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Experiences with Access to Seeking and Maintaining Home Health Care Services in Low-Income Communities

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MSA, Central Michigan University, 2007

BS, University of Cincinnati, 1991

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Home health care services (HHCS) are a cost-effective service option often underutilized by individuals living in low-income communities. For this population, barriers to care may result in higher health care costs and poor health outcomes. Gaps in literature indicated a need to explore experiences of accessing and maintaining home health care among individuals living in low-income communities. The purpose of this qualitative research study was to gain insight into how individuals living in low-income communities perceive their access to HHCS. The conceptual framework used for this phenomenological study was Penchansky and Thomas's model of access, which addresses access from seven dimensions: (a) affordability, (b) accessibility (c) availability, (d) acceptability (e) adequacy and accommodation; and (f) awareness. Open-ended questions were used in interviews with 14 participants who live in low-income communities and receive HHCS. Themes that arose from the data were: (a) types of HHCS and competent staff, (b) acceptable behaviors and conduct, (c) accommodation and ease of scheduling, (d) availability and access to HHCS, (e) affordable HHCS, and (f) communication. This study identified a need for effective policies to ensure safety for HHC workers, a policy requiring HHC agencies to establish a health equity plan for all patient populations to ensure equitable treatment and access to HHCS, and a policy that requires HHC agencies to provide routine staff training and professional development. Potential implications for positive social change from this study include improved HHCS yielding favorable outcomes and a better patient experience, a highly skilled workforce, and increased safety to ensure equitable treatment and greater access to HHCS.

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Dedication

I would like to dedicate my dissertation to my daughter. Through this process, she has had to endure the short holiday celebrations, late nights, and long days. My daughter stood by me during difficult times, motivated me to be the best I could be, and has been diligent and exceeded expectations in her academic studies. I am so grateful to have her in my life and by my side. I am even more grateful that God chose me to be her mom and a role model in her life.

To my mother, who has been one of my biggest supporters and encouraged me not to give up but to see what the end would be. I thank you, Mom, for being calm and an example of never letting anyone or anything disturb my peace.

To my friend, Janis Flournoy, for being my sounding board and motivator.

To my new husband, who always encourages me to persevere, who thinks I am the smartest person he has ever known and is ever so proud of me. Most of all, he pushes me to greatness—and I am ever so thankful.

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Dr. Martine Steed, thank you for being my co-chair. From the beginning you put me on point on how to approach and proceed with this dissertation project. You understood there was limited research around my dissertation topic and directed in a way that allowed me to proceed by utilizing similar research that could be applied to my topic. You gave me hope, and I thank you.

Last, to my pastor and the members of Impact Worship Center: Thank you for your encouragement and continued prayers.

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Chapter 1: Introduction to the Study

The number of adults in the United States over the age of 65 with chronic conditions is significantly increasing, and the desire to age in place or remain at home is essential for this population (Landers et al., 2016). Home health care services (HHCS) is a valuable service option to support the increased demand for long-term care (LTC) for an aging population needing support and postacute care such as physical or occupational therapy and skilled nursing care (Golberstein et al., 2009). Home health care (HHC) can improve an individual's functionality and mobility, promote optimal health and wellness, help avoid hospitalization and long length of stay by assisting patients in staying at home (Bawa & Sinha, 2020). Individuals residing in low-income communities often face health challenges due to their housing environment, such as safety concerns, thermostat irregularities (low or high temperatures), unsanitary conditions, and poor housing conditions (Tsuchiya-Ito et al., 2019). Patient preference and patient satisfaction have become performance measures for most health care organizations, including home health care agencies (HHCAs), to gain knowledge around how health care can be improved (Bawa & Sinha, 2020).

HHC is different from home care (HC) even though they both are considered HHCS and accounts for the majority of LTC in the United States. HHC is often provided by caregivers such as family members at no cost, even though some HHCS rendered by caregivers may be reimbursable by insurance companies (Landers et al., 2016). With the rising cost of health care and common desire to age in place, HHC is becoming an increasingly viable option for cost-effective transitional care rather than formal inpatient care (Landers et al., 2016). Health outcomes and access to health care are interrelated and could result in a lack of health care for individuals with a low or limited financial income (McMaughan et al., 2020). Experiences of HHC and HC services by health care providers have been researched, but a research focus on the experiences of adults receiving HHC is rare (Suurmond et al., 2016). Despite the demand for HHCS, there is a lack of information around access for seeking these services among individuals residing in low-income communities. Identifying the experiences of adults living in low-income communities regarding access to receiving and maintaining HHC will provide information to health care professionals that can assist them in creating effective solutions and policies to mitigate HHC challenges for people living in low-income communities and could lead to greater life expectancy among this population.

This research study provides information to HHCAs that can aid them in their certification and recertification process by meeting specific metrics within the Centers for Medicare and Medicaid Services (CMS) HHC quality reporting program. The CMS (2020) HHC quality reporting program includes five HHC outcomes measures: (a) care of patients, (b) communications between providers and patients, (c) specific care issues, (d) overall rating of care, and (e) patient willingness to recommend a home health aide (HHA) to family and friends (CMS, 2020). This study also provides information to HHCAs that may help improve care and meet CMS quality of care metrics.

In this chapter, I provide background information for this study and describe the problem statement and the purpose. Next, I introduce the research question, theoretical foundation, and the nature of this phenomenological qualitative study. Finally, I provide terms and definitions, assumptions, scope and delimitations, and the significance of the study.

Background

HHC is the distribution of continuous or intermittent health and personal care provided in the home by paid health care providers (CMS, 2003). Good quality HHC can improve an individual’s health and quality of life, lower hospital expenditures, shorten length of stay, and prevent unplanned hospital readmissions (Wang et al., 2017). HHC provides support for those who require extra care to remain at home and is less expensive than most services provided by assisted living centers and nursing homes (Reichel, 2019). Lower-income individuals are more likely to be hospitalized due to poorer health and functional status, and hospital and nursing home care is more costly and less desirable for many people with the option of receiving HHC (Golberstein et al., 2009). Unmet needs for HHCS can be perceived as an access issue if services are not available when needed or if determined by a medical physician that other levels of care are not medically necessary (Gilmore, 2018). Understanding individual experiences in receiving and maintaining HHC may produce knowledge that can be used to improve overall health care access.

Problem Statement

There remains a gap in the use of HHCS by individuals of low-income status that may contribute to poor health outcomes and health disparities (Miner et al., 2017). A lack of access to HHC can lead to greater disease incidence for individuals who are poor and of low socioeconomic status (SES), resulting in an increase of chronic conditions

(Spencer et al., 2019). Studies indicate that racially diverse groups and low-income individuals access HHC less than other groups do (Miner et al., 2017).

There is minimal research related to access to HHC among individuals living in low-income communities; however, I was able to find research that identified challenges to accessing overall health care services by individuals living in low-income communities. The challenges included minimal pharmaceutical supplies available, travel distance, cost of care, visit wait times, quality of the facility where services are being provided, and medication adherence (Ligido-Quigley, 2019). HHCS are widely promoted as a mechanism for providing safe, cost-effective care when transitioning from an inpatient hospital setting to a HHC setting (Alliance for Home Health Quality and Innovation, 2020). Individuals can receive postacute care in a myriad of settings, including in their home, via HHCAs (Beeuwkes-Buntin, 2005). Understanding perceived access concerns to HHC would be useful information for community and health care stakeholders. Identifying barriers to HHCS will provide information for low-income individuals, health care providers, discharge nurses, and caregivers to help guide and support appropriate care management decisions.

Purpose Statement

The purpose of this qualitative research study was to understand the experiences of individuals residing in low-income communities toward accessing and maintaining HHCS. The goal was to gain insight into how individuals experience access to HHCS while residing in low-income communities to enhance knowledge that can help appropriately direct patient care needs. Further, the information can help providers streamline care (i.e., policies, procedures, workflows, etc.) efficiency to help reduce the cost of care (CMS, 2019).

Research Question

What are the experiences of individuals toward accessing and maintaining HHCS in low-income communities?

Conceptual Framework

HHC is a transitional cost-effective option of treatment for those with chronic and serious health conditions (Wang et al., 2017). Understanding access to HHC can provide health care stakeholders data to move toward finding a solution to address concerns. The Penchansky and Thomas theory of access model adapted by Saurman in 2016 addresses access from six different dimensions: (a) accessibility, (b) availability, (c) acceptability, (d) affordability, (e) accommodation and adequacy, and (f) awareness. I used this model to guide this research study.

The first dimension is accessibility, which defines the location of services to be within a certain radius to the consumer with respect to time and distance (Saurman, 2015). The dimension of availability in terms of supply and demand ensures there are enough services available to meet the needs of the consumer and the community (Saurman, 2015). Acceptability is another dimension derived from the consumer and provider experiences around the attributes of the service considering cultural and social issues (Saurman, 2015). The fourth dimension is affordability, discovering affordable services by assessing direct costs to both provider and consumer (Saurman, 2015). Adequacy and accommodation together are the fifth dimension and are defined as individuals being able to use services and take into consideration appointment/referral scheduling, office hours including after-hours care, facility structure, and handicap accessibility (Saurman, 2015). Because this study is focused on HHC, after-hours care and office hours do not apply . The last dimension is awareness, which involves assessing health literacy and ensuring that communication is effective at all levels for all users—primarily consumers and the community (Saurman, 2015). For this research study, I focused on all the dimensions of the Penchansky and Thomas access model; however, for the dimension of accommodation and adequacy, my primary focus was facility structure, the home, including handicap accessibility, and the ease of appointment scheduling for HHCS.

Nature of the Study

A phenomenological qualitative study was the methodology for this research study. The plan was to interview current and former recipients of HHCS who reside in low-income neighborhoods to gain their experiences from seeking and maintaining services. A phenomenological qualitative approach was the best and most appropriate methodology to use for this research study because it allowed me to study a phenomenon through how it is perceived by subjects engaged in the situation (Ravitch & Carl, 2016). Interview questions were developed to engage adult recipients of HHCS to gain an understanding around their experiences accessing and maintaining HHCS.

Definitions

The definitions below give insight into HHCS and further clarify the context of this study:

Activities of daily living (ADL): Basic survival/living functions to maintain a normal life (Alliance for Home Health Quality and Innovation, 2020).

Home health care agency (HHCA): An agency or organization primarily engaged in providing skilled nursing services and other therapeutic services (CMS, 2020); provides for supervision of these services by a physician or registered professional nurse (CMS, 2020). HHCAs are licensed pursuant to state or local law or approval for meeting the standards established for licensing by the state or locality (CMS, 2020).

Home health aide (HHA): Assists patients with needs such as walking, bathing, getting out of bed, wound care/dressing changes, and clothing (John Hopkins Medicine, 2020). Some HHAs receive specialized training to assist with specialized care under nurse supervision (John Hopkins Medicine, 2020).

Home care (HC): Nonmedical care provided by licensed and non-licensed caregivers who assist with daily living activities such as bathing, cooking, and cleaning (D'Mello, 2020).

Home health care plan: An outline detailing the plan of care for a particular illness or injury, includes services needed, medical equipment needed, provider rendering services, frequency (how often services are needed), and expected outcomes (Centers for Medicare and Medicaid, 2020).

Home health care services (HHCS): A cadre of medical, social, and clinical services, such as medication administration and management; physical, occupational, and speech therapy; case management by a social worker; nursing care; personal care;

nutritional care; and companion care provided in the home for an illness or injury (Medicare, 2020).

Home health nursing care: Wound care, medication administration, intravenous (IV) therapy, ostomy care, pain control, and supportive services (John Hopkins Medicine, 2020).

Medicare Advantage: Insurance offered to Medicare recipients through a private-sector health insurance company; plans provide the same benefits as the government Medicare program (Medicare, 2020).

Medicare Part A: Insurance that helps reimburse for inpatient hospital care and short-term skilled nursing care following an inpatient stay. Some hospice and HHC may be covered under Medicare Part A (Medicare, 2020).

Medicare Part B: Provides coverage for medical and behavioral health services, such as doctor visits, counseling, therapy, ambulance services, durable medical equipment (DME), outpatient care, and HHC (Medicare, 2020).

Medicare Part D: Provides insurance coverage for prescription drug medications (Medicare, 2020).

Assumptions

Based on previous research regarding access to health care, an assumption could be made that some participants may have experienced barriers to accessing HHC in the same manner as those trying to access general health care services. Barriers encountered may include structural barriers, such as availability of services, financial barriers including whether there is insurance coverage or other monetary resources and support, personal barriers such as cultural or ethnic considerations as well as acceptability of services being rendered in a home setting versus a traditional care setting (Karikari-Martin, 2010). For this study, I made the following assumptions: There would be enough available participants residing in low-income communities. The participants would be honest in their interview responses. Participants would comprehend the questions being asked. Participants would feel comfortable being interviewed.

Scope and Delimitations

Due to the limited nature of this topic around individuals in low-income neighborhoods and their experiences toward receiving and maintaining HHCS while residing in these communities, I conducted participant interviews. Interviews were the primary source of data collection for this study. Participants included adults over the age of 18 who reside within 10 low-income communities within an urban area in the Midwest. Participants must have used HHC within the previous 12-month period.

There could have been limitations finding enough participants who reside within one of the 10 communities who have received HHC within a 12-month period. Therefore, I planned to expand the participant pool by including an additional 10 communities and extend services received to 24 months. Another challenge could have been the participants’ ability to comprehend the interview questions. To address this, I ensured that questions were clear, concise, and presented at a basic level. Due to the COVID-19 pandemic and CDC guidelines, face-to-face interviews were allowed with social distancing guidelines in place; however, video conference or telephone interviews were as an option for participation. This could have presented limitations on who could participate in the interviews if they did not want a face-to-face meeting but did not have access to the technology needed for a virtual or telephone interview. All participants agreed to have a face-to-face interview.

Summary

This chapter introduced the research study and provided background information on HHCS. The problem statement, the need for the study, the purpose, the research question that was answered by the study were discussed. The chapter provided information on the framework that was used to help guide the study, the methodology used to develop the study, and key definitions to bring about clarity and understanding of terms used in the study. I identified assumptions that could be made based on previous research studies and potential limitations were identified that could have impacted the study. The next chapter will provide an overview of the research literature that was reviewed, the theoretical foundation used to examine access to HHCS, and key concepts that arose from the literature review.

Chapter 2: Literature Review

Introduction

There is an increase in the number of older adults in the United States living with comorbidities and physical injuries impeding mobility and normal functionality (Landers et al., 2016). Those most in need of HHC are underserved and of low SES (Goodridge, 2012). Underutilization of HHC may contribute to poor health outcomes and health disparities (Miner et al., 2017). Differences in race and ethnicity are factors in HHC use depending on whether individuals have caregivers in home, their level of functionality, or the severity of their illness or injury (Chase et al., 2018). The purpose of this research study was to gain knowledge regarding individuals' experiences of seeking and maintaining HHC while living in low-income communities. The goal was to obtain insight and advance knowledge that can guide health care professional patient treatment care plans.

Literature Search Strategy

To review the literature on the topic of HHC access, I used the following databases and search engines to locate existing research: MEDLINE with full text, SAGE Journals, Education Source, Google Scholar, EBSCO host, CINAHL Plus with full text, CMS, Ohio Department of Medicaid, and Thoreau multidatabase search. The search words I used when searching for peer-reviewed scholarly articles published between 2010-2022 were *HHC, homecare, long-term care, HHCS, postacute care, HHC access, low-income community, low socioeconomic status, HHC reimbursement, HHC barriers,* *Medicaid home health benefits, Medicare home health benefits,* and *home health utilization*.

Theoretical Foundation

The theoretical framework used for this study was the Penchansky and Thomas model of access developed in the early 1980s. This model was used to examine various aspects of access as the degree of fit between patient health care needs and the health care system's ability to meet the need (Saurman, 2015). Penchansky and Thomas explored seven dimensions of access; for this study, I combined two dimensions and focused on six in total: (a) affordability, (b) accessibility, (c) availability, (d) acceptability, (e) adequacy and accommodation, and (f) awareness.

Affordability is one dimension of access and is examined to determine whether services are reimbursable for both provider and consumer (Saurman, 2015). Accessibility is the second dimension of access and refers to geographical location; however, accessibility also includes enabling patients to receive needed care, the right care, from the right provider, in the right place, and at the right time (Saurman, 2015). Availability, the third dimension of access, examines whether ample services and resources are available to meet the needs of the consumers and communities served (Saurman, 2015). Acceptability is the fourth dimension and gauges consumers' comfort and trust levels with providers rendering care, including the provider's work experience, bedside manners, and personal characteristics, such as ethnicity, social class, and age compared to consumers' own characteristics (Saurman, 2015).

The fifth dimension is awareness, which entails more than knowing that a service is available; awareness involves understanding and using that information to explore options (Saurman, 2015). Awareness includes identifying the service need, knowing how the service is rendered, knowing when it is available and how to use the service, comprehending why the service would be used, and retaining that information (Saurman, 2015). Awareness recognizes health literacy as content and context specific; health literacy is the result of effective communication and involves accessing, understanding, and using the knowledge to make health care decisions (Saurman, 2015). Awareness is reciprocal and ensures that effective communication occurs throughout the community, with providers and with the impacted patient population (Saurman, 2015). The last dimension is accommodation and adequacy, which examines whether individuals can use services and considers scheduling, referrals, hours of operation, facility structure, and handicap accessibility. Because my focus here was HHC, I examined the ease of scheduling HHCS and the home structure, gauging the ability to safely place equipment in the home and whether the structure of the home was handicap accessible.

Penchansky and Thomas’s access model has been used to guide and influence health policy, such as the Patient Protection and Affordable Care Act (PPACA), by examining the impact of health policy on specific patient populations (Karikari-Martin, 2010). This access model allows individuals to examine the various aspects of access and affordability of health care services, which are a concern for elderly people who often consider not only their health insurance coverage when seeking care, but whether their financial situation can accommodate care (Fret et al., 2019). Awareness of service availability affects an individual’s ability to access services; they may not be advised that HHC is a service option or a covered benefit (Fret et al., 2019). When considering how to access health care, an individual’s home environment that displays specific household characteristics and income is important when assessing health care access holistically (da Costa et al., 2020). Ferris (2016) indicated that an appropriate housing environment is essential to safe home care. Some individuals needing HHCS may not obtain them due to a lack of trust and security in having someone they do not know in their home (Fret et al., 2019).

Availability determines how many relevant resources are available, such as personnel (professional and informal care givers who can assist in the home, such as family members) and technology for care coordination purposes (Fret et al., 2019). There is a demand for HHAs used in conjunction with HHCS who provide personal care in the home; some aides perform vital checks and administer medications under the supervision of a registered nurse or health care practitioner (Reichel, 2019). Availability of HHAs is a concern because they support HHCS and ADL for individuals needing HHC when family members cannot; however, compensation for HHAs remains as low as $11.12, which makes recruitment challenging (Reichel, 2019). Acceptability explores how patients experience their care, patient satisfaction, and patient attitudes toward their health care provider (Karikari-Martin, 2010).

Literature Review Key Concepts

Home Health Care Services

Momentum is building toward initiatives making home and community health care a focal point in the delivery of integrated care because of issues of population health and social determinants of health (O’Connor, 2017). HHC can assist indigenous older populations with postacute care and ADLs to avoid future emergency room visits and hospital readmissions (Chase et al., 2018). HHC can provide transitional care from hospital settings for those who need ongoing treatment and support (Gardham, 2016). The use of HHC varies depending on recipient gender, age, living circumstance, functional disability, and other sociodemographic factors (Kleiner, 2018). HHC is underutilized by racially diverse indigenous populations who could benefit from receiving care in the home (Miner et al., 2007). HHC is more cost effective than inpatient care for acute care illnesses; HHC costs an average of 52% less than inpatient care (Dwilson, 2018). Reduced cost health care settings such as HHC may be instrumental in lowering the cost of care and improving health outcomes (Maddox et al., 2018). HHC supports aging in place to help sustain quality of life for an aging population (Szanton, 2016).

Independence and sustaining current lifestyle are important to those who are aging and want to avoid nursing home care; HHC can make this possible (Lyn & Johnson, 2011). HHC can improve the well-being of individuals who are homebound and poor (Chen et al., 2018). For individuals who desire to stay at home rather than go to a nursing home or hospital, HHC is a cost-effective option that may be used if needed services are available (Gilmour, 2018). The population ages 65 and over is expected to grow and become 22% of the total population by 2040 in the United States; therefore, the need for HHC increasing (Joynt-Maddox, 2018). Little is known about health outcomes in a HHC setting for people of color and those residing in low-income neighborhoods; some research suggests that people of color do not fare well compared to other populations (Joynt-Maddox, 2018). Older adults experiencing financial hardships are more likely to want to use HHC; often, they have pre-existing chronic conditions and a greater physical need for assistance (Dupraz et al., 2020).

Health Insurance Coverage

Most adults ages 65 and older seeking HHC are covered by Medicare insurance, which requires patients to meet HHC criteria to be reimbursable (Jones, et al., 2017): (a) must be under a physician's care, (b) HHC must be medically necessary and certified by a physician, (c) patients must be homebound (unable to leave home or experience difficulty leaving home). CMS expanded Medicare Advantage plans to include coverage for HCS and HHCS previously not covered under Medicare, such as home cleaning, meals, social support, case management, transportation, and more, to address social determinants of health (Cabin, 2020). HHCS are covered under the Medicare Part B plan, which covers medically necessary services and preventive services (Medicare Basics, 2021). HHC is reimbursable at 100%; however, the coverage is provided in 60-day increments, so if services are necessary beyond 60 days, the physician must recertify continuation of care (Medicare Basics, 2021). HHCS must be rendered by a Medicare certified HHCA (Medicare Basics, 2021). Medicare benefits for HHC include skilled nursing care; HC (rendered by HHAs); occupational, physical, and speech therapy; social services: DME; and medical supplies (Medicare Basics, 2021). Medicare does not cover 24-hour in-home care, custodial or personal care, household services, or home meal delivery (American Association of Retired Persons, 2020).

Medicaid is a federal- and state-funded insurance program for low-income individuals; eligibility varies from state to state (John Hopkins Medicine, 2020). The Ohio Department of Medicaid (ODM) offers the Home Choice transitional program in which individuals are transitioned from an institutional setting, such as an inpatient hospital or nursing home setting, to a home- or community-based setting for transitional support and health care services (ODM, 2020). Program eligibility requirements include enrollment in Medicaid, over the age of 18, income to support community living, 90-day consecutive residency in a LTC facility, participation in a community needs assessment, and can be sufficiently addressed in a home- or community-based environment (ODM, 2020). Medicaid is an option for the most vulnerable populations; 74% of older adults who do not receive Medicaid benefits could finance an average amount of HHC for 2 years if they have discarded their assets (Johnson & Wang, 2019). Only 58% of adults ages 65 and over could finance 2 years of extensive HHC if they dissolved their assets (Johnson & Wang, 2019).

The U.S. Department of Veterans Affairs (VA) pays for HHC in full if the following criteria is met: patient must be 50% disabled as a result of a service-related illness or injury, approval from a physician, and HHC is rendered by the VA hospital-based HHC division (John Hopkins Medicine, 2020). HHC benefits cover medically necessary HC services resulting from the need of HHCS but do not cover non-medical HC (John Hopkins Medicine, 2020). Most third-party payors or commercial insurance plans provide coverage for HHC; however, benefits depend on the type of health plan selected (John Hopkins Medicine, 2020).

Socioeconomic Factors

Individuals of low SES are likely to have reduced life expectancy, multiple chronic conditions, and worse self-reported health (Aprey et al., 2017). HHC that is paid for can yield significant health outcomes; however, individuals receiving care often pay high out-of-pocket costs for their care (Johnson & Wang, 2019). Pathways to HHC can impact access through the following socioeconomic factors: (a) SES affects health status, which impacts HHC use; (b) home ownership or lack thereof influences options for HHC such as formal care like residential and nursing home care versus informal care, care provided by family member or other caregivers; (c) education levels are impacted by SES and whether individuals will understand how to navigate the health care system and comply with treatment plans; and (d) socioeconomic factors determine ability to pay for services, copayments, or deductibles if an individual is uninsured or underinsured (Freedman et al., 2004). There is a correlation between SES, health care access and health outcomes; a lack of financial resources could result in limited access to health care (McMaughan et al., 2020). Individuals with lower incomes and lower education levels are more willing to use home HHC when there is not an out-of-pocket expense required (Goodridge et al., 2012).

Environmental Factors

Home health nurses perform home assessments to determine whether care can be rendered safely in the home (Irani, 2020). Properly functioning roofs, plumbing, space, and heating/cooling systems are critical to providing HHC in a safe home environment (Ferris et al., 2016). Other factors to consider are physical barriers such as stairs, door size, and handrails, as they can impede one’s ability to receive sufficient HHC (Tsuchiya-Ito et al., 2019). Unsafe and poor sanitary conditions such as: clutter, filth, rodents, bugs, and poor lighting, may present health risks and interfere with HHCS being provided (Tsuchiya-Ito et al., 2019). The type of housing an individual resides in can impact service accommodation depending on services needed and whether the home is a single dwelling, multi-dwelling home or an apartment with multiple levels (Celeiro et al., 2016). Environmental factors must be considered when accessing HHCS to ensure care can be provided safely and effectively in the home and to ensure good health outcomes (Ferris, 2016).

Race/Ethnicity/Cultural Factors

Home health care utilization and access may be different for those who are non-European American and have a diverse racial and ethnic background (Chase et al., 2018). There are clinical factors such as comorbidity of chronic conditions, enabling factors including caregiver availability to assist with HC and ADL needs, and economic constraints such as limited income and resources that may impact access to care because of their culture, race, and ethnicity (Chase et al., 2018). Racial disparities exist in Medicare HHC utilization depending on the types of HHC needed (Yeboah-Korang, et al., 2011). Hispanics were less likely than European Americans to receive HHC, but when they did receive HHC Hispanics had more visits than European Americans (Yeboah-Korang, et al., 2011). African Americans received fewer visits from all clinical disciplines including nurses than European Americans (Yeboah-Korang, et al., 2011). AHHQI Chartbook (2019) provided insight into HHC use by Medicare beneficiaries with respect to race/ethnic demographics, clinical factors, and income. Below are some insights provided:

African American Medicare users who live alone and receive HHC account for 42.5% of users, Hispanic Medicare users who reside alone and receive HHC make up 29.5% of users, and all other races/ethnicities account for 37.8% of HHC Medicare users (AHHQI, 2019). The data shows that Hispanics make up 79.6% and African American of Medicare HHC users with three or more chronic conditions make up 79.7% of users All other races/ethnicities account for 80.5% (AHHQI, 2019). African American Medicare users with two or more ADL limitations account for 26.8% of users, Hispanics were 34.9%, and all other races accounted for 27.8% (AHHQI, 2019). For those Medicare users who report fair or poor health conditions, Hispanics was the highest reporting of 61.1% of users, African American account for 50.8% of users, all other race/ethnicities make up 46.2%, (AHHQI, 2019).

According to AHHQI, 84% of African American HHC Medicare users reported incomes below 200% of the federal poverty level (FPL). Hispanic HHC users account for 88.1% with incomes below the FPL, and all other races/ethnicities accounted for 64.0% below FPL (AHHQI, 2019). Income distribution by race and ethnicity for those with an annual income of $25,000 or below are as follows: Hispanics account for 83.2% of HHC Medicare users, African Americans were 76% of its users in this category, and all other races/ethnicities accounted for 56.4% of HHC users (AHHQI, 2019).

Overall, there is a broad income disparity (a little more than a 20% gap) for African Americans and Hispanic users of HHC, compared to other populations. Hispanics have slightly more challenges with ADL limitations, than African American and other race/ethnicities. African American and Hispanics report having fair to poor health more than other races and ethnicities, however all user groups equally report having three or more chronic conditions.

Availability of Home Health Care Providers

There are significant geographical differences in the availability of HHC throughout various regions of the United States (Wang et al., 2017). Counties within regions of the United States who have a large senior population, families with no transportation, median incomes, and those who are African American, Hispanic, and of non-European American races have a greater chance of having HHC available to them than their white counter parts due to the governments focus on population health (Wang et al., 2017). The number of Medicare HHCAs has fluctuated from 11, 317 in 2018 to 11, 221 in 2020 mostly due primarily to HHCAs consolidation with health care systems and other agencies (Statista, n.d.). Workforce availability is a concern in the HHC industry, as previously stated there is a shortage of HHAs due to low compensation (Reichel, 2019). There is high turnover with nurses particularly registered nurses (RNs) and concern around clinical expertise and training in skilled areas of care (Landers et al., 2016). In

2016, 78% of HHCAs were certified by Medicaid whereas 98% of HHAs were Medicare certified, however being certified did not enhance compensation (National Center for Health Statistics, 2019).

There is another home-based care programs that offer the same types of services rendered by HHCAs such as the VA Home-based Primary Care program which provides interdisciplinary home-based medical care to veterans who need ADL support, skilled nursing care, and case management (Landers, et al., 2016). Another program available to elderly individuals needing home health or HHC is the Program of All-Inclusive Care for the Elderly also known as PACE which is a Medicare and Medicaid program where PACE organizations enter a contractual agreement with various providers to offer supportive services, nursing home level, and medical treatment throughout various communities (Landers, et al., 2016).

Summary and Conclusions

HHC is becoming an essential service for an aging population in need of long-term care and desiring to age in place at home versus a nursing home facility (Victor et al., 2018). There is minimal research pertaining to the experiences of adults residing in low-income communities around challenges to obtaining and maintaining HHCS (Suurmond, et al., 2016). HHCS are a cost-effective option to health care treatment in lieu of more costly care provided in inpatient and nursing home settings (Reichel, 2019). A thorough research of peer-reviewed articles containing the following subjects: HHC, low-income, HHC access, low-income, community, low SES, home health reimbursement, HHC barriers, Medicaid home health benefits, Medicare home health benefits, long-term care, home care, and home health utilization, were used to explore previous research related to HHCS in low-income communities to help contribute to this research study to expand and add knowledge to patient experiences and experiences with obtaining HHCS. The literature included detail around socio economic factors, race, cultural, and ethnicity factors, environmental factors, health insurance coverage, provider, and service availability. There is no research found that examines the experiences of adults receiving and maintaining HHCS in low-income communities. This study will explore barriers to accessing HHC in low-income communities so that health care providers can proactively provide solutions to ensure that vulnerable populations will have access to care without restrictions or challenges. Interviewing individuals residing in low-income neighborhoods who have received HHCS will provide detail of their experiences and experiences to determine how services can be more improved and more accessible.

Chapter 3: Research Method

Introduction

The purpose of this qualitative research study was to gain knowledge of the experiences of individuals residing in low-income communities around obtaining and maintaining HHCS. The goal was to understand how individuals experience access to HHCS and to advance knowledge that can help create solutions to alleviate barriers to receiving HHCS. Additionally, this information can help providers create appropriate policies and procedures to provide more efficient cost-effective health care (CMS 2003). Data for this study were collected through structured interviews using open-ended questions to explore the experiences around obtaining and maintaining HHC. Participants were individuals currently receiving or who have previously received HHCS. This chapter will include the research design and rationale, the role of the researcher, the research methodology used, issues of trustworthiness, and a summary.

Research Design and Rationale

The research question used to guide this study was:

What are the experiences of individuals toward accessing and maintaining HHCS in low-income communities?

The central concept of the study was understanding the experiences of accessing and retaining HHCS among adults living in low-income communities. The Penchansky and Thomas model of access was the theoretical framework used to guide the research study.

Three types of research can be used to conduct a study: qualitative, quantitative, and mixed methods (Creswell & Creswell, 2018). Quantitative research is a statistical approach which limits bias due to its objectivity; however, it does not provide the in-depth detail necessary to gain knowledge of the experiences of individuals with a phenomenon (Yin, 2016). In this research study, I conducted interviews to gather data this allowed participants to describe their experiences, feelings, and opinions about obtaining and maintaining HHC. Therefore, a qualitative approach was most appropriate for this study, rather than a quantitative or mixed-methods approach (Creswell & Creswell, 2018). Phenomenological qualitative research allows a researcher to gain insight into individual experiences and viewpoints in a natural setting instead of a controlled environment (Creswell & Creswell, 2018).

A myriad of approaches could be used in qualitative studies. In narrative research, a researcher gathers stories of individuals' lives concluding with viewpoints from both participants and the researcher (Patton, 2018). Narrative research can be used to explore issues around individuals being oppressed and to collect personal stories about experiences of oppression (Ravitch & Carl, 2016). The narrative approach was not the best approach for this study because this study was not related to individuals who have experienced life issues with respect to oppression. Grounded theory is a research approach in which a researcher develops theory based on the views of the participants and involves various stages of data collection (Ravitch & Carl, 2016). This research study was not conducted to develop a theory, but rather to examine individuals' lived experiences. Ethnography is the study of cultural groups in natural settings based on experiences in a field setting. A researcher studies the cultural group over time by collecting information via interviews and observations (Ravitch & Carl, 2016). The ethnography approach was not the best approach for this study as it focuses on studying cultural groups. In this study, a basic qualitative study was conducted using interviews to gain knowledge around individual experiences and not cultural group patterns of shared behavior.

Phenomenological research culminates individual experiences of a phenomenon in which candidates have experienced the same phenomenon (Creswell & Creswell, 2018). A phenomenological design was a good approach for this study because this study was explorative; I sought to obtain information about individual experiences accessing services, human experiences about a phenomenon or an encounter with the same event or occurrence. For this research study a phenomenological qualitative study gave the respondents the opportunity to be open and share their experiences so I could gather information to add knowledge, impact policy, and effect social change. This was the best approach for this study.

Role of the Researcher

My role was to conduct personal interviews with individuals who were receiving or had received HHCS to gather information on their experiences of accessing and maintaining services while residing in low-income communities. Due to COVID-19, I gave the option for video conference interviews; however, all participants agreed to have face-to-face interviews, which allowed me to observe body language and facial expressions to capture a better understanding of their feelings. All interviews were recorded via the computer audio recording functionality so I could review and recapture critical details for additional insight. As a researcher, I would have disclosed any bias I might have had pertaining to this research study. Although I presently work in health care, I did not have any current or previous work experience in HHC. I did not have supervisory power or a personal or professional relationship with any of the participants. I did not have any conflicts of interest or bias with participants involved in this study.

Ethical Responsibilities

My role as a researcher was to ensure that I fully disclosed the purpose of the research study and to ensure trust and confidentiality and to protect respondents from culpability. I demonstrated respect, honored promises given, caused no harm, and did not pressure anyone to participate in this study (Rubin & Rubin, 2012). All tapes and transcripts will be maintained and kept for a minimum of 5 years (Walden University, 2022). If identifiable health information was disclosed during the interview process, records will be maintained for a minimum of 6 years (HHS, 2018).

I offered a $10.00 Walmart gift card to compensate participants for their time and burden. Compensation may be offered to research participants for the fair value of their time, research-related burdens, and their contributions to the study; research studies can be akin to employment, which is also compensated (Gelinas et al., 2018). My goal for compensation was to support recruitment and retention efforts as all research participants would be compensated equally. The value of the gift card was set at $10.00 to mitigate coercion and undue influence; compensation was solely for participants taking time to contribute to the study. Gift cards were hand delivered to participants at their homes after interviews were completed.

Methodology

Participant Selection Logic

All participants in this study were required to meet inclusion criteria. The criteria for inclusion in the study was: adults ages 18 and over who were currently receiving or had received HHCS in the past 12 months and resided in low-income neighborhoods. Low-income neighborhoods were defined as contiguous areas within an urban area of a Midwest city in which 24% or more of the population has an annual household income at or below the federal poverty level (Assistant Secretary for Planning and Evaluation, 2021).

The recruitment strategy was two-fold. First, I created a letter of cooperation (Appendix A) to request permission to place flyers (Appendix B) to participate in my research study in all Metropolitan Housing Authority (MHA) apartment buildings and community room billboards in a total of 12 adult day care and senior centers all located in low-income neighborhoods. Second, I contacted community health centers, libraries, and community recreation centers to place recruitment flyers in their locations and requested the opportunity to present the research study at these various locations before or after scheduled activities. These presentations would help me attract interested participants who were already present for the activity they were attending.

Sample Size

For qualitative research studies, there are four common methods used for sampling. First, there is purposive sampling when a researcher seeks to meet specific criteria (Patton, 2016). Second, snowball sampling is when a researcher depends on participants to draw other participants into the research study (Patton, 2015). The third method, quota sampling, is when a tailored sample is taken that is in proportion to a characteristic or trait of a population when participants are chosen from various subgroups (Patton, 2015). Last, convenience sampling is when a researcher collects data from those participants who are convenient (Patton, 2015). Saturation, or redundancy, is when a researcher stops collecting data because there are no new revelations or insights to be discovered (Creswell, 2018).

Sample size in qualitative research can be determined in three ways. First, a researcher can cite what is recommended by qualitative methodologists (Marshall et al., 2013). Second, a researcher can cite methodologies used in previous research studies with a similar design and interview questions (Marshall et al., 2013). Last, a researcher can demonstrate data saturation (Marshall et al., 2013). Saturation for a phenomenological qualitative research study typically occurs with five –25 participants, with six being the suggested number; however, a researcher must go above saturation to ensure no new information or concepts arise (Latham, 2013). For this phenomenological qualitative study, I selected 14 participants for interviews to ensure saturation.

Instrumentation

For this research study, I developed an interview guide (Appendix C) to provide a framework to organize and sequence the questions and determine which questions may lead to follow-up questions to ensure the proper time was allotted to explore the information provided by the participant. The interview guide contains a list of questions to ensure consistency in questioning among participants to make the best use of my time

(Patton, 2015). The interview guide consists of a list of primary themes and follow-up questions as needed. The theme questions addressed the primary content for the research study, which allowed participants to speak openly about their experiences (Kallio et al., 2016). The main questions were asked of every participant, and the interviews began with a general ice-breaker question to gain knowledge about the participant; then, I led into more logical or emotional questions to gather in-depth detail about their experiences (Kallio et al., 2016). The main questions ended with lighter themes to conclude the interview (Kallio et al., 2016). I used follow-up questions to bring clarification to primary themes to make it easier for participants to comprehend (Kallio et al., 2016). Follow-up questions were spontaneous based on participant responses and the need to gain additional insight and clarity of their answers (Kallio et al., 2016).

Pilot Study

A pilot study was conducted to discover potential barriers or concerns pertaining to recruitment of candidates, to engage in a trial run as a researcher in a compassionate and culturally competent manner, to better understand the interview process, to discover potential challenges that might arise, and to refine the interview questions to gain the best insight and knowledge about participant experiences (Kim, 2019). I requested approval from the Walden University Institutional Review Board (IRB) to conduct the pilot study, which mirrored and followed the same recruitment, participation, and data collection method as the full research study but on a miniscule scale. A smaller sample size between 10% and 15% of the full study was selected for the pilot study (Connelly, 2008). The percentage chosen for the pilot study was reasonable for a qualitative study with a small sample size (Connelly, 2008).

The pilot study candidates were interviewed to test the research study and address any improvements necessary (Connelly, 2008). The number of individuals used in a pilot study varies; many researchers suggest a minimum of five participants (Dworkin, 2012). For this pilot study, I interviewed three participants. To ensure validity in the study, interviews were conducted at different times and in different locations; exact questions were asked in the same manner to each participant.

Data Collection

Interviews are one of the most common forms of data collection for qualitative research and are used to examine the experiences, beliefs, views, and motivations of individual participants (Gill et al., 2008). There are three forms of interviews. First is the structured interview where a predetermined set of questions are asked verbally with minimal variation and no capacity for follow-up questions; these are typically conducted in a face-to-face setting (Patton, 2015). Second is the unstructured interview which is more liberal; there is minimal organization and structure to the interview process and questions are developed based on participant responses (Patton, 2015). Last, there are semi structured interviews that include key questions regarding key areas being examined; these interviews also allow for further expansion to gain additional knowledge and detail from the participant (Patton, 2015). For this study, I conducted semi structured interviews. Interviews were recorded using a computer recorder. Recordings were sent to the NVivo transcription service to be transcribed. Interviews were conducted in the participants place of choice i.e., local community center, library, on the property of their residence, or in their home. One hour was the allotted for interviews to ensure enough time to conduct the interview and allow for further elaboration when necessary.

In the event participant recruitment was low, the follow up plan was to request approval to recruit participants at city community recreation centers a total of 5 recreation centers all located within low-income neighborhoods. The community recreation centers are open to the public and are owned and operated by the city. They offer various recreational activities and programs to residents of all ages residing within the city's low-income community in the Midwest region of the U.S.

As previously stated, flyers were posted in common areas of MHA buildings and public community recreation centers. The flyers contained information that described the study, eligibility requirements, and included my contact information. I was allowed to present a brief description of the study, eligibility requirements, and my contact information at center activities. I developed a brief screening questionnaire that asked potential participants if they were over the age of 18 and if they had received HHCS within the last 12 months to ensure participants met the eligibility criteria. When a participant contacted me by telephone, I reviewed the screening questionnaire with them to ensure that they were eligible for the study. If they contacted me by email, I emailed them the screening questionnaire. Once I determined that the participant met the criteria for the research study, I explained what would happen during the interview process, my ethical responsibilities to ensure their safety and privacy including the informed consent form (Appendix E). I discussed data storage, and retention, their rights and responsibilities including access to their data, discussed the times and options for a meeting place of the participants choice to conduct the interview. If they were a potential participant, I explained that I would provide them with the informed consent form prior to the interview either by email or mail, so they could review it. They sent it back by email or returned it in person at the time of the interview, depending on if the interview was conducted via video conference, phone, or face-to-face. I contacted someone at the meeting location and scheduled a date and time for a meeting room, once I contacted the participant to confirm the interview.

At the beginning of each interview, I reviewed the informed consent, to ensure that the participant did not have any questions and ensured that they agreed to participate. Each participant was asked a set of questions (Appendix D) as part of the interview process which included follow up questions, when necessary; however, the interview was kept to no longer than one hour. Upon completion of interview, each participant was thanked for their participation, and I explained how their answers would be helpful to the research. Participants were advised that a summary of results would be available to them once results were analyzed. Also, they were informed that a follow up call or member check would occur to review my interpretation of the information provided and to gain their feedback (Patton, 2015). Participants were asked if they were interested in participating in a follow up interview, should further clarification around the details of their interview would be needed and all responded yes. As previously stated, each participant received the $10.00 Walmart gift card incentive for their time and participation.

Data Analysis Plan

Each interview required data analysis to determine the meaning of the information collected provided by participants (Creswell & Creswell, 2018). A phenomenological approach was used to analyze the data, the interviews were transcribed to develop a textual and structural description of the respondent's experiences understanding the condition and situation in which they experienced the phenomena to gain an overall view of their experiences (Netzer & Mayseless, 2014). Interviews and notes were imported, auto transcribed, and coded using the data analysis software program NVivo 12 Pro. The process for data analysis included the following: first, each individual transcript was reviewed multiple times to gain insight into the opinions and experiences of participants. Second, significant statements were coded, then placed into categories with themes in the vernacular used by the participants to capture a summative essence of the interview data (Saldana, 2016). Third, discrepancies were addressed by further analyzing the information to avoid drawing my own conclusions through impression or guesstimating (Saldana, 2016). Fourth, themes will be examined to find correlation between themes (Netzer & Mayseless, 2014). Themes will be clustered or grouped together to develop a description of participants experiences (Netzer & Mayseless, 2014).

Issues of Trustworthiness

Validity, also referred as trustworthiness, is a process qualitative researcher's use to achieve complexity through assessing the rigor of a research study (Ravitch & Carl, 2016). There are five different ways to approach validity they include: (a) descriptive validity is the accuracy of the data being collected, interpretive validity is the correlation between the meaning imputed to participants actions and the actual participants experiences, (b) theoretical validity is when a study describes a phenomena being studied, (c) generalizability validity questions whether outcomes would exist if the data was different, and (d) evaluative validity examines whether data can be described and understood by the researcher without judgement or being evaluative (Ravitch & Carl, 2016). Enhancing the credibility of qualitative research is essential to producing a quality research study (Patton, 2015). The trustworthiness of qualitative research usually includes terms such as: credibility, dependability, conformability, authenticity, and transferability (Elo, et al., 2014). There are four related inquiry elements that the credibility of qualitative research depends on: systematic, in-depth field works that yields quality data, systematic and conscientious analysis of data with the focus on issues of credibility, the credibility of the researcher, and the readers and users views in the value of qualitative inquiry (Patton, 2015).

Credibility

Credibility is when the researcher assesses the complexities presented in a study and address the patterns that cannot be easily explained (Ravitch & Carl, 2016). Prolonged engagement where the researcher spends an extended period of time and contact with respondents to evaluate distortion possibilities and their relevance or importance, is one approach to credibility (Lincoln & Guba, 1986). Persistent observation is a thorough assessment of elements that are very important resulting from prolonged engagement (Lincoln & Guba, 1986). There are four types of triangulation which include data sources, investigator triangulation consisting of two or more researchers providing different observations and outcomes, different methods, and theoretical triangulation which is the use of hypotheses or theories when exploring a phenomenon (Lincoln & Guba, 1986). Peer debriefing, is being transparent before a professional peer who has no personal interest in the research, assists in creating working hypotheses, create and test evolving designs, obtains pure and authentic emotions (Lincoln & Guba, 1986). Last, member checks can be performed to ensure credibility by sharing the investigator's understanding of the respondent's interview and soliciting the respondent's feedback, and formal testing of the final results by sharing them with a representative sample of stakeholders (Lincoln & Guba, 1986). For this study, to ensure credibility I used the participant interviews as my data source, which was obtained from different participants, at different times, and at different locations. I compared the interviews with the observations of the participants during the interviews and performed member checks to obtain feedback from the participant to ensure clarity and to further validate the interview data (Lincoln & Guba, 1986).

Transferability

Transferability is a way that the findings of qualitative studies can be transferable to broader contexts without losing context richness (Ravitch & Carl, 2016). Transferability is rich descriptive data about the context so that opinions about the degree of fit may be made by others who may want to use all or parts of the findings in a different study (Lincoln & Guba, 1986). To ensure transferability, I provided descriptions and rich content including detail about the locations in which I conducted the research study, the selection of participants, and the method used to collect the data so that this study can be replicated to conduct additional research (Ravitch & Carl, 2016).

Dependability

Dependability is the consistency and stability of data over time (Ravitch & Carl, 2016). For this study to ensure dependability, an audit review was conducted based on how the data was collected and analyzed including descriptions of the codes and the rationale for the themes (Patton, 2015).

Confirmability

Confirmability in qualitative research does not claim objectivity, but strives to have confirmable data, neutrality, and reflexivity to ensure freedom from researcher bias (Ravitch & Carl, 2016). One goal of confirmability is to check and recheck the data to ensure that the outcomes would be the same if the studied was conducted by others (Ravitch & Carl, 2016). For this study, to ensure confirmability I used the process of reflexivity by focusing on self-knowledge to gain a clear understanding of myself to monitor bias, personal beliefs, and experiences to maintain objectivity and credibility in the research study (Ravitch & Carl, 2016).

Ethical Procedures

To gain access to participants a letter of cooperation (Appendix A) was sent to MHA, senior centers, and adult day care centers as previously stated for approval to place recruitment flyers in their locations. The recruitment flyer (Appendix B) described the purpose of the study, the time involved in the study, the participant criteria for the study, and my contact information including email and phone number to contact me if they were interested in participating in the study. The screening tool (Appendix C) was used to screen participants to ensure they met the criteria to engage in the research study. I received approval from the Walden University IRB, approval number 02-08-0477082 to ensure that the research including human subjects would be conducted according to and in agreement with all federal, institutional, and university guidelines.

An ethical concern for recruitment is ensuring that participants are safe and understand that their participation is voluntary and that there is no pressure to participate. I addressed this concern by clearly communicating that participation was voluntary and included the same verbiage in the flyer that was posted at the recruitment locations. I made certain that research questions were clear and concise and devoid of sensitive content (Walden University, n.d.). To further address ethical concerns and to ensure that participants were fully educated around the research study an informed consent form was reviewed with and completed by each participant.

An ethical concern related to data collection is receiving honest feedback from participants. To address this concern, I guaranteed their confidentiality and privacy by password protecting information stored on my computer so that no one other than myself has access to information. Checking and rechecking the data was done to confirm accuracy and the results of the data which was another way to address ethical concerns around participants providing incorrect information (Noble & Smith, 2015). Participants can have access to their interview information when requested. All transcripts will be maintained and kept for a minimum of 5 years (Walden University, 2022). I had no conflicts of interest; I did not recruit any subjects from my employer or any organization that I have any affiliation.

Summary

A phenomenological qualitative design was the approach used for this study. This design allowed me to obtain knowledge and information around the experiences participants encountered with access to seeking and maintaining home health care in low-income communities. My role as the researcher was to conduct face-to-face interviews to gather data for this research study. I disclosed the purpose of this research study and protected participants from culpability by gaining their trust and maintaining their privacy and confidentiality. Participants received a $10.00 gift card to Walmart for their time and contribution to the research study. The criteria for selection included individual adults aged 18 and over currently receiving HHCS or have received HHCS within the past 12 months who reside in low-income communities. A flyer was placed in MHA apartment buildings and community boards as well as adult day care and senior centers with their permission to recruit participants for this research study. A selection of 14 participants were chosen to participant in the study to ensure saturation. An interview guide was used to organize the sequence of the questions with follow up questions being more spontaneous based on respondent’s answers. A pilot study was conducted with a smaller participant sample to inform and refine the main research study. Again, data was collected by conducting semi-structed interviews, which is one of the most common forms of data collection for qualitative research (Gill, et al., 2008). Once the interviews were completed, the interview data was imported, transcribed, and coded using NVivo 12

Pro, a data analysis software program. Each interview was examined several times so that I could collect detail around the experiences of the participants. The trustworthiness of this qualitative study included the following:

1. Ensuring credibility by performing member checks to gain feedback from participants to clarify data.
2. Providing descriptions and content sample size, participants, participant selection, data collection, and analysis method to ensure transferability.
3. Auditing responses, analyzing data, identifying description codes and the rationale for the themes to support the dependability of the study.
4. Clearly understanding myself to understand monitor bias, personal beliefs, and my own experiences to remain credible and objective to ensure confirmability.

Ethical procedures were addressed by developing a letter of cooperation for recruitment locations, a flyer that was posted up in recruitment locations to recruit participants for this study, a screening tool, and consent forms for face to face, video conferencing, and pilot study were developed, if needed.

Ensuring participants understood that the research study was strictly voluntary, and that their information is being kept private and confidential by placing paper documents in secure locked locations as well as password protecting computer data to address ethical concerns with respect to recruitment and data collection.

Chapter 4: Results

Introduction

In this chapter, I present the results of my exploratory qualitative phenomenological research study of the lived experiences with access to seeking and maintaining HHCS in low-income communities. I interviewed 14 participants over the age of 18 to collect data and gain insight regarding their experiences with accessing HHCS in low-income neighborhoods. The purpose of this qualitative research study was to understand the experiences of individuals residing in low-income communities regarding accessing and maintaining HHCS. The goal was to gain insight into how individuals experience access to HHCS while residing in low-income communities to enhance knowledge to help appropriately direct patient care needs. Further, the information can help providers streamline care efficiency (i.e., policies, procedures, workflows, etc.) to help reduce the cost of care (CMS, 2019). The research question that guided this study was: What are the experiences of individuals toward accessing and maintaining HHCS services in low-income communities? In this chapter, I will describe the pilot study, setting, participant demographics, the data collection process, data analysis, evidence of trustworthiness, results, and summary.

Pilot Study

For the pilot study, I interviewed three participants who resided in low-income communities. Flyers were posted throughout apartment buildings, senior centers, and an adult day care center so that potential participants could reach out to me to participate in the pilot study. I screened each participant to ensure they met the research study criteria.

Once the criteria were met, participants indicated they wanted to have the interviews where they lived in their housing unit. Each participant and I worked together with an onsite social service coordinator to find a date, time, and a private room to schedule the interviews. The interviews took place onsite at the residential apartment building in a reserved and locked private community room where no other residents were allowed to be present. Each participant received, reviewed, and signed the informed consent form prior to the interview. I used an interview guide (Appendix C) to conduct the pilot study to determine if the questions were clear and understood by the participant or if the interview questions needed to be adjusted. Each interview was audio recorded and I took notes during each interview.

The pilot study revealed that more specific questions needed to be asked to understand the various types of HHCS being provided for participants. The interview guide questions were updated and finalized to include specific service offerings provided by the HHA. The specific services added to the questions in the interview guide included home care (personal services i.e., bathing, cooking, and cleaning), medical care, nursing care, and physical and occupational therapy. Updating the interview guide provided greater clarity around the services participants were receiving from HHCAs, and it helped me gain better insight into participant experiences. The finalized questions were used to conduct the research study.

Setting

The research study interviews took place in person and onsite at two residential apartment communities located in two low-income neighborhoods where participants resided. Each participant had a scheduled interview that was conducted in a locked private community room in the apartment building where no other residents were present.

Demographics

For this study, no demographic information was collected.

Data Collection

The research study included a total of 14 participants. I conducted semi structured interviews onsite at a residential housing apartment building in a low-income community in an urban area in the Midwest. Flyers were posted throughout the apartment buildings to recruit potential participants for the study. Each resident who was interested in participating in the research study contacted me directly by telephone. I prescreened each person to determine whether they met the criteria to participate in the research study. Once I determined they met the criteria and could participate, both the participant and I contacted the onsite social service coordinator to schedule a private room at a date and time convenient for both the participant and me. One hour was allotted for each interview; the shortest interview lasted 40 minutes and the longest interview was 90 minutes. The average length of interviews was 60 minutes. I conducted interviews from March 14, 2022, through March 28, 2022.

Each participant received the informed consent form. I reviewed the informed consent with the participant, and each participant signed the informed consent form prior to their interview. For the interviews, I used a printed copy of the interview guide for each participant. I assigned a number to the participant, which was documented on the interview guide so that both the audio recording, transcribed data, notes, and nonverbal gesture documentation were aligned. Each interview was recorded on a laptop media wave recorder and then transcribed through NVivo 12 Pro. A few of the recorded files were not transcribed accurately, which required manual transcription to ensure that interview details were captured appropriately. After each interview, I thanked each participant for their participation and provided them with a gift card to compensate for the time spent with me for this research study. Also, I asked for the participant's telephone number to perform a member check follow-up call to ensure accuracy and resonance with their experiences. I completed 14 follow-up phone calls to review my interpretation of the information received and to gain participants' feedback. All the participants agreed to my understanding of the interview and no changes were made.

Data Analysis

Each participant's interview and notes were imported and auto transcribed in NVivo. First, I reviewed each individual transcript and notes several times to gain knowledge about participants' experiences with access to HHCS in low-income communities (Hagens et al., 2009). Second, I made corrections to each transcript where necessary when the translation was not clear or accurate (Hagens et al., 2009). Third, I coded significant statements made during the interviews and placed them into categories and themes in the dialect spoken by the participants to gauge the tenor of the interview data (Saldana, 2016). Fourth, I found no discrepancies among the interviews (Saldana, 2016). Last, I reviewed themes for correlation and then grouped them together to describe the participants' experiences (Zhang & Zhu, 2017).

Codes

The codes generated from significant interview statements were: appropriate dress for work, behavior on the job, boundaries between client and worker, HHC worker safety, community location, delay for services, handicap accessibility, health insurance, happy with HHCS, not happy with HHCS, HHA services, home health agencies, incompatibility, job knowledge, lack of communication, mental health and substance abuse, nurse services, participant personal safety, race and ethnicity, HHA salary, scheduling HHCS, service availability, staffing availability, personal stolen items, support system, timeliness of care, trust in caregivers, and work habits. After creating the codes, I reviewed and organized the codes by combining similar codes together. This is where I identified patterns from which categories and themes emerged to answer the research question. The codes, categories, and themes that emerged from the data analysis can be found below in Table 1. The themes included (a) type of HHCS and competent staff, (b) acceptable behaviors and conduct, (c) accommodation and ease of scheduling, (d) availability and access to HHCS, (e) affordable HHCS, and (f) awareness and communication.

Categories were generated after careful analysis of participant responses, which yielded the results and outcomes of this study. The categories that emerged were: (a) HHC worker job knowledge and ability to provide quality HHCS, (b) community environment and impact on accessing HHCS, (c) HHC workers' poor attitudes and participants' lack of trust, (d) problems with scheduling HHCS, (e) equipment use and apartments with handicap accessibility, (f) health insurance coverage, (g) Council on

Aging (COA) and family support, (h) timeliness of HHCS, (i) limited availability, (j) HHC worker competitive wages, (k) communication between HHC workers and participant, (l) safe working environment, (m) participant concerns about their living environment and personal safety, (n) types of HHCS, (o) HHC workers stealing from home, (p) poor work performance, (q) satisfaction with services, and (r) overall dissatisfaction with HHCS. The themes and the corresponding participant responses are detailed below in the results section of this chapter. There were no discrepant interviews.

Table 1

Themes, Codes, Categories

Themes	Categories	Codes
Types of HHCS and competent staff	HHC worker job knowledge Ability to provide quality HHCS	Job knowledge Nurse services Physical therapy HHCS
Acceptable behaviors and conduct	HHC workers' attitudes Participants' lack of trust Work ethic	Appropriate dress for work Boundaries Incompatibility Behavior on the job Trust in caregivers Stealing out of home Work habits
Accommodation and ease of scheduling	Timeliness of scheduling Handicap accessibility	Scheduling HHCS Equipment use Handicap accessibility
Availability and access to HHCS	Positive and negative experiences Competitive wages Staffing shortages HHC worker and participant safety	Delay/availability of HHCS Staff availability HHA salary Participant race and ethnicity HHCA concerns Dependable Helpful Mental health and substance abuse Community safety Participant satisfaction
Affordable HHCS	Financial support	Health insurance coverage Support system
Communication	Three-way dialog	Lack of communication

Issues of Trustworthiness

To ensure evidence of trustworthiness, also referred to as *validity*, is worthy of consideration when having protocols and procedures in place that support the efficacy of the research (Connelly, 2016). Trustworthiness in qualitative research usually includes the following criteria: credibility, dependability, transferability, and confirmability (Connelly, 2016). In this research study, I established trustworthiness through descriptive validity by ensuring accuracy of the data collected (Ravitch & Carl, 2016).

Credibility

A credible research study provides confidence that the results are accurate and true (Connelly, 2016). For this research study, I established credibility by spending a considerable amount of time with each participant and repeating back their responses during the interview to gain clarity and to ensure I understood their responses. I asked participants to elaborate on responses that were unclear and that warranted further explanation. I observed nonverbal gestures for a prolonged period to gain greater insight into their responses and experiences. I conducted a follow-up call to review the transcript and my understanding of their responses with each participant to receive feedback to further validate the data. No changes were required by the participants. The participants described their personal experiences genuinely and elaborated when asked, which helped provide a deeper understanding of their experiences.

Dependability

A phenomenological study of a participant’s experience may be the same or similar from time to time which establishes dependability (Connelly, 2016). Data for this study was collected from the interviews conducted and was analyzed based on the participant responses. In this study, the experiences of the participants were similar I asked clear and concise questions to ensure that the responses provided were answered based on the questions asked. When responses were not clear, the participant was asked to elaborate to ensure understanding. All participants received and signed the informed consent form and all interview appointments scheduled were maintained which also demonstrates dependability.

Confirmability

Consistency in the findings of a research study that is void of researcher bias allows the study to be repeated and obtain the same consistency is confirmability of research (Connelly, 2016). For this research study I used a process called triangulation, triangulation of data was done by cross checking the consistency of information derived from the participants. I reviewed notations of participant behaviors and gestures for consistency. The participant findings were consistent, their gestures and behaviors were similar when describing their experiences while receiving HHCS. I focused on reflexivity around HHCS which I have minimal knowledge of HHCS to ensure that there was no personal bias to maintain credibility. I remained objective not to assume anything or inject my personal views or opinions based on the participant responses again to ensure credibility and validity.

Transferability

Findings that could be useful to individuals in other settings is considered transferability of a research study (Connelly, 2016). In this research study, I had the opportunity to interview different participants at different times and at different locations. I compared the interviews, different behaviors, and gestures to determine if there was consistency. This research study was conducted using set protocols such as: informed consent, an interview guide, and screening tool which allows for this study to be replicated in a different setting with different participants.

Results

There was one research question for this research study: What are the experiences of individuals towards accessing and maintaining HHCS in low-income communities? Six themes emerged from the data analysis. The six themes, the description of the themes, and supporting participant quotes are presented below.

Types of HHCS and Competent Staff

Participants described the types of services they received from their HHC staff. They also discussed their experiences and expressed concern about some of the HHC workers ability to perform the tasks of caring for and assisting participants with their needs. Some participants indicated that the HHC staff did not understand their work responsibilities. This brought concern to participants questioning whether the HHC workers could perform the needed tasks. One participant suggested that HHC staff should receive continuing education to ensure that they are competent in performing their jobs. Participant 13 stated:

> I was a HHA when I was an aide, we had in-service training like one Saturday of the month. They would do a special training and we would talk about what we could do or couldn’t do, and I think that is still needed.

Participant 8 stated: “She didn’t know her job. She didn’t understand her job. The HHA act like she didn’t know how to take direction. She waited for me to tell her exactly what to do.”

Participant 6 stated:

> I have a concern about adequate services and the lack of communication. I’m not going to sit in the house and try to think about whether she (HHA) comin’ or ain’t comin’ she should call me. My aide is not always reliable. She should call me the day before and say, “Ms. Participant, I’ll be there. The younger girls aren’t able to be on time no way but call me and let me know if you can’t come. I used to be a nurse aide to before I retired. I did this kind of work I know what it takes. But I was always honest with my patients. I told them if I couldn’t come that day, I tell them I’m not going to be there today.

There were participants who stated they had multiple HHC workers because they did not perform their jobs well, had poor attitudes, or they did not trust them. Participant 7 stated: “This is about my fifth HHA, I had a HHA that came and stayed on her cell phone. If you work for me, I don’t want to listen to your conversation. They just didn’t want to work.”

The participants described the various types of HHCS that they received through the HHCAs. Half of the participants had both nursing care provided by a nurse and assisted living care provided by an HHA. Some participants had in-home physical therapy. Often, these participants cannot perform the essential and personal household duties particularly after a procedure or surgery. They were often transitioned from surgical or inpatient care with a HHCA that helped support them with their ADL. The frequency by which they receive assistance from the HHCA varies amongst the participants and depends on a myriad of factors one being need and medical necessity. Participants described their HHCS with the following statements: Participant 1 stated: “My HHA gives me a bath, cleans my apartment, she does everything including drive me to the grocery store. I see a nurse also she comes by and take my vitals.” Participant 2 stated: “I had HHA who did light cleaning, she really helped me clean my bathroom and keep it sanitized. I did not have a nurse, but when I had my knee replacement, they sent me home with physical therapy.”

Participant 3 stated:

> I had a nurse who came to check my vitals, check my oxygen and tubes. I had a HHA who came to help me with household chores and bathing because I was previously in rehab for a broken arm and needed help.

Participant 4 stated:

> I had a HHA, she helped me in my home with taking a shower, washing my clothes, and cleaning my house. The HHA also helped me when I got my colonoscopy, she picked me up and drove me back home and she didn’t even get paid for doing that. If I need to go to the grocery store, she will take me, if I need my windows washed. She will wash my windows.

Participant 5 stated, “I have a nurse and a HHA. The nurse did medication check and checked my vitals. The HHA helped me with getting in and out of the bathtub and light weight cleaned my apartment.”

Participant 6 stated:

> I just have a HHA, she helps me make my bed up, clean my bathroom, vacuum, my kitchen, and my stove because I can't do that, and help me mop and sweep. I had to have a HHA because I couldn't do my laundry. I couldn't do anything really, because I had steps to go up and down, I couldn't do that after that knee surgery. I don't have or need a nurse right now.

Participant 7 stated:

> I have a HHA she helps me with my kitchen, bathroom, and anything else that needs to be done. She goes shopping for me too. I don't have a nurse; my brother helps me with my medication about once a week. I have a nurse practitioner that comes to my apartment to check my blood pressure, check all your vitals, and ask you a hundred questions. I just get a HHA lady that comes three hours for once a week she helps clean the bathroom, cleans the kitchen and she cleans the living room.

Participant 9 stated:

> I had a HHA that did light housework like dusting, cleaning my china cabinet, and window sills. My daughter helped me with bathing. I had a physical therapist coming to give me physical therapy because I had shoulder surgery.

Participant 10 stated:

> I only get two hours with a HHA she helps with housework, groceries, and run errands for me. I have a nurse who come in and take my vitals and everything. Also, I get physical therapy in home twice a week.

Participant 11 stated:

> I have a nurse and a HHA, the nurse gives me two shots per week, and he sets up my medication for me to take all week. The HHA helps me wash my clothes, make up and straighten my bed up she helps me with taking a shower, and with my dishes. Just light housekeeping.

Participant 12 stated:

> I have a HHA, her name starts with a V, she washes my clothes, sweep, mop my floor, and that's about it. I have a nurse that comes every 3 months to check my vitals you know and review my medications. I do need somebody to help me with my medication because sometimes I'm so forgetful.

Participant 13 stated:

> I've got a HHA she supposed to come and help me with laundry and household work different stuff like that. I have a nurse she come in and check my medicine, make sure that they are correct and check my vitals. Participant 14 stated:
>
> I have a HHA to help me with household cleaning. I had a nurse after my surgery, she checked up on me when I first came home, and she checked my vitals. I had physical therapy in home after my surgery too.

The participants described having experiences with receiving a variety of HHCS, often each encounter was different depending on the type of service being provided.

Acceptable Behaviors and Conduct

Participants described experiences where HHC workers were untrustworthy, HHC workers displayed poor mannerisms and behaviors, HHC workers crossed professional boundaries, HHC workers were lazy and did not want to work. Some participants explained that HHC workers had stolen money and jewelry from their homes which created a lack of trust. One of the participants described a HHA's personal grooming and appearance while at work. Participant 11 stated, "You have somebody new, somebody different everyday some of them wasn't groomed well. How you gonna groom, me, and you're not groomed yourself? It was a mess. It was a mess." A participant described her experience with a HHC worker who crossed boundaries which made her question the workers professionalism. Participant 7 stated: "I just feel like you work for me, some people put pressure on you she wanted to know my personal life. No, I don't roll like that, I'm private." Other HHA's did not seem very interested in working. Participant 13 stated: "I could tell like she didn't want to be here that she wanted to be somewhere else."

Some of the participants described incidents where merchandise or money was stolen from their homes, and they indicated that the HHC worker was the culprit. This was a huge concern for them as this caused trust and safety concerns. One participant intentionally laid out jewelry when the HHC worker left they noticed the item was gone. The participant contacted the HHCA, and the agency never returned her call or responded to her concern. Participant 7 stated the following: "I had a HHA take a piece of jewelry for me. I called the HHC company, and they wouldn't respond back. I've set things out on purpose, and I went back to the same spot, and it wasn't there."

Participant 12 stated:

> I just don't leave my money or my purse and stuff around them HHAs because some have stolen from me, I know what I have, and I know where I had it and

> when they (HHA) leave, I look to see if it’s there and it’s not. I had earrings and finger rings; I had a lot of earrings and now I have none.

Another participant explained that they had cash stolen and reported it to the police department. Participant 3 stated: “We had a HHA who stole $600.00 from our home. We contacted the police and had a police report taken. It’s been hard to find anyone that is trustworthy.” Participant 5 stated: “The first HHA was not reliable, we feared that she would steal money from us, we didn’t trust her. We had some money missing before. You must pick the right agency to get the right staff.” Some of the participants stated that it is known by the residents that live in the community that some HHC workers steal. Participant 6 stated: “I’ve heard people say they’ve had; you know people come in and steal and miss thangs.”

A concern that stood out clearly amongst many of the participants interviewed was the HHC workers attitudes and behaviors. Below are a few examples of participants describing some of the HHC workers poor attitudes, behaviors, and unprofessional communication which made some of the participants reluctant to continue receiving HHCS even though they needed the help. Participant 2 stated:

> The first girl (HHA) I had for 5 years, she was good, but then I started to walk on eggshells around her. I couldn’t say nothing. The HHA decided to leave me, and I asked her what did I do? She said, oh, it’s just the way you talk to me. I said, after five years, how did I talk to you? She said, well, I won’t to go into that. The HHA plugged her phone in my kitchen outlet, and she didn’t ask me she just did it. She was in my bathroom for thirty minutes I asked her what she was doing, and she

> went off on me, cursing saying “I can’t use your bathroom, I cleaned this mother f er and then I asked her to leave. I believe she was smoking or getting high or something because her attitude, just was unnecessary. I heard her outside talking about me like a dog, and the residents was telling me.

Participant 13 stated, “She had an attitude I felt unsafe, I just didn’t feel comfortable it was just her whole attitude, it was just her whole being. You can come into somebody house and your body language can tell the whole story.”

A couple of the participants described concerns around HHC workers being young, undependable, and inadequate to perform their job duties. Some participants requested that the HHCA not send young HHC workers because they did not do a good job at their job duties. Participant 2 stated the following:

> They sent me a girl (HHC worker) she plugged her phone in my kitchen outlet and didn’t even ask me she just did it. These young people come they sit on the phone, and they text and on the phone all the time. After I got rid of the first HHA I told the agency whoever you send next they have to be over 40, I won’t deal with these young people. The HHCA called me and said I have someone for you, and you will like her because she’s 55.

Participant 3 stated the following: “The HHA didn’t finish up the job.” A few of the participants described the HHC workers as being mean or having bad attitudes, in addition to not working very hard. Participant 5 stated: “The HHA was mean, she wanted to just play on her phone, she didn’t want to work. She didn’t provide good care.” Participant 8 stated the following: “The HHA just wasn’t into it, you know? You know, sometimes young people, they have their own agenda they want to be on social media, you know?" Participant 9 stated:

> The HHA came to work late, she asked if I mind her answering her phone, I said it's okay cause she said it was her little girl's school, but I made it plain I'd appreciate it if you don't be on your phone. Well, every time she came, she was on the phone when she walked in the door "she said good morning, I'm gonna be off in a minute." I said, no that's not polite I asked you not to be on the phone when you come. The HHA was late a few times and had a lot of problems, she just didn't work out for me.

One of the participants explained what she described as turnover or "moving around" due to poor work habits. Participant 11 stated: "The HHAs move around because they don't want to work. They are not consistent because they don't want to work you can't make them work, the HHA didn't do a good job." Participant 12 stated:

> I'm supposed to have someone (HHA) for three days. They come when they feel like it, they might come Monday then might come Friday, and not come on Wednesday they can't come on Tuesday, Thursday, or Saturday because I go to dialysis. They are just young girls they are not in their 40s or something. They're young and they are just lazy. They just don't want to do nothing. They don't clean the toilets; they don't wipe down my shower and my shower need wiping down. Young girls are lazy sometimes I'm like oh God they young and just lazy. They don't want to do nothing they want to sit down, and they be on the phone you ain't supposed to do all that.

Participants explained that they were made to feel like HHC workers didn’t want to be at work and gave the impression that they didn’t like their work, so they opted to let them go and relieve them of their duties. Participant 14 stated: “There have been a couple of HHAs that I basically opted to let them go, and it’s because they did not want to do the work, or they would be staying on their phone a lot.”

Accommodation and Ease of Scheduling

Participants described limitations around scheduling HHCS and concerns with HHC workers not receiving competitive pay, therefore causing a barrier to getting timely HHCS because HHC workers are shopping for better pay and working for HHCAs that may increase their salary to incentivize them to work in poorer communities. Participant 13 stated:

> They probably don’t pay them enough money. That’s what I really think it is. If they would really pay them more money, they would probably want to work over here. It is cause some communities you go in, they pay more. I know they do. My granddaughter was going to come over here and work, but she said, “Grandma, they don’t pay enough.” I said, What you mean? She said the agency that she worked for would have paid her X amount of dollars, but then she went to the Price Hill community, and she made $3.00 more an hour. Participant 2 stated: The HHA was only getting two and a half hours with me, and she wanted more money. The other lady, she was getting three days a week four hours with a day. It is hard to replace HHAs. COA said it has been a shortage of aides for about a year.

Accommodation addressed whether where participants lived could accommodate their equipment, supportive devices to assist them in moving around. Many of the participants indicated that they used some form of equipment for assistance primarily a cane or wheelchair to assist them with standing and walking. They also discussed whether or not they were able to obtain a handicap accessible apartment to support them with their HHC needs. The participants stated the following:

Participant 1 stated: "Yes, I have a handicap accessible apartment and I use a cane." Participant 2 stated: "I have not got a handicap apartment, but I do have a shower chair in my shower and the building is handicap accessible. I have lifeline service too." Participant 4 Participant 4 stated: "Yeah, I live on the first floor. I have the rails and stuff in my bathtub and shower. I only got a cane." Participant 5 stated: "Yes, I have a wheelchair and a hospital bed." Participant 6 stated: "Yeah. I have a scooter. Everything is on the first floor here. I'm on the first floor." Participant 7 stated: "Yeah. I have a scooter and walker." Participant 11 stated: " It's a regular apartment, but the building is handicap accessible. I have a rollator walker and I have a regular cane." Participant 14 stated: "Yes. I have a cane. At this time, I have a cane. There was a point where I had to use a walker."

Participants described their experiences with scheduling HHCS, some participants did not have issues obtaining services and described having assistance from their referring doctor or COA, an agency which helps connect seniors to health care services. Others described delays in scheduling, long wait periods, "no-shows", and staffing shortages as reasons for scheduling barriers. Participant 1 stated, "Yes, the doctor helped schedule HHCS as soon as I called, I was seen immediately, it really came soon.” Participant 3 stated: “The passport agency and my doctor helped me schedule. HHCS was not scheduled quickly due to staffing issues and shortages.” Participant 8 stated: “The got to it pretty quick scheduling me, first they had to see if I qualified. COA helped me schedule services.” Participant 9 stated: “You know, the agency was still trying to find somebody. So, they said that if they found somebody else, that they would call me. I think it was some months later, that they called me.” Participant 10 stated: “Well, I immediately got it. It didn’t take me long. I’d say about two or three weeks.” Participant 12 stated:

> I’m supposed to have someone for three days. They come when they feel like it, they might come Monday, then might come Friday they might come Wednesday they can’t come on Tuesday, Thursday, or Saturday because I go to dialysis. They don’t come hardly. They haven’t been here shoot in about a week and a half.”
>
> Lord it was about two months before I got the first HHCS scheduled.

Participants also described personal in-home safety as a safety concern particularly using their home medical equipment such as bath chairs in their showers. Participants stated the following:

Participant 1 stated: “I have a hard time with the bathroom because the bathtubs are so high. I got a chair for the bathroom for the tub it is so deep I fell one time.” Participant 6 stated: “You know, if a fire really breaks out, I wonder some time how we gonna get out, I can’t jump out a window I know that I’m on the third floor.”

Availability and Access

Participants described their experiences and concerns about crime and safety within the community in which they lived, and they often felt that this could have an impact on them receiving quality care and good HHC workers. They described incidents in their neighborhood that may have deterred HHCAs and HHC workers from wanting to provide HHC in their community.

Participant 2 stated the following:

> There was a shooting I seen a guy get killed the guy just killed the man and that just traumatized me. HHAs and nurses may not want to come over here that's why it be hard to get good people.

Participant 4 stated:

> Living in this Housing and Urban Development (HUD) senior building has had a big impact on me being able to get services. It's for low-income people and we not treated like other people who don't live here, we get limited access to services, I think.

Participant 14 stated the following:

> I do know that sometimes there's a tendency to see a difference as far as how these HHAs respond, depending on the location that they're working in. This one young lady I know that worked as a HHA, and I knew her personally. She was in a different part of town. Basically, she was in Hyde Park, and she told me that they never would settle for some of the stuff that she sees, or have heard about in a community, like this one. Another friend of mine who was a HHA said similar

> stuff, based on what she said I think that the location could have an impact on getting services.

A participant described that they thought that their race and ethnicity might have an impact on access to care and felt like they were treated differently. Some participants made statements that they were concerned that their race may impact their ability to get timely HHCS. They described concerns about HHC staff being dependable and consistent with showing up for work and providing care. Participant 8 stated: “Well, I think sometimes it depends on being African American and where you live, you kinda be limited on HHCS you can get.” Participant 7 stated: “This is about my 5th HHA, they are not reliable over here because we African American.” Participant 11 stated the following:

> I can’t describe it in words, but I just think that race has something to do with me being able to get services because I see other people who I don’t think be having problems with this like me. Sometimes the way the apartment manager handles things in here she put people in handicap apartments of a different race, but not me. I moved in here; I moved here under disability. But it was a mental disability, not a physical disability. Then the HHA act like I don’t need much help. I live on the third floor all the way at the end like the green mile, but then I see these people move in here they are almost to the front door. They seem to get more help from the aides.

Service reliability was a theme throughout the interviews, participants described experiences that they encountered on getting reliable nursing services. Participant 11 stated:

> They found somebody, and it worked out for about maybe six months or so. Then that person never came back. My nurse that I have is with divine home health, he left at the first of the month and went home to Africa, to see his father and so between him and COA they didn't get me no other nurse to come, but at one point I did have so many HHAs you would have thought they were kin to me the way they was coming in and out of my apartment, but they didn't do a good job.

Participants described concerns they had about the impact of the COVID pandemic being a factor for not being able to get a HHC worker. Participant 13 stated:

> The agency had nobody, right. You know, the agency was still trying to find somebody. So, they said if they found somebody, that they will call me. So, I think it was some months later, they called me. I had somebody who was going to come, but she didn't have her COVID shots through her agency, and she was kind of mad, but I said, no you need to go and get your shots. I can't do that.

Participants described concerns about their neighborhood being safe enough for HHC workers to come into and provide services which they think may have an impact their ability to get services. Participant 3 stated: "Yes, the agency stopped coming to building, people don't like this community. It's rough a neighborhood with shooting and stuff like that." Participant 5 stated: "Yes, because of this community I don't think the agency want to be here there is killings and death out here. I have no safety concerns other than the community not being 100% safe." Participant 6 stated: "Yeah, they have trouble in this neighborhood so people might be concerned, but you know we have a pretty nice facility and it's pretty secure." Participants described community safety concerns that impact their personal safety, therefore causing concern for HHC workers who need to assistant them. Participant 2 stated:

> I like to go to bingo and most bingo halls are open at night, and I’m afraid to come home at night because of the area. I know one time I came home, and somebody was walking a pit bull through the parking lot, and I just sat in the car until I didn’t see them. I saw something bad happen near the PNC Bank I was in my window on the phone, and I seen the guy just kill the man and that just traumatized me so if HHC workers see this on the news they might not want to come here.
>
> Participant 4 stated: People are always coming in and out the door you know, when they buzz people up, people standing outside be trying to get in. You know what I’m saying? They come in behind the next person that get buzzed up, which is a safety concern, but that’s my only concern.

Participant 7 stated:” As long as the HHA can come in the daytime because I can’t see, and I worry at night. I don’t have safety concerns if they only come in the daytime.” Participant 8 stated: “Yes, it’s a lot of people that be wondering around asking for money and stuff like that which I know everybody can get down. But you don’t know what people be plotting.”

Participant 14 stated:

> Well, some of the concerns would simply be that in this community and around this building particularly you have a lot of mental health patients. So, I’m concerned about if I’m coming in late at night. I had an incident where one of the

> mental health patients here in the building was trying to do everything he could to get through my door and he wouldn't go away, come to find out later that someone had given him a drink. He thought this apartment was his. So, we do have issues in this building where sometimes certain things get out of control. Now I understand that people on medication may not be taking that medication they may do some other things. So, you always have those concerns when you are living in a place where there's a number of mental cases.

> Participant 12 stated: Since I've been living here that's why my nose be running, I cough all the time because of people smoking and it's a non-smoking place and it could catch fire because the residents smoke. Something else, half of the HHAs don't get those COVID shots. I had one girl that didn't get them at all. I said, "oh no" and then I messed around with her and got the COVID myself three months ago.

Affordable HHCS

All the participants had health insurance with dual eligibility status meaning that they were eligible for both Medicare and Medicaid services. Most of the participants were connected with the COA which supports older adults with receiving assisted living services including skilled and intermediate care such as: medication management, mobility, hands-on help with dressing, bathing, toileting, grooming, meal preparation and more (COA, 2022). The assisted living services program is funded by county tax levy dollars and a federal Ohio Medicaid waiver for those individuals who are low-income and eligible to receive Medicaid benefits which is how the participant's HHA services are covered. When the HHCA is not available most of the participants have family members and friends that can help them with ADL. Nursing services, and physical therapy are covered under Medicare and Medicaid. Participants made the following statements about their support system and health insurance coverage:

Participant 1 stated:

> No, I don’t pay for HHCS. Aetna and Blue Cross Blue Shield dual plan (Medicare/Medicaid) is what I have. COA helps get services approved for the nurse and the HHA. I have support to help me, my sister.

Participant 2 stated:

> Right now, I have Anthem (dual plan) and they’re gonna disenroll me if I don’t get this Medicare, Medicaid Qualified Medicare Beneficiary (QMB) stuff together. Job and Family services is gonna cut me from QMB, which is a form of Medicare/Medicaid. COA helps me get HHCS. My sister will help me and COA.

Participant 3 stated:

> “I have Medicare for the nurse visits. Medicaid and COA helps with HHCS my daughter and my friend will help me if I need them too.” Participant 4 stated: “I have MyCare a dual program, which means I have a Medicare and Medicaid. I do have my two sisters and I have a sponsor for narcotics anonymous (NA) for support.” Participant 5 stated: “I have Molina Medicare/Medicaid plan. I have my daughter, sister, and spouse for support.” Participant 6, like other participants indicated that they relied on COA for support in accessing HHCs. Participant 6 stated the following: “Yes, I have United Healthcare insurance Medicare

> advantage. I have a beautiful family, my cousins, and my daughter will help me. COA helps me." Participant 7 stated: "I have Aetna duals plan and my brother helps me, and COA helps me."

Family support is critical and necessary for those receiving HHCS, particularly those in need of assistance when the HHCA is not present or available. Participant 8 stated the following: "I have United Health care Medicaid/Medicare plan. Medicaid pays when Medicare doesn't pay. My kids help me if I need them too when nobody else is available." Participant 11 stated the following: "My kids have to come out here to help me, it's a lot but they can't help set up my medicine." Some participants made statements about having health insurance and COA which helped alleviate out of pocket expenses for participants which is a relief for them financially. Participant 9 stated: "I have Medicare I don't owe nothing out of my pocket. My daughters and COA support me." Participant 11 stated: "I have Aetna dual Medicaid/Medicare insurance, I have no out of pocket payment."

Some participants indicated that they had very little support and the expression on their faces and body language indicated that this concerned them. A participant indicated that she did not have much of a support system, so she pays a "friend" who lives in the apartment building to help her with chores, however that was a concern because the participants are on fixed incomes. Participant 12 stated: "I have Molina dual I don't have to pay nothin, I have a friend in the building she supposed to be my friend, but I have to pay her to help me." Participant 10 stated: "I got Medicaid; Medicare United Health Dual complete." My sister is my support; I have no other support." Participant 13 stated: "I have Humana Gold Plan and I don’t pay anything. I normally call COA to help me, but my daughter can help me too, I can’t depend on my sister.” Participant 14 stated: “I have Anthem and I have Medicaid. I have my family, some friends, and my church family that can support me.”

Communication

A participant described incidents where the communication between the HHCA, the HHA, and the participant was significantly lacking. Participants were not always made aware when a HHC worker was unable to come to work or had a change in schedule. There was often miscommunication about the work schedule, HHC staff calling off work, or not showing up when expected. Participant 6 stated:

> I have a concern about adequate services and the lack of communication because you know, there’s places I want to go. I’m not going to stay home all the time and I’m not going to sit in the house and try to think about whether the HHA or nurse is comin or ain’t comin they should call me. Call me the day before and say, Ms. (Participant name) I’ll be there at such a such a time. See you have to be on time all the time. I know that because the younger girls aren’t able to be on time, no way but call me and let me know if you ain’t comin ain’t no harm in doing that. It’s a lack of communication between the girls and the agency, you know what I mean? It’s a lack of communication because now my girl comes off and on, she don’t call and say well, I’m not coming, or I am coming. We need to have communication with the girls and the girls need to have communication with us. I

> told them if they can’t come on a day then maybe they can come another day. Communication is the best thing in the world.

Another participant indicated that there were challenges communicating with the HHA that she was sensitive which made it difficult to talk to her. Participant 2 stated: “I started to walk on eggshells around her I couldn’t say nothing”.

Summary

This research study sought to answer the research question: What are the experiences of individuals towards accessing and maintaining HHCS in low-income communities? This study provided an opportunity for research participants to articulate their lived experiences. The results from this study provide an educational opportunity and information about patient perspectives about HHCS which HHCA’s, insurance providers, HHC workers, and policy makers can use to improve and enhance HHCS and the way HHC is rendered to future recipients. Chapter 5 includes an introduction to the chapter, interpretation of the findings, limitation of the study, recommendation, and implications of the study, and positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This phenomenological research study was conducted to explore individuals' experiences accessing and maintaining HHCS while living in low-income communities. In this research study, participants living in low-income communities described their lived experiences with accessing HHCS. With the increased demand for health care services, costs are steadily rising and HHCS is becoming a viable option in lieu of inpatient hospitalization for the most vulnerable populations (Howard et al., 2019). The purpose of this research study was to understand and gain knowledge about barriers experienced by individuals who live in low-income communities in regard to accessing and maintaining HHCS. The goal was to obtain insight and advance knowledge that can guide health care professionals in providing holistic health care to ensure patients can access services with minimal to no barriers.

Key Findings of the Study

Six themes emerged from the data in this research study. The first theme, types of HHC and competent staff, captured the way participants described the need for HHC workers to receive continuous job training. Participants expressed concern around HHC staff lack of knowledge and ability to perform their work tasks. Theme 2 was acceptable behaviors and conduct, which captured participants' descriptions of HHC workers having rude conduct by cursing at them, talking to them in a disrespectful tone, and plugging their phones in using electricity without asking permission in advance. Participants expressed a lack of trust and discomfort with some HHC workers in their home due to their attitudes and their experiences with personal items being taken out of the home by HHC workers.

Theme 3 was accommodation and ease of scheduling. Some participants described their scheduling of HHCS experience as quick, particularly when they received assistance from their doctor or COA. Other participants described their experiences in scheduling HHCS as having lengthy delays due to staffing shortages, unvaccinated HHC workers, and insurance precertification processes. Some delays took 1–4 months to schedule and receive HHCS. Most participants used some form of equipment to assist them with walking, standing, and their health care needs, including oxygen machines, walkers, rollators, scooters, shower chairs, or wheelchairs. The apartment buildings in which the participants live are handicap accessible; some participants have handicap accessible apartments that include bathroom rails, lower apartment applications and equipment, and wider doors. Some participants experience disparate treatment when it comes to being assigned a handicap accessible apartment.

Theme 4 was availability and access. Participants described acts of crime, loitering, and the stigma of living in a low-income housing unit and the impact they felt this had on their ability to receive quality HHCS and workers due to fear of their community. Because of safety concerns, participants felt this impacted their access to HHCS. Some participants described concerns for their own personal safety within their communities. Some participants described experiences accessing HHCS as untimely and stated they felt their race and where they lived impacted the availability of staff and service offerings.

In Theme 5, affordable HHCS, participants described their health insurance. Most participants were considered dual eligible having both Medicare and Medicaid; if they were not dual eligible, they had at least one form of insurance coverage, primarily Medicare. All participants were connected to COA, which offers Medicaid waivers and payment for assisted living services. No participant had out-of-pocket expenses for HHCS, and every participant had at least one person they could count on for additional support.

Participants described Theme 6, communication, as the lack of communication between the HHCA, the HHC worker, and participants. Participants were never informed by the HHCA or HHC worker when the HHC worker had called off work or when there was a change with the worker's work status or with HHCS. Often participants were left waiting for workers to show up who never did. Participants viewed this action as discourteous and unprofessional. One participant stated, "Communication is everything"; simple communication would alleviate the waiting and allow participants to make other plans.

Interpretation of Findings

The first theme, types of HHCS and competent staff, indicated that HHC workers need constant guidance and direction from participants. HHC workers were unprofessional and needed additional training. Participants described the various types of HHCS they received, including nursing care, HHA assistance, and physical therapy. Additionally, there was considerable turnover of HHC staff. Participant 7 noted they had five HHAs at the time of their interview. These findings confirm that HHC staff availability is a concern in the HHC industry; there is a shortage of HHAs due to low compensation (Reichel, 2019). This finding also confirms Landers et al. (2016) who reported a high turnover of nurses and concern around clinical expertise and training in skilled care.

The theme acceptable behaviors and conduct captured participants' distress at being treated poorly by HHC staff and HHC staff talking on their cell phones and stealing from them. The findings in this research study confirm the following themes described in previous research studies: Accommodation and ease of scheduling confirms that workforce limitations are a concern in the HHC industry; there is a shortage of HHAs due to low compensation (Reichel, 2019). The theme type of HHCS and competent staff confirms there is high turnover with HHC workers, particularly registered nurses, and concern around clinical expertise and training in skilled areas of care (Landers et al., 2016). The theme also confirms that CMS has expanded Medicare Advantage plans to include coverage for HCS and HHCS previously not covered under Medicare such as home cleaning, meals, social support, case management, transportation, and more, to address social determinants of health (Cabin, 2020).

Independence and sustaining current lifestyle are important to those who are aging. To avoid nursing home care, HHC can make this possible (Lyn & Johnson, 2011). The theme affordable HHCS confirms that health insurance companies and the Ohio Medicaid waivers provide coverage for services previously not covered. HHCS is a cost-saving health care alternative. HHC is a cost-effective option that may be used—provided the services are available (Gilmour, 2018). CMS has also expanded coverage for home care services under Section 1115, demonstrations and waiver authorities in Section 1915 of the Social Security Act, which allows states the opportunity to test new and existing ways to provide and pay for health care services for ODM beneficiaries (ODM, 2021). Medicare benefits for HHC include skilled nursing care; HC (rendered by HHAs); occupational, physical, and speech therapy; social services; DME, and medical supplies (Medicare Basics, 2021).

The theme availability and access to HHCS confirms the previous finding that race and ethnicity may have an impact on access to HHCS. Home health care utilization and access may be different for those who are not Caucasian and have a diverse racial and ethnic background (Chase et al., 2018). Not much is known about health outcomes in an HHC setting for people of color and those residing in low-income neighborhoods; some research suggests that people of color do not fare well compared to other populations (Joynt-Maddox, 2018). Environmental factors must be considered when assessing HHCS to ensure care can be provided safely and effectively in the home and to ensure good health outcomes (Ferris, 2016).

The following findings disconfirm the findings in this study: HHC that is paid for can yield significant health outcomes; however, individuals receiving care often pay high out-of-pocket costs for their care (Johnson & Wang, 2019). Participants in this research study had no out-of-pocket expenses because of the Medicare expansion to cover qualified HHCS. In this study, participants were dual eligible, having both Medicare and Medicaid, and met the eligibility guidelines to have HHCS provided under the 1115 waiver program that expands benefits and pays for assisted living services that were not previously covered.

The following findings extends knowledge in this study: the theme that emerged availability and access identified HHC worker safety risks due to concerns with violence and crime in the communities worked in which is a form of workplace violence. Participants stated that some HHCAs would not come to their communities, they also said that HHCAs were short staffed due to community safety concerns, limiting the number of HHC workers available creating a barrier to accessing HHCS. HHC workers jobs placed them in vulnerable and unsafe situations because they were required to go into stranger’s homes, work alone, and work in dangerous communities (Andrew, 2018). The need for homecare workers is increasing, but the supply of workers is declining due to workplace violence (Andrew, 2018). Participants also described concerns about HHC workers stealing out of their homes. There are certain expectations that a health care provider will render the appropriate services with good will, recognizing the vulnerability of the patient that they are caring for (Rasiah, S. et al., 2020). Respectful communication between health care providers and patients decreases uncertainty, increases social support safety, and patient satisfaction with their health care (Kwame & Petrucka, 2021. Last, there is the daunting task of separating the duties of paraprofessionals who are limited in their scope of practice, but emotionally engaged in the holistic care of the patient can impact job performance (Rossman, 1997).

Findings: Conceptual Framework

Six of the findings for this study are aligned to the seven dimensions of the Penchansky and Thomas model of access which includes (a) affordability, (b) accessibility, (c) availability, (d) acceptability (e) adequacy and accommodation (f) awareness. The theme of Types of HHCS and Competent Staff found that participants felt that they had not received adequate HHCS and that HHC workers needed additional training and guidance from the participant. Participants felt that the HHC workers were not knowledgeable and were unprofessional. They thought that HHC workers would benefit from regular in-service hands-on training. This theme aligns with the dimension of adequacy. The dimension of adequacy includes individuals being able to use or receive convenient and appropriate services (Saurman, 2015).

The theme Acceptable Behaviors and Conduct addresses participants perceptions of HHC workers behaviors and conduct on the job. This theme aligns with one of the dimensions of the model of access called acceptability. Acceptability is when the participant is comfortable with the providers characteristics, behavior, and their ability to care and provide services to them (Saurman, 2015). The theme Accommodation and Ease of Scheduling emerged because participants identified problems with scheduling HHCs, use of medical equipment, and apartments with handicap accessibility. This theme aligns with the dimension of accommodation which describes how providers can meet the constraints and preferences of the client (Saurman, 2015).

The theme Access and Availability of HHCS described participants experiences that services and staff are not always available because of staffing shortages. They also discussed barriers to gain access to HHCS due to HHCA and HHC worker concerns of coming into the community in which they lived. This theme aligns with two of the model of access dimensions of availability and access which are described as the geographical location and the sufficiency of service availability to meet the needs of the patient (Saurman, 2015).

The theme Affordability of HHCA aligns with the dimension of affordability. The dimension explores whether the cost and services are affordable to the client and the provider (Saurman, 2015). The affordability theme describes how participants HHCS are paid for. Awareness is a dimension of the model, the theme that emerged was Communication where participants described the need for full communication to bring about awareness when HHC workers are unable to come to work instead of simply not showing up and to so that all engaged parties are informed when staff is unavailable. The dimension of awareness examines effective communication and information strategies with individuals using their services (Saurman, 2015).

Limitations

There was one limitation to this qualitative research study, as there are with any research study. The limitation encountered was in communicating with the participants who used slang to articulate their experiences making it challenging at times to understand what was being described. This required further clarification to ensure that I comprehended what they meant. There were no other limitations identified for this study. I was able to interview fourteen participants both male and female who lived in two of the low-income communities I planned to utilize in my proposal. All the participants understood the interview questions and were able to respond. I was able to conduct all interviews in person, face to face, therefore eliminating the need to use online platforms such as Zoom due to COVID concerns. However, I did conduct all interviews wearing a mask as did the participants.

Recommendations

The research study revealed a few findings that are worthy of further investigation. To gain greater insight around whether these findings are specific to individuals in low-income communities or if these findings would be the same in suburban communities, I would recommend a study to explore the experiences to accessing and maintaining HHCS in suburban communities.

The findings revealed that community safety concerns affected whether participants had access to HHCS. Another recommendation would be a study to explore whether having onsite professional security personnel inside housing properties located in low-income communities would expand access to HHCS. Another finding revealed that HHC workers were not knowledgeable about their jobs and would benefit from additional training. A recommendation would be to study whether regular in-service or professional training for HHC workers promote a better patient care experience. Last, the findings revealed that HHC workers seeking greater compensation had an impact on staffing and service availability to those individuals living in low-income communities. I would recommend a research study that would examine HHC staff turnover in suburban communities to explore if there are service and staff availability issues there.

Implications

This research study offers an opportunity for positive social change as it provides HHCAs and policy makers with information that could help improve access and the overall patient experience with HHCS in low-income communities. HHCAs can use this study to develop opportunities for additional professional training to increase job knowledge. HHCAs could also consider additional safety protocols, for example, pairing up HHC workers in the same communities and aligning their schedules so that workers do not have to go to work alone. HHCAs may consider upskilling HHC workers to increase compensation which may increase job satisfaction, the ability to recruit and retain staff, and ultimately yielding a better patient experience. HHCAs may implement policies to ensure clear and concise communication between workers and clients. HHCAs can include theft and stealing from patients into an annual ethics training to remind them of expectations and repercussions if caught stealing from clients. HHCAs should solicit the feedback of their clients to gain greater insight into the patient care experience. This information can be used to train their employees and to improve how care is being rendered. Policy makers can require HHCAs include these suggested policies into their audit or certification process to ensure that all HHCAs are compliant and held accountable for ensuring workers receive continuing education, adherence to code of conduct policies to alleviate the lack of communication, threating communication, and aggressive behavior toward clients. They can also require policies and trainings that reinforce acceptable behaviors including how they care for clients with dignity and respect and to gain client trust through honesty and integrity.

Conclusion

HHCS are becoming one of the most common cost-effective step-down options for transitional health care from hospitals and nursing homes (CMS, 2021). Though CMS has come to this realization and has created enhanced reimbursement models and federal waivers to compensate for HHCS (COA, 2022). This study identified that there is a need for effective policies to ensure HHC worker safety, a policy that requires HHCAs to provide routine staff training and professional development, and policy that provides access to HHCS for people living in low-income communities. CMS and other regulatory agencies need to ensure the oversight and accountability of HHAs to ensure that their clients are receiving the care necessary to restore them back to good health and provide them with a good patient experience. There is an opportunity to improve patient satisfaction, expand the scope of HHCS and HHC providers educational training to enhance their technical knowledge to improve the quality of care (Zhou, R., et al, 2021). With the limited research available around HHCS, there are great opportunities to study and better understand HHCS, HHCAs, and HHC providers to add knowledge and impact social change to improve how care is provided.

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Appendix A: Letters of Cooperation

Dear Metropolitan Housing Authority:

My name is Staci Wagner, I am conducting a doctoral research study as a Ph.D. student at Walden University to successfully complete a doctorate degree in Health Services, specializing in Public Health Policy.

The study is called *"Experiences with Access to Seeking and Maintaining Home Health Care Services in Low-Income Communities."*

This is a study that could help inform home health care providers and improve access by gaining knowledge of experiences individuals encounter accessing and maintaining home health care services in low-income communities.

Your housing units are located throughout low-income communities with residents who receive or may have received home health care services. I would like to recruit individuals from within the community who can provide me with information for this research study.

I am contacting your agency to gain approval to post a flyer (see attached) in the common areas of your apartment buildings and community rooms to recruitment individuals who may be interested in participating in this study. This study is strictly voluntary, and participants will receive a small gift card for their time.

If you approve of me posting flyers in your apartment buildings and community rooms, please respond to this letter via email at Staci.kennedy@waldenu.edu with the following statement:

I approve flyers being placed throughout Metropolitan Housing Authority properties and their common areas for the recruitment of participants for the research study. Please include your name, address, and telephone number in the email.

Should you have any questions or concerns, please feel free to contact me at (513) 309-5890.

Thank you for your time and I look forward to hearing from you.

Sincerely,

Staci Wagner, Doctoral Student, Walden University

Dear Adult Day Care/Senior Center:

My name is Staci Wagner, I am conducting a doctoral research study as a Ph.D. student at Walden University to successfully complete a doctorate degree in Health Services, specializing in Public Health Policy.

The study is called *"Experiences with Access to Seeking and Maintaining Home Health Care Services in Low-Income Communities."*

This is a study that could help inform home health care providers and improve access by gaining knowledge of experiences individuals encounter accessing and maintaining home health care services in low-income communities.

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Should you have any questions or concerns, please feel free to contact me at (513) 309-5890.

Thank you for your time and I look forward to hearing from you.

Sincerely,

Staci Wagner, Doctoral Student, Walden University

Appendix B: Flyer

Research study seeks participants who reside in low-income communities who has received or is currently receiving home health care services.

There is a new study called *"Experiences with Access to Seeking and Maintaining Home Health Care Services in Low-Income Communities."*

This is a study that could help inform home healthcare providers to improve access to care by gaining knowledge about access to home health care services in low-income communities. For this study, you are invited to describe your experiences accessing and maintaining home health care.

This survey is part of the doctoral study for Staci Wagner, a Ph.D. student at Walden University.

About the study:

- One interview lasting up to 60 minutes in a location setting of your choice
- To protect your privacy, information will be kept confidential and securely stored under lock and key.
- **Volunteers must meet these requirements:**
- 18 years old or older
- Reside in one of the communities referenced above
- Currently or previously received home health care services

To confidentially volunteer:
Contact Staci Wagner at (513) 309-5890 or via email at:
staci.kennedy@waldenu.edu

Appendix C: Constructs for Interview Questions

Saurman's adaptation of Penchansky and Thomas's theory of access to health care services is the framework used to develop the questions for this research study. The questions were created around the seven dimensions of access to health care services as described by Saurman which include (a) affordability, (b) accessibility, (c) availability, (d) acceptability (e) adequacy and accommodation, (f) awareness.

Affordability (financial and incidental costs)

1) Please explain how your health care services are paid for (type of insurance-Medicare/Medicaid/commercial/self-pay).
2) Describe any expenses that you pay for out of your pocket for home healthcare services.

Accessibility (location: time and distance) This does not really apply to home health care services since they are received at home.

1) Please describe what your experience(s) has been when seeking the specific home healthcare services that you need?
2) Describe your experience maintaining home health care services for as long as you need them?
3) Explain any delays in receiving home health care that you have experienced?

Availability (supply and demand: volume of services to meet community need)

1) Are there home health care agencies available to service your community? If not, explain what options are available to you to meet your HHCS needs?

2) Do the home health care agencies that offer services in your community provide the services that you need? If not, can you describe the reasons you have been given for the lack of service availability?
3) Do you think where you live has an impact on the HHCS available to you? If yes, can you elaborate on why?
4) Do you think the availability of home health services you received were impacted by your race, ethnicity, or your current living situation? If yes, please explain.

Acceptability (consumer perception of services)

1) Do you think that the home health care services you received were impacted by your race, ethnicity, or current living situation? If yes, please explain?
2) Do you think where you live has an impact on the quality of care or services that you receive? If yes, please explain how.

Adequacy/Accommodation (scheduling/facility/home structure)

1) Please describe how your healthcare provider made your referral to HHCS?
2) Did you or the provider contact the HHA?

If you contacted the agency, please describe your experience scheduling your HHCS.

If the provider scheduled the service for you, how soon were you able to receive HHCS?

3) Is your home handicap accessible for the use of wheelchairs and home health care equipment?

If no, as part of your HHCS do you need special equipment?

If yes, how do you plan to get the equipment into your home?

4) Do you have any safety concerns that would impact you receiving and maintaining adequate HHCS?

If yes, please describe any safety or hazard concerns that you have that prevent you from receiving and maintaining adequate HHCS?

5) Do you require a support system to assist you with your HHC needs?

If yes, please describe your support system.

If no, please describe how are you obtaining the support that you need to help you with your HHC needs?

Awareness (communication of information/health literacy)

1) Please describe the type of information that you received from your medical provider and the HHA to inform you about HHCS.
2) Was the information that you received clear and easy for you to understand?

Appendix D: Interview Guide

I will introduce myself and give each participant an overview of what will take place during the interview process. The script will be as follows:

Hi, my name is Staci Wagner, I am student at Walden University pursuing a doctorate degree in Public Health Policy. As part of my academic studies, I am conducting a research study to understand individual’s experiences accessing and maintaining home health care services in the community in which they live.

As part of this research study, I would like to review the informed consent with you.

As previously stated, I am requesting that you permit me to conduct an audio-recorded interview for approximately 60 minutes. Do you still consent?

1) How long have you lived in ____________community?

2) Please describe the type of home health care services that you have received.

   - ✓ Bathing
   - ✓ Toileting
   - ✓ Activities of Daily Living: Cooking, Cleaning, Groceries
   - ✓ DME/Home Infusion services
   - ✓ Nursing: Medication Management, Injections, Vitals, Wound Care, etc.
   - ✓ PT/OT

3) Describe what your experience(s) was/has been when accessing the home healthcare services (HHCS) that you need.
4) Explain any delays in receiving HHCS that you have experienced.
5) Are there home health care agencies that provide services in this community? If not, explain what options are available to you to meet your HHCS needs.
6) Do the home health care agencies that offer services in your community provide the services that you need? If not, can you describe the reasons you have been given for why the services are not available in your community?
7) Do you think where you live has an impact on the HHCS available to you? If yes, can you elaborate on why?
8) Can you explain how your HHCS were/are paid for (type of insurance-Medicare/Medicaid/commercial/self-pay).
9) Describe any expenses that you pay for out of your pocket for HHCS.
10) Did you or your referring doctor/provider contact the home health care agency or other home health care organizations to get you connected to services?

    If you contacted the home health care agency or home health care organization, please describe your experience scheduling your HHCS.

    If the provider scheduled the service for you, how soon were you able to receive HHCS?
11) Is your home handicap accessible for the use of wheelchairs and home health care equipment, please describe?

    If no, as part of your HHCS do you need special equipment?

If yes, how do you plan to get the equipment into your home?

12) Do you have any safety concerns that would impact you receiving adequate HHCS? If yes, please describe any safety or hazard concerns that you have accessing adequate HHCS.

13) Do you have a support system to assist you with your HHCS needs?

If yes, please describe your support system.

If no, please describe how are you obtaining the support that you need to help you with your HHCS needs.

14) Do you think the availability or the level of services that you received was impacted by your race, ethnicity, or your current living situation? If yes, please explain.

15) What concerns do you have about receiving HHCS in the community in which you currently live?

That concludes my questions, I will make a follow up call to you to share my interpretation of the interview and to get your feedback, this is called member checking and should not take any longer than 20-30 minutes of your time.

You will receive a gift card in the mail, or via email within the next 10 days for taking the time to discuss your experiences with me. This is the conclusion of our interview, thank you for your time.

Should you have any questions or concerns and would like to follow up with me, please give me a call at (513) 309-5890 or email me at staci.kennedy@waldenu.edu.

Appendix E: Codes and Participant Responses

Codes	Participants Response
Appropriate Dress for Work	Participant 11 stated: “You have somebody new, somebody different everyday some of them wasn’t groomed well. How you gonna groom, me, and you’re not groomed yourself? It was a mess. It was a mess.”
Behavior On The Job	Participant 2 stated: “The first girl I had her like five years she was good but then I started to walk on eggshells around her, I couldn’t say nothing because she had an attitude.”
Boundaries Between Client and Worker	Participant 7: “I just felt like you (HHC worker) do work for me, people put pressure on you she wanted to know about my personal life. No, I don’t roll like that.”
Building Management	Participant 12 stated: “I think it’s the head people in here they not doing their job. They only have one what you call people that clean up Maintenance. They only have one person come in here and that lady can’t do all this work. They don’t check enough. Then when you call and tell them about different things like they smoking, they don’t check it out. They don’t care. I don’t think it’s clean enough and it’s not clean it’s nasty the carpet is nasty.”
Community Safety	Participant 2 stated: “I don’t like to go to bingo and most bingo halls are at night, and I’m afraid to come home at night because of the area. I know one time I came home, and somebody was walking a pit bull through the parking lot, and I just sat in the car until I didn’t see them. I mean, it be shooting out here I seen a guy get killed. It’s been a while back, but the guy that got killed when the bank was there near PNC Bank, and I was in my window on the phone, and I seen the guy just kill the man and that just traumatized me.” Participant 3 stated: “The agency stopped coming to building, people don’t like Lincoln Heights. It’s rough and sometimes violent in this community. It’s a rough neighborhood.” Participant 4 stated: “People be coming in and out the door when they buzz people up, people standing out there be trying to get in. They come in behind the next person that they buzz up, but that’s my only concern.” Participant 5 stated: “Because this community that we live in I don’t think the agency want to be here. There is killings and death out here. No concerns other than the community not being 100% safe. Participant 6 stated: “They have trouble in this neighborhood. They do, but we have a pretty nice facility because it’s pretty secure. The people inside the building they sometime let people in that ain’t supposed to be in here that’s another concern, you know? You don’t let people in that you don’t know that’s another thing, just be letting people in here naw if you don’t know them, don’t let them in. Also, how we gonna get out of here if a fire really breaks out, I wonder some time how we gonna get out I can’t jump out a window I know

Codes	Participants Response
	that. I looked at that too." Participant 7 stated: "As long as they (HHC worker) can come in the daytime I feel better. I don't see at night I feel safe because they come in the daytime. Participant 8 stated: "It's a lot of people that be that be wondering around asking for money and stuff like that. which I know everybody can get down. But you don't know what people be plotting." Participant 11 stated: "HHAs and nurses don't want to come in this area. It seems like a pretty decent area to me. But you know, you watch the news, and you see a lot of things going on." Participant 12 stated: "Since I've been living here that's why my nose be running, I cough all the time because of smoking and it's a non-smoking place and it could catch fire because they smoke that's a safety issue to me." Participant 13 stated: "Something else half of them don't get those COVID shots. I had one girl that didn't get them at all. I said oh no and then I messed around with her and got the COVID myself three months ago." Participant 14 stated: Some of the concerns I have would simply be that in this community and around this building you have a lot of mental health patients. I'm concerned about if I'm coming in late at night. I had an incident where one of the mental health patients here in the building was trying to do everything he could to get through my door and he wouldn't go away, come to find out later that someone had given him a drink. He thought this apartment was his. I understand that because people be on medication that they're not taking so they may do some other things. So, you always have those concerns when you are living in a place where there's a number of mental cases."
Community Location	Participant 2 stated: "It's not safe because of the people in the area? I mean, there be shooting in this community." Participant 4 stated: "Living in this HUD senior building has had a big impact on me being able to get HHCS, I think." Participant 14 stated: "There are concerns that I do have about the living in this neighborhood and the community in this building, I knew a home health aide, I knew her personally. She worked in a different part of town. Basically, she was in Hyde Park, and she told me that they never would settle for some of the stuff that she see or have heard about in this community, they don't want to come to this community location because of the stuff going on."
Delay for Services	Participant 3 stated: It took 1 month to get my HHCS because of issues with insurance. Participant 9 stated: "I needed a new HHA because she quit. The HHCA said if they found somebody else, that they will call me. So, I think it was some months later, they called me. I couldn't get services because they didn't have, they COVID shots." Participant 11 stated:" It takes a while to get services it might be a week, sometime a month. I had to wait until I got on Social Security

Codes	Participants Response
	My kids have to come out here to help me, it's a lot and they can't help set up my medicine." Participant 12 stated: "I called council on aging to get HHCA, but it don't seem like they trying to do nothing. I've been trying to get a power wheelchair for one year and my doctor done sent in a prescription three times and they claim they haven't found them or something and then they lie." Participant 14 stated: "When they was changing aides for me, I had to wait a very long time. At one point it took maybe a few months and I literally end up going to my senior care person that's assigned to me, and she was able to get the company to finally get someone else in to help me."
Dependable	Participant 1 stated: " My HHA was very reliable and dependable." Participant 3 stated:" It was hard getting reliable people. The HHAs didn't finish up their job." Participant 6 stated: "I've been here two years, you know, and there's some of them really reliable and some that are not." Participant 10 stated: "Physical therapy and the nurse they was very reliable."
Equipment	Participant 1 stated: "I have a cane" Participant 2 stated: "I have a shower chair" Participant 4 stated: "I have a cane" Participant 5 stated: "I have a wheelchair and a hospital bed." Participant 6 stated: " I got a scooter"/ Participant 11 stated: "This is called a rollator walker. I have a scooter to it runs by batteries." Participant 14 stated: "I have a cane, I used to have a walker."
Handicap Accessibility: Apartment	Participant 6 stated: "Everything is on the first floor here. I'm on the first floor." Participant 8 stated: "I got like little bars in the bathroom like you can pull up on and get out." Participant 9 stated: "Yeah, I have a handicapped apartment. I mean, it's equipped. The bathtub-- the only thing about it is, the bathtub is just so high. Participant 11 stated: "I have a regular apartment, I didn't get a handicap one, but with help I do ok."
Health Insurance	Participant 1 stated: "I have Aetna and Blue Cross Blue Shield." Participant 2 stated: "I have Anthem and they're gonna disenroll me if I don't get this Medicare QMB straightened out." Participant 3 stated: "I have Aetna, Medicare Advantage." Participant 4 stated: "I have Medicare and Medicaid." Participant 5 stated: "I have United Health Care Medicare Advantage." Participant 6 stated: "I have Aetna duals." Participant 7 stated: " I have United Healthcare through Medicare." Participant 8 stated: " I have a Medicaid dual plan." Participant 9 stated: "I have Medicare." Participant 10 stated: "I have Aetna Dual plan." Participant 11 stated: "I have Molina Healthcare dual plan."

Codes	Participants Response
	Participant 12 stated: “I have Humana Gold plus.”
	Participant 13 stated: “I have Medicaid.”
	Participant 14 stated: “I have Anthem dual plan.”
Helpful	Participant 1 stated: “I can’t walk I have been having problems with my back and my legs and so HHCS helps me.”
	Participant 4 stated: “We had to have somebody (HHA) to come and pick me up and drive me back home. That’s what she did, even though it was on her time, that has been so helpful.”
	Participant 8 stated: “She’s (HHA) a really big help. The thing about it is the lady is older than I am, actually. But she’s a good worker.”
	Participant 13 stated: “I’m happy I just get three hours, and that’s a big help to me. she helps me out.”
	Participant 14 stated: “The nursing and the physical therapy was very good. It was very helpful. So that was very good.”
HHC Services	Participant 1 stated: “My HHA takes me to the store if I need to go or she goes shopping, she goes to the grocery for me.”
	Participant 2 stated: HHA helps with cleaning my bathroom. Keep it clean, sanitized.”
	Participant 3: stated: “HHA primarily helps with bathing”
	Participant 4: stated: “HHA helps me with my shower, washing my clothes, cleaning my house, if I need to go to the grocery store, they’ll take me, if I need my windows washed, she will wash my windows. You know, this girl is good.”
	Participant 5 stated: “My HHA helps me with bathing.”
	Participant 6 stated: “My aide make my bed up, clean my bathroom, my kitchen, my stove because because I can’t do that and I cook a lot and I use my oven quite a bit I bake a lot. So that’s what she has to do she mops and sweep.”
	Participant 7 stated: “They help me maintain my space. HHA cleans my kitchen, the bathroom, and anything else that needs to be done She goes shopping for me”
	Participant 8 stated: “She (HHA) clean the bathroom. She cleans the kitchen and cleans the living room.”
	Participant 9 stated: “The aide helps me with my housework.”
	Participant 10 stated: “The HHA helps me clean do housework, go to grocery store and run errands.”
	Participant 11 stated: “HHA wash my clothes. She makes up my bed, and she helps me with the shower. HHA also do lighthouse keeping like vacuum and takes my trash out.”
	Participant 12 stated: “She wash my clothes, mop and sweep my floor.”
	Participant 13 stated: “The HHA supposed to come and help me with laundry and different stuff like that.”
Home Healthcare Agency Concerns	Participant 9 stated: “I don’t think they’ve got enough home health agencies.”
	Participant 11 stated: “The agency said they couldn’t keep the HHAs. They kept sending different ones, so I told them I’m going to try a different agency.”

Codes	Participants Response
	Participant 12 stated: “They (HHA) not good. They didn’t offer to help me get the wheelchair.” Participant 14 stated: “Some of them are more on top of things than others.”
Incompatibility	Participant 2 stated: “The HHA had a problem with me, or she wanted more hours or whatever. She went off on me, cursing saying I can’t use it (the bathroom) and I cleaned this MF er I said, oh honey, you got to go. She called the agency and told them Ms. ____ don’t want me here no more, so I got to leave.”
Job Knowledge Qualifications	Participant 6 stated: “I used to be a nurse aide before I retired. I was a nurse aide I did this kind of work I know what it takes, they need more training.” Participant 8 stated: “She (HHA) act like she didn’t know the direction to take.” Participant 13 stated: “She (HHA) had to wait for me to tell her exactly what to do.”
Lack of Communication	Participant 6 stated: “There is a lack of communication between the girls in the agency, you know what I mean it’s a lack of communication because now my girl, she comes off and on. One day she don’t come and don’t tell me and that’s what I don’t like. She don’t call and say, well I’m not coming, or I am coming. We have to have communication with the girls and the girls need to have communication with us. Communication is the best thing in the world.”
Mental Health & Substance Abuse	Participant 2 stated: “I believe she (HHA) was smoking, or she was getting high or something because of how she was acting.” Participant 4 stated: “I’m in the program of Narcotics Anonymous for 17 years.” Participant 14 stated: “I’m concerned about if I’m coming in late at night. I had an incident where one of the mental health patients here in the building was trying to do everything he could to get through my door and he wouldn’t go away.”
Nurse Services	Participant 1 stated: “I see a nurse; they come by and take my vitals.” Participant 2 stated: “ When I had my knee replacement, they sent me home with a physical therapist.” Participant 3 stated: “I have nurse visits to check vitals and oxygen.” Participant 5 stated: “I have a nurse who did medication checks and vitals.” Participant 8 stated: “I had a nurse practitioner who checks your blood pressure and vitals.” Participant 9 stated: “ They gave me physical therapy” Participant 10 stated: “The nurse came in and take my vitals and everything, and I got physical therapy.” Participant 11 stated: “I have a nurse I get two shots per week, and he sets up my medication.” Participant 12 stated: “The nurse checks my vitals, you know, and review my medications.”

Codes	Participants Response
	Participant 13 stated: "I have a nurse. She comes in and check my medicine and check my vitals." Participant 14 stated: "I had physical therapy and a nurse she basically checked my vitals."
Participant Satisfaction	Participant 1 stated: "My experience with my HHA it's been great. I've had no complaints." Participant 4 stated: "You know, this girl (HHA) is good." Participant 6 stated: "They (HHA) call me from time to time and they ask me, I'm satisfied with this and this and that, and I say yes." Participant 8 stated: "I'm happy I just get three hours, and that's a big help to me." Participant 10 stated: "Overall, services were pretty good."
Personal Problems	Participant 9 stated: "She (HHA) was a little young girl, and I-- and I've got daughters. And I know they have problems with them boyfriends and stuff. She told me that she just moved, and I just got a lot going on. People was telling her stuff about him. He was going in her house when she'd leave to go to work, and she was trying to watch him." Participant 12 stated: "Some (HHA) say they car won't start they don't have a babysitter."
Race and Ethnicity	Participant 1 stated: "I don't think my race or ethnicity impact my care or services." Participant 11 stated: "I can't describe it in words, but I just think that my race and ethnicity have something to do with it because I see other people, I don't think be having no problems with this like me."
Salary Compensation	Participant 2 stated: "She (HHA) could get more money, she was only getting two and a half hours with me, and she wanted more money. The other lady, she was getting like three days a week for four hours a day." Participant 9 stated: "They probably don't pay them enough money. That's what I really think it is. If they would really pay them more money, they would better workers. It is cause some communities you go in, they pay more. My granddaughter said" grandma, they don't pay enough" I said, what do you mean? "She said the agency that she worked for would have paid her X amount of dollars." But then she went to Price Hill, and she made $3.00 more an hour."
Scheduling HHCS	Participant 1 stated: "As soon as I called in for HHCS, I got them immediately." Participant 3 stated: "Passport through COA helped me, and my doctor helped me get scheduled. It took a short time." Participant 4 stated: "COA helped me get scheduled; it took a few weeks." Participant 8 stated: "They got to it pretty quick, after I first had to see if I qualified for it, but qualifying took some time." Participant 9 stated: "The doctors office set it up it took a few weeks." Participant 10 stated: "I'd say about two or three weeks" Participant 12 stated: "Oh Lord, it took about two months."

Codes	Participants Response
	Participant 13 stated: “ I wanted to do my own interviews, I had a couple come down, it took a little time, but not too long to schedule.”
Service Availability	Participant 2 stated: “ Physical therapy came the same week, HHCS took a long time about a year.” Participant 4 stated: “Services were available” Participant 8 stated: “I think sometimes it depends on where you live you kinda be limited in what you can get.”
Staffing Availability	Participant 2 stated: “I got a call from council on aging, they said that I should keep the help because if something should happen at my age, that I would need somebody, and it wouldn’t be nobody available cause it’s a shortage.” Participant 7 stated: “ This is my 5th HHA, they don’t stay around.” Participant 9 stated: “The agency had nobody, the agency was still trying to find somebody they said if they found somebody else, that they will call me. So, I think it was some months later, they called me.” Participant 11: stated: “I had maybe seven HHAs, they move around.” Participant 14: stated: “I literally and end up going to my my senior care person that’s assigned to me, and she was able to get the company to finally get someone else in to help me. Another problem that I’ve encountered is if my aide is on vacation, I’ve never been able to get a replacement.”
Stealing out of home	Participant 3 stated: “We had a HHA who stole $600.00 from our home” Participant 5 stated: “The first aide was not reliable, we feared that she would steal money from us, we didn’t trust her. We had some money missing before.” Participant 6 stated: “I’ve heard people say they’ve had, you know, have people come in and steal and miss thangs.” Participant 7 stated: “I had an aide take a piece of jewelry.” Participant 12 stated: “I just don’t leave my money my purse and stuff around them because some have stolen from me. Because I know what I had, and I know where I had it and then when they leave, I look to see if it’s there. It’s not.”
Support System	Participant 1 stated: “My support system is my sister. I have a psychiatrist and an emergency telephone number that I can call to talk to the crisis intervention people.” Participant 2 stated: “I have my sister as my support.” Participant 3 stated: “I have my daughter and my friend.” Participant 4 stated: “I have my two sisters. I have NA sponsor as well.” Participant 5 stated: “My daughter and spouse is my support.” Participant 6 stated: “ I have a nice family; my daughter is close and she comes over.” Participant 8 stated: “ My kids help me.” Participant 9 stated: “My daughter comes and gives me a bath.” Participant 10 stated: “ Me and my sister help each other.”

Codes	Participants Response
	Participant 11 stated: “My kids come out her to help me and it’s a lot.” Participant 13 stated: “I have a daughter who can help me, when I need her to.” Participant 14 stated: “My family, friends, and my church family support me.”
Timeliness of Care	Participant 1 stated: “The nurse only has to come through like every six months.” Participant 6 stated: “The younger girls aren’t able to be on time. She only come on Wednesdays, but she don’t have no scheduled time, she should have a special time when she come, you know”? Participant 9 stated: “ Participant 10 stated: “Well she was running late traffic not often though.” Participant 12 stated: “They don’t come hardly; they haven’t been here shoot in about a week and a half. It’s been over a week now.”
Trust in Caregivers	Participant 3 stated: “I couldn’t find anyone that was trustworthy.” Participant 6 stated: “This girl has been with me for five years, she’s honest and she don’t steal I know that. Participant 7 stated: “I don’t trust people; I have trust issues anyhow. I like this HHA I got now.” Participant 11 stated: “It’s been challenging going through so many people (HHC workers). You can’t get a relationship or trust with them because they end up leaving.”
Work Habits	Participant 2 stated: “The first HHA she plugged her phone up in my bedroom wall and she shut the door and locked it. She didn’t want to work. she was in there thirty minutes. Then the second time she plugged her phone in my kitchen outlet. She didn’t ask me she just did it. I didn’t say nothing. I try to go along with these young people. Then she started using that bad language to me the second time she was here, it was like a whole change, so she had to be in the bathroom getting high or something because her attitude, just was unnecessary. Participant 3 stated: “The HHA didn’t want to do their job.” Participant 5 stated: “She (HHA) wanted to just play on her phone, she didn’t want to work.” Participant 7 stated: “I had a HHA that came, and she stayed on the cell phone and if you work for me I don’t want to listen to your conversation. You should be working.” Participant 8 stated: “The HHC worker I had just wasn’t into it. You know, sometimes young people, they have their own agenda the want to be on social media. They not interested in working. Participant 9 stated: “she was in there for about a few minutes, and she came and sit down. So, I offered her something to drink I asked her to wipe out the windowsills, Well, she said she don’t wash windows. I didn’t say wash windows, just wipe out my windowsills because I had a few knick knacks in the windowsill.” Participant 11 stated: “The HHAs move around because they don’t want to work. They didn’t do a good job either.”

Codes	Participants Response
	Participant 12 stated: “They just young girls they like not in their 40’s or something. They’re young and they lazy. They just don’t want to do nothing. They don’t clean the toilets; they don’t wipe down my shower my shower needs wiping down. They young girls, I’m like oh God they young and just lazy. They don’t want to do nothing they want to sit down, and they be on they phone you ain’t supposed to do all that.” Participant 13 stated: “I could tell like she didn’t want to be here that she wanted to be somewhere else. So, that’s why I called the agency and told them that I didn’t need her help right then maybe later I can get a HHA.” Participant 14 stated: “There have been a couple of HHAs who been here that I have basically opted to just to let them go. Because even they did not want to do the work, or they would be staying on their own phone a lot. If they did laundry, they would stay gone. Instead of coming back to finish up what they needed to do. They are slacking on the work, staying on the phone, and coming in late things of that sort.”