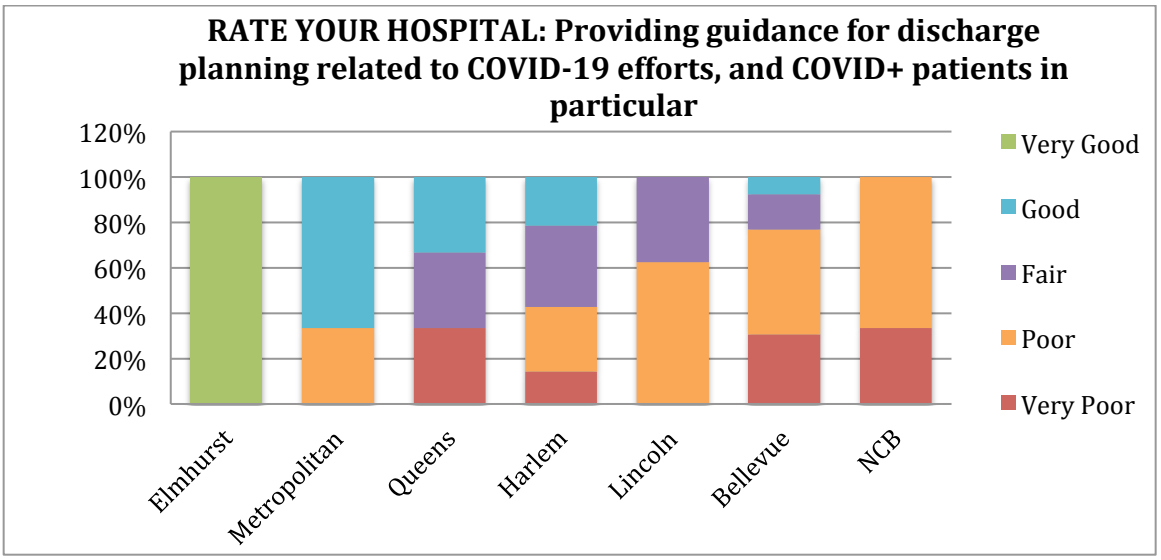
Our **experience during the COVID-19 pandemic:**

Through a series of virtual meetings and a survey with 77 respondents, we gathered the following data:

- **Training**: It follows that with an influx of patients there is an increased need for comprehensive discharge planning, a role primarily performed by Social Workers. Despite this being a foreseeable need, our departments failed to provide adequate training for those reassigned to medical floors. Among the 54 workers to whom this applied, 78% said training was either Poor or Very Poor. On a daily basis, staff showed up to work unsure of how to perform their new roles because management never told them how to.

- **Workflow**: Two processes core to discharge planning continually changed as guidance from the CDC and DOH evolved: criteria for "safe discharges" and the resources available to coordinate these discharges. Many of us were unable to obtain clarity on what was considered "safe," including consideration for household composition, availability of food, medication and disinfectant supplies, appropriate transportation and ADL support if needed. As new policies were established, Managers frequently forwarded convoluted emails for Social Workers to sift through to glean pertinent information without providing updated training, departmental Q&A or supervisory support.

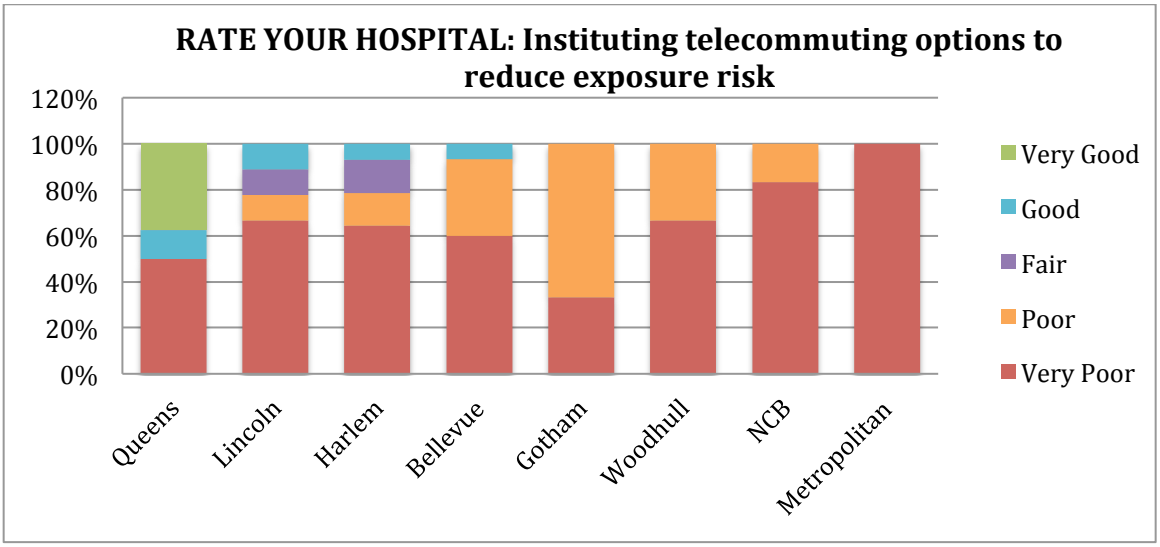
  While most Elmhurst, Metropolitan, Queens and Harlem Social Workers rated their Managers as Fair or better, but the rest were Poor or Very Poor. It appears effective guidance was developed in some locations, but not circulated throughout all facilities.



- **Telecommuting**: Early in the crisis, our union sent you a letter advocating for widespread implementation of telecommuting for Social Workers, noting that the vast majority of what we do can be done remotely. Other hospital systems, both private and the VA, instituted telecommuting for broad groups of Social Workers, meeting both the operational needs of the hospitals and dramatically reducing exposure. You deferred those decisions to the local hospital CEOs, many of which flatly refused to accommodate their Social Work departments, though comprehensive, common sense telecommuting proposals were submitted. Even where Department Directors expressed openness to these plans, CEOs rejected them, citing the need

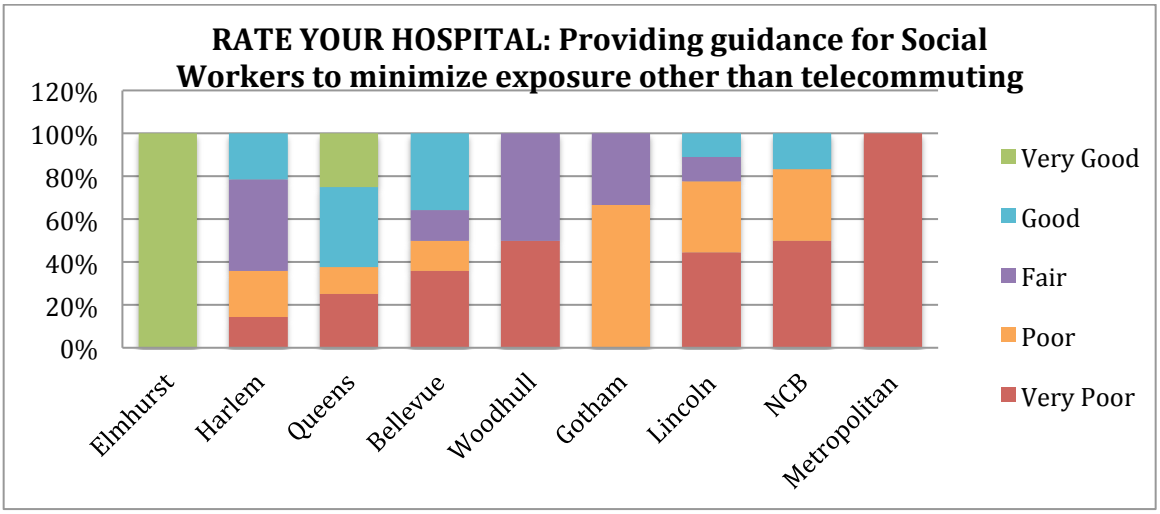
for workers to be available for the general labor pools. This despite the fact that all proposals were limited to the period Social Workers remained assigned to their Social Work roles. Additionally, we have not heard of any Social Workers being reassigned to the general labor pools, further undermining this rationale.

Managers were arbitrarily and unnecessarily putting us at significant risk for contracting COVID-19. Among our survey respondents, 82% reported Poor or Very Poor consideration of telecommuting options.



- **Reducing exposure (other than telecommuting):** While working on site, other opportunities to reduce exposure include allowing our interactions with inpatient COVID+/PUI clients to be performed via bedside telephones and daily rounding with teams held via phone- or video-conference completed from our offices.

Overall, 46% of respondents said their Managers did at least a Fair job in this area, but the experience varied considerably across facilities, with Metropolitan reporting Very Poor accommodations. Again, practices were developed at some hospitals that effectively balanced the needs of departments with staff's desire to minimize exposure, and these best practices were not adopted consistently across the system.



- **PPE availability and use:** While PPE availability was a national problem, and Health+Hospitals used every available means to procure more, we feel there were opportunities for improvement. Only 37% of respondents felt they had both the proper training and PPE materials to perform their roles based on the guidance at the time. Social Workers were often not included in PPE trainings provided to Nurses, and our Directors only arranged for us to be trained much later in April or May, if at all. Additionally, Social Workers were given conflicting information of where to obtain the necessary PPE, with Nursing Managers and Social Work departments each expecting the other to provide it.

  While we don't have adequate survey data from Elmhurst, anecdotally we heard that extremely clear and effective PPE protocols were developed, essentially eliminating gaps in training and availability by stationing staff at entrances to clearly marked hospital 'zones' to ensure all staff donned and doffed the correct PPE appropriately.

  Again, best practices were developed, but not widely adopted. Some Managers were proactive in protecting their staff, regardless of the facility's protocols, and others were not. Social Workers in many locations felt that they were an afterthought in regards to PPE and were being unnecessarily put at higher risk for exposure.