuable in understanding multi-level, nonprofit long term care organizations in the Midwest; however, application to other geographic locations and organizational capacities should be applied cautiously. Participants of the study provided individual perspectives of leadership practices within their respective location, and responses may contain bias or be affected by psychological and emotional states at the time of the survey. Furthermore, the favorable use of the LPI instrument (Kouzes & Posner, 2013) presents a perception that may be considered industry bias.

Future Research

The present study's findings were valuable for filling a gap in the literature with respect to providing empirical evidence for the long term care industry and direct care workers specifically. However, further research is warranted to evolve the long term care industry's understanding of the relationship between transformational leadership and organizational commitment. A larger sample of DCWs would be helpful to increase the sample sizes of other types of long term care settings besides nursing facilities. An evaluation of demographic characteristics for potential relationships would also be beneficial. For example, gender and race may or may not be a factor in DCWs' perceptions of transformational leadership as a predictor for organizational commitment; previous research on demographic characteristics has revealed inconsistencies (Al-Hussami, Darawad, Saleh, & Hayajneh, 2014; Emery & Barker, 2007; Mathieu & Zajac, 1990; Meyer & Allen, 1997; Qiao, Khilji, & Wang, 2009; Williams & Hazer, 1986). Furthermore, the lack of finding an inverse relationship between leadership and continuance commitment does not lessen the need for further research on the issue of pay in long term care. Future researchers could take quantitative, qualitative, or mixed-method approaches to collecting leadership and organizational commitment data. Examining leader behaviors and organizational commitment through interviews, surveys, and observation could provide additional insight into successful and exceptional leadership in long term care. Furthermore, longitudinal studies may be useful in tracking data over time with long term care organizations willing to commit to such an endeavor. Organizations undertaking leadership development training could also benefit from research that analyzes pre- and post-training.

With respect to the LPI survey instrument (Kouzes & Posner, 2013), Tourangeau and McGilton (2004) encouraged revision of the LPI to shorten its length for use in health care to relieve participant burden as well as decrease research costs. Subjectively, participants in this study commented on the length of the survey, and some participants did not complete the survey because they did not feel they had the time or could leave their work. Future researchers may wish to consider tackling this issue. Other areas of further research on transformational leadership and organizational commitment could include an analysis of other

factors, such as demographic characteristics, stress, health and well-being, and conflict as they relate to the variables and a comparison of for-profit and nonprofit long term care organizations.

Conclusion

Changes in long term care, partly due to health care reform, are demanding more of long term care providers in the implementation of effective care practices. Such demands can be taxing on both leaders and DCWs who are instrumental to successful implementation. The study findings are useful in advancing contributions to scholarship, considering modifications of operational policies, revisiting human resources practices, identifying training and development needs, and considering policymaking interventions. Within scholarship, researchers have advocated for further study on transformational leadership in hierarchical levels other than middle to senior levels (Avolio, 2011; Heldenbrand & Simms, 2012). While warranting additional research, this study provided empirical evidence into the relationship between transformational leadership and organizational commitment at lower hierarchical levels in long term care, recognizing the input of DCWs who are the foundation of long term care services. Within industry practice, leaders would benefit from collaborating with internal stakeholders to review operational policies to reflect the mission, vision, and values of the organization and use them to establish standards of excellence as goals for others to follow as shared aspirations. Likewise, leaders in long term care should collaborate with others to assess alignment issues and modify expectations and practices accordingly, potentially utilizing organizational tools such as employee satisfaction surveys to articulate priorities.

Furthermore, leadership development training should be considered for continuing education requirements for supervisors at all levels. Coaching as a leadership practice in long term care has revealed benefits in communication skills, staff empowerment, and feedback processes (Cummings et al., 2014). Leadership skills training must be accessible to supervisors in a broad context to reach as many direct supervisors as possible within organizational constraints. Study findings supported the need to evaluate the content of workforce resources incorporated into policy development as well. Looking beyond compensation, policymakers must consider other options for tackling the DCW supply challenge, such as contemplating leadership skills as a continuing education requirement for administrators and other licensed professionals working in long term care in positions of supervisory authority and including leadership training as a reimbursement incentive. Leaders within the industry must face these challenges not only by addressing a wide range of external factors but also by looking inward to leadership practices directly affecting the workforce they hope to retain. As the health care landscape continues to change, long term care providers will need to have the leadership skills necessary to overcome challenges, implement new policy and operational models, and address workforce retention.

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