HOME HEALTH AIDE

PANDEMIC PREPAREDNESS

WORKBOOK

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VNS Health

March 9, 2022

To: Pandemic Preparedness Panel

Dear Panel Members,

Thank you for agreeing to participate in our panel meetings to develop a roadmap and priority recommendations for pandemic preparedness that promote the health and safety of direct care workers -- and essential care for their patients – in ongoing or future communicable disease crises.

Enclosed is a packet of materials we created to facilitate your participation in the panel meetings. We encourage you to flip through this workbook and the included appendices to learn more about our research findings. Your fellow panel participants are from varied backgrounds: agency leaders, home health aides, association leaders, and union representatives. We believe it is important for everyone to work together to create this roadmap, so we are looking for a lively and interactive discussion. We are looking forward to our collaboration.

Sincerely,

The Research Team

*220 East 42nd Street * New York, NY 10017*
www.vnsny.org/research

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ALTMAN FOUNDATION

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Agenda

DAY 1 - MARCH 23,2022

TOPIC	TIME
Introductions/Overview	11:00-11:25
Breakout Groups	11:25-12:05
Break	12:05-12:10
Report Backs	12:10-12:25
Discussion	12:25-1:00

DAY 2 - MARCH 30, 2022

TOPIC	TIME
Welcome Back	11:00-11:10
Breakout Groups	11:10-11:50
Break	11:50-11:55
Report Back	11:55-12:25
Discussion	12:25-1:00

DAY 3 - APRIL 20,2022

TOPIC	TIME
Welcome Back	11:00-11:05
Breakout Groups	11:05-11:30
Report Back	11:30-11:45
Break	11:45-11:50
Discussion	11:50-1:00

Overview

This panel was developed to provide an opportunity to reflect on the experiences of the home health aide workforce and home health agencies throughout the COVID-19 pandemic, challenges and issues encountered, and lessons learned. We have included information we collected in our own research and expect you will bring in your own reflections. Over the course of three meetings, we will go through a set of activities that will allow you review the issues and identify practices and strategies to address. The ultimate intention for this panel is to develop a set of recommendations for increasing the support going to and the preparation of the home health workforce in ongoing/future public health crises based on your input.

List of Attendees

RESEARCH TEAM

NAME	TITLE	AFFILIATION
Alexis Stern	Research Analyst II	VNSNY Center for Home Care Policy & Research
David Russell	Research Associate	VNSNY Center for Home Care Policy & Research
Maddie Sterling	Assistant Professor of Medicine	Weill Cornell Medicine Division of General Internal Medicine
Margaret McDonald	Associate Vice President	VNSNY Center for Home Care Policy & Research
Mia Oberlink	Senior Research Associate	VNSNY Center for Home Care Policy & Research
Nicole Onorato	Research Analyst II	VNSNY Center for Home Care Policy & Research
Penny Feldman	Director Emerita and Senior Scientist	VNSNY Center for Home Care Policy & Research
Sasha Vergez	Research Assistant	VNSNY Center for Home Care Policy & Research

PARTICIPANTS

NAME	TITLE	AFFILIATION
Amy Thomas	Vice President, Home Care	Selfhelp Community Services, Inc.
Andrea Thomas	Associate Director	Sunnyside Community Services, Inc.
Babita Gill	Home Health Aide	Partners in Care
Becky Preve	Executive Director	Association of Aging in New York
Bernhard Schiel	President and CEO	Bestcare, Inc.
Christy Johnston	VP of Governmental & Managed Care Services	Premier Home Health Care Services, Inc.
Darby Anderson	Executive Vice President & Chief Strategy Officer	Addus Home Care
Denise Tripodi	Vice President NY LHCSA Shared Services	Personal Touch Home Care
Diana Yunga	Home Health Aide	Partners in Care
Frances Sadler	Assistant Director	1199 SEIU Funds Home Care Industry Education
Greg Olsen	Director	New York State Office for the Aging (NYSOFA)
Jim Rolla	Senior Vice President and CEO	Partners in Care
JoAnna Ciampaglione	Senior Vice President/ GM	Accent Care Personal Care Services
Kathryn Haslanger	CEO	JASA
Kathy Febraio	President	NYS Association of Health Care Providers
Lana Goykhberg	Executive Director of Home Care	JASA
Malvina Franklin	Home Health Aide	Partners in Care
Natalia Selezneva	Director of Patient Services, Quality & Compliance	Personal Touch Home Care
Natinnindje Cisse	Home Health Aide	Partners in Care
Rachel Pine	Program Officer	Altman Foundation
Stephen McCall	Data and Policy Analyst	PHI
Susan Brett	COO, Senior VP	People Care, Inc.
Tiffany Thompson	Home Health Aide	Partners in Care

Pandemic Preparedness:

Supporting the Home Health Aide Workforce

March 2022

David Russell, PhD,[1,2] Madeline Sterling MD, MPH, MS,[3] Margaret V. McDonald MSW,[2] Alexis Stern,[2] Sasha Vergez, [2] Mia Oberlink, [2] Nicole Onorato, [2] Penny Feldman, PhD [2]

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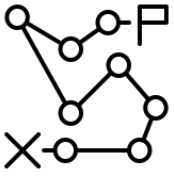
Russell, D., Sterling, M., McDonald, M., Stern, A., Vergez, S., & Feldman, P., (2022). Pandemic Preparedness: Supporting the Home Health Aide Workforce. *VNS Health*

Panel Purpose and Organization

This panel seeks to develop a **roadmap** and a set of **recommendations** for preparedness of the home care workforce in ongoing/future public health crises

Panel activities will be conducted over the course of **three meetings**, during which time panel members will review issues and develop action plans

To start, we'll cover five **problems and issues** identified from our research



Case Study: Long-Term Client with Trusted Relationship

Melissa, a 42-year-old Home Health Aide working in NYC, has cared for her client Mrs. Jones for the past 3 years. Melissa works with Mrs. Jones Monday to Friday, 5 days a week. Her 45-minute commute on two NYC subways is the fastest route. Mrs. Jones and Melissa work well together and enjoy each other's company. They keep a close eye on the news and follow the most up to date pandemic guidelines. Both she and Mrs. Jones wear a mask when they go outside. They also keep a safe distance from others.

Melissa is close with Mrs. Jones's daughter, who is around more lately since she's been working from home. While Mrs. Jones loves the extra visits from her daughter, she wants to keep Melissa safe. Mrs. Jones tries to have her daughter over only after Melissa has left for the day. Melissa is happy working with just one client during the pandemic and she feels that her chance of exposure is much less when she is with a patient she trusts. While it would be nice to see Mrs. Jones's daughter, Melissa appreciates the extra caution. Melissa worries about what would happen if she or Mrs. Jones contracted COVID-19? What would happen to Melissa's job and financial stability?

Case Study: Short-Term Clients, Reaching Supervisors, and Unsafe Work Environments

Joy, a 28-year-old Home Health Aide, is on her way to see her first client of the day. After the recent passing of her long-term client due to COVID-19, she has been assigned a series of shorter-term clients who each receive services for a few weeks (or less). Joy has been very concerned about taking subways and prefers to walk or take the bus if possible. She's concerned for the safety of her family. She would use car services, but she can't afford to.

Joy visits her first client of the day, Mr. Abreu, who greets her at the door. Joy is relieved to see that he is already wearing a mask! She enters the home and sees that Mr. Abreu's two daughters and grandson are visiting and are not wearing masks. Joy politely asks them to put masks on. They refuse and tell her she's only an "aide" and that it's not her house. Joy calls her supervisor for support but can't reach her. With just two hours left in the assignment, Joy focuses on getting her work done while trying to keep a safe distance from the client's family. Joy's next client of the day, Mrs. Robinson, turns her away at the door because she is hesitant having a new aide in the home. Joy contacts her supervisor again, and is able to reach her after a few attempts. She directs Joy to the next patient, who is luckily just a few blocks away.

Home Health Aide Pandemic Issues & Problems

Overview of Issues Related to Pandemic Preparedness

1
Health Risks, PPE & Vaccination

2
Financial & Work Instability

3
Communication & Emotional Support

4
Recruiting, Training, & Retaining a Reliable Workforce

5
Home Health is an Essential Part of the Healthcare System

Home Health Aide Pandemic Issues & Problems

Methods for Researching the Experiences of Aides and Agencies During COVID-19

<u>Survey Questionnaires (Aides)</u>

1,316 Aides employed by a large agency in NYC about:

- Health & Well-Being
- COVID Worries & Concerns
- Feelings on Preparedness
- Economic/Practical Impacts
- Feelings on Communication
- Personal & Client Safety

<u>Focus Groups (Aides)</u>

6 focus groups with 17 Aides about COVID-19 experiences

<u>Interviews (Aides)</u>

56 interviews with aides to understand attitudes towards COVID-19 vaccines

<u>Interviews (Agencies & Other Stakeholders)</u>

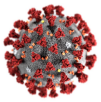
13 interviews with industry stakeholders, including 11 leaders of licensed home care agencies about:

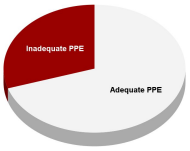
- Policies & Programs
- Safety Protocols
- Scheduling & Services
- Staff Supports
- Recruitment & Retention

***All data comprising this research project were collected between Summer 2020 and Summer 2021**

Home Health Aide Pandemic Issues & Problems

Health Risks, Personal Protective Equipment & Vaccination





26% *of aides reported that PPE supplies for their clients were inadequate at the outset of the pandemic*

Aides viewed their jobs as placing them and their family members at increased risk of COVID-19 due to close personal contact with clients

"Essentially, aides are putting their lives on the line, risking exposure, for a minimum wage." -
Agency Administrator

Personal Protective Equipment, including masks and gloves, were in short supply early in the pandemic

"Getting PPE supplies was a big problem … There was a tremendous shortage of supplies … Costs tripled at one point for masks."
- Agency Administrator

38% *of aides reported being* ***extremely*** *worried about being infected with COVID-19*

30% *of aides reported that they or someone close to them experienced one or more of the following due to COVID-19: falling ill, hospitalized, quarantined, death*

Aides also have a **higher rate of chronic conditions** compared to all U.S. employed adults, including hypertension (28%) and diabetes (12%)

Agencies went into high gear to secure PPE, using multiple and concurrent strategies

Aides and clients were both apprehensive about starting new services, for fear of becoming infected with COVID-19

Home Health Aide Pandemic Issues & Problems

Health Risks, Personal Protective Equipment & Vaccination

Aides carefully considered COVID-19 vaccines based on information, personal experiences, perceived susceptibility and severity of COVID-19, benefits of, and barriers to vaccination, and getting their questions answered by trusted sources

Information Sources
- News Media
- Government Agencies
- Medical Professionals
- Friends & Family
- Co-Workers & Clients

Demographics & Health
- Age
- Health Conditions

Work and Family Experiences
- Caring for COVID-19 clients
- Loss of Family & Friends
- Prior Influenza Vaccination
- Perceived Work Treatment
- Prior healthcare experiences

Personal Beliefs
- Religious Beliefs
- Trust in healthcare systems

Perceived Susceptibility & Severity
- Perceived risk of transmission
- Infection control/prevention practices
- Previous infection of self/others
- Perceived consequences of COVID-19

Benefits of Vaccination
- Reduced infection risk to self
- Reduced infection risk to clients, family, friends and public
- Reduced illness severity
- Trust & social approval from clients
- Satisfying work requirements
- Return to "normal" pre-pandemic life

Barriers to Vaccination
- Concerns for vaccine safety, efficacy, and rapid development/testing
- Side-effects & health consequences

Vaccination Mandates

Weighing Pros & Cons

Decision-Making Process

Getting Questions Answered

Advice from Trusted Sources

Home Health Aide Decision to Receive a COVID-19 Vaccine

* Diagram is adapted from the Health Belief Model

Home Health Aide Pandemic Issues & Problems
Financial and Work Instability

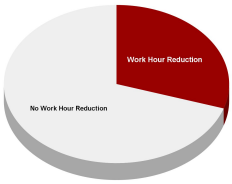
"One concern I had is that, if ever I were to come down with COVID … I would be basically knocked out of any work at all which could be [a] disaster" *- Home Health Aide*

Home Health Aides expressed concerns about their financial security due to loss of work related to COVID-19

"A lot of families put their services on hold … because they were fearful and didn't want people into their homes … and because people [family caregivers] were at home to help" *- Agency Administrator*

Aides reported significant reductions in work hours following the COVID-19 outbreak

30% of aides reported a reduction in their work hours



Agencies faced reduced demand for home health services at the height of the pandemic

Fewer aides were available for work due to fear of infection, quarantine from exposure to infected persons, or infection

*Average work reduction was **10 hours per week***

25% of Home Health Aides reported trouble paying their rent or mortgage during COVID-19

Clients declined service due to a fear of infection and availability of household members to provide necessary care

Home Health Aide Pandemic Issues & Problems
Financial and Work Instability

Factors that <u>Threatened Financial Stability</u> and <u>Decreased Work Access</u>

- Private purchase of PPE to supplement agency supplies
- Fear of using public transportation to reach clients
- Out-of-pocket expenses for private transportation
- Reduced hours & household income; higher household expenses
- Agencies accrued overtime costs without reimbursement

93% *of Home Health Aides reported they were very concerned about using public transportation since the onset of the COVID-19 pandemic*

1 out of **5** Home Health Aides reported they held another job in addition to their agency role; those who did were almost twice as likely to earn > $35K

- Financial benefits (i.e. hazard pay & bonuses)
- Ability to find work with other agencies and employers
- Essential worker passes and travel vouchers

Factors that <u>Supported Financial Stability</u> and <u>Increased Work Access</u>

Home Health Aide Pandemic Issues & Problems

Communication & Emotional Support

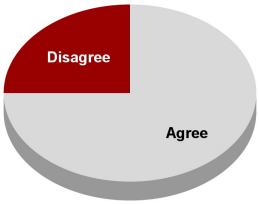
"A supervisor called me to see how we were doing … I found out I was not the only one that didn't get PPE. I told her I was out of PPE. Three days later there was a big package." *- Home Health Aide*

While most aides were satisfied with the level of COVID-19 agency communications, some could not easily reach their supervisors

"Our biggest frustration was mixed messaging … [from] the State, City, CDC … You're constantly switching gears … People work better in a consistent environment with a consistent message." *- Agency Administrator*

Agency communications and supervisory relationships played an important role in aides' experiences during the pandemic

25% **of aides said they disagreed with the statement that "*Since the COVID-19 outbreak started, I have been able to easily reach my supervisor when I have questions or concerns*."**



Agencies scrambled to communicate with aides during a period of mixed messages from government agencies

Agencies viewed supervisors as a link of support and communication among aides, clients, and care management staff at managed long-term care plans

Agencies worked with their vendors to deploy multiple media, including social media, video, phone and text to communicate information with their aides; technologies played an important role in these communications

Home Health Aide Pandemic Issues & Problems

Communication & Emotional Support

"When the pandemic began, I was working … I didn't have [a] mask. I didn't know what to do. I had to [go to] my job. I was scared … I was sick." *- Home Health Aide*

There was an acute need for emotional support among aides, who were coping with the loss of clients, family members, and friends

"You know, things are happening so quickly, and we were so focused on the PPE and service delivery…we've relied on our employee benefits assistance, but it's probably something you could do more with." *- Agency Administrator*

Anxiety and fright were high among aides and their clients at the start of the pandemic

18% of aides reported severe psychological distress at the beginning of the COVID-19 pandemic; an additional **43%** of aides reported moderate psychological distress at the start of the pandemic

"One of the biggest challenges at the start of the pandemic was trying to manage fear among aides, [and their] clients and families."
- Agency Administrator

Agencies took steps to provide emotional support to aides to help them manage personal and job-related fear and stress

Aides provided (uncompensated) emotional support to clients. While not limited to the pandemic, emotional support was central to their work with clients, most of whom were confined to their homes and had little interaction with the outside world

Agencies implemented a variety of emotional support strategies, including sessions on stress management and emotional support calls, which were well-attended; many aides reported difficulties communicating with supervisors and accessing agency supports

Home Health Aide Pandemic Issues & Problems

Recruiting, Training, and Retaining a Resilient, Prepared and Reliable Workforce

"You don't know what you're walking into. You gotta be careful and be prepared … Have precautions and everything … I have my PPE [and an] extra uniform to change." - *Home Health Aide*

While most aides felt their agency prepared them for a pandemic; nearly one in four aides said they did not receive training on public health emergencies

"We expect a lot of aides, and they have a lot of responsibility. Their training level, it's the lowest in healthcare. We expect them to be out there functioning alone with minimal training."
- Agency Administrator

Aides expressed a heightened sense of awareness and preparation for protecting themselves during COVID-19

23% of aides said they did not receive training from their agency related to public health emergencies prior to the pandemic

Infection control is part of an aide's routine training but special training was needed for donning PPE and reducing COVID-19 exposure

Aides desired greater transparency about the risks they faced during COVID-19 and stronger lines of communication with their supervisors

Agencies had to quickly flip from in-person training to remote training platforms through online media

Home Health Aide Pandemic Issues & Problems

Recognizing Home Health as an Essential Part of the Healthcare System

"I'm proud to be a home health care worker … Without us I don't know what people will have done during the pandemic" - *Home Health Aide*

Many aides continued to care for clients during the pandemic despite an increased risk of infection and close contact with clients diagnosed with COVID-19

"Aides are undervalued … they're putting their life on the line, risking exposure for a minimum wage … As an industry we need to stand up and scream that from the top of the rooftops" - *Agency Administrator*

Despite limited recognition, aides were motivated to work during the pandemic by a belief they provided essential services to clients

7 out of every **10** Home Health Aides reported they ***never turned down work*** for COVID-19 reasons

30% *of Home Health Aides cared for one or more clients who had an active or recovering COVID-19 infection*

Agencies advocated for greater recognition of the risks and sacrifices that aides made during the COVID-19 pandemic

Aides recognized that many of their clients lived alone and/or lacked support from family caregivers

There was a fundamental lack of understanding about what home health aides do and why their care was essential

Health Risks, Personal Protective Equipment (PPE) and Vaccination

Challenge:

Mitigating health risk and increasing safety: PPE, vaccinations, testing, client management

Problem Statement:

Home health aides are at high risk of infection due to difficulties in accessing personal protective equipment (PPE) (for themselves and their clients; for use on the job and in between clients). Aides were apprehensive about accepting new clients and short-term cases because of unknown health risks and the uncontrolled environment in the client's home. Aides weighed the risks of contracting COVID-19 with benefits and perceived risks of vaccination and felt that concerns were not always adequately addressed. With the institution of mandates, a significant portion of aides in NYS received the COVID-19 vaccination, but many did so with residual concerns and sought more information about their development and efficacy. This may have consequences for future initiatives as well as workforce retention.

Notes

Questions to Consider Regarding PPE:

- How can employers obtain appropriate PPE and access to testing at the outset of a disease outbreak and throughout its course?
- How can employers assure that aides are able to easily access PPE for themselves and their clients at the outset of a disease outbreak and throughout its course, and how can aides be prepared for its effective use?
- What local, state, and federal government supports are needed to facilitate PPE access at the outset and throughout the course of a public health emergency?

Possible Recommendations and/or Strategies

Questions to Consider Regarding Additional Safety Practices:

- What additional practices can be put in place to prevent or address safety issues that aides encounter in clients homes?
- What kinds of information and through what channels can aides be informed of preventive measures and illness status of clients and client households?

Possible Recommendations and/or Strategies

Questions to Consider Regarding Vaccinations:

- How can vaccines be promoted in a way that fosters trust in their safety and efficacy?
- In the context of vaccine mandates, how should agencies follow up to address residual concerns or distrust?
- What employer and governmental actions would address access and geographic barriers to vaccination?

Possible Recommendations and/or Strategies

Financial Instability and Work Access Issues

Challenge:

Addressing financial instability and work access issues

Problem Statement:

The intermittent nature of aide assignments, significant reductions in hours worked, challenges in transportation, lack of paid leave, and increased costs for childcare and other work related items, exacerbated in a pandemic situation, created financial hardship for aides and their employers.

Notes

Questions to Consider:

- How can the financial instability and associated financial difficulties experienced by aides as a result of the pandemic be alleviated through the policies and actions of government, intermediaries (e.g., MLTC) and employers?
- What measures, instituted by whom, could address the transportation, child care and other financial challenges and costs faced by the aide workforce?

Possible Recommendations and/or Strategies

Communication and Emotional Support

Challenge:

Improving communication (types of information and modes used) and increasing emotional supports

Problem Statement:

Intermittent and inconsistent information came to agencies from multiple sources, but aides needed clear, concise information and emotional support to help them manage uncertainty, stress, and anxiety.The aides' satisfaction with level of communication and ability to reach supervisors varied. Their reports were mixed on receiving emotional support or being able to access available emotional support programs, when offered. It is unclear what types of information, information channels, modes of communication and support mechanisms would promote greater consistency, clarity and effective support.

Notes

Questions to Consider Regarding Communication:

- What were the most beneficial modes of communication between aides and agency?
- What pieces of information are vital to share and when?
- How was technology leveraged and how can it be maximized?

Possible Recommendations and/or Strategies

Questions to Consider Regarding Emotional Support:

- What emotional supports were made available to aides and how effective were they?
- How can we ensure that effective support mechanisms are put in place in advance of a public health crisis so that all aides have access to the emotional support they need?

Possible Recommendations and/or Strategies

Home Health Aide Recruitment, Training, and Retention

Challenge:

Recruiting , training and retaining a resilient, prepared and knowlegeable workforce.

Problem Statement:

Nearly 40% of aides who responded to a 2020 survey did not remember any training related to public health emergencies prior to the COVID-19 outbreak; 15% still felt unprepared 5-6 months into the pandemic. Thirty-five percent said they were very or somewhat likely to leave their job in the coming year, while 30% reported they were more likely to call out after the outbreak of COVID-19 than before. Respondents who felt prepared were 20% less likely to call out than those who did not feel well prepared. These findings have potentially serious consequences for continuity of care not only in current or in future pandemic conditions but in normal conditions as well. Agency leaders report significant concerns about recruitment and retention of this workforce.

Notes

Questions to Consider:

- To what extent can pandemic training be incorporated into other public health emergency training?
- To what extent is a separate approach needed?
- What are other strategies to help home health aides to feel prepared?
- What strategies in addition to training can agencies use to increase aide commitment to providing care "day in and day out" in a pandemic situation?
- What is the role of remote training in a crisis situation? for recruitment? What are the implications for the future?

Possible Recommendations and/or Strategies

Home Health as an Essential Part of the Health Care System

Challenge:

Promoting recognition of home health as an essential part of the health care system

Problem Statement:

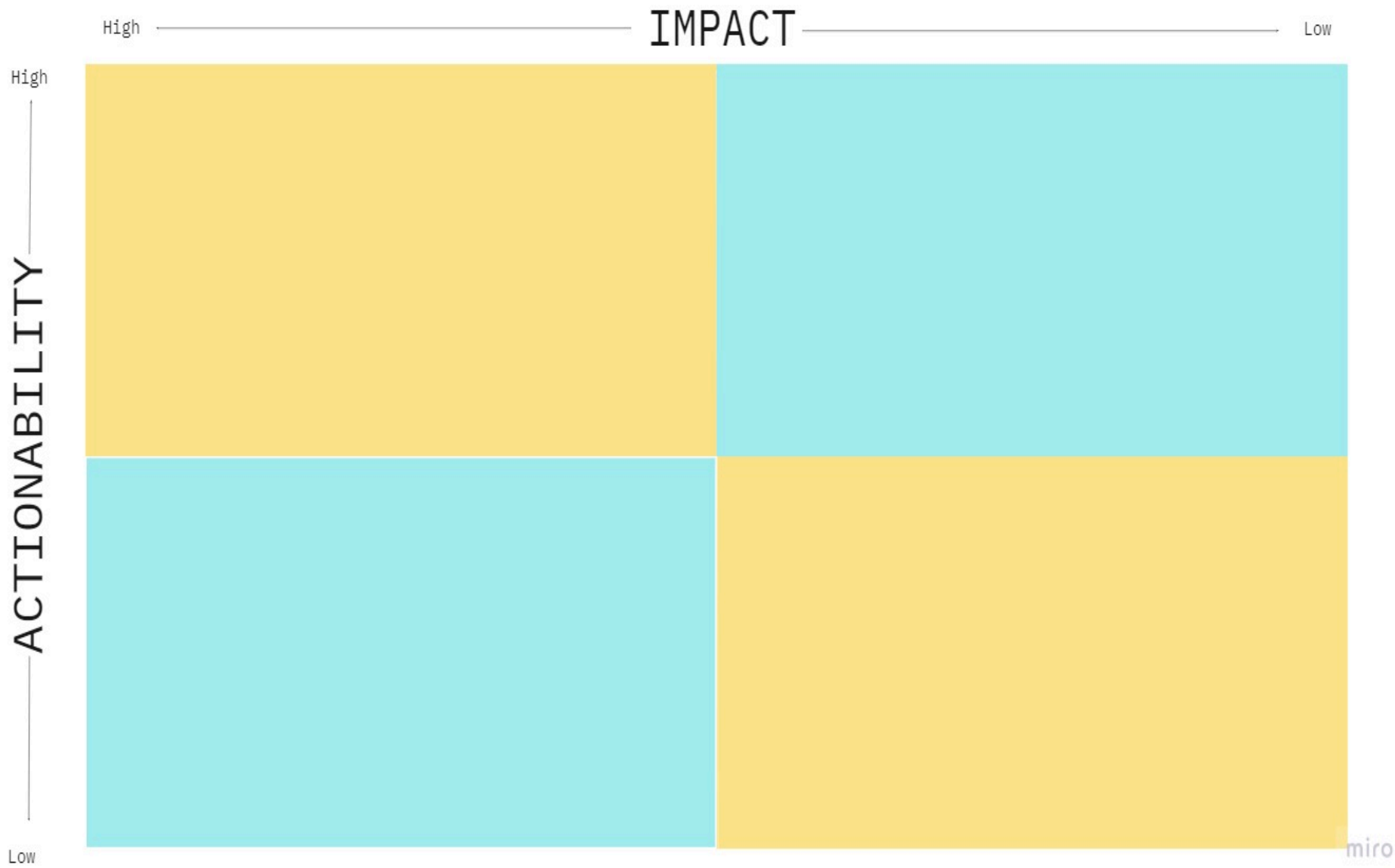
Despite providing essential client care and emotional support, home health aides were not treated like essential workers nor recognized for their contributions. Home care lagged behind other parts of the New York health care system in its access to PPE. Further, New York State lagged behind other states in providing supplemental supports and programs to cover the additional financial hardships that developed during the pandemic.

Notes

Questions to Consider:

- How do we ensure home health aides are treated as an essential workforce moving forward?
- How do we get lawmakers and other decision-makers to understand home health care and its vital part of the healthcare systems, especially during the pandemic?
- What government policies need to be addressed?
- How can home health aides be better recognized in general?

Possible Recommendations and/or Strategies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Appendix

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Impact of the COVID-19 Pandemic on the Home Health Aide (HHA) Workforce:

Perceptions of HHAs Surveyed During the Summer of 2020

March 4, 2022

ABOUT THE SURVEY

- During the summer of 2020, we surveyed 1,316 Home Health Aides (HHAs) employed by a large New York City Licensed Home Care Service Agency.
- The aim of the survey was to understand, six months into the pandemic, how COVID-19 had affected the health, well-being and work life of this essential workforce. This information can help industry leaders and policy makers as they develop pandemic preparedness plans to protect the future health and safety of direct care workers and the clients they serve.
- Whenever possible, survey questions were drawn from validated, published research studies.
- The survey was conducted from August 6 to September 20, 2020.
- HHAs could complete the survey via smartphone, computer or telephone.
- Participation in survey was voluntary, confidential and anonymous.
- To thank them for their participation, survey respondents were eligible to enter a drawing for a chance to win one of 100 $25 gift cards.

HOW TO INTERPRET THE DATA

1) **Survey participation was voluntary; respondents could choose to skip any question. Percentages are based on the number ("n") of HHAs that provided an answer to that survey question.**

2) **Percentages from questions answered by a small subset of survey respondents should be interpreted with caution.**

3) **Totals may not add up to 100% due to rounding.**

4) **Totals from questions that directed respondents to "Check all that apply" do not add up to 100%**

WHO TOOK THE SURVEY

DEMOGRAPHIC CHARACTERISTICS OF THE 1,316 HOME HEALTH AIDE SURVEY RESPONDENTS

AGE (n=1,196)	
Under 35	15%
35 to 54	53%
55 to 64	27%
65 or older	6%

GENDER (n=1,300)	
Female	96%
Male	4%
Non-binary	<1%

ANNUAL INCOME (n=533)	
Under $15,000	50%
$15,000 to $34,999	37%
$35,000 or more	13%

EDUCATIONAL ATTAINMENT (n=772)	
No diploma or GED	18%
High School or GED	29%
At least some college	53%

RACE/ETHNICITY (n=1,208)	
Black or African-American (not Hispanic or Latino/a)	64%
Hispanic or Latino/a (and any race)	24%
White or any other race (not Hispanic or Latino/a)	12%

LIVING ARRANGEMENTS (n=772)	
Lives alone	10%
Lives with others	90%

HOUSEHOLD SIZE (n=772)	
Mean	3.5

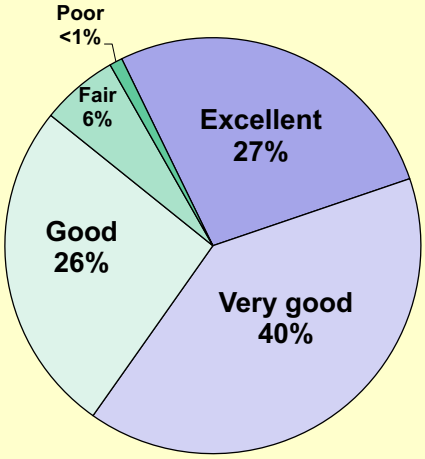
ADULTS AGE 65 AND OLDER IN HOUSEHOLD (n=758)	
Yes	28%
No	72%

CHILDREN UNDER 18 YEARS OLD IN HOUSEHOLD (n=766)	
Yes	48%
No	52%

IMPACT OF COVID-19 ON HHA HEALTH CONCERN

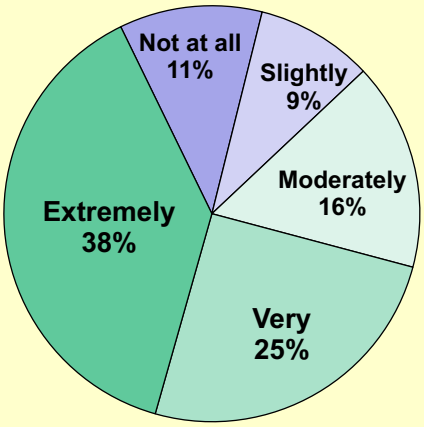
SELF-REPORTED HEALTH STATUS:

In general, would you say that your health is… (n=796)



WORRY ABOUT BEING INFECTED:

How worried have you been about being infected with COVID-19 since the outbreak began? (n=959)



IMPACT OF COVID-19 ON HHA HEALTH

MENTAL HEALTH:

Respondents were categorized as having experienced "severe," "moderate," "low," or "no" mental distress using a modified version of the validated Kessler-6 Scale of Mental Distress (K6). Respondents' level of mental distress was calculated based on their respondents to the following sets of questions:

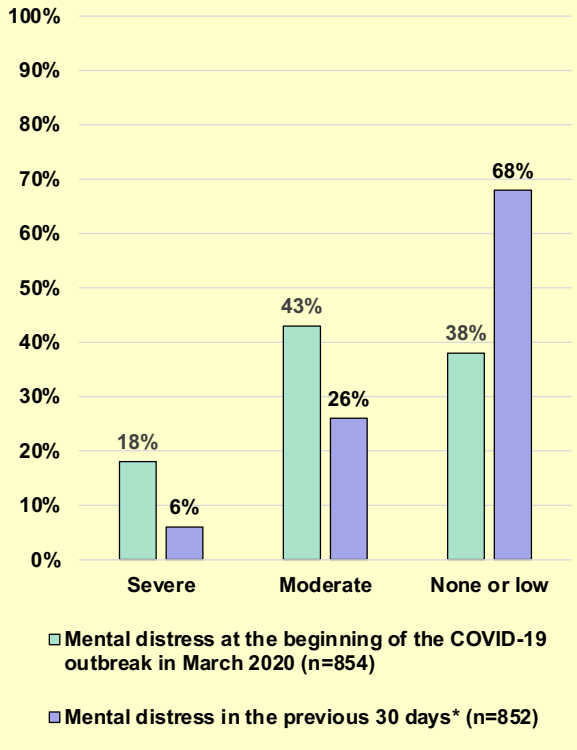
1. Thinking back to when the COVID-19 outbreak began (in March) about how often did you feel...

a. **… nervous?**
b. **… hopeless?**
c. **… restless or fidgety?**
d. **… so depressed that nothing could cheer you up?**
e. **… that everything was an effort?**
f. **… worthless?**
g. **... lonely**

Response options for a to g:

1. **All of the time**
2. **Most of the time**
3. **Some of the time**
4. **A little of the time**
5. **None of the time**

2. The same set of questions was asked starting with "In the past 30 days how often did you feel…"



*** Data was collected August 6-September 20, 2020**

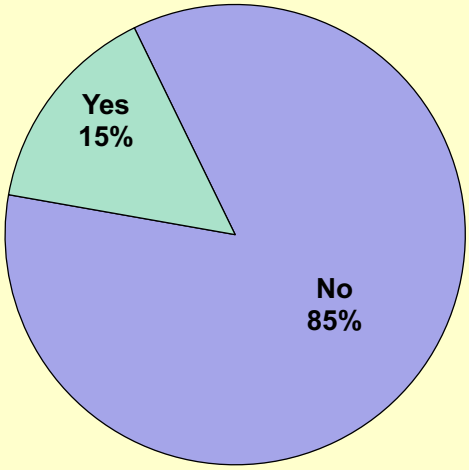
IMPACT OF COVID-19 ON HHA HEALTH

DIRECT IMPACT ON HHA HEALTH:

"Yes" includes respondents who gave any of the following responses to survey questions:

1. **Selected either of the following responses to the question "Have you been diagnosed with COVID-19 or suspected that you had it?"**
   - **"Yes, had positive test"**
   - **"Yes, medical diagnosis, but no test"**
2. **Checked any of the following responses to the question "How has the COVID-19 outbreak affected you?"**
   - **"Was not able to work due to COVID-19 related illness"**
   - **"Was in self-quarantine for possible COVID-19 exposure at a client's home"**
   - **"Was in self-quarantine for possible COVID-19 exposure from family members or friends"**

(n=888)



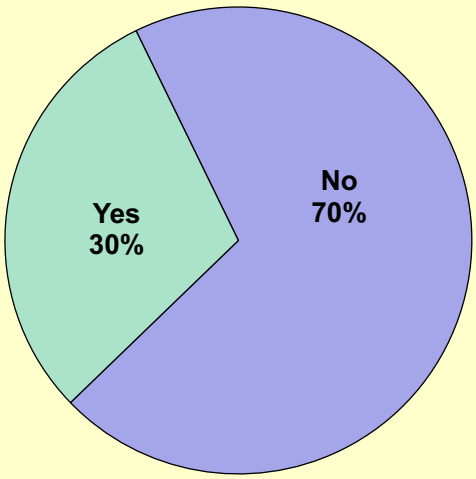
IMPACT OF COVID-19 ON HEALTH OF PEOPLE CLOSE

HEALTH IMPACT ON PEOPLE CLOSE TO HHA:

"Yes" includes respondents that checked any of the following responses to the question "Have any of the following happened to any one close to you (including immediate family, housemates, or close friends) because of Coronavirus/COVID-19? *Check all that apply.*":

- **Fallen ill physically**
- **Hospitalized**
- **Put into self-quarantine with symptoms**
- **Put into self-quarantine without symptoms (e.g., due to possible exposure)**
- **Passed away**

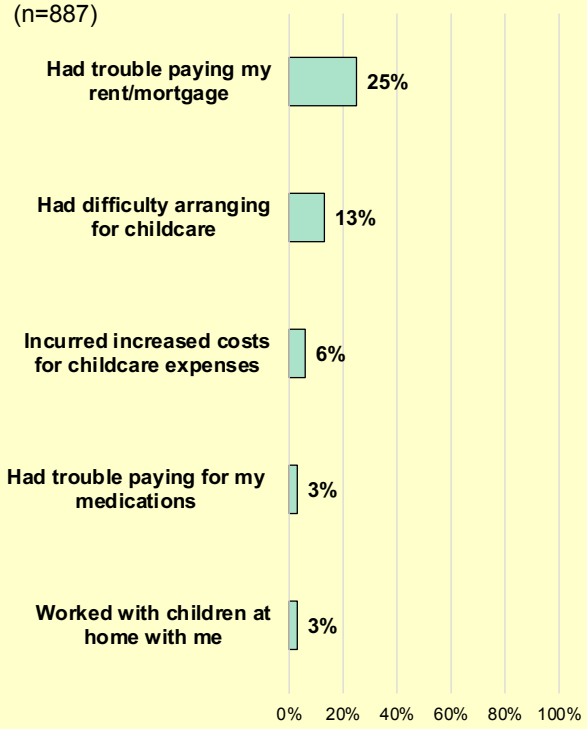
(n=883)



ECONOMIC AND PRACTICAL IMPACTS OF COVID-19

IMPACTS ON HHA:

How has the COVID-19 outbreak affected you? ***Check all that apply.***
(n=887)

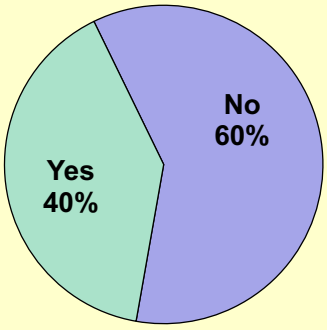


SOMEONE CLOSE LOST EMPLOYMENT INCOME:

"Yes" includes respondents who gave any of the following responses to survey questions:

1. **Checked either of the following responses to the question "Have any of the following happened to any one close to you (including immediate family, housemates, or close friends) because of Coronavirus/COVID-19?"**
   - **Lost or been laid off from job**
   - **Reduced ability to earn money**
2. **Checked the following response to the question "How has the COVID-19 outbreak affected you?"**
   - **Someone in my household became unemployed or had their hours reduced due to COVID-19**

(n=880)

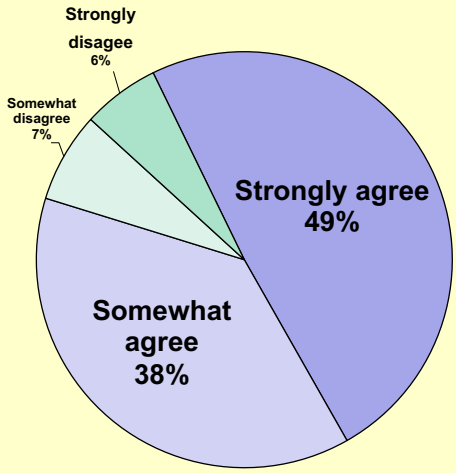


HHA PERCEPTIONS OF PRIOR HEALTH EMERGENCY AWARENESS AND TRAINING

AWARENESS:

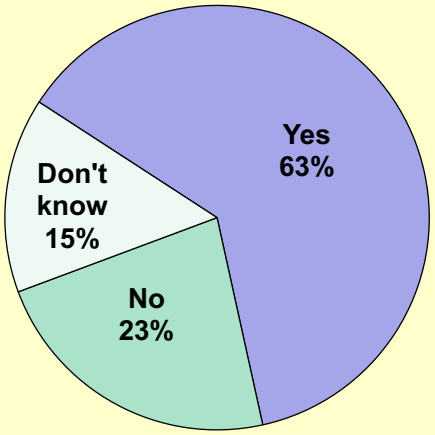
How much do you agree or disagree with the following statement:

"Before the COVID-19 outbreak, I knew that it was possible that I would be asked by [employer] to respond to a public health emergency." (n=1,108)



TRAINING:

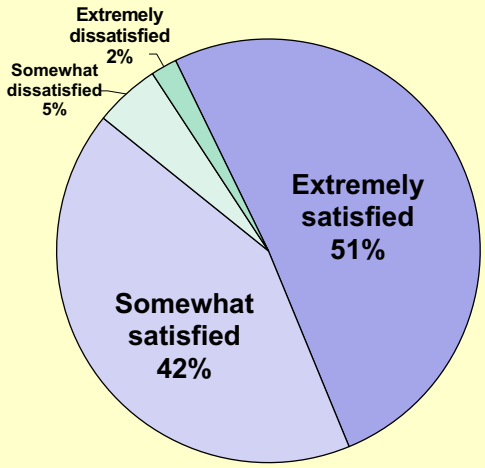
Before the COVID-19 outbreak, did you receive any training related to public health emergencies from [employer]?
(n=1,114)



HHA PERCEPTIONS OF COVID-19 COMMUNICATIONS

AGENCY COMMUNICATIONS:

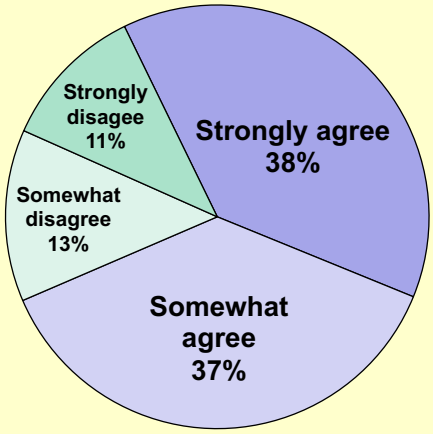
How satisfied are you with the level of communication from [employer] about the COVID-19 outbreak? (n=819)



SUPERVISOR COMMUNICATIONS:

How much do you agree or disagree with the following statement:

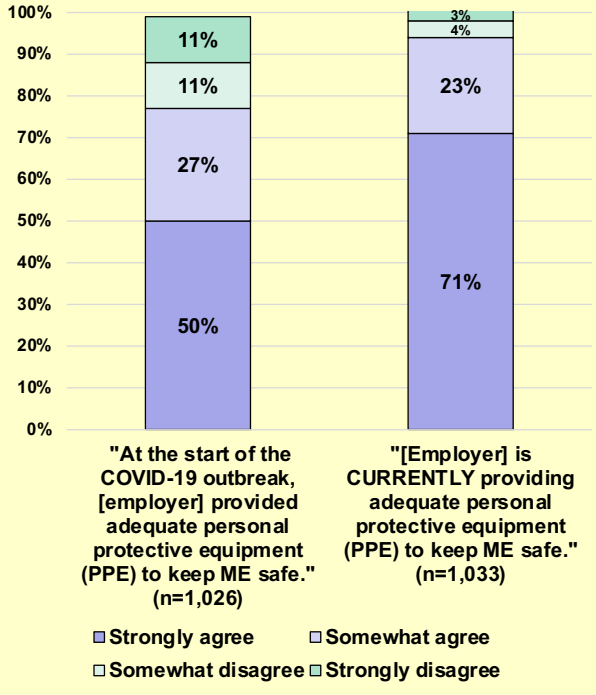
"Since the COVID-19 outbreak started, I have been able to easily reach my supervisor when I have questions or concerns." (n=982)



HHA PERCEPTIONS OF PERSONAL AND CLIENT SAFETY

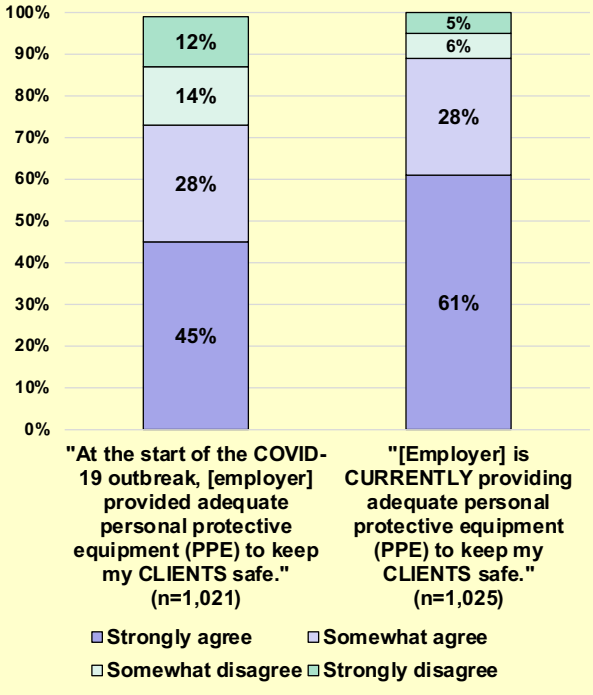
PPE FOR SELF:

For the following questions please indicate how much you agree or disagree with the below statements.



PPE FOR CLIENTS:

For the following questions please indicate how much you agree or disagree with the below statements.

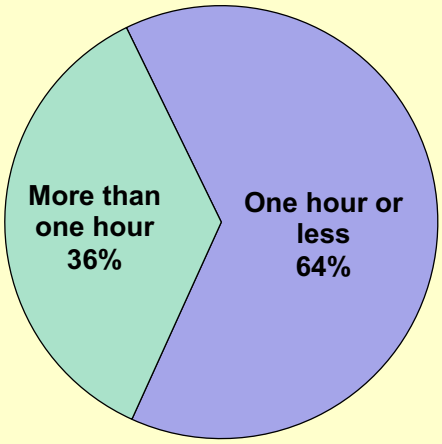


WORK STATUS AND COVID-19 IMPACT

FACTORS THAT MAY AFFECT HHA WORK SAFETY OR SATISFACTION:

TRAVEL TIME:

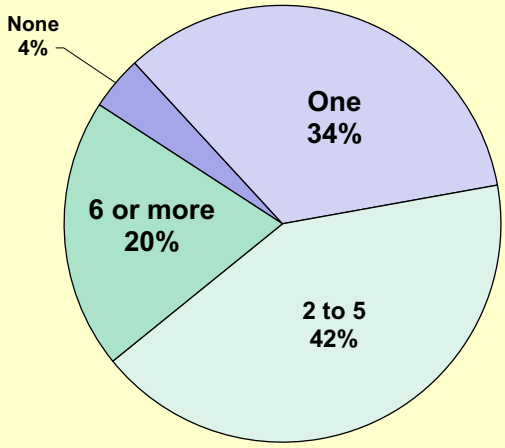
In total, how long do you spend traveling from home to your work locations and back? (n=1,028)



NUMBER OF CLIENTS SERVED SINCE MARCH 2020:

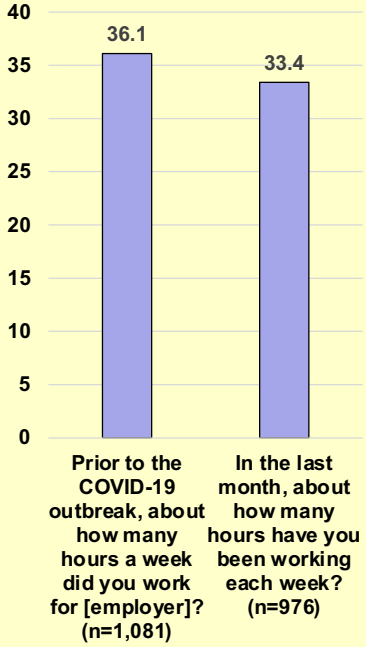
Since the COVID-19 outbreak began (in March), approximately how many different clients have you served?

Include all clients, not just COVID+ clients (n=1,129)



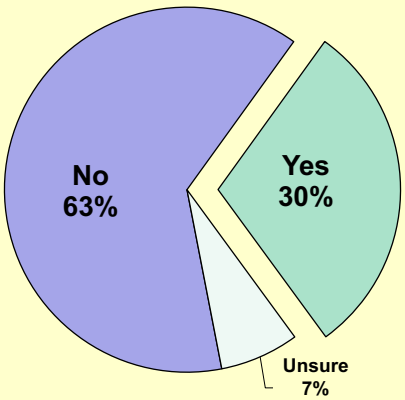
WORK STATUS AND COVID-19 IMPACT

NUMBER OF HOURS WORKED PER WEEK (MEAN)



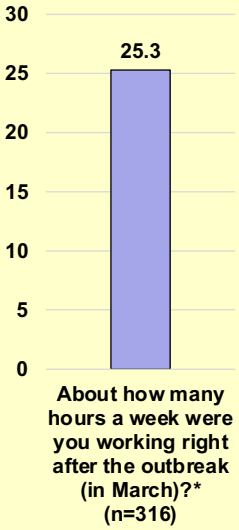
HOURS REDUCED DUE TO COVID-19:

Were your hours reduced right after the COVID-19 outbreak? (n=1,136)



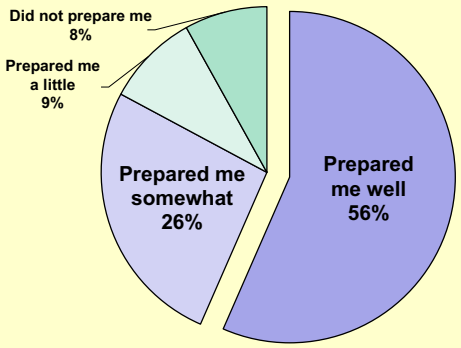
HOURS WORKED PER WEEK RIGHT AFTER START OF THE COVID-19 THE OUTBREAK (MEAN)

This question was only asked to those that said their hours were reduced right after the COVID-19 outbreak.

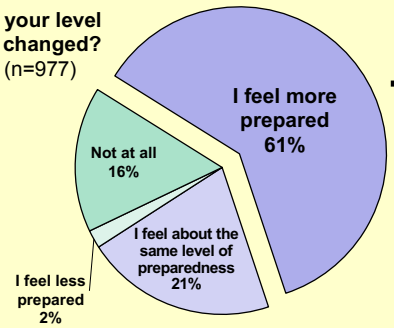


HHAs' PERCEIVED PREPAREDNESS FOR COVID-19

A. **In the beginning of the outbreak in general, how well did [employer] prepare you to respond to the COVID-19 outbreak?** ***You may think of areas of handling personal protective equipment (PPE), infection control procedures and knowledge, and other safety issues.*** (n=983)



B. **Over time has your level of preparedness changed? Would you say...** (n=977)



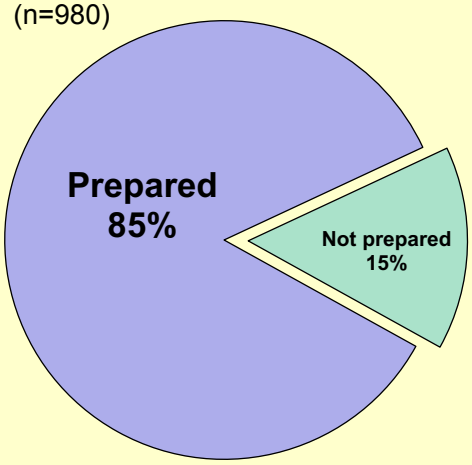
HHAs were considered "prepared" if they said:

1. **Their employer prepared them well in the beginning of the COVID-19 outbreak** (question A)

and/or

2. **They feel "more prepared now" than at the beginning of the COVID-19 outbreak** (question B)

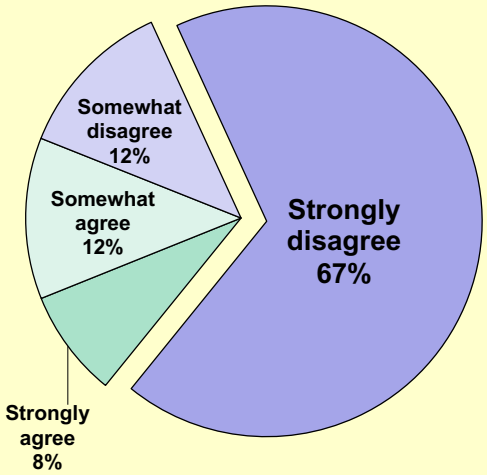
(n=980)



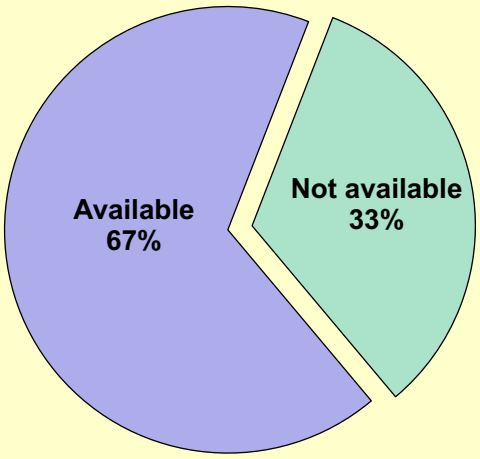
PANDEMIC WORK AVAILABILITY

AVAILABILITY:

Indicate how much you agree or disagree with this statement:
"I called out during the COVID-19 outbreak more than I usually would."
(n=943)



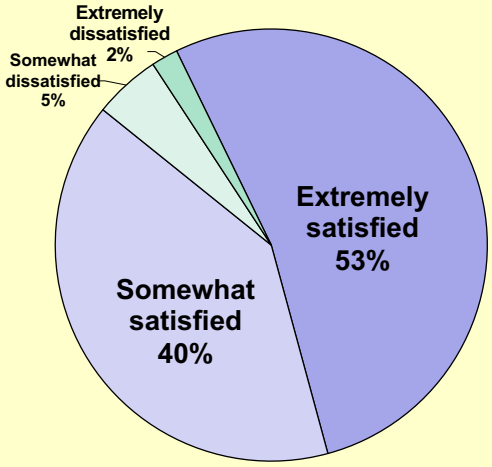
HHAs were considered "available" if they indicated that they did not call out from work during the COVID-19 outbreak more often than they usually would. (n=943)



COVID-19: JOB SATISFACTION AND POTENTIAL TURNOVER

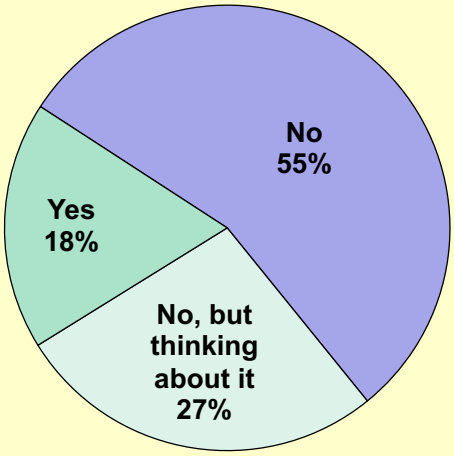
JOB SATISFACTION:

How satisfied you are with your current job as a home health aide at [employer]? (n=833)



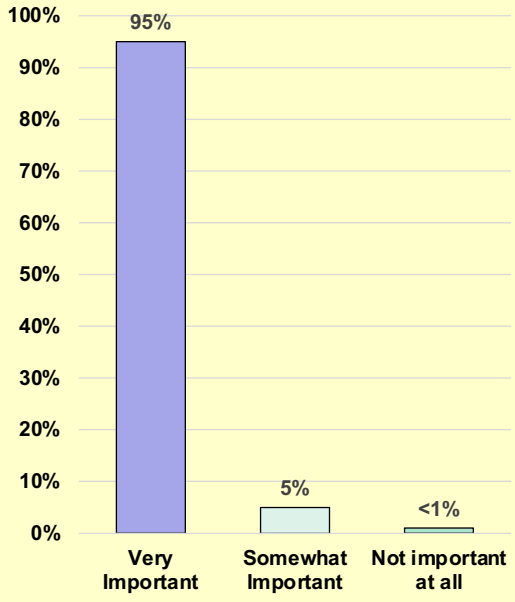
LOOKING FOR ANOTHER JOB:

Are you currently looking for a different job either as a home health aide or doing something else? (n=836)

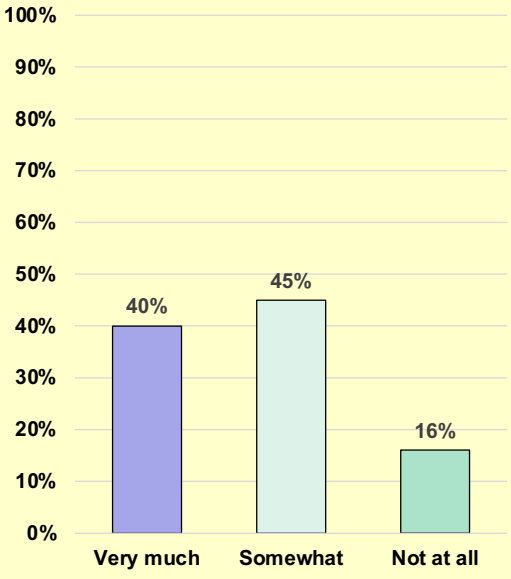


HHA PERCEPTION OF HOW IMPORTANT THEIR WORK IS VERSUS HOW VALUED OR APPRECIATED IT IS

How important do you think your work as a Home Health Aide is? (n=886)



How much do you think society values or appreciates your work as a home health aide? Would you say…? (n=890)



Narrative of Themes Identified from Focus Group Interviews with Home Health Aides: Experiences and Perceptions During the COVID-19 Pandemic

November, 2021

Background

This study component explores in-depth the COVID-19-related experiences and perceptions of Home Health Aides (HHA) approximately a year after the initial arrival of the COVID-19 pandemic in NYC. We conducted six virtual focus groups with HHAs to examine: (1) their concerns and the challenges they faced throughout the pandemic, (2) the role that home health care agencies played in supporting HHAs during the pandemic, and (3) lessons learned from HHAs' COVID-19 experiences that could inform future preparedness efforts in home care and its delivery. Thematic analysis was used to code and categorize interview excerpts. The narrative below details findings related to each of the research objectives described above.

Home Health Aides' Concerns and Challenges Throughout the COVID-19 Pandemic

Work Dried Up: Financial and Economic instability

HHAs highlighted the precarious nature of their work, including fluctuations in their work hours without a guarantee of work being available and the absence of paid sick leave. While these issues were problems with direct care work before the pandemic, they became worse during the pandemic. For instance, the pandemic highlighted how HHAs were not offered paid leave when they had a suspected exposure to COVID-19, or became sick themselves from the virus following an exposure at work. These aspects of their work generated financial uncertainty and emotional distress for HHAs, due to an unreliable income stream, made worse if they contracted COVID-19. Aides expressed concerns about their financial security, including declining cases that they might otherwise accept due to fear of exposure to COVID-19, the need to find additional work, sometimes at other agencies, when available cases became scarcer.

> "*One concern I had is that, if ever I were to come down with COVID, … I would be basically knocked out of… any work at all which could be disaster*" [Home Health Aide, Focus Group May 6]

Scared to Death: Concern for Personal and Family Safety

HHAs expressed concerns for their personal and family safety. In the early days and weeks of the pandemic, HHAs noted a lack of Personal Protective Equipment (PPE) and saw their jobs as placing them and their family members - including family members with chronic conditions - at increased risk due to close personal contact with clients and others in their homes. Aides also expressed a sense of personal responsibility for mitigating the risk of transmitting of COVID-19. HHAs level of concern and perceived safety was related to their case characteristics and client relationships. For instance, HHAs who cared for longer-term "*permanent*" clients tended to feel more comfortable with their day-to-day work and safety compared to HHAs who cared for

shorter-term post-acute clients. This was because HHAs could better gauge longer term clients' infection prevention and control precautions and negotiate mitigation practices.

> "*I had two permanent cases in the week and on weekends … but, for the first time I became very concerned too about you know my own safety. Yes, I talked to about my clients, and would there be other persons in the home and the how careful will they be about the protocols issued, so you know, I was very reluctant to tell the truth about accepting other cases that were sent on my day off [short-term assignments] … I found that my two cases, they were very, very careful about not contracting COVID and so you know I felt very safe.*" [Home Health Aide, Focus Group May 6]

Unknowns and Dangers: Commuting on Public Transportation and Client Risk Awareness

Aides described a New York City that was on edge during the first wave of the pandemic, highlighting tense interactions on public transportation and passengers who refused to wear masks or maintain physical distance with others on buses or trains. Aides expressed a concern for their personal safety and were exasperated at passengers who refused precautions. Owing to these circumstances, some HHAs limited their caseload to clients within walking distance of their homes, to minimize use of public transportation.

> "*I see a lot of people still come on the train not even wearing a mask when I'm in a car and somebody come close to me. And they didn't have a mask when the train stops. I move from the side or go to another car because um if you don't wear a mask you're not going to come close to me at all.*" [Home Health Aide, Focus Group, June 3]

Beyond transportation, HHAs faced challenges with navigating new cases. That is, many were left unaware about the situations they would encounter when they walked through the door. For instance, aides described how they did not receive disclosures from their agency about the COVID-19 infection status of their clients, and that this made them feel less prepared when they entered a client's home for the first time. Additionally, family members living with the client may not have practiced COVID-19 precautions and may have visited during HHAs' shifts without them knowing, leading to tense interactions with some clients who refused to wear masks or adhere to infection prevention precautions. Some aides described being asked by patients to take their masks off.

> "*We didn't know what we were walking into some of the buildings, I went into I don't know anything I was just going in blindly.*" [Home Health Aide, Focus Group, April 28]

Keeping Calm: Home Health Aides Provision of Emotional Support to Clients

HHAs provided (uncompensated) emotional support to their clients. While not limited to the pandemic, emotional support featured prominently in their work during this period. Clients were often confined to their homes and had little interaction with the outside world, especially those who lived alone or lacked immediate family who would visit them. Aides spoke about

how their clients were often scared, frightened, and concerned about becoming infected with COVID-19. Aides provided reassurance and emotional support to their clients, and served as a lifeline of information about the pandemic and related events.

> "*Most people live by themselves, there's so much you could do for person who has no family lives by themself so by you coming everyday showing up you know you've given them, you know happiness and you know they happy to see you, and that that keeps them going ... A lot of them don't understand what's going on, so by you talking to them, explaining to them, they feel more comfortable you know what you underneath you know they relax*." [Home Health Aide, Focus Group, July 1]

<u>The Role of Agencies in Supporting Home Health Aides During the Pandemic</u>

No One There: The Role of Supervisory Interactions and Supports for Home Health Aides

Supervisory relationships played an important role in HHAs experiences during the pandemic. However, HHAs described contrasting degrees of supervisory communication and support. Those HHAs who were able to reach their supervisors by phone or messaging application expressed appreciation for their role in providing support and helping them navigate work issues, as well as arranging for PPE deliveries when they were running low on supplies.

> "*There was a supervisor who called me once in a while to see how we were doing. You know, it was a good call and I found out, I was not the only one that didn't get PPE. The lady called me one day and asked me when I told her that I was out of PPE. Three days later. There was a big package.*" [Focus Group, April 19]

Supervisors served as information resources, and a lack of communication with supervisors left HHAs feeling isolated and unsure about their work.

> "*I feel they [supervisors] could have done better ... Nobody check up on us, nobody see how we're doing. 'Are you guys okay?', 'Do you guys need anything?' 'Is there anything we can do?' No. They're only going to call us when 'Hey, we have this hours, this place, Can you go?' Yeah, that's how it works..*" [Focus Group April 28]

Additionally, supervisory approval was needed to obtain N95 masks and to make changes to workplace policies affected by the pandemic, such as restrictions on accompanying clients to hospital waiting rooms and doctor appointments.

Missing It: Supplies and Receipt of Personal Protective Equipment by Home Health Aides

HHAs reported variable experiences with receiving PPE from their agency. Some aides described not having adequate supplies of PPE for their visits to clients. This was especially common among aides who spoke about the early months of the pandemic when masks and gloves were scarcer. Inadequate supplies of PPE led some to pay out of pocket to purchase

masks. Aides' concerns about PPE were magnified when they felt sick or were unaware of actions to take to keep themselves and their clients safe. While mail packages were generally seen by aides as a successful method to transport PPE supplies from the agency to their homes, not all of the aides we spoke with received their PPE packages due to mailing and other address issues. Additionally, aides would also provide PPE to their clients and family members when they lacked supplies, further limiting their available PPE stock. PPE supplies became more readily available later in the pandemic (by the Summer and Fall of 2020).

> "*The PPE I don't have those. I didn't have mask. I didn't know what to do … I was scared.*" [Home Health Aide, Focus Group, April 19]

Feedback and Discussion: The Role and Importance of Emotional Support Groups

While they were not always easily accessible during a time when they could attend, HHAs expressed appreciation towards the emotional support groups organized by their agency. Aides saw support groups as helpful. However, they also placed importance on being able to immediately reach their supervisor, which was seen as being equally (or even more) important than support groups during moments of stress. Aides suggested that "*sometimes you need the immediate feedback*" associated with being able to reach an agency representative on the phone system.

> "*I'm also someone who often could not participate [in the emotional support group], because of the schedule… Often I get a frail patient and we're in the bathroom so we can't even reschedule. We're on the job - that kind of thing is less supportive … You sort of get a 20/20 hindsight. Sometimes some very interesting information and discussion comes out of [the support group] but, again, it's after the fact and it's not being able to talk to someone at the moment about a concern… The problem is long gone, and you've made your decisions and that kind of thing.*" [Home Health Aide, Focus Group, May 6]

<u>Preparing for a Future Pandemic; What Did Aides Learn? What do Aides Want?</u>

Bottom of the Food Chain: Recognizing the Essential Role of Home Health Aides

Despite perceiving a lack of recognition from the healthcare system and public at large, aides were motivated to work during the pandemic by a belief that they provided essential services to clients. Their essential work included both physical assistance as well as emotional support for clients. They recognized that many clients they served lived alone and lacked support from family caregivers. Aides expressed that they hoped the public would recognize their contribution as essential workers and offer similar appreciation and support as to that which was offered to other healthcare professionals (e.g. doctors and nurses). Aides expressed frustration with their perception that they were not always recognized as essential workers. They expressed frustration with the insufficient recognition they received for the perceived risks they were taking (e.g. close contact with clients who may have COVID-19).

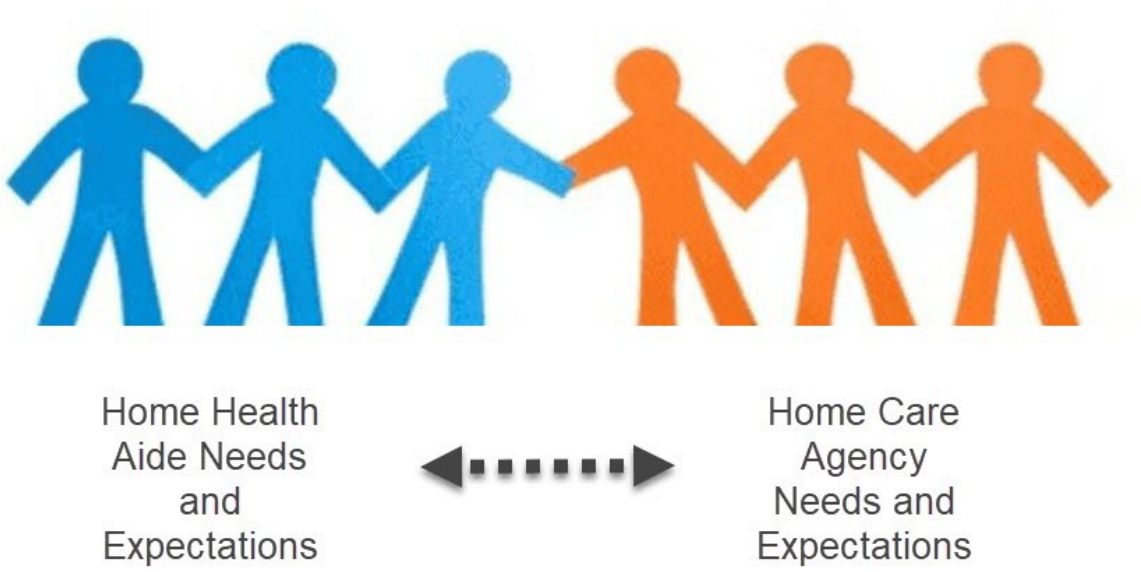
> "*I'm proud to be a home health care worker … without us I don't know what people will have done during the pandemic.*" [Home Health Aide, Focus Group, April 19]

Prepared for Anything: Promoting a Resilient, Prepared, and Knowledgeable Workforce

When asked about their lessons learned from COVID-19, HHAs described their resiliency in the face of challenges and a mentality that they must be prepared for anything. This belief that they must be prepared for anything was related to the observation that they often do not know what they are walking into when they visit clients. To cultivate and maintain a strong workforce of HHAs, aides expressed a desire for greater transparency in the risks associated with their service delivery, including information about COVID-19 exposures, and stronger communication lines between aides and supervisors during emergency situations.

PANDEMIC PREPAREDNESS: SUPPORTING THE HOME HEALTH AIDE WORKFORCE

Themes Identified from In-Depth Interviews with Leaders of New York City Licensed Home Care Service Agencies and Other Home Care Stakeholders



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Background

The purpose of this project is to promote preparedness and increase support for the home health aide workforce in ongoing and future communicable disease crises – especially but not exclusively widespread events such as COVID-19. The attached narrative is a compilation of findings from 18 interviews we conducted with New York City (NYC) home care stakeholders approximately a year and a half after the onset of COVID-19 in NYC. The experiences and perceptions of licensed home care service agencies were the main focus of our interviews. We interviewed leaders from a cross-section of 11 agencies to explore: (1) the concerns and challenges they faced throughout the pandemic; (2) the ways they communicated with and supported their home health aides during the pandemic; and (3) lessons learned that could inform workforce preparedness in ongoing and future communicable disease crises. Interviews with stakeholders from other sectors (union, provider associations, and government) complemented the agency interviews, providing different perspectives on the same issues. Thematic analysis was used to code and categorize interview transcripts, and direct quotations from interview participants were extracted to illustrate the themes we identified. The findings presented below are organized according to five topics that will be the focus of panel discussions. We believe the challenges we have defined and the themes we have derived are relevant to a broader group of home care organizations than those we interviewed. However, because this was a qualitative study conducted in one city, our findings may not reflect the experiences and views of stakeholders in other areas.

Health Risks, PPE, and Vaccination

Problem Statement

Home health aides are at high risk of infection due to difficulties in accessing personal protective equipment (PPE) (for themselves and their clients; for use on the job and in between clients). Aides were apprehensive about accepting new clients and short-term cases because of unknown health risks and the uncontrolled environment in the client's home. Aides weighed the risks of contracting COVID-19 with benefits and perceived risks of vaccination and felt that concerns were not always adequately addressed. With the institution of mandates, a significant portion of aides in New York State (NYS) received the COVID-19 vaccination, but many did so with residual concerns and sought more information about their development and efficacy. This may have consequences for future initiatives as well as workforce retention.

Health Risks, PPE, and Vaccination

Every agency leader we interviewed was acutely aware of the risks to health and life faced every day by their aides in the field, and PPE was their number one challenge at the outset of the pandemic.

> *How do you tell New York City on March 16 we're shutting down, stay home unless you're an essential worker. Oh, you essential worker, you go risk your life. You go out and risk your life…but we don't have any PPE. We were calling the Department of Health regularly*.

PPE Access and Distribution

Distributing PPE and determining the appropriate level of PPE to be used by the aide in the presence of a COVID-positive client were challenging. In addition, aides had to be fit tested, supplied with the proper sized mask, and trained to appropriately don and doff PPE – daunting tasks given social distancing requirements and a dispersed workforce. Further, many agencies provided masks to clients to wear while the aide was in the client's home. However, masks generally were not provided for other persons in a household, presenting additional health risks to the aide, with concomitant concerns about entering a client's home.

Procuring and Distributing PPE:

Agencies went into high gear to *secure PPE* at the outset of the pandemic, and they emphasized the importance of building up a stockpile to be ready for what might come in the future. Multiple strategies – often more than one at a time – were deployed to acquire PPE. These included: 1) designating an internal point person and a team to contact every commercial supplier known to the agency; 2) using an outside purchasing agent; 3) tapping into local government and union resources when available; 4) working with the Greater New York Hospital Association to gain access to hospital supply lines; 5) calling on the contacts of agency board members; and 6) where an organization had agencies in other regions, redistributing PPE from lower needs areas to NYC.

> … *there was a tremendous shortage of supplies, and costs tripled at one point for masks. They've come down considerably now…gloves were really, really difficult to acquire at any reasonable price, but you had to pay for what you had to pay… our purchasing agent did a good job and kept everything going.*
>
> *We worked really hard to identify, order, and procure supplies for our direct care workers in all of our locations…We were shipping and trying to deal with things in seven different states and multiple offices in different states.*

Different methods to *store and distribute* PPE – sometimes defined as a 6-month inventory – included: 1) appropriating existing storage rooms and sacrificing offices; 2) sending aides home with two-week supply bundles to reduce the frequency of travel to central or regional dispensing locations; and 3) identifying most-at-risk clients and those with the longest hours, and "triaging" distribution to aides serving those clients.

> *…the biggest lesson we learned: we've established an offsite storage facility that we plan to keep fully stocked going forward. In hopes of, you know – not in hopes of it, but in case there is a similar type of pandemic.*
>
> *…it was hard, but we were able to procure in larger numbers… And the goal was to have enough supplies to provide to the aides in two week cycles.*

Fitting and Using PPE

The agencies in our sample faced logistic challenges in preparing aides to wear and use PPE properly. N95 masks required fit testing for safe use and recommendations for their use continually changed.

> *…you need to use N95 masks because the CDC recommended. Okay, so for this distributed workforce, how do you fit them? … And say we're using an N95, if they don't fit, it's a waste of the mask. So, there's a lot of things that, you know, policymakers made decisions on very easily, thinking that the workforce is all coming to one facility, or the factory floor … They don't think about the distributed nature of home care…*

<u>Screening for exposure, symptoms and positive diagnoses</u>

Devising screening tools and methods to obtain daily information from aides about their COVID-19 exposure and symptoms posed yet another challenge to agencies. In most cases obtaining and transmitting information started out as a phone, email, and/or text process. However, as agencies were able to tool up existing technology, information was increasingly transmitted electronically (e.g., through electronic visit verification systems).

> …*we created a screening tool that if anybody had any symptoms they'd complete, and then it will be sent to our clinical department, which is in our corporate office, and it would be evaluated and their determination will be made, what the next steps were, they couldn't work until they got cleared.*

<u>Repercussions of health risks and safety issues</u>

Difficulties accessing and using PPE, uncertainly about what an aide would find in a client's home, as well as exposure to and/or diagnosis of COVID-19 led to an increase in aide "call outs." This, in turn, made it difficult for agencies to meet the needs of their clients.

> *…the shortage remains today. We never had so many open shifts in my history working with this organization. When I look at it now, almost every single day, it looks like a day before Christmas, you know, and we would have that many open shifts for Christmas or Easter or something like that. It's just Christmas every day now. It's absolutely staggering.*

Vaccines

Once vaccines became available, agencies focused on increased outreach to aides to educate them about the vaccine, answer any questions, correct misinformation, and encourage them to be vaccinated. The agencies also had to develop means for reliably tracking the vaccination status of their workforce. After vaccination was mandated, agencies had to strategize how to best staff cases in the event that aides continued to decline vaccination and were not able to work.

Outreach pre-mandate

> *I think a lot of the resistance we're encountering is due to people who have misconceptions about the safety of the vaccine, misinformation, maybe they've read certain things online that really don't make a lot of sense, but they believe that could happen.*
>
> *We did everything for our aides and patients to get them vaccinated. We made appointments for people, we had them talk one on one with a nurse to explain the benefits of the vaccine, and we're still in the area of 40%.*

Preparation for the mandate

> *… I think as we've come out of the pandemic…we don't have workers anymore. …. When the vaccination mandate goes into effect, we are going to have even more of a problem…and if we have people pulling out of the workforce, or we have trouble tracking down documentation that they've been vaccinated, and we're gonna have to deal with that, and there's been no recognition of the increased costs.*
>
> *… ultimately, we have a roadmap in place -- as we get closer to the deadline, aides who are still resistant will receive individual calls from our nurses … to try to alleviate their fears.*

Financial Instability and Work Access

Problem Statement

The intermittent nature of aide assignments, significant reductions in hours worked, challenges in transportation, lack of paid leave, and increased costs for childcare and other work-related items, exacerbated in a pandemic situation, created financial hardship for aides and their employers.

Financial Instability and Work Access

Both licensed agencies and home health aides have faced financial instability due to COVID-19. Agencies faced reduced demand for services at the height of the pandemic due to clients' fears of becoming infected or, in some cases, the availability of household members to assume caregiving duties. For some agencies, business was down 20% or more. Home health aides faced significant reductions in work hours due to the reduction in service demand and fear of infection from exposure to infected persons. The intermittent nature of aide assignments, significant reductions in hours worked, lack of paid leave, and increased costs for childcare and other work-related items created financial hardship for a significant proportion of aides.

<u>Licensed agencies: lower revenues and higher costs</u>

For many licensed agencies, the costs of doing business under pandemic conditions were high, and for the most part the agencies were on their own, whether that meant finding and buying PPE; upgrading information systems; giving aides a bonus or hazard pay to retain them; subsidizing transportation costs to ensure that aides made it to clients' homes; or paying higher unemployment insurance rates due increased numbers of aides who opted for unemployment – all the while contending with a worker shortage. One way agencies dealt with the worker shortage and reduced clients' exposure to possible infection was to pay aides overtime, adding even more expenses to agencies' balance sheets.

> *During the pandemic, overtime went up because agencies and workers wanted to protect the clients they were caring for. Families didn't want five aides; use of overtime allowed the same worker to stay in a client's home and avoid multiple aides.*

Several agencies placed the blame for their increased expenses on New York State and Managed Long Term Care systems (MLTCs).

> *There has been no financial support from the state. There have been no increases in MLTC rates, there has been no money passed through to help support PPE purchasing. There's been nothing, whether it's PPE, sick pay, or overtime, there has been no acknowledgement financially from the legislature, from the executive branch.*

Agencies that operated in multiple states noted the stark contrast between how other states responded to their needs during the pandemic and how New York responded.

> *We are in six other states. We had financial support from five of them – Illinois provided monthly payment add-ons to pay for PPE and you could apply for additional financial support. In New Jersey, you could apply for COVID funding. In Massachusetts, they took the reduced medical spending from their managed care plans and had them pass it through to providers. North Carolina did rate increases to pass through to the workforce. Connecticut had a fund that you could apply to get financial support for PPE and other COVID related expenses. New York had nothing… It's just frightening.*

Somehow the New York agencies managed. At times it came down to "who you know." For example, those agencies that had strong relationships with foundations were able to get grants to help pay for PPE, transportation, and extra pay for the aides, but not all costs were covered by grants or financial assistance from other entities, and some agencies just went ahead and paid for equipment and extras out of pocket. Agencies with a national reach seemed to be in a better position to absorb these costs than smaller agencies.

> *Managed long term care plans could have helped us by giving us the money to pay a differential to the workers who continued to work. We raised it through philanthropy. I mean, look, there were fewer hours being delivered. So they [i.e. the managed long term care plans] had to have been pocketing the surplus…Supports for extra care meetings, phone calls, extra counseling sessions, we did all that stuff on our own dime. It was pretty frustrating to see the parts of the system that are better resourced …and then parts of the system that aren't but were willing and able to step up, and nobody was helpful, and I'm still pretty pissed off about it. We provided a pay differential to some people (one or two dollars) and we did that for as long as we could, where it was going to be important to keep services in place for high-risk clients.*

> *We did not have a grant, the Union helped us with some travel. If you could not get to work, and you called me and said, you know, I really can't get to work and we needed to get you to work…we put you in an Uber …. there was really nothing that we wouldn't do.*

> *I think that we were fortunate to have the broad shoulders of a national company behind us, so we were able to do things, like transportation, like Metro cards, like PPE for them and their family, for their patients. A lot of others couldn't.*

Home health aides: reduced hours and financial uncertainties

According to a survey of home health aides conducted by the Center for Home Care Policy & Research, seven out of every ten aides reported that they never turned down work for COVID-19 reasons. But about a third of aides reported a reduction in work hours, averaging about 10 hours per week, and a quarter of the sample reported problems paying their rent or mortgage.

Home health aides were in a very difficult position: Go to work and risk getting infected; stay home and lose pay and benefits. Although some agencies were able to provide the aides with hazard pay or bonuses, these were not large enough to motivate many aides who were staying at home to avoid being infected with COVID-19 or care for others. The situation improved markedly for stay-at-home aides who were eligible for unemployment insurance payments when the federal government approved the $600 unemployment insurance add-on. The unintended consequence of this development, however, was that aides were suddenly making the same amount or more money from unemployment benefits than they had when they were working. Licensed agencies that had already been struggling to recruit additional aides suddenly became competitors with the federal government.

> *It's hard for them to come back when they were being paid more to stay home. And that's what we did for a year and a half, we (i.e. the government) paid them more to stay home than we did for them to go to work. And that's a hard choice for people.*

> *I think at the height of the pandemic, at one point, we had 500 aides refusing to work due to a COVID reason. And we have not really seen much relief on that for recruitment till the last three weeks when they ended the unemployment supplement.*

The pandemic has been hard on everyone, including licensed agencies and their home health aides. Summing up the range of their agency's pandemic era experiences, one respondent said:

> *We saw the best of the best. And then we saw the worst of the worst. I had nurses say, I'm not coming to work anymore… and then you had aides who would come to me and say, "any COVID patient just give them to me, I will take them. I can't sleep at night thinking that people won't take care of them."*

Home care: An under-resourced system, with negative consequences

Many of our interview participants mentioned that they were frustrated, disappointed, and even angry about the treatment of licensed agencies and home health aides during the pandemic.

> *At no point did the state say you are valuable, you are the resource that we need. And at no point have they come and said, let us help you.*

This points to a larger issue about the chronic lack of investment in home-based care over many decades. As one agency representative put it: "*Everybody wants homecare, but no one wants to pay for it."* The implication is that until there are major investments in the homecare industry, it will continue to be the "poor relation" in the larger healthcare "family."

> *You can't recruit workers into this industry unless you start dealing with wages, unless you start dealing with some of the other challenges on the workforce side of things. And, there are a lot of expenses that employers incur, that are ignored over time – all sorts of different little nuanced costs that are there for a reason, and particularly for the workers. And it's all well deserved. But unless there's an investment in this sector, none of these problems will be solved. That's the challenge… And I really wish I had the answer.*

Communication and Emotional Support for the Home Health Aide Workforce

Problem Statement

Aides' reports on satisfaction with the level of communication and their ability to reach their supervisors varied. It is unclear what types of information and modes of communication work best. Stress levels were high, particularly at the beginning of the pandemic, but also continued for months into it. Reports from aides were mixed on receiving emotional support or being able to access available emotional support programs when offered.

Communication and Emotional Support for the Home Health Aide Workforce
From the outset of the pandemic, agencies faced the challenge of sifting information, deciding what to communicate to whom, and transmitting it most effectively. Intermittent and inconsistent information came from multiple governmental and private sources. But frontline aides needed clear, concise information via the right medium at the right time. Aides also needed emotional support to help them manage uncertainty, stress, and anxiety. Agencies employed a variety of strategies to address these challenges.

<u>Communication demands</u>

Communication demands on agencies took multiple forms, each requiring somewhat different information, communication modes, technical resources, and support mechanisms. Demands included:

1. General information about the pandemic, signs and symptoms of illness and ways to prevent individual and community transmission
2. Information for the entire aide workforce about procedures and protocols to keep aides safe on the way to work and in clients' homes
3. Region-specific information on where, when, and how to access PPE
4. Precise, individualized information on client assignments and schedules
5. Timely responses to myriad, individual questions or concerns that arose when an aide was in a client's home
6. Daily, reliable screening data on an aide's potential COVID exposure, symptoms, diagnoses, or suspected infection
7. Emotional support to help aides manage personal and job-related fear and stress
8. Assurance to clients and families that aides would protect their health and safety

Much of the information to be conveyed was top-down from employer to aide. Information on COVID exposure or illness was bottom-up from aide to employer. In some instances (e.g., answering questions, addressing concerns, providing emotional support) effective communication required timely and sensitive interaction between the aide, the aide's first line supervisor (the field coordinator), and a case manager, nurse or other clinician responsible for the client's care.

Imperfect information

Information came from diverse sources – the CDC, the governor or mayor, state and local departments of health, the Medicaid bureau, provider associations, the media, and others. Information from even one source could be vague, conflicting and/or confusing.

> *Our biggest frustration was the mixed messaging and the changing…. No matter what the situation is, it would be better to have one voice—the state, the city, or the CDC – so that you have one way of communication, not everybody making up their own rules that affect the way we operate. Because you're constantly switching gears and, you know, people work better in a consistent environment with a consistent message.*

Varied levels of technological sophistication

Technological sophistication and technology solutions varied across agencies. Early in the pandemic, phone calls, broadcast texts, and individual text messages were the predominant form of communication. The lack of agency-provided cell phones, aides' hesitance to use a personal cell phone for work and/or their lack of an email address, all resulting in incomplete contact information, hampered communication.

> *We're trying to get the aides comfortable with using the cell phone so we can broadcast text messages. We do broadcast emails. Every aide has a cell phone these days, you know, some of them are a little more challenged….*

Social media platforms, video and other web-based communications were used by some agencies to complement or fill the void in personal contact data. Over time, a number of agencies, often with the help of technology vendors, were able to adapt existing electronic visit verification or record systems to facilitate communication with their aides. Paying a vendor or purchasing a platform, however, was another unreimbursed cost incurred in a period of declining agency revenues.

> *I think we've made leaps from where we were before this to where we are now and to be able to communicate with the aides. Through that we've built a database of email addresses and phone numbers and alternate phone numbers.*

Use of technology to advance the role of the home health aide

In several cases the pandemic accelerated agencies' prior plans and efforts to better integrate aides and coordinators into the client's care team. With the help of outside vendors a few agencies began to adapt their electronic visit verification or electronic record systems – and even a prototype telehealth application – so that aides could capture client observation data and enter it directly into an application via cell phone or tablet. Others informally encouraged coordinators to elicit aides' observations about noticeable changes in a client's condition and to communicate that information to clinicians or case managers.

> *We've been hoping that the [coordinator's] role will change more away from, you know, here's your schedule, and make sure you clean the bathroom or whatever, to more of a "have you noticed any changes in the condition of the consumer," and then their role would be to liaison with…the case manager or nurse or physician or somebody else to communicate those observations – upstream to the more physical health providers.*

Varied reliance on field coordinators as sources of information and informal support

Just as agencies varied in technological sophistication, they varied in how they mobilized staff to communicate information and provide support. For the most part, agencies expected that their field coordinators – the aide's first line supervisor – would be readily available to address the aide's or the client's COVID-related concerns.

> *The coordinator's role is to support the aide and help with communication between the aide, the client, and the care manager. I don't think that generally changed how they [the coordinators] did it. The subject matter changed but no, their role did not.*

A few agencies adopted a coordinator "role model" approach. The aim was to demonstrate that field coordinators, like aides, were continuing to work "as normal."

> *That way we could say we understand you're scared, everybody's scared. But we're out there too. We took the subway to get in, we're in this together, we're doing what we need to do to be there for our clients. And… that was probably one of the most effective things we did to keep our aides going.*

Reactive support strategies

Interview participants said they realized early on that aides were in need of emotional support if they were to continue to provide client care in the face of COVID-19. In addition to concerns about their own health and safety, many aides were dealing with loss of clients, friends, and family members. Anxiety was high.

> *One of the biggest challenges at the start of the pandemic was trying to manage fear among the staff, the aides, as well as our clients and families…I think we've been in a reactionary mode.*

> *I think in terms of the workforce, giving enough support to the aides, that was the biggest challenge and making sure that they are comfortable going to work... Everybody was at risk, but I think we've done our best.*

Agencies used a variety of approaches. Informal support was a central piece.

> *We never had a shortage of people saying – 'how are you holding up', you know, giving them support, letting them know we're there for them if they need us, maintaining the open line of communication for, you know, the worst.*

In addition to informal support some agencies referred aides to their employee assistance or union benefits funds.

> *We have an employee assistance program through our medical plan. So, any employee of the company, whether you're enrolled in our medical benefits or not, was able to call, they have 24-hour helpline. So between that, and also the union medical plan, we were able to give out numbers so that anybody could reach out, especially around you know, we lost a lot of patients and a lot of aides during this. So there was a lot of need for support.*

One agency incorporated a session on managing stress into its COVID-19 training program. Another implemented twice weekly emotional support calls, which were well attended but inconveniently scheduled for some aides.

Overall, however, managing the logistics of daily operations and pandemic-related financial issues took precedence over developing formal strategies to provide emotional support to frontline aides. The sense from interview participants was that providing emotional support in times of crisis is an area that needs future work.

You know, things are happening so quickly, and we were so focused on the PPE and service delivery...we've relied on our employee benefits assistance, but it's probably something you could do more with.

Home Health Aide Recruitment, Training, and Retention

Problem Statement

Nearly 40% of aides who responded to a 2020 survey did not remember any training related to public health emergencies prior to the COVID-19 outbreak; 20% still felt unprepared 5-6 months into the pandemic. Thirty-five percent said they were very or somewhat likely to leave their job in the coming year, while 30% reported they were more likely to call out after the outbreak of COVID-19 than before. Respondents who felt prepared were 20% less likely to call out than those who did not feel well prepared. These findings have potentially serious consequences for continuity of care not only in current or in future pandemic conditions but in normal conditions as well. Agency leaders report significant concerns about recruitment and retention of this workforce.

Home Health Aide Recruitment, Training, and Retention

When the pandemic became a reality, the licensed agencies in our sample quickly realized that routine state-required training for home health aides would not be sufficient to address the exigencies of COVID-19. They faced three challenges: 1) rapidly assembling and distributing COVID-specific content; 2) providing 12 hours of annual in-service training in the midst of a public health crisis; and 3) recruiting and training a sufficient number of new aides to fill service gaps, meet rebounding demand as crisis conditions waned, and assure an adequate future workforce.

<u>Mandatory requirements and COVID-19 training</u>

New York State requires that licensed agencies implement disease prevention training for all personnel at the time of employment and yearly. The explicit purpose of the training is to prevent exposure to "body substances which could put [HHAs] at significant risk of HIV or other blood-borne pathogen infection [Italics added] during the provision of services." [https://regs.health.ny.gov/content/section-76611-personnel]. While much of this training may be applicable to COVID-19, its transferability may be neither complete nor obvious to a home health aide. Each of the agencies in our sample instituted COVID-specific procedures and incorporated them into COVID-specific training programs that moved from traditional vehicles – in-person, PowerPoint, text – to more sophisticated technological applications.

Infection control is part of our annual training, and the aides were comfortable. But in addition, we had clients recovering from COVID...And we took different precautions. Higher level PPE, like a gown, was needed and at that point … we

used nurses for one-to-one training. We also developed a PowerPoint presentation for the aides … And a little later we purchased [training] software.

We were very fortunate that we were one of the Workforce Investment Organizations, so we had dollars. We put together a training on COVID-19. We did some by zoom, some in person, but then we did move this to a learning management system. So we could do it – virtual training. And we thought it was so good. We eventually had all staff do it, not just the frontline staff.

Federal and state waivers

Several interview participants praised the New York State Department of Health for implementing a series of federally permitted waivers affecting both entry level training programs and the annual 12-hour in-service requirement for home health aides. The state waivers were issued in the form of "DALs" (Dear Administrator Letters) to licensed agencies starting in 2020, and were to be extended at the "discretion" of the Department until the "end of the first full quarter following the declaration of the end of the Federal Public Health Emergency" (21-09.pdf (ny.gov)), which was renewed in January 2022. At the same time, the Department informed agencies that "providers should immediately initiate efforts to restart these activities [including in-home aide supervision and in-home client assessments] and be able to demonstrate to Department surveyors that there is a plan in place for compliance as soon as practicable" (21-11.pdf (ny.gov)). In receipt of these letters, some agency leaders perceived that by late summer 2021, the waivers were being lifted with "little advance notice."

…the Department of Health was helpful in putting out certain waivers for in-service requirements and things like that, so we could focus on servicing patients rather than bringing in large groups of people for in-service education.

The state at the beginning of the pandemic provided quite a bit of policy waivers... And then by June, they started to rescind some of those waivers...I feel like now is just not the time …we're still dealing with the workforce crisis, trying to get aides vaccinated…

Virtual training "takes off" – supported by technology vendors and government waivers

At the outset of COVID-19, some of the agencies in our sample were at the early stages of technology adoption; others were relatively advanced. Equipping and training aides with devices, email accounts and applications so they could access technology for screening and in-service training [and other communications] was an immediate

challenge for some. A typical progression for an agency was from phone, text and/or email to social media to an app specifically tailored to home care training. Existing relationships with technology vendors facilitated this progression.

> *We were a very in-person training organization. We had not moved to different media, different platforms to train, remote training. But we did that very quickly. And set up…a YouTube channel, and some other mechanisms to do training on the PPE and infection control and COVID and things of that nature. We also transitioned the bulk of our in-services online….. It has worked….*

Recruiting new aides: online entry level training

Some of the agencies in our sample traditionally offered their own in-person entry level certification courses as a means for recruiting new aides. The pandemic interrupted these courses, impeding agencies' ability to recruit and prepare new workers, at least in the short run. The introduction of new on-line and hybrid training models introduced a new recruitment vehicle into the equation. How effective it would be in addressing long-term recruitment issues remained to be seen.

> *When the pandemic hit, it became a total crisis. Of course, because of social distancing, we had to suspend our training program for maybe about six months. I think we were actually able to resuscitate that class in the summer of 2020. The challenge we're currently facing is still adhering to some kind of social distancing. Because of our limited space, we're only able to train on average about 11 individuals. Now mind, you have 11 people in the class and then you have attrition, then you end up training the class with six or seven individuals. So it continues to be a challenge for us.*

Gradually, however, a few of the agencies received state approval to resume certification courses with a hybrid in-person/remote model – an option that the state instituted in the last quarter of 2020. (https://www.health.ny.gov/facilities/home_care/dal/docs/20-09.pdf)

> *We are one of the few agencies who got approved to do virtual, or this hybrid home health aide certification training. We don't love it, but we are finding it useful due to social distancing requirements, and it's a hybrid model. So it's not really Virtual Training, no one's gonna learn to be a home health aide on their own time...it's really face to face, like over zoom, but using a learning management system where small groups come into the office for certain hands on training.*

Rethinking in-person training

All of our agency participants saw advantages in remote learning, and all anticipated a future with significant redesign to accommodate a mix of in-person and online learning.

> *…the fact that we're able to now train online, I think was a really good lesson. The fact that we needed another way to certify people and onboard them without an in-person class. Like that was a big move for the industry.*
>
> *I think probably some of our trainers and our clinicians would agree that all training shouldn't be done online. You know, there's an importance to being in person. And obviously, there's some hands-on practical training, but not all didactic training should be in person OR online…. So, I think it worked. I think there are probably some positive takeaways for the future …there are opportunities to be able to do different things.*
>
> *You know, if a pandemic happened again, tomorrow, I could push out, you know, training courses on PPE, on COVID … they can see it on their phone, their tablet, their computer. And we can acknowledge that training. So, we learned that now, by having a telehealth program...that kind of resource is invaluable…and now in any emergency situation, we are so much more well equipped to handle it, whether it could be tornado, hurricane flood, whatever it may be. I think the industry has moved forward, probably 10 years in the past two.*

Home Health: An Essential Part of the Health Care System

Problem Statement

Despite providing essential client care and emotional support, home health aides were not treated like essential workers nor recognized for their contributions. New York State lagged behind other states in providing supplemental supports and programs to cover the additional financial hardships that developed during the pandemic.

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Every person we interviewed commented on the failure of policy makers, politicians, and the public at large to see home care as a vitally important service that complements, supplements, bolsters, and sometimes even substitutes for medical or institutional care. Several interview participants observed that the lack of recognition was all the more ironic as people sought alternatives to hospitals, nursing homes, and residential facilities – all COVID-19 hotspots.

> *Home care is more necessary now than ever. People don't want to go into hospitals. They don't want to even go to assisted living, because like congregate settings, like you're around a million people. Like homecare is saying it's the*

> *wave of the future. It 'is' the future. And the problem is that we haven't been recognized for what we have contributed and how necessary we are now.*

Essential Designation and access to PPE

The experience of accessing PPE for home health aides at the outset of the pandemic was emblematic of the larger problem of gaining recognition for the industry and its workforce. An executive order signed by former New York State Governor Andrew Cuomo in March 2020 (https://www.governor.ny.gov/news/governor-cuomo-issues-guidance-essential-services-under-new-york-state-pause-executive-order) included "home health care workers or aides for the elderly" in a list of "essential" workers. Nevertheless, this designation did not translate into ready access to PPE. The frantic process of obtaining PPE early in the pandemic affected virtually all healthcare sectors, but it seemed to interview participants that home care was among the last to receive PPE for their aides and clients.

> *I think we found, even at that early stage, a fundamental lack of understanding about what home care is, what hospice is, what they do, and why PPE was so important for home health aides. I remember seeing correspondence from the New York City Department of Health and Mental Hygiene, which basically established a list of those that could qualify for PPE from the stockpiles. Home care and Hospice weren't on the list.*

Lack of recognition: not a new problem

In some sense, the agency leaders we interviewed were "primed" to expect a lack of recognition, given what they perceived as the longstanding failure of policymakers to understand the importance of the aide workforce to the wellbeing of their clients.

> *I think that caregivers are undervalued. Clearly, the work that they do is undervalued… The safest place to be is in your own home…They should be dumping money into home care right now. I don't think we've done enough as an industry to stand up and scream that from the top of the rooftops.*