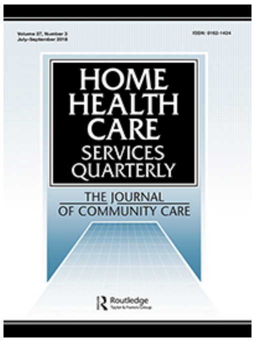

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Protecting workers in the home care industry: workers' experienced job demands, resource gaps, and benefits following a socially supportive intervention

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ABSTRACT

The Community of Practice and Safety Support (COMPASS) program is a peer-led group intervention for home care workers. In a randomized controlled trial, COMPASS significantly improved workers' professional support networks and safety and health behaviors. However, quantitative findings failed to capture workers' complex emotional, physical, and social experiences with job demands, resource limitations, and the intervention itself. Therefore, we conducted qualitative follow-up interviews with a sample of participants (n = 28) in the program. Results provided examples of unique physical and psychological demands, revealed stressful resource limitations (e.g., safety equipment access), and elucidated COMPASS's role as a valuable resource.

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Introduction

Home care workers (HCW) are a quickly growing and vulnerable segment of the working population. Due to the rapidly increasing elderly population, the number of HCWs in the United States is projected to grow by 50% over the next decade (Bureau of Labor Statistics, 2014). Although HCWs are in high demand, they receive low wages (national average of $10.00/hour, Bureau of Labor Statistics, 2014) and often work in poor conditions with little to no interaction with other care providers. Their duties include cleaning, shopping, driving their consumer-employers (CE) to appointments, and physically assisting them with dressing, bathing, and mobility. Unsurprisingly, given these

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physical demands and unregulated work environments (i.e., CE's homes), HCWs experience prevalent musculoskeletal pain (Larsson, Karlqvist, Westerberg, & Gard, 2013) and have a lost work time injury rate about 3.5 times the US national average (Bureau of Labor Statistics, 2015). HCWs are also at-risk for health conditions such as arthritis, high blood pressure, and migraine headaches (Denton, Zeytinoglu, Webb, & Lian, 1999) but have difficulty obtaining health insurance (Butler, Brennan-Ing, Wardamasky, & Ashley, 2014), which can limit preventive care.

Despite known hazards and the potential for a crisis-level shortage of HCWs in coming decades (Ozga, 2015), little empiricism has addressed how to best improve working conditions for HCWs. One key area of research is evaluating socially supportive workplace programs for HCWs. To address some known resource gaps for caregivers, the Community of Practice and Safety Support (COMPASS) program was developed for HCWs who provide publicly funded in-home services in Oregon as independent contractors. This development and research took place within the Oregon Healthy Workforce Center – a Center of Excellence in *Total Worker Health*® (grant U19 OH010154, National Institute of Occupational Safety and Health). As previously described (Olson et al., 2014, 2015), COMPASS provides a series of group meetings involving scripted instruction, goal setting, and structured and collaborative social support processes. The program integrates evidence-based strategies including scripted peer-led team elements (Elliot et al., 2007, 2004; Goldberg et al., 1996; Kuehl et al., 2014) and activities from social support groups (Delbecq & DeSchryver Mueller, 2012; Toseland, Rossieter, & Lebrecque, 1989).

In a randomized controlled trial (Olson et al., 2016), COMPASS produced significant improvements in social resources, health and safety behaviors, and some objective health outcomes. However, strong quantitative results failed to capture the drama or complexity of workers' emotional and physical work demands, resources and resource gaps, or how workers experienced the program and its benefits. Thus, qualitative follow-up research was undertaken to illuminate more fully the nature of the work and the experiences of normally isolated workers participating in a socially supportive program.

Background on publicly funded home care services in Oregon

In Oregon, publicly funded in-home services are overseen by the Department of Human Services and the Oregon Home Care Commission (OHCC). The OHCC is charged with ensuring that older adults and people with disabilities receive high-quality services. The OHCC provides training and resources for HCWs and serves as the employer of record for collective bargaining purposes. The workforce is represented by the Service Employees International Union (SEIU) Local 503. HCWs are paid through a state payment system.

The Department of Human Services offers person-centered CE-directed programs. Oregonians who qualify for public-funded in-home services are referred to as "consumer-employers" because they directly hire HCWs to provide their needed services and supports. Case managers, employed by agencies within the Department of Human Services that support the elderly and people with disabilities, are responsible for completing a needs assessment and developing a service plan and task list. Each task list identifies the specific tasks/services and supports that a HCW is authorized to provide for a specific CE and the amount of time they are allowed to spend on each task. HCWs are managed by the CE or their representative who is responsible for hiring and firing, directing/instructing how their services and supports should be provided, verifying hours worked by their HCW, and setting employment guidelines. If a HCW has a concern about their task list or their safety while working in a CE's home, they can contact that CE's case manager to resolve issues. HCWs who are actively working are paid their hourly rate to complete OHCC trainings. The current qualitative research was conducted with the first groups of workers to take the COMPASS program as a paid OHCC training course.

Job demands and resources

To explain how working conditions impact employee well-being, Demerouti et al. (2001) developed a *job-demands-resources* model emphasizing the following:

1. *job demands* that require sustained effort and can be associated with health issues and burnout, such as excessive or chronic physical challenges and emotional pressures.
2. *resources* that protect or motivate workers, including physical, psychological, social, or organizational aspects of the work such as pay, autonomy, and task significance.

To illustrate, home care demands may include unpredictable scheduling, conflict with CEs, exposure to chemicals, and physically challenging tasks (Denton, Zeytinoglu, & Davies, 2002). Reported psychological resources may include a sense of meaning and personal accomplishment, close bonds with CEs, social and organizational resources (although variable and often limited), and job flexibility (Butler et al., 2014).

Social support is a resource that may reduce job strain and contribute to a wide range of positive outcomes including empowerment for making changes and goal accomplishment (Ashing-Giwa et al., 2012; Viswesvaran, Sanchez, & Fisher, 1999). Social support can also be critical to health intervention effectiveness (Johnson, Scott-Sheldon, & Carey, 2010; Prestwich et al., 2014). By offering safe spaces for discussing job issues, supportive programs (or people) may magnify health benefits for disadvantaged individuals (Kominiarek, Gay, & Peacock, 2015), especially when offered in the absence of external expectations or power differentials (Murray, 2006). Although the general utility of social support groups is established, little is known about the specific mechanisms underlying effective social programs for disadvantaged populations such as HCWs.

Qualitative investigation of intervention effectiveness begs attention to subtle psychosocial dispositions and processes apprehensible through interviewing (e.g., Hildingh, Fridlund, & Segesten, 1995; Lipman, Kenny, & Jack, 2010; Waite-Jones, Hale, Raven, & Lee, 2013). Interview studies have identified socializing processes as strong forces for HCWs' continued caregiving (Dellve & Hallberg, 2008) and the importance of finding dignity in distasteful work through feelings of task accomplishment and relationships with CEs (Stacey, 2005). A meta-synthesis of 13 qualitative studies of HCWs confirmed the importance of these relationships (Lindahl, Liden, & Linkblad, 2010). However, in our search, we did not identify any qualitative investigations of HCWs experiences following a socially supportive intervention.

The present study contributes to this literature with an examination of a program that uniquely offered both educational and social support resources to HCWs in order to improve their safety, health, and well-being. The qualitative research prioritized the perceptions and experiences of this often-silent worker population.

Methods

COMPASS is a research project of the Oregon Healthy Workforce Center, a NIOSH Center of Excellence in Total Worker Health® (CDC-NIOSH, 2015). To date, the project has involved three samples and program adaptations:

(1) a pilot involving a workshop and 6 monthly meetings (Olson et al., 2015) plus an additional 6 monthly meetings with a variation in meeting structure (unpublished).
(2) a randomized controlled trial, where the intervention arm participated in a workshop and 12 monthly meetings (Olson et al., 2016).
(3) the current research sample, involving an adapted program for an Oregon training system with 7 bi-weekly meetings over 3.5 months.

Following an explanatory sequential mixed methods design (Creswell, 2014), quantitative research (Olson et al., 2015; Olson et al., 2016) was followed by the current qualitative investigation of demands, resources, and experienced learning and social support in the intervention. This study focused on understanding the phenomenological realities of participants (Erickson, 1986; Mabry, 2012; Wolcott, 1995) – what HCWs themselves found influential, their meaning-making, and the contexts and conditionalities that promoted or inhibited positive impact.

Data collection

Five groups of 5–10 HCWs each (*n* = 42) participated at three Oregon sites. Participation was voluntary, and all participants were eligible to serve CEs in publicly funded programs, although a few lacked current CEs. All participants were paid their hourly wage by the OHCC to attend COMPASS meetings and were paid by the research team to complete a follow-up interview after their final meeting. Participants attended an average of 5.6 (SD = 2.0) of 7 possible meetings. Staff observed 35 meetings and conducted 28 one-on-one interviews. Observation notes were transcribed and ten observations were written up as more extensive experiential vignettes (Atkinson & Hammersley, 2007; Mabry, 2012). Guided by peer-reviewed protocols, all interviews were audio-recorded, transcribed, and checked for accuracy. To enhance validity (Maxwell, 2004), semi-structured interview data (Kvale & Brinkmann, 2009; Rubin & Rubin, 2012) were triangulated by source and method (Denzin & Lincoln, 2005). Informal observations by research staff during the entire research program supplemented these data.

Procedures were reviewed and approved by Oregon Health & Science University's Institutional Review Board. Pseudonyms for participants are used to protect confidentiality.

Participants were primarily female (83.3%), Caucasian (78.5%), and averaged 48.8 years of age (SD = 12.0) and 7 years (SD = 8.0) of home care experience. Individuals averaged 23.1 work hours per week (SD = 16.5) caring for 1.6 public (SD = 1.0) and/or 0.8 private (SD = 0.7) CEs. Hourly care (73.8%) was more prevalent than live-in, and most worked for non-family members (73.9%).

Data analysis

Thematic content analysis of data was collaborative and inductive (Mabry, 2012; Miles, Huberman, & Saldana, 2013; Wolcott, 1994). In an *a posteriori* approach consistent with qualitative methodology (Von Wright, 1971), data were organized by location and date, reorganized topically, and reorganized again according to emergent themes that were continuously refined. Independent preliminary analyses by research team members were followed by five weekly sessions of analytic discussions. Between discussions, interviewers and observers searched data each had collected to identify theme-related data related to preliminary interpretations.

The analytic advantages of constructing a *logic model* (Knowlton & Phillips, 2013) were rejected as unhelpfully mechanistic in favor of Bronfenbrenner's (1979) ecological levels of analysis. Focused primarily on the *microsystem* of interpersonal HCW–CE interactions, attention was also devoted to the *mesosystem* of caregivers' relationships with their CEs and others, the *exosystem* for organizing and governing home care work, and the *macrosystem* of values and beliefs, with attention ultimately to some ideological dissonance between government systems prioritizing CE care vs. HCW well-being. Reporting of results includes quotations to deepen readers' tacit understandings (Von Wright, 1971) through vicarious experience (Carter, 1993).

Results and discussion

Analysis of interview and observation data revealed several areas of concern for HCWs. Demands related to both physical and emotional labor were often reported as especially challenging for HCWs. Working alone in private homes caregivers lacked opportunities to check decisions, and mindful of CE privacy, could not turn to family and friends for social support. This double isolation intensified work demands. Results below are organized into two themes: (a) physical labor and health in isolation and (b) emotional and relational demands in isolation. Each thematic section addresses work demands, resources and resource gaps, and experienced intervention resources and impacts.

Physical labor and health in isolation

CEs often needed assistance with mobility, and their frailties or disabilities often intensified physical work demands. HCWs reported performing demanding tasks like moving furniture and helping CEs move from beds, toilets, and bathtubs. During COMPASS group discussions, the top three hazards listed by one group were lifting or transporting CEs, bathing CEs, and cleaning bathrooms (observation, June 5, 2015). Explained one, "Transferring clients is a gamble because you may do it incorrectly and get hurt" (Tate, June 5, 2015).

Physical tasks, typically performed by worker teams or with mechanical equipment in more formal health-care settings, were undertaken single-handedly: "I have to take those risks when I am working alone" (Tucker, June 5, 2015). HCWs reported that risks were exacerbated by lack of assistance and the remoteness of resources. Lower back, shoulder, knee, and neck pain, which are common HCW complaints (Wipfli, Olson, Wright, Garrigues, & Lees, 2012), were elaborated by interviewees who described chronic pain (e.g., Olive, April 11, 2015) and injuries resulting in surgery or absenteeism (e.g., Tate, May 22, 2015).

Resources and resource gaps

Structural resources include supportive mechanisms available to HCWs through the OHCC and the SEIU Local 503. Issues concerning HCW safety are addressed structurally through labor/management committees, training, manuals, and the collective bargaining agreement.

Resources provided by the OHCC included a *Safety Manual for Homecare Workers* (Oregon Home Care Commission, 2012) and substantial training system offering 25 course topics, including offerings such as "Taking responsibility for personal safety" and "Protecting against sprains and strains" (Oregon Home Care Commission, 2011). The OHCC requires HCWs to take at least one safety training every two years in order to stay on the OHCC Registry, which is a resource CEs use to find and hire HCWs. Many COMPASS participants described OHCC classes as useful but said that the lecture format did not facilitate peer connections or provide adequate training with protective tools (e.g., slide boards, transfer belts, portable lifts).

Procedures for acquiring safety equipment were often unknown or reported as complicated, time-consuming, and rarely successful. In the Oregon work arrangement, equipment/tool acquisition must be driven by CEs or their family members with support from the CE's case manager. If workers' efforts survive communication hurdles and sheer fatigue, only limited types of durable medical equipment are reimbursable through Medicaid. As a consequence of all the challenges with acquiring tools, HCWs often experienced stress, obtained their own tools, or did without.

COMPASS resources and effects on physical labor and health

COMPASS's scripted lessons about ergonomic tools, practice with protective equipment, and group discussions improved HCW safety awareness and practices. Interviewees noted their greater alertness to worksite hazards and increased use of injury-reducing postures and tools. One described purchase and CE reimbursement for mops with ergonomic handles (Kennedy, May 23, 2015), and others said,

> For years [I got] down on my hands and knees [to] scrub the bathtub … [but, now, I] use kneepads. Put those down, put your knees down, and maybe get a long-reaching handle … [and it's] less stress on the back. (Juniper, May 23, 2015)

> I'm starting to realize that I need some assistance from durable medical equipment … There's things my [CE] should be having that would make the care worker's job easier … There's days that my [CE] can't stand up and use her legs. (Tate, July 3, 2015)

The COMPASS guidebook was developed to expose workers to low-tech ergonomic tools based on their utility and need for isolated caregivers. This includes some tools that are reimbursable (e.g., transfer boards) and others that are not (e.g., *Gimme-a-Lift*®). Popular tools introduced through

COMPASS included turning disks for pivoting a seated person and the *Gimme a Lift*® device to support transitions like moving from sitting to standing. Participants also shared other tools they used in their work, such as anti-friction draw sheets for transitioning clients in bed or pulling them into wheelchairs (observation, June 5, 2015).

When tools were not applicable or unavailable, workers reported that COMPASS information about neutral spine postures helped alleviate body strain. For example, rather than reaching across a bed to be made, one caregiver began to "make first one side, and then go around and make the other side. That's been much easier on my back" (Cooper, May 26, 2015). Another summarized, "This [COMPASS] class teaches to think about ourselves … even if it is a few minutes, to do something for my body" (Olive, May 23, 2015).

The benefits of increased use of safety equipment and postures were extolled by virtually all participants. Most could specifically describe how their new-found awareness had translated into protective action: "I realized there were some safety hazards … I'm using a little scrubby-type thing with a handle… and I use that knee pad" (Esme, May 23, 2015).

Safety behavior changes included improved communication with CEs regarding workplace hazards. When one participant found her CEs "kind of hesitant" about pro-safety changes, this caregiver reported that she was able "to explain to them this is going to help my back" (Esme, May 23, 2015). Another persuaded her CE to stand differently in the shower so that the HCW could avoid poor posture during bathing (Nora, July 10, 2015). "Certain concerns that I've had with my employer that I found …I'm more comfortable and confident in addressing … I have learned that I am just as important as my employer" (Leighton, June 19, 2015).

In addition to safety changes, COMPASS also addressed healthy eating and exercise through lessons and goal setting. Participants iterated improvements they had made to diet and exercise: "eating healthier, cutting out some of the carbs and adding more of the fruit and vegetables, getting active and walking more" (Juniper, May 23, 2015).

> I go back to the [COMPASS] book … [Also, I am] tracking for vegetables … I use this … bead bracelet … [and] the step counter … The exercises, too – at home, I'm doing it. And I remember the positions [neutral spine posture] … I implement it in my life and in my work. (Olive, May 23, 2015)

Thus, COMPASS resources addressed physical hazards through information, practice with tools/postures and communication strategies, goal setting, and supportive group discussions. Some physical hazards were allayed through communication with CEs, tool acquisition or increased tool use, and changed safety practices. Information and goal setting were reported as helpful for making additional health behavior changes.

Emotional and relational demands in isolation

Intense emotional stressors for caregivers became apparent as a result of the phenomenological approach taken in the qualitative research. Complex histories, habits of tangled interdependence, and fractured decision-making often trapped HCWs in difficult situations. Relationships with CEs proved a paramount source of tension as HCWs both bonded with them and simultaneously struggled with complex employment relationships.

In some cases, the advent or experience of CE death generated deep HCW concern:

> [For] 90% of our clients … we're going to come to work one day, or we're going to get a phone call, and they aren't going to be there anymore … Every day, I go to my client's house, and I open the door. I always call out to him, and if he doesn't answer, I panic. (Jasper, June 17, 2015)

> I was able to hold [my care recipient's] hand when she died … It's not an easy thing … watching a client pass away slowly in front of your eyes. (Titus, May 23, 2015)

In less extreme cases, declining CE abilities strained caregivers who witnessed them "mentally struggling with what they cannot do." One grieved with a well-traveled CE who had lost mobility: "She's lost so much of her life … being disabled" (Phillipa, April 28, 2015). Such plights redoubled many HCWs' vigilance and empathy:

> If you say you're going to be there at 9:00 for someone, you're going to be there at 9:00! Now, if you have a person who's waiting for you and laying in bed because they can't get up by themselves, and you're 20 minutes late … can you imagine – "I can't get up by myself, and I gotta go to the bathroom. I don't want to wet my pants … I'll be so humiliated!" (Clara, May 19, 2015)

Relationship maintenance

While many COMPASS participants experienced close connections with CEs, they also described relationships as complicated. It was hard to maintain boundaries related to assigned hours and tasks while also maintaining positive relationship with CEs and their family members. This duality frequently led to complex emotional responses by HCWs:

> If [CEs] want something, they want it right now … Just about the time you're getting ready to leave, your client goes, "Could you do this before you go?"" It's not that they want that done – they want you to stay with them … They want to be a person." (Jasper, June 17, 2015)

Ambiguity lurked in the interstices between approved task lists and actual CE needs. Some unapproved tasks presented themselves vividly; others accrued as incremental, almost unnoticed, encroachments over time. Often feeling helpless as the boundaries of their jobs stretched to fit circumstances, many participants became victims of task creep. Moreover, financial vulnerabilities often discouraged HCWs from speaking up out of fear that they could lose their job.

Inappropriate requests could be innocent: “I think the consumer-employers are confused about the expectations of what we’re to do” (Kennedy, May 23, 2015). Some caregivers themselves reported difficulty recognizing improper requests. Unapproved tasks might arise spontaneously and be accomplished before HCWs had time to reconsider. And, completion of an approved task might necessitate prior completion of an unanticipated and unapproved task. Task lists could fall out of date or underestimate actual needs.

Stress was amplified when CEs’ needs exceeded the HCWs' assigned duties. For example, while the husband of her CE “was in the hospital for a long period of time,” Avery continued to care for her assigned CE, his wife. “When he was able to come home, he still had a lot of support needs,” such that Avery felt compelled to move into their home. Ultimately, Avery felt trapped: “I just knew I needed to move out … [but] I certainly didn’t want them feeling I abandoned them” (June 24, 2015).

When demands originated with a CE’s family members, a hapless HCW could be outnumbered. For example, the husband of one CE treated his wife’s HCW like she was also *his* caregiver and his maid, and repeatedly asked her to do things that were not on her task list (Clara, May 19, 2015). When HCWs were uncertain about how to handle such requests, their isolation prevented in-the-moment clarification by case managers. Over time, one caregiver “felt as though she had to do everything that a consumer-employer told her” (Leighton, June 19, 2015).

Even when HCWs clearly understood their duty limits, CEs and families could be forceful in pushing boundaries:

> I worked for a [CE] disabled on crutches … [and discovered] he’s picking up all kinds of drugs from different doctors…and selling them … I told him, “You can’t be selling drugs,” and he said, “You can’t tell me what to do. I’m your boss.” I said, “This is illegal!” … I called his mother and said, “[He’s] doing things I can’t work with,” and she said, “We don’t want you anyway”. (Atticus, May 23, 2015)

Subject to summary dismissal by their CEs, HCWs tended to comply with demands for unlisted tasks. Bound to their “dirty work” (Stacey, 2005) by their income needs, one participant explained: “Most caregivers don’t have a lot to fall back on financially” (Ariel, May 19, 2015).

Emotional isolation

The work often created on-the-spot exigencies requiring quick thinking. Working alone, HCWs reported no opportunities to communicate with colleagues to try to determine the optimal response. Afterward, caregivers’ diligent protection of their CEs' privacy preempted post-event venting, collaborative reflection, or catharsis:

> You can't just speak out to anybody, like your best friend or anybody, about a problem at work … [As] caregivers, we get [challenges], but we don't always have some place to go fix it. (Juniper, May 23, 2015)

> I had to keep it to myself. The only person that can know is the doctor, and I cannot express to him what I feel because he only goes through the science process and not the feeling process. (Olive, May 23, 2015)

Also perilous were the effects of serving "people who are abusive – I mean verbally and physically. We still have to work with and for them – cope with them " (Hadley, June 10, 2015).

Isolated from conventional personal support, their conscientious guarding of CE privacy magnified stress for themselves, articulated in words such as these: "I had a tendency to take everything on myself because I didn't have that support system" (Leighton, June 19, 2015).

Resources and resource gaps

The OHCC offers several paid trainings to help HCWs cope with the emotional challenges of the job. Participants reported particular appreciation of OHCC courses in stress management, relaxation techniques, and coping with grief and loss. One participant shared OHCC class materials with a COMPASS group member grieving the death of his CE. Additionally, the OHCC offers trainings to help HCWs set professional boundaries and communicate more effectively with CEs. However, there were often reports of constrained opportunity to interact with other caregivers in these trainings: "We barely know each other, barely see each other in [OHCC] trainings … You're sitting in a place, and you're just staring at a head" (Clara, May 19, 2015).

While case managers provided a task list and service plan, HCWs often found CEs' needs were typically more complicated than task lists suggested and that case managers were too busy for real-time support: "Sometimes, they don't have the time. They have a lot of work" (Olive, May 23, 2015). Moreover, it was the purview of CEs as employers, not the HCWs themselves, to initiate any changes to task lists or service plans.

COMPASS resources and effects on emotional and relational demands

Underlying many caregivers' persistence despite insufficient resources was a disposition to prioritize the needs of others over themselves: "I have always cared for others and neglected myself. It just comes natural. It's not something I've ever really thought about" (Leighton, June 19, 2015). This pervasive tendency was so deeply embedded that "some caregivers actually pay their own money to get the stuff they need to do a better job" (Clara, May 19, 2015). HCWs' so-called "helper personalities," invaluable for caregiving, typically displaced concerns about their own families, homes, finances, health, and safety. Thus, the very qualities that predisposed them to caregiving left them in heightened need of self-care. COMPASS "seemed to 'flip the script' in a way that we were able to focus on our own needs" (Leighton, June 19, 2015) and to "think about … how to take care of ourselves" (Olive, May 23, 2015). The rarity of explicit focus on self-care was explained by a participant: "I've taken other home care training classes [that were] about how to take care of the client … not focused on the care worker and their health problems" (Paige, June 24, 2015).

Providing a forum to reconsider a self-sacrificing mindset, COMPASS was "important because we usually don't think about ourselves" (Olive, May 23, 2015). One COMPASS participant described the resulting dispositional change as a precursor to later behavioral manifestation: "Something, I feel, has changed. I'm more willing to express my concerns when it comes to my health or safety" (Leighton, June 19, 2015). The impact of attitude adjustment on caregivers' lives could be immense, as when group encouragement helped Avery, who had been pressured into moving into her CE's residence, return home (June 24, 2015).

A professional community of practice

COMPASS explicitly fostered professional and personal support. This was a primary reason for many HCWs' willingness to participate: "I was interested in becoming part of the group … so that I could build connections" (Leighton, June 19, 2015). Interviewees insisted that peer connections constituted the single most needed and valuable aspect of COMPASS. Interconnections had been recommended but not deeply facilitated "at the SEIU in meetings and trainings," and in OHCC classes (Leighton, June 24, 2015). At the top of the list of positive program outcomes were professional contacts and collaborative problem-solving with peers. For most, COMPASS provided their first supportive network, a unique "opportunity to open and say things that you never would be saying at other classes" (Adair, June 10, 2015).

> I had been holding it all in, [but after sharing with my group], I felt good. Sometimes … you're just thinking you're going to scream, but you cannot scream. I felt that way … I felt like I got rid of something. (Olive, May 23, 2015)

At each COMPASS meeting, participants shared updates and issues from work or home during recurring segments entitled "WorkLife Check In" and "Work-Life Support." Prompting feedback from empathic others, facilitated group discussion of problems in a confidential environment was highly valued by participants: "I felt like [I was] in a safe space" (Avery, June 24, 2015).

Most interviewees expressed appreciation of such support, but one who did not complained, "Most of the time, [brainstorming] just kind of degenerated, and everybody spoke about everything at the same time" (Heather, May 26, 2015). More typically, collaborative discussions “[are] what I like about COMPASS…opportunity to express ourselves” (Olive, May 23, 2015).

In near-unanimity, interviewees extolled the benefits of group brainstorming and problem-solving as “hugely helpful to me in my own work, even [when] the problem wasn’t mine. A lot of the solutions [were] things I wouldn’t have thought of” (Phillipa, May 26, 2015). Participants recognized that “one person can’t think what ten people can think [and sometimes, you] *can’t* think about it – it’s too overwhelming. But when you get a group together that’s supporting you, and they’re giving ideas …’Oh, yeah!’” (Atticus, May 23, 2015).

Some participants planned to sustain their supportive COMPASS connections: “I’ve built relationships with other home care workers and feel comfortable in knowing I can pick up the phone and call them or e-mail them” (Kennedy, May 23, 2015). The group approach that produced these positive effects prompted some HCWs to initiate formal ongoing opportunities: “COMPASS broke the isolation, and we all became friends … We are planning on the second Saturday for lunch and stuff with the rest of the group” (Titus, May 23, 2015).

Such plans, some underway before the COMPASS sessions ended, not only demonstrated the value of its group approach but also predicted a longer-term outcome: self-sustained communities of practice (Wenger-Traynor & Wenger-Traynor, 2015).

Thus, interview data revealed COMPASS’s value for enhancing HCW well-being by addressing emotional needs and reducing isolation. In what had been a professional void, COMPASS provided “a support group [of] people with similar experiences … I really think that’s a positive thing for people who work alone” (Ada, June 16, 2015).

Conclusions

The goal of the current study was to conduct an in-depth qualitative examination of the experiences of HCWs who participated in a socially supportive safety and health program. Given the growing demand for HCWs and the hazardous nature of the work, it is critical to understand how interventions can improve working conditions to attract, protect, and retain these critical caregivers. Interview data suggested that HCWs were able to improve health and safety conditions and behaviors observed in prior quantitative research (Olson et al., 2016) with the help of interacting resources: (a) improved knowledge base, (b) facilitated support, and (c) goal-setting and social accountability for making changes.

From the caregivers’ perspectives, COMPASS’s greatest contribution was opportunity to learn from and share with peers and develop supportive relationships. This benefit corresponded to the program vision of fostering a *community of practice*, a “group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly” (Wenger-Trayner & Wenger-Trayner, 2015). Formal or informal, such groups share commitment; engage in resource coordination, problem-solving, and social learning; and create resource reservoirs.

On this significant dimension, COMPASS filled a void. Although in-home caregivers face tricky relational problems that require a high level of social problem-solving, other training resources had not provided for networking or collaboration, and confidentiality imposed limits on caregivers’ access to social support. Consequently, HCWs really needed each other, and they used COMPASS to share resources – especially themselves. Workers also valued how the program revealed the importance of safety and health self-care, rather than exclusively focusing on CE needs at the expense of their own well-being.

Overall, our qualitative investigation illuminates the unique demands and resource gaps experienced by HCWs, as well as the potential for supportive interventions to address some resource gaps and generate positive impacts for HCWs. Although this study represents a key step in improving the lives of HCWS, future research and policy work should emphasize the combination of individual-level or group interventions, like COMPASS, with policy, systems, or physical resource changes. System-level interventions are necessary to ensure adequate assessment and elimination/control of work hazards, such as assessment of physical tasks and efficient provision of equipment and training. This is a particularly important area of future experimentation in publicly funded home care arrangements where there are no traditional supervisors for workers who are functionally operating as independent contractors (the consumer is also the employer or supervisor, but has limited to no training in occupational safety and health). While the Oregon arrangement includes some elements of traditional safety programs (e.g., training, handbooks, resources, and protections specified in a collective bargaining agreement), the nature of the HCWs’ nontraditional workplace setting makes it challenging to implement other important components of traditional employer-based safety and health programs directed by safety and health professionals. For example, safety audits/inspections/job hazard analyses would be useful tools for assessing potential hazards and identifying trends, and safety committees would provide opportunities for interactive discussion and problem-solving.

An example policy intervention might be requiring a CE’s home to pass a safety inspection prior to the onset of home care services, with follow-up inspections to permit continued services. A structural safety support system could include the creation of a safety and health director position to oversee field safety advocates (parallel to, and integrated with the CE case management system). Field safety advocates could conduct home inspections and work in tandem with case managers to help the CEs and their families maintain safe working environments and provide each worker with the physical equipment needed to complete all assigned tasks safely. Safety advocates could also help prevent stressful and inappropriate "task creep." Another possible resource is the operation of an equipment library for workers to check out low-tech ergonomic tools that are not funded or easily obtained through Medicaid. Training on how to use the tools could be provided through existing training programs, or by field safety advocates. Investments in system-level interventions would be most sustainably funded by the state and would need to generate savings through reduced worker turnover and workers' compensation premium costs. In this regard, the relevant workers' compensation insurer and union are also stakeholders that could play a role in funding and supporting system-level interventions.

As the population ages in the United States and demand for HCWs is at an all-time high, it is critical to evaluate both individual- and system-level changes that can protect both CEs and their caregivers. Such efforts may help us improve working conditions, protect workers, and attract and retain new workers to meet the rising home care needs created by the historic ongoing shift in population demographics.

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Decleration of interest

The authors declare no conflicts of interest.

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