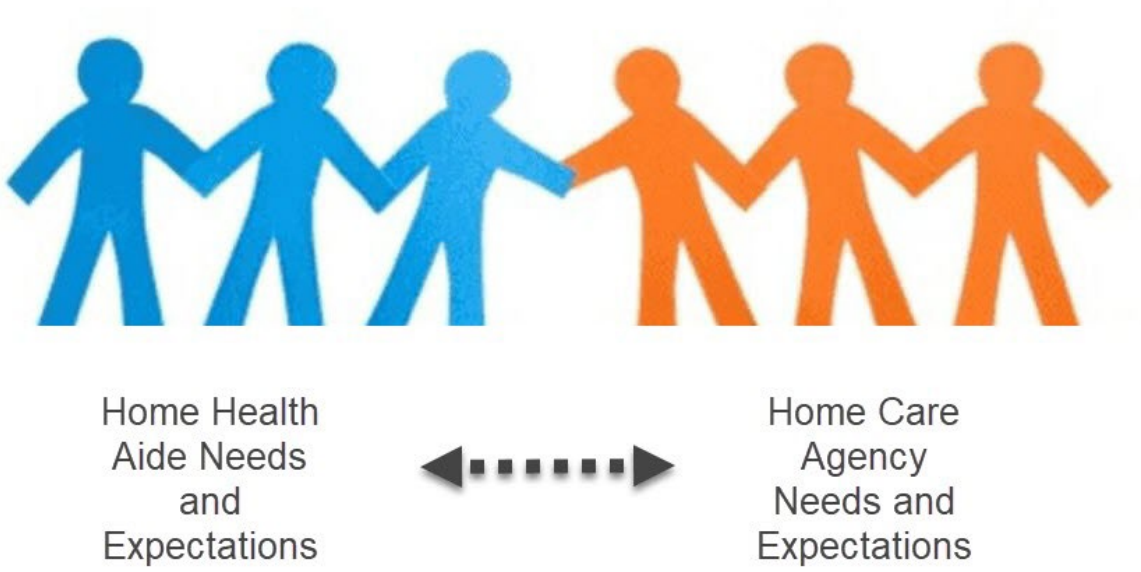
PANDEMIC PREPAREDNESS: SUPPORTING THE HOME HEALTH AIDE WORKFORCE

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



Citation: Feldman PH, Oberlink M, Onorato N, Russell D, McDonald MV, (2022). Pandemic Preparedness: Supporting the Home Health Aide Workforce - Themes Identified from In-Depth Interviews with Agency Leaders (Report). Center for Home Care Policy & Research at VNS Health. https://www.vnshealth.org/wp-content/uploads/2022/08/In_Depth_Interviews_with_Agency_Leaders_07_21_22.pdf

Table of Contents

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.

Licensed agencies: lower revenues and higher costs

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.

Home health: An essential Part of the Health Care System

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.*