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THE HOMEMAKER-HOME HEALTH AIDE

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For the past several years, many social workers have utilized the services of various disciplines as members of interdisciplinary teams as one approach to practice. There is ample evidence that social workers are increasingly beginning to utilize the newly constructed service of the Homemaker-Home Health Aide (H/HHA) when working with various client populations.¹ In the United States, there are approximately 74,000 H/HHAs who provide social welfare and health services to the aged, disabled, and chronically ill.² By 1985, there is a projected need for three times this number.³

The H/HHA's social welfare services include child care and maintenance of the home when a parent(s) must be absent due to mental and/or physical illness, consumer education, household management, and assistance with bathing, dressing, or other routine day-to-day activities. Health services of the H/HHA include monitoring and assisting clients in performing physical, occupational, and speech therapy exercises, being alert to safety needs in the home, reporting health complaints and/or possible health problems to the appropriate professionals and performing personal care activities such as feeding, bathing, grooming, and changing linens.

Historically, homemakers have tended to perform either the social welfare service or the health oriented service. The type of service provided depends upon the goal(s) and/or funding source(s) of the employing agency. The dichotomy is currently being reinforced and is becoming more obvious due to Medicare reimbursement regulations which provide payment only for the health oriented service. While this dichotomy has historically existed there is empirical evidence that it is false and the distinction arbitrary.⁴

Most recently, the third evolutionary step saw homemakers combine these two functions informally, necessarily, and against their agencies' policies.⁵ The National Council for Homemaker-Home Health Aides (NCH/HHA) along with several provider agencies, have recently established a single definition for the two combined functions of the homemaker - that of the homemaker-home health aide (H/HHA).⁶ Previous studies have indicated that both the social welfare service and the health oriented service are often needed by the same client. Yet, only a minority of agencies have the same employee performing both services. The majority of agencies provide the social welfare services, the health oriented services, or have both services provided by different employees.

PROBLEM

Most previous studies have focused on homemakers performing in either the social welfare service or the health oriented service. There is an abundance of evidence that the homemaker role has continued to evolve beyond the mere combining of the two services. However, due to the H/HHA's relatively new status, there has been little time for studying them.

We as social workers must know exactly what H/HHAs do with a client if we are going to continue to recommend their services to various clients that we feel may benefit from their services. However, despite the rapid past and projected future growth rates of the H/HHAs, few (if any) empirical studies have been conducted regarding how much time the H/HHAs spend on the two separate services and what specific activities are associated with each. The literature is also void on their patient relationships, their present job satisfactions, their goals in working with clients, and their achievement of objectives when part of a multi-disciplinary team.⁷ Thus, the purpose of this article is to present the results of an empirically based research project that will shed data on the above concerns and to provide implications for the effective utilization of H/HHAs into generic social work practice.

AGENCY SETTING AND SAMPLE

This research project was conducted in the second largest Visiting Nurse Association (VNA) in the country, which is located

in a large Southwestern metropolitan area.⁸ The agency provides a wide array of home health services including nursing, physical, occupational, and speech therapies, medical social work, nutrition services, meals-on-wheels, home health equipment, chore services, and H/HHA services.

The theoretical population for this study consisted of all of the 74 full-time H/HHAs employed by the VNA in August of 1976. Out of this population, 21 left the agency before the study was completed, 3 refused to participate, while 2 more were unavailable due to scheduling problems. The 48 remaining H/HHAs participated, which composed the sample for this study. Out of the total sample, 45 were black and 47 were female. The average age was 43.9 years old where 23 had a high school diploma or above. Twenty-six had completed nurses aide training and 2 had previous Licensed Vocational Nurse (LVN) training before employment by the VNA. Thirty of the H/HHAs were married and 33 owned or were buying their own homes. The mean longevity of employment was 3.9 years where they saw an average of 7.6 clients per week.

METHOD

The only instrument utilized in this study was an 18 page, structured opinion questionnaire containing 14 open and 129 close-ended questions, which took a little over an hour to complete. The sample was interviewed by a single professionally trained social work interviewer over a period of three months. To produce maximum disclosure, each of the 48 interviewees was told that her responses would be held in the strictest confidence.

FINDINGS AND DISCUSSION

Functional Dichotomy

The H/HHAs were asked what percent of their work time each week they spent in five specific activities within the social welfare and health oriented services. Table 1 presents the distribution of their responses. The H/HHAs spent approximately the same amount of time in each service, however, they spent 12.3% more time in performing health services than in performing social welfare services.

Table 1
 PERCENT OF PAID WORK TIME BY SERVICE CATEGORY
 AND ASSOCIATED ACTIVITY (N=47)

Type of Activity	Service Category		
	Social Welfare	Health Oriented	Other
personal care	---	54.1	---
environmental services	38.4	---	---
child care	3.3	---	---
escort service	.1	---	---
not authorized	---	---	4.2
average work time	41.8	54.1	4.2

There is obviously a need for both social welfare and health oriented services among the client population of a comprehensive home health agency. Having both services delivered by one agency rather than by two separate agencies and delivered by the same paraprofessional rather than by two separate ones may offer less fragmented and more efficient service to the client.

Third party payor reimbursement regulations which allow for reimbursement for only the social welfare or health related service may be found to produce one or more negative results in home health agencies and their clients. The provision of less services than are needed by the client who chooses to remain in his home rather than be inappropriately institutionalized may result in personal hardship for the client and/or his family and in conditions not conducive to their mental and/or physical health. As

a result of this hardship and the wearing down of health, some persons may be inappropriately institutionalized because of their eligibility for only the social welfare or only the health related service when both services are actually needed.

In a humanitarian effort to avoid inappropriate institutionalization or hardship to clients, personnel within some agencies may allow certain clients to receive mainly non-reimbursable services while these services are billed to the third party payors as reimbursable services. This, of course, places the affected agencies in jeopardy of losing their Medicare and/or Medicaid certifications. For most agencies these are the main sources of funding H/HHA services. A related result which may be due to the confusing maze of reimbursement sources is that non-reimbursable services may be mistakenly rendered in quantity and not reimbursed, which may result in devastating financial effects for provider agencies.

Counseling Activities

The VNA in which this study was conducted as well as the NCH/HHA prohibit H/HHAs from counseling clients. The H/HHAs are proscribed only to listen to their clients' problem(s) and/or to refer the troubled clients to their superiors. In contravention to this proscribed role, 38 H/HHAs felt they should counsel their clients if a request for advice and/or counseling was initiated or needed by the client. Twenty of those felt it would be impossible to keep from giving counseling even if they wanted to stop this activity. It is unlikely that a policy can be enforced when so many H/HHAs feel they should act, or cannot help but act, in the contravention to that policy. It may be time that the reality of the existence of this aspect of the role of the H/HHAs was accepted by the NCH/HHA and provider agencies, thus obligating the provider agency to effect quality control of this aspect of H/HHA service.

Thirty-five H/HHAs reported having offered counseling to at least one client in the previous 5 working days, while the average H/HHA counseled 27.7% of her caseload in that same time period. Table 2 displays the breakdown of counseling activities into six specific categories, with the percent of H/HHAs (N=48) giving each type of counseling and the percent of clients (N=364) receiving the counseling.

Table 2

PERCENT OF COUNSELING ACTIVITIES IN A FIVE DAY PERIOD

Type of Counseling	Extent of Activity	
	H/HHAs providing counseling (N=48)	clients receiving counseling (N=364)
reassurances of health	79.2	39.6
personal problems	39.6	13.6
important life decisions	33.3	8.2
referral to other VNA services	29.2	5.6
medication	16.7	3.0
referral to other resources	12.5	1.9

The H/HHAs reported counseling and/or advising clients in the areas of important life decisions and personal problems more frequently than they reported referring clients to other VNA services or to other community resources. A referral to the appropriate resource for help constitutes the use of an interventive technique labeled concrete environmental modification. The data in this project supports earlier findings regarding the low use of this interventive technique.⁹ Since concrete environmental modification techniques are generally accorded less prestige than psychological services, it is not surprising that a greater number of clients were offered psychological services than were offered concrete environmental services. This data suggests H/HHAs should be trained in the skills of such techniques, i.e., the appropriate use of available community resources offering food, money, shelter, companionship and other services. A greater knowledge of this technique by H/HHAs may result in an increase of effective, appropriate intervention with

the client population who receive H/HHA services. Presently, many H/HHAs are largely unaware of community resources and of some resources and services within the VNA itself.

Job Satisfactions

Table 3 presents 15 sources of job satisfactions and dissatisfactions. The H/HHAs were asked what they felt brought them the most satisfaction in their job followed by what caused them the most dissatisfaction. Both questions were open-ended and only the first two responses were coded.

The data indicates job satisfaction is largely derived from the work itself and achievement of objectives, recognition, personal growth, creating positive affect in clients, and providing services and companionship. Only a small percentage of the respondents indicated satisfaction derived from hygiene factors, i.e., from their work environment.¹⁰ Of those who did report satisfaction derived from hygiene factors, physical mobility involved in the job and material benefits gained from employment were the two sources reported.

Hygiene factors were more frequently mentioned as dissatisfiers. Salary and other hygiene factors account for the largest source of job dissatisfaction. These findings regarding sources of job satisfaction and dissatisfaction are generally consistent with earlier findings.¹¹

The inefficient or inappropriate use of H/HHA's time were the next two largest sources of dissatisfaction. The inefficient use of time refers to the scheduling of home visits which requires the retracing of miles between visits resulting in the inefficient use of time and travel resources. The inappropriate use of time refers to tasks that H/HHAs felt demanded skills lower than those they possessed, the provision of services not necessary to the well being of the client, and to resentment felt as a result of their inadequate integration as members of the treatment team.

Table 3
 EXPRESSED JOB SATISFACTION FROM VARIOUS SOURCES BY CATEGORY
 (IN PERCENTAGES)

Source	Category of Source	
	satisfier	dissatisfier
Serving clients/Providing companionship	46.5	
Achievement of objectives/The work itself	44.2	
Recognition/External reinforcement for performance	41.9	
Creating a positive affective state in a client	34.0	
Personal growth	20.5	
Self-satisfaction with performance	7.2	
Hygiene factors	6.1	
Inefficient use of time		44.4
Salary		36.2
Inappropriate use of time		27.3
Lack of positive reinforcement from clients		26.0
All other hygiene factors		21.1
Change		20.9
Denial of achievement by external sources		12.9
Inappropriate requests or expectations of clients		11.3

Professionals and H/HHA supervisors frequently neglect to provide feedback regarding action taken or treatment procedures indicated after a H/HHA makes a written report regarding observations of patient behavior, expression of feeling, and especially after a report regarding health related variables. Inclusion of the H/HHA as a full member of a treatment team is generally accepted philosophically by management, but implementation is resisted by service professionals.

Inclusion of the H/HHA as a full member of a treatment team is often argued against due to scheduling difficulties and loss of person hours in case conferences that could be used providing services. In spite of this, some agencies include H/HHAs in case conferences on a limited basis. Inclusion of the H/HHA as a fully integrated team member may increase effectiveness of service and job satisfaction and therefore might be an even more efficient use of public and private funds. Increased job satisfaction has been linked to decreased employee turnover which represents a drain on organizational resources.¹²

Objectives of Service Delivery

The H/HHAs were asked how many of their present clients they had specific goals for. Their responses were converted to a percentage of their total caseload. The average H/HHA had goals for 49.4% of her clients. The H/HHAs were asked to list their most common goals in working with clients. Twenty-nine listed increased independence or decreased dependence goals for their clients in their activities of daily living. Twenty-nine listed physical rehabilitation goals which included increased ambulation, use of extremities, and building up strength and flexibility. Thirteen listed the social goals of increasing the clients degree of caring about themselves and improving the clients self images while helping them accept their disabilities and ten listed the related social goals of keeping the attitudes of their patients and their families as positive as possible. Eight listed relationship goals, i.e., building a relationship of trust and respect with clients. Seven listed comfort goals and these were concerned with maintaining the client in as clean and comfortable of condition as possible and six listed maintenance as a goal feeling that preventing inappropriate institutionalization was a common goal of theirs. Five listed client

health as a goal and five listed environmental safety and hygiene as a common goal. Seven did not have goals for any of their clients.

The H/HHAs had goals for less than 50% of their clients which seems to be the result of the combination of three organizational factors. First, they are not well integrated as team members. Second, they lack easy access to case records where objectives are or should be recorded. Finally, objectives are not usually recorded or formalized by professional staff. The lack of goals for clients may be attributed in part to an ignorance on the part of some H/HHAs of the goal of maintenance. Only six H/HHAs listed maintenance (the prevention of inappropriate institutionalization by providing some basic homemaking and health services in the home) as a goal which is obviously suitable for many of the program clients. The overcoming of these as well as other organizational variables which have a negative relationship to goal directed behavior on the part of H/HHAs may result in greater achievement of objectives in home health agencies and greater movement toward the attainment of the multiple goals of home health care.

Objective Achievement

Forty H/HHAs felt they had clients who would probably have to enter a nursing home if H/HHA services were denied to them. The mean of their responses indicated that this applied to 42.5% of the entire client population. This represents a substantial savings of tax and private dollars as long term institutionalization would be more costly for most of the clients represented in this study.¹³ Additionally, it may be assumed that nearly all of these clients prefer remaining in their homes.¹⁴ In support of this assumption, 16 H/HHAs felt they had clients who could be better cared for in a nursing home, which applied to 9.7% of the total patient population. Retraction of services to these clients would probably force institutionalization in only a minority of these cases. In most cases it might mean the client would continue to remain in his own home at greater personal hardship to him and/or his family. Additionally, the H/HHAs reported that in 13.5% of the total cases an adult would have to quit work to stay home with the client if services were stopped.

Table 4 contains data regarding the H/HHA's opinion of their achievement of the four major program objectives of Title XX. The

four objectives are the prevention of client neglect, removal of client environmental hazards, prevention of client exploitation, and the prevention of verbal/physical abuse of clients. All of the objectives were defined for the H/HHAs. Neglect was defined as a patient being left alone when supervision is needed for reason of safety and/or health, a patient not receiving personal care at the level needed, or a patient not eating regular meals due to an inability to prepare them himself and/or due to not having anyone to prepare them for him. Environmental hazards were defined as fire hazards/other dangerous or unsanitary living conditions in the home. Exploitation was defined as taking advantage of an aged, very young, or disabled client by taking their money, checks, or valuables and using them for their benefit rather than for the client's benefit. Verbal/physical abuse was defined by giving examples, such as, striking a patient out of malice, locking them up, and making them feel unloved, worthless, or a nuisance.

Table 4

PERCENTAGES OF CLIENT POPULATION EXPOSED TO FOUR ADVERSE SOCIAL AND HEALTH SITUATIONS APPROPRIATE FOR INTERVENTION ALONG TITLE XX GOAL LINES BEFORE AND AFTER H/HHA SERVICE (N=364)

Program Objectives	Percentages			t-value	p*
	Before	After	Difference		
prevention of neglect	29.4	17.4	12.0	3.35	.001
removal of environmental hazards	20.7	11.9	8.8	2.71	.05
prevention of exploitation	5.6	4.1	1.5	1.16	.127
prevention of verbal/physical abuse	4.8	3.1	1.7	1.36	.091

*one-tailed test

As one can note from table 4, the achievement of two of the Title XX program objectives, namely the prevention of client neglect and the removal of client environmental hazards, resulted in a significant decrease in these two types of situations after the intervention of H/HHA's services. The two remaining Title XX objectives resulted in a decrease of these two situations but not at a significant level. On a general level, the H/HHAs indicated that they were very effective in executing the four program objectives.

In addition to the previously reported organizational impediments to goal achievement, the hesitancy or refusal of some H/HHAs to report situations involving client neglect, verbal/physical abuse, or exploitation to their supervisor, a nurse, or a social worker also may impede goal achievement. This hesitancy or refusal to report such situations may stem from two sources. First, the H/HHAs generally lack skills with which to cope with the emotionally volatile situation they are confronted with once the client and his family suspect or become aware that the H/HHA reported the situation. Second, some professionals fail to adequately protect the H/HHA as their source of information, to adequately involve the H/HHA in the appropriate steps involved in improving the situation and to adequately support the H/HHA emotionally.

SUMMARY

The H/HHA role has presently evolved beyond the mere combining of the social welfare and health oriented services to include activities proscribed by the NCH/HHA and provider agencies and which are unacknowledged in the literature. There is a need for both social welfare and health oriented services among the client population of a comprehensive home health agency. Third party payor reimbursement regulations which allow for reimbursement for only the social welfare or health oriented services may result in situations inconducive to client health.

H/HHAs' job satisfactions and dissatisfactions generally support current job satisfaction theory, where their dissatisfactions point to ways to improve home health care delivery through integrating the H/HHA as a full team member and through better quality control. The H/HHAs believe they are effective in preventing inappropriate institutionalization, in reducing hardship on the chronically ill or disabled and their families, and in keeping adults employed who would

have to otherwise quit jobs to stay home with chronically ill or disabled family members. The H/HHAs believed they were effective in reducing the neglect, exposure to environmental hazards, exploitation, and verbal/physical abuse of clients.

In general, the results of this study point to the fact that H/HHAs can be a vital part of interdisciplinary teams and are apparently an effective and efficient approach to social work practice. Even though this study was a descriptive study, it is hoped that the results will encourage social workers to utilize H/HHAs whenever they feel a client may benefit from their services.

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