"I'm a home health aide, not a home health maid" : an analysis of how home health aides talk about and interpret their role

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“I’m a Home Health Aide, Not a Home Health Maid”:
An Analysis of How Home Health Aides Talk About and Interpret Their Role

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“I’m a Home Health Aide, Not a Home Health Maid”:
An Analysis of How Home Health Aides Talk About and Interpret Their Role

Abstract

Home health aides are paraprofessionals who are critical to the health and well-being of elderly adults and their ability to continue living in their own homes for as long as possible. However, a crisis is looming because the demand for home health aides is rapidly increasing as America ages. Filling today’s need for home health aides is already difficult, and turnover rates are high across the country. The job is physically and emotionally challenging, while financial rewards are severely constrained by public policy and the lack of value placed on the position. Conflicting expectations of home care agency supervisors, clients and the aides themselves lead some aides to call their job a no win situation. Increasing our understanding of how members of this low status, understudied group make sense of their role and how they negotiate the competing expectations that they often face can help shed light on a difficult but important job and identify strategies to enhance the working conditions of aides and to improve aide recruitment and retention. Using interpretive research methods, this study examines the talk of home health aides, supervisors, and clients from both rural and urban areas in order to understand their perspectives about their working environment and interactions. I propose a Social Ecological Model of Role Influences to examine the proximal and distal influences on the role of home health aides. Finally, this study identifies role dialectics that home health aides face and examines strategies that aides use to manage those dialectics.
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CHAPTER ONE

INTRODUCTION AND PURPOSE OF THE STUDY

Background and Statement of the Problem

The U.S. population is aging rapidly, due to longer life spans and the graying of Baby Boomers. By 2030, when the youngest of the Baby Boomers will be older than 65, one in five Americans will be age 65 or older, twice the number as there were in the year 2000 (CDC, 2007). Among these older adults, there is a growing prevalence of chronic diseases. Modern medicine has made great progress in eradicating death from acute diseases and in enabling people to live much longer with chronic diseases (Thompson, Robinson & Beisecker, 2004). Mainly because of ongoing, complex management of chronic diseases, elderly people interact with the health care system more than other populations (CDC, 2007). The ever-increasing cost of health care and long-term care makes it more attractive for older adults to remain living at home as long as possible, where care and living costs are less expensive (Landers, 2010). Also, technological advances, such as electronic monitoring, have made home-based care more feasible (Landers, 2010). In addition, the vast majority of seniors want to remain in their homes (AARP, 2000). As seniors age, however, chronic illnesses or disabilities could prevent them from living independently in their homes without some outside help (Crimmins, 2004). Seniors turn to informal sources of support first, such as family members and friends. However, family dynamics are changing, with smaller family sizes and a greater likelihood that children live farther from their elderly parents and are working outside the home (Stern, 1995). Thus, though family members are the most frequently turned-to source of outside help, formal paid sources make up a growing portion of this help (Stone
& Wiener, 2001). In fact, the demand for direct care workers, such as home health aides, makes it the third-fastest growing occupation in the U.S., with an expected 69 percent increase in demand between 2010 and 2020 (Bureau of Labor Statistics, 2012).

**The Job of a Home Health Aide**

Direct care workers is the overarching term that covers several categories of individuals who provide hands on, personal services to people (often seniors) who require help to remain living at home. These categories include home health aides, who are typically certified by the state, work under the direction of a healthcare professional, and provide health-related services that may be reimbursed by Medicare and Medicaid; and personal care workers, who help with activities of daily living but do not usually require any additional training (Stone, 2004). Typically, the job of a home health aide requires no more than a high school education and just a few weeks of training (Rossman, 1997).

Home health aides enable seniors to remain in their homes longer by helping with personal hygiene, such as bathing, and dietary regimens, such as meal preparation and grocery shopping; by providing assistance to help the seniors adhere to health care management regimens, such as reminders to take medicine or to perform exercises, which enable the seniors to maintain their health status as long as possible; and by supplying the seniors with social support to help maintain quality of life (Landers, 2010; Rossman, 1997; and Piercy, 2000). These activities rely on communication to a great extent and on the relationships that form between home health aides and their elderly clients. In fact, Grainger (2004) noted that “the quality of older adult care is in large part down to the carer-caree relationship” (p. 479). Such care can impact the physical health status of the elderly client. In addition, because the social network of homebound elderly
tends to shrink significantly with age (Piercy, 2000), home health aides provide social interaction that can contribute to the mental well-being of the senior (Stone, 2004). While the work of a home health aide can be beneficial for the elderly, overall, the care is both physically difficult and emotionally challenging for the aides (Stone, 2004).

Home health aides can be hired privately or through a governmental or private agency. Because the focus of this study is organizational communication, this analysis will concentrate primarily on home health aides who work through an agency. These home health aides work independently in the home, but under the direction of a nurse who provides the aides with precisely defined care plans for each older client (Rossman, 1997). The majority of direct care workers are female, from a minority racial or ethnic group, and of low socio-economic status (Seavey, 2010-2011).

**Challenges in Providing Home Care**

Both home health aides and home care agency management face a number of challenges. Agency management is trying to manage a growing demand for home health aides coupled with high turnover rates (Stone, 2004; Feldman, 1993). They are constrained by public policy that establishes payment rates for home health aide services near minimum wage and that restricts the work tasks that home health aides are allowed to do (Seavey, 2010-2011). With only a high school education and two weeks of training, home health aides enter a physically and mentally demanding job, responsible for making day-to-day decisions that can impact the health of seniors, while balancing competing expectations from their employer, their clients, and their clients’ family members (Rossman, 1997).
By most measures, the job of home health aides has low status in our society. Work can be demeaning, pay is minimal, hours can be irregular, and benefits are few (Seavey, 2010-2011; Feldman, 1993), all contributing to high turnover rates (Stone & Wiener, 2001). Retention of direct care workers is a challenge for most organizations, some of which experience turnover rates as high as 100 percent annually (Stone & Wiener, 2001). The high turnover rates affect the remaining aides, who must cover for departed co-workers, and work with seniors who are potentially disgruntled from their experiences with a revolving lineup of aides. Agencies may not invest much in additional training, promotion opportunities, or retention efforts, in the expectation that the aides will soon be gone and can be replaced.

**Training.** The minimal training that home health aides receive—typically just two to three weeks—focuses mainly on the tasks that they will be asked to perform on the job. Research suggests that additional training of direct care workers can enhance their job satisfaction and enable them to contribute in more ways to their work. Several studies suggest that certified nursing aides in nursing homes can improve the amount and type of communication that the aides have with elderly residents (Burgio et al, 2001; Allen-Burge, Burgio, Bourgeois, Sims, & Nunnikhoven, 2001). Training has also been found to be effective in fighting the assumptions of ageism, or negative beliefs often held about older people. When direct care workers were provided with communication skills training based on gerontological developmental theory, their feelings grew from just tolerating older people into “an acceptance of the client as an individual” (Minehan & Lessner, 1993, p. 433).
Occupational hazards. Home health aides work in one of the most hazardous occupations. The Bureau of Labor data lists nursing, psychiatric and home health aides as reporting the third highest number of injuries and illnesses, after truck drivers and laborers (Bureau of Labor Statistics, 2006). A lack of both appropriate training and suitable devices to help lift or support functionally impaired clients leads to frequent injuries among aides (Seavey, 2010-2011). When coupled with the fact that many aides do not have health insurance and are of low socioeconomic status, they are left in an even more vulnerable economic position. If aides are injured on the job, they may not be able to work, and if they do not work, they do not get paid.

Limitations on job functions. Home care agencies create detailed care plans that home health aides are expected to adhere to, but those constraining plans do not always match on-the-job realities, such as dealing with a noncompliant patient (Rossman, 1997). A care plan is typically a form filled out by a nurse, who checks off various tasks that the aide will perform, such as helping with bathing, reminding the client to take medications, and assisting the client in moving from the bed to a chair. Aides are also limited in the tasks that they can perform by state regulations that restrict certain care practices, such as actually administering medicine or caring for wounds, to nurses (Stone & Wiener, 2001). Job limitations also stem from the lack of a career ladder or additional training opportunities that make being a home health aide a dead end job without the possibility of advancing or bettering one’s position (Stone & Wiener, 2001).

Government policies. Policies established by both federal and state governments have a significant influence on home health aides. Medicare and Medicaid policies set reimbursement levels that impact the wages and benefits that aides receive. The current
median pay for a home health aide is less than $10 an hour (Bureau of Labor Statistics, 2012). Home health aides are indeed the working poor. Nearly half rely on government assistance programs such as food stamps, Medicaid, or subsidized housing (U.S. Department of Health and Human Services, 2013). Low pay and few, if any, benefits for home health aides contribute to difficulties in recruiting and retaining home health aides (Feldman, 1993; Brannon, Barry, Kemper, Schreiner & Vasey, 2007; Zeytinoglu, Denton, Davies & Plenderleith, 2009).

**Purpose and Significance of the Study**

Increasing the number of people who want to work as home health aides is critical to meet the growing demand of a workforce needed to address the health and wellbeing of the elderly who want to remain living in their homes. However, the job as it is now conceptualized does not provide a living wage nor the social status to make it an attractive career option. Improving the working situation of home health aides starts with a better understanding of the aides’ experience. By building knowledge of how home health aides make sense of their roles and how they manage the role tensions that they face, we can begin to identify sources of stress and negative tensions that are inherent in the current job and to suggest changes to improve the working conditions of the aides. Understanding the perspectives of the aides’ supervisors and clients contribute to a better understanding of the home health aide experience.

Though they are a key part of the home care team and critical to the health of the growing number of seniors and the ability of those seniors to remain living in their homes, home health aides remain understudied by communication scholars. They are not typically included in health care team studies. Most studies focus on professional health
care team members—doctors and nurses. Studies that do look at paraprofessionals typically study CNAs in an institutional setting. Studying home health aides is challenging because they work independently in remote home settings. Finding opportunities to recruit and talk with home health aides and their clients takes considerable time and effort.

The knowledge gained through this study may also provide insight into role making and role development in other occupations, especially those that are low status and involve working remotely. Most studies that examine organizational roles focus on professional jobs or high-tech workers, and it is unknown whether the findings from those studies extend to workers in different contexts, such as low status remote workers. By extending the social ecological model to the analysis of roles, this study suggests a framework that can be used to analyze the influences that shape how occupants of an position view and enact their role. Such a framework could be especially informative for those roles in highly regulated healthcare fields.

This study also extends the role dialectics study of nurses by Julie Apker and colleagues (2005) to low status members of a health care team—home health aides. Though most health communication studies have focused on health care professionals, this study makes a case for the importance of including paraprofessionals in studies. These direct care workers spend the most time with clients and have a significant impact on the health of seniors and their ability to remain living in their homes as they age.
Research Questions

To better understand the work experiences of home health aides and how the role of home health aides is communicatively constructed by the aides, their supervisors, and the clients, this study asked the following research questions:

1. What role influences, both proximal and distal, can be identified through the talk of homes health aides, their supervisors and their clients?
2. What role tensions can be identified from the talk of home health aides, their supervisors and their clients?
3. What communication strategies do home health aides employ to manage the identified role tensions?

Summary of and Rationale for the Research Methods

To understand how home health aides make sense of their role and negotiate their role amidst a plethora of proximal and distal influences on their behavior, this study employs interpretive methods, specifically interviews with home health aides, supervisors and clients across the state of New York. The immediate environment of home health aides consists of interactions with their supervisors and their clients. These are the people with whom aides interact face-to-face, and it is through the interactions of these three groups of participants that aides pick up a great deal of information about their role. An analysis of the interview data, using an approach informed by grounded theory, is used to identify the people, organizations and processes that influence the role of home health aides. A further analysis of these influences is conducted to identify role dialectics that home health aides face and strategies that aides use to manage these tensions. This methodological approach allows the perspectives of the participants to be better
understood. Further details and rationale for the research methods will be provided in Chapter 3.

**Summary and Overview of Dissertation**

In this chapter, I have made a case for studying the work experiences of home health aides to learn how they understand and negotiate their role as aides. I provided a summary of the problem faced by our nation due to a rapidly aging population and a shortage of direct care workers to care for them in their homes. The significance of this study is further explained by the contribution it makes to the study of occupational and organizational roles, especially in a health care context. It draws upon and adds to general organizational communication scholarship and the scholarship of occupational roles in health contexts, expanding on work done with roles and nurses, and with roles and teamwork. This study also provides a scholarly contribution in that it adapts the social ecological model, using it as framework to understand influences on role making and role development, especially for low status workers and remote workers.

In Chapter Two, I provide an overview of current scholarship about organizational communication and roles, especially in a health care context. First, I draw on general organizational communication studies about roles, including studies on socialization, role negotiation, and identification. Next, I look at scholarship that has examined organizational roles in a health care setting. I also provide details about the two theoretical perspectives that prove useful for understanding and analyzing the data—the Social Ecological Model and Role Dialectics.

In Chapter Three, I provide an overview of the research methodology for this study and the rationale for using these methods in this study. I also elaborate on the
methodology in detail, including specifics about the participants, the data collection and the analysis.

Chapter Four is the first of four chapters that present findings from the data analysis and interpretation of the data. This chapter discusses the Social Ecological Model of Role Influences, specifically as it applies to home health aides. The model is adapted from the model and framework developed for child development studies by Bronfenbrenner (1979). This chapter continues by presenting how home health aides, supervisors, and clients talk about the macro-level role influences—government regulations, third-party payers, and societal perceptions—and the meso-level influences—the work environment, transportation issues, the physical demands of the job, the clients’ family members, and the aides’ family members.

Chapter Five is the second of four chapters that present findings and interpretation of the data. This chapter discusses how home health aides learn about their role from their interactions with supervisors and clients at the micro level.

Chapter Six is the third of four chapters that present findings and interpretation of the data. This chapter examines the expectations that supervisors, clients and their family members, and the home health aides themselves have concerning traits of a “good aide.” From these expectations, aides implicitly learn about their role.

Chapter Seven is the fourth chapter that presents findings and interpretation of the data, specifically identifying role dialectics that home health aides face. It then examines the talk of home health aides to understand the strategies that home health aides employ to manage those dialectics.
In Chapter Eight, I provide a summary of the study findings, including theoretical implications and practical implications. Also included in this chapter are limitations of the research and future research directions.
CHAPTER TWO
Review of Relevant Literature

Organizational communication scholars have long studied roles and role behavior. In fact, organizations have been defined as a “system of roles” (Katz and Kahn, 1978, p. 187). Within this system of roles, communication is fundamental since it is the interaction with others that helps workers define their roles and learn what the expectations are for those roles (Weick, 1995). Most scholarship on roles has been derived from general organizational communication studies. A subset of this scholarship looks at roles specifically in healthcare settings. This chapter summarizes what is known about organizational communication and roles, and health communication and roles, and reviews the theoretical framework for this study.

Organizational Communication and Roles

Organizational communication has grown over the past 70 years from a discipline heavily concerned with business speech and supervisor-employee communication to a discipline that focuses on a variety of communicative behavior in organizational settings (Redding, 1985). Scholars in organizational communication “are concerned with the creation of meaning, the production of messages, and the processing of information that makes organizing possible” (NCA, n.d.). This study contributes to a growing number of studies that look at roles in organizational settings (Apker, 2001; Ashforth & Kreiner, 1999; Cheney, 1983; Jablin, 1987; Kramer, 2004; Lucas, 2011; Meiners, 2004; Miller, Joseph & Apker, 2000; Scott, 2007, to name a few examples). A few studies have examined the experiences of low-status workers (Gibson & Papa, 2000; Lucas, 2011; Lucas & Buzanell, 2004; Tracy & Scott, 2006). A number of communication scholars
have studied communicative processes involving remote workers, most of whom are engaged in technical work (Fay & Kline, 2011; Jacobs, 2006). However, few communication studies have looked at working situations similar to that of home health aides, which combine low-status with a remote work location. This combination adds challenges to supervision and could have a negative impact on organizational identification.

Scholars have looked extensively at organizational communicative processes that impact how people adjust to work and negotiate their roles. Heavily studied have been organizational socialization, role development and role negotiation, and identification. Role dialectics is a relatively new concept being studied in organizations.

**Socialization.** When newcomers enter an organization, they gather information from their supervisor and from their coworkers about “task, performance and interpersonal expectations” (Jablin, 1987, p. 701). The information that newcomers gather can affect the meaning that they ascribe to their role because the early weeks of becoming part of an organization involves learning the particulars of the job, and becoming familiar with the organization’s values, norms and expected behaviors (Mignerey, Rubin, & Gorden, 1995). This socialization process involves both assimilation, in which the organization tries to influence the new employee with both formal and informal strategies, and individualization, in which the employee tries to shape the work environment to meet his or her needs (Mignerey, Rubin, & Gorden, 1995; Schein, 1968). Even before an employee starts work, in the anticipatory socialization phase, individuals gather information about roles from family, friends, the organization and society at large about both the organization and the position within that organization.
(Jablin, 1987). Information gained during this anticipatory phase of socialization creates expectations, which if unmet can affect job satisfaction and organizational commitment (Pearson, 1995).

**Role Negotiation.** When a newcomer joins an organization, it is critical for them to build an understanding of what their role in that organization will be—what work they will do, what they will be accountable for, and how their performance will be assessed. Katz & Kahn (1978) define roles as “specific forms of behavior associated with given positions; they develop originally from task requirements” (p. 43). Employees figure out what they are expected to do in their jobs by interacting with others, most importantly with their supervisor (Graen, 1976). To learn how to do their jobs, employees engage in such activities as asking questions, testing limits, and observing others “to clarify newcomers' roles, to indoctrinate newcomers to organizational practices, to ease newcomers into membership in their work groups, and to help newcomers begin to develop new self-images in keeping with their new roles and organizations” (Miller & Jablin, 1991, p. 92).

New employees first learn how to perform the expected tasks of their job (role-taking) and then move onto role negotiation (role-making) in which they adapt the role expectations to better meet their needs (Miller, Johnson, Hart, & Peterson, 1999). Employees engage in role negotiation when they interact with others concerning possibly altering expectations about the role (Miller et al, 1999). Kramer (2004) discussed role negotiation as a two-part process: first, an agreement is reached on what role will be performed; and second, discussion focuses on how that role should be performed. Research suggests that an individual’s negotiation power and their ability to make
demands about their roles are influenced by factors surrounding their entry into the organization (Kramer, 2004). For example, employees who were highly sought after and are perceived as valuable to the organization have greater power to negotiate their roles. Scholars have found a connection between turnover and unmet expectations (Pearson, 1995), so an employee’s inability to successfully negotiate role changes to meet one’s needs or expectations could lead to higher turnover. As low status employees, home health aides may have little power to negotiate their roles, but the low level of supervision allows them a degree of freedom to shape their role as they wish.

**Identification.** Closely related to roles and how employees make decisions about what to do on the job is organizational identification. Organizational identification refers to a “oneness” that an employee has with an organization (Mael & Ashforth, 1992) or an alignment of an employee’s inner thoughts and decision-making processes with those of the organization (Cheney, 1983). Identification can be enhanced by an organization through persuasion techniques, such as training communications and unifying symbols (Cheney, 1983). A person who strongly identifies with an organization is more likely to remain working for that organization and to make decisions that are in the best interest of that organization (Cheney, 1983). Because home health aides primarily work independently in the homes of elderly clients, they find themselves in the position of having to make decisions without a great deal of supervision. A home care agency would benefit if an aide’s inner voice spoke in unison with the agency’s voice. Also, stronger identification with the agency could have an impact on the high turnover rates of home health aides (DeMoura, Abrams, Retter, Gunnarsdottir, & Ando, 2009).
Several studies suggest that an employee’s relationship with his or her supervisor is key for establishing commitment to an organization and identification. For example, communication with a supervisor, and the relationship with the supervisor and co-workers have been found to be related to a subordinate’s level of identification (Myers & Kassing, 1998; Scott et al., 1999). Other studies have looked at situations where employees have multiple potential targets for identification. One such study, which looked at identification when the employees are geographically dispersed or working remotely, found that identification was more likely to occur with more localized targets, and that tenure in a position has an influence on identification (Scott, 1997). A study of contract workers found that they identified with their employing organization to the extent that they found this organization to be positively distinct, to value attributes that are congruent with attributes that they themselves valued, and had colleagues who were likeable and management that was trustworthy. Identification with the client organization was associated with only the quality of relations with colleagues and supervisors in that organization (George & Chattopadhyay, 2005). These findings could apply to home health aides who work for an organization, but interact mainly with clients and family members away from the organization’s offices.

Another potential identification issue that could relate to home health aides is the concept of disidentification. When others negatively evaluate their work status, menial workers have strategies for self-protection to deal with status deprivation and the threat to their work-related identity (Jackall, 1978). One common coping strategy is dis-identification, where the individual contends that they are just temporarily in that position
(Jackall, 1978). For example, they might state that they are not really a home health aide, that they are just doing this work until something else, something better, comes along.

**Health Communication and Roles**

Over the past 40 years, health communication has emerged as its own field of study initially examining communication in the delivery of health care and in health promotion (Kreps, Bonaguro, & Query, 1998). A growing number of studies have examined organizational issues in a health context, such as health care teams, health care decision-making, and roles. Organizational communication in a health setting has the added significance of examining “processes of fundamental human import” (Thompson, 2003, pg. 1)—health issues. Health care organizations are defined not only by the impact their processes have on life and death situations, but also by their complex structures, and their highly regulated work environments (Lammers, Barbour, & Duggan, 2003). A preponderance of these studies has focused on health care professionals, such as doctors and nurses. A few scholars have begun studying direct care workers, who while not healthcare professionals, are paraprofessionals who work under the direction of a nurse, who spend the most time with the client, and who have a great deal of influence on the health of the client (Majerovitz, Mollott, & Rudder, 2009). As mentioned previously, the communication studies that have been done on direct care workers have largely looked at certified nursing assistants who work in hospitals or nursing homes. Home health aides, who work in a home setting and who are an important part of a frail seniors’ health care, are understudied. Yet the health care services that they provide are central to the provision of home health care to the growing number of elderly in the United States.
Within health communication, studies have looked at influences on doctors and nurses roles, such as managed care and teamwork. When Apker (2001) examined ways that hospital nurses develop and make sense of their professional roles in a changing managed care setting, she found that “nurses’ communicative relationship with their managers helped them construct, develop and understand their roles” (p. 124). She also found that nurses continuously check role expectations in interactions with other organizational members and confirm or modify those expectations as needed. In several health communication studies, it was found that supervisors in particular are important in helping health care professionals construct and understand their roles (Apker, 2001; Rossman, 1997). Expectations of others can be a source of confusion and conflict, though. A study of home health aides found that aides must negotiate their roles by considering the expectations of both their supervisors and their clients, which can conflict with each other (Rossman, 1997).

Another study looking at the influence of managed care on health care roles found the perceived influence of regulation and third-party payers. Specifically, the study found that physicians feared that the financial controls imposed by managed care could threaten their independence (Barbour & Lammers, 2007). The system of managed care imposes “formal, contractual arrangements between patients, providers, organizations and practitioners provide care and ways in which governments, employers and insurance companies pay for care” (Barbour & Lammers, 2007, p. 205), all of which can influence a caregiver’s role and level of satisfaction.

Team interactions have also been studied in a healthcare context for their influence on shaping roles. Scovell (2010) looked at nurse-to-nurse handover in patient
care and found this ritual helps shape professional identity and roles, and provides socialization into the culture of the ward. In a study of an interdisciplinary geriatric oncology team, Ellingson (2003) found the clinic backstage served as a setting where team members can learn and clarify roles, as well as share understandings of norms. When Poole and Real (2003) looked at healthcare teams, they found that teamwork can be undermined by rigid role demarcation and role confusion. Their study suggests that conflict within a team can be triggered by constant efforts to clarify ambiguities regarding role expectations.

The concept of “professionalism” and how it influences the role of healthcare providers has also been studied by communication scholars. Morgan & Krone (2001) found that “the emphasis on maintaining a ‘professional’ appearance in caregiving largely constrains actors to perform along their scripted roles” (p. 317). Caregivers struggle with detached-attached tensions, and the expectation that professional caregivers maintain objectivity despite the emotional demands of caring for people. The impact of power disparities in healthcare settings on emotional labor demands was noted in this study, with doctors being able to delegate certain emotional labor duties to other workers who are lower in the hierarchy.

Identification in a healthcare setting is also related to roles. One study found that the perceived identity and external image of a healthcare organization was related to the strength of the physicians’ identification with the organization (Dukerich, Golden, & Shortell, 2002). If the doctors had positive perceptions of the organization’s identity, and if they believed that outsiders also had positive perceptions of the system, they were more likely to have stronger identification with the system. Given these findings, it can be
surmised that establishing a strong sense of identification in home health aides might be difficult since society does not attach prestige or status to the position of home health aide. However, research has found that direct care workers who are faced with both low pay and low job status can create meaning and a sense of satisfaction for themselves as needed givers of care involved in helpful relationships with older adults (Ball, Lepore, Perkins, Hollingsworth, & Sweatman, 2009). Thus, though society does not value their work, home health aides themselves may find value in their work, which could contribute to identification with their employing organization.

Theoretical Framework

Two theoretical frameworks are useful for organizing, understanding and analyzing the data from home health aides, their supervisors and clients. These two theories are social ecological theory and role dialectics.

Social Ecological Model. This study proposes a social ecological model for understanding roles. The concept of the influence of proximal and distal layers of the environment has been modified for use in health promotion by a number of scholars. A few communication scholars have used social ecology theory to understand influences on health behavior (Cohen, Scott, White, & Dignan, 2013; Evans, Abroms, Poropatch, Nielsen, & Wallace, 2012; McLeroy, Bibeau, Steckler, & Glanz, 1988; Paek & Hove, 2012; Stokols, 1996), civic engagement (Kim & Ball-Rokeach, 2006) and conflict communication (Oetzel, Ting-Toomey, & Rinderle, 2006). These ecological models suggest that behavior is influenced by the social environment, and that the various levels of influences enable specific behaviors to be identified. Stokols (1996) suggests that one of the strengths of the social ecological model is that it views “behavior as being affected
by, and affecting the social environment” (p. 355). The multi-layers in the model enable researchers to “focus attention on different levels and types of social influences” (p. 355) and thus develop appropriate interventions. To date, scholars have not employed this model for use in understanding organizational roles.

Bronfenbrenner (1979) introduced the concept of Ecological Systems Theory to understand and explain child development. He suggests that human development is influenced by the multiple layers of environment which surround the individual. These layers included the microsystem, which involves other individuals and organizations with which a child has direct, face-to-face contact; the meso-system, which involves connections between people and organizations in the microsystem; and the macro-system, which involves broader processes and organizations such as culture or social classes. Bronfenbrenner proposed that as human beings grow from childhood, they are influenced by their interactions with people and organizations in their environment. An important aspect of his theory is the interconnectedness of the people and the systems and how that influences the developing child. He suggests that “objects, activities, and especially other people send out lines of force, valance, and vectors that attract and repel, thereby steering behaviors and development” (Bronfenbrenner, 1979, p. 23). Bronfenbrenner suggests that this model enables the researcher to detect and understand developmental influences. “Detection of developmental influences becomes possible only if one employs a theoretical model that permit them to be observed” (Bronfenbrenner, 1979, p. 4). Analyzing the talk of home health aides, their supervisors and their clients within the framework of the multi-level social ecological model system provides an
organizing tool for the data analysis, as well as a visualizing tool to better envision how the various influences are interconnected.

In this study, I adapt Bronfenbrenner’s Social Ecological Model to use it as a framework for examining and understanding roles within an organization. I propose that the model describing the macro-, meso- and micro-levels of influencers that surround home health aides sheds light on the tensions that home health aides face as they endeavor to learn and develop their role. This concept, that people are influenced in their development as human beings by both proximal and distal forces, is readily applicable to the concept of employees developing in their role within an organization. For example, in much the same way that developing human beings are shaped by their environment, such as parents, schools and national policies, so too a new healthcare employee is shaped by interactions with the supervisor, national regulations, and the work environment. By analyzing the data from interviews with home health aides, their supervisors and their clients, the framework for the social ecological model of role influences was created. Chapter 4 will discuss this model in greater detail.

**Role Dialectics Perspective.** Apker, Propp, and Ford (2005) merged concepts of Role Theory with relational dialectics to produce a theory that views contradictory forces as “neutral components instrumental to role enactment” (Apker et al, 2005, p. 97). Organizational communication scholars have used Role Theory to study roles with their socially defined expectations and norms. In Role Theory, communication is key to role construction and negotiation, a dynamic process that involves interaction with one’s supervisor, co-workers, clients, and others, along with training and socialization.
processes (Miller, Johnson, Hart, & Peterson, 1999). Through these interactions, employees determine how they are expected to behave on the job.

Communication scholars have used dialectics as a useful framework for examining contradictions in dyadic and familial relationships. Baxter and Montgomery (1998) suggest that with the dialectical perspective, contradictions are inherent to human interactions. These oppositional forces are ever-present and a natural part of relationships. As people interact, they constantly define and negotiate their relationships by managing these contradictory forces. Research has been extending dialectics beyond interpersonal relationships. For example, Kramer (2004) used the dialectical perspective as a framework to study group dynamics.

Apker and colleagues (2005) developed the theory of Role Dialectics, by intertwining Role Theory with dialectics, providing an alternative way of viewing the construction and negotiation of roles. Role dialectics recognizes that the nature of roles is dynamic and fluid, along with the importance of contradictions, noting that it is “the ongoing interplay of contradictions that produce, shape, and maintain behaviors associated with a particular role” (Apker et al, 2005, p. 97). Role Dialectics was used by Apker and colleagues (2005) to examine work team relationships. Specifically, their research explores nurses’ role tensions and investigates how nurses communicatively negotiate role contradictions.

Research Gaps

Despite their importance in the field of home care, home health aides remain an understudied population by communication scholars. Most health communication research has focused on the healthcare professions—doctors, nurses and teams of
healthcare professionals. A few scholars have looked at the experiences of being a direct care worker, but even fewer have studied home health aides. Those few studies have looked at the types of relationships that develop between older clients and home health aides (Piercy, 2000), how home health aides manage “dirty work” and deal with nakedness and disgust (Twigg, 2000), and how nurse/home health aide collaboration can enhance diabetes management in home care (Vetter, Bristow, & Ahrens, 2004). Hokenstad, Hart, Gould, Halper, and Levine (2006) used focus groups with home health aides to gain insight into how they experience their work and their relationship to family caregivers. A more comprehensive look at the proximal and distal influences on the role of home health aides is lacking. The perspectives of all three parties at the center of the home health aide experience—the aides themselves, their supervisors and their clients—can shed light on what being a home health aide means to individuals in that position and the strategies they employ to manage the tensions inherent to the position. This knowledge is important to understand the role and enable improvements to be made that could improve the job for members of all three groups, but especially for the aides, as well as enhance recruitment and retention of aides.

This study also contributes to organizational communication role scholarship. Though the number of studies that look at low status jobs is growing, there is still a need to more closely examine roles of low status workers and their roles. Also understudied are low status remote workers. Communication scholars who have looked at remote workers have focused on white-collar teleworks who are working out of their homes and have technical connectivity with their supervisors and coworkers (Fay & Kline, 2011; Fonner & Roloff, 2012; Leonardi, Treem, & Jackson, 2010). The home health aide
remote working situation is vastly different from what has previously been studied. The importance of aides to the growing home care industry and the health of seniors warrants studying them and how they learn their job and understand their role.

**Research Questions**

Examining how home health aides construct and negotiate their roles and how social ecological forces influence the way that aides take on their work roles and manage competing forces can foster a better understanding of the tensions that make being a home health aide and working with home health aides difficult and challenging.

Examining what tensions impact home health aides, and how home health aides construct and negotiate their role can contribute to a better understanding of the job of a home health aide and how to improve it.

To that end, this study will ask the following questions:

1. What role influences, both proximal and distal, can be identified through the talk of homes health aides, their supervisors and their clients?
2. What role tensions can be identified from the talk of home health aides, their supervisors and their clients?
3. What communication strategies do home health aides employ to manage the identified role tensions?
CHAPTER THREE
Research Design and Methods

The aim of this study is to examine how home health aides learn and understand their role through their interactions with home care agency supervisors and their clients. It also examines the strategies that aides employ to manage role dialectics that they experience. As described in Chapter 2, this study uses two theoretical concepts as a framework for better understanding how home health aides understand and negotiate their roles: Social Ecological Theory and Role Dialectics.

The research questions are explored using interpretive methods, primarily using in-depth interviews to understand the perspectives of home health aides, home care agency management and clients and family members. Observation and text analysis were used to sensitize me to possible issues and tensions and to help me better understand the world of home health aides.

Interpretive or qualitative research methods are ideal for this study because of the focus on “how” and “what” questions (Green & Thorogood, 2009). Qualitative methods provide a way to learn about the world from the participants’ point of view and “get at the inner experience of participants, to determine how meanings are formed” (Corbin & Strauss, 2008, p. 12). When the researcher wants to better understand a person’s values and perceptions and does not seek to measure that experience or propose cause and effect relationships, qualitative methods provide appropriate tools. Understanding the participants’ point of view and their inner experience is the type of knowledge that this study is seeking to reveal. This is in line with Bronfenbrenner’s (1979) suggestion that
how people think about and talk about their environment is more important than how “it may exist in ‘objective’ reality” (p. 4).

In this chapter, I describe in detail the setting, the participants, data collection methods, and data analysis methods.

**Setting and Participants**

A total of 62 individuals—34 home health aides, 16 supervisors of aides, and 12 clients or their family members—participated in this study. All participants live in the State of New York, which provides a wide variety of contexts in which home health aides work, from dense urban settings to rural communities.

The 34 home health aides were recruited from six different home care agencies located in both rural counties and urban areas. I recruited more than half of the aides by making a short announcement during continuing education classes and training classes at two different agencies, and allowing interested aides to sign up. Another group of aides was recruited via a sign-up sheet posted on a company bulletin board. The rest were recruited via social networks (a posting on Facebook, an email to friends, and word of mouth). The participants represent a cross-section of contexts in which New York State home health aides work—large urban settings, smaller cities, and rural counties. I approached the agencies after receiving suggestions and contact information from a home care trade association. Originally, I had planned to interview up to 25 aides, but once I had interviewed a number of aides in New York City and a number of aides in other parts of the state, I realized that the contexts were sufficiently different that additional participants would be needed to achieve data saturation.
Demographic data was collected from the aides, who ranged in age from 21 to 67 years, averaging 44.4 years in age (See Table 3.1). They had worked as home health

Table 3.1. Demographics of Home Health Aides

<table>
<thead>
<tr>
<th>Name*</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
<th>Number of years as aide</th>
<th>Environment</th>
<th>Education</th>
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<tr>
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<td>40-49</td>
<td>F</td>
<td>B (Black)</td>
<td>6-10</td>
<td>Small town</td>
<td>Some college</td>
</tr>
<tr>
<td>Betsy</td>
<td>30-39</td>
<td>F</td>
<td>W (White)</td>
<td>11-15</td>
<td>Small town</td>
<td>12th</td>
</tr>
<tr>
<td>Carla</td>
<td>20-29</td>
<td>F</td>
<td>B</td>
<td>1-5</td>
<td>Small town</td>
<td>11th or lower</td>
</tr>
<tr>
<td>Darlene</td>
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<td>F</td>
<td>W</td>
<td>6-10</td>
<td>Small town</td>
<td>--</td>
</tr>
<tr>
<td>Emily</td>
<td>60-69</td>
<td>F</td>
<td>W</td>
<td>26-30</td>
<td>Small town</td>
<td>12th</td>
</tr>
<tr>
<td>Faith</td>
<td>40-49</td>
<td>F</td>
<td>W</td>
<td>1-5</td>
<td>Small town</td>
<td>Some college</td>
</tr>
<tr>
<td>Georgia</td>
<td>30-39</td>
<td>F</td>
<td>B</td>
<td>6-10</td>
<td>Medium City</td>
<td>12th</td>
</tr>
<tr>
<td>Hailey</td>
<td>50-59</td>
<td>F</td>
<td>W</td>
<td>26-30</td>
<td>Medium City</td>
<td>Some college</td>
</tr>
<tr>
<td>Irene</td>
<td>50-59</td>
<td>F</td>
<td>W</td>
<td>21-25</td>
<td>Medium City</td>
<td>11th or lower</td>
</tr>
<tr>
<td>Jackie</td>
<td>50-59</td>
<td>F</td>
<td>B</td>
<td>21-25</td>
<td>Medium City</td>
<td>Some college</td>
</tr>
<tr>
<td>Kelly</td>
<td>30-39</td>
<td>F</td>
<td>W</td>
<td>1-5</td>
<td>Small City</td>
<td>Some college</td>
</tr>
<tr>
<td>Lorraine</td>
<td>40-49</td>
<td>F</td>
<td>B</td>
<td>1-5</td>
<td>Small City</td>
<td>Some college</td>
</tr>
<tr>
<td>Mia</td>
<td>40-49</td>
<td>F</td>
<td>W</td>
<td>16-20</td>
<td>Small City</td>
<td>11th or lower</td>
</tr>
<tr>
<td>Nathan</td>
<td>50-59</td>
<td>M</td>
<td>B</td>
<td>21-25</td>
<td>Small City</td>
<td>11th or lower</td>
</tr>
<tr>
<td>Olivia</td>
<td>60-69</td>
<td>F</td>
<td>W</td>
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<td>12th</td>
</tr>
<tr>
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<td>F</td>
<td>B</td>
<td>6-10</td>
<td>Small City</td>
<td>12th</td>
</tr>
<tr>
<td>Rose</td>
<td>60-69</td>
<td>F</td>
<td>W</td>
<td>11-15</td>
<td>Small City</td>
<td>11th or lower</td>
</tr>
<tr>
<td>Sophia</td>
<td>40-49</td>
<td>F</td>
<td>W</td>
<td>6-10</td>
<td>Medium City</td>
<td>12th</td>
</tr>
<tr>
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<td>F</td>
<td>W</td>
<td>16-20</td>
<td>Medium City</td>
<td>11th or lower</td>
</tr>
<tr>
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<td>F</td>
<td>W</td>
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<td>Medium City</td>
<td>Some college</td>
</tr>
<tr>
<td>Beth</td>
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<td>F</td>
<td>B</td>
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<td>Large City</td>
<td>Some college</td>
</tr>
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<td>College grad</td>
</tr>
<tr>
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<td>F</td>
<td>B</td>
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<td>Large City</td>
<td>Some college</td>
</tr>
<tr>
<td>Eddie</td>
<td>40-49</td>
<td>M</td>
<td>B</td>
<td>1-5</td>
<td>Large City</td>
<td>12th</td>
</tr>
<tr>
<td>Faye</td>
<td>20-29</td>
<td>F</td>
<td>B</td>
<td>1-5</td>
<td>Large City</td>
<td>12th</td>
</tr>
<tr>
<td>Gina</td>
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<td>F</td>
<td>B</td>
<td>11-15</td>
<td>Large City</td>
<td>12th</td>
</tr>
<tr>
<td>Hildie</td>
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<td>B</td>
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<td>Large City</td>
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</tr>
<tr>
<td>Isabelle</td>
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<td>12th</td>
</tr>
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<td>Judith</td>
<td>40-49</td>
<td>F</td>
<td>B</td>
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<td>Medium City</td>
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</tr>
<tr>
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</tr>
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<td>B</td>
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<tr>
<td>Neva</td>
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<td>F</td>
<td>B</td>
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</tr>
<tr>
<td>Oliver</td>
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<td>M</td>
<td>B</td>
<td>&lt;1</td>
<td>Large City</td>
<td>Some college</td>
</tr>
</tbody>
</table>

*Pseudonyms were assigned to each participant, and ranges were given for age and years working as an aide to protect confidentiality.
Aides for a period of time ranging from less than one year to 28 years, with an average of 11 years. Most of the aides (59%) were black, 38% were white, and one (2.9%) was South Asian. In addition, 88% (30) were female, and 12% (four) were male. The aides who participated come from a variety of backgrounds. Nearly all of the participants working in New York City were black, many were recent immigrants, and most were from lower income neighborhoods. For this group, being a home health aide represented an entry into the job market and perhaps a stepping stone to a better job. The participating aides who lived in smaller cities and rural communities were more likely to be white and to come to home care after another career, such as daycare or working as a certified nursing assistant (CNA) in a nursing home where they became disenchanted with the inability to spend one-on-one time with the residents.

A total of 16 supervisors of home health aides participated in this study, representing five home care organizations, from New York City to upstate urban and rural areas. Supervisors were recruited in a number of ways. In one large agency, an email was forwarded from me by the manager of Human Resources explaining my research goals and asking for interested volunteers to contact me directly. In another agency, a notice on the agency bulletin board let supervisors know that I was in the conference room if they would like to participate in the study. For smaller home care agencies, I called the agencies directly and talked with the supervisors about the study and asked if they would like to participate. The agencies ranged in size from having less than 10 home health aides to having thousands of home health aides. The supervisors from upstate areas were nearly all trained as Registered Nurses and frequently worked
with the clients in that capacity. The supervisors in New York City did not typically have a healthcare background and worked more in an attendance and coaching capacity.

In addition, 12 individuals were recruited to represent the client side of the interaction—five clients and seven family members, all of whom live in upstate New York. Most of these participants were recruited through social networks and social media. I also received permission from the manager of a seniors-only, subsidized housing complex to ask passersby in the community room if they would like to participate in the study. Four clients were recruited this way. The fifth client lived in her house with her son. Many frail elderly clients who use home health aides are not cognitively able to participate in research interviews. When that was the case, their family members were selected as the participants, in essence to speak for the client. The family members in this study, typically spouses and children of clients, were intimately involved in hiring and working with the aides.

**Data Collection**

The primary form of data collection was through in-depth interviews of home health aides, home care agency supervisors, their clients, and client family members to gain an understanding of their perspectives concerning the role of home health aides.

Participant interviews provide a good way to gain an understanding into how individuals make sense of their world. Holstein and Gubrium (2004) suggest that “interviewing provides a way of generating empirical data about the social world by asking people to talk about their lives” (p. 140). Interviews are “well-suited to understand the social actor’s experience and perspective” (Lindlof & Taylor, 2002, p. 173). The interviewer asks the participant questions, and the participant responds by describing
events, interactions or perspectives from their point of view, and using their words. In this way, the researcher has access to information and details that he or she might not be able to access through just observational techniques, such as feelings or tensions or past experiences (Lindlof & Taylor, 2002). Interviews provide insight into how participants construct meaning because the interview itself is a meaning-making process (Holstein & Gubrium, 2004). The interview provides an opportunity for an interviewee “to formulate and talk about experience, opinions, and emotions in particular ways, implicating the interviewer, on the other side” (Holstein & Gubrium, 2004, p. 151).

Interviews consisted of semi-structured, open-ended questions. The interviews with the home health aides began with a broad question asking the participant to describe a typical day at work. Follow-up questions and probes were used to keep the conversation going (Rubin & Rubin, 2005), and to seek depth and detail from the participant. Additional lines of questioning included asking aides to describe the job of a home health aide, how they learned to be an aide, why they decided to become an aide, how family and friends view the work that they do, and what they would do to make their job better. Supervisors were initially asked to describe the job of a home health aide, and what qualities they look for when they hire aides. Subsequent questions included asking about the training involved in being a home health aide, the challenges they think home health aides face on the job, and what could be done to improve the job of home health aides. Clients and family members were also asked to describe the job of a home health aide. They were subsequently asked such questions as what are the challenges of having a home health aide work in their home, how they typically interact with home health aides,
what are the characteristics of a good aide, and what could be changed to make working with a home health aide better. The interview schedules are included as appendices.

The home health aide interviews ranged in length from 10:23 minutes to 55:07 minutes, averaging 30.26 minutes in length. About half of the interviews were conducted in a private room within the aides’ home care agency facility. The other interviews were conducted at a location selected by the aide for convenience, typically a coffee shop or a fast-food restaurant. The aides were paid $15 for their participation. Only the aides were compensated because they typically occupy a much lower socio-economic status level than the other two groups of participants in the study, are paid by the hour for their work, and may find it more difficult to give up an hour of their time for this study. The supervisor interviews ranged from 18:51 minutes to 48:34 minutes, averaging 34 minutes in length. The client and family member interviews ranged from 8:58 minutes to 52:40 minutes, averaging 24:15 minutes in length. Supervisors, clients and family members were not reimbursed for their time. The interviews were audio-recorded and transcribed in their entirety, resulting in 1,136 pages of double-spaced transcripts.

**Data Analysis**

To analyze the data in this study, I used an approach informed by grounded theory, which is a systematic, iterative way of working with qualitative data (Charmaz, 2006). It involves cycles of collecting data, analyzing them to suggest further data collection and further analysis, until “saturation is reached when no new concepts are emerging” (Green & Thorogood, 2009, p. 203). Charmaz (2006) suggests that researchers enter the field with some “sensitizing concepts and general disciplinary perspectives” (p. 11) and then let the analysis of the data lead to “an abstract theoretical
understanding of the studied experience” (p. 4). I did enter the field with some initial theoretical perspectives in mind, given the scholarship that I had reviewed about home health aides. I began this study seeking to understand the perspectives of home health aides, supervisors, and clients regarding the role of aides, how home health aides construct and negotiate their roles, and how communicative processes influence the way that aides adjust to their work and find meaning in their work. My approach was informed by the grounded theory approach explained by Charmaz (2006), who brings a social constructionist interpretation to grounded theory. She assumes “that any theoretical rendering offers an interpretive portrayal of the studied world” (Charmaz, 2006, p. 10). The steps that she suggests are similar to those laid out by other grounded theorists but emphasize flexible guidelines and an acknowledgement that data and theories are also social constructions.

The steps of grounded theory that informed this study were:

- **Open coding.** Open coding began immediately after the first interview was completed and transcribed. This involved going through the data line by line and attaching labels to segments of the data. As Charmaz (2006) suggests, in this initial coding, I paid close attention to the action, and used gerunds or ‘-ing’ words frequently to stay close to the data and not think in conceptual terms at this point. A combination of coding, reflecting on the data and writing memos about the data then shaped further data collection. NVivo qualitative data analysis software was used to facilitate coding and analyzing data.

- **Memoing.** Grounded theorists start writing memos along with the initial coding to begin the process of asking questions about the data and making “constant
comparisons” of data (Corbin & Strauss, 2008, p. 73). Memos help the researcher “think about the data and to discover your ideas about them” (Charmaz, 2006, p. 73). I wrote memos regularly during the data collection and analysis to provide a way to reflect on what I was learning from the data.

- Axial coding and integrating categories. The next step in my analysis involved making connections between the open codes and between categories and then writing memos about those connections (Charmaz, 2006; Lindlof & Taylor, 2002). Whereas open coding creates as many categories to break up or open up the data, axial coding and integrating categories begin to piece the data back together by identifying connections between data.

A code list was developed from the open coding. The initial codes were grouped into categories which included challenges of aides and supervisors, characteristics of “a good aide,” aide interactions with supervisors and clients, teamwork, the care plan, and rewards of being a home health aide. Coding categories, including role influences and role dialectics, were identified and discussed with my advisor and refined throughout the process.

As I mentioned earlier, I began this study with some initial theoretical perspectives on how home health aides construct and negotiate their roles, and how communicative processes influence the way that aides adjust to their work and find meaning in their work. As I began analyzing the data, however, the initial findings took me in unexpected directions. For example, the social ecological model concept grew out of an attempt to organize the influences that emerged when aides and supervisors talked about the challenges and rewards of being an aide. In mapping the influences in
concentric circles from direct interaction to more distant influences, the model developed. This led to a search for other models that might explain role influences. Though nothing was found that directly related to roles, the Bronfenbrenner model (1979) provided a helpful framework that could be adapted to roles. It became apparent that there are many similarities between children developing into adults and learning adult roles and newcomers entering an organization and learning their job role. Additional analysis of the interview data further defined the Social Ecological Model of Role Influences for home health aides.

The data analysis also showed that home health aides deal with a number of role tensions. This led me back to the literature to see what we already know about role tensions in healthcare jobs. The work by Apker, Propp, and Ford (2005) proved informative and led me to dip back into the data with the construct of role dialectics in mind.

**Ethical Considerations**

The protocol for this study was reviewed and approved by the Institutional Review Board for the University of New York, State University of New York. In addition, one home care agency required its own IRB approval.

Several steps were taken to protect the confidentiality of participants. All participants were assigned a code number and their names were not attached to their interviews transcripts. Pseudonyms are used throughout this study. I was the only person who listened to the interview recordings, and I transcribed the interviews myself. My advisor reviewed portions of the transcripts, but nothing that contained identifying information. Original audiotapes of participant interviews are kept locked in my office.
Electronic versions of interviews are kept in password protected files on my computer. Though demographic information was collected about the home health aides, age ranges and years employed as a home health age were converted to a range to prevent the inclusion of potentially identifiable information.

I reviewed the consent form with all participants before they signed it, stressing the voluntary nature of their participation in the research, and their freedom to decline to answer any questions or to end the interview at any time.
CHAPTER FOUR: Findings and Interpretation, Part One

Macro- and Meso-Level Influences on the Role of Home Health Aides

Research Question 1 asks what role influences, both proximal and distal, can be identified from the talk of home health aides, their supervisors and their clients. This analysis includes data from the interviews, as well as data from outside sources, such as government websites and home care agency literature. This chapter introduces the Social Ecological Model of Role Influences, which has been adapted for use as a tool to organize and understand influences on roles. It then looks specifically at role influences at the macro and meso levels, those beyond the interpersonal interactions of the aides, supervisors and clients. At the macro level, the influencing factors that emerged from the interview data included third-party payers, government regulations, and societal perceptions of aides. Influences at the meso level that emerged from the data included the work environment, transportation issues, physical demands of the job, family members of the client, and family members of the aide.

Social Ecological Model of Role Influences

Initial efforts to organize and analyze the interview data led to the development of the Social Ecological Model of Role Influences. Concept mapping was used initially to organize the vast amounts of data. From this mapping exercise, a graphical representation of the main influences began to take an ecological form, with some influences emerging from the direct interactions of aides, supervisors and aides and other influences taking place at a distance from the aides’ every day interactions. A literature survey found that Bronfenbrenner (1979) introduced a social ecological model to understand human development. When Bronfenbrenner (1979) proposed the Social Ecological Model for
Child Development, he suggested that the development of children is influenced by people and objects in the children’s environment. Other scholars then used the ecological approach to better understand the interplay of personal and environmental factors in a variety of studies, such as health promotion (McLeroy, Bibeau, Steckler, & Glanz, 1988; Stokols, 1996) and conflict communication (Oetzel, Ting-Toomey, & Rinderle, 2006).

In the Social Ecological Model of Role Influences (See Figure 1), forces at the micro level that shape role development and enactment result from interactions of home health aides with their supervisors, coworkers and clients or customers. At the meso level, the model suggests that role influences come from community and organizational forces. These might include such factors as family members, pay and benefits, and the work environment. At the macro level, role influences result from government, societal and other high-level, broad processes and people. This study, which examines the influences identified through the talk of home health aides and supervisors, focuses on the micro, meso and macro levels. The intrapersonal influences were not examined in this study.

The ecological approach is a useful framework for understanding role influences, because as with most employees, home health aides do not work in a vacuum. However, because aides largely work independently in the homes of clients and have limited contact with their home care agency supervisors, the influence of other forces in their environment may be greater, and the influence of the supervisors lesser, than most employees. In addition, the healthcare industry is highly regulated, adding another layer of influences on the role of home health aides. To understand the lived experiences of
home health aides, it is helpful to understand the environmental factors that influence how they think about themselves and how they interact with others.

The applied model (Figure 4.2) illustrates graphically that home health aide roles are influenced by the multi-layered environment in which the aides live and work, similar to the concept that Bronfenbrenner (1979) suggests with child development. I propose a three-layered model developed from an analysis of interviews with aides, their supervisors and their clients. At the center of the model is the micro level, which includes the interactions of the aides and their supervisors, and aides and their clients. This level involves interpersonal interactions with important others, often face-to-face communication, but occasionally mediated. Bronfenbrenner (1979) suggests that interactions at this level are key both to constructing the role of the individual and to making sense of the influences from the environment. These interactions are similar to the key communication sources of information that organizational scholars have suggested for newcomers as they learn their jobs: the organization, supervisors and co-workers (Jablin, 1987). As mentioned earlier, one of the reasons that the role of aides appears rife with problems is that the influence of supervisors tends to be muted by a lack of frequent interactions. In addition, home health aides rarely see or interact with other aides. The interactions between these participants are also colored by people, organizations and processes located outside of this inner circle. Thus this model allows a way of broadly viewing the various influences on home health aide roles and their interactions with their supervisors and clients. Just beyond the micro-level interactions is the meso level of influences. This level in this model includes people, organizations and processes that are in the employees’ everyday life experiences, such as transportation
Figure 4.1: Conceptual Social Ecological Model of Role Influences
issues, the work environment itself, the physical demands of the job, and family members of both the clients and the aides. These are factors talked about by the aides, their supervisors and the clients. The macro level includes factors that influence the role of the home health aide but which take place at the national or state level, involving societal views or public policy. The macro-level influences include those from a large scale social perspective, such as the government, third-party payers and society at large.

Bronfenbrenner (1979) talks about the interconnections of people and organizations in the various levels of the social ecological model and how that influences child development. Similarly, the people and organizations in the Social Ecological Model of Role Influences are interconnected and through their interconnectedness further influence the role that home health aides understand. For example, the national policies established for Medicare and Medicaid at the macro level regarding reimbursement and number of approved hours affect training and scheduling practices at the meso level, which in turn influences the interaction between home health aides and their clients at the micro level.

The value of the model is that it allows role influences to be displayed graphically and better understood. The model is a tool that assists with understanding and explaining. On a practical level, if an analysis suggests that there are concerns or problems with a particular role—i.e., there are difficulties recruiting and retaining sufficient aides to meet the need—the model can be used to pinpoint influences that can be addressed to achieve improvements in the job of home health aides.
Figure 4.2: Social Ecological Model of Role Influences—Home Health Aides
Macro-Level Influences

**Government and Third-Party Influences.** At the macro level, the aides, supervisors and clients talked about role influences that include third-party payers, government agencies, and societal perceptions of aides. Government agencies such as the State Department of Health establish regulations for what aides are allowed to do, and what they are not allowed to do (Stone & Wiener, 2001). Third-party payers include Medicare, Medicaid and private insurance companies which set the rates that aides are paid for their work and establish the number of hours that aides can spend with each client. Another influencer at the macro level is society’s perceptions of aides. The image that aides have in society-at-large has an influence who decides to become an aide (Rossman, 1997; Stone, 2001), and it affects the role and image that aides construct of themselves.

**Reimbursement levels.** Aides and supervisors talked about the impact that macro-level influences have on the role of home health aides. Nearly all aides and supervisors agreed that the reimbursement levels set by third-party payers severely limit what home health aides are paid. The hourly wage is typically just above minimum wage (Bureau of Labor Statistics, 2012). Our society measures success and value by pay (Ng, Eby, Sorensen, & Feldman, 2005)—it is a way to keep score and determine who is winning. The message sent by the low pay rates is that home health aides are not valued. Aides who articulated the importance of their work also talked about the need to be paid more. Aide Diana said, “We don’t get paid enough for our job. We seriously need a raise.” Similarly, Aide Ava said, “We’re not getting paid for what we are doing,” and Aide Pam said, “I’m always telling them that I need a raise. ‘When are you going to give me $10? I
need $10.’” Another aide shared that she has worked for more than seven years at the same low hourly rate. Many supervisors expressed a desire to be able to pay the aides more. They talked about the importance of the work that the aides do and shared a feeling of compassion for their aides, with Supervisor Angie noting that “it’s difficult for them to make a living on what they make.”

The fact that aides are not paid a livable wage, with nearly half relying on government assistance programs (U.S. Department of Health and Human Services, 2013), reinforces their low status in their organization. However, policies at the federal level establishing reimbursement rates are unlikely to change in a down economy. Some agencies turn to innovative solutions to bolster the aides’ pay, such as applying for grants or holding fundraisers to pay for bonuses for aides. If agencies want to enhance the aides’ perceived job satisfaction, they may need to investigate solutions beyond pay raises.

**Limited hours.** Another major impact on the role of home health aides that is derived from Medicare and Medicaid policies involves the amount of time aides are allowed to complete their work with each client. Supervisors talked about the impact of Medicaid and Medicare reducing the number of hours that an aide can spend with each client in an effort to reduce costs. A manager in a New York City home care agency, Robert, said that the reduction in hours per client changes the work that the aides do. Because a case that might have previously been approved for eight hours a day now might only get four or two hours a day, “An aide has to be much more nimble, much more aggressive in the way they carry out the plan of care because many times, they’re going to do two or three cases in a day, whereas before they had the whole day to do all the tasks on the plan of care.” Robert also pointed out that the trend is to continue to
constrict hours, so that aides will continue to be asked to do more with less time, requiring the aides to work harder than they did in the past. Patricia, a supervisor in a rural county, commented on how busy aides are while working, stating “I would like to slow their day down a little bit. I would like them to have a little more time with their patients and feel like they’re not in a constant state of headless chickens.” The aides also talked about working under a time pressure to complete the tasks. Georgia explained how from the time she enters a patient’s house, “you don’t get five minutes to get a sip of water…For me, from the time I get in that patient house, I start working…until I leave, I never… stop.” The shortened hours force the aides to focus more on task completion, leaving less time for socialization activities. Socialization with their elderly clients is one aspect of the job that aides talk about enjoying the most and which make it rewarding. Aide Anne explained that she loves talking with her clients “because I learn a lot…from them. They talk about when they were kids, their family, their religion, we sit there. We have a nice conversation.” Thus, the government policy change that shortened hours allotted per client has the potential of reducing the aides’ job satisfaction.

At the same time, the supervisors indicated that the shortened hours require aides to see more clients in a day, resulting in them spending more time traveling, which is often not reimbursed. Many of the aides talk about their dislike of the travel aspect of their job, which is often an unpaid, unproductive part of their day. Aide Georgia said that she does not like driving from client to client because “sometimes you’re so tired.” Another aide who talked about disliking all of the driving involved in her job is Jackie, who said that to improve her job she would change “all this driving here and there. It’s the driving. You know, that’s tiresome.” The national policy change in reimbursable
hours has the effect of reducing the emotional and compassion aspects of care and increasing the characterization of care as a commodity. It also increases the part of the job that they dislike (traveling from client to client) and decreases the part of the job that they enjoy (socializing with their clients), thus contributing to lower job satisfaction.

Another factor impacting the number of hours that aides work is overtime pay. In New York State, legislation called the Domestic Workers Bill of Rights took effect November 29, 2010 (NYS Department of Labor, 2013). It requires that domestic workers be paid overtime, at a rate of time and a half, if they work more than 40 hours in a week. However, home care agencies are not reimbursed by Medicaid, Medicare or third-party payers at a higher rate when aides work overtime, so the agencies try to avoid assigning overtime. Several supervisors said this legislation resulted in the aides’ hours and their pay being greatly decreased. Supervisor Robert said that with the new legislation that “nobody gets overtime anymore … They used to get 60-70 hours a week … Now we’re about 29, 30 hours a week, which is tough, very, very tough especially if you’ve established yourself in a mortgage.” He said he suggests to aides who need more hours to go to work for a second or third agency, which results in “aides working at two, sometimes three agencies to get the hours, but they’re not getting the overtime.” One such aide is Gina, who confirmed what Robert said, “I work for two different agencies … ‘Cause a lot of time agencies don’t have enough hours. So in order to make the money, I go somewhere else.” The Domestic Workers Bill of Rights, which was enacted in New York State to help workers, but which did not include an increase in the reimbursement rate from Medicare and Medicaid, has resulted in a reduction of the aides’ hours and their overall pay. In addition, this legislation has resulted in many aides working for multiple
agencies, thus reducing their commitment to any one agency. A policy change touted by its supporters as a benefit to aides in effect hurts their economic situation and has them scrambling for additional work hours at other home care agencies. This has implications that extend beyond a lessened commitment to the original agency. It can influence identification with the original home care agency, which has an impact on job satisfaction (Vandenberg & Lance, 1992). It also has an impact on the status that aides may perceive they have in their employing organization, reinforcing that they are not valued and should look for additional hours elsewhere.

The lack of hours is one of the aides’ biggest complaints, and aides are constantly asking their supervisors for more hours. Aide Carla said, “I would rather have more hours than what I’m getting now... Something that I know I can definitely count on.” One New York City aide talked about how prior to the Domestic Workers Bill of Rights, she used to work 12 hours a day, 7 days a week for one client, but now she shares that client’s hours with another aide, so she works only four days a week. This insufficient number of work hours is exacerbated by the fact that most home health aides are paid per diem; they receive pay for each hour that they work. Aide Isabelle put it, “You don’t work, you don’t get paid.” If their clients’ health status improves so that they no longer need as much help at home, or if their clients’ health status declines so that they must enter the hospital or a nursing home, the aides lose the hours, and thus receive less pay. Isabelle elaborated, “Let’s say your client dies. You wait awhile before you get another client.” Hours fluctuate constantly for aides, so they do not have a steady source of income that they can plan on. Aide Pam elaborated on this problem:

People go in and out of the hospitals and stuff like that. So hours go. You might
have 30 hours one week, next week you might break it down to 12 hours … It’s always kind of hard to pick that back up, especially if your transportation is not right and stuff like that, you can’t pick up the hours, so it goes up and down like that. It’s a struggle.

The inconsistent hours coupled with the financial pressures on home health aides encourage aides to view their clients as a commodity, and as the means to a paycheck. When a client dies or is hospitalized, the concern that an aide might have for the passing of a client could be offset by the negative impact of the death on the aide’s income.

**Defining what tasks an aide can do.** In addition to limiting the hours and the pay that aides get, government regulations define the tasks that aides can do and what they cannot do. One agency provides a handout to their clients listing the services that certified home aides will provide. For example, it states that aides “can remind an individual when to take his or her prescribed medications, but they are not allowed to administer medications.” Aide Judith talked about the impact of these regulations, noting that she can remind a client to take medicine or she can put the medicine in front of the client, but “I can’t physicallypour it in theirhand and give it to them. That I can’t do. I can’t do it.”

In some ways, the government regulations seem overly restrictive to some aides. For example, Judith said that she had been “med certified” in her previous job at a school for disabled youth, but that training was discounted when she applied to be a home health aide. She explained, “When I was in my interview, she (the interviewer) was like, ‘Well, you’re not supposed to give medicine, so you don’t have to worry about that.’ ‘Ok. But I have my certification if I need to.’ ‘Don’t worry about it.’” Judith felt that she had useful
training that should be helpful when working with older clients, but state regulations would not allow her to use those skills. The restrictions on what aides can and cannot do contribute to the aides’ feeling of low-status and lack of respect within the organization. From the government regulations to the care plan and from their supervisor to the client and the client’s family members, the home health aide receives orders from many directions about how she should perform her role.

**Societal Influences.** The role of home health aides is influenced by the views that the aides think that members of society have of the role. Many aides said that others in society look down on the job that home health aides do. They said that their friends or family members ask them how they could do the work, because as Jackie said, “a lot of people ain’t about going in there, cleaning nobody’s dirty toilet or cleaning nobody’s butt, or stuff like that. They’re like, ‘I can’t do that.’” The aides talked about a stigma applied to them related to having to diaper people or clean them. Aide Georgia said that her brother spoke disparagingly about her becoming a home health aide. Referring to the personal care, she said, “My brother said, ‘You will never like that job if you have to do that.’” Michael, a young aide from New York City, talked about the reactions of others when he became a home health aide, stating “At first, I felt that people would judge me and to be honest they did … I always tend to get the wrong expression from people when they see me, and they ask me what I do and I tell them I’m a home health aide. The first thing they ask me is ‘Why?’” Michael shared that though he was somewhat reticent to tell others about his work, he was proud of the work he does and sees the value of it. The aides are often faced with negative opinions from others about their role. Other aides said that society as a whole views the job of a home health aide as “a menial job,” a job that is
“hard and a very trashy job,” “a second class job,” a job that is “not that valuable in the healthcare profession” and that aides are not viewed as important or “somebody that you really look up to.” Some aides even say that “it’s not really a job you can be proud of.” Some aides say they feel “degraded” by others for being an aide, and they hide the fact that they are aides when they are in public. Aide Eddie told about some aides who “are scared to wear even the uniform on the street. They wear the normal clothes, come here and go in the bathroom and change it.” Supervisor Cheryl provided a similar example:

Some of the aides what they try to do is cover it up, act like they’re nurses on the train because they don’t want anyone to know that they are an aide because it’s a demeaning job. Some of them have to clean the patient’s feces and people look at them really bad because they do that. How I look at it, it’s just a job that has to be done.

Because people strive to maintain a positive social identity (Ashforth & Kreiner, 1999), aides attempt to resolve society’s negative image of them. Some aides said they know that they are doing worthwhile work and try to dismiss the negative images. For example, Aide Michael said, “I really don’t care what people think to be honest because it’s not helping me in any way. There’s a lot of, as you may say, ignorant people out there. They may judge you and talk down on you and talk down on the job you do, but you gotta be strong.” This aide was confident in the value of the job that he does, and he is able to push back on the views that he believes that society has about aides.

Several aides mentioned that society’s image of aides has been further tarnished by newspaper accounts of home health aides accused of stealing from their clients or physically abusing their clients. They said the media never covers the good work that
aides do. Aide Teri said, “It’s just what you read in the papers that has happened to different agencies. That’s how they get bad names.” Some of the supervisors concurred, such as Ellen, who said, “I’m going to tell you that the half percent that will steal from the patient, abuse the patient or whatever, that’s what you hear about.” The aides felt that the community is not well served by the media with regard to the value of aides.

The supervisors also talked about a lack of respect that aides get from society. Supervisor Angie suggested that aides are viewed as lower level workers than they are in reality. “We see them as this helper person but maybe not as the level of care that they do provide the patient … Not that they’re like a professional level but they really are a good caregiver and resource for us so we should really be honoring that a little bit more.”

Perceived societal views of what a home health aide does and how they should be treated contributes to the low status role of the home health aide. If the job of a home health aide is not respected within society, this would detract from recruitment efforts and contribute to retention issues. If one feels that the need to hide what their job is from others, it negatively impacts one’s social identity and would negatively impact job satisfaction. Other workers dealing with the stigma of being dirty workers often access social resources within their workgroup to reframe the stigma or compare themselves favorably to other workers (Ashforth & Kreiner, 1999). However, home health aides work in isolation and do not have a workgroup to draw upon and help them lessen the impact of society’s negative labeling. In the face of negative labeling and a lack of social resources to counter the stigma, aides may engage in disidentification. When others negatively evaluate their work status, menial workers have strategies for self-protection to deal with status deprivation and the threat to their work-related identity (Jackall, 1978).
One common coping strategy is disidentification, where the individual contends that they are just temporarily in that position (Jackall, 1978). For example, they might state that they are not really a home health aide, that they are just doing this work until something else, something better, comes along. Many aides talked about plans to go to school and move up in the healthcare world, for example Lauren, who said, “I want to be an LPN,” and Faye, who said, “I’m going to school for occupational physical therapies.” In reality, most aides do not go back to school, due to limited resources and limited free time. Aide Judith shared that she had signed up to go to school for medical billing and coding, but had backed out because her mother recently died. She said, “I just feel right now, it’s just not a good time.” Another aide, Betsy, has delayed going to nursing school for more than a decade now. She said, “I wanted to become a nurse, but having my kids young, that threw me off to go to college after I graduated from high school.” Home health aides are typically struggling to make ends meet, working at a physically challenging job. Finding the time and money to go back to school when they are stretched to the max already is a daunting task.

**Meso-Level Influences**

At the meso level, home health aides and supervisors talk about a number of influences that shape the aides’ role. Meso-level forces are those forces closer to home that impact the role of home health aides, including the work environment, transportation issues, physical challenges of the work, family members of clients, and family members of aides. These influences may vary from community to community, from agency to agency, from client to client and from aide to aide. They shape how aides do their job, how they feel about the job that they do, and how they define their role.
Work Environment. The work environment of home health aides can have an influence on the role of the aides. Both aides and supervisors talk about how working in clients’ homes provides a far different work environment than if they were doing the same tasks in an institution, such as a nursing home or an assisted living facility. They describe walking into houses that they are not familiar with, working independently with no coworkers or supervisors down the hall, and having little or no control over their working conditions.

Dirty or uncomfortable conditions. Unlike an institution that has a cleaning staff and is generally kept in a state of order and cleanliness, aides could walk into a home that is spotless, or wade through debris to get into another home. The environment may not be comfortable to work in. The client may not have or may not use air conditioning, or the client may smoke or have pets. The homes may be kept too cold in winter or too hot in summer, because the elderly may be trying to keep down utility costs, and yet the aide must perform hard physical labor in this environment. Supervisor Angie described what aides might walk into, saying, “So you’re in a home that might have six cats, a dog, a crazy neighbor that yells and screams when you park in front of their house. These are a lot of things that go into the home that you as an aide don’t have any control over.” The aide is expected to do physical labor and provide emotional support in uncomfortable, even distressing conditions. Yet, the aides said such conditions just show how much they are needed. Aide Betsy said, “These people still need help, regardless of how they live, they still need help.” Another aide, Lauren explained that she wants the clients’ home to be clean not only for the patient but also for her because she works in that home for multiple hours each week. She added, “You have to really have that environment clean,
‘cause I wouldn’t want to be in no filth. I would like to be in a clean environment for her and for me.” Supervisor Ellen built on that thought, saying, “We have to respect the way that people live, how they choose to live, what their culture is. It’s not for us to pass judgment, and say, ‘Listen, I’m not going to Mrs. Smith’s because the place is a dump or the place is dirty.’” Walking into the unknown is part of the job. When aides first go to a client’s homes, aides do not know if they will have to deal with frayed electrical cords, rats and cockroaches, hot and humid conditions, or messy clutter. Unpleasant working conditions can detract from the enjoyment that aides get out of their job.

**Unsafe conditions.** In addition to the varying states of cleanliness and comfort that aides may encounter on the job, aides may also face unsafe or threatening situations when they enter someone’s home. Betsy talked about a client that physically abused her, stating, “I had one case where this guy beat me up … He grabbed me by my hoodie and he just yoked me around a little.” Supervisor Ellen described homes where aides are met with a gun lying out in view and family members are “selling crack. They’re smoking pot,” and Supervisor Jan talked about client homes where there is a family member present who is “coming out of jail for the first time. There’s drug use in the home.” They describe this as an unsafe environment for the aide.

Additional safety issues may include being exposed to parasites or infections. Aide Betsy talked about a client’s home that was infested with “bed bugs so I had to be removed out of there for a while; I couldn’t go in until it was cleared out.” Along similar lines, Supervisor Robert said, “We went through the bed bug thing. We’ve had MRSA infections (a difficult to treat bacterial infection).” The aides can be exposed to infections or parasites that they then are at risk of bringing home to their own family.
**Sexual advances.** Another situation that can make working uncomfortable for an aide is when a client or family member makes sexual advances to the aide. Supervisor Robert said it is not unusual for aides to have to deal with “that whole sexual thing that happens sometimes. Most of the aides can handle it. Every once in a while you’ve got a male patient, even if his wife’s in the house he’s still going to try.” Aide Ava described how uncomfortable interactions with the son of a client caused her to leave that client:

> The son I felt was saying too many personal things. He’d comment on my hair. He’d comment on what I was wearing. I’d had my hair cut and nobody noticed it, not even my own damn family, right. I go in and he goes, “Oh, your hair looks so nice” … and so I stopped going … I don’t do conflict well … I couldn’t have confronted him with that and if someone else had confronted him, it would have made it awkward for me.

Though aides may know how to handle sexual advances or avoid them, it is a part of the job that makes aides uncomfortable, enough so that they might quit working for a client that they care about.

**Weather challenges.** In addition to socially created challenges, Mother Nature can add to the difficulties that aides face. When Hurricane Sandy hit New York City in 2012, home health aides dealt with even more challenging work environments, including difficulties in traveling to and from work and finding no electricity at the clients’ homes. Liz, a New York City supervisor, described some of these challenges:

> I had two (clients) that my patients stayed in their houses. Mind you, no heat, no electricity, no elevators. The aides walked up almost 15 flights of stairs and their patients were wrapped up with blankets with no food. Just getting food from like
the neighbor next door. And they (the aides) went and stayed with them.

Aide Lauren, who works in New York City, told the story of her efforts to take care of her client during the storm:

She needs me. My family’s OK. I’m going to stay and take care of her. When she don’t have nobody, you … put yourself forward. I’m going to help her today. I’m not going to leave ‘cause it’s time for me to leave. She’s going to be stranded here by herself.

This aide left her family during the storm and stayed with her client for days to make sure she was safe. Such elevating of the client’s physical and emotional needs over those of the aides speaks to the dedication and compassion of the aides. When required to make a choice between the client’s needs and their own needs, most aides put their clients first.

**Isolation.** The work environment is also challenging because of its remoteness from supervisors, other aides or any support system. Supervisor Karen described the aides as working “in an isolated job” and “out there by themselves.” Their working environment is not like that of CNAs, who though they have similar training and perform similar tasks as home health aides, work in a nursing home where they have peers to work with, and with a nurse located just down the hall to provide help should it be required.

Supervisors talked about trying to provide support to aides who find themselves in intolerable situations. They report bedbugs or cockroaches to a landlord and insist that the home be cleaned up. They intercede when an aggressive dog or a disrespectful family member makes an aide uncomfortable. Supervisor Ellen elaborated:
There have been times that we say, “If you want the aide to come, we need to know that she’s safe. So you need to put the dog away or speak to your family member. The aide is there for you. Not to have interference from a family member that’s degrading.”

These findings are consistent with a survey of home health aides conducted by Hayashi, Gibson and Weatherley (1994) in Washington State, which found that more than 25 percent of aides reported verbal abuse, sexual harassment or racial discrimination on the job, indicative of a lack of respect for the aide. Struggling with uncomfortable work environments or harassment from clients or family members adds to the stress that home health aides must deal with, influencing the role that the aides take on.

**Transportation.** Transportation is also a factor that impacts not only the work that home health aides do, but who can become a home health aide. Aides typically travel to a number of different homes each day, though in New York City, one aide may stay at the same home most of the day. Because of the travel between clients, most home care agencies outside of New York City require aides to have their own car, which can be a daunting requirement for individuals living on the bottom rungs of society. In most cases, aides are not reimbursed for travel, nor are they paid for the time that they are on the road between clients. Because of the travel demands, transportation problems become major issues for agencies and aides. Ellen, a supervisor in a medium sized city, explained:

It doesn’t matter if you live inner city or you live out in the rural community, people need to have a car when they are providing a service for someone else that requires them to go shopping, to do errands, whatever, to get from one place to
another in a reasonable period of time and not have to depend on public transportation.

Though the aides may be required to have a vehicle to be hired, they may not be able to afford a reliable car. Supervisor Karen talked about the fact that “sometimes they start working and they have a car and then a month later, the car breaks down.” Having car trouble and transportation issues are common. The socioeconomic status of many people who are working as home health aides makes buying a car difficult. Though the agency where Ellen is a supervisor reimburses aides for mileage, she said that because the aides are typically short of cash, they “tend to take that as income, not as an aside for their transportation, for their maintenance of their vehicle.” Aide Betsy agreed that transportation is an issue for many aides, including herself, noting, “My car’s transmission dropped and it just wasn’t worth fixing.” Those aides who use public transportation are at the mercy of bus or subway schedules which can cause issues with timeliness.

As mentioned in the previous chapter, many aides do not like all of the driving that is associated with being a home health aide. Aide Georgia commented on how daunting the driving is, noting that “sometimes you’re so tired, I wish I could stay right here for just two more hours” instead of working for two hours, then having to drive to the next client.

In the more rural areas of the state, the transportation challenges are magnified. Supervisor Bonnie said that “sometimes it’s close to an hour we need to travel one way.” Aide Carla, who works in a small town, takes a taxi to reach one of her clients, and pays for the cab herself. That means that she pays at least $10 out of her pocket for a two-hour
client visit that pays her less than $20. From her viewpoint, however, she does not see any other options to get to her assignment.

Some agencies attempt to ameliorate the transportation issues for their aides in a number of ways. The agencies attempt to schedule cases close together to keep mileage and non-working time to a minimum. A few agencies reimburse the aides for their mileage, as Supervisor Karen explained, “We pay them for mileage which most places don’t and travel time so if it takes them 20 minutes to get from one house to the next, they’re getting paid for that.” Some agencies provide bus passes. Gayle is a supervisor for an agency that provides taxi rides for aides in emergency situations. She explained that her agency has a contract with a taxi company and “if it’s our fault why they had to get stuck somewhere or we desperately need to cover a case because the person can’t go without service, we cab them … We pay for that.”

Transportation issues increase the stress that home health aides must handle. The aides must try to stay on a tight schedule, moving from one client to the next while dealing with unreliable transportation. The typically unpaid travel time means that low-paid aides must spend numerous hours each week traveling between clients but receiving no pay for that time. As mentioned earlier in this chapter, reduced hours per client put the aides on the road more often, and this is a part of the job that no aide said that they enjoy.

**Physical Demands of the Job.** Being a home health aide is a physically demanding and dangerous job. The number of work-related injuries and illnesses sustained by nursing, psychiatric, and home health aides is high relative to most other occupational groups (Bureau of Labor Statistics, 2006). Aides frequently help physically challenged older adults transfer from the bed to a chair, or in and out of a shower. They
also do “light housekeeping” chores, such as vacuum, dust, laundry, change bedding. Given the previously discussed shorter time frame allowed for each client visit by third-party payers, aides have little downtime at each client’s house. Patricia, a supervisor in a rural county, worked as a home health aide before completing her nursing degree and expressed sympathy for how physically demanding the job is. She said, “I was a home health aide for a long time when I was much younger, and it can be, depending of what environment you work in, it can be a physically, really backbreaking job … Your back hurts. Your legs hurt. It’s a lot of walking.” Betsy is an aide in her 30s who has been working as an aide for 11 years. She shared the toll that being an aide can take on one’s body:

I just wore my body out to where I got a pinched sciatica nerve. I was working too much and pregnant … I think as the years have gone on, my body’s felt it. My body’s worn out from bending and lifting … Me and my kids’ father were talking about me taking off a little bit of time to get my leg healed. Because I’m working now so much, and my leg is hurting me at night.

This particular aide said that she cannot afford to pay the more than $150 per week for the healthcare coverage offered by her home care agency. Instead, she and her family of four children rely on Medicaid.

Aides are only paid for the hours that they work so they try not to call in sick when they are not feeling well or have an injury, even though the work that they do is physically demanding. The individuals working in one of the jobs most beset by on-the-job injuries are the same individuals most lacking in health care coverage and sick pay. Workers who receive low pay and no health benefits while working in a physically
challenging job no doubt feel undervalued and unappreciated.

**Family Members of Clients.** Both aides and supervisors pointed out that a major influence on the work of home health aides are family members of the clients. They reported both good and bad interactions with family members, but the negative interactions were the ones that caused the most discussion. The positive interactions tended to be family members who showed support and friendliness, or who tried to help out. Aide Kayla provided an example, saying, “Her daughter would come and help out, make sure I had all the supplies I needed.” The more negative interactions are generally situations where the family members ask the aides to do more than what is on the care plan. Aide Kayla also provided a negative example: “She [the daughter] wanted me to go into the front of the house and vacuum and clean her areas, and when I said, no, she started screaming at me.” Aide Anne talked about the tension caused by family members’ expectations:

I had a client where you’re not supposed to drive the client anywhere, and then you have a family member that says, “Well, you need to take Miss Jones so and so yourself because I have to do this. Then you’re stuck between a rock and a hard place, because you know you can’t, but then how Miz Jones gonna get there if this family member don’t want to take her. So you’re like, “Should I call the agency or should I say No?”

The interactions with family members can be enough to cause anxiety among the aides, as Aide Georgia noted when she said, “There are some houses you’ll go in and you’ll be like, well, you know, I hope the daughter is not coming over today or I hope the son is not coming over.” Negative interactions can result in an aide asking to be
reassigned to a different client. This was the case when Aide Kayla was screamed at by the daughter, and she said, “I had to call the office and remove myself.” Some supervisors complained that family members treat the aides “like they’re slave” or like they just want a housekeeper.” Supervisor Angie described some of the challenges that come up with family members:

We’ve had some of the aides call and say, “You know, So-and-so’s daughter wants me to vacuum the basement and pick up the attic.” And I say, “No, it’s just the client’s living area, and you shouldn’t really have a lot of time to be cleaning there. You’re in there to give a bath and help her with her toileting and do all the things you’re supposed to do, and then if you have a little bitty time, you can straighten and tidy the patient’s area.

Most supervisors said that family dynamics can be a challenge and described problems that aides have with some family members. Supervisor Irene elaborated.

The patient who lives by themself. It’s ok. Often times, there’s no problem. But when they live with a whole bunch of family members, everybody in the household thinks that aide is there for everybody in the household … the nurse in return speaks to the family member to try to let them understand how this works. They have a responsibility to the patient. We have one. So, we try to separate the roles of the aide from the family.

In some instances, the conflict with family members stems from the aide being uncomfortable with how the family members are treating the client. Aide Gina said that she was pulled off a case after she spoke up to the husband of a client about the treatment of his wife. She explained:
Because things that I saw I didn’t like, and it really wasn’t my place to speak on it but I spoke on it. I started thinking maybe I shouldn’t have because it was creating tension … Her husband didn’t like me speaking on things that I saw. …And he was like, “I’m the husband. I’ve been here. I know what’s good for my wife.” No, not really. No, you don’t. I mean, because your religion says, “Don’t eat.” And the medication says, “Eat, taken with food.”

The aide was expressing concern about the health of her client, and her opinion conflicted with that of the family member.

The family members can add another layer of instruction for the aides, giving them sometimes conflicting demands. Supervisor Irene noted that “some aides will tell you they don’t like to service patients with family because it comes with a whole bunch of confusion.” The expectations of the family members compete with those of the client and the agency, and the home health aides must figure out how to manage the tension. This dialectic is discussed in greater detail in Chapter 7.

**Family Members of Aides.** Another impact on the role of home health aides is the influence of their own family members. Many aides are single parents or are married with children. Some people become home health aides because the hours and flexibility of the job allow them to handle their own family demands. Trying to juggle work, a family and the demands of life on little income can be a struggle. Supervisor Leann described a situation where the home health aide was providing care to a client on Sundays. A conflict occurred because in their community, a Medicaid dentist provides appointments for children one Sunday every month, “so she was at the dentist with her child, got delayed, and couldn’t make it to her next client.” Supervisor Bonnie said that
she encourages her aides with young children to have a back-up babysitter “because I think it’s the babysitters we have trouble with. They quit without notice.” If the babysitter quits, it often results in the aide missing work, and leaving a senior without needed care.

Discussion

Looking at the role influences at the macro level, we see that the work that home health aides do is highly regulated, establishing levels for the number of hours works, the pay, and the tasks of a home health aide. The third-party payers—both the government, with Medicare and Medicaid, and insurance companies—establish reimbursement levels for home health aide work which severely limits their pay level. Aides learn that the job they do is not deemed valuable enough to pay a living wage for. The low pay is a signal from society that they are not highly regarded, though both supervisors and aides talk about the importance of the job that aides do. The lack of a livable wage reinforces the low-status and lack of power that characterizes the role of home health aides.

At the macro level, we also note the constricting of work hours for aides due to government policy changes. Hours are cut back in two ways. First, clients are being approved for fewer hours per client per day. Second, the requirement to pay overtime for hours over 40 has actually resulted in less pay for aides because agencies cut back on the number of hours that aides are allowed to work. This cut back has several repercussions. With fewer hours per client, aides are forced to work harder to complete the tasks on the care plan in less time. With little down time on the job, they get to spend less time interacting with the clients. In addition to the interaction being a part of the job that they really enjoy and value, it is also important to the mental wellbeing of the clients. The aides may be the only person that some clients talk with during a day. The reduction in
hours allowed for each client also results in aides working for more clients each day, which means more travel time between clients. This is typically non-paid time, and in most communities involves driving, which many aides do not like. Finally, the reduced hours force many aides to work at additional agencies so they can pick up additional work hours. Working for more than one agency could reduce commitment to the original agency, leading to a lack of identification with any one agency. It could be extremely useful for home health aides to identify with the agency because they work remotely and largely unsupervised. Having them make decisions with the home care agency in mind would be a way to ensure that agency rules are followed. Identification is also linked to job satisfaction and lower turnover.

Also at the macro level, we see that aides are strictly limited in what they are allowed to do for their clients. For example, they are not allowed to clip their clients’ toenails for fear of causing a skin break. The restrictions on what they can and cannot do feels overly confining to some aides, who say they feel overly restricted by the regulations and documentation. They have very little control over what they do. Many feel that they could do more and that they are not respected for what they could offer. Everyone watches what they do; everyone tells them what to do. This reinforces their low status and that they are at the bottom of the totem pole and are responsible to everyone.

Finally, at the macro level, we can see the influence of society’s perception of home health aides. It is difficult for an aide to have a strong positive image of the work that they do when others around them are saying it is a dirty job. The home health aides sense the stigma attached to their work and feel degraded by others for what they do. As a result, some hide what they do from the public or engage in dis-identification. Others try
to rise above the image given to them by society by emphasizing the importance of what they do or talking about it being “a calling.”

The macro level influences point out that the home care industry is not designed with the needs of home health aides in mind. The low pay, lack of sufficient and consistent hours, and lack of a growth path leaves them wanting. Despite the importance of the work that they do, the structure of the work does not reward aides adequately either financially or psychologically. The talk about the influences at this level points out the ill-considered public policy that premises an entire home care industry on the exploitation of a class of workers.

Looking at the influences at the meso level, we see that aides are faced with potentially dirty and dangerous work environments, transportation difficulties, physically challenging work that wears the body down, difficult encounters with family members of clients, and competing demands from their own family members.

The influences at this level reinforce the feeling of aides that they have no control over their work environment. The homes in which they labor could be messy and uncomfortable, with difficult clients or demanding family members. Into this environment, the aides go alone, with no support on site. Clients and family members voice competing expectations for what the aides’ job should be, treating them like a slave or housekeeper, and denying them a role that focuses on the health care that they deliver. The remoteness of their work, away from the agency offices and co-workers, make it more difficult for aides to establish a commitment with the agency and to develop a sense of identification with the agency. When aides feel uncomfortable in their working environment, it adds to their stress levels and makes it more difficult to interact with
clients and establish rewarding relationships with their clients.

The lower economic status of aides makes transportation an ongoing challenge for many aides, and even limits who can become an aide, for those agencies that require that their aides have a car. Transportation issues add to the stress and uncertainty that aides face. Driving, especially in winter conditions, and finding clients’ homes can be stressful, as can keeping on a tight schedule with traffic or public transportation uncertainties. Transportation issues can impact their already low pay; if aides cannot get to their jobs, they are not paid. For workers already on the edge financially, the need to travel daily from client to client can be an overwhelming and difficult to manage requirement.

The job’s physical demands—supporting frail elderly people and helping them transfer from place to place—and the lack of good medical coverage put aides in a financially vulnerable position. They are more likely to get hurt on the job than other categories of workers, and if they get hurt, they cannot work. If they cannot work, they do not get paid.

At the meso level, many of the influences, which are closely connected with the policies established at the macro level, are economic influences that reinforce the low value given to aides. If the aides were indeed valued, they would be paid a more livable wage, which would ease some of these daily stressors. The influences at this level reinforce their low status and the non-valued image of themselves—that their role is at the bottom of the home care hierarchy.

When aides are learning their jobs and what their role is, a number of influences reinforce to them that their job has a low status and is not well valued. Everyone who they interact with on the job seems comfortable giving the aides directions. Aides must
decide how to handle the conflicting directions, and how to maintain a positive self-image in the face of others describing their job in negative terms.
CHAPTER 5: Findings and Interpretation, Part Two
Micro-Level Influences on the Role of Home Health Aides

Continuing the findings for Research Question 1, this chapter looks at the microlevel of the social ecological model and how aides, supervisors and clients talk about role influences in their interactions with each other. These interactions help home health aides learn what is expected of them on the job. In addition, from this talk, a number of role influences can be identified. Aides and supervisors talked explicitly about learning the tasks that aides are expected to perform and the rules they are expected to follow. In addition, implicit in their talk was how aides learn about behavioral cues and social norms from their supervisors and clients.

Supervisor-Aide Interactions

The primary interactions that home health aides have with supervisors in which they learn about their role expectations include the training sessions, when the aide is introduced to a new client, and during performance feedback and coaching.

Training. For many home health aides, training can be the encounter phase of assimilation into an organization, when newcomers begin to learn their organizational roles (Jablin, 1987). Both aides and supervisors described the training that is required to become certified as a home health aide—typically two weeks of classroom training plus a practical session, where aides work with an elderly person under the supervision of a trainer. Some agencies add an additional week of training. There is also on-the-job training, including shadowing, as well as advice and instructions from patients and from nurses. Supervisors in agencies that do not provide their own certification training talked about trying to hire people who are already trained.
To be a certified home health aide in New York State requires 75 hours of training, with at least 59 hours in the classroom and 16 hours of supervised practical training (NYS Department of Health, 2012). The certification class consists of both practicing hands-on with a manikin and other aides, as well as written material. The classes typically consist of modules, with readings and a written test. The training curriculum includes such topics as nutrition, assistance with medications, bathing, accident prevention and responses to emergencies in the home, taking of blood pressure, skin care, use of medical equipment, assisting with prescribed exercise, measurements and tests to monitor the patient's medical condition; and ostomy care (NYS Department of Health, 2006).

Supervisors and home health aides discussed the training, providing both explicit talk about the influence of training on role development and implicit references to how training influences role development.

*Supervisors’ talk about formal training.* Supervisors described the two or more weeks of training as an opportunity for aides to get an introduction to both the tasks and the rules that they will be expected to follow on the job. In general, most supervisors expressed the opinion that home health aide training was adequate to provide the basics that the aides will need on the job. Supervisor Irene described the training as “intense,” so that once they are on the job “all they have to do is follow the training.” One example of how the training covers both tasks and policies was shown when Supervisor Karen explained that “if they miss any days of training, they are automatically disqualified. We have to be strict about that.” This instills in the new aides the importance of attendance.

One supervisor, Gayle, discussed the importance of providing training in a real
home environment. She described training that took place at a different agency that she
did not think was ideal.

They didn’t even go into the home. They went into an adult home which is more
like a facility. The client had a little room. They went and vacuumed that room.
But it’s a totally different atmosphere and it’s controlled. Where you can go into a
home that’s absolutely drop down gorgeous clean … And you can go into a home
that you don’t want to be in.

In this supervisor’s opinion, this particular training was not providing a realistic
view of what the aides would encounter on the job. Working at a senior living facility
provides quite a different experience from the variety of environments that the aides
might see in homes. However, the supervisor did acknowledge how difficult it would be
for one instructor to meet in homes individually with up to 20 aides in a class, noting,
“That would be a lot of pulling your hair out.” By providing the hands-on experience in
an assisted living facility, they are able to supervise multiple aide trainees at the same
time.

Another supervisor, Nadine, expressed the opinion that the two-week training
course is “a very short program” for the aides to learn all that they need to. In addition to
focusing on tasks, suggestions were made that training should include additional content,
such as how the aide works with other members of the home care team, and how, as
Gayle suggested, “They are clinicians that are working very independent on somebody
else’s license.” Gayle was concerned that the aides do not understand their role in home
care and how they are not working independently, but are working with a nurse or
therapist to provide care for clients.
One large agency provides an additional week of training for the home health aides. In addition to the interactions in which aides learn their roles, the agency uses the time to observe the aides and determine if they will be good aides. Robert, a manager from that agency explained:

The instructors are told to put people in stressful situations, to challenge their coping skills, to see what kind of tools they have. Because if you can’t handle yourself in a three-week training class with peers, what’s going to happen when the Alzheimer’s patient asks you for a glass of water 500 times in five minutes? Are you going to be able to handle that? … I would much rather have somebody not handle it here than once they get out in the field.

Robert indicated that he saw the training classes as an extended interviewing process, where the new recruits could be observed in various conditions. This was important to him because once the aides are on the job, there are few opportunities to observe the aides in action.

*Aides’ talk about formal training.* Some aides said that the training they received did a good job of preparing them for their work as a home health aide. For example, Georgia said, “I think the training was great” and Lorraine said, “They trained you to the fullest.” Another aide, Eddie, talked about how important the training is, and he encouraged new hires to listen to the teachers:

Some people come and may think that home health aide, it’s very easy. It’s not. You’ve got to listen and listen collectively, and the things that they teach you, ‘cause you’re going to get a test on these things at the end of the classes … It prepares you for what you’re going out there to see.
Some aides said that the content of the training should be revised. For example, it was suggested that the teachers cover some information, such as transferring patients using a Hoyer lift, too quickly, and thus they do not think that the training adequately prepares them for the work. Until they have the opportunity to use the training with a real client, the aides suggested that what they learned was just academic. Lorraine talked about this, saying, “You may think that you can do it, and then you get in the home and you can’t really … you can do it but it’s kind of scary, so. You know, like a Hoyer lifts … am I going to drop?” It was only when they got into the home setting that the aides got a real taste of what was involved in being a home health aide. Lorraine explained:

You really never know what you’re getting into until you go and experience it. You have to live it for a minute. Even though you might be certified and you learned all this and you saw all these tapes, and you read all this literature, it’s a different approach when you actually get in the home because things do change. They vary all the time.

Anne echoed those thought that every home and every client is different:

The training that they teach you in there can be a little different than training in the home. Because they’ll say, this is what you have to do when you go in somebody’s home. But everybody’s home is different. And everybody do everything different.

Another aide, Michael, said that beyond the training about tasks, he thought that too much attention was given to the negative aspects of the job, such as warning aides about stealing, about clients that treat aides as slaves or about dirty houses. She said that more attention should be given to the good aspects or the benefits of being an aide, such as the
importance of the job to the health and well-being of their clients.

The teachers have got to really explain the benefits, not just the benefits, but the good things about this job … Some teachers will tell you due to their experience how the job is or what’s not, but they don’t really get into how good an experience this job is and it really gives you an idea … if this is something you want to do the rest of your life, you know. When I was in class, they would mostly stick on the negative parts

It was also suggested that aides are not allowed to use all their training on the job. Many of them felt that they had learned skills and were prepared and able to do more than they are asked or allowed to do. Pam explained:

We got the same training that the CNAs have here … But when you put us in the home, you don’t expect us to do all that. You bring all these other people in here to do this, that, take vital signs, to test for edema, stuff like that. When you can pay us more and eliminate a lot of that type of stuff.

Many of the aides had suggestions for how to improve the formal training to make it more relevant to the work that they do on the job. Their suggestions extended beyond just tasks to other aspects of the job, such as how aides should view the importance of the work that they do.

Additional training and learning opportunities. Besides the formal certificate training, aides also learn their jobs by shadowing other aides, and while on the job, from nurses or the patients themselves. In addition, they take 12 hours of in-service classes each year to maintain their certification (NYS Department of Health, 2012).
Shadowing. Shadowing involves the new hire following a more experienced aide to perform tasks at a client’s house. The newcomer learns how to perform tasks and interact with clients by watching what the other aide does with the patient. Georgia said that she is frequently asked to have a newcomer shadow her, and explained, “Sometimes I let her do some of the care … whatever you show them and you tell them, whenever they are on their own, they are now going to do the same thing.” Another aide, Teri, described the time that she shadowed another aide.

When I first started, I went out with one of the aides a couple times to see how they do things and watch them. And they would tell me, “Well, you have to do your gloves so. And paper towels have to be just so. And your apron” … So you always have to watch all those things that they do … so that when you go out on your own, you have to make sure that you do those same things … So I would say, pay attention to whoever you go out with to watch them how they work so that you know how to do things and what to do.

While shadowing is an ideal way for aides to learn their jobs, it can be difficult to arrange. Efforts to arrange the shadowing can be complicated by transportation and scheduling issues. Supervisor Gayle explained:

How are we going to get this aide to meet up with that aide? We have a couple very willing and experienced home health aides that we do that with, but they’re in the outer banks of the county. So it requires them to be able to get there and a lot of times, they don’t have transportation.

In some cases, what would be nice to do in the aides’ training turns out to be impractical. Time constraints and scheduling problems are most frequently mentioned
concerns, both when it comes to having new aides shadow another aide or providing the hands-on component of training in an assisted living facility as opposed to a more true-to-life experience in a client’s home. What this means to the aides is that when they go to their first job they will encounter situations and expectations for which they are not totally prepared.

*On the job.* The reality of what a home health aide does on the job varies from client to client, from the environment to the tasks that need to be done, to the personality of the client. Thus, at least a portion of learning the job has to happen on the job. This training can come from nurses, the patients themselves, or occasionally, other aides.

Several aides suggested a number of recommendations for how new aides learn what to do on the job. Diana said that newcomers should “just ask the patients ‘cause half the stuff you learn in the classroom you don’t use it ‘cause each patient is different … They know their care better,” adding that that is how she learned what to do. Teri added that “sometimes the patients will tell you what to do or how they want things,” enabling the aides to tailor their care to the individual client. Though supervisors stated that the classroom training is sufficient, the aides spoke of the need to adapt to each client and learn from each client.

Another source of helpful information about how to behave on the job can come from the nurses who visit the clients in their homes. Michael told how he learned nutrition information from the visiting nurse:

They are very helpful … Even though you learnt it in classes, they break it down to tell you the stuff you need to know. They tell you about the client from their time working with them. And they make sure they hand me out slips and stuff to
This aide was a younger man in New York City, and he talked about appreciating the help that nurses gave him in learning to cook more nutritionally for the client. Information that helps aides learn to do their jobs can come from a variety of on-the-job sources, including the clients and the nurses.

**In-service training.** Aides are required by the state to take 12 hours of in-service training to maintain their certification (NYS Department of Health, 2012). This training is designed to refresh aides’ basic training or provide updated information. How the training is conducted and which topics are included is largely determined by the home care agency management. Some agencies use the time to cover topics specific to their needs, like the introduction of technology for the aides, documentation requirements, or information that the aides can pass on to their clients, such as nutrition or senior resources. The aides implied a lack of enthusiasm concerning the in-service training, calling them “lovely in-services” or minimizing their worth by using the word “just” when they talked about the continuing education classes. For example, Aide Carla described the in-service training by saying, “It was just pretty much going over what we did in class again. Make sure we didn’t forget … like how to make sure you’re using the equipment right.” Some agencies take the time and make the effort to have face-to-face classes for in-service training, also providing an opportunity for aides to interact informally with other aides. In other agencies, the aides are given booklets to read on specific topics, which they can take home to read and complete a worksheet on their own time.
**Introductory Meeting.** Once an aide is assigned to a client, in locations outside New York City, typically an introductory meeting is held. This meeting is where the aide, the nurse and the client meet to review the care plan and to enable the client and aide to meet. It is an opportunity for all parties to discuss and agree upon the tasks that will be done by the aide. Supervisor Karen explained that expectations are laid out for both aides and clients at this meeting, noting that “They’re told, ‘This is the aide’s role.’ The primary role being assistance with personal care.” Aide Anne shared that the introductory meeting helps give the aide credibility in the eyes of the client, “So they know that you know what you’re doing.” The meeting allows the nurse to introduce the aide to the client, and Aide Lorraine said that it gives the clients a chance “basically to meet, to see … if they want another nurse or another aide in there.” This meeting also provides an opportunity for the client to be introduced to the aide and for the aide to gain an understanding of the client’s medical needs and what tasks the aide is to do. Aide Nathan explained that goal of the introductory meeting is “to make sure you understand he has to have a bath and skin care … And that has to be documented and understood between you, the nurse and the client before you can begin.” Setting the expectations of the client is a key part of this meeting. Several agencies provide a handout for the client that lists what the aide can and cannot do, especially when it comes to defining light housekeeping. Aide Karen pointed out that light housekeeping “is not moving the furniture and washing the windows,” though some clients request that sort of work. Supervisor Nadine noted that in the introductory meeting, “we have to be very specific in letting our patients know because they’ll think that the home health aides are there to clean their house. And we
make it perfectly clear that the home health aides are there to assist them with personal care.”

The success of the expectations being set during the Introductory Meeting relies a great deal on the nurse. Sandy, a long-time supervisor, described how the nurse can help or can hinder the setting of appropriate expectations with the clients.

There are some nurses who are really, really excellent in setting the framework for how the whole plan is going to work. They’ll say, “This is so-and-so. She’s here two hours a day, three days a week to help you with your bathing and your dressing. She can’t do your banking and she can’t give you your medicines, but she can remind you” … So that initial contact is laid out, and then the care plan reinforces it. But sometimes, it just is, “Well, this is the aide. She’s going to help you. I’ll see you.” And that is when you run into problems because it’s kind of a gray area.

The aides agreed that when the nurse does not do a good job of setting expectations at that initial meeting, confusion about what the aide can and cannot do tends to cause problems. Aide Kayla provided an example:

Sometimes the nurses aren’t too sure exactly what our role is and what we can do ... Sometimes, you know, there’s a little confusion about what we can and can’t do ... I’ve had instances where the nurse will tell the client, “You know, if you don’t want to do the bath, just tell the aide, and I’m sure she’ll check off that she did it.” And it’s like sometimes the nurse doesn’t realize that I really can’t.

Despite this meeting to set expectations, aides are still met with demands from the
client and family members to do tasks not on the care plan. The expectations discussed in the introductory meeting may not be remembered by the clients. Supervisor Karen explained, “It doesn’t always register because they have so much information that they get when they’re first admitted that sometimes by the time referral is made for aide services, maybe a week goes by so already they’ve forgotten what they were told.” Some families are experiencing a lot of stress when they turn to a home care agency for help, and Supervisor Irene said that they may see the aide as someone who can take on more responsibilities “not realizing that the scope of practice really restricts the aides for regulatory purposes for things they can do and they cannot do and they have to stick to it.”

Most supervisors outside of New York City described the introductory meeting as mandatory, required to occur before the aide begins working with the client. For example, Ellen said, “An aide cannot provide care to a patient unless she is oriented to that care plan by the nurse or a therapist” and Patricia described it as “a joint visit done by the RN and the home health aide, and they physically review the plan of care together; that’s required.” But when the aides were asked if the introductory meeting always happens and that expectations are addressed, several aides said that does not always happen, “not all the time.” Scheduling issues can cause it to fall through, as Karen pointed out when she said, “Lots of time they get there and the nurse doesn’t come right away. It’s maybe a two-hour case and she doesn’t get there until the last half hour.” Also, aides typically do not receive an introductory visit if they are filling in for the permanent aide. Jackie pointed this out when she said, “I might be new to the patient, but the intro has already been done, so they (the nurses) don’t have to be there every time.” In those instances, the
aide simply follows the care plan. It was suggested that an aide filling in for the permanent aide does not need the introductory meeting because of the standardized training that all aides receive. Supervisor Irene explained, “Every aide is trained to do the same thing, so there shouldn’t be an aide in any classroom who’s going to go to a home and say, ‘I don’t know how to do this. I wasn’t taught.’ That’s not true. They are trained straight across the board. That’s why the plan of care is there.” This supervisor contended that the training prepared the aides to walk into any home, review the plan of care and provide care to any client. As aides mentioned earlier, every client and every home is different, but supervisors contend that the training prepares them to provide standard care to each client.

**Performance Evaluation and Feedback.** Supervising aides and appraising their performance is difficult because aides work independently in the clients’ homes. Some agencies rely on occasional observations or spot checks, while some rely on reports from nurses, clients or the family members of clients, and some use technology to help them supervise the aides.

Supervisors who are not located in New York City talked about government regulations that require the agencies to supervise the aides at regular intervals, from two weeks to two months, depending on which program was paying for the care. The supervisors will observe the aide providing personal care and will talk with the client to gather the client’s feedback on the aide’s performance. Supervisor Bonnie said that she likes to do surprise visits, adding, “The majority of my supervisions are a surprise because then I really know what’s going on when I walk in.” The aides talked about “pop-up visits,” which are surprise visits “to make sure you’re doing what you’re
supposed to be doing,” as Aide Carla put it, and doing the tasks “the way that you need to do it,” such as wearing gloves, as Aide Anne explained.

Supervisors rely to a great extent on reports from others about the aides’ performance. Reports can come from the clients themselves who will say whether they are happy with what an aide is doing. Supervisor Bonnie said, “We speak to our patients at least once a week. They will say, ‘Do you know what Susie did for me today? Ah, she’s so wonderful. I’m so appreciative.’” They also get reports from family members, nurses or representatives from social services—anyone who might have the opportunity to observe the aide at work. Day-to-day supervision is difficult because as Supervisor Irene notes, the aides “are on their own … It’s not like we are seeing them.” Irene said that sometimes she finds out about inappropriate aide behavior from a nurse who might be doing an impromptu visit with the patient and observe and report on the aide’s actions.

Family members can also be helpful in gathering information about aide performance. Again, Supervisor Irene talked about how this helps her evaluate an aide’s performance.

You find patient’s family who call and report the behavior of the aide. Or the appearance, the way the aide dress and come to work. To me, that’s helpful, too. We’re not there to see them as much as the family. They’re like, ‘I don’t like how this aide comes to work.’ I don’t call it complaining because to me, it helps.

One of the most challenging aspects of supervising home health aides results from the remoteness of the work. Supervisors may rarely interact with their aides face-to-face. They may rarely see them in action on the job. This remoteness makes it difficult for the supervisors to appraise the aides’ performance, so the supervisors rely on the reports of
others, primarily nurses, the clients and the clients’ family members. The fact that aides know that supervisors rely on nurses, clients, and family members for their evaluations further distances the aides from their supervisors and weakens their relationship even more.

**Technology-mediated supervision.** Some agencies turn to technology to help them supervise their aides. One agency provides each aide with a PDA (personal digital assistant) and trains them to use the technology. Another uses a computer call-in system to help keep track of when aides arrive at work.

Aides who use the PDA have the care plans on the device for all the clients that they will see in a day. Each task that the aide is to accomplish that day must be addressed and recorded on the device or the aide cannot move on to the next client. The device also contains contact information, such as the name and contact information for the client’s nurse. It can be used to email messages to the office, but cannot be used as a telephone. Mileage between clients is also recorded by the device. Its GPS (global positioning system) capabilities provide aides with directions to clients’ homes, and also allows the agency to know where aides are at any moment. The devices significantly cut down on paperwork that the aides have to do. In addition, the devices provide strict control over what the aides do. Aide Teri explained, “We have (the PDAs) and all the patients, their care plan is in there and we go to that to see what we’re supposed to do.” The aides who use the PDAs express mixed feelings about the technology. The PDA provides the aides with directions to clients’ homes, but it means constant surveillance of their location. Aide Judith said, “Do I like the fact that they know my every move? No.” Supervisors say it improves accuracy on documentation of tasks completed and on mileage between
clients. (The agency that provides PDAs also reimburses their home health aides for mileage between clients.)

The agency that has the call-in computerized system uses it to enhance its supervisory abilities. The aides are required to phone into the computer system from the client’s home telephone when they arrive there to work. By phoning in on the client’s home telephone, it lets the supervisor know whether the aide got to work on time or not. The computer system prints out a list showing which aides called in appropriately, which aides called but from an incorrect number, and which aides did not call in at all. The supervisor, who might be in charge of 100 or more aides, will then get on the phone and track down the errant aides. Supervisor Irene said that this system helps supervisors “ensure that everybody is where they ought to be.” The print-out of “no shows” listing clients who do not have an aide in their home is “a priority” for the supervisors, who call these clients to see what the situation is. Even if the client states that the aide is there, the supervisor will ask to speak to the aide because, as Irene explained, sometimes “the patient will lie for the aide.” For this agency, dealing with thousands of aides reporting to work each day, the computer system enables supervisors to at least know that the aides are in the clients’ homes at the beginning of their shift.

**Performance feedback and rewards.** Given that supervisors must rely heavily on others to learn how well aides perform on the job, it is not surprising that rewards and discipline are typically tied to reports from others, especially clients. Supervisors talk about rewarding aides who receive complimentary notes from their client, such as Irene who said, “We also do surveys to the clients and if they come back really well, we attach the letters.” In fact, the most frequent form of feedback and recognition that aides talk
about is when their clients thank them. They talk about how this feedback lets them know that they have done a good job. Aide Isabelle said, “When my client is thankful for what I’ve done for her, I know I’ve done a good job,” and Aide Nathan echoed that he feels rewarded “when a person genuinely thanks you for what you’ve done for them, no matter what it is. The aides talked about receiving compliments from supervisors, but these are usually tied to receiving a compliment from a client or the clients’ family members. Compliments may also come from nurses or therapists who observe the aide working with the client. Aide Teri shared, “I have had patients that the nurses would say, ‘Gee, you’re doing a good job. Her skin looks good.’” In most cases, the compliments, even when they come from the supervisor, originally come from the clients or nurses.

Some agencies have more formal reward systems. Manager Robert talked about his agency’s service awards dinner “where we honor 5, 10, 15, 20, 25 and next year 30 year winners with gifts,” such as jewelry, designer handbags and clocks. He described this reward as one of the steps that he takes to help make the aides “feel part of something when they’re here twice a year or on the phone with their supervisor.” He is acknowledging the difficulty of establishing identification or commitment among aides who work remotely and have little contact with their supervisors.

Another agency offers a ladder reward system for aides, providing a monetary bonus for aides who meet performance goals, such as consistent attendance, completing in-service training, and receiving complimentary notes from clients. To fund this program, the agency uses innovative funding streams, including grants and fundraisers. Several aides talked with pride about achieving the ladder rewards, including Jackie who boasted, “I do that. Every year, I get it … I look for it every year, too.” Other aides from
that agency talked about the ladder requirements being difficult to achieve. Judith called
the bonus “minimal” compared to the requirements, and just reinforced for her the feeling
of being “at the bottom of the totem pole…I don’t like being at the bottom of the totem
pole, considering if it wasn’t for us there are a lot of things that nurses would not know.”

Some aides have received special awards, such as Aide of the Year, or Above and
Beyond Care Award, which typically involve a special dinner and a small monetary
bonus or a gift, in recognition of the compliments they receive from the clients. Isabelle
proudly said that she has received three awards in six years with her agency, and has
received small bonus checks each time, noting that “I got a check for travel. I got a $50
voucher.” Judith acknowledged that the award dinner and bonus were nice, but “it’s not
like we do it every month. We do it once in a while. Like every four months or something
like that.” The pay that an aide receives can make it difficult to make ends meet day-to-
day. The bonuses are not something they can count on to help meet daily expenses.

On the other end of the performance scale are the aides who receive disciplining
or coaching, which Supervisor Paul called “one of the more dreaded parts of the job.”
Some agencies are making an effort to improve how they handle discipline by providing
supervisors with special training on how to coach better performances. Robert is a
manager at one such agency and he explained that supervisors used to “call people in and
yell at them and write them up.” Now that the focus is on coaching rather than discipline,
he said that there has been a reduction in the time that his agency spends on discipline
because “if you do it right the first time, and you do it in a thorough manner, you don’t
have to have those conversations over and over again.” Though aides and supervisors
rarely meet face-to-face, when discipline is involved, they do meet, and not under
pleasant circumstances. This does little to establish a good working relationship between aides and their supervisors.

**Client-Aide Interactions**

The primary interactions that home health aides have with clients in which they learn about their role expectations include when they are introduced, during the performance of care plan tasks, and when clients present extra demands. These interactions parallel several of the interactions of aides and supervisors.

**Introductions.** As mentioned previously, a formal introductory meeting involving the aide, supervisor and client does not always take place. In New York City, for instance, some agencies choose not do such meetings. In other areas of the state, the ideal is to hold those meetings, but timing and logistics may prevent a planned meeting. In those cases, making introductions is left up to the aide. The initial introduction is a time when the aide and the client begin to learn about each other, evaluate each other, and decide if they want to “pursue a relationship with one another” (Pillet-Shore, 2011). Two New York City aides, Faye and Lauren, talked about how they approach a new client when there is no introductory meeting.

When you first come, you just ring the bell and then you show them your ID, where you come from. “My name is X. I’m from (the agency). I’m here to take care of you for the day” … You present yourself … The nurse leaves the care plan for you usually on the refrigerator so you can see what you are supposed to do for the patient

I introduced myself, gave her my ID, showed her who I was professionally …
Because they don’t know you. You got strangers coming in your house … You have to be in a positive state, where they can actually feel the positivity and the goodness coming off of you. And then they’ll be like, “Ok, I can trust you.”

When aides are left to introduce themselves to their clients, it requires them to establish role expectations at the same time that they are managing the impression that they are making with their client. This requires sophisticated interactional skills which the aides may not have. It potentially leaves the client uncertain about what they can expect the aide to do. In turn, most conflict that occurs between aides and clients appears to stem from competing role expectations—clients asking aides to do tasks that are not on the approved care plan.

**Identifying Tasks to Perform.** When aides arrive at clients’ homes, they are armed with general training and knowledge, but the specifics of the job are contextual. What tasks they do and how they do it varies from client to client. The aides say that they learn what specifically they should do for each client in two ways: they refer to the care plan that a home care nurse drafts and approves, or they ask the clients directly.

**The care plan.** For each client, a care plan is developed by a home care nurse and posted in the home. The aides talked about the importance of the care plan in letting them know what tasks they will undertake while in the home. Lorraine said that there is “always a care plan that you have to follow that coincided with what you have to do with the client. Basically, that’s what I would do. I would have to follow the care plan.” With the details on the care plan, the aides said that they do not necessarily need an introductory visit with the nurse. For example, Georgia said, “I can go into a patient home, look at the care plan and don’t need somebody to explain anything to me, and I go
get started from there.” The care plan both dictates what the aides are supposed to do and restricts what they do, or as Aide Mia put it, “It tells you what you’re allowed to do and what you’re not.” Aide Emily elaborated:

We are required to follow that care plan. Every day that it tells us to do that particular thing on that particular day, if we do, I have one patient that I do four days a week, so every time I go to visit him, he gets shaved. He gets some type of a bath whether it’s a shower or a sponge bath depending on what’s determined for what days

The care plan also empowers the aides. When they do not feel that they are able to persuade a client to comply with a care task, they can use the power of the care plan to give additional weight to their persuasion. Aide Kayla provided an example of this when she said, “Sometimes you’ll get people that, like you know, they have to be bathing, and they’ll say, ‘Oh, I don’t need to do bathing.’ And I’ll look at the care plan, and I’m like, ‘Yeah, we do have to.’” The aides also talked about turning to the care plan for additional support when they are asked to do additional tasks by their clients or the family members of clients. Aide Rose said, “I just tell them, ‘It’s not on the care plan. I can’t do that. If you want me to do that you need to call the office or I can call the office and have it changed. But if it’s not on that care plan, I can’t do it.’” The care plan enables aides to deny the request in a way that levels the playing field and places the responsibility for the denial on the agency and the care plan.

**Learning from the clients.** Even with generalized training and an individualized care plan, aides spoke about the need to talk with clients to determine the specifics about how the tasks should be carried out. Aide Diana shared that “the best thing is to ask the
patient. They know their care better. That’s how I learned … Each patient is different.”

Though the tasks may be generally the same, clients may want them performed in a particular order or in a particular way. Teri reiterated that “sometimes the patients will tell you what to do or how they want things,” and sometimes the aides ask the clients what they want as a way of ensuring the clients’ happiness. Aide Carla explained, “I mostly have them tell me what they want to be done. So that way I know that it’s getting done and that they won’t complain and they won’t have no problems that it didn’t get done.” Occasionally, by following the directives of the clients, aides are faced with those demands conflicting with the care plan, which leads to the next type of interaction between clients and aides.

Extra Demands from Clients. Nearly every aide in this study reported being asked to do extra tasks by their clients, tasks that were not included on the official care plan. The aides may simply deny those requests, pointing out that they are not covered by the care plan (as mentioned earlier). Another strategy that aides use to handle extra demands from clients is to comply if it is a minor request, or to comply initially but defer ongoing compliance to the nurse. Georgia gave an example of a client who wanted her laundry done, but it was not on the care plan, so she told the client, “You know, I’m gonna do it today, but next time the nurse come, I think we should just put it on there for just in case we need it done again.” By employing these various strategies, the aides attempt to walk a fine line, adhering to the care plan while also keeping the client happy.
Discussion

Interactions between aides and their supervisors and between aides and their clients at the micro level have a major influence on how home health aides learn their job and negotiate their roles.

The two weeks of training that aides receive is a minor amount of time to enable the newcomers to be exposed to all the health care responsibilities that they have. The focus of the training is largely on tasks, such as changing a bed around a bed-ridden client and giving a bed-bath to a patient. In-service training also focused on tasks and documentation. Not addressed in the training that was discussed were relational issues, which might be helpful to the aides who must regularly deal with interpersonal tensions with their clients or their clients’ family members. Home health aide training also neglects geriatric education, which might enable aides to be better informed about the best way to talk with their clients or activities to undertake with their clients to enrich the clients’ lives and their interactions. Such knowledge could make their work more rewarding and contribute to job satisfaction. The focus on tasks reinforces the role of home health aides as low level employees who are expected to focus on just executing the care plan.

Starting to work for a client is a time when specific role expectations for that assignment are established. If this is done appropriately by the agency representative, either the supervisor or nurse, in a formal introductory meeting, there is less likely to be confusion or conflict down the road. The introductory meeting also allows the aides to hear a reiteration of role expectations from their supervisor about what tasks they are to do, how they are to do them, and what agency policies are regarding attendance and
documentation. However, nurses may set the wrong expectations or the aides might have to begin work without a meeting to set expectations. That places more responsibility on the aide to handle inappropriate demands from their clients or the clients’ family members. Aides do not occupy a position of power in their interactions with their clients or the clients’ family members, so they may not feel on equal footing to negotiate their tasks. When presented with demands that conflict with the care plan, the aides must use other strategies to manage the competing expectations. This dialectic and the aides’ strategies are discussed more fully in Chapter 7.

Once on the job, the aides then receive direction from both their clients and the family members of their clients. Aides frequently receive conflicting directions from these various sources and must make decisions on which to follow and which to deflect or ignore. Lack of regular supervision by the supervisor contributes to confusing role expectations. Relying on others to tell the supervisors how the aide is doing requires those others to have an understanding of what the role expectations are. Aides tend to talk about positive reinforcement coming from clients, while discipline tends to come from supervisors. This further distances the aides from their supervisors and encourages them to establish closer relationships with their clients. The lack of connectivity with the agency results in even weaker identification for the aides with their agency. They are more likely to relate to the needs of their clients than with the requirements of the agency.

Reward systems are one way to provide incentives and positive feedback to recognize desired behaviors. Incentive ladders, anniversary dinners and gifts all have the potential of strengthening the aides’ connections and identification with the home care agency. It is important to note, though, that the reward systems for home health aides
tend to reinforce the importance of making the clients happy, which could strengthen the relationship between the aide and the clients, and further erode the importance of the connection between the aide and the supervisor. Supervisors are the source of discipline and coaching; clients are the source of rewards.
Chapter Six: Findings and Interpretation—Part Three
Competing Expectations Concerning Traits of a ‘Good Aide’

In addition to interactions where role expectations for a home health aide are explicitly discussed, there are opportunities for desired traits to be implicitly communicated. The talk of supervisors and clients suggests that they hold specific opinions about what traits make a “good aide” and may share these expectations implicitly in interactions with aides. These traits also come into play when supervisors and clients decide who to hire, how to evaluate performance and how to bestow rewards. It is also informative to learn from the aides what traits are valued in an aide.

This section explores the characteristics that supervisors in home care agencies say they look for in hiring individuals to become home health aides. It also looks at what characteristics clients and their family members say that they would like to see in aides. Finally, it explores what characteristics the aides themselves say are important to look for when hiring an aide, and why they themselves chose to become an aide.

Traits Valued by Supervisors

Agencies are constantly recruiting home health aides to meet their staffing needs. With demand for aides estimated to grow at 69 percent increased demand between 2010 and 2020 (Bureau of Labor Statistics, 2012) and turnover rates as high as 100 percent annually (Stone & Wiener, 2001), agencies must continually fill the pipeline with new recruits. Most supervisors are able to describe the characteristics of the type of person they are seeking, and they typically rely on personal interviews to help them find that person. An example is Patricia, a supervisor in a rural county who said she looks for “a person who has many assets…patience, compassion, listening skills, versatility skills, just
physically able to go through the body mechanics that they have to do safely for not only themselves but for the patients.” Another supervisor, Gayle, who works in a small urban area, said that she relies on her first impressions when she meets an applicant, noting, “If I get the sense that I can’t trust this person, I don’t want them to go into somebody’s home and be alone.” Trust is crucial, because a home health aide works largely unsupervised with vulnerable, frail elderly adults. Many supervisors, such as Leann, talk about looking for people who are friendly and trustworthy, a person “you want to be in your home with your mother or your father.” In addition, supervisors mentioned the following characteristics as being desirable in home health aides.

**Rule Followers.** Individuals who can follow rules were described as important to the position of home health aide by many supervisors. Employees who will adhere to policies and follow agency rules can be critical to home care agencies, which are highly regulated by both state and federal governments. Supervisor Leann said that she looks for someone who “shows up for work” and “gets all of her paperwork in, with the signatures of the clients.” Supervisor Irene said she wants an aide who “follows all the rules, follows the company policy and keeps us informed, reporting and recording.” Supervisor Liz said that she wants home health aides who will be “punctual with time.” Documentation and punctuality are important for a number of reasons, including liability issues. Liz explained that if the agency agrees to provide an aide for a client beginning at 8 a.m., but the aide does not arrive until 8:30 a.m., and something happens to the client, such as a fall, between 8 a.m. and 8:30 a.m., the agency can be held liable. In order for agencies to be reimbursed by Medicare, Medicaid or private insurance companies for the services that aides provide, the work that they do must be documented. Agencies want the aides to
be meticulous about attendance and about documenting the tasks they perform. These are the issues they talk to the aides about frequently and to which they dedicate training session. For one large urban agency, the bulk of the supervisors’ job is focused on checking up on aides who are late or do not show up on the job. Through such interactions, aides implicitly learn that these are important traits for them to embody in their role.

**Compassionate.** At the same time that agencies want rule-followers, supervisors are also looking for what Supervisor Karen termed “a special kind of person” with “the patience and reliability and kindness to be able to do this kind of work, and what Supervisor Cheryl called candidates with “a positive attitude.” Robert, the manager of supervisors in a large urban area, said that aides have to be “incredibly emotionally strong” and “willing to go the extra mile and willing to deal with any situation at any moment and be prepared.” Nearly all agency supervisors said they want aides who are compassionate. Cheryl said that she looks for people who are “caring, they’re loving, they’re willing to help people.” The job of a home health aide is more than the tasks of personal care and housekeeping. An important part of the job is the social interaction with the elderly. Leann described an applicant who did not have her home health aide certification when she applied for a job:

> She talked to me as a person. She talked to me from her heart. She showed me that she was trustworthy. She was committed. I said, “She’s going to do a great job. I’m going to send her to home health aide training. I’ll get her the skills.” She’s one of the top home health aides that we have … If they show me that
they’ve got heart and they’re compassionate and they’ll be trustworthy, I’ll bend over backwards to get them on board.

Another supervisor, Sandy, expressed similar sentiments about a new hire, who demonstrated impressive communication and interpersonal skills:

You just know immediately. She walked in. She made eye contact with the patient. She said, “Hello. My name is … How are you feeling today?” An immediate acknowledgement of the person as an individual … And then she very quietly did things that needed to be done … She’s going to be a great aide.

Several supervisors mentioned that compassion is a desirable trait, but not a trait that can be taught. Leann elaborated, “You can teach someone a skill for the most part … but if they’re not invested and they don’t have their heart into it, eventually we won’t have them.” Robert discussed the importance of hiring aides with the desired personality traits, noting, “Our training can teach somebody to be a good home health aide. It can’t teach them how to be a good person.” Therefore, identifying which applicants have these innate personality traits that the supervisors value is important.

**Maturity.** Though the state simply recommends that applicants be age 18 or above, most supervisors said that they prefer an aide that has a sense of maturity and years of life experience. They contend that the more mature aides present fewer problems, that they tend to have fewer attendance issues, and as Supervisor Jan noted, “take the job seriously” and “get there on time.” Jan continued, “Let’s say the patient’s a diabetic. We try not to send a lot of young aides to these clients.” Supervisor Cheryl said that she has a number of hospice clients, “so you need to get aides that are more mature. They’re willing to work with any of patients. They’re not just there for a paycheck,
they’re actually there to work.” Some spoke of “maturity” but framed it as more of an attitude of responsibility than an age-related characteristic, meaning, as Cheryl framed it, “someone who takes the initiative, who knows exactly what they need to do.” Given the responsibilities that aides are asked to take on, without much supervision, a mature individual is deemed essential.

**Traits Valued by Clients and Family Members**

Though clients and family members are not directly involved in recruiting, they do have a vested interest in the types of people who are recruited as aides. An agency will assign one of their aides to care for an elderly client, but the client and the family members have the final say on whether an aide remains in the home or not. Thus, it is in an agency’s interest to hire aides who will meet the client and family member needs. Though family members are generally considered part of the meso level, because they are often involved in the hiring of an aide for their loved one, their talk will also be considered here. The client and the family members have specific needs and a real interest in having those needs met, so their opinions about what characteristics can be found in a “good aide” are important. In their interactions with aides, these traits may be implicitly communicated to the aides and rewarded through praise and comments to supervisors. What clients and family members describe as good characteristics of a home health aide is somewhat different than what supervisors and home health aides articulate. The following are characteristics that clients and family members talked about wanting to see in home health aides.

**Personality.** Clients and family members place greater emphasis on the personality of the aide and the attitude of the aide. The social aspects of the job that aides
do are important to this group. Instead of having an aide who just focuses on doing the job, they want an aide who, as Client Frank said, “takes an interest in you,” or as Client Joanie noted, “They’re easy to get along with.” Client Sharon pointed out that it is important that aides be “caring and respectful” of the client. Family members want to know that this aide will take the same loving care of their loved one that they would, or as Family Member David said, “someone who is going to be very attentive” to the client. Because after all, the aide is basically stepping into what has traditionally been a family role, taking care of an elderly parent or spouse, allowing the family member to continue with their life.

**Dependability.** The second trait that clients and family members focus on is dependability. They want someone who will be punctual and have good attendance. Family member Marlys, who has a home health aide to help her with her husband said, “I had a problem with the caregiver not showing up on time … And then I had them not showing up.” This can cause particular stress when the family member has to leave for work or an appointment of their own. This trait is also important to supervisors who are charged with supplying aides for clients, and it is related to the rule-following traits that supervisors value. However, dependability can be a challenge for individuals of low socioeconomic status who are living on the edge. Issues such as transportation and child care are more difficult to manage on a less-than-livable wage.

**Hard-Working.** Clients and family members also want aides who are well trained and can do a good job with the tasks, and who have, as David said, “a good knowledge base about caring for people.” One client, Barbara referred to the care plan when she said that the ideal aide is “a person that’s going to do what she has to do in the
home … She don’t have to be a hard worker. Just do what’s on the paper.” This client was asking that the aide follow the care plan and complete the tasks listed on that document. She was less interested in the social aspects of having a home health aide. Especially when the client is funding the aide privately, there is more focus on making sure the aide is working and focusing on completing the tasks when she is on the job. This trait is important to supervisors, also, who focus on task completion for reimbursement purposes.

**Communicative.** Family members talked about wanting aides to be good communicators so that the aides can share their observations about the client with the family members. For example, David said, “My mother is going through a period of some urinary tract infections. And if they’re paying attention, we can talk about it. I can pick up some things on the way home to test her urine the next morning. That’s what I want.” Another family member, Lilian, said that being non-communicative resulted in the termination of one aide. “She stopped saying, ‘Oh, we’re out of milk. We have no more bread.’ And then once I get home, I can’t go get it.” This family member was the primary caretaker of an elderly aunt in the evenings after work and would not be able to run out to the store to pick up staples, if needed. When the aide did not communicate to her what things were needed in the home, it left the family member in a bind. This was a serious enough problem that Lilian dismissed the aide.

**Maturity.** In addition, family members echoed supervisors in stating that they want an aide who has experience and is more mature. Family Member Marlys talked about an aide that did not work out for them, attributing the problems to her youth, stating, “She was good enough but she was a little hyper … I think it was just her youth.”
Client Sharon said that she thinks that seniors prefer having aides work for them who is closer to her own age so that she “can understand a little bit more about the difficulties that they have in doing certain things.” The way that clients and family members talked about maturity characteristic seems more related to personality. When supervisors talked about maturity, they were focused on responsibility and reliability, while the clients and family members were focused on the type of interactions that a more mature aide would have with the client and family members. For example, a more mature aide would relate to the older client with more understanding than a younger aide.

**Longevity.** Clients and family members also want aides who will stay with them for a number of years. It can be wearing on the family member to break in new aides frequently. It takes time to build a relationship with the client and to develop trust with the whole family. Family Member Marlys spoke of the problems that are caused when aides leave and a new aide must be found, stating that “it’s hard to come into somebody’s home and start up a rapport instantly … I don’t want a different person showing up for my husband. I don’t want to have to go through the whole thing, and I certainly don’t want to leave a stranger in the home.” Family Member Anita explained why longevity was especially important for some clients:

With certain types of people, especially Alzheimers, people with dementia, TBIs … it affects them in a lot of different ways to be having different people come into the home. They’re used to having things done on a schedule and having it done this way, so it’s impossible to have somebody come in and train them and actually doing the work.
Once a client and family members find an aide that behaves in an acceptable manner and who has a personality that works well in that family, they want to keep the aide and not have to train and break in another aide.

**Non-Disruptive.** Finally, clients and family members want to find aides who can fit in with their households without being disruptive to their lifestyles. Family Member Marlys wants the aide to adapt to her family’s way of living, so that “they’re in tune with what your household is doing without trying to make it fit their level.” Another family member, Connie, told of dismissing an aide who tried to get the client to adapt to the lifestyle of the aide, describing how she would say to the client, “We’re going to do this today. We’re going to do that today.’ And my mother did not like that.” The aide was too focused on her own agenda and not the wishes of the client or the rhythm of the household.

**Traits Valued by Home Health Aides**

Home health aides also described characteristics for what they think are traits of “a good aide,” expressing some of the same sentiments as their supervisors, including the need to be dependable, to show up for work on time, and to be trustworthy. Aide Georgia said that when she thinks about what makes a good aide, it is someone who “I can feel comfortable leaving that person to be here with my mom or my dad or any family member.” Nearly all of the aides echoed their supervisors in talking about the importance of being compassionate and caring, in short, “a people person.” In addition, aides talked about traits that only they described as important, due to their unique perspective of having worked as aides. These traits include the need to have patience and the need to have an inner drive to be an aide.
**Patience.** Perhaps because home health aides know what their job actually entails, the aides emphasized characteristics that other groups did not. For example, patience was mentioned over and over again. For example, Michael described patience as “one of the most important things in this job.” They explained that patience is needed to deal with client demands, especially from clients with dementia issues or impaired physical abilities. Aides Hildie and Judith provide examples:

You have to be patient because … sometimes he goes off the wall … And you know the way he is, when he asks, when he wants to do something, he want to do something quick … He want something right away. He has to have it. When you tell him, “No.” He so mad. He want to make you do it. That’s why you have to be patient and understand him. Because if I don’t be patient, you can’t deal with it.

One of my patients, she’s 94 years old … She’s getting slower. There’s lot of stuff she can’t do … And if you don’t have the patience for it, she would get on your nerves … and she repeated everything, and repeated after repeated. So like I said, if you don’t have patience, you won’t be good at this job.

The concern was raised that if an aide did not have patience, he or she might lose their temper with these vulnerable elderly persons. They prided themselves on being able to be patient in situations that would test ordinary people.

**Inner Drive.** The aides themselves suggested that being a home health aide takes a special type of person, not someone who is going to do it for the money, because as Pam noted, “It’s not about the pay.” In fact, Isabelle suggested that aides have to be caring and have “got to have a heart” for the work and should “forget about the money.”
Georgia said that the drive to become an aide “has to come from within” and that to be a home health aide, a person has to “do it because you love taking care of the elderly people.” They said that agencies should look for people who are dedicated to taking care of the elderly, because as Anne put it, “Older people, even though they are old, they still need love.” Several aides said that working as a home health aide is a calling. Nathan shared that being an aide “was God-given to me. This is what he wants me to do.” In a similar vein, Judith said that “I think that’s my reason for being here, basically.” These aides found worth in their job by ascribing to it a higher meaning. Though others may describe the work of an aide as dirty or demeaning, aides reach inward to find meaning in their role. To enable them to construct a positive identity in the face of negative characterizations, aides reframe their work in positive terms and describe it “in value-laden terms” (Ashforth & Kreiner, 1999, p. 421), and tying it to a larger purpose. Without validation from society, aides frame their work in more positive terms. Doing this is more difficult for aides than other “dirty workers” because they do not have a work group to help them make sense of their role.

Discussion

This chapter points out the differing expectations of supervisors, clients, family members and aides when it comes to what traits are implicitly encouraged and rewarded in home health aides. (See Table 6.1.) In their talk, supervisors placed more emphasis on rule-following characteristics, aides who complete documentation, who are punctual, and who complete the tasks on the care plan. Clients and family members placed a greater importance of the relationship between the aide and the client. They emphasized
Table 6.1

Desirability of Home Health Aide Characteristics*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Supervisors</th>
<th>Clients</th>
<th>Family Members</th>
<th>Home Health Aides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule-Following</td>
<td>Key</td>
<td></td>
<td>Important</td>
<td></td>
</tr>
<tr>
<td>Compassion/Caring</td>
<td>Important</td>
<td>Important</td>
<td>Important</td>
<td>Important</td>
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<tr>
<td>Communication Skills</td>
<td>Important</td>
<td></td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>Flexible/Versatile</td>
<td>Desired</td>
<td></td>
<td></td>
<td>Desired</td>
</tr>
<tr>
<td>Friendly/Positive</td>
<td>Important</td>
<td>Key</td>
<td>Key</td>
<td>Desired</td>
</tr>
<tr>
<td>Has Inner Drive</td>
<td></td>
<td></td>
<td></td>
<td>Key</td>
</tr>
<tr>
<td>Trustworthy</td>
<td>Important</td>
<td></td>
<td>Desired</td>
<td>Desired</td>
</tr>
<tr>
<td>Dependable</td>
<td>Important</td>
<td></td>
<td>Key</td>
<td>Desired</td>
</tr>
<tr>
<td>Mature</td>
<td>Important</td>
<td></td>
<td>Important</td>
<td>Desired</td>
</tr>
<tr>
<td>Patience</td>
<td>Desired</td>
<td></td>
<td></td>
<td>Key</td>
</tr>
<tr>
<td>Completes Tasks</td>
<td>Important</td>
<td>Important</td>
<td>Important</td>
<td></td>
</tr>
<tr>
<td>Longevity</td>
<td></td>
<td></td>
<td>Important</td>
<td></td>
</tr>
<tr>
<td>Fits in With Lifestyle</td>
<td></td>
<td></td>
<td>Desired</td>
<td></td>
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</tbody>
</table>

* The characteristics were ranked from high to low as key, important or desired, based on an analysis of the interview data.

the need for an aide to be positive and friendly and to remain on the job for a long time.

In addition, family members also wanted their home health aides to be punctual and dependable so that the family members can continue with their daily activities such as work or appointments. Home health aides emphasized two unique characteristics, which were overlooked or rarely mentioned by the other three groups. They pointed to the
importance of an inner drive within the aide to provide this service and to the importance of being patient when dealing with the elderly.

The characteristics articulated by supervisors and by family members are the most similar. That could be because both supervisors and family members find themselves in similar roles themselves—hiring aides to take care of a frail senior. Both groups see the implications of such characteristics as maturity and trustworthiness. Family members want aides to be reliable substitutes for themselves. They want to be able to continue their lives outside of the client’s home, with as little disruption as possible. To do that, they need the client to be happy and well taken care of. Thus, the aide’s personality, maturity level, and their capabilities are important to them. In addition, they need the person to be punctual, to not have attendance issues, and to remain on the job for the long run. The dependability trait is important to family members, who rely on the aides to care for their loved ones, so that they can continue with their jobs and other life activities. If an aide is late or absent, it disrupts their lives, as they have to scramble to find a substitute or change their plans to care for the loved one themselves.

The clients that were interviewed saw the role of the home health aide from a more narrow view—what they experienced within their home. They spoke of the need for a friendly and caring aide who completes the tasks. On the other hand, the aides have the unique perspective of actually living the role. That is perhaps why they mention characteristics that no one else does, such as the need for the inner drive, and why they emphasize patience, because they have seen the need for it firsthand.

It is also interesting to consider the wide range of skills and personality traits that are sought among home health aide candidates. Supervisors described a vast array of job
skills that require a degree of sophistication that normally someone in an entry-level job might not have. They talked about eight different traits of a good aide. They want someone who is caring and compassionate and can develop a relationship with the client, yet at the same time someone who knows what their job is and how to do it. Because the aides will be working without much supervision, they also look for independent workers, who can think on their toes and not need much help or advice. Yet, for an aide who embodies all of these task and interpersonal skills, the pay rate remains just about minimum wage and offers few, if any, benefits.

The aides have a unique perspective on what traits make a good home health aide. They have walked many miles in the shoes of a home health aide and know what is expected and what it takes to make it work. Nearly all of them spoke about the need for aides to be caring, compassionate, and patient. To them, the importance of the job centers not so much on the tasks that need to be accomplished, but on the relationship they have with their clients, and the value that they bring to their clients.

This analysis shows that aides face competing expectations. They are hired by supervisors who place a great deal of emphasis on following protocol yet want individuals who are caring and compassionate. They have clients who want companionship, and family members who want them to be skilled and dependable. They face tensions when forced to stay within a tight schedule, as dictated by third-party payers, yet they feel pressure to show patience to their clients. How home health aides manage such role dialectics is addressed in Chapter 7.
CHAPTER SEVEN: Findings and Interpretation—Part Four

Role Dialectics that Influence the Role of Home Health Aides

This chapter presents the findings for Research Questions 2 and 3—identifying role dialectics that influence the role of home health aides, and the strategies that aides use to manage these tensions. From the talk of aides, supervisors and clients, two broad issues emerged during the data analysis, representing four main dialectical tensions faced by home health aides. For each of the dialectics, aides discussed strategies that they use to manage these tensions and construct their role. The two broad issues are 1) issues of organizational competing tensions; and 2) issues of negotiating relationships on the job. The dialectics represent influences from the micro, meso, and macro levels, reinforcing the interconnectedness of the three levels. (See Table 7.1.)

Table 7.1

<table>
<thead>
<tr>
<th>Role Dialectics of Home Health Aides and the Strategies Used to Manage Them</th>
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<tbody>
<tr>
<td><strong>Organizational Competing Tensions</strong></td>
</tr>
<tr>
<td>Negotiating competing expectations at work</td>
</tr>
<tr>
<td><strong>Strategies</strong></td>
</tr>
<tr>
<td>• Use the power of care plan or supervisors to fend off other demands</td>
</tr>
<tr>
<td>• Ask to have the care plan changed</td>
</tr>
<tr>
<td>• Offer to do extra requests if there is time</td>
</tr>
<tr>
<td>• Suggest different resource to handle request</td>
</tr>
<tr>
<td>Viewing their job as important despite being treated as inferior</td>
</tr>
<tr>
<td><strong>Strategies</strong></td>
</tr>
<tr>
<td>• Privilege their view of the job’s importance over the negative characterizations of others</td>
</tr>
<tr>
<td>• Distance self from the role by stating that it is only temporary</td>
</tr>
<tr>
<td><strong>Negotiating Relationships on the Job</strong></td>
</tr>
<tr>
<td>Managing compassion and caring without getting too close</td>
</tr>
<tr>
<td><strong>Strategies</strong></td>
</tr>
<tr>
<td>• Disregard directives from management to not get too close</td>
</tr>
<tr>
<td>• Establish personal boundaries in interactions with their clients</td>
</tr>
<tr>
<td>Managing emotional labor demands</td>
</tr>
<tr>
<td><strong>Strategies</strong></td>
</tr>
<tr>
<td>• Defer to the need of the client, putting own needs second</td>
</tr>
<tr>
<td>• Derive happiness from making clients happy</td>
</tr>
</tbody>
</table>
Issues of Organizational Competing Tensions

Home health aides talk about the competing tensions they deal with as they negotiate their role through their interactions with supervisors, clients and the family members of clients. In figuring out their role, the aides must manage a number of competing organizational tensions, ranging from juggling multiple and competing demands, and handling important health-related tasks despite being treated like an inferior. Also, they must manage competing relational issues, such as their degree of closeness with their clients and the emotional demands of the job. How aides manage these dialectics help them define their role as home health aides.

“I do not do leaves:” Negotiating competing expectations at work. When it comes to defining the work that home health aides do, there are many competing views. Supervisors and care coordinators from the home care agency determine the work that aides are to do and codify it on a care plan. The care plan is filled out by the case management nurse, who meets with the client to discuss his or her personal healthcare needs. Aides are instructed to follow the care plan to the letter. Though aides do not always agree with all of the tasks that are on the care plan, they are not allowed to make changes without first getting permission. State health department regulations also limit what aides are allowed to do. For example, aides can remind their clients to take medications, but they are not permitted to actually administer the medications. Within these tight constraints, aides must adapt to each patient and be flexible enough to respond to any environment. The clients and family members often ask for aides to do additional work, beyond what is on the care plan. In fact, many aides report that clients and family
members treat them like they are maids. The aides talked about four strategies that they employ in their interactions to manage these competing expectations.

*Use the power of the care plan or their supervisors to fend off other demands.*

When clients or family members ask the aides to do tasks not on the care plan, aides often point to the plan’s constraints on what they can do. Lorraine, a home health aide, explained, “We politely and firmly at the same time … let them know that that’s something we can’t do for them.” Another aide, Georgia, said that she tells clients, “I’m sorry, but it’s not on the care plan, and we can’t do it.” The care plan can be a constraining document, limiting what aides can do for their clients, but it can also provide aides with additional power in negotiating their role. Jackie, an aide with more than 20 years of experience described how she negotiates with her client:

She asked me about doing the leaves out there. I said, “I do not do leaves. That is not on the care plan. We’re here to help you with your personal care, do a little light housekeeping.” I specify to them what we’re supposed to do … I say, “This is what we’re supposed to do. This is what’s on our care plan.”

When aides are presented with demands from clients or family members that conflict with the tasks listed on the care plan, they are instructed to call their supervisors for further instructions. Aide Jackie said that she is not allowed to do anything that is not on the care plan without first getting permission, so she explains to her client that before she can do additional tasks, she has to call the office for permission. “Then when the nurse comes, then we ask the nurse if she could put that on the care plan to do.” If clients or family members persist in their demands, Aide Teri said that she will call the office and ask a supervisor to “talk to the patient themselves.” The office can give the aides a
verbal approval to do the task, or if the task is not allowed, the word of the supervisor can give added authority to the aide in handling the denial with the client. If that is not sufficient, the nurse or supervisor, who both have more authority than the aide, may be asked to intervene and talk to the patient themselves. By bringing in the care plan or the supervisor or nurse, the aide gains additional power or authority that her position does not inherently have. The low status of home health aides makes it difficult for them to negotiate their tasks from an equal power dynamic with their supervisors, clients or clients’ family members. By referring to the care plan or a supervisor, the aides can level the playing field and enable the aides to negotiate their role more readily.

*Ask to have the care plan changed.* Because the aides spend more time with the clients than other members of the care team, they frequently see changes that are needed on the care plan and may ask to have the care plan changed. Aide Lorraine said that she successfully asked that the care plan be changed because her client had got to the point “where she couldn’t do the showers anymore” and needed to be given bed baths. Some aides indicated that nurses are good about making changes while others say their requests are dismissed without consideration. Kelly, who has been an aide for a few years, told of asking for a change in the care plan to reflect that her client no longer needed help shampooing. The aide said that rather than remove the task completely, the case management nurse changed the instructions on the care plan to state, ‘shampoo when needed’, thus allowing the aide to help with shampooing if needed, but still requiring the aide to continue to check it off the plan. Aides rarely challenge what is written on the care plan. When they do ask to have the care plan changed, they are met with mixed results.
The care plan is a powerful document that aides are directed to follow, and most aides follow it without question.

**Offer to do the extra requests if there is time.** When aides are asked to do tasks beyond those that are on the care plan, a common strategy is to offer to do the extra requests if there is time. Sometimes their willingness to tackle the extra work depends on their relationship with the client. Teri said she will do the extra requests for her clients because she views them as “little things that aren’t really anything, and you don’t mind helping them out once in a while.” Isabelle explained that she will often handle the request to make her client feel more comfortable, adding that “sometimes you go a little above and beyond … just to make the client happy.” The explanation is often contextual, with the decision to do the extra requests dependent upon how extensive the request is and how close the relationship is with the client. Sophia, a soft-spoken aide in Upstate New York described how her close relationship with her client increases her willingness to do extra tasks for her:

If (the client) would like me to help organize her closet because everything is all askew, yes, I will do that for her, if I’ve done everything else. If I know that everything else is taken care of, then yes, I will do those things for her.

Fulfilling these requests may make the client happy and contribute to maintenance of the close relationship between the aide and the client. Taking on the extra requests requires the aides to disobey the directions from their supervisors to do only the tasks on the care plan and nothing else. By performing the additional tasks, the aides are privileging the needs of the client over the directives of the agency.

Because the requested task is not included in the care plan, this leads to another
communicative behavior—not telling the agency. The aides selectively disclose when they agree to extra demands. To avoid getting in trouble with their supervisor, they do not share that information with the agency. Sophia shared that she chooses to disregard her home care agency’s rules to help her client:

There’s times that I’ve maybe picked up something at the store that I know he needs … which we’re not supposed to do, but I do that stuff because it’s not a big deal. But they have rules against stuff like that. We’re not supposed to do that.

In choosing to do the extra task and not tell their supervisors, the aides are privileging the needs of their clients over the instructions from their agency. The close relationship that aides establish with their clients and the lack of a close working relationship with their supervisor no doubt contributes to the decision to defer to the client and hide their actions from the agency.

Suggest a different resource to handle the request. Another communicative strategy for dealing with competing demands is to suggest alternative ways to handle the demand, usually a family member or outside company, such as a cleaning service. Lorraine provided an example. When asked to wash curtains and hang them, as part of spring cleaning, she countered to her client, “Talk to your daughter. Maybe she could help you with that.” Using this strategy, the aides decline the request, but offer another solution, enabling the client’s needs to be met without violating the dictates of the care plan or the supervisor’s direction.

“The aide’s the one that keeps them alive”: Viewing their job as important despite being treated as inferior. Perceptions of the value that a home health aide provides varies from person to person. Aides receive messages from others that their job is “dirty”
and “demeaning.” The aides described a stigma that society places upon their chosen line of work. Michael, a young aide in New York City talked about the stigma, noting that others think of the job as “very trashy” and adding that they may “talk down on you and talk down on the job you do.” Jackie said that some friends and family ask aides how they can handle some of the personal care tasks such as bathing or diapering an adult, stating, “I don’t see how you can do that.” Pam, who has been an aide for nearly 10 years, explained that home health aides are treated as “the cleanup squad. We take orders from everybody—the therapist, the nurse, the occupational therapist.” Isabelle said that some people look down on home health aides. “A home health aide is not somebody that you really look up to. It’s just like a second class job that you’re doing.” This stigma stems in part from the taint associated with dealing with bodily fluids and working in a servile position (Tracy and Scott, 2006). Jackie provided a more explicit explanation, “Because a lot of people ain’t about going in there, cleaning nobody’s dirty toilet or cleaning nobody’s butt, or stuff like that. They’re like, ‘I can’t do that.’” Darlene described an even harsher reaction, stating, “When you say what you do, there’s people that react like ‘Oh, you’re an ass-wiper.’”

On the other hand, home health aides talked about the importance of the work that they do and how they contribute to the health of their clients. They frequently describe themselves as “the eyes and ears” of the nurses. The aides discussed two communicative strategies for dealing with this dialectic.

*Privilege their view of the job’s importance over the negative characterizations of others.* Home health aides almost universally accentuate the positive aspects of their work, while minimizing the more negative aspects of their job. Some refer to their work
as “a calling,” and Darlene said to be a home health aide, “You’ve got to be the right kind of person. Not anybody can do what we do.” In this way, they are reframing the meaning of their work with more positive values (Tracey & Scott, 2006; Wrzesniewski, McCauley, Rozin, & Schwartz, 1997). Nathan, who has been an aide for more than 20 years, explained that becoming an aide “was God-given to me. This is what he wants me to do.” Jackie put it similarly, “I feel my purpose is that I’m here to do what I do. I was put here to take care of people, sick people and just be the person that I am.” Several aides note that they do not do the work just for the money, but for the sense of gratification that comes from helping older, vulnerable clients. Georgia explained, “You’ve got to do it because you love taking care of the elderly people.” When viewing their work as a calling, aides are elevating the status of their role and focusing on how socially useful their work is.

Most agencies require that aides wear gloves and often an apron when providing personal care to their clients. This serves to put a type of barrier between them and the “dirty work” and distances them from that aspect of their work. Twigg (2000) suggests that gloves protect aides “from the full intimacy of bathing and (puts) a barrier of professionalism between the client and the worker” (p. 404). This allows them to further distance themselves from the negative aspects of their work and to focus on the positive.

The aides frequently dismiss the negative views of others stating that the others just do not understand the job. They note that the misunderstanding may result from the fact that others rarely see what happens on their job. The work in the home is isolated and private, hidden from the view of others. Aides counter the negative attributions by referring to the value that they see in the work that they do. Isabelle said that aides have
“got people’s lives and their hearts and their emotions in your hands.” In the hierarchy of the healthcare world, the home health aide role is deemed less important than an LPN or an RN role, but Kelly noted that “the RNs, the LPNs look at us for the answers. We’re the ones that tell them what’s going on with a patient, what needs to be changed.” That view was echoed time and again by the aides who say that they keep the nurses informed with what is happening. Nathan elaborated:

A nurse will see ‘em once or twice maybe a month, once or twice a week perhaps. Doctors, you see them at scheduled appointments, but your home health aide is the one that really helps that person get well, get better because we’re there to oversee their overall health and to assist them with it and of course, where are we? The last ones on the totem pole. But … as far as I’m concerned, I’m the top, I’m the head of the totem. I know what I do has the greatest impact on my client.

The aides emphasize that that their work is not just about housekeeping; it’s about keeping the patient healthy. They note that unlike doctors and nurses, aides are in the clients’ homes as often as daily. They are the ones who make sure clients eat and take their medicine. They are the ones who protect clients from falls and keep them clean. They are the ones who report when something is wrong with the clients. Bonnie, a supervisor of aides in a rural county, agreed stating, “Nurses are important. Doctors are important, but you know what? The aide’s the one that keeps them alive.”

Despite the negative attributes placed upon their work by others, many aides simply shrug off those characterizations and speak of both the value that they provide and the benefits they get from being a home health aide. They say they love working with older people. They describe how they learn from them. They say they like helping people
and taking care of people. Many characterize themselves as “a people person.” It is the relational aspects of the job that make it rewarding to the aides.

**Distance self from the role by stating that it is only temporary.** Another communicative strategy that home health aides employ is the concept of dis-identification, where the individual contends that they are just temporarily in that position (Jackall, 1978). When others negatively evaluate their work status, workers employ strategies such as self-identification for self-protection to deal with status deprivation and the threat to their work-related identity (Jackall, 1978). For example, they might state that they are not really a home health aide, that they are just doing this work until something better comes along. Many aides state being a home health aide is a stepping stone to a better job. Some are going to school while working as an aide, planning to advance in the field of health care in such professions as an LPN or a physical therapist. Eddie, an aide in New York City said that he is going to school to become an LPN, adding that the home health aide is like a start … you start there.” They see the job of a home health aide as providing valuable hands-on experience in the field. Some of the larger agencies provide support to help make that next step happen. Kelly, a fairly new aide in Upstate New York, described that she became an aide so that she could have a chance to receive free LPN training:

“The main reason I became a home health aide is because I have been trying twice now to get my LPN, and things happen in life and I’ve had to withdraw from getting my LPN. Financially I’m not able to do it myself, and there are agencies and different corporations out there that help you go through the schooling. You sign up with them as a home health aide, stay with them for a
year, you have a chance to get into their LPN program and they take care of it for you. They cover the cost.”

While some aides dream of climbing the ladder in the healthcare field, the reality tends to be a bit different. Working long hours as a home health aide leaves little time and energy to go to school and study. The manager of a large home care agency said that at most one or two aides complete school each year and go on to a higher paying position.

**Issues of Negotiating Relationships on the Job**

Relationships are an important part of the job of home health aides. Aides provide important social support for seniors. They might be the only person that a senior has an opportunity to talk with during a day. Working one-on-one with their client for years, providing personal, intimate service develops close relationships. Often the seniors and aides consider each other as family. Jackie said that a lot of elderly clients do not have close family members, “so they get the security and they feel that love, and they look for you to come back the next time, where we sometimes are more family to them than their own family.” Close relationships are one of the reasons most aides enjoy their work. Two role dialectics were identified that deal with relationships on the job.

**“You can get attached, but don’t get too attached”: Managing compassion and caring without getting too close.** Aides report that the management of homecare agencies often caution them to not get too close emotionally to their clients. There are concerns that aides might take advantage of their clients, such as accepting gifts or not following procedures. There are also concerns that clients might take advantage of the aides, such as asking them to make small purchases such as picking up groceries for them.
or do extra work around the house. The aides discussed two strategies to deal with this dialectic.

*Disregard the directive from management to not get too close.* Most aides said that when they care for an elderly person for many hours a day for years at a time, it is nearly impossible to avoid forming close relationships. As aide Hailey noted, “I’m a people person. I can’t help it.” The agency directive is seen as counter-intuitive by some aides, since agencies hire compassionate, caring individuals, place them in intimate situations with vulnerable seniors for years, and then instruct them not to get close to their clients. However, the aides find it hard not to get close to them, because as Kelly said, “These are little old people. It’s your grandma, your grandpa. Aides stated that they enjoy interactions with seniors, so they choose to follow their hearts and not the agency rule. They dismiss the instruction from their agency as a restriction that they cannot abide by. They simply choose to ignore it. By asking the aides to do something that they find nearly impossible to do, health care agencies are in effect encouraging aides to break the rules. This scenario seems to convey to aides a lack of understanding on the part of the supervisors about the aides’ work environment.

*Establish personal boundaries in interactions with their clients.* A minority of the aides said that they attempt to follow the agency instructions and purposefully put limitations on their actions with their clients. They take steps to keep their relationship more professional by not visiting outside of work, by deflecting personal questions, and by not giving out their personal phone number. Aide Kelly recommended keeping home life separate from work. “When you go into a client’s home, they ask you questions about your family, your children, and that right there, I think, is what causes more of the
attachment. So try to keep one-word answers. It kind of keeps a distance.” Another aide, Lorraine, explained that she does not give out her personal phone number because “they might want to call you in the middle of the night.” Such contact outside of work would cross the line into the aide’s personal life.

While some aides establish boundaries on the advice or direction of their supervisors, others said they limit their attachment to their clients to protect themselves emotionally. Lauren explained, “You care about patients. You really, really care about them. It goes deep, you know, but you have to really be like, you know what, you’re here for one reason, to take care of them. You don’t want to overwhelm yourself.” This action of setting limits speaks to the emotional labor that many aides do, which is discussed in the next dialectic below.

Establishing boundaries may be easier to accomplish if the aides frame their relationship with the clients as “a job.” While the bonds they make with their clients may feel like a family bond, they are in fact not family. Aide Neva said that she reminds herself of this fact especially when family members come to visit her client. Despite the fact that she is made to feel like a part of the family, she consciously steps back when family members gather. “You have to pull back because you don’t have to be in their family affair.” In this way, she keeps her distance and reminds herself that it is a working relationship that she has with her client. Having the self-awareness to recognize a status as complicated as “family, but not family” is a sophisticated skill that few people have.

“I’m happy as can be, whether I’m sick or not”: Managing emotional labor demands. Part of being a home health aide is managing emotional labor. Emotional labor is defined by Hochschild (1979) as work which involves managing one’s emotions to fit
the expectations or requirements of a job. Home health aides deal with emotional labor in several ways. First, they fulfill an important social role for seniors who are often living isolated, lonely lives. Most aides report that exhibiting a cheerful personality while working with the elderly is an important part of their job. Yet they are often personally struggling with financial issues, personal problems or illnesses, which might make being happy difficult. Second, they develop a close relationship with their clients, which can end abruptly either through death or other circumstances, such as hospitalization. Death is a fairly common occurrence—nearly every aide has had at least one client die during his or her care, though typically not in their presence. Most aides are prepared for such an eventuality since after all they care for elderly individuals in frail health. Yet the emotional toll can be great, and Kelly admits that when a client dies, she cries. “Honestly, that’s what I do. That’s how I just kind of move on, and I still think of her.” Others talk about having their heart broken when their work with a client ends. Aide Kayla told how the death of a client left her “kind of in shock. We knew it was happening … She also had hospice care coming in, so it was something we were kind of preparing for … It was hard. I cried.” Aides discussed two strategies for dealing with this dialectic.

**Defer to the needs of the client, putting their own needs second.** Many aides talk about privileging the needs of the client over their own needs, especially when it comes to emotional needs. They talk about the importance of contributing to the mental well-being of their client, and the need to enter the client’s home every day with a smile on their face. Aide Pam described how she feels compelled to put on a happy face at work:

You’re not coming in with an attitude. “Oh, gosh. It’s 7 o’clock. I don’t want to be here.” It’s always, when I open that door, a smile is on my face and I’m in la-la
land. I’m happy as can be. Whether I’m sick or not. I still put it on.

Several aides talk about the need to exhibit a happy persona even when they feel sick or are dealing with personal problems. Since most aides do not get paid if they do not work, they typically try to go to work even if they are feeling bad or need to deal with a personal problem.

The aides’ personal difficulties often take a back seat to the needs of the clients. When a destructive hurricane slammed the large urban area where many of the aides in this study live, this became even more apparent. Aide Lauren told the story of her efforts during the storm to help a stranded client:

She needs me. My family’s OK. I’m going to stay and take care of her. When she don’t have nobody, you … put yourself forward. I’m going to help her today. I’m not going to leave ‘cause it’s time for me to leave. She’s going to be stranded here by herself.

This aide left her family during the storm and stayed with her client for days to make sure she was safe. Such elevating of the client’s physical and emotional needs over those of the aides speaks to the dedication and compassion of the aides. When required to make a choice between the client’s needs and their own needs, most aides put their clients first. These behavior choices demonstrate how the aides view the importance of their job and the need to take care of their older, vulnerable clients.

**Derives happiness from making their clients happy.** Aides said that making their clients happy makes them happy. Aide Kelly said that she is happy “just knowing that the client is happy.” Many aides say that they know they have done a good job when their
client is pleased. Anne, who has worked as an aide in a small town for nearly 10 years said that she feels good “when I leave and they are happy and they are smiling, and they say, ‘I’ll see you in the morning.’ That makes me good, that makes me feel like I did something.”

Bringing happiness and relief to people in need provides the aides with a gratification that surpasses the personal troubles they may be dealing with. Their sense of self-worth comes from the gratitude their clients show them, when, as Kelly said, their client “has a big smile on their face and thanks me from head to toe every time I leave.” Despite the physical difficulties of the job and the negative societal views of the job, when they are able to bring their clients comfort and put a smile on their faces, they feel good at the end of the day.

**Discussion**

The role dialectics that impact home health aides require strategies and role management that may be beyond the experience and training of aides. They are constantly responding to competing expectations and juggling demands amidst long-term emotional personal relationships.

Being a home health aide requires skills in interpersonal skills and decision-making that are typically undervalued and underutilized. Aides are faced with juggling and prioritizing demands from multiple sources, ranging from government policies that delineate what an aide can and cannot do to the care plan that specifies what tasks an aide should perform for a particular client, to requests made by clients and family members. Though aides are told to focus strictly on the care plan tasks, in reality, they are predisposed by their personalities to please the people with whom they work and interact.
daily. By working remotely with minimal interaction with their supervisors, aides talk about being closer to their clients and more interested in making them happy, even if they have to not tell the agency what they are doing on the job. Not only do aides tend to privilege the needs of their clients over the directive of their agency, they also chafe at the low status, “bottom of the totem pole” position where the agency places them. Aides talk about the importance of their role in the health and well-being of their elderly clients. Rejecting the low status role designated by their agency, aides turn to other sources for reinforcement of their worth—proclaiming their work to be “a calling” or “God-given.” They see themselves as special people who do a job that not just anyone can do, and that few people understand. It takes a strong person to be able to hold a positive view of one’s role in the face of conflicting views from others, especially since aides work alone and not with other aides. Having coworkers also engaged in low-status, dirty work can help an individual form a more positive work identity (Ashforth & Kreiner, 1999). However, home health aides rarely interact with other aides and thus cannot use that resource to help them construct a positive work identity.

Aides tend to disregard the directive from their agencies when it comes to another tension—managing compassion and caring without getting too close. Nearly all aides said that though their supervisors tell them not to get too close to their clients, they find it nearly impossible not to. Working remotely without regular interactions with their supervisors contributes to the aides choosing the relationship with their clients over the directive from the agency.

When Apker, Propp and Ford (2005) examined the role dialectics that nurses face, they found tensions related to issues of hierarchy and status. Nurses are faced with
competing expectations between being encouraged to participate in decision-making with physicians and working within a deeply ingrained hierarchy. Also, the nurses were found to adopt different communicative strategies depending on whether they are interacting with physicians or with subordinates. Home health aides also deal with issues of hierarchy and status, but since they view themselves at the “bottom of the totem pole,” their communications are always aimed upward, at individuals whom they view as holding a higher status in the organization. Aides talk about being treated as the bottom rung of the homecare hierarchy by others in their agencies and dismissed by society as “dirty workers.” They receive low pay, just above minimum wage, and few benefits, another marker of low status. They are constrained in what they can and cannot do by government regulations. However, they talk about personally believing that their role is critically important and not appropriately valued by the home care organization and society at large. The aides’ communicative strategies for dealing with the hierarchy is similar to the nurses in some ways, in that they may deny the hierarchy, for example by dismissing their supervisors’ advice to not get too close or by choosing to do extra tasks for their clients which are not on the care plan. However, these acts of denying the hierarchy are not open defiance of it, but more of an underground rebellion against the rules. Also similar to the nurses, the aides may openly accommodate the hierarchy, choosing to follow the rules to the letter, to hold out the care plan as the final say in what tasks they perform, and to not make waves.

The role dialectics’ study of nurses also found that nurses struggle with professional identity issues, including a detached-attached role dialectic. This tension stems from the pressure on nurses to be an objective, independent professional and the
pull to meet nursing standards for compassionate care and positive affective
communication with team members. Home health aides also struggle with a similar
tension between the directive from their supervisors to remain detached and not get too
close, and their natural caregiving desire to develop close relationships with those whom
they provide intimate, long-term care. However, aides lack many of the nurses’ resources
to manage this dialectic. They do not have work cohorts with whom they could interact
and engage in sensemaking activities, nor do they have frequent supervisor interactions to
help them manage this dialectic.

In the study by Apker and colleagues (2005), the nurses were found to segment
their communication and use different types of communication with different audiences
to better meet the range of role expectations demanded of them. While home health aides
also deal with a range of role expectations demanded of them, they may not have the
sophisticated communication skills to segment expectations as the nurses do. Instead,
they turn to other resources to deflect competing demands, such as referring demands to
the care plan or their supervisor. Additional interactional training and role playing could
better prepare the aides for managing this dialectic.
Summary and Purpose of the Study

This study was designed to provide an understanding of how home health aides make sense of their role and how they negotiate the role tensions that they often face. Using interpretive research methods, this study examines the talk of home health aides, supervisors, and clients from both rural and urban areas, and from that talk identifies influences on the role development of home health aides. I adapted a Social Ecological Model to use as an organizing tool to examine the proximal and distal influences on the role of home health aides. The data from the interviews was then analyzed to identify role dialectics that aides are faced with. Finally, this study sheds light on strategies that aides use to manage those dialectics as they seek to understand and negotiate their role.

The findings indicate that home health aides must manage a number of role dialectics as they learn and negotiate their roles. Their strategies that aides employ to manage these dialectics suggest that they lack both the power and the sophisticated negotiation skills to effectively negotiate these dialectics. They turn to avoidance and deflection, such as discretely ignoring directions from their supervisors or holding up the care plan as the reason they cannot comply with a client’s request.

Theoretical Implications

This study contributes to theory in several ways. First, it provides evidence that using the Social Ecological Model of Role Influences provides a useful framework for identifying and analyzing the people, organizations and processes that can influence the
development of roles. Second, it studies how organizational communication processes such as role dialectics and identification work with low status, remote workers.

**Social Ecological Model of Role Influences.** In this study, the Social Ecological Model displays the layers of influencers on the role of home health aides—influences derived from the talk of the aides, their supervisors and their clients. Employees pick up clues about what they should do on the job and how they should act by interacting with those around them. In most cases, an employee’s supervisor is instrumental in this role-making phase. However, for a home health aide, the influence of the supervisor is muted by the remoteness of the aide’s work location and the infrequent interaction between the two. Thus, it is even more useful to examine the other—non-supervisory—influencers on home health aides. Also, healthcare takes place in a highly regulated environment, increasing the distal influences on the role of home health aide. The model organizes these influences and enables their interconnectedness to be more readily observed.

**Organizational Communication Processes.** As the Social Ecological Model of Role Influences indicates, home health aides deal with a number of influences as they learn and negotiate their role. These various influences, from the micro, meso and macro levels, work together to create a number of role dialectics that aides must manage. The findings also suggest implications for organizational identification issues that could be addressed in order to enhance the aides’ job satisfaction.

**Role dialectics.** This study extends the use of role dialectics, as introduced by Apker, Propp, & Ford (2005), to look at how home health aides learn and negotiate their roles, given the remoteness and independent aspects of their work. The analysis of the role dialectics that aides face found that aides deal with complex issues of competing
expectations, perceived low status of their role, and relational issues. Aides have used strategies that help them manage the dialectics despite a lack of training in how to deal with such issues. For example, when faced with competing demands, aides do not appear to be able to argue from a level playing field. They do not have a positional power stance from which to negotiate, nor do they typically have strong negotiation skills that would help them. Thus, aides either turn to the care plan or their supervisor for the added power to deflect a client’s request, or they perform the requested tasks and choose not to disclose this information to their supervisor. These strategies may not be the ideal way for aides to negotiate their role. Neither approach empowers aides and neither seems to achieve a fully satisfying resolution to competing expectations.

**Identification.** This study suggests new applications for organizational identification concepts with low status, remote working employees. As discussed earlier, identification could be a good management technique for employees who work independently. If the employee identifies with the company, they would more likely make decisions with the company in mind, despite the fact that they are working remotely and away from supervisor oversight (Cheney, 1983). An employee’s relationship with his or her supervisor can be key for establishing identification. However, the relations between home health aides and their supervisors are typically weak, and many aides expressed confusion about the identity of their supervisor. Those who said they know their supervisors talked about having infrequent interactions with them. Given that aides work closely with their clients and have little interaction with their supervisors or co-workers, it is understandable that aides may feel greater identification with their clients than with their home care agency. It is likely that aides feel some level
of identification with both their home care agency and their clients, as multiple identification targets are possible among remote working employees (Scott, 1997). Previous studies found that remote employees are more likely to establish identification with local targets, suggesting that aides would identify more with clients. Both home care agencies and home health aides could benefit from a strengthening of identification with their home care agency, as enhanced job satisfaction could follow stronger identification.

**Practical Implications**

Being a home health aide requires skills in interpersonal skills and decision-making that should not be undervalued. The role dialectics that impact home health aides require strategies and role management that may be beyond the current experience and training of many aides. They are constantly responding to competing expectations and juggling demands while managing long-term emotional personal relationships. To enable home health aides to do as good of a job as possible, and to make the job a more positive experience for the aides, these findings suggest some implications for practice. This study suggests a number of practical implications that should be considered to improve recruiting, training and retention of home health aides.

**Recruiting.** When recruiting aides, the findings of this study suggest that agencies should improve rewards for aides and enhance the status of this important job. One important change to make that happen would be to offer a more livable pay and benefits package. If traditional reimbursement levels remain constrained by government and third party payer policies, home care agencies should consider more innovative funding streams to better the compensation of aides. One approach that has worked for
some agencies is to apply for grants and turn to fundraising to support better pay and benefits packages. Currently, home care services are not designed with the needs of the aides in mind. Offering aides full-time, regular hours with better pay and benefits would go a long way toward helping aides achieve more financial stability and higher status.

In addition, efforts to improve the image of home health aides would be helpful in recruiting efforts. Other types of workers who deal with “dirty work,” such as paramedics and daycare workers, are able to maintain a higher status in society. Communication campaigns to elevate the status of home health aides by focusing on the value of the work they do would be a start. In addition, the status of home health aides could be improved by treating them as more important members of the home care team. Care management nurses should be provided with more interpersonal skills training to better equip them to understand the importance of the role of home health aides and to help the nurses make the aides feel valued and appreciated.

**Training.** The findings from this study suggest that training of home health aides should be expanded and enhanced. Currently, training focuses mainly on tasks, such as how to do a bed bath or transfer a person from a bed to a chair. Additional time should be spent focusing on the relational aspects of the job. Aides could receive training in interpersonal communication skills development to help them better negotiate completing demands. Managing these dialectics can require a degree of sophisticated decision-making and interpersonal skills that many of aides currently do not have. In addition, training should include more biopsychosocial education about working with the elderly. By enhancing their knowledge about what their clients are experiencing, aides can do a
better job of understanding their clients and enriching their lives. It could also enrich the
jobs of the aides and increase job satisfaction.

**Retention.** The close relationships that aides form with their clients may cause
identification issues or a conflict within an aide about who they work for. Identification is
linked to retention. Because aides work in a home setting and rarely see other aides or
their supervisor, when faced with competing demands, they tend to defer more to what
their clients want. One step that might improve retention would be to strengthen aides’
ties to their supervisors. While many aides in this study did not even know who their
supervisor is, studies suggest that an employee’s relationship with his or her supervisor is
key to their job satisfaction and retention (Stringer, 2006).

**Conclusion**

Current public policy has built the home care industry on the premise of
exploiting a main body of the field’s workers. Nothing in the system is designed with the
needs and well-being of the home health aide in mind. This study suggests that a number
of changes at every level could be implemented to enhance the role of home care
workers, increasing job satisfaction for the aides, along with recruitment and retention
efforts. For example, a revision of reimbursement policies at the macro-level to enable a
living wage for these important workers could provide the aides with added status and
dignity, and not require them to rely on government welfare. In addition, changes in how
supervisors interact with aides could strengthen the aides’ relationship with their
supervisor, enhance their status, and lead to increased job satisfaction.
Limitations and Future Research

This study examines the experiences of 34 home health aides in one state. Though the state offers a wide diversity of contexts from which participants were recruited, from large urban areas to rural counties, the experiences of other geographic regions, with differing state policies, may be different. Also, because the majority of the aides were recruited for this study during company-run in-service training sessions, the participants could have been concerned that the investigator was linked in some way with their agencies and thus they might not have been as open as they might have been if recruiting efforts had been totally separated from their employer.

This study raises issues for further study. Additional research using the Ecological Model of Role Influences are called for to further understand the usefulness of the model for shedding light on how people, organizations and processes at various levels can influence roles, especially within a healthcare setting. In addition, how identification processes work with low status, remote employees should be investigated further, to determine if there are differences between them and either higher status workers or low status workers who are not working remotely. Identifying such strategies to enhance the working conditions of aides and to improve aide recruitment and retention is important to the home care industry and meeting the needs of homebound elderly to remain living in their homes.
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Interview schedule for Interviews with Managers at Home Care Agencies

Thank you for agreeing to be interviewed. Before we get started, we need to go through what they call an “informed consent” process. Whenever someone at a university does a project that involves gathering information from people, we have to go through a process called informed consent, which means that you formally give your consent to be interviewed after I inform you about the details of the project, what will be done with the information you provide, and your rights as a participant.

[complete the informed consent process using the informed consent form; be sure that the participant gets a copy to keep and that you keep a signed copy]

1. I’d like to ask you a few questions about your work with the home care agency.
   a. How would you describe the job of a home health aide?
   b. What qualities do you look for in a home health aide?
   c. What training is involved in being a home health aide?
   d. How difficult is it to recruit and retain home health aides?
   e. How important is it to recruit and retain home health aides?
   f. Can you tell me what a typical day at work is like for you?
   g. How do home health aides learn their jobs?
   h. If home health aides have a question about what to do on the job…where should they turn?
   i. What do you think are the special challenges of being a home health aide?
   j. Do instructions from the agency ever come in conflict with what the clients ask them to do or what their family members ask them to do? Can you give me an example? How are such conflicts resolved?
   k. Can you give me some words that describe the values that the agency espouses?
   l. If you could change one thing to make the job of a home health aide better, what would that be?

2. Do you have any questions for me about the research project this is part of?

I want to thank you again for your time today.
Interview schedule for Interviews with Home Health Aides

Thank you for agreeing to be interviewed. Before we get started, we need to go through what they call an “informed consent” process. Whenever someone at a university does a project that involves gathering information from people, we have to go through a process called informed consent, which means that you formally give your consent to be interviewed after I inform you about the details of the project, what will be done with the information you provide, and your rights as a participant.

[complete the informed consent process using the informed consent form; be sure that the participant gets a copy to keep and that you keep a signed copy]

- I’d like to start by asking you a few quick questions about yourself that are related to your work at a home health aide.
- [check off demographic information as the participant answers]
  - Age/Educational background/Years working as a home health aide
- Now I’d like to ask you a few questions about your work as a home health aide.
  - Can you tell me what a typical day at work is like for you?
  - How would you describe the job of a home health aide?
  - Where did you learn how to be a home health aide?
  - When you have a question about what to do on the job…where do you turn?
  - Has your view of your job changed from what it was before you began working as a home health aide? If so, why or what caused the change?
  - Why did you decide to become a home health aide?
  - How do you describe what you do to family and friends?
  - How do your friends and family view the work that you do?
  - Do you see this as a long-term employment option for you? Why or why not?
  - What work did you do before becoming a home health aide?
  - Do your instructions from the agency ever come in conflict with what your clients ask you to do or what their family members ask you to do? Can you give me an example? How do you resolve such conflicts?
  - What do you think of the image of your employing agency? Can you give me some words that describe the values that the agency espouses?
  - If you were completely free to choose, would you prefer to stay working at this agency?
  - How satisfied are you working here?
  - Do you have opportunities to interact with other home health aides? When and how?
  - Do you recall messages (tips and suggestions) that have been significant for your experiences of work life?
  - What is one thing that could be changed to make the job of a home health aide better?
- Do you have any questions for me about the research project this is part of?

I want to thank you again for your time today. (Provide $20 thank you payment.)
Interview schedule for Interviews with Clients/Family Members

Thank you for agreeing to be interviewed. Before we get started, we need to go through what they call an “informed consent” process. Whenever someone at a university does a project that involves gathering information from people, we have to go through a process called informed consent, which means that you formally give your consent to be interviewed after I inform you about the details of the project, what will be done with the information you provide, and your rights as a participant.

[complete the informed consent process using the informed consent form; be sure that the participant gets a copy to keep and that you keep a signed copy]

- How long have you been employing home health aides?
- Why did you decide to begin employing a home health aide?
- Do you typically have one aide who works here or several?
- Can you describe for me what the job of a home health aide is?
- Do you ever need/or want the home health aide to perform a function differently than he/she might want to perform it?
- How do you typically interact with the home health aide? Do you talk with him/her face-to-face, leave notes, talk on the phone?
- Can you describe a typical interaction that you might have with a home health aide?
- What are the challenges of having a home health aide work here?
- What is one thing that could be changed to make your working with a home health aide better?

- Do you have any questions for me about the research project this is part of?

I want to thank you again for your time today.
APPENDIX B: IRB APPROVALS AND CONSENT FORMS
Institutional Review Board: DHHS FWA00001970
Notice of Approval
IRB Protocol Number: 12-156

Date: June 21, 2012
Incentive? ☑ Yes ☐ No

Principal Investigator: Muriel Scott

Title: An Exploration of how the Role of Home Health Aides is Perceived and Enacted

Review Type: ☑ Full ☐ Expedited Approval Type: New Expedited Category # 7

IRB Board00000589

Approval Term: June 21, 2012 through June 20, 2013 Review Cycle: 1 Year

1. Provisions of Approval: n/a
2. Consent Forms: All subjects must receive a copy of the consent form as approved with the University at Albany Institutional Review Board stamp. Copies of the signed consent form must be kept on file unless a waiver has been granted.
3. Adverse Events: Any adverse event(s) or unexpected event(s) that occur in conjunction with this study must be reported to the Office of Regulatory Research Compliance within 10 calendar days of the occurrence.
4. Principal Investigator Responsibilities: It is the responsibility of the PI to ensure that all investigators and staff associated with this study meet the training requirements for conducting research involving human subjects, follow the approved protocol, use only the approved forms. keep appropriate research records, and comply with all University at Albany Policies, federal, state and local laws, Declaration of Helsinki and the Belmont Report.
5. Research Records: Accurate and detailed research records must be maintained. All research records (including all IRB correspondence) must be kept for a minimum of 3 years after the completion of the research. This research is subject to an audit under the terms of the IRB’s Quality Improvement Program.
6. Changes: Any changes in the above referenced study may not be initiated without prior IRB review and approval. Changes include (but are not limited to) study personnel, consent forms, protocol, procedures, addition of funding source.
7. Lapse of Approval: If approval for this project lapses, all research must stop IMMEDIATELY until continuation approval is granted. If approval lapses before the continuation is reviewed, your project must be resubmitted as a new protocol.
8. Yearly IRB Approval Continuation: Approval is valid until the expiration date above. You are required to obtain annual IRB approval continuations prior to your expiration date for as long as the study is active. An annual continuation reminder will be sent to you, but it is your responsibility to ensure that you submit and receive the yearly approval in a timely manner.
9. Funded Research: If your research is funded, you must also submit sponsor information and a copy of the grant/funding application for IRB review with the human subjects section(s) highlighted. This is true whether the source of funding is internal or external.
10. University Permissions: A.) Institutional Research, Planning and Effectiveness (IRPE) permission may be required if your research participants are recruited from the UAlbany campus. It is the responsibility of the investigator to contact IRPE at (518) 437-4791 for a determination. B.) All UAlbany permissions (e.g., classroom, team or organization permissions) must be kept on file with your research records.
11. Posters or Flyers: All flyers posted to recruit participants must have the IRB stamp. If posters or flyers are to be posted on the UAlbany campus, they must be registered with the Office of Student Involvement and Leadership in Campus Center 130 prior to posting on the academic Podium.
12. External Permissions: All external permissions (e.g., schools, businesses, organizations, etc.) must be kept on file with your research records.

Upon receipt of this letter you may begin your research. The IRB wishes you success with your research.

cc: Annis Golden
Date: October 12, 2012
Incentive? ☑ Yes ☐ No
$15 for home health aides (30)

Principal Investigator: Muriel Scott
Title: An Exploration of how the Role of Home Health Aides is Perceived and Enacted
Review Type: ☑ Full Committee ☐ Expedited IRB Board 00000589
Approval Type: ☑ Modification

Approval Date: October 12, 2012 Expiration Date: June 20, 2013

1. Summary of Modification: Modify consent form for subjects recruited at Visiting Nurses Service New York
2. Provisions of Approval: n/a
3. Consent Forms: All subjects must receive a copy of the consent form as approved with the University at Albany Institutional Review Board stamp unless a waiver has been granted. Copies of the signed consent form must be kept on file.
4. Adverse Events: Any adverse event(s) or unexpected event(s) that occur in conjunction with this study must be reported to the Office of Research Compliance within 10 calendar days of the occurrence.
5. Research Records: Accurate and detailed research records must be maintained. All research records (including all IRB correspondence) must be kept for a minimum of 3 years after the completion of the research. This research is subject to an audit under the terms of the IRB's Quality Improvement Program.
6. Changes: No changes in the above referenced study may be initiated without prior IRB review and approval. Changes include (but are not limited to) study personnel, consent forms, protocol, procedures, addition of funding source.
7. Lapse of Approval: If approval for this project lapses all research must stop IMMEDIATELY until continuation approval is granted. If approval lapses for longer than 30 days, your project must be resubmitted as a new protocol.
8. Yearly IRB Approval Continuation: Approval is valid until the expiration date above. You are required to obtain annual IRB approval continuations prior to your expiration date for as long as the study is active. An annual continuation reminder will be sent to you, but it is your responsibility to ensure that you submit and receive the yearly approval in a timely manner.
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12. External Permissions: All external permissions (e.g., schools, businesses, organizations, etc.) must be kept on file with your research records.

The IRB wishes you success with your research.

cc: Annis Golden
Institutional Review Board: DHHS FWA00001970
Notice of Approval
IRB Protocol Number: 12-156

Date: November 1, 2012
Principal Investigator: Muriel Scott
Title: An Exploration of how the Role of Home Health Aides is Perceived and Enacted

Review Type: ☑ Full Committee ☐ Expedited
Approval Type: ☑ Modification

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<tr>
<th>Approval Date</th>
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<tr>
<td>November 1, 2012</td>
<td>June 20, 2013</td>
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1. Summary of Modification: Increase the number of subjects to recruit from the "home health aide" and "supervisor" populations
2. Provisions of Approval: n/a
3. Consent Forms: All subjects must receive a copy of the consent form as approved with the University at Albany Institutional Review Board stamp unless a waiver has been granted. Copies of the signed consent form must be kept on file.
4. Adverse Events: Any adverse event(s) or unexpected event(s) that occur in conjunction with this study must be reported to the Office of Regulatory Research Compliance within 10 calendar days of the occurrence.
5. Research Records: Accurate and detailed research records must be maintained. All research records (including all IRB correspondence) must be kept for a minimum of 3 years after the completion of the research. This research is subject to an audit under the terms of the IRB's Quality Improvement Program.
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12. External Permissions: All external permissions (e.g., schools, businesses, organizations, etc.) must be kept on file with your research records.

The IRB wishes you success with your research.

cc: Annis Golden
Institutional Review Board (IRB)

Institutional Review Board: DHHS FWA00001970
Notice of Approval
IRB Protocol Number: 12156-02

Date: May 16, 2013
Incentive? □ Yes □ No

Principal Investigator: Muriel Scott
Title: An Exploration of How the Role of Home Health Aides is Perceived and Enacted
Review Type: □ Full Committee □ Expedited Expedited Review Category # 7 IRB00000589
Approval Type: □ Yearly Approval Continuation without Modification Continuation # 1

Approval Term: May 16, 2013 through May 15, 2014 Review Cycle: 1 Year

1. Provisions of Approval: n/a
2. Consent Forms: All subjects must receive a copy of the consent form as approved with the University at Albany Institutional Review Board stamp unless a waiver has been granted. Copies of the signed consent form must be kept on file.
3. Adverse Events: Any adverse event(s) or unexpected event(s) that occur in conjunction with this study must be reported to the Office of Research Compliance within 10 calendar days of the occurrence.
4. Research Records: Accurate and detailed research records must be maintained. All research records (including all IRB correspondence) must be kept for a minimum of 3 years after the completion of the research. This research is subject to an audit under the terms of the IRB's Quality Improvement Program.
5. Changes: No changes in the above referenced study may be initiated without prior IRB review and approval. Changes include (but are not limited to) study personnel, consent forms, protocol, procedures, addition of funding source.
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9. University Permissions: A.) Institutional Research, Planning and Effectiveness (IRPE) permission may be required if your research participants are recruited from the UAlbany Campus. It is the responsibility of the investigator to contact IRPE at (518) 437-4791 for a determination. B.) All UAlbany permissions (e.g., classroom, team or organization permissions) must be kept on file with your research records.
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The IRB wishes you success with your research.

Cc: Annis Golden
Informed Consent Form/Interview/HomeHealthAide

Study title: An exploration of how the role of home health aides is perceived and enacted

Researcher: Muriel Scott, Department of Communication Doctoral Student, University at Albany, Albany, NY 12222. Email: mescott@albany.edu; Phone: 518-810-3128. Faculty Advisor: Annis G. Golden, PhD, Department of Communication, University at Albany, Albany, NY 12222. Email: agolden@albany.edu; Phone: 518-442-4879.

Study description: This study looks at the role of home health aides and how the role is learned and negotiated, using observation and interviews.

Study procedures: You will participate in an individual interview that will take less than one hour, and will be audiotaped.

Participation information: Your participation in this research is completely voluntary. During the interview, you may decline to answer any question for any reason, you may end the interview at any time without penalty, or you may ask that the tape recorder be turned off while the interview continues. Original audiotapes of participant interviews will be locked in the researcher's office. The tapes will be kept indefinitely for possible use in further research that the researcher plans in the area of home health aides and health communication. Electronic versions of interviews will be kept in password protected files on the researcher's computer. All information obtained in this study is strictly confidential unless disclosure is required by law. In addition, the Institutional Review Board and university or government officials responsible for monitoring this study may inspect these records.

Possible risks and benefits: Participants' chief concern in a study of this nature is that someone with unauthorized access might gain access to the information, and that this will adversely affect them. The researcher is taking the following steps to minimize this source of risk:

- All participants will be assigned pseudonyms, which will be used in field notes, transcripts of tape recordings and final written products associated with the project.
- Full interview transcripts will not be made available to anyone outside the research team; the only information that will be shared with others will be research reports that will primarily present common themes that occur in participants' interviews.
- Selected quotes from your interview may appear in the products of this research, but they will be attributed by your pseudonym, and personal identifying details will be masked.

While no direct benefit can be promised to you as an individual, your participation may lead to advancing knowledge about home health aides. In appreciation for your participation in this project, you will receive $15 at the end of the interview. If, after the start of the interview, you decide to end the interview for any reason, you will still receive the payment at that time.

If you have any questions about your rights as a research participant that have not been answered by the investigator or if you wish to report any concerns about this study, you may contact the University at Albany Office of Regulatory Research Compliance at 518-442-9050 (toll free 800-365-9139) or email orrc@albany.edu.

Your participation in this project is voluntary. Even after you agree to participate in the research or sign the informed consent document, you may decide to leave the study at any time without penalty or loss of benefits to which you may otherwise have been entitled. I will retain and analyze the information you have provided up until the point you have left the study unless you request that your data be excluded from any analysis and/or destroyed.

By signing below, you are indicating that you have been informed about this study, and that you consent to be interviewed. One copy of this document will be kept together with the research records of this study, and you will be given a copy to keep.

Name __________________________ Signature __________________________

Phone number __________________ Date __________________

By signing below, you are confirming that you consent for the interview to be audio recorded.

Name __________________________ Signature __________________________

12-156

Approved by IRB
Valid Thru: JUN 20 2013

The University at Albany
Informed Consent Form/Interview General

Study title: An exploration of how the role of home health aides is perceived and enacted

Researcher: Muriel Scott, Department of Communication Doctoral Student, University at Albany, Albany, NY 12222. Email: mescott@albany.edu; Phone: 518-810-3128. Faculty Advisor: Annis G. Golden, PhD, Department of Communication, University at Albany, Albany, NY 12222. Email: agolden@albany.edu; Phone: 518-442-4879.

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Name __________________________________ Signature ________________________________

Phone number __________________ Date __________________

By signing below, you are confirming that you consent for the interview to be audio recorded.

Name __________________ Signature _____________________________
Hello,

Your help is needed....and it will take just 30 minutes of your time.

I’m a doctoral student from SUNY Albany studying the experience of home health aides. The role of home health aides in the healthcare of seniors is understudied in academia, yet their role is so important to the ability of older adults to remain living at home. I would like to understand how home health aides construct and manage their role, given the varying expectations that they have to manage. Results of this study could be useful in recruiting people to become aides, in shaping expectations of aides as they enter the field, and in addressing potential tensions on the job. This study has been approved by the VNSNY Institutional Review Board.

I will be visiting VNSNY on (dates) to observe training and meetings and to interview home health aides and supervisors. Would you be interested and willing to talk with me for about 30 minutes for this study? If so, please email me back with your availability on those dates.

Participation is totally voluntary, and all interviews will be confidential, with participants identified by a number, not their name. The research is for my dissertation and publication in scholarly journals.

If you have any questions, please feel free to contact me. Thank you again for your consideration.

Muriel Scott
UAlbany Communication Department
mescott@albany.edu
518-810-3128