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"We want to hear your problems and fix them": A case study of pandemic support calls for home health aides

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ABSTRACT

Home health aides and home care agencies, who operate in a high work stress environment under normal conditions, were placed under extraordinary demands during the COVID-19 pandemic. In this paper, we examine the unfolding effort at one agency in New York City to offer phone-based support calls to aides. We used a qualitative, single case study design involving semi-structured interviews with call staff and agency leaders (n = 9) and analysis of one year of thematic notes from the calls. We found that the calls resulted in multidirectional communication between agency staff and aides, an increased sense of empathy among staff, and a greater integration of aides into the agency's overall infrastructure. We explore how these calls might contribute to aide retention, worker voice, and mental health. We note the facilitators and barriers to implementing this type of job-based support to help other agencies that may be considering similar models.

KEYWORDS

Caregiving: Work Issues; Community and Home Care; Health Promotion: Stress Reduction; Long-Term Care: Staff Roles/Turnover/Staffing Patterns

The COVID-19 pandemic placed extraordinary demands on home health aides and home care agencies that employ them. Even prior to the pandemic, research showed that home health aides faced multiple forms of work stress, in a context of limited support on the job (Franzosa, Tsui, & Baron, 2019; Muramatsu, Sokas, Lukyanova, & Zanoni, 2019). The pandemic then substantially exacerbated both the demands of this work and aides' need for emotional, financial, instrumental, and informational support (Sama, Quinn, & Galligan et al., 2020; Sterling, Tseng, & Poon et al., 2020; Bandini et al., 2021). With the context of preexisting limited job-based support and the pressures of home care work during the pandemic, aide retention issues were increasingly drawn to the forefront for many agencies (Sama et al., 2020; Tyler, Hunter, Mulmule, & Porter, 2021).

In this paper, we examine the unfolding effort at one large home care organization in New York City to respond to the extraordinarily stressful working conditions that home health aides have experienced during the

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pandemic. While this effort began as a phone-based group support call for aides, it came to encompass a wider range of changes and shifts in thinking about aides and their well-being within the agency. One aide who we interviewed for a separate project initially drew our attention to these calls by saying:

> "This is the first period–since COVID–that we've had a chance to really be in touch with anybody [at the agency] on a personal level, to let them know what we're feeling, what we're going through, with the support calls. So, a lot of these things I think they're working on fixing so that, you know, we could have more support. [. . .] With the support calls, they're taking ideas or suggestions that we give on those calls, to see how far they can go with it and to create some kind of change in the organization."

We describe this effort in order to help document ways that home care agencies thoughtfully and creatively responded to aides' needs during the pandemic. Specifically, we describe how the support calls came about and what form they took, what kind of support the calls offered, and what higher level changes they helped to mobilize. We also explore how these calls could potentially contribute to aide retention and job satisfaction.

As background, we note that aides' retention and job tenure are shaped by multiple factors. These include several aide-level factors, like age and education, but also work-based factors like wages, inconsistent hours, poor communication with the agency, degree of autonomy and control over work, and contextual factors like local unemployment rates (Faul et al., 2010; Butler, Brennan-Ing, Wardamasky, & Ashley, 2014; Gleason & Miller, 2021). Job satisfaction among aides is also shaped by multiple factors, including greater control over work (e.g., ability to make decisions about how to do the work, and job security), greater support at work (especially respect from the agency and supervisor support), and social support from friends and relatives (Gleason & Miller, 2021; Delp, Wallace, Geiger-Brown, & Muntaner, 2010; Yoon, Probst, & DiStefano, 2016).

The effort we discuss in this paper was located at the Visiting Nurse Service of New York (VNSNY), a multifaceted not-for-profit home- and community-based care organization based in New York City and one the largest not-for-profit providers of home care in the United States, with approximately 9,000 home health aides employed prior to the pandemic and approximately 6,100 aides employed currently. VNSNY traces its origins back to 1893, and provides a variety of home care services, as well as hospice services and community-based mental health services. Home health aide services are delivered primarily through VNSNY's division Partners in Care. These aides are unionized under 1199 SEIU and have access to a variety of benefits through the union, including an employee assistance program that provides individual phone-based mental health support. Partners in Care also runs a large home health aide certification program and an in-service training program for aides to meet

annual requirements. While Partners in Care/VNSNY is unique in its size and structure, our case study suggests a range of lessons learned that may be relevant to a variety of agency types.

Materials and methods

Design and data collection

We used a qualitative, single case study design using multiple forms of data. First, we conducted key informant interviews with staff implementing the support calls (the "core team") and those more senior staff who hold decision-making power and/or made use of the notes ("agency leaders") (n = 9) in Spring 2021. Core team members were identified by the call manager (n = 5), and relevant agency leaders (n = 4) were identified by core team members and through review of the notes. Second, we analyzed thematic notes made for each week of support calls over the course of one year (n = 50, April 2020-April 2021), and circulated to agency leaders weekly. These were taken by a member of the core team and were typically 1–2 pages in length, and provided some reflection on the week's calls, followed by a list of quotes from aides and staff responses organized into major themes. Finally, we also observed one week of calls in April 2021, and reviewed e-mails related to the development of the calls.

Analysis

Our approach to analyzing the interview data was inductive, beginning with open coding. We used a more deductive approach in analyzing the notes (similar to directed content analysis (Hsieh & Shannon, 2005)), in the sense that we knew in advance that we wanted to attend to how the staff and organization reacted to aides' requests on the calls and what was mobilized as a result. Two analysts (ET and ML) developed initial lists of codes and code definitions. These preliminary codebooks were then applied to the data (by ET, ML, and MH) and the evolution of the coding scheme was discussed periodically. We used diagramming and memoing to advance the analysis. In July 2021 we presented our preliminary findings to a selection of core team members and agency leaders as a form of member-checking (Lincoln & Guba, 1985), incorporated their feedback, and then shared a written summary of findings with all interview participants, requesting their comments.

RESULTS

In the sections that follow, we explore the nature of the support calls effort in detail, focusing on key organizational outcomes of the calls.

Organizational context for the support calls

Two aspects of Partners in Care's context emerged as particularly relevant to the development of the aide support calls: 1) The proximity of hospice and mental health expertise within the larger organization (VNSNY) allowed for swift access to a trained facilitator to lead the calls, and 2) Due to the pandemic, Partners in Care's census of home care aides was reduced substantially, as was the case at many agencies. This shortage thus led to rapid recognition for the need to provide greater support to aides in order to retain them. Prior to the pandemic, interviewees described support for aides as largely informal, provided sporadically by supervisors, usually via face-to-face visits at the main office, or taking place in person during training sessions.

Support call goals, structures, and processes

Emergence and goals of the calls

In April 2020, near the beginning of the pandemic in New York City, an urgent desire to "figure out how we can support our employees emotionally" (core team member) led Partners in Care staff to launch the calls. Because of the urgency to get started, there was not much initial discussion about the calls' specific goals. The facilitator's approach came to define the effort; it was driven by two underlying therapeutic principles: 1) "all parts [of a person] are welcome" in a support group, and 2) emotional dimensions of operational issues are as important to address as the issues themselves. As the facilitator noted, "If I respond [only to the operational concern with information], there's a human being I'm missing. So I'm always listening – what's the unstated emotion? – and my goal is to really affirm that," in addition to addressing other concerns.

The calls also sought to nurture a sense of community and grew to address an array of needs that arose for aides. As another core team member said, "In the beginning, I thought [the calls were] more just giving the moral support. And it turned out that, because of the circumstances, we had to give them support in every way – administratively, emotionally, and every way that we can."

Core Team and Characteristics

In order to address these diverse needs, a team with a range of backgrounds and specialties evolved to staff the calls (Table 1).

Logistics

Aides employed by Partners in Care were initially notified of the calls through e-mails and texts sent by the agency and were reminded of the calls weekly. The 45-minute calls were offered three days per week for the

Table 1. Core team members, roles, and key characteristics.

Core Team Members	Role on Support Calls	Key Characteristics
Call facilitator	Primary "voice" on call; responsive to both emotional and operational needs for support, either through therapeutic methods or guidance to other resources/next steps.	Social worker with extensive clinical experience leading support groups and building trust; came from within larger organization but outside of PIC so had "outsider positioning."
Operations manager	The go-to problem solver around operational and other day-to-day issues for aides; answers questions during call and helps aides with follow-up via phone or e-mail.	Long work history of helping to troubleshoot problems at the organization; in this newly created role, was given time to respond and act swiftly specifically to aides' concerns.
Call manager	Manages behind the scenes logistics; takes and circulates thematic notes to leadership, through which acts as an advocate for aides.	Expertise in organizational change, and long work history with organization. Skilled in communications and leadership development.
Nurses (2)	Informational support on COVID-related and other clinical issues during calls.	Previously worked with aides in other capacities; clear understanding of needs of aides and challenges of their working conditions.

first two months (May-June 2020), and were reduced to two days per week after that, when caller numbers dropped from 150–300 callers per week to just under 100 callers.[1] During the period we studied, although the facilitator was the primary voice on the calls, he communicated with other core team members in real time via Microsoft Teams to help answer aides' questions. Since early on, the calls were run using a managed dial-in phone number. Aides pressed star (*) when they wanted to ask a question or make a comment; otherwise, they listened while muted. Calls took place midday when the facilitator was available. Communications about the calls and the calls themselves were offered only in English, though core team members provided some simultaneous interpretation for Spanish-speaking aides.

Calls typically began with some framing, reflection, and a brief guided meditation, and then were opened up for aides' questions and comments. While the facilitator most often provided an initial response, aides sometimes addressed each other's questions and concerns, providing ideas or resources. If aide comments were slow to arrive, the facilitator reflected on topics that they might want to discuss, or posed reflective questions to help aides begin to put words to their experiences. Members of the team responsively evolved toward an action-oriented stance on the needs they learned of on the calls. One important venue for their advocacy was the thematic notes from the calls. As one core team member said, without the notes, "I think that these calls might have either dropped off or they wouldn't have gotten the momentum and the leaders wouldn't be aware [of what aides were sharing]." Figure 1 highlights key characteristics of the support calls.

- Treating aides as whole people: "All parts are welcome"
- Flexibility to respond to aides' emotional & operational concerns in real time
- Summarized in thematic notes with recommendations for action that were disseminated to leadership

Figure 1. Key characteristics of calls.

Content of the calls

Topics and requests discussed on the calls evolved with the pandemic. These included most commonly: COVID-related challenges and questions around PPE, patient care, vaccination, transportation, and financial concerns. Difficult emotions were a dominant theme among the issues that aides raised, including sadness, grief, frustration, and anger. As an example, one aide described her "nerve-racking" experience with trying to complete an online training for three weeks while also dealing with a sick child who needed a medical procedure. In a moment of frustration, she wanted to "throw my hands up" and give up her job.

Another core theme of the call notes was aides' appreciation for two primary aspects of the calls: agency responsiveness to their requests and the emotional support received. For aides, these were notable in the context of broader experiences of not feeling that their work is adequately recognized societally, particularly during the pandemic. Regarding agency responsiveness, one aide enthusiastically commented that she received a response to her request via e-mail on the same day, while another aide stated, "I feel that this program (the support calls) has helped so much with our requests (complaints about uniforms, masks, etc.)." This countered some aides' expressions of frustration with supervisor-related support and communication, a long-standing challenge in the industry. Aides also strongly appreciated the emotional support received from the call facilitator, other core team members, and other aides during the call. Callers noted that this was an opportunity for aides to "talk and express our feelings." Changes that the organization had implemented, and the opportunity to feel heard and validated on the support calls made them "feel respected."

Outcomes

The impact of the support calls went far beyond the direct emotional and informational support provided. As described in Figure 2 below, the calls, notes, and agency reactions substantially altered VNSNY's approach to communication with aides and among non-aide staff, creating a trusting

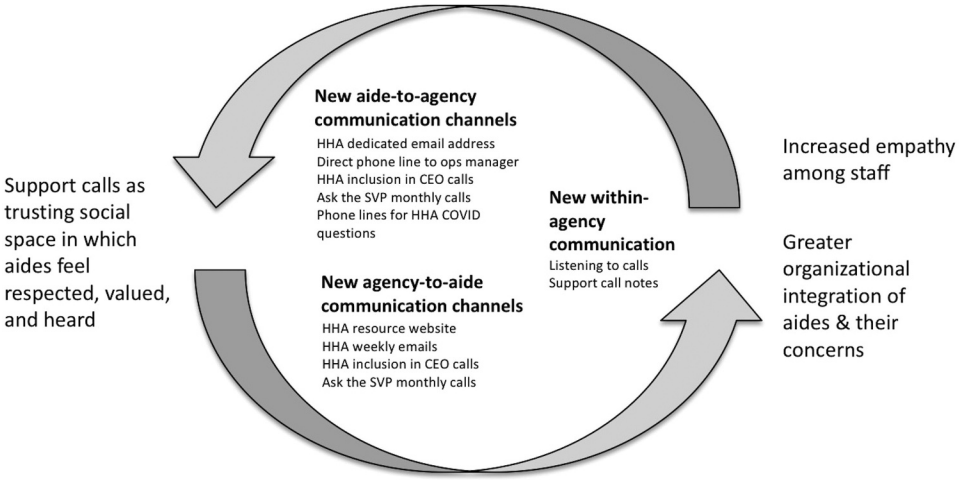

Figure 2. Multidirectional Communication Generates Dynamic Outcomes for Aides and the Agency

social space in which aides felt valued and respected, while also increasing empathy among staff and organizational integration of aides and their concerns.

Responsive, multidirectional, multichannel communication

The support calls vastly improved the depth, emotional intelligence, and responsiveness of agency-to-aide communications. At the same time, the calls allowed aides to provide critical feedback to the agency in wholly new ways. In ways that were both influenced by the calls and independently generated, VNSNY created multiple channels of communication in both aide-to-agency and agency-to-aide directions, while the call notes and staff participation on calls increased communication among non-aide staff within the agency about aide-related issues.

As Figure 2 shows, aides could now reach the agency through a wide range of avenues including new phone lines, e-mail, and group calls. These channels generally were dedicated solely to aides and provided an "immediacy" and reliability that was in contrast to the past. The agency also developed new ways of communicating to aides, including a dedicated webpage and a weekly e-mail. Aides were also given access to the company-wide CEO call and recordings. In 2021, a monthly call with PIC's Senior Vice President (SVP in Figure 2) was created in which aides could discuss operational issues with agency leaders. Separately, the agency increased their use of e-mail and text messaging to reach aides. As a member of the core team said, "I have never seen the organization treat the aides with as much respect as we have in this past year. [. . .] I think we've provided an open feedback mechanism to them that wasn't

necessarily there before." An agency leader articulated their message to aides as, "We want to hear your problems and fix them. We don't want you to just deal with them."

Increased empathy in the workplace

The growth of empathy as a result of participation in the support calls was a significant outcome observed throughout the interviews with the core team. This empathy fueled the efforts at responsiveness and improved communication described above, and stemmed from "just hearing what [aides are] going through, where they're anxious" (core team member). One core team member commented, "I always knew about the aides and felt good about their work, but to know what they're doing and they make not that much money, and it's just all been really humbling."

Greater organizational integration of aides' perspectives

With the dissemination of the notes, empathic responses to aides' experiences spread beyond the core team. As one agency leader said, prior to the calls, "I don't think that [staff] understood or people really appreciated what the ask was of our home health aide population. [. . .] People at the highest levels of the company [now] have a more, not just an intellectual, but an emotional connection to [aides' experiences]." This leader then described how this shift positions aides more centrally in terms of organizational decision-making. Several interviewees spoke about improved integration of aides into the larger organization. As one core team member said, "I think [the aides] feel like they really belong. Now we're listening. Now we're including them." Some of the concrete ways this happened are delineated in the broader outcomes for aides listed in Table 2, like allowing the operations manager position to support the calls almost full-time throughout much of the year and tailoring technology

Table 2. Direct and broader outcomes of support calls for aides and agency.

	Direct outcomes	Broader outcomes	Limits on outcomes
For aides	• Emotional support/ validation • Group identity & support from peers • Opportunity to be heard, • Access to info • Opportunity to have problems addressed	• Operational issues being addressed more responsively • Improved recognition of aides within broader org • Tailoring of technology based on aides' feedback • Improved aide health & well-being?	• Improved pay • Improved supervisor relationships • Improved financial & user support for tech
For the agency	• Increased emotional connection and empathy for aides' experiences • Improved understanding of aides experiences	• Greater integration of aides into organization • Improved usability of aide technology & supply workflow • Improved aide satisfaction? • Greater retention of aides?	

based on aides' feedback. Note that outcomes listed with a question mark are those that are plausible but that can only be definitively demonstrated through systematic evaluation.

Unresolved dynamics

While a wide range of positive outcomes for aides and the agency were observed, some limits to the outcomes for aides were identified (see Table 2). These tended to be associated with compensation and other financial issues that are strongly driven by policy decisions related to home care financing and labor. Additionally, there was disagreement among interviewees about the degree to which the complex issue of supervisor relationships had been effectively addressed by the support call effort. While one core team member felt that relationships between aides and supervisors had improved during the pandemic ("I think now, the supervisors are listening, and learning how to listen"), most felt that this was an ongoing challenge due to supervisors' caseloads, time pressure, and job orientation.

Facilitators and barriers

Several key factors appear to have facilitated the development, unfolding, and achievements of the support calls.

(1) Organizational recognition of the urgent need for emotional support for staff during the COVID-19 pandemic.
(2) The unique structure of this home care organization, which includes highly skilled mental health and organizational change professionals working in-house who became part of the core team.
(3) The evolution toward a core team that was uniquely situated and motivated to support aides both inside of and beyond the calls.
(4) Flexibility of call topics and offerings, including the ability to address both emotional and operational issues.
(5) The decision to disseminate a weekly summary of call themes to agency leaders and other stakeholders, which increased empathy for aides' needs and organizational integration of aides' concerns.
(6) Challenges in maintaining an adequate supply of aides due to the pandemic raised their visibility within the organization.

In the first year of this effort, relatively few barriers arose to the implementation of the support calls. This is likely due to the factors identified above, particularly the urgent needs created by the pandemic, the sociopolitical events of 2020–2021, and the rollout of the COVID-19 vaccine. Notably, none of the interviewees appeared to view cost as a barrier. Resources that were required to run the calls included: staff time for each of the core team

members, communications support, and a fee for the phone line. Staff time ranged from two hours per week (for the facilitator and nurses) to 50% of the operations manager's full-time position during the most difficult periods of the pandemic. It is also worth noting that VNSNY has demonstrated flexibility and community-mindedness during emergencies historically and that spirit is evident here as well (Christopher & Goldstein, 2014). When we concluded our study of the calls in April 2021, there was a strong commitment to continuing them. That said, in the latter months of the year of calls, some tensions regarding the degree to which the support calls should continue to address both emotional and operational issues arose among leaders and core team members. Settling this question presents a challenge and will likely shape the outcomes of the calls going forward. While we do not see these tensions as a risk to the continuation of the calls, they seem likely to influence the degree to which operational issues are addressed alongside emotional issues on the calls.

Discussion

In this article, we have described how one large agency shifted how it supports aides emotionally and operationally in response to the COVID-19 pandemic, how this led to an increase in empathy among those managing the support calls and key leaders in the organization, and how aides' experiences became more integrated into organizational decision-making as a result.

Concerns about recruitment and retention of aides as the need for their work grows are long-standing, and are more urgent now than ever (Tyler et al., 2021). In order to improve retention and job satisfaction, researchers have recommended that home care agencies develop stronger systems of communication, emotional support, and "respect/consideration/appreciation" for aides, in addition to improved compensation (Butler & Rowan, 2013; Weller, Almeida, Cohen, & Stone, 2020). Though the calls only directly reached a small percentage of employed aides overall, they did appear to extend and enhance the emotional support available to these aides. Given the level of individualized operational support offered beyond the calls, the calls may also have helped some aides to address problems like inconsistent hours and job security, which may impact retention and satisfaction (Butler et al., 2014). It is important to note though that inconsistent hours and job insecurity are problems that stem from the organization of home care labor more broadly, and thus can only be systematically addressed through changes to long-term care policy and financing (Campbell, Del Rio Drake, Espinoza, & Scales, 2021). Finally, the calls also appear to have substantially improved communication and respect for aides within the organization, a shift that has the potential to reach a larger percentage of the organization's employed aides. Though we

cannot know the full contribution of the calls to aides' retention and job satisfaction without a systematic evaluation, these are provocative examples of the potential of agency-level action in improving these outcomes.

One notable dimension of the calls is how they may have shaped aides' perceptions of their level of control at work and ability to influence organizational actions that concern them, another key determinant of retention and job satisfaction (Gleason & Miller, 2021). Though the call notes and interviews did not address this topic, the quote we included earlier in this article from an aide involved in a separate project suggests an emergent sense of empowerment to influence work and work organization. There is a substantial literature in the fields of organizational behavior, employment relations, and human resources on the topic of worker voice (e.g., Wilkinson, Gollan, Kalfa, & Xu, 2018). This literature highlights several dimensions of worker voice that could be analyzed, including level (at which participation takes place), scope, form (e.g., individual vs. collective), agenda (e.g., issues that are shared vs. contested between employees and management), and influence (e.g., communicating suggestions vs. influencing workplace decisions) (Oyetunde, Prouska, & McKearney, 2021). Considering how these dimensions work together to produce types of worker voice that result in aide retention may be an important step going forward. The question of how worker voice might influence worker health outcomes is also an intriguing one. While employee voice and managerial responsiveness have been associated with decreased burnout among nurses (Holland, Allen, & Cooper, 2013), there generally appear to be relatively few studies thus far examining the role of worker voice in worker health outcomes.

One of the innovations of this effort is its central emphasis on the importance of aides' mental health and the value of their work. Though aides face many hazards on the job (Markkanen et al., 2014), the psychosocial stressors threaded throughout this work are a complex and critical determinant of aides' health. Relationships with clients and their families produce a wide array of challenging emotional demands. These include: being asked to do tasks outside of job duties(Franzosa et al., 2019; Karlsson, Markkanen, Kriebel, Galligan, & Quinn, 2020); clients' personalities, dementia, and mental health issues (Markkanen et al., 2014); dysfunctional dynamics in clients' families (Markkanen et al., 2014; Franzosa & Tsui, 2021); work-family conflict for aides (Franzosa et al., 2019; Tsui, Franzosa, Cribbs, & Baron, 2019); the death of clients (Tsui et al., 2019; Boerner, Burack, Jopp, & Mock, 2015), and verbal and physical abuse (Karlsson, Markkanen, & Kriebel et al., 2019). That aides must typically navigate these demands with extremely limited training and job-based support further exacerbates the work's mental health impact. While the effort described in this article is modest in comparison to the wide range of psychosocial stressors pervasive in this work, it represents

a notable departure from typical agency approaches that fail to recognize these stressors, or leave aides to navigate them in isolation and without recognition of the demands of this labor. Additionally, this agency's effort is just one example of many improvisations that agencies may have undertaken to better support aides. Capturing how home care agencies broadly are evolving how they think about supporting aides in light of the COVID-19 pandemic and workforce shortages may help us to understand what is most promising and feasible for improving aide retention and health through action at the agency level, as well as where barriers lie.

Limitations. This study has a range of limitations. Most significantly, we did not include primary data collection with aides who participated in the calls, and thus that perspective is missing from our analysis. Our rationale for this choice was that our primary goal was to document the nature of this unfolding effort and its effects within the organization (not to evaluate its effects on aides), and to begin a conversation about how agencies are shifting the way they support aides. That said, a systematic evaluation of the effort's effects on aides going forward would be immensely useful. Another limitation is that the call notes were generated by a member of the core team with the goal of garnering recognition for the calls and aides' voices, not with systematic research in mind. The notes thus highlight certain aspects of the calls (with a particular emphasis on their achievements) and likely fail to report others. In observing one week of calls though, we found the notes and the experience of the calls themselves to have a strong correspondence, with few significant themes left out. Finally, the single-case study design leaves open the broader question of how other types of agencies may have reformulated their support for aides during the pandemic, and is not able to assess the facilitators and barriers across agencies. The uniqueness of Partners in Care's size and structure may work against the replicability of very similar efforts at other agencies, but insights about the larger process that Partners in Care underwent in formulating this effort may be transferable (Lincoln & Guba, 1985).

Conclusion

The retention and mental health of aides were issues in need of urgent attention prior to the COVID-19 pandemic and are even more pressing now. Effectively addressing these issues will require action at multiple levels, including shifting long term care policies and financing so that aides can receive better pay, benefits, and more predictable hours and schedules. However, the practices of home care agencies are important working conditions that influence aides' stress and mental health, as well as their recruitment and retention. The need for agencies to take this role more seriously is long-

standing, and we look forward to further research that documents and evaluates innovations focused on aide health and well-being from the COVID-19 pandemic period.

Note

1. To preserve the anonymity of aides, the core team did not collect information about which individual aides participated and how often. We know from aides' comments in the thematic notes that some did participate repeatedly. For this reason, any effort to estimate what percentage of employed aides were reached by the calls has significant limitations. We do know, however, that it was a small percentage, given that the total number of employed aides ranged from 9000 to 6100 during this period.

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