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"A Major Issue": The Impact of the COVID-19 Pandemic on How Home Care Leaders Perceive and Promote Aides' Mental Health and Well-Being

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Abstract

Home care aides play a critical role in the care of older adults, but they do this under difficult working conditions. The COVID-19 pandemic exacerbated aides' stress and worsened their mental health, raising the question of how agencies can better support aides. We explore how home care industry leaders in New York perceived and addressed home care aides' mental health and well-being prior to and during the pandemic through in-depth interviews conducted in 2019 (n = 8 agencies) and 2022 (n = 14 agencies). We found that these topics became more central in leaders' thinking, reflected in a range of new internally and externally funded agency actions, albeit limited by ongoing financial constraints. Maintaining a skilled and reliable aide workforce is critical to societal health but will remain challenging without continued investment in aide support of the kind described in the Surgeon General's Framework for Workplace Mental Health and Well-Being.

Keywords

home care, workforce, mental health, stress, qualitative methods

What this paper adds

- COVID-19 created challenges for home care agencies not only in the realms of infection control and staffing but also around staff mental health.
- Home care leaders appear to be more motivated than in the past to address home care aides' mental health and well-being.
- In spite of motivation and effort on the part of some agencies, their actions remain constrained by limited funding.

Applications of study findings

- Actions and funding supporting the mental health and well-being of aides are needed to ensure a skilled and reliable aide workforce.
- Actions undertaken by agencies using existing funding sources should be rigorously evaluated to assess effectiveness and transferability to other agency settings.

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Introduction

As our population ages, people increasingly prefer to receive care at home (Binette & Vasold, 2018). Home care aides—who assist older adults and people with disabilities with the activities of daily living, instrumental activities of daily living, and health care support at home—provide the core labor fueling home care services (PHI, 2019). Not only do they provide the majority of the care hours delivered in the home, they also make important and unique contributions to the quality of care provided (Franzosa et al., 2018). While this work is sometimes intrinsically rewarding for aides, interacting closely with clients and families can be emotionally taxing, particularly when aides are isolated from co-workers, supervisors, and the protections of more traditional employment (Franzosa et al., 2019).

The history of domestic labor and racist exclusions from labor laws in the United States, as well as the fragmented structure of the home care industry, are key determinants of home care aides' health and well-being (Baron et al., 2022; Quinn et al., 2021). As a result of these factors, the hazards of aides' work are extensive, and come in physical, psychological, and structural forms (Baron et al., 2022). Aides' mental health, in particular, is underaddressed and multifaceted. For instance, research describes the many kinds of emotional labor and psychosocial stress involved in this work (Franzosa et al., 2019), as well as the prevalence of verbal and physical abuse (Karlsson et al., 2019). Additionally, client death, on which this study partially focuses, can produce grief and financial insecurity for aides and contributes to burnout (Boerner et al., 2015, 2017; Tsui et al., 2019). Notably, home care aides report worse physical and mental health than similar institution-based workers (Sterling et al., 2021). This is all in the context of social and economic marginalization, which affects the vast majority of home care aides who are disproportionately women and people of color, earn near poverty-level wages, and have limited access to health insurance and other benefits (PHI, 2019).

The COVID-19 pandemic exacerbated aides' stress and the challenges to their mental health. In addition to experiencing client, coworker, and sometimes family deaths, aides faced infection risks without sufficient personal protective equipment (PPE) and often insufficient work hours (Sama et al., 2020; Sterling et al., 2020). In a New York-city-based survey of aides, two-thirds indicated that it was harder to manage their mental health since the pandemic (Pinto et al., 2022). Research also shows that workers in long-term care experienced a dramatic increase in turnover during the pandemic (Frogner & Dill, 2022). Importantly for this study, research has also shown that a supportive work environment during the pandemic reduced work stress for aides (Feldman et al., 2023).

Home care organizations were thus challenged as they worked to respond to the needs of their patients and workers. They assumed new responsibilities around infection prevention and, due to their exclusion from many government-provided supports (Franzosa et al., 2022), leaders often worked tirelessly and against the odds to secure appropriate PPE and set up new screening and support systems (Franzosa et al., 2022; Sama et al., 2020). In addition, leaders had to figure out how to keep aides on the job under the increased psychosocial job demands described above (Markkanen et al., 2021).

Faced with urgent questions about how workplaces for the most vulnerable workers might support mental health and well-being, in this paper, we explore how home care leaders' thinking about home care aides' mental health (and client death) shifted during the COVID-19 pandemic, what steps they have taken to support aides' mental health and well-being, and what paths toward progress in this area might exist.

Methods

Design

This analysis is based on two interview studies with similar study populations and related purposes, spaced in time. The purpose of the 2019 semi-structured interviews was to understand how agency leaders in NYC conceptualized and addressed client death for aides, with the goal of developing stronger aide support around this work stressor. This topic provides a focused window into how leaders think about aide mental health and well-being, and their role in supporting aides. In exploring this, we also learned about agencies' efforts to support aides more broadly. The purpose of the 2022 semi-structured interviews was to share research findings on aides' experiences of client death and mental health support with some of the same agency leaders and some new leaders. We explored how they saw these issues during the COVID-19 pandemic and what actions they were taking. The 2022 interviews sometimes also included leaders' reflection on change over time. The two studies on similar topics with overlapping samples allow us to assess change longitudinally for a subset of agencies and to describe which mental health and well-being supports a diverse sample of agencies had put in place by 2022. Both interview studies were reviewed and approved by the CUNY Graduate School of Public Health & Health Policy IRB.

Recruitment and Sampling

In the first study, we conducted fourteen interviews with leaders from eight home care agencies in New York City. We purposively sampled agencies of different sizes and profit status, using the boards of the Home Care Association of New York, the 1199SEIU Home Care Industry Education Fund, and New York State Medicaid Redesign network participants as starting points. Recruitment was often challenging, requiring substantial time and effort to assemble even this small

sample. In this sample, all agencies accepted Medicaid clients and all provided both personal care and home health care services, except for one that provided personal care only. In the second study, we not only invited all agencies who were contacted for the 2019 interviews but also expanded and diversified our sample. We again used purposive sampling and similar recruitment channels, adding recommendations from a local industry association. Recruitment was much swifter for this study. Ultimately in 2022, we conducted nineteen interviews with representatives from fourteen agencies (including six of the eight agencies interviewed in 2019) and included three non-agency industry leaders. In this sample, one agency accepted only private pay clients (no Medicaid), and three provided personal care services only (see Table 1 for a side-by-side comparison of sample characteristics in each study).

Our 2022 sample differed from the 2019 sample in key ways. It included (1) a wider range of agency sizes, (2) proportionally more for-profit agencies, (3) one agency that did not employ unionized aides, and (4) two agencies that were part of national chains. In both studies, we spoke primarily with individuals at the director or vice president level and above. The three non-agency leaders were at similar levels in their organizations, and represented a union, an association, and a home care consultancy. While this sample is still unique to New York in many ways, the addition of smaller agencies, more for-profit agencies, and national chains better represents agency types nationally (Campbell, 2020).

Data Collection and Analysis

The semi-structured interviews were conducted by the first and second authors in person or by phone in 2019 and over Zoom between February and May 2022 (see Appendix A for interview guides). Interviews ranged from 30 minutes to over an hour, with the majority of interviews taking approximately 1 hour. Recorded interviews were professionally transcribed; data for the second study were also managed and coded in Dedoose.

Integrating our 2019 and 2022 data, we have longitudinal data at both time points for some agencies ($n = 6$), 2022 data only for some ($n = 6$), and 2019 data only for some ($n = 2$); therefore, we analyzed the 2019 and 2022 data separately and together. To analyze these data separately in responsive and actionable ways, we initially used directed content analysis (Hsieh & Shannon, 2005) in both studies to explore: (1) how agencies conceptualized aides' mental health and well-being, (2) actions that agencies had taken to support aides around client death and more broadly, and (3) facilitators and barriers to action. This approach was appropriate given our team's existing, multifaceted understanding of these issues (Boerner et al., 2015, 2016, 2017; Tsui et al., 2019, 2021; Tsui, Franzosa, et al., 2022; Tsui, LaMonica, et al., 2022). We engaged with the data iteratively while developing a codebook, which incorporated both a priori and emergent codes. These steps were undertaken by the first author for the 2019 data and first and second authors for the 2022 data. In each study, we also utilized the framework method (Gale et al., 2013), in which we charted coded data into matrices, which facilitated comparison within and across participants. To analyze change across these datasets we took two approaches: (1) We made comparisons of change in aggregate, and (2) we analyzed the six agencies for which we had data at both time points more granularly, by creating a comparison matrix summarizing each agency's conceptualizations and actions at each time point, and then assessing the change across time points (see Table 2 for comparison matrix).

Findings

In the following sections, we first describe shifts in agency leaders' views of aides' mental health and well-being around client death and beyond it. We then assess shifts in their actions to protect and promote aides' mental health and well-being. A fuller analysis of leaders' views and efforts prior to

Table 1. Sample Descriptions of Home Care Agencies.

Characteristic	2019 Study	2022 Study
Number of agencies represented in sample	8	14
Number of non-agency organizations represented in sample	0	3
Total interviewees	14	19
Range of agency sizes	600–10,000 aides	150–8000 aides
Median agency size	1600 aides	1387 aides
Small (≤1,100 aides)	3	7
Medium (1,101–2,000 aides)	3	1
Large (>2,000 aides)	2	6
Agencies with unionized aides	8 (100%)	13 (93%)
Agencies that are for-profit or proprietary	3 (38%)	8 (57%)
Agencies that are multi-state chains	0 (0%)	2 (14%)
Agencies that are part of larger organizations providing multiple community-based social services	4 (50%)	4 (29%)
Agencies providing personal care services only	1 (13%)	3 (21%)

Table 2. Changes in Support at Six Agencies (2019–2022).

Agency	Type	Summary of Client Death Support (2019)	Summary of Emotional Support (2019)	Summary of Client Death Support (2022)	Summary of Emotional Support (2022)	Change Over Time[a]
A	Large, non-profit	Reactive and informal approach to client death for aides. Death and dying training only as a separate, elective in-service (offered every month	Interest in support seems more focused on patients. If the agency's training staff taught more about "dying, coping with family needs and the emotional needs of the family, it will be very helpful for us [as an agency] to better serve our patients"	As part of group support calls, aides receiving further support around client death from peers and a social worker	New aide group support calls system running for two years and becoming institutionalized; increased access to agency employee assistance program (EAP); re-envisioning coordinator role and doing associated training; enhanced web resources for aides during pandemic; sense of aide needing to see value in the employer (and not only the employer seeing value in the aide, "two way street"); wanting to "really connect with our employees"	**Major** change in thinking about emotional support; **major** change in emotional support actions; **minor** change in client death support. Huge shift toward orienting around understanding aides' perspectives and meeting their needs organizationally, and particularly in terms of emotional support. Shift from informal and reactive to numerous formal and large-scale efforts
B	Large, for-profit	Largely reactive and informal approach to client death for aides, though standard training includes proactive end-of-life (EOL) training (which leader acknowledges may be out of date)	Sense of needing to be accountable to aides, as well as clients, but without formal systems for doing so	Increased client death training for aides (offer extended version of hospice training annually now)	Largely informal support to aides from staff. Primarily relying on the union for emotional support	**Limited to no** change in thinking about emotional support; l**imited to no** change in emotional support actions; **minor** change in client death support

(continued)

Table 2. (continued)

Agency	Type	Summary of Client Death Support (2019)	Summary of Emotional Support (2019)	Summary of Client Death Support (2022)	Summary of Emotional Support (2022)	Change Over Time[a]
C	Small, for-profit	Largely reactive and informal approach. Did some palliative care training last year in response to request from a contractor, but no longer doing this. Strong emphasis on patient/client needs when considering client death, little emphasis on aides	Not strongly motivated around aide support, given how "stretched" the agency is and the "tiny" profit margins	No change	Greater recognition of issues in aides' lives that could complicate their work. Added a new position to act as liaison or mentor to aides. This was initially envisioned as focused on "non-compliant" aides, but leader is considering how to make this role more supportive as a supplement to the work that coordinators do	**Minor** change in thinking about emotional support; **minor** change in emotional support actions; **limited to no** change in client death support
D	Small, non-profit within a multiservice organization	Largely reactive and informal approach, with minimal death and dying training as part of general curriculum	Feels very strongly about the importance of supporting aides, including around client death, but feels very limited by the payment model. Agency offers self-care training to show that they care about aides too	No change	Largely informal support to aides from staff, though there was energy and intention around this during the pandemic to ensure that there was a communication mechanism that was not solely task-focused. Leader and coordinators conducted support check-ins by phone with aides. Reliance on the union for emotional support largely remains; but wishes for more of a "partnership model," meaning that aides would see value and support from the employer	**Minor** change in thinking about emotional support; **limited to no** change in emotional support actions; **limited to no** change in client death support

(continued)

Table 2. (continued)

Agency	Type	Summary of Client Death Support (2019)	Summary of Emotional Support (2019)	Summary of Client Death Support (2022)	Summary of Emotional Support (2022)	Change Over Time[a]
E	Medium, for-profit	Largely reactive and informal approach ("death is hard and not something the agency is comfortable talking about"), with minimal death and dying training as part of general curriculum. More robust death and dying training available but offered very infrequently	Emphasis is on how to create "a better patient experience," aides are included in this but not central	Advocating for using Federal Medical Assistance Percentage Rate Increase (FMAP) funding for 3-day bereavement leave after client death. Leader working to cultivate awareness and create buy-in within organization around what happens when patients die	Largely informal support to aides, though the leader and staff devoted significant attention to this during the pandemic. Desire to be more connected with aides	**Minor** change in thinking about emotional support; **limited to no** change in emotional actions; **minor** change in client death support
F	Small, non-profit within a multiservice organization	Minimal death and dying training as part of regular curriculum; elective in-service for additional training. Potential support for client death through existing broader systems of support, but this has not been a focus. Leader articulated a strong motivation to develop a standard way of dealing with client death and supporting aides	Agency wants to be sensitive to the needs of the aide; they have a private Facebook group they post to for aides. They also have mentors and peer coaches who were initially grant-funded and then institutionalized. They wish to hire a counselor for all aides to help with when they are having issues on or off the job	Aide mentors are now better equipped to provide individualized support to aides around client death. They received a grant around trauma-informed care training and mentors went through this training	Leader conceptualizes her work as connecting the aides to the agency, to resources, and to each other. Mentorship program continues to provide a range of individualized support to aides. Private Facebook group took on new life. They started using the group chat function, video chats, and launched trivia Thursdays as a place for aides to connect. The page also became an important source of information throughout the pandemic	**Minor** change in thinking about emotional support; **minor** change in emotional support actions; **minor** change in client death support. Amplification of strong existing sense of the need for aide support; growth in aide support practices that build on existing infrastructure

[a]For summary purposes, change over time in (1) thinking about emotional support, (2) emotional support actions, and (3) client death support is interpreted into three ordinal ratings: Limited to no change, minor change, and major change. All change was in the direction of increased support.

the pandemic was published previously (Tsui et al., 2022a). Note that Agencies A through F were interviewed at both time points, G and H only in 2019, and the remaining agencies only in 2022 (see Appendix B for full details).

Shifts in Leaders' Views of and Motivations to Address Aides' Mental Health and Well-Being

Prior to the COVID-19 pandemic, agency leaders who were motivated to address aides' experiences of client death, typically cited combinations of three reasons: (1) a sense of responsibility to aides, (2) concerns about aide retention in the face of an insufficient supply of aides, and (3) potential improvements in care quality. The sense of responsibility to aides was a minority viewpoint among the eight agencies interviewed in 2019 and was strongly connected to retention concerns and care quality goals. As one agency leader said, "I think [aides'] job satisfaction is incredibly important, and we gotta figure out how we do that in the context of this environment where it's all about reimbursement and it's also client-centered and not necessarily about the people that are supporting this work" (Agency D, medium, non-profit, 2019). Only one interviewee who had been an aide themself before becoming a manager overtly underscored the humanity of aides and their families. They said they would advise aides' supervisors, "We need to first remember that these aides, when they come to work for us, they have a family behind them. You care for them, you care for their own too" (Agency B, large, for-profit, 2019). Another agency embedded in a multiservice organization mentioned a staff member who supported aides in securing benefits (e.g., housing, food, child care, and bills) because aides have "their own social problems" (Agency H, small, non-profit, 2019).

In 2022, leaders' motivations for providing support to aides demonstrated a stronger and broader awareness of aides' humanity, their stress, and their societal positioning. One leader had difficulty continuing speaking when recalling the early days of the pandemic. They said, "It was not easy. It was not easy sending people [out] not having [equipment]." They went on to say, "There was just this energy of fear, of grief, of sadness. Home care workers lost family members" (Agency E, medium, for-profit, 2022).

In this round of interviews, we asked participants directly how they think about aide health and well-being. Most discussed these topics with a dimensionality and the kind of personal resonance that Agency E's representative expressed above. As one leader said, aides' financial well-being, their access to support, and their mental health—things "that weren't as much on my radar in the past"—were now top of mind. In particular, some participants mentioned the ways aides are impacted by "the social determinants of health," referring to the idea that health is shaped by multiple structural and intermediary factors, including work and income, neighborhood environment, food access, and housing, among other variables (Solar & Irwin, 2010). As one said, "Our aides are a diverse multicultural population. Some have certain barriers, in terms of even nutrition and housing and social determinants of health. And I think some come from disadvantaged backgrounds, and don't always have the education and the supports to address physical and mental health issues" (Agency M, large, for-profit, 2022). A leader of a small, for-profit agency said they conceptualize aides as a "fragile workforce": "So, like an unexpected $400 event could really domino into their life" (Agency N, 2022).

Many leaders also spoke directly about aides' stress and mental health. One agency leader, when asked about what came to mind when they thought about aide health and well-being, immediately responded: "Mental health, emotional health" (Agency J, small, for-profit, 2022). Discussions of the stress of the work and the need for support were abundant, with leaders noting how isolating and difficult the work is (Agencies A, D, I, and L), and that "the work gets very emotionally draining and takes a toll" (Agency O, large, for-profit, 2022). Another highlighted the need to "acknowledge the impact the job has on the individual, which of course, cannot be any more present to all of us than the past two years" (Agency B, large, for-profit, 2022). In answering this question, one non-agency leader closed by saying that they wanted to "go back and just talk more about the mental health needs of the staff. And that's what we've heard from agencies, meetings that I've been at where they've identified that as a major issue, where they've had to either make available mental health services, or at least make available resources. And that's something that a lot of them have never done before."

Shifts in Leaders' Actions Addressing Aides' Mental Health and Well-Being

In 2019, we asked leaders about four ways of supporting aides around client death (that were documented in the literature): paid time off, case reassignment practices, emotional support, and training. We learned that agencies' efforts in these areas, when they existed at all, were largely informal and reactive. Importantly, agency leaders reported that emotional support was most often provided by aides' administrative coordinators (staff members who assign them to cases) and only when aides expressed a need for support, though they acknowledged that numerous factors could deter aides from voicing these needs, such as agency warnings against developing close relationships with clients. Some agency leaders described sporadic bereavement support groups for aides. Unionized agencies also noted that union-based employee assistance programs (EAPs) were available for individual counseling. While agency leaders generally felt very limited by available resources and the home care payment model when trying to support aides (e.g., perception that funding for the aide ceases when a client dies), two agencies

(notably those embedded in multiservice organizations) also shared information about their broader efforts to support aides in accessing benefits and navigating work stress. One of these included a private Facebook page for aides that allowed them to connect with agency staff about work challenges (see Tsui et al., 2022a for further details).

New Actions to Support Aides Mental Health and Well-Being in 2022. In the 2022 interviews, agencies demonstrated that they had engaged in a range of new, enhanced, or invigorated supports for aides. Table 2 summarizes how agencies involved at both time points shifted their practices toward varying levels of additional action in support of aide mental health and well-being. Table 3 then summarizes types of actions described across all of the 2022 interviews. We note that when agencies interviewed only in 2022 reflected on their earlier approaches to aide mental health and well-being, their starting points demonstrated a similar range to those agencies in Table 2, with most not doing much and a few doing more.

Table 2 shows that agencies made changes that varied in magnitude from different starting points. Agency A (large, non-profit), for example, made the most substantial and broadest changes. This agency went from providing little formally in the way of emotional or client death support to multiple supportive systems and actions. Notably, this included offering group support calls for aides, where issues raised were responded to both at the individual and agency level, thus bringing aides' voices and experiences into leaders' decision-making (for more detail, see our paper: Tsui et al., 2022). Agency F (medium, non-profit), on the other hand, made less sweeping changes, but because they had started with stronger systems for providing aide support, they also described a robust array of support in 2022. Both of these agencies appeared to be building an organizational identity around supporting aides' mental health and well-being. The remaining agencies described changes of a more minor and/or narrower variety, including changes in policies, training, staffing, and communications. Some unionized agencies

Table 3. Agency Actions Supporting Aide Mental Health and Well-Being in 2022.

Category	Actions
Improving and supplementing staffing to better support aides	Improving support provided by coordinators to aides: • "A massive reeducation and training and redefinition" of the [coordinator] role to emphasize coordinators' efforts around aide engagement, regular contact, and increased emotional support (Agency A) • Directing coordinators to be more responsive to and respectful of the work of aides (Agency I). New support staff to supplement coordinators: • Staff member experienced with agency operations tasked with troubleshooting any individual issue an aide raised (Agency A) • Staff member for troubleshooting, as well as a peer liaison. As this leader said, "[These are] positions that are there more for the satisfaction of the caregivers, [and their] health and well-being" (Agency N) • In some agencies (especially smaller ones), leaders themselves offered support directly to aides one-on-one during the pandemic (Agencies D, E, and L) • Staff of COVID response teams tasked with one-on-one supportive outreach to aides, though often limited to earlier phase of pandemic (Agencies M and O) Enhanced and new peer mentoring programs to provide additional support: • 14-Year old mentorship program enables aides to be promoted into roles from within (as a form of career advancement). Mentors are tasked with regularly contacting and supporting aides, and received multiple kinds of additional training during the pandemic (Agency F) • New program assigns an aide mentor "who checks in with [aides] during the first month [of employment] or so but [is] more oriented around outreach if things are going wrong" (Agency C)
Increasing communication with and support for aides through technology	• Enhanced use of existing private Facebook page, including use of group chat and video features for the first time, as a vehicle for aides to "express their fears," "see our faces," and "connect with one another" (Agency F) • Enhanced informational offerings for aides via websites (Agencies A, F, and I) • Remote town hall-style meetings where aides could raise issues (Agencies A and N) • Videos in which agency leaders express appreciation to aides (Agency A) • Supporting aides during Zoom-based trainings (Agency N)
Improving access to mental health services and other benefits	• Enhancing the EAP available to aides for emotional and other forms of support (Agencies A and N) • Improving benefits like access to a medical plan, retirement plans, base pay, and creating a financial hardship fund (Agencies N and O)

reported relying primarily on their unions to provide emotional support (Agencies B and D), though we note that all agencies interviewed at both time points reported some increase in actions taken.

Table 3 provides examples of the type and range of actions that agencies had taken by 2022 to increase support for aides. These fell into three broad categories: (1) improving and supplementing staffing to better support aides, (2) increasing communication with and support for aides using technology, and (3) improving access to mental health services and other benefits. Agencies were most active in better supporting aides through alternative staffing arrangements. As past research has shown, administrative coordinators typically have the most contact with aides but are rarely equipped in terms of time or training to provide emotional or others forms of support (Franzosa et al., 2019; Tsui et al., 2019). These efforts thus sought to improve coordinators' ability or motivation to provide this support, supplement coordinators with other staff who could support aides, and train peer mentors to provide individualized support to aides. Agencies also reported multiple examples of how they improved communication and benefits.

Engaging With New Opportunities for Funding and Advocacy to Support Aides in 2022. In New York during this period, there were two significant new opportunities for funding and advocacy that agency leaders mentioned in conjunction with their actions to support aides. The primary funding opportunity was made available through the American Rescue Plan Act (ARPA). Agency leaders referred to this as "FMAP funding" (referring to the Federal Medical Assistance Percentage Rate Increase) (New York State Office of Mental Health, 2021). This funding provided additional support for Medicaid Home and Community-Based Services (HCBS) during the COVID-19 Emergency (New York State Department of Health, 2021). Specifically, around the time of our interviews in 2022, home care agencies were eligible to apply for funding to increase home care aide retention. They could use the funding to improve retention in a wide variety of ways. One agency leader discussed an informal, non-profit agency coalition that had been built while applying for these funds, which now collaborated on policy advocacy (Agency J, small, non-profit). Agencies noted that they were considering using this funding for improved coordinator training to provide emotional support (Agencies B and D), launching peer-to-peer programs (Agency P, small non-profit), and initiating a bereavement leave policy for aides after client death (Agency E, medium, for-profit).

The major advocacy effort in which some leaders were involved was the "Fair Pay for Home Care" campaign, which sought to raise home care aides' wages throughout New York State to 150% of the minimum wage. While small wage increases were included in the 2022–2023 budget, these increases were not as high as advocates and home care constituencies had hoped, nor did leaders believe that they were adequately funded through Medicaid reimbursement increases (Donlan, 2022). Currently, advocacy efforts for the wage increase to 150% of the minimum wage continue (Meyersohn, 2023).

Discussion

This study contributes to our understanding of how home care agencies were impacted by the COVID-19 pandemic and what they have learned during this period. Most existing agency studies emphasize access to PPE and infection control information and staffing challenges (Sama et al., 2020; Tyler et al., 2022). This study also contributes to the literature highlighting the critical but understudied role of work in the COVID-19 mental health crisis.

Our research shows how much more central aides' mental health and well-being had become in the thinking of industry leaders by 2022. Most leaders either identified with the challenges that aides had experienced during the pandemic and/or were able to see more clearly how aides' lives and health are shaped by the social determinants of health. The shared experience of the stresses of the early pandemic seem to have brought this into view, as some research triangulating perspectives of clients, aides, and managers has shown (Markkanen et al., 2021). Pressure to retain aides has long driven agency leaders' decisions (Gleason & Miller, 2021), but these pressures no longer appeared to be the only motivator for providing support. New understandings motivated a range of responses by agencies of varying levels of development and institutionalization, and at varying levels in the hierarchy of agency actions on worker well-being articulated in the occupational health literature (Lee et al., 2016; Tsui et al., 2022).

We now consider these findings in the context of the Surgeon General's Framework for Workplace Mental Health & Well-Being (Office of the Surgeon General, 2022) in order to bridge what we learned with broader conversations around workplace mental health. This framework recognizes the immense impact of work on employees' mental health and well-being in both positive and negative ways and was developed as a result of the increased visibility of this issue during the COVID-19 pandemic. It views workplaces as potential "engines of mental health and well-being" and offers concepts and tools for realizing this vision. Specifically, the Framework includes five elements, all anchored in worker voice and equity: (1) Protection from harm, (2) connection and community, (3) work–life harmony, (4) mattering at work, and (5) opportunity for growth.

In our 2022 interviews, leaders spoke most to mattering at work, community and connection, and protection from harm (see Table 4.). Most efforts toward mattering at work—including prerecorded videos or newsletters to show gratitude to aides—appeared to be more unidirectional than the Framework (and best practices in occupational health [McLellan et al., 2017]) would recommend.

Table 4. Mapping Actions Taken to the Surgeon General's Framework for Mental Health and Well-Being.

Elements of Surgeon General's Framework	Key Actions Recommended	Actions Taken by Participating Home Care Leaders and Agencies
Mattering at work	Provide a living wage	• Advocating for increased wages for home care aides
	Engage workers in workplace decisions	• Engaging workers in workplace decisions was not explicitly addressed in interviews, though worker voice was increasingly being attended to at some agencies
	Build a culture of gratitude and recognition	• Taking steps toward building cultures of gratitude and recognition (e.g., support via coordinators, peers, and other staff)
	Connect individual work with organizational mission	• Taking steps toward connecting individual work with organizational mission (e.g., appreciation videos and town hall meetings)
Community and connection	Create cultures of inclusion and belonging	• Creating warmer and more supportive connections between aides and coordinators/other support staff • Building peer-based and expert-led systems of support • Seeking additional ways of connecting with aides in the absence of regular in-person contacts
	Cultivate trusted relationships	• Creating warmer and more supportive connections between aides and coordinators/other support staff • Building peer-based and expert-led systems of support • Seeking additional ways of connecting with aides in the absence of regular in-person contacts
	Foster collaboration and teamwork	• Creating warmer and more supportive connections between aides and coordinators/other support staff • Building peer-based and expert-led systems of support • Seeking additional ways of connecting with aides in the absence of regular in-person contacts
Protection from harm	Normalize and support mental health	• Supporting mental health through improved staffing models • Improving access to EAPs and other mental health supports
	Prioritize workplace physical and psychological safety	• Prioritizing infection control and physical safety of aides (see literature; not a major focus of this study)
	Enable adequate rest	
	Operationalize Diversity, Equity, Inclusion, and Accessibility (DEIA) norms, policies, and programs	
Work–life harmony	Increase access to paid leave	• One agency was working toward using FMAP funding for paid bereavement leave for aides after a client dies
	Provide more autonomy over how work is done	
	Make schedules as flexible and predictable as possible	
	Respect boundaries between work and non-work time	
Opportunity for growth	Offer quality training, education, and mentoring	• There is a training infrastructure for aides, though that has been complicated by the COVID-19 pandemic and the need for remote training
	Foster clear, equitable pathways for career advancement	• Providing peer mentoring at some agencies
	Ensure relevant, reciprocal feedback	• Creating pathways for career advancement is a long-standing issue for aides that was addressed during interviews briefly in discussions of peer mentoring programs

Note. In rows where no actions are listed in column 3, this indicates that leaders did not discuss activities aligning with these key recommended actions in the interviews. We should note that it is possible that work in these areas is taking place but is not currently seen as contributing to aide mental health and well-being.

However, a number of the efforts listed under Community and Connection, particularly the peer-based systems of support that had responsive linkages to home care agency staff and leadership (like the group support call system and the enhanced private Facebook page), aligned with the Framework's commitment to centering worker voice and equity. Notably, these innovations arose at an unusually large and multifaceted home care agency that was able to

divert resources to the support calls, in one case, and a strongly mission-driven multiservice agency in the case of the private Facebook page. Research suggests that the extent to which agencies can continue to work toward making aides' voices a dimension of these initiatives will shape the effectiveness and sustainability of these efforts (Punnett et al., 2013). Finally, the dimension of protection from harm that was most addressed in these interviews was normalizing and supporting mental health by (1) improving staffing in ways that can support aides mental health and well-being and (2) providing improved access to mental health services. We know also that many leaders worked with dedication to protect workers from the physical harms of COVID-19 (Markkanen et al., 2021; Sama et al., 2020).

Elements of the Framework that were less actively addressed in our 2022 interviews were work–life harmony and opportunity for growth. Work–life harmony is a complex issue for aides as flexibility and autonomy are part of the attraction of home-based labor. Yet the work remains structurally insecure (pay is based on being assigned cases that may or may not be a fit) and the way it can function as a "labor of love" frequently produces work–life strain (Baron et al., 2022). Similar to work–life harmony, creating opportunities for growth for aides is an industry-level issue. Annual in-service training is required for aides, and a variety of training opportunities exist, though most do not link directly to career advancement. Aides' lack of opportunities for career advancement have long dogged the industry broadly, though some innovative small-scale models exist (Espinoza, 2019), like the peer mentoring programs described in this study. Taking the Framework elements together, we emerge with a picture of the home care industry as one in which a partial foundation (e.g., training infrastructure) has been laid and a few initial steps toward a more holistic practice of workplace mental health and well-being for aides have been taken by motivated agencies.

One implication of this research is that evaluating innovations emerging from this period is crucial, so that we can learn about the effects not only on aide retention but also on aides' mental health and well-being. High-quality intervention research on home care aide health interventions is urgently needed (Gebhard & Herz, 2023). While some of the efforts described in this article were funded within home care organizations and through unions, several innovations that we heard about were made possible by the American Rescue Plan Act (ARPA) funds. These funds can be spent through March 2025, and thus the effects of these experiments in retention and aide support remain to be seen (Famakinwa, 2022). Differences in the types and sizes of home care agencies that were able to make best use of these funds should be explored.

Sources of funding beyond ARPA are needed to continue this important work. Optimistically, we are cognizant of the ways in which the acknowledgment of carework in society has increased recently. As noted above, our current Surgeon General has identified six priority areas, two of which relate directly to the issues discussed in this article: workplace mental health and well-being and health worker burnout (Murthy, 2022; Office of the Surgeon General, 2022). The need to support care infrastructure was also a major national conversation during the crafting of the federal Infrastructure Investment and Jobs Act in 2021. And as recently as April 2023, the President issued an executive order seeking to strengthen our child and long-term care infrastructure (The White House, 2023). Further research should continue to track how federal policies supporting carework affect the mental health and well-being of home care aides.

This research has a range of limitations. First, these interview studies were not designed to produce a systematic comparison across two time points with identical questions asked. As the conditions on the ground changed dramatically in home care, different questions and framings were needed. This analysis allows us to look at differences in how leaders conceptualize and operationalize nuanced ideas of aide support. Second, as we sampled purposively in both studies, participants tended to be actively engaged in thinking about aides and home care as an industry. Additionally, for agency leaders participating at both time points, 2022 outcomes may have been influenced by their involvement and learning through the 2019 study. Third, the vast majority of participating agencies employed unionized aides, which is more common in New York than in the rest of the United States.[1] Finally, leaders spoke to how home care is practiced in New York State only, and there is substantial heterogeneity in state-level approaches to home care financing and structures. For these reasons, we anticipate that participating leaders reported greater efforts to support aides than typical home care leaders would. Whether these findings are transferable to other areas and settings is best assessed by readers (Lincoln & Guba, 1985). Some findings are likely to be common, while others are unique. For instance, access to ARPA funds and the limitations on home care financing are present throughout the United States, but the particular ways that policies and practices supportive of aides have emerged vary substantially by location.

Conclusion

Home care is a growing industry that is powered day-to-day by the work of aides. Aides were subject to difficult working conditions and experienced poorer mental health than similar workers even prior to the COVID-19 pandemic, which then further amplified their stress. As a result, agency leaders now appear more motivated to address the mental health and well-being of aides than previously but are hampered by constraints stemming from the financing of the home care industry (e.g., reliance on and underfunding of Medicaid) when

attempting to create workplaces that can holistically and durably support aides. Until this happens, maintaining a skilled and reliable aide workforce, which is critical to societal health, will remain challenging.

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Ethical Statement

IRB Protocols

The studies reported on in this paper were approved by the CUNY Graduate School of Public Health & Health Policy IRB, #2016-1353 and #2021-2136-PHHP.

Informed Consent

We secured informed written consent from all participants.

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Supplemental Material

Supplemental material for this article is available online.

Note

1. In 2010, researchers estimated that approximately half of home health aides and all personal care aides in New York City were unionized (PHI, 2010). At the national level, approximately 30% of aides are unionized (Cancino, 2014).

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