Feature Article

Home Care Aide Safety Concerns and Job Challenges During the COVID-19 Pandemic

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Abstract

Home care aides are on the frontlines providing care to vulnerable individuals in their homes during the COVID-19 pandemic yet are often excluded from policies to protect health care workers. The goal of this study was to examine experiences of agency-employed home care aides during the COVID-19 pandemic and to identify ways to mitigate concerns. We used an innovative journaling approach with thirty-seven aides as well as in-depth interviews with fifteen aides and leadership representatives from nine home health agencies in New York and Michigan. Workers described a range of concerns around workplace safety including uncertainty around whether a client had COVID-19, inadequate access to personal protective equipment and safe transportation, as well as fundamental changes to interactions with clients. Agencies also faced challenges acquiring personal protective equipment for their aides. This research points to needed resources to support home care aides *and* home health agencies both during a public health crisis and in the future.

Keywords

home care aides, caregivers, COVID-19, workplace safety, qualitative methods

> *The experience I have now is that nobody [is] safe as an aide or a resident. I'm putting my life on the line everyday to take care of these sick dying people.*—Aide

Introduction

Home care aides are on the frontlines during the COVID-19 pandemic yet are often excluded from conversations and policies to protect health care workers.[1,2] These caregivers support individuals with COVID-19 who are quarantined in their homes, who need post-acute care following discharge from the hospital due to COVID-19,[3] and those who have a disability or other chronic condition unrelated to COVID-19.[2] One subset of paid caregivers are home care aides (hereafter referred to as "aides") who in particular are in a precarious position because of increased exposure to COVID-19 given the physical proximity required and frequency of interactions with clients who are often more susceptible to mortality due to age or comorbid conditions.[4] Aides often lack autonomy, are on one of the lowest rungs of the pay scale of paid caregivers, and receive minimal or no paid sick leave, resulting in difficult decisions regarding work attendance to not lose vital income during the pandemic.[5,6] We sought to examine the barriers that aides in two regions of the United States, Western New York and Southeast Michigan, experienced in caring for clients in their home during the early months of the COVID-19 pandemic and the supports aides and home health agencies may need to more effectively address the current public health crisis as well as the future of home health care as a field.

Background

Home care aides provide vital support for the elderly and individuals with disabilities, which allows them to

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stay in their homes as a cost-effective alternative to receiving care in a nursing home facility.[7] There are several job titles for home care aides, including home health aides and personal care aides; in this article, we refer to these individuals as "home care aides" or "aides" for short. Home care aides' primary duties include assistance with instrumental activities of daily living including housekeeping, meal prepping, personal care, upkeeping family demands, and providing companionship and support.[8,9] Some home care aides provide assistance with activities of daily living including bathing, toileting, and dressing.[10] Aides also provide support beyond practical and clinical tasks, including emotional support and companionship.[9] This support helps keep their clients safe, decrease hospitalizations, and cut health care costs.[11] Nationally, aides are among the fastest-growing occupations with a projected growth rate of 36–37 percent.[5] Yet, aides receive little training [7] and face an unstable occupation that offers low wages and poor support benefits.[11] Home care aides can be employed by agencies or employed directly by clients; in this article, we focus on aides employed by agencies.

Home care aides are a largely marginalized group of individuals who are primarily women, non-white, middle-aged, immigrants, and have a high school education or less.[12,13] The average income for aides is about $20,000. A little less than half utilize public assistance in both New York (47 percent) and Michigan (42 percent).[14] Aides are entrusted with delivering compassionate care yet are put at an emotional disadvantage because of stressful workloads and a lack of benefits and low pay. Due to inadequate working conditions and lack of autonomy, turnover rates among aides are high.[15]

Previous research on pandemic and emergency planning has emphasized the roles and supports needed from home health agencies including plans for preparedness education, acquiring a stockpile of supplies, and ensuring staffing for home care aides.[16,17] A 2008 New York study[18] found that while 63 percent of aides would be likely to report to work following an influenza outbreak, only 5 percent of agencies had a written disaster plan in place and 86 percent of agencies did not offer pandemic preparedness education. After the 2009 H1N1 outbreak,[16] the majority of home health agencies surveyed claimed to have a widespread pandemic plan, infection control education, and an extra supply of personal protective equipment (PPE) at their facilities; however, smaller agencies were less likely to adopt these elements compared to medium- or larger-sized agencies.[16,18] In addition to the high-risk nature of aides' job demands during a pandemic, these low-income workers have a higher possibility of exposure outside of the workplace due to crowded living conditions or insufficient health care access. Previous research also pointed to the need to sufficiently and respectively account for aides during a crisis, emphasizing the need to develop secure alternatives to child care and transportation, provide access to health care, and distribute essential infectious control training.[17]

In response to COVID-19, a recent qualitative study[19] explored experiences and hardships of home care aides from various agencies in New York City, one of the early epicenters of the pandemic. The authors reported several recurring themes among aides including feeling invisible while on the frontlines of combating COVID-19, increased risk for transmission, inconsistent levels of agency support in terms of PPE and education, dependence on sources of support outside of their agency, and compromising health for income. Most notably, these workers greatly depended on public transportation and received insufficient PPE, both of which were factors that heightened their risks of contracting and spreading COVID-19 to their clients.[19]

The purpose of this study was to explore and examine the main challenges that aides experience in their current roles during the COVID-19 pandemic in Western New York (WNY) and Southeast Michigan (SEMI) and to identify potential solutions to mitigate these concerns and support both aides and home health agencies. The study team used journaling as a data collection approach to identify concerns and supports to more effectively address the current needs due to the pandemic and for the future of home health care as a field. To complement the journal entries and provide additional insight on challenges during the pandemic, we conducted semi-structured interviews with aides as well as with representatives from home health agencies in WNY and SEMI to elucidate agency perspectives on the challenges of the pandemic on home health care and to identify innovative approaches and strategies to mitigate these concerns.

Methods

Recruitment

We recruited agency-employed aides for the journaling and interviews using a limited snowball sampling method to draw from organization contacts within the WNY and SEMI regions including the Ralph C. Wilson Jr. Foundation and local organizations (i.e., Healthcare Workers Rising and the Detroit Area Agency on Aging). Some aides who enrolled in the study also referred us to additional aides to contact for recruitment. The team developed supplemental materials and messaging to highlight study details and the benefits of participation along with contact information for aides interested in participating. A study team member reached out directly to those who expressed interest for a screening call to obtain basic demographic information and data as well as obtain initial preferences on journaling method(s) (e.g., paper, Google form, email, audio recording). Eighty-nine aides (sixty WNY, twenty-nine SEMI)

expressed interest in the study; seventy-two aides were screened (forty-four WNY, twenty-eight SEMI), and sixty-seven aides (forty WNY, twenty-seven SEMI) were eligible to participate in the journaling.

As a measure to help protect the anonymity of aides who participated in the study, we did not collect agency-specific information from them. To obtain agency perspectives during COVID-19, we recruited representatives from home health agencies in WNY and SEMI for in-depth interviews through a public search of home health agencies in both regions as well as direct contact with the New York State Department of Health and the Detroit Area Agency on Aging.

The study was approved by the RAND Corporation's Human Subjects Protection Committee prior to recruiting participants. The team identified relevant local, regional, and national mental health and grief support services to include in informed consent materials and in our responses to weekly journal entries in cases of emotional distress or crisis needs.

Journaling

Writing presents an opportunity to improve the well-being of caregivers and qualitative data collection methods for researchers.[20] Journaling promotes awareness and emotional regulation, develops insight, and allows the writer to conduct deeper reflection and introspection regarding their feelings and relationships.[21] Relatedly, journal entry methods offer a contactless option for data collection and can leverage technology such as audio recordings and email for contact-less data collection.[20]

For a period of six weeks, thirty-seven aides in WNY and SEMI submitted journal entries at least weekly. We enrolled participants on a rolling basis, spanning from April to July 2020, to capture different moments in time during the COVID-19 pandemic. The research team sent varying prompts for participants on a weekly basis via email. We developed recruitment materials and prompts at an eighth-grade reading level and intentionally offered participants the opportunity to audio record their entries if they were not comfortable writing. We also offered the option to journal in Spanish, but no participants chose this option, and emphasized to all participants not to worry about spelling and grammar. Prompts included questions such as: "What parts of your job were particularly challenging this week? Where and when did these happen?" and "What would be helpful to you this week to deal with challenges related to coronavirus?" The team reviewed entries weekly and provided individual feedback, words of encouragement, or requests for clarification when sending out each subsequent set of prompts to encourage participation and build rapport with participants. Many participants did not anticipate feedback on their entries and expressed appreciation that the research team was "listening" and felt as though their voices were being heard. In some cases, the feedback included prompts to better understand a specific issue or elicit more detail from the participant which resulted in slightly more information in the following week's entry. Participants received $50 per week for every week they submitted at least one journal entry; incentives were paid in two installments: once after three weeks of journaling and once after the six weeks.

Interviews

We also conducted interviews with aides who participated in the journaling process (N = 15) as well as one aide who did not participate in the journaling process. We selected aides based on a range of journaling response options and experience levels. Interviews focused on how COVID-19 affected aides' interactions with clients in the home, how aides managed and coped with the additional stressors introduced by COVID-19, and perspectives on the journaling process. We also conducted nine interviews with representatives of home health agencies (five from WNY, four from SEMI) focused on any additional policies introduced related to the COVID-19 pandemic, resources and supports offered to aides, and needed supports for employers.

Analysis

Journal entries were collected on a rolling basis, so data collection of the journal entries and the interviews occurred simultaneously with data analysis using a thematic analysis.[22] Journal entries were transcribed when not in a document format (i.e., when received via audio recording or paper form). Interviews were recorded, with permission, and transcribed. All data including journal entries and interviews were uploaded to Dedoose,[23] a qualitative software program to facilitate systematic coding.

A preliminary codebook was developed from the journaling prompts and interview protocols. A set of fifteen journal entries and six interview transcripts were coded using the preliminary codebook, which was then further refined based on the identification of new codes and discussions among the team. These initial coding documents were re-coded according to the revised codebook, followed by coding of an additional set of journal entries and interview transcripts. Members of the coding team kept a running log of questions around coding and discussed discrepancies throughout the coding process. In order to establish inter-rate reliability among the three coders, we achieved a combined kappa score[24] of 82.7 percent using the coding test feature in Dedoose. The remaining journal entries and interview transcripts were coded primarily by two coders.

Findings

Table 1 presents demographics of aides who participated in the journaling process. Slightly less than half of aides (n = 17, 45.9 percent) reported an annual income of less than $20,000, and the same number had an annual income between $20,001 and $40,000 while two aides (5.4 percent) reported an annual income above $40,001. About half of aides received Medicaid (n = 20, 54.1 percent), while the remaining purchased their health insurance directly (n = 6, 16.2 percent), had no insurance (n=3; 8.1 percent), or received from other sources (n=8; 21.6 percent). The majority of aides (n = 26, 70.3 percent) had one paid job while eight (21.6 percent) had two or more jobs.[1] Fifteen aides (40.5 percent) had a high school diploma or GED, eight (21.6 percent) completed through Grade 12, six (16.2 percent) had some college credit, five (13.5 percent) had an associate's degree and three (8.1 percent) had a bachelor's degree.

We describe the findings from this study in three sections. First, aides described a range of challenges and concerns they faced in their work in providing care to vulnerable clients in the home during the COVID-19 pandemic that centered around workplace safety concerns. Second, we report on the impact of COVID-19 on aides' job responsibilities. Third, we describe potential solutions or needed supports that agency representatives used to mitigate some of the challenges that aides faced during the pandemic.

Aide Workplace Safety Concerns

One of the main challenges that aides described in their work during the pandemic centered around concerns for their own safety in the workplace (i.e., clients' homes) and the potential for contracting COVID-19. Aides described their concerns around (a) putting themselves at risk in the client's home, (b) access to PPE, and (c) transportation challenges.

Putting oneself at risk in the client's home. Many aides described the frustration that they had to put themselves at risk while only receiving minimal compensation for their work during the pandemic. Several aides also expressed concerns around putting their own family members at risk because of the possibility of bringing home the virus from their job, as noted by this aide: "We are risking our own life, going out to work not knowing if we are going to take 'the virus' home to our family or not."

Aides raised apprehensions around their clients or their clients' family members who did not take proper precautions, putting aides at even greater risk. One aide described her deep frustration with her employer because she was not notified that her client had come into contact with someone who may have had COVID-19, and it was not until the client reported this directly to the aide herself that she was informed of this incident. Many aides worried about the negative consequences of possibly coming in contact with COVID-19 on the job and having to miss work, ultimately not being able to provide for themselves and their families:

> We are on the frontline not knowing if our client's family or them were exposed to the virus, which can transfer to us and our family. Then, we will be another minority out of work waiting for unemployment or taxes to come in, hypothetically speaking.

In other words, concerns around safety in the workplace extended beyond aides' own safety to the risks they took

Table 1. Aide Demographics (N = 37).

	SEMI n = 7	WNY n = 30	Total n = 37 (percent)
Age			
18–25	1	6	7 (18.9)
26–35	0	9	9 (24.3)
36–45	2	7	9 (24.3)
46–55	3	6	9 (24.3)
56–65	1	2	3 (8.1)
Gender, n (percent)			
Female	6	26	32 (86.5)
Male	1	4	5 (13.5)
Race and ethnicity, n (percent)			
Black or African American, non-Hispanic/Latino	6	23	29 (78.4)
Other—Puerto Rican	0	4	4 (10.8)
White, non-Hispanic/Latino	0	1	1 (2.7)
Black or African American, Cuban	0	1	1 (2.7)
Choose not to answer	1	1	2 (5.4)

SEMI = Southeast Michigan; WNY = Western New York.

for their families and the potential implications for economic insecurity if they were to contract COVID-19 on the job.

Many aides also wrote about their concerns around safety in relation to feeling as though their voices as marginalized home care aides were often forgotten in the broader discourse around the risks taken by other frontline care providers during the COVID-19 pandemic, such as doctors and nurses. As one aide wrote,

> I think that it's important to share that we need to thank all health care workers all around the world and not just in one community. Just because you're working in a hospital doesn't mean you're doing more work than people going to people's homes.

Several aides noted that they appreciated the opportunity for their voices to be heard through the journaling because home care is often undervalued and lacks recognition, as this aide wrote: "I am grateful for this journaling experience and I really enjoyed it. I hope this helped with letting everyone know us aides go through a lot and sacrifice a lot as well. We're essential but we're also human."

Access to PPE. Concerns around workplace safety also centered around availability of PPE. Aides reported feeling overwhelmed because they did not have access to an adequate supply of PPE including face shields, disposable gowns, and N95 masks. Some aides reported that resorted to purchasing their own PPE because their employer was unable to provide PPE:

> It wasn't easy to get them [PPE], and they were limited. They made us reuse the mask which was not sanitary because the surgical masks that they give us clearly state one time use only. I personally went out and purchased my own reusable, cloth, washable mask.

One aide wrote about the lack of attention provided to home care aides during the pandemic and how this impacted their access to PPE:

> And home care hasn't quite given us the proper PPE to help the home care workers and also indirectly our clients. And there should be more recognition for home care workers. A lot of people don't recognize our effort during this pandemic.

Some aides also mentioned the need for better quality PPE, such as face shields in addition to face masks, that would provide better protection against the highly contagious virus.

These challenges around inadequate quality and quantity of PPE were particularly strong and prevalent in journal entries submitted at the beginning of the pandemic in April and May during the national shortage of PPE. While entries received later in the data collection period in June and July 2020 referenced PPE as necessities to providing care safely to clients, there was much less concern around the availability of PPE during this later time.

Transportation challenges. Transportation to and from work was also a safety concern for aides during the pandemic, particularly for aides who relied on public transportation to get to clients' homes. COVID-19 restrictions often limited public transportation options or created delays, as described by this aide who resorted to choosing clients within walking distance because of transportation challenges:

> Now it's fifteen people that can get on the bus, if I'm number sixteen, I can't get on the bus and I'll have to wait for the next one. This affects our hours right now. It affects how we get to work.

Some aides described similar experiences with delays for ride-sharing services because of low driver availability and having to wait long periods of time, which largely impacted aides' ability to report to work and get home: "Because I use Lyft it has been a challenge getting to and from work. I was told that there aren't many drivers out there so the wait time could be an hour to hour and a half."

Impact of COVID-19 on Aide Job Responsibilities

Changes to caseload. Aides reported a range of impacts related to their job responsibilities due to the COVID-19 pandemic. Some aides reported an increased caseload because of other staff calling out of work, creating additional burden of having to take on additional hours. Other aides, however, described a decrease in their caseload due to a reduced demand for aides as family members were available in the home for caregiving or because of client or client family concerns of having a home care aide in their home during the uncertain times of the pandemic. Lastly, some aides reported a reduction in their caseload because of their own anxiety and hesitation around taking on new or unfamiliar clients during the pandemic because of the risks. One aide wrote: "I'm scared to take them [new clients]. I don't know if they have the virus or not and I don't want to take it home to my family."

Transformations in client interactions. The pandemic also impacted fundamental interactions between aides and their clients. Although many aides expressed passion for caregiving and personal connection as core reasons

for choosing to work in this field, many also described this very connection as being diminished during the pandemic due to social distancing needs, covered faces, and general fear between people. One aide said: "Makes you feel almost like you are not human, like you are a robot who is going to take care of somebody who once before, you held their hand without a glove on, you gave them a hug." Similarly, aides also conveyed a deep sense of responsibility to protect clients physically and emotionally, with that burden increasing as a result of the pandemic. Some aides had clients who suffered from a decline in mental health due to social distancing and loneliness, while others displayed increased anxiety. One aide said, "We're sitting there on pins and needles and if we cough or sneeze, they can have a whole panic attack. It had an impact on the way we communicated and how I can do my job." In other words, some aides expressed having to manage clients' own fears related to contracting COVID-19, which impacted how they interacted with clients.

New challenges for everyday tasks. Many aides described increased or changed tasks, especially related to the need to sanitize clients' homes, whether self-prescribed or requested by the client. Additional cleaning took extra time and effort and was often accompanied by stress due to the client not having the proper cleaning supplies, fears that the home was not kept clean before entering, or a responsibility to protect themselves and the client. Aides also conveyed an increased need to keep themselves and the client clean, typically through handwashing. Other types of tasks were also altered. Multiple aides reported that though grocery shopping for clients was a typical responsibility, the task became increasingly burdensome due to norm-disruptive social distancing protocols and increased tension within stores. Some reported having to change the timing when they usually shopped for clients or having increased shopping duties because the client was no longer going to the store for themselves.

In addition, precautions due to COVID-19 increased day to day challenges for aides. Aides described difficulties related to wearing masks with clients such as trouble breathing, discomfort wearing masks for long periods, trouble remembering and adjusting to the new requirement, and clients' inability to recognize them or hear them talk with their face covered. Lastly, many aides expressed the difficulty or inability to follow public health guidelines in this line of work, given the overwhelming need for direct contact, as noted by this aide who stated: "He [client] cannot lay on the bed on his own. He's in a wheelchair . . . It's a challenge for this coronavirus because you can't keep a distance from your clients, it's a direct contact."

Agency Perspectives to Improve Workplace Safety Concerns

Agency representatives raised a range of needed supports to mitigate concerns they heard from aides and experienced themselves as employers during the pandemic. These representatives articulated changes implemented during the pandemic to ease some of their workers' concerns including increasing communication between aides and agencies, monitoring symptoms to help prevent the spread of COVID-19, and ensuring reliable transportation. Lastly, agency leadership representatives also noted areas for improvement on a structural level in terms of policies to better support aides and strengthen the appreciation and recognition of aides as essential workers. Increased communication among employers and aides was one important area identified to mitigate workplace safety concerns around risks to themselves during the pandemic. Some of the agency leadership representatives we interviewed spoke about implementing a system to check in personally with aides on a daily basis, as noted by this agency representative in WNY:

> We're texting the aides every day and then calling them intermittently to see how things are going . . . And then keep calling and tell them not to go to work if they aren't feeling well and to call a doctor. They aren't in it alone.

Another manager from SEMI stated that their agency is in contact with aides more than in the past, finding new virtual ways to communicate:

> Before we wanted to see them face to face and have that dialogue. Now, it's harder to get them in, but we've been communicative more than ever . . . texting, calling, we have Zoom dates if you need someone to talk to.

These communication strategies were designed to maintain regular contact with aides and provide support when needed.

To minimize the spread of COVID-19 and help ensure safety of both aides and clients, some leadership representatives from agencies spoke of monitoring COVID-19 symptoms through the use of technology. One agency representative reported that their agency implemented a text message communication system with staff with a reminder about temperature checks. Some representatives described the potential for a daily virtual check-in system, such as an electronic visit verification system that would enable aides to complete their timesheet without needing to go to the agency office and allow for same day pay. However, agencies described cost limitations and noted the need for increased funding for home health care to be able to implement this type of

system and others that would require other technologies including phones or tablets.

As noted earlier, accessibility to PPE was a challenge for most aides, and many agency representatives themselves recognized these concerns and described limitations in their own ability to supply aides with proper protections to be able to safely do their jobs. Even agencies that already had a stock of PPE prior to the pandemic faced challenges obtaining PPE, and some reported paying price gouges to be able to supply aides with needed protection, suggesting that further emergency preparedness planning may be needed for agencies.

In terms of transportation, some agencies provided vouchers for ride-sharing services for aides during the pandemic, despite aides' reported challenges with delays or wait times. One representative explicitly recognized these issues around unreliable transportation, stating that their agency has been more lenient in disciplinary policies for aides. To mitigate challenges and changes to caseloads due to the pandemic, some agencies trained workers from the retail and food industry who became unemployed during the pandemic to recruit them into home health care to address gaps in coverage for clients. In addition, another representative spoke of a partnership with another home health care agency for staffing and to ensure availability of aides to cover for other aides if they were to cancel on a client at the last minute.

Agency leadership representatives spoke of the need to increase appreciation and recognition for home health care in general, both on the individual level to recognize the aides' work and on a structural level in terms of policies to increased agency funding to better support aides. Agency representatives acknowledged the low pay aides receive, coupled with the challenges of the job during COVID-19:

> I think in general for traditional caregivers even previous to this since we are a government-based program and partnered with non-profits—you could imagine that the pay can't be as large as we would want to be able to award our staff with. For them to have the stress of the pandemic on top of that, some people just didn't feel that the money was worth compromising their health for. Which is understandable.

Discussion

This research highlights workplace safety concerns and experiences of aides in WNY and SEMI during the COVID-19 pandemic. While much of the attention during the pandemic surrounding safety in health care has focused on providers on the front lines in in-patient settings, this study examines home health care worker perceptions of risk, stress, and anxiety while they provided direct care to vulnerable populations during a highly uncertain time.[25,26] Aides are low-wage workers who are undervalued and lack autonomy in their roles yet care for a high-risk, vulnerable population of individuals who may have COVID-19 but need to stay in their homes and out of the hospital. This creates additional burden for aides who themselves are vulnerable during an already challenging time. Both aides and agency representatives mentioned the need to increase visibility and appreciation for their work during the COVID-19 pandemic, particularly among policymakers to provide increased supports to home health care as a work force.

While this was an exploratory study to examine concerns and challenges encountered by aides during the pandemic, our findings have implications for future research. Specifically, many of the key factors that aides identified as impacting their lives align with a conceptual model that Dennerlein et al.[25] recently adapted to explain the structure of pathways between factors that are expected to influence worker safety and health outcomes during the COVID-19 pandemic. Factors from their model include individual worker behaviors and characteristics, the work environment, and workplace policies and practices, which mirror issues noted by aides in our study. For example, the physical work environment of the client's home coupled with issues around access and availability of PPE and required job tasks that were challenged by COVID-19 affected individual aides' safety and perceptions of risk. These factors exacerbated aides' overall feelings of stress and strain during the pandemic with little autonomy in their positions. Given that our findings are consistent with key factors in their model, research is needed to (a) verify the directionality of the pathways in their model, (b) understand the strength of these pathways, and (c) identify additional aide-focused outcomes such as burnout, stress, and mental health that are likely to be impacted by these factors.

In contrast to earlier work around concerns among aides during the COVID-19 pandemic,[19] this study examined perspectives of not only aides but also of home health agencies to understand their concerns and limitations during the pandemic. Despite prior research on emergency preparedness for home health care,[17] several of the concerns and challenges raised by both aides and agencies in this study point to areas previously identified as opportunities for planning including having an adequate supply of PPE and securing transportation for aides. Many of the solutions and needed supports identified by home health agencies point to the need for increased funding and structural policy changes to better support home health care.

Policy Recommendations

Agency leadership representatives who we interviewed described temporary solutions to mitigate challenges during the COVID-19 pandemic but were often limited in their ability to make substantial or long-term changes. Structural-level policies are needed to support home health care as a field particularly during a public health crisis, such as the COVID-19 pandemic, but also for the future of home health care.

Many concerns raised among aides around their safety in the workplace centered around issues around communication with their home health care agency employer, particularly around the fear of entering a client's home and the uncertainty of whether or not the client had COVID-19 or had been around someone who had COVID-19. Policies to improve cadence and mechanisms of communication among agencies, aides, and clients around potential cases of COVID-19 are important to promoting a safe work environment for aides. Improving connectivity among agencies and aides through technology through remote symptom monitoring may also be an avenue to mitigate concerns around safety. Increased availability of COVID-19 testing is also crucial to ensure safety of both aides and clients. Clear guidance for aides about how to communicate with their clients about proper precautions may also help to ensure safety and prevent transmission of COVID-19.

As the pandemic continues, home health agencies should continue to ensure that aides have adequate access to PPE in the short-term and prepare emergency supplies for the longer term. Structural policies to support agencies in accessing PPE are needed to ensure that agencies are able to provide aides with proper supplies. Clear and consistent guidance on both the state and federal levels around how to provide home health care to clients during a pandemic and policies around infection control are also needed to ensure home health care worker safety. For example, current guidance from the Occupational Safety and Health Administration (OSHA) for the COVID-19 crisis does not specifically include home care in its risk categories.[27] If OSHA mandated the health and safety protection of this direct care work force, it would likely help to facilitate insurance reimbursement coverage for agency employee expenses for PPE.[28] Benefits including paid sick leave are also crucial for aides to ensure that they do not risk not receiving a paycheck because they have contracted COVID-19 or put their clients at risk by reporting to work. Currently, the Families First Coronavirus Response Act does not include home care aides, and additional policies are needed to ensure that aides receive paid sick and family leave.[29] While this direct care work force provides essential services to vulnerable individuals,[30] these workers should be included as essential workers to receive the needed support and resources to safely perform their job responsibilities.

Agencies may also explore partnership models with other agencies to ensure adequate staffing and safety of staff and clients, particularly during the uncertain and stressful time of a pandemic. Building relationships with other agencies may mitigate burdensome caseloads for aides and help resolve challenges around last-minute cancellations due to the presence of COVID-19 symptoms or other COVID-related challenges including child care responsibilities. This change may also help mitigate the shortage of home care aides due to an aging population.[31] In addition, agencies may also consider recruiting and training workers from other sectors who have become unemployed during the pandemic to further increase their staffing capabilities.

As demonstrated from our study of aides in WNY and SEMI, safe transportation during a public health crisis is a complex issue that was not always resolved by offering vouchers for ride-sharing services during the pandemic because of delays and unreliability of these services as an alternative to public transportation. Agencies may consider increased flexibility or overlap between aides in scheduling to allow for delays in transportation. Agencies may also need increased state-level funding to provide aides with improved methods for safe transportation. Access to reliable transportation to and from work is critical for ensuring safety for both aides and their clients, particularly to minimize risk and potential exposure from public transportation.

Lastly, both aides and leadership representatives from agencies spoke of the need for increased visibility of home health care as an essential service and for home health care workers' voices to be heard. Recognizing aides as "essential workers" will also help ensure that when a vaccine for COVID-19 becomes available, aides will be included in the group of essential workers who receive the vaccine first. Policy-makers should also engage directly with aides and agency representatives to understand their perspectives and to develop thoughtful and worker-centered policies for home health care. In addition, many of the needed supports identified by agencies around communication options and ensuring PPE require structural-level policies to support home health care agencies through increased infrastructure and funding.

Limitations

We recruited aides from our connections to agencies or home health care networks, leading to a biased sample. Many of the aides were from WNY, and we had a limited sample from SEMI. We also faced challenges with attrition that largely occurred between enrollment in the

study and submission of the first journal entry. The rolling basis of journal entry collection also presented analytic challenges, particularly with the changing nature of the external environment including national reactions to COVID-19 and increased availability of PPE over time. It is also important to note that these data are shaped by societal tensions around racial injustice in the U.S. Aides reacted strongly to protests around racial inequality during this unsettled time and reported additional concerns related to safety concerns for both themselves and their clients due to the potential for the spread of COVID-19 with an increase in protests in their communities. These events also created additional stress that we cannot disentangle from the very real impacts that the pandemic was happening. Relatedly, to the extent that interactional effects between the pandemic and societal events impacted aides, we were unable to account for this phenomenon.

Conclusion

This study highlights important challenges faced by home care aides during the COVID-19 pandemic notably around workplace safety and the impact of COVID-19 on job responsibilities, which created elevated levels of stress related to the uncertainty and fear of the virus. These findings point to areas for future research to support policies to improve safety of aides during a public health crisis and beyond.

Declaration of Conflicting Interests

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Note

a. The number of jobs among the three additional aides (8.1 percent) was unknown.

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