



Organizational Responsiveness to the COVID-19 Pandemic: a Mixed Methods Social Validity Assessment of Human Services Care Providers

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Abstract

Objectives The COVID-19 pandemic posed many challenges to human services organizations serving persons with pre-existing conditions and health concerns. Study objectives were to assess organizational responsiveness to the pandemic through training, safety, and risk mitigation initiatives at community-based group homes for adults with intellectual disability (ID) and acquired brain injury (ABI).

Method This was a two-phase mixed methods study with human services care providers. In phase 1, 54 focus group participants responded to standardized interviews about leadership actions in the early months of the COVID-19 pandemic and discussed implementation effectiveness. These qualitative findings informed the design and distribution of a multi-item questionnaire in phase 2 that quantified acceptance and approval of leadership actions among 498 participants.

Results Both focus group and questionnaire participants identified several consistent leadership actions that had a positive impact on risk mitigation, health promotion, and participant satisfaction. Participants also converged on priority needs and recommendations for performance improvement.

Conclusions The study supports previous research on the effects of pandemic health crises among frontline healthcare workers and more definitively the impact on direct care providers of adults with ID and ABI during COVID-19. Care providers were able to judge organizational effectiveness and provide feedback to aide strategic planning. Mixed methods research provides an approach to large-scale program evaluation through integrated qualitative and quantitative analyses.

Keywords COVID-19 · Health crises · Human services organizations · Social validity

The COVID-19 pandemic brought massive changes to all facets of society including human services organizations providing long-term congregate care to vulnerable populations such as adults with intellectual disability (ID) (Thompson & Nygren, 2020) and acquired brain injury (ABI) (Malec et al., 2021). Frontline personnel delivering services during the early stage of the pandemic experienced the brunt of responsibility for client care and consequently the most significant stressors. Notably, research on the impact of an epidemic/pandemic on healthcare workers demonstrates

that an infectious outbreak may be associated with emotional exhaustion and burnout (Bussing and Glaser 1999; Marjanovic et al., 2007) as well as insomnia, alcohol and drug misuse, and symptoms of depression, anxiety, and post-traumatic stress disorder (Stuijzand et al., 2020). In a survey of 353 healthcare professionals in Italy during the early months of the COVID-19 pandemic, Guisti et al. (2020) reported that more than 71% of respondents had clinically elevated scores for anxiety and depression. Other research suggests the healthcare workers with greater exposure risks (McAlonan et al., 2007) including COVID-19 (Lai et al., 2020; Zhang et al., 2020) experience more negative psychological symptoms than persons in secondary roles. However, work-related distress is also apparent among non-direct care employees who often receive less information and vocational support in times of a health crisis (Blake et al., 2020; Tan et al., 2020).

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A thematic analysis by Embregts et al. (2020b) concerning the effects of infection outbreaks on healthcare workers at long-term care facilities revealed that they experienced (a) fear, tension between colleagues, stress, and confusion; (b) ethical dilemmas that involved isolation of infected clients, loneliness, and medical care that was not understood; and (c) problems with work attendance, refusing care to afflicted persons, and conflicting childcare and eldercare obligations. These stressors may further contribute to burnout and ill health already experienced by long-term staff due to shift assignments and demanding caseloads (Embregts et al., 2020b; McHugh et al., 2011; Westermann et al., 2014).

Care providers for persons with ID and ABI are at risk for burnout, physical and emotional distress, turnover, and related occupational struggles (Britton Laws et al., 2014; Firman et al., 2013; Mitchell & Hastings, 2001; Murray et al., 2019). These matters were intensified by the COVID-19 pandemic and necessitated increased staff support, training, and direction in service settings (Cox et al., 2020; Kornack et al., 2020; Maguire et al., 2021; Malec et al., 2021; Thompson & Nygren, 2020). Consider that the threat of virus infection and serious illness to adults with pre-existing conditions, physical health comorbidity, and cognitive limitations created the need for quarantine, social distancing, changes to routines, and activity restrictions that burdened direct care providers on many levels (Courtenay & Perera, 2020; Glover et al., 2017). Further, they were responsible for implementing multiple and sometimes novel risk mitigation strategies including but not limited to teaching clients to tolerate face coverings, donning personal protective equipment (PPE), following enhanced hygiene guidelines, and disinfecting environments (Gravina et al., 2020).

Embregts et al. (2020a) conducted a descriptive qualitative study on the impact of the COVID-19 pandemic among direct care providers of adults with ID. Four principal themes emerged highlighting emotions (e.g., fear of infection, sense of responsibility, disappointment), cognitions (e.g., coping, problem solving, perseverance), practices (e.g., preventive measures, remote consultation), and professional conduct (e.g., cooperation, mutual support). Summarizing their findings, the researchers recommended that managers at service settings for adults with ID communicate and express concern for direct-care staff, build collaborative teams across different levels and job functions within an organization, and support adherence to high priority policies and procedures. Also, “it is essential that healthcare organizations emphasize that direct support staff are not alone responsible for this endeavor and that they can count on the healthcare organization in general and on managers and psychologists in particular” (p. 489).

Among post-acute rehabilitation facilities for adults with ABI, Malec et al. (2021) reported that many group home and community settings established specialty-staffed “recovery

houses” for patients who tested positive for COVID-19. Other alterations to conventional service delivery were increased utilization of telehealth therapies, remote consultations, and restricted visitation policies. Formal and informal feedback from care providers revealed that danger from the pandemic and the many adjustments to programming caused them stress regarding personal safety, job security, employee benefits (e.g., sick time, paid leave), and organizational viability.

Apropos to the significant challenges and risks to direct care providers serving adults with ID and ABI during the COVID-19 pandemic, perceived organizational support (POS) plays an important role in assuaging the effects of crisis situations on healthcare workers (Eisenberger et al., 1986; Marjanovic et al., 2007). The basis of POS is leadership assessment of workforce attitudes, opinions, and impressions about the care employees receive and efforts to improve occupational satisfaction. Information gleaned from POS assessment during a health crisis can inform leaders to consider performance enhancing initiatives such as asking employees to volunteer for new assignments rather than mandating deployments, regularly disseminating updated health information, and training new job tasks with personal infection control as a priority (Brooks et al., 2018; Stuijtzand et al., 2020). In function, POS is similar to the concepts and objectives of social validity assessment with direct and indirect consumers of educational, treatment, and habilitation services (Luiselli, 2021; Schwartz & Baer, 1991; Wolf, 1978).

The purpose of the present two-phase study was to assess the perceptions of direct care providers at a human services organization for adults with ID and ABI at the onset of the COVID-19 pandemic. In phase 1, we formed care provider focus groups that responded to the actions of organizational leaders toward risk mitigation, health safety, and support of service-recipients and employees. These preliminary qualitative findings informed the direction of phase 2 which assessed approval and acceptance of leadership initiatives from a large sample of direct care providers throughout the organization. The study represents a mixed method approach to program evaluation (Jason & Glenwick 2016) that is applicable to healthcare concerns confronting persons with multiple disabilities and their care providers (Luiselli, 2016) and highlights service implications posed by the unique circumstances at the early stage of the COVID-19 pandemic and beyond.

Phase 1

Method

Participants

The setting for phase 1 of the study was a private human services organization within the northeast USA serving

several hundred children and adults with intellectual, developmental, and neurological disabilities. Participants were 54 employees from one division of the organization that supported 28 adults (22+ years old) with ID and ABI who lived in seven community-based group homes. Among the participants, 56.6% identified as female and 44.4% identified as male with an average age of 44.8 years and an average of 6.8 years employment tenure. Within this convenience sample, 90.7% of the participants were employed as direct care providers, and 9.3% of the participants were employed as group home managers. They were recruited for the study based on their availability to attend focus group meetings (described below), voluntary participation, and approval of a group home supervisor.

Procedures

Four of the authors were focus group leaders and, in that role, conducted interviews with four to six participants in attendance at a single meeting scheduled in each of the seven group homes. Meetings began with the focus group leader explaining that the participants would be asked questions about their experiences working in the group homes during the first 4 months (March–June 2020) of the COVID-19 pandemic. They were encouraged to speak honestly, informed that confidentiality would be maintained by not revealing their identity, and advised that what they said would not affect employment at the human services organization.

Focus group interviews lasted between 45 and 60 min and were conducted virtually and video-audio recorded for later analysis. All of the participants consented to these conditions. The focus group leaders followed a written script that specified nine interview questions: (1) What was it like working here in the first few months of the pandemic, (2) What worked well during this time, (3) What did not work well, (4) What could we have done better as an organization to support staff, (5) What, if anything, could we put in place in response to the crisis that we should have been doing all along, (6) What things would you still like to see the organization do in response to the pandemic, (7) How did you feel about your job before COVID-19, (8) How do you feel about your job now, and (9) What lessons or takeaways should the organization learn from this crisis?

The interview script also included guidelines for eliciting responses from participants, clarifying information, and answering questions. For example, if participant responses to interview questions were unclear, focus group leaders were instructed to comment, “Could you please be more specific,” and “What other details could you add?” The guidelines also specified that focus group leaders ensure that participants fully understood all of the questions presented to them by re-phrasing inquiries as necessary. Focus group

leaders practiced the interview protocol several times before meeting formally with the participants.

Measures

Each recorded focus group meeting ($N=7$) was observed and scored independently by two randomly assigned group leaders using a standardized form. Group leaders never scored the meetings they had conducted. During observation, group leaders followed a guide that instructed them to document words and phrases they thought properly addressed each question specified by the interview script. They wrote as many actual quotes from focus group participants as possible on the form with the words and phrases time-stamped for later comparison scoring. In illustration, group leaders would write the full comments from participants such as “I think the assistant directors really communicated well with us about what was going on” and “Yeah, I definitely felt kept in the loop” in response to questions about communication within the organization. Documenting these and similar comments as simply “communication” would not represent acceptable and correct scoring.

Data Analyses

Following the principles of grounded theory coding (Kenny, 2012), the first author identified codes from the common words and phrases the focus group leaders documented in the recorded meetings. Similar and related codes were later combined into larger categories that formed themes from responses to the interview questions (Saldana, 2009). In a final step of qualitative analysis, the research team reviewed the derived themes to confirm accurate representation of focus group content. The codes and themes are summarized in the “8” section.

Using the qualitative method of triangulation for “comparing and cross-checking data collected through observations” (Merriam & Tisdell, 2016, p. 245), the first author also compared the paired focus group recordings completed by group leaders. An agreement was defined as both group leaders documenting the same words and phrases from participant responses to interview questions. The comparison score across all of the paired focus group recordings was 78.9% ($SD=6.09$).

Results

Several themes emerged from the focus group meetings during phase 1 of the study and are summarized with direct quotes in Table 1. First, a general response from participants was that they “loved” their jobs before the pandemic despite the sense that they received low pay and insufficient compensation. Participants also believed that they were prepared

and comfortable prior to the pandemic and had purpose and connection to the work. Next, participants indicated even greater job importance following onset of the pandemic, appreciated that they had a job when so many people were unemployed, yet described fear and anxiety about their physical health and safety as well as the lives of family and the adults they supported. Participants commented further that the restrictions necessitated by the pandemic made their jobs more demanding. Other consistent themes from focus groups were uncertainty about virus transmission, availability of essential PPE, and financial stress imposed by lost income.

Participant responses to organizational leadership actions during the pandemic are summarized in Table 2. Positive themes that emerged were implementation of comprehensive protocols to mitigate risks and promote safety, the “Stay Healthy in Place” (SHIP) program in which employees remained on shift without leaving a group home for more than 72 h, and incentive pay for employees who were willing and able to work during the early months of the pandemic. A theme of “what did not work well” during the pandemic revealed that participants were frustrated with having to use accrued benefit time if not working, dissatisfied with seemingly rapid shift changes at the group homes, and sometimes confused about inconsistent communications from leadership to direct care personnel. Additionally, the eventual termination of incentive pay was generally criticized. Beyond leadership actions in response to the pandemic, participants responded consistently about support strategies that group home managers and supervisors put in place. This theme involved assistance such as scheduling additional staff coverage, dropping off groceries and PPE, delivering “care packages” of favorite foods, writing thank you notes, and fostering teamwork.

A final theme, illustrated in Table 3, was participant recommendations for continued strategies during the pandemic and in preparation for future health crises. There were suggestions that the organization reinstate incentive pay and

reimburse benefit time for employees who had to use earned vacation hours during shifts. Other points of emphasis were providing employees with an ongoing supply of PPE on the job and to take home for personal use, disseminating guidelines that inform employees about safety measures on and away from the job, and continuing with environmental cleaning and hygiene practices at group homes. Finally, participants urged the organization to maintain a “hands-on approach” to program support, engage employees with strategic planning, and formally recognize performance accomplishments.

Phase 2

Method

Participants

Participants were 498 care providers, 68% identified as female, 30% identified as male, and 2% without identification employed at the same human services organization described in phase 1 as of March 15, 2020. From this sample, 62% of participants had direct care positions in group homes, 21% were residence directors, 11% were assistant residence directors, 3% were shift nurses, and 3% were undefined. Within the organization’s network of programs, 74% of participants provided care to adults with ID, 12% supported adults with ABI, and 14% transitioned between service-recipient populations. Participants had been employed at the human services organization for less than 6 months (8%), 6 months–1 year (10%), 1–5 years (35%), 5–10 years (25%), and more than 10 years (23%). During the period of March–June 2020, 56% of participants had been involved in the SHIP program, 43% had not, and 1% were unsure; 29% of participants had to quarantine on at least one occasion during the same period.

Table 1 Focus group responses to changes in work experience during the COVID-19 pandemic

How did you feel about your job before COVID-19?	How do you feel about it now?
<ul style="list-style-type: none"> ■ Loved the job (e.g., “I loved my job before COVID-19, and love it after COVID-19,” “I loved my job,” etc.) ■ Felt prepared and comfortable (e.g., “we knew what we had to do,” “easy going,” “it was a comfortable atmosphere,” “I had no concerns,” etc.) ■ Sense of purpose and connection (e.g., “we find our job as important,” “we love them [the individuals] because they are part of our family,” “coming to work, enjoy going out with the guys,” “can become close to coworkers, individuals...”) ■ Poor pay/compensation (e.g., “low pay and compensation,” “we are essential but not paid well,” etc.) 	<ul style="list-style-type: none"> ■ Greater sense of job importance (e.g., “our job is important because the measures we took saved people’s lives,” “taking care of individuals is when we get more blessings,” “didn’t know how important we were until COVID-19, wow, we are an essential worker,” etc.) ■ More challenging now (e.g., “added responsibilities, making sure the individuals wear a mask, social distancing...,” “a lot of restrictions,” “we just have to be more creative, keeping them [the individuals] more engaged...,” etc.) ■ Fear/anxiety (e.g., “a little bit concerned, we want to be protected and to protect the individuals,” “you fear for your life,” “it’s terrifying sometimes,” etc.) ■ Appreciation of job (e.g., “it made me appreciate my job more; you know so many people have lost their jobs,” “we love our jobs that’s why we’re here,” etc.)

Table 2 Focus group responses to leadership actions during the COVID-19 pandemic

What was it like here during the first few months of the pandemic?	What worked well during this time?	What didn't work well?
<ul style="list-style-type: none"> ■ Fear of virus transmission (e.g., “scary,” “feared for your life,” “coming to work is risky,” “you do not want to be a carrier to your family,” etc.) ■ Lack of supplies / essential PPE (e.g., “one point where we had only two pairs of gloves left,” “hand sanitizer and paper towels out of stock,” “...the masks, maybe next time we have more masks,” “company did not have any supplies,” etc.) ■ Financial stress / loss of income (e.g., “I was having a lot of financial stress,” “we lost our jobs for a month or plus and that did affect a lot of people,” etc.) 	<ul style="list-style-type: none"> ■ Generally a positive regard for agency’s response (e.g., “I think [the agency] did well to support us,” “a lot of things Seven Hills did really great on,” etc.) ■ Implementing protocols and restrictions (e.g., “the protocols that were put in place early on,” “the visitors protocol... when we instituted temperature checks...,” etc.) ■ “Stay Healthy in Place” / lockdowns (e.g., “the way they locked down... protected the individuals and staff,” “once we locked down, I felt safe,” etc.) ■ Incentive pay (e.g., “we appreciate the sentiment of \$5,” “adding \$5 to our salary is really appreciated,” etc.) 	<ul style="list-style-type: none"> ■ Use of benefit time (e.g., “if you have two jobs you can’t file for unemployment,” “[the agency] should not have used our time off,” “we were told for people who are staying home [the agency] will use [our] PTO and [our] PTO will be reimbursed,” etc.) ■ Staff schedule changes / taken off shift (e.g., “sitting around doing nothing when you are willing to work,” “some people depend on their second job and we didn’t get enough time to adjust [to new schedule,” etc.) ■ Termination of incentive pay (e.g., “the pandemic is still on and they just took [the incentive pay] off,” “I do not know why they took [the incentive pay] off,” “the raise was just for a short period of time, like for a month, we are still in the crisis so I think the raise should continue,” etc.) ■ Communication (e.g., “the communication and preparation should have been handled a little better during the chaotic time,” “I think there was a drop in communication,” “there was information coming from all over the place,” “communication... we don’t know anything,” etc.)

Table 3 Focus group recommendations to organization leadership

What could the organization have done better to support staff? What things would you still like to see the organization do in response to the crisis?	What, if any, things did we put in place in response to the crisis that we should have been doing all along?	What lessons or takeaways should the organization learn from this crisis?
<ul style="list-style-type: none"> ■ More training on protocols (e.g., “maybe more training for staff,” “giving us guides and training us on protocols,” etc.) ■ Provide more PPE (e.g., “gloves, gowns, that is where we were lacking,” “needed more than we had,” “provide proper PPE,” “the PPE... if we can have that ready and be able to boost the morale a little too because you know we have the things we need to protect ourselves,” etc.) ■ Communication (e.g., “communication during the initial period,” “information could be disseminated better,” etc.) 	<ul style="list-style-type: none"> ■ Emphasis on cleaning / ensuring good hygiene in supported individuals (e.g., “doing our best to clean the house, disinfecting, encouraging individuals to use hand sanitizer,” “encouraging guys to wash hands,” “hygiene, social distancing,” etc.) ■ Ongoing storage of supplies (e.g., “gowns, masks, etc.... keep them in storage because you never know,” “now would be a good time to stock up on supplies,” “open a stockroom like a pantry where supplies are stocked and stored for the next situation,” etc.) ■ Staff appreciation (e.g., “staff appreciation, like gift cards, should be constant,” “recognition for the job I do,” etc.) 	<ul style="list-style-type: none"> ■ Appreciate staff (e.g., “respect the DSPs, they are taken for granted but look at the job they did,” “the organization needs to know it has a good team of workers, committed workers,” “definitely appreciate the staff more... they put their families at risk to come to work every day,” etc.) ■ Be prepared for future crises (e.g., “teaching us to be prepared,” “be ready for whatever comes,” “they should be proactive and know what they’re going to do in case of another pandemic,” “we should always be prepared, anything can happen,” “have a focus group to figure out what to do in a situation like this,” etc.)

Procedures

Based on the findings from phase 1 and discussion with organization vice presidents, the research team constructed a list of leadership actions in response to the COVID-19 pandemic (Table 4) according to six categories: (1) changes in schedules and work assignments, (2) delivering services remotely, (3) changes in administrative activities, (4) adding new safety practices, (5) enhancing existing supports, and (6) improving technology resources. The leadership actions were subsequently converted to a 31-item questionnaire that was sent to the participants via online survey platform. Other than requested demographic information, the questionnaire was completed anonymously and returned on or before a deadline date.

Measures

Each item on the questionnaire represented one leadership action. Participants were requested to rate the impact of these actions during the period of March–June 2020 on a five-point scale: 1 (very positive impact), 2 (somewhat positive impact), 3 (no impact), 4 (somewhat negative impact), and 5 (very negative impact). The ratings produced quantified measures by which to evaluate organizational effectiveness in response to the pandemic. Participants could also rate items with “I am unable to evaluate the impact of this item.”

Data Analyses

An exploratory factor analysis (EFA) using principal component analysis of the questionnaire showed support for a one-factor solution based on a flattening point on the scree plot following the first factor. Additionally, the one-factor explained almost 38% of the total variance, whereas the next factor explained only 8% of the total variance. The EFA revealed that 30 of the 31 items on the questionnaire were associated with the one-factor scale at reasonable level as demonstrated by factor loadings above 0.3 (Furr & Bacharach, 2014). The one item that did not meet this threshold, “temporary incentive pay for direct support staff,” had a factor loading of 0.264.

Outcome measures were first determined by identifying participants who rated a minimum of 10 questionnaire items. Participants who did not meet this criterion were excluded from the analysis. A mean rating per item was computed by summing the ratings on each item and dividing by the respective number of participants (not all participants rated every item).

Table 4 Leadership actions in response to the COVID-19 pandemic

1.Changes in schedules and work assignments	<ul style="list-style-type: none"> ■Adding 12-h shifts ■Permitting certain activities be done remotely ■Redeploying clinicians to operational support ■The “Stay Healthy in Place” (SHIP) initiative ■Redeploying day services staff to group homes
2.Delivering services remotely	<ul style="list-style-type: none"> ■Remote delivered structured activities for residents by affiliate staff ■Remote day program services for residents by Aspire! staff ■Increased structured daily activities ■The use of telehealth services ■Remote clinical consultation to residents ■Remote clinical consultation to support staff ■Remote referral screening
3.Changes in administrative activities	<ul style="list-style-type: none"> ■Weekly meetings with RDs, conducted remotely ■Staff meetings conducted remotely ■Hiring interviews conducted remotely ■Temporary incentive pay for direct support staff
4.Adding new safety practices	<ul style="list-style-type: none"> ■Centralized purchase, storage, and distribution of PPE ■Recurrent, daily sanitization protocols ■Posters and signs for safety practices and regulations ■Written safety guidance and updates from CDC, Board of Health, DDS and SHF ■Recurrent (daily, less than daily) COVID-19 conference call providing updated information and guidelines ■Providing masks to programs ■Providing advanced PPE (gowns, face shields) to programs when needed ■Providing advanced PPE (gowns, face shields) to programs when needed ■Mobile COVID-19 testing at the home
5.Enhancing existing practices	<ul style="list-style-type: none"> ■Daily activity programming for residents of group homes during SHIP ■Increased recognition for support staff during the crisis ■Promoting, modeling, and supporting teamwork ■Increasing communication, sharing information, coordinated across all levels ■Grocery and other delivery to homes during isolation and SHIP
6.Improving technology resources	<ul style="list-style-type: none"> ■Ensuring residence directors had laptops ■Adding remote cameras to residence computers ■Improving Wi-Fi and ability to connect to the internet in the residence

Results

The mean rating across all items on the questionnaire was 1.71 ($SD = 0.58$) for participants who rated a minimum of ten items or average impression that leadership responsiveness to the COVID-19 pandemic had a “somewhat positive impact.” Table 5 presents the rank-ordered mean ratings for every item on the questionnaire (none of the participants rated every item). Items with the strongest endorsements from participants were “Mobile COVID-19 testing at the group home” ($M = 1.31$, $SD = 0.68$), “temporary incentive pay for direct support staff” ($M = 1.31$, $SD = 0.66$), and “providing masks to programs” ($M = 1.33$, $SD = 0.81$). The weakest endorsed items from the participants were “redeploying day services staff to group homes” ($M = 2.20$, $SD = 1.16$), “conducting hiring interviews remotely” ($M = 2.19$, $SD = 1.14$), and “adding remote cameras to residence computers” ($M = 2.03$, $SD = 1.21$). Finally, five items on the questionnaire were scored “I am unable to evaluate the impact of this item” by more than 25% of participants,

specifically “adding remote cameras to residence computers” (35%), “conducting hiring interviews remotely” (29%), “remote day program services for residents by vocational training staff” (29%), “remote referral screenings” (26%), and “redeploying clinicians for operational support” (25%).

Discussion

We conducted a mixed methods study that assessed the opinions of direct care providers about leadership responsiveness to the COVID-19 pandemic at a human services organization for adults with ID and ABI. The reasons for conducting workforce assessment are many, including evaluation of organizational effectiveness, identification of areas in need of improvement, and solicitation of program recommendations from employees (Eisenberger & Stinglhamber, 2011; Eisenberger et al., 1986). Demonstrating sensitivity to the attitudes of employees also shows commitment to valued services and client care that most employees would perceive

Table 5 Mean and rank-ordered questionnaire ratings

Questionnaire items	<i>N</i>	<i>M</i>	<i>SD</i>
Mobile COVID-19 testing at the home	331	1.31	0.68
Temporary incentive pay for direct support staff	355	1.31	0.66
Providing masks to programs	360	1.33	0.81
Written safety guidance and updates from CDC, Board of Health, DDS, and SHF	356	1.42	0.70
Providing advanced PPE (gowns, face shields) to programs when needed	353	1.43	0.90
Recurrent, daily sanitation protocols	358	1.44	0.82
Posters and signs for safety practices and regulations	357	1.47	0.76
Grocery and other delivery to homes during isolation and SHIP	320	1.49	0.83
Increasing communication and sharing information, coordinated across all levels	343	1.52	0.81
Prompting, modeling, and supporting teamwork	341	1.54	0.84
The use of telehealth services	334	1.57	0.83
The “Stay Health in Place” SHIP initiative	329	1.60	0.90
Daily activity programming for residents of group homes during SHIP	319	1.63	0.87
Permitting certain activities to be done remotely	336	1.63	0.87
Increased recognition for support staff during the crisis	340	1.65	0.98
Recurrent (daily, less than daily) COVID-19 conference call providing updated information and guidelines	319	1.66	0.85
Improving Wi-Fi and ability to connect to the internet in the residences	308	1.69	1.07
Weekly meetings with RDs, conducted remotely	309	1.77	0.99
Remotely delivered structured activities for residents by affiliate staff	330	1.78	0.89
Centralized purchase, storage, and distribution of PPE	338	1.78	1.08
Increased structured daily activities	331	1.81	0.89
Remote clinical consultation to residents	298	1.84	0.96
Adding 12-h shifts	326	1.90	1.12
Staff meetings conducted remotely	347	1.90	1.13
Remote day program services for residents by Aspire staff	259	1.91	0.96
Remote clinical consultation to support staff	287	1.92	0.95
Remote referral screenings	272	1.96	0.91
Redeploying clinicians to operational support	272	1.99	1.00
Adding remote cameras to residence computers	236	2.03	1.21
Hiring interview conducted remotely	258	2.19	1.14
Redeploying day services staff to group homes	278	2.20	1.16

Note: *N* number of participants from 498 who rated the questionnaire item

as meaningful POS (Kurtessis et al., 2017). Discussed below, there were several key findings from the study specific to issues raised by the COVID-19 pandemic, results of prior research, and mixed methods inquiry targeting health topics.

Within focus groups, the responses from participants suggested they were capable of working through fear, uncertainty, and doubt at the start of the pandemic and emerge with a stronger sense of the importance of their jobs. Their apparent resilience may have been the result of the rapid response to safety concerns, distribution of PPE, and SHIP program which were perceived as critical risk mitigation strategies within group homes. Also, the positive experiences reported by participants may have been nurtured by group home managers and supervisors who promoted collaborative teamwork, acknowledged exemplary performance, and added supports that relieved

day-to-day burdens. Importantly, these findings suggest that human services care providers are keen observers of how their leaders react to crises and will form lasting judgments about an organization on this basis.

The recommendations from focus group participants further reflected the desire to prepare for future health crises. For example, participants suggested that the human services organization could improve its training and emergency response guidelines. While programs were eventually able to meet PPE needs, participants recommended rapid availability and storage of a broader range of equipment. And many participants enthusiastically endorsed continued recognition and positive support of employees from organizational leaders and program managers that was evident during the early months of the pandemic.

Phase 2 results were generally positive for many of the COVID-19 leadership actions rated by a large sample of direct care providers. Immediate and conspicuous initiatives such as performing mobile surveillance testing at group homes, offering temporary incentive pay, and supplying PPE were highly regarded among other directives toward risk mitigation and health promotion. The appeal of these leadership actions may have reflected positive regard for the immediate corrective plans that were put in place and the appreciation care providers felt for steps taken to guard their health and personal welfare. At the same time, participants viewed some initiatives as having less impact, or they were not able to endorse a rating, for example, adding remote cameras to computers, conducting hiring interviews remotely, and assigning day-services employees to group homes. It appears that the top-rated items on the questionnaire including other approved strategies (e.g., fluid communication, information sharing, delivering of materials to group homes) quantified the impressions of focus group participants. However, we propose that all of the items and respective ratings from the questionnaire provided the human services organization with meaningful measures to evaluate the scope and effectiveness of its COVID-19 pandemic responsiveness, decide about performance maintenance, and plan strategically. And, as referenced previously, the highly endorsed leadership actions from focus group and questionnaire participants were tangible contributions to job satisfaction that usually appeal to employees and heighten their opinions about POS (Kurtessis et al., 2017; Rhoades & Eisenberger, 2002).

Mixed methods research intentionally integrates and combines qualitative and quantitative data as a methodology to evaluate programs from multiple perspectives, build cooperative relationships with research participants, contextualize the questions being studied, and compare-contrast findings in the broadest context (Jason & Glenwick, 2016; Plano Clark, 2010; Tebbes, 2012). As illustrated in this study, initial qualitative analysis often has the purpose of designing an instrument for acquiring measures pertinent to health-related services and outcomes (Bowers et al., 2013; Fetters et al., 2013; Song et al., 2010). For example, Jason and Reed (2015) described mixed methods approaches toward myalgic encephalomyelitis (ME)/chronic fatigue syndrome (CFS), starting with patient and illness support group interviews that addressed symptom presentation, access to treatment, negative encounters with medical professionals, and stigmatization. Qualitative analysis within a grounded theory framework was followed by quantitative measurement through several screening instruments and rating scales which refined demographic variables and diagnostic criteria among ME/CFS patients. The acquired measures also suggested alternative treatment modalities and sources of community support to help cope with the illness. Relative to the objectives

and benefits of mixed methods research, Jason and Reed (2015) concluded that “Quantitative research provided us the data on the magnitude of this illness, whereas the qualitative methods allowed us to better understand the unique challenges and stigma that the patients had experienced from their families, friends, and treatment professionals” (p. 10).

In summary, the present study adds to the emerging literature on the effects of the COVID-19 pandemic with healthcare workers including service providers for adults with ID and ABI (Blake et al., 2020; Courtenay et al., 2020; Embregts et al., 2020; Giusti et al., 2020; Tan et al., 2020). Our focus was on human services care provider perceptions of the effectiveness of leadership actions and recommendations to prepare for future health crises. The research participants prioritized the impact of several leadership initiatives and emphasized other actions to institute organization-wide. This integrated assessment produced qualitative and quantitative measures that were merged as a comprehensive and socially valid performance evaluation.

Limitations and Future Research

Interpretation of our findings is limited on several levels. First, results are not easily generalizable because the study was conducted with a convenience sample at one human services organization. Also, circumstances at the time of the study dictated that the focus groups be interviewed remotely; thus, it may be questioned whether in-person meetings would have produced different responses from participants. And third, the study relied on self-report measures, none of the participants in phase 2 rated every item on the questionnaire, and our demographic data did not include educational level, SES, and racial/ethnic background of the participants.

Another potential limitation is that mixed methods evaluation may be too time- and labor-intensive for some human services organizations (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2003). Yet, a scaled-back methodology could be the focus of future research by assembling a team of in-house professionals who have shared responsibilities and address organization-supported objectives as incorporated in this study. An additional research direction is determining how the work experiences of care providers, time on the job, and roles at a human services organization influence their perceptions of leadership responsibility and effectiveness.

Author Contribution All authors contributed to the design of the study; JC, NMD, DF, MT, and JW conducted assessments; and AWR, JNR, and JKL analyzed data and wrote the manuscript.

Declarations

Ethics Approval All procedures conformed to ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent All individuals consented to participation in the study.

Conflict of Interest The authors declare no competing interests.

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