DOI: 10.1111/1475-6773.13954

RESEARCH ARTICLE

HSR Health Services Research

Perspectives of certified nursing assistants and administrators on staffing the nursing home frontline during the COVID-19 pandemic

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Funding information
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Abstract

Objective: To identify best practices to support and grow the frontline nursing home workforce based on the lived experience of certified nursing assistants (CNAs) and administrators during COVID-19.

Study setting: Primary data collection with CNAs and administrators in six New York metro area nursing homes during fall 2020.

Study design: Semi-structured interviews and focus groups exploring staffing challenges during COVID-19, strategies used to address them, and recommendations moving forward.

Data collection: We conducted interviews with 6 administrators and held 10 focus groups with day and evening shift CNAs ($n = 56$) at 6 nursing homes. Data were recorded and transcribed verbatim and analyzed through directed content analysis using a combined inductive and deductive approach to compare perceptions across sites and roles.

Principal findings: CNAs and administrators identified chronic staffing shortages that affected resident care and staff burnout as a primary concern moving forward. CNAs who felt most supported and confident in their continued ability to manage their work and the pandemic described leadership efforts to support workers' emotional health and work–life balance, teamwork across staff and management, and accessible and responsive leadership. However, not all CNAs felt these strategies were in place.

Conclusions: Based on priorities identified by CNAs and administrators, we recommend several organizational/industry and policy-level practices to support retention for this workforce. Practices to stabilize the workforce should include 1) teamwork and person-centered operational practices including transparent communication; 2) increasing permanent staff to avoid shortages; and 3) evaluating and building on successful COVID-related innovations (self-managed teams and flexible benefits). Policy and regulatory changes to promote these efforts are necessary to developing industry-wide structural practices that target CNA recruitment and retention.

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KEYWORDS
certified nursing assistant, CNA, COVID-19, long-term care, nursing home, workforce

What is known on this topic

- Certified nursing assistants (CNAs) are the cornerstone of nursing home care, but turnover is high due to the emotionally and physically challenging work and low job quality.
- The COVID-19 crisis has likely worsened the growing nursing home workforce shortage.

What this study adds

- Transparent and responsive leadership, open communication, and work–life and mental health supports helped CNAs manage the COVID-19 crisis.
- Stabilizing the direct care workforce will require multi-level efforts that promote increased permanent staffing, staff empowerment, and teamwork across staff and leadership.
- CNAs know best what they need on the job and should be included in operational and job quality improvement initiatives.

1 | INTRODUCTION

Certified Nursing Assistants (CNAs) are the cornerstone of nursing homes, providing the majority of hands-on care and gaining intimate knowledge of residents and their needs.[1–3] While their work is physically and emotionally demanding in the best of times, the COVID-19 crisis added extraordinary personal and professional stressors.[1,4,5] Emerging research shows that the pandemic led to widespread CNA staffing shortages, threatening resident care and nursing home viability.[6,7] Lower staffing ratios, increased use of temporary agency staff, and lack of adequate sick leave were associated with COVID-19 outbreaks and resident death.[8–10]

While COVID-19 may have exacerbated the nursing home workforce crisis, the pandemic did not create it. Nursing homes have long suffered from inadequate staffing and difficulty recruiting and retaining CNAs due to low pay and poor job quality, potentially undermining care quality.[11–15] Prior to the pandemic, national surveys of nursing home administrators and CNAs consistently showed that staffing shortages were a top concern, and CNA positions were the most difficult to fill.[15,16]

Ensuring the future viability of the nursing home industry and meeting the need for safe, high-quality long-term care requires stabilizing the existing direct care workforce while building a pipeline of

TABLE 1 Characteristics of participating study nursing homes compared to metro New York and New York State nursing homes

	Study sample	Metro New York[a]	New York state
Total[b]	6	285	606
Number of beds (mean)[c]	422	228	187
Profit status[c]			
Non-profit	100%	23.5%	30.9%
Proprietary	-	73.5%	64.2%
Government	-	3.0%	4.8%
Unionized[b]	83%	92%	70.5%
Staffing[d]			
CNA hours per resident per day (mean)[e]	2.4	2.3	2.3
Total nursing hours (RN, LPN, CNA) per resident per day (mean)[f]	3.8	3.8	3.9
Quality rating (1–5 stars)[d]	3.3	3.7	3.3

[a]Five boroughs of New York City, Long Island, and Westchester county.
[b]1199SEIU analysis of 2019 New York State nursing home cost reports.
[c]New York State Department of Health Nursing Home Profile data (health.data.ny.gov) as of 9/21/21.
[d]Centers for Medicare and Medicaid Services provider data catalog (https://data.cms.gov/provider-data/dataset/4pq5-n9py as of 9/1/21).
[e]Recommended CNA staffing levels are 2.8 h per resident per day.
[f]Recommended total nursing staffing levels are 4.1 h per resident per day.

new workers. The lived experiences of the staff that quickly put new practices and systems into place during COVID-19 provide an instructive blueprint. Our qualitative study sought to identify nursing home staffing best practices in the New York City metro area, the initial epicenter of the pandemic during spring 2020.[17,18]

2 | METHODS

2.1 | Recruitment and data collection

From October–November 2020, we conducted 45-min focus groups and 30 to 45-min interviews exploring workers' and administrators' COVID-19 experience in the New York metro area as part of a larger evaluation of a New York State Department of Health long-term care workforce recruitment, training, and retention initiative.[19] Our partners from a participating workforce investment organization purposefully identified nine of the 280 nursing homes they served, and our study team contacted them to request an administrator interview and two CNA focus groups (day and evening shifts). Six agreed, although one facility was unable to schedule focus groups due to the fall 2020 COVID-19 resurgence. (See Table 1). Focus groups were held in-person at each facility in a private space allowing for safe distancing and were moderated (by Emily Franzosa) remotely. On-site champions recruited participants and obtained written consent. CNAs completed a 10-item demographic and work experience questionnaire, and received a $25 gift card. Interview and focus group guides explored COVID-19 challenges, strategies and recommendations, and probed four domains of potential support (training/preparation, job benefits, work–life, and emotional) as well as emergent issues (see Interview and Focus Group Guides, Appendix A).

2.2 | Data analysis

Our approach drew from directed content analysis.[20] Study team members independently reviewed two interviews and two focus groups, noting key themes, issues, debates, and questions, and met to compare findings and develop an initial codebook. The authors separately coded the remaining interviews and reviewed each other's codes. We maintained rigor via in-depth writing and weekly discussion of key findings and accuracy of code definitions.[21] We compared findings between and within roles, sites, and shifts (day/evening) to surface concordant and divergent perspectives. Data were analyzed using Dedoose qualitative software.[22]

Results presented here include data from all participating sites, but due to the sensitive topic and small sample, we did not tie them to specific facilities to maintain confidentiality. However, groups at three nursing homes generally reported feeling more supported and confident in their ability to manage pandemic stressors than the two others, and we stratified our results by these two environments. This study was approved by the institutional review board at The New Jewish Home.

3 | RESULTS: CHALLENGES AND STRATEGIES TO MANAGE COVID-19

We interviewed 6 administrators and held 10 focus groups with 56 CNAs (See Tables 1 and 2 for site and CNA characteristics).

3.1 | Strategies to fill staffing gaps

Administrators and CNAs both identified staffing as their greatest concern (See Table 3). CNAs felt inadequate pre-pandemic staffing

TABLE 2 CNA demographic characteristics and work experience ($N = 56$)

		N	%
Gender	Female	53	94.6
Age	20–29	1	1.8
	30–39	12	21.4
	40–49	15	26.8
	50–59	18	32.1
	60–69	9	16.1
	Missing	1	1.8
Race and ethnicity	Black/African American	45	80.4
	Hispanic/Latina	4	7.1
	Asian	4	7.1
	Other	1	1.8
	Missing	2	3.6
Education	High school/GED graduate	28	50.0
	Some college	17	30.4
	Associate's degree	5	8.9
	Bachelor's degree	3	5.4
	Graduate degree	2	3.6
	Missing	1	1.8
Marital status	Never married	15	26.8
	Married/domestic partner	27	48.2
	Widowed	5	8.9
	Divorced or separated	9	16.1
CNA experience	Less than 1 year	1	1.8
	Between 1 and 3 years	3	5.5
	Between 3 and 5 years	6	10.9
	Between 5 and 10 Years	12	21.4
	More than 10 years	33	58.9
	Missing	1	1.8
Years at current facility	Less than 1 year	1	1.8
	Between 1 and 3 years	7	12.5
	Between 3 and 5 years	9	16.1
	Between 5 and 10 years	8	14.3
	More than 10 years	29	51.8
	Missing	2	3.6

TABLE 3 Certified nursing assistants' perceptions of challenges and strategies to support frontline workers

Challenges	Examples from CNAs	
Experience of staffing gaps *Note: both "more-supported" and "less-supported" groups reported staffing as their primary challenge*	If we have enough staff, we could give the level of care [dying residents] really need… maybe some extra time to hold their hands to go through the traveling process or just give them the comfort that is needed, that we would want in their position. If you work Friday short, Saturday short, Sunday short, Monday on or short, you expect for us to come for the next day because we are overwhelmed, right. Then we better stay home instead of coming in and drop somebody or injure ourselves. One of our co-workers, she [fell] sick and when she called me and I said, "oh, we are only two on the floor", she [canceled] the sick call. I see all the sacrifice I gave [the facility] during the COVID. And leave my kid to come just work here. Now I'm being laid off because they said they are struggling with income.	
Strategies	**Groups reporting more supportive work environments**	**Groups reporting less supportive work environments**
Teamwork across staff and management	[My unit] is rehab, so we have different people coming in and the therapists and the doctors all the time. They also chip in to help.	[Management should] stop separating yourself from us and come down and help us…especially if you are not gonna give us the staff. It was like a nightmare because some security did not want to help, and we had so many bodies to take [to the morgue] and they refused to help…we called the supervisors and see if they could help. And they said they was gonna speak to the director or somebody and see, you know, why they are not helping the CNAs or the nursing staff…nobody really wanted to cooperate. [The nurses] do not really ask us anything, they only do what they want to do.
Accessible and responsive leadership	You could [request training] through your nurse educator, you can bring it up with your floor manager… our nursing office is an open door. You can even go into the nursing office and speak to the nurse… and they'll take it from there and they'll run with it. I was at the [front entrance] taking temperatures and [the administrator] was out there at times with us…I said, "we need help. We need counseling. We need somebody to talk to.' And he said, "I thank you so much for letting me know this. We're going to put in place people that you guys can talk to."	I probably just need [leadership] to listen to all [staff] in the building. From nursing, to housekeeping, to maintenance, dietary. They need to really have - I mean, we have the town meetings, but most of the time the town meetings are based on what they have to tell us…They should have a town meeting where *we* can let *them* know what's going on. The protocol to follow is the supervisor or your floor nurse, I do not think we go beyond that. Sometimes we are not heard.
Transparent communication	There were very transparent with everything that every day you have different updates… making sure we get those updates in real time and that we could prepare for the day to come or just change whatever changes we need to make. They just give it to us as they get it. The most important thing [is] the information that the managers give us here on a daily basis about the pandemic. They were really open and honest about everything as they get it, about every change as they get it. I think knowledge is power. [Daily in-service updates] just give you a sense of security and a sense of comfort.	When they start to tell you what you need to do, that one basic person is the one that should really be telling you, not 20 people 'cause then you get lost. And this is what can damage a lot of us along with the residents because you get lost in the shuffle. [If we know] we have active [COVID] cases in this floor or this room we [know we] have to take extra precaution…so that communication is very important.
Recognition of mental health and work–life balance	We basically know [who has children] so we really work around this, "okay, she's coming in [late] at eight", as long as we know we have someone coming. [Administrators] were calling you finding out if you need somebody to come take care of your kids so you can work, or if you want to drop them somewhere. I think it is helpful to have someone to stop by, get talked to when they get burned out.	Instead of say[ing], "This person was here. They did not get sick. They did not take vacations. They did not take nothing. Let us give this person a break." They do not mind here. All they want here is that their job is being done. Just come to work and when you drop dead, fine. I'm feeling a little overwhelmed, I just need a day for me ….but then you are not going to want to take care of you because you need the income.

contributed to severe shortages during the initial COVID-19 surge, generating concerns around safety, care quality, and staff burnout as they worked without time off because "residents are relying on us." CNAs across groups worried short-staffing increased COVID-19 risk for residents and staff (e.g., "floating" staff between COVID and non-COVID units), and difficulty meeting isolated residents' physical and emotional needs, particularly during the dying process.

Administrators attempted to bring in part-time and temporary workers to fill gaps, often at "astronomical rates" which were "almost unsustainable." However, CNAs in most groups felt agency aides and nurses were not an adequate solution as they required training and were unfamiliar with facility workflows or residents' needs and preferences. As one CNA noted, "it's like you're doing your job and you're also doing the person's job."

Administrators also employed creative staffing strategies, sometimes supported by state and federal emergency waivers of licensing and certification requirements.[23,24] Administrators reassigned staff from closed adult day centers, used administrative and social work staff to help change beds and feed residents, and created positions such as an unlicensed "unit assistant" to answer phones and facilitate virtual family visits.

Despite ongoing shortages, CNAs and administrators worried funding pressures and a low patient census might force facilities to further reduce staff. An administrator noted that "it's a personal source of conflict for me to have to potentially lay off the people who worked really hard…it's horrible." One CNA participant also revealed that she had just been laid off.

3.2 | Recognizing emotional health and work–life balance

CNAs in many groups said employers seemed more aware of their need for flexibility and support to balance the intense emotional toll of their work and juggle personal and job responsibilities. Workers appreciated new accommodations for child care, transportation, or caring for sick family members. CNAs in one group described working with supervisors to adjust their team's work schedules around child care, while others suggested flexible or staggered shifts would be useful in the future. Child care services were also an important new benefit for many workers. CNAs wanted these benefits to continue and be equally accessible to night and weekend shift workers.

CNAs also noted the importance of paid time off. While most had vacation time, they either had not been able to use it or did not want to use it for mental health purposes. Several groups mentioned that administrators tried to give them time off to recuperate, with one facility providing an extra week of paid leave and others allowing days off when the resident census was low, although it was unclear if this was paid time.

All administrators also described conscious efforts to provide mental health and coping resources, from support groups and meditation classes to quiet spaces. Several facilities partnered with the CNAs' union to offer telehealth counseling and connect staff to mental health benefits through the union health plan, which was appreciated by the CNAs who used these services.

3.3 | Teamwork across staff and management

Both administrators and CNAs in more supportive facilities described an "all-hands-on-deck" approach across hierarchical lines. CNAs were particularly appreciative when other staff pitched in to help change beds, distribute meals, and perform care tasks. Administrators similarly stressed the importance of making staff "feel that they're not in it alone." However, CNAs in several groups were frustrated that management was rarely visible. While some CNAs felt supported and appreciated by unit nurses, others felt left out of care decisions. CNAs also relied on peer support, "rallying together" to hand-off care tasks, remind each other of COVID-19 protocols, and provide emotional support.

Many workers appreciated the visible recognition and appreciation of CNAs, which some felt was a change from usual practice. Administrators described efforts to recognize staff, offering meals and gifts, greeting staff at the door, and creating a labor-management staff recognition committee including union delegates. However, both CNAs and administrators acknowledged these modest supports were inadequate. "The reality was, people were working double shifts, seven days a week," shared one administrator. "It was like being in a war zone, and you're on the frontline (saying) 'well, here's a pizza.'"

3.4 | Accessible and responsive leadership

CNAs in groups describing more supportive work environments cited open-door policies and direct access to supervisors, managers, and administration that made them feel heard and valued. This included avenues to request training, support, and mental health services. However, not all CNAs felt they had access to facility leadership. One group expressed frustration over the hierarchical reporting structure, noting CNAs were often "not heard" and discouraged from reporting problems not directly related to resident care.

Across groups, CNAs emphasized that clear, direct, "real-time" communication from leadership was critical. While all administrators stressed efforts to establish or maintain open communication channels across the facility through regular meetings and daily in-person or email briefings, several groups, particularly evening workers, felt communication efforts were inadequate.

4 | DISCUSSION

During the initial COVID-19 surge, administrators and CNAs in our study employed a range of strategies to maintain care for residents under extraordinarily challenging circumstances. Teamwork across disciplines and departments, open-door access to management, and supporting workers' emotional needs and home life were valued by

CNAs. However, ongoing staff shortages continued to be administrators' and CNAs' greatest concern, consistent with other research in this area.[25] Our sample represented nursing homes that were already actively engaged in workforce retention efforts yet still experienced severe staffing challenges, suggesting that these issues may have been greater for other facilities. The continued financial impacts of COVID-19, including low nursing home admissions and ongoing funding challenges, may further threaten the stability of the workforce and resident care.[26] While our results suggest nursing homes and researchers can and should further explore these organizational adaptations, stabilizing the workforce long-term will also demand more fundamental policy and regulatory efforts, including appropriate financing for those who need institutional-level care.

4.1 | Organizational/Industry strategies to support the workforce

Collaborative practices and "open-door" policies made CNAs in our study feel recognized and valued, while also helping manage an unsustainable workload. With this support, CNAs in many of our focus groups felt empowered to work closely together to coordinate staff schedules and patient hand-offs. Our findings suggest an opportunity to further test self-managed teams,[27–29] although these efforts will also require adequate support and compensation for CNAs to take on these new roles without creating additional job strain.[30–32]

Trust in leadership alongside transparent, real-time communication of rapidly changing information was also essential to CNAs in our study. Open, accurate communication has been shown to reduce CNA turnover[33] and as the pandemic evolves, keeping two-way communication channels in place may help build trust and confidence. High-road best practices including huddles, routine information sessions, open-door policies, or "office hours" where staff can directly approach supervisors or leadership may help increase self-efficacy and a supportive practice environment.[34,35]

Finally, the emotional toll of the pandemic alongside critical staffing shortages required administrators in our study to directly address workers' emotional health and work–life needs to keep them on the job. CNAs reported expanded benefits and mental health supports were critical to helping manage pandemic-related stresses so they could continue working. Workers in our study also noted that staff often had differing needs (e.g., child care vs. elder care responsibilities). This suggests an opportunity for researchers and employers to explore the impact of different types of compensation, as well as different benefit structures (e.g., paid family leave, flexible benefit menus). Our findings showed that while administrators made genuine efforts to support their workforce, these were more often superficial rather than structural (e.g., offering food) and temporary, like time off during low census. While both administrators and CNAs identified specifically needed supports, such as paid time off and higher pay, these largely did not materialize either from lack of will or financial pressures.

Moving forward, the industry has the opportunity to further study the impact of these strategies. Surveys across a wider sample of nursing homes, for instance, might investigate how practices were received across staff, and how nursing homes with and without these strategies have fared throughout the pandemic to inform future efforts to recruit and retain workers. Importantly, our study also shows that frontline workers know best what they need on the job and identified strategies that helped them cope as well as those that undermined their efforts. CNAs should be included in designing and implementing these initiatives, and analyzing the impact of COVID-19-related changes and quality improvement efforts.

4.2 | Policy and regulatory strategies to stabilize and grow the workforce

COVID-19 magnified the danger of lean staffing models, leaving nursing homes that CNAs in our study felt were already inadequately staffed with critical gaps. Yet, while both CNAs and administrators acknowledged that short-staffing adversely affected care quality, facilities had either initiated layoffs or feared future layoffs. In addition to the number of staff, type of staff also mattered. Our participants suggested that the high cost of temporary agency workers unfamiliar with residents and protocols, and the burnout experienced by overworked CNAs, could pose a larger financial and quality risk than hiring additional permanent staff. Several studies have similarly found that temporary nurse aides may negatively impact care quality,[36,37] and that hiring full-time workers rather than a higher number of part-time staff may reduce COVID-19 transmission.[38] Future policy efforts should support nursing homes in exploring alternate proactive and sustainable cost containment options, alongside adequate public funding to increase permanent nursing home staffing to levels recommended by experts in the field.[39,40] For instance, efforts to increase federal Medicaid matching funds for states could be tied to increased worker wages and other job benefits to support and retain this workforce.

While our participants did not directly address policy and regulatory strategies to recruit and retain workers, such changes could incentivize nursing home leaders in building more collaborative workplaces. These include peer mentorship programs, advanced training tied to wage increases, Registered Apprenticeship Programs (RAPs),[41] and cross-training for workers such as home health aides (HHAs) to apply existing health credentials toward CNA or dual HHA/CNA certification.[29,42] However, these measures can only be effective if they go hand-in-hand with improved job quality and work environments.

Our study had several strengths and limitations. Virtual moderation allowed us to reach CNAs across facilities at a time when outside researchers were not permitted onsite, and including both CNAs and administrators in the study gave us a multi–perspective view. Our findings may not reflect the experience of CNAs and administrators in different regions; for-profit, smaller, and non-unionized facilities; or those who resigned during the pandemic. However, they align with

media reports and national surveys identifying staffing shortages as a top priority and stressor.[4,7,43,44]

5 | CONCLUSION

COVID-19 placed the nursing home industry and its workforce under extreme and unprecedented strain. However, it also provided an opportunity for facilities to explore more collaborative, compassionate workplace practices. Rather than return to "business as usual," the industry now has the opportunity to further study and build on these lessons. These strategies must also go hand in hand with policy and regulatory efforts to stabilize the nursing home industry, its workforce, and the older adults they serve.

ACKNOWLEDGMENTS

The authors thank the Ladders to Value Workforce Investment Organization (WIO) for funding this work, especially Georgina Weyhe and Kathryn Santos for their assistance in identifying sites. We also thank the 56 CNAs and six administrators who generously shared their experiences during a uniquely challenging time and the staff at each facility who helped coordinate and facilitate our focus groups.

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How to cite this article: Franzosa E, Mak W, R. Burack O, et al. Perspectives of certified nursing assistants and administrators on staffing the nursing home frontline during the COVID-19 pandemic. *Health Serv Res*. 2022;57(4):905-913. doi:10.1111/1475-6773.13954

APPENDIX A: NURSING HOME ADMINISTRATOR INTERVIEW GUIDE

A.1 | Introduction/Purpose

Thank you so much for talking to me today. I know you have a busy schedule, and I really appreciate you taking this time.

We'll be using the information you share with us today to help learn more about nursing homes' experience during COVID-19 and how that has affected their staffing and training needs. Obviously, the last few months have changed the nursing home landscape and your work considerably. So, I hope we can talk about how you might be thinking about training and staffing needs going forward. Our interview should take about 30–45 min.

A.1.1. | Background

1. First, I'd like to ask a few questions about you.
   1.1. How long have you worked in this position? For this facility.
   1.2. How would you describe your role and major responsibilities?

A.1.2. | Core questions

Now, I'd like to move on to talking about your facilities' COVID experience.

2. What were the biggest challenges your facility faced during the COVID-19 surge in the spring? How did you manage them?
3. In terms of staffing, what helped you the most to deal with COVID-19 in the nursing home? What was most challenging?
4. What type of training and support do you think are needed for direct care workers in preparation for the future?
5. What do you need to have in place moving forward to be prepared for the possibility of another wave of the pandemic?
6. What are the barriers to accomplishing this [reference answers to #5]? How might those be addressed?

A.1.3. | Wrap-up

7. What are the most important lessons you've learned from the past six months?
8. Is there anything I didn't ask about that we should know?
9. Do you have any questions for me?

That's all of my questions. Thank you so much for your time! If there's anything else you think of later that you want to add, or if you have any other questions for me, you have my contact information. Feel free to reach out at any time.

APPENDIX B: CERTIFIED NURSING ASSISTANT (CNA) FOCUS GROUP GUIDE

Let's start with some introductions. Let's go around the room, and please share your name and how long you've been working at [facility].

B.1. | Core questions

B.1.1. | Challenges/Concerns

1. We realize that COVID-19 has put us all through challenges we've never faced before at work and in our personal lives. In terms of your work over the past 6 months, what has been the most challenging?
2. How have you managed these challenges?
3. Who helped you manage these challenges?
4. What do you worry about most going forward?

B.1.2. | Supports

5. I'd like to talk more about what changes could be made to help address these concerns. If we were to experience another round of COVID-19, what would you need to feel safe at work?
6. What forms of communication would be most helpful between leadership and staff? Between staff?
7. I'm going to suggest a few types of possible supports. On a scale of 1–10, how helpful would you find:

a. *Training and preparation*: Things like training on infection prevention/safe work practices, care of patients with COVID, grief and loss, working with residents' families
b. *Benefits*: Things like paid time off, sick leave, "hero" pay
c. *Work–life support*: Things like meals/groceries, child care support, help with transportation, flexible scheduling
d. *Emotional support*: Things like mindfulness training, peer support groups, recognition from leadership

If it's hard to assign a number because one of these would be helpful but another wouldn't, feel free to share that – it will help us understand your needs better.

8. Which of these would be most important? Why? Are there other supports you'd want that I didn't mention?
9. Which of these supports would you be most likely to use?

B.1.3. | Wrap-up

10. Of everything we've talked about, what is the single most important thing your employer could do to support you on the job?
11. Is there anything we didn't ask, but should have?

Thank you so much for your time! All of the information you shared with us today is incredibly helpful. I know our time was short, so if there's anything else you would like to add, or that you didn't get to say, you all have my contact information and you should feel free to email or call me to follow-up.