

# Recreational Therapy in Nursing Homes

History, Regulations, COVID-19, and Beyond

## Invited Paper

Tarah Loy  
Dawn DeVries  
M. Jean Keller

## Abstract

The current pandemic has changed the way allied health professionals, including recreational therapists, provide care in the nursing home setting. This article aims to address concerns for older adults residing in nursing homes by reviewing the history of nursing homes, analyzing the impact regulations have had on the recreational therapy profession, and offering considerations for future practice in a COVID-19 world.

## Keywords

*COVID-19, history, nursing home, recreational therapy/therapeutic recreation, regulations*

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**Tarah Loy** is an assistant professor and program director of the Therapeutic Recreation Program at Regis College.

**Dawn DeVries** is an associate professor and Program Chair of the Therapeutic Recreation Program at Grand Valley State University.

**M. Jean Keller** is a professor in the Department of Kinesiology, Health Promotion and Recreation at the University of North Texas.

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Please send correspondence to Tarah Loy, [tarahloy@gmail.com](mailto:tarahloy@gmail.com)

Carl Sagan once said, “We have to know the past to understand the future” (Goodreads, 2020). The history and development of recreational therapy (RT), and delivery of its services in nursing homes, needs to be shared in order to advance practice. Understanding the value of RT in nursing homes allows professionals to articulate its outcomes and contributions. The Coronavirus disease of 2019 (COVID-19) pandemic has affected RT in nursing homes through budget shortages, layoffs, furloughs, disproportionately high numbers of residents’ illnesses and deaths, social distancing, and closure of facilities to families and friends (Miller, 2020). Yet, RT continues to contribute to quality of care and life of residents.

In the U.S., 15,600 nursing homes (Centers for Disease Control & Prevention [CDC], 2016) served 1.4 to 1.5 million people (Howley, 2019). Currently, 17.1% of Certified Therapeutic Recreation Specialists (CTRSs) work in skilled nursing facilities, 3.4% adult day centers, and 6.3% work in assisted living (NCTRC Job Analysis, 2014). A total of 30.4% of CTRSs work with the geriatric population, the second highest percentage of primary population served (NCTRC Job Analysis, 2014). Understanding RT’s past, present, and future relationship with nursing home residents’ care may ensure future longevity in this setting and increase the delivery of quality services. The intent of this piece is to review the historical development of nursing homes and governing regulations as well as the contributions of RT professionals to residents. Practice and research recommendations influenced by COVID-19 and other future changes likely to influence RT are overviewed.

## **The History of Nursing Home Care in the U.S.**

The history of nursing homes in the United States (U.S.) dates to the beginning of the country’s settlement by Europeans. As a mostly agricultural society, families served as primary caregivers for those who needed any type of assistance. For those without family, another household might provide care that was reimbursed by the town (Kaffenberger, 2000). With a life expectancy at middle age, few older adults needed care. By 1850, the average life expectancy was approximately 45 years (University of Oregon, n.d.). As society shifted toward industry and people moved away from family, a growing need for alternatives to caregiving of older adults developed.

In the 1800s, almshouses, also known as poor houses, developed for those unable to provide for themselves financially or care for themselves physically or mentally (Hoyt, 2018; Kaffenberger, 2008; Singh, 2016). Over time, this form of charitable housing was known for its poor conditions, inhumane treatment, abuses, and costliness. States began to create facilities and encouraged benevolent and religious organizations to serve the residents (Hoyt, 2018; Kaffenberger, 2008; Singh, 2016). Individuals who had wealth frequently opted for private homes or boarding houses, called “rest homes” (Hoyt, 2018). As health care became more professionalized, so did the development of care facilities.

By the beginning of the 1900s, nonprofits provided the majority of institutionalized care to older adults (Kaffenberger, 2008). Limited government support was provided so individuals were expected to pay for these services out-of-pocket. During the Great Depression of the 1930s, federal and state governments provided financial assistance for care and growth of for-profit older adult care communities (Hoyt, 2018; Kaffenberger, 2008; Singh, 2016).

## The Impact of Policy and Payment Development

Following World War I, Americans became more open to public social insurance, which provided funding to those unable to care for themselves (Kaffenberger, 2008). The shift in attitude contributed to the passage of the Social Security Act of 1935 (SSA), landmark legislation that allocated federal monies for assisting older adults who were poor (Kaiser Family Foundation [KFF], 2017). With older adults having social security payments, care institutions for older adults expanded (Kaffenberger, 2008). In 1946, the federal government approved construction funds under the Hill-Burton Act, which contributed to the building of hospitals and nursing homes (Hoyt, 2018; Singh, 2016). In the 1950s, SSA was amended to pay nursing homes for the care they were providing and states required nursing homes to be licensed (Hoyt, 2018; KFF, 2017). The next significant change occurred in 1965 when Medicare and Medicaid were developed, providing financial support based on age (Medicare) and need (Medicaid). The Older Americans Act (OAA) was enacted at this time creating the Administration on Aging to focus more attention on the growing needs of older Americans.

In the wake of governmental support and funding without regulations, for-profits responded more quickly and aggressively than non-profits to nursing home ownership (Institute of Medicine [IOM], 1986; Morford, 1988). For-profit homes serving older adults successfully banded together to influence policies (Kaffenberger, 2008) and become powerful leaders for this growing industry (Kingsley, 2018). This profit-driven industry advanced nursing homes toward a medical model of care (Morford, 1988; White-Chu et al., 2009). In 1986, comprehensive regulations for nursing homes were instituted (KFF, 2017; Passmore et al., 2016; Singh, 2016). Quality and professional standards of care for Medicare and Medicaid certified nursing homes (referred to as skilled nursing facilities [SNFs]) were then developed by the Centers for Medicare and Medicaid Services (CMS) (Committee on Nursing Home Regulation, 1986) formally known as the Health Care Financing Administration (HCFA).

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) transformed the nursing home industry. Resident rights, quality of care standards, personnel credentials, and financial regulations were established to ensure and protect older adults living in nursing homes (Singh, 2016). A shift from the medical model of care to a quality of care emphasis occurred (Buettner, 2001; Legg et al., 2010; Martin & Smith, 1993). OBRA '87 included the establishment of standards for activity departments and identified qualified activity professionals that included Certified Therapeutic Recreation Specialists (CTRSs) (Richeson & Kemeny, 2019). Additionally, the Minimum Data Set (MDS), care planning and documentation standards improved assessment and quality of care following the full implementation of OBRA in 1994 (KFF, 2017). These standards aligned well with the practice and delivery of services by CTRSs.

The next significant change transformed how nursing homes received payment. The Balanced Budget Act of 1997 (BBA '97) required Medicare to shift to the Prospective Payment System (PPS), moving the industry from reimbursement on a retrospective per diem basis to coverage based on resource utilization (Passmore et al., 2016; Singh, 2016). The MDS now served not only as an assessment tool to ensure quality and appropriate care, but became a financial tool used to determine payment (Passmore et al., 2016). Based on services provided (i.e., physical therapy, occupational therapy, speech-language pathology, respiratory therapy, medications, nursing level

of care, etc.), resources were placed into the Resource Utilization Groupings (RUGs) which generated varying levels of payment. CMS defined RT as a distinct service from the activities program, and CTRs who provided physician ordered active treatment could capture their days and minutes of treatment in MDS 2.0 Section T (currently and Section O in MDS 3.0 Section O) (Buettner & Legg, 2011; CMS, 2006; DeVries, 2014).

Such a significant change for nursing homes was soon followed by the implementation of quality measures. Quality measures used MDS data to identify and score a nursing home in comparison to other nursing homes. This data became publicly available in 2002 via Nursing Home Compare on the CMS website, using this data for assessment, payment, and quality measurement (Passmore et al., 2016). Quality measures were replaced with the Five-Star Quality Rating System (CMS, 2019), which is the system currently used today.

Effective October 1, 2019, the Patient-Driven Payment Model (PDPM), a new case-mix classification model, was implemented for classifying skilled nursing facility residents. PDPM was designed to improve accuracy and appropriateness of payments, reduce administrative burden, and improve payments for underserved groups (such as people on ventilators and people living with HIV/AIDS) (Medicare Learning Network [MLN], 2019). Modifications to the MDS were made, such as diagnosis by clinical categories and functional scoring. Use of the RUGs was discontinued with resources now allocated to therapy, nursing, and non-therapy ancillaries with each having an impact on the payment received for Medicare Part A services (MLN). With this change as well as the increasing complexity of the health care needs of older adults, CMS and state regulatory standards were revisited to better reflect the level of services and professionals providing services to residents.

## **Regulations and Recreational Therapy Services in Nursing Homes**

The MDS was part of the original regulations put forth in the OBRA '87 as a means to ensure nursing home residents were properly assessed and plans of care were created to promote optimal care and quality of life (Buettner, 2001). The MDS was a part of the Resident Assessment Instrument (RAI) that also included the Resident Assessment Protocols (RAPs). The assessment areas on the MDS addressed areas of functioning and served as a basis for the RT plan of care (Buettner, 2001; Passmore et al., 2016).

Since implementation in 1990, the MDS has undergone several changes with multiple revisions leading to the current MDS 3.0 (Passmore et al., 2016). The 1998 and 2000 revisions identified RT as a distinct profession and its addition to Section T – Special Treatments. CMS defined RT as

Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist. (CMS, 2002, pp. 3–215)

In contrast, CMS defined activities in F-Tag 248 as “any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health” (CMS, 2006, p. 74). By including RT on the MDS, CTRSS could include their resident treatment under Medicare Part A. CTRSS were encouraged to document their services and provide physician ordered RT to individuals needing RT services within SNFs (ATRA, 2004).

The MDS 3.0 2010 version included RT and moved it to Section O—Special Treatments and Procedures (Buettner, 2010) where it is considered a rehabilitation treatment option and can be ordered by a physician (De Vries, 2014). Physicians can order RT for residents as medically necessary and appropriate and it becomes a facility’s obligation to provide this service (De Vries, 2014). Despite attempts to educate CMS and recommendations to include RT in the payment system, this has not occurred under PPS or PDPM. Due to this lack of coverage, many administrators, nurses, and other therapists remain unaware of RT and its benefits to residents.

Even though CMS, state regulatory agencies, and current legislation support meaningful and active engagement of residents through a program designed to meet the physical, psychosocial, and well-being needs of residents, RT has yet to be considered acceptable as a covered service by CMS (De Vries, 2014). This continues to result in many CTRSS being underutilized in the role of activity directors and activity assistants (Buettner, 2010).

### **Scope of Recreational Therapy in Nursing Homes**

RT services have been provided in nursing homes since the mid-1960s (e.g., Kurasiik, 1965). Since that time, more CTRSS are working in nursing home settings (Ross & Snethen, 2017). The NCTRC (2014) indicated that 17% of CTRSS are working in SNFs, second only to those employed in hospitals (NCTRC, 2014).

Due to the complexity and demanding regulatory changes that have occurred over the last 30 years, the need for RT in nursing homes has grown. As nursing homes focus on health, recovery, and well-being in all areas of life, RT similarly promotes health, autonomy, independence, optimal physical and cognitive functioning, and emotional and social well-being (Carter & VanAndel, 2020; NCTRC, 2020). Specific to nursing homes, RT may provide residents with non-pharmacological behavior interventions, activities’ modifications to match functional levels, meaningful engagements and social interactions, maintenance and restoration of physical and cognitive abilities, and fall reduction. The following sections summarize regulatory updates overviews areas where CTRSS are competent to deliver RT interventions that differ from those of other professionals working in nursing homes (DeVries, 2014).

### **Regulatory Requirements Updated**

In 2018, CMS implemented updated SNF regulations placing increased emphasis on person-centered care, safety, quality care, and staffing competencies (LeadingAge-NY, n.d.). These regulations were followed by the PPS changes on October 1, 2019, leading to PDPM that was previously discussed. Person-centered care, defined as the resident being at the center of all decisions having independent choices and autonomy, was emphasized (Wigman, 2017). This included having a comprehensive person-centered RT care plan and resident rights emphasizing the resident as an integral part of the care planning process (Wigman, 2017).

CMS continued to build on the quality of life requirements which state “each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care” (CMS, 2017, p. 244). The quality of life standards focus on the provision of group and individual activities to meet a person’s interests, support their well-being, promote independence, and encourage community interaction (Wigman, 2017).

### ***Activity Director Certification (ADC) and CTRS***

F-tag 680 (previously F249) details the requirements of leadership in the SNF activities department. Qualified individuals include professionals credentialed with the CTRS, occupational therapists or occupational therapy assistants, persons with two years of experience in a social or recreational program within the last five years (one year must be in full-time employment), or individuals who have completed a state approved training course (CMS, 2017, p. 246).

While many nursing homes employ individuals with an Activity Director Certification (ADC) to lead their programs, those with CTRS certification bring extended education and experience to address and meet resident needs. The current requirements for ADC include a minimum of a high school diploma/GED, 12,000 hours working in an activities department in the past six years (required for those with only a high school degree), 40 hours of continuing education within five years, a 180-hour training program, and an exam (National Certification Council for Activity Professionals, 2019). Training includes topics on aging, leisure, leadership, public speaking, interpersonal relationships, regulations, and programming. In contrast, a CTRS has a minimum of a four-year bachelor’s degree in RT, therapeutic recreation (TR), or recreation with an emphasis in TR from an accredited university, 18 semester hours in specific RT content (minimum of five courses), additional coursework in anatomy and physiology, abnormal psychology, human growth and development, completion of a 560-hour internship, and successful completion of a national certification exam (NC-TRC, 2019). Also, the internship experience must cover the 69 items in the job analysis (NCTRC, 2020).

The more in-depth training on disability, psychology, programming, adaptation, and health provides the CTRS with a greater knowledge-base and experience for working with residents having complex medical issues. CTRSs go beyond the provision of meaningful activities and engagement provided by the ADC by working to restore, remediate or rehabilitate functioning and independence (Buettner, 2011; NCTRC, 2020).

### ***Resident-Centered Programming***

F679 (formerly F248) emphasizes the need for resident-centered programs that provide opportunities for a “meaningful life” (CMS, 2017, p. 242). The regulations address assessing and engaging residents according to their individual interests and lifestyles. The regulations offer guidance on interventions and approaches to address various behaviors and mood issues, many specific to dementia. An emphasis is placed on reflecting daily life, instead of a formal activities program (CMS, 2017, p. 245) and to demonstrate a typical life routine (rather than that of an institution). Each of the regulations address components and competencies CTRSs employ, including the APIED



process (individualized assessment, planning, implementation, evaluation, and documentation) to meet the residents' holistic needs.

**Survey and Agency Outcomes.** Limited research is available on the outcomes CTRSs may have on nursing home evaluations often referred to as surveys. Buettner and Legg (2011) noted RT had a positive effect and \$30,000 to \$70,000 return on investment in nursing homes related to residents' quality of life, fall prevention, and non-pharmacological behavioral interventions. However, other research illustrates nursing home administrators' lack understanding of what RT is and its impact (Loy et al., 2019).

**Culture change** is a model of person-centered care which moves away from the medical model of care (White-Chu et al., 2009) and also shares a similar scope of practice with RT. Person-centered care embraces non-pharmacological interventions, resident autonomy, and opportunities for purposeful leisure experiences (Fazio et al., 2018) and has been recognized by CMS as a regulatory requirement to increase the quality of life of residents (American Health Care Association, 2016). Studies have shown that nursing homes that embraced culture change were associated with better resident care and less deficiencies (Grabowski et al., 2014).

CTRSs focus on individual personal experiences and interactions to influence their interventions; and, in a similar fashion culture change emphasizes communication and relationships (Fazio et al., 2018). Relationships are necessary among residents, staff, and administration to ensure that resident autonomy flourishes. In a study conducted by White-Chu et al., residents who were given more choice and opportunity engaged in more active interpersonal activities and rated themselves as having a higher quality of life (2009). CTRSs support the culture change process through their professional preparation and dedication to our professional standards of practice and ethics code that encourage residents' growth, development, and self-determination.

**Non-Pharmacological Behavioral Interventions.** Many nursing home residents experience mood and behavior issues, related to life changes, aging, or specific diagnoses such as dementia and Alzheimer's disease. The CDC (2019) reported that 46.4% of nursing home residents have a diagnosis of depression, with 47.8% having dementia or Alzheimer's disease. It is well documented that "Activity, a positive therapeutic modality, has potential to enhance quality of life and reduce behavioral symptoms in persons with dementia—outcomes eluding pharmacological treatment" (Trahan et al., 2014, p. 70S). The federal guidelines (F679) specifically require activity adaptations and interventions with individuals living with dementia. Specific suggestions are offered for individuals who wander, display behaviors that impact a home-like environment, become overstimulated, rummage, withdraw or isolate, display attention seeking behavior, and are delusional or hallucinate (CMS, 2017).

The *Dementia Practice Guidelines* (DPG), an evidence-based practice resource for CTRSs, provides specific strategies for integrating RT into resident care of treatment for behavioral and psychological symptoms of dementia (Fitzsimmons et al., 2014). The DPG provides a framework and individual RT protocols to support residents' goals.

In addition to the DPG, researchers have found that RT interventions such as cognitive, music, sensory, and reminiscence simulations assist in the effort to decrease the use of pharmacological interventions with residents (Buettner, 2001; Buettner & Ferrario, n.d.; Buettner & Fitzsimmons, 2011; Buettner et al., 2011; Cohen-Mansfield et al., 2017; Kolanowski et al., 2010; Lewis, 2007; Seitz et al., 2012).

**Adaptation.** Adaptation is an important factor to increase engagement based on residents' abilities and limitations. Modifications to materials, objects, space, social requirements, and sequencing and/or timing can promote residents' engagements while also reducing behavioral and mood symptoms (Trahan et al., 2014). CTRSs are skilled at selecting resident activities designed to decrease behavioral symptoms by modifying physical environments such as lighting, sound, and group size that have been shown to yield effective outcomes (Trahan et al., 2014). Supporting residents in reducing frustration, increasing successful activity completion, and engaging in meaningful activities are competencies CTRSs employ with residents in nursing homes (DeVries, 2014).

**Meaningful Engagement.** Engagement is considered a human need (Cohen-Mansfield et al., 2017), and RT plays an important role in its facilitating it. Successful programs use residents' past life experiences and occupations to design programs that are meaningful to each individual (Silvers et al., 2010), further promoting the person-centered care model. The federal regulations actually require activities to "reflect a person's interests and lifestyle, are enjoyable to the person, help the person to feel useful, and provide a sense of belonging" (CMS, 2017, p. 242). F679 states the intent of this regulation is "to create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy, and meaning)" (CMS, 2017, p. 242). CTRSs are skilled to promote connectedness and communication, continuing of life roles, promoting self-esteem, enhancing personal meaning and accomplishments, and maintaining functional abilities while reducing social isolation and depression (Advanced Senior Care, 2010; Bedini et al., 2019; Buettner, 2001; Buettner & Ferrario, n.d.; Sellon et al., 2017).

**Restoration, Maintenance of Function, and Falls Prevention.** CTRSs in nursing homes can play a vital role in helping to restore, maintain, and improve functional abilities of residents receiving care under Medicare Part A (commonly referred to as subacute care), as well as those in long-term care. CTRSs provide active treatment to improve physical, cognitive, social, emotional, and leisure domains of function captured under Section O on the MDS if physician ordered for residents receiving Medicare Part A services (Buettner, 2010; DeVries, 2014).

For those remaining in the nursing home, CTRSs can restore and maintain a variety of abilities through individual treatment and small group interventions (Buettner & Legg, 2011; DeVries, 2014). Involvement in restorative nursing programs by the CTRS can impact the facility's PDPM rate when captured under Section O of the MDS in Restorative Care (DeVries, 2014). CTRSs also provide interventions to reduce the risk of falls and, thus, injury to residents (Buettner & Legg, 2011; DeVries, 2014).

**Co-Treatments.** RTs can work with other allied therapy disciplines to provide treatment and interventions to improve the person's functional abilities. Co-treatments, whether individual or group, can be done with speech language pathology, as well as physical and occupational therapies (PT, OT). CTRSs working with residents with neuropsychiatric conditions, depression, behavioral issues, strokes, Parkinson's, arthritis, and dementia can affect outcomes for these individuals (Buettner & Legg, 2011). CTRSs reinforce therapy treatment with walking, exercise, balance, communication, and cognitive interventions to improve outcomes, as well as serve as a discharge site when OT, PT, and SLP complete treatment (Buettner & Legg, 2011; DeVries, 2014).



## **Threats to Recreational Therapy Service Delivery in Nursing Homes**

### **Lack of Understanding of Recreational Therapy**

Administrators, nurses, and allied professionals in nursing homes are instrumental in advocating for the services and therapies needed by the residents (Buettner, 2001). Limited physician and nursing education programs or textbooks accurately describe RT (Buettner, 2001). Research has determined that although other therapists value interprofessional collaboration and their perceptions of RT are high (De Vries, 2016), administrators are unfamiliar with the field of RT (Harkins & Bedini, 2013; Loy et al., 2019). Consequently, services delivered by CTRs have not been well understood in nursing homes.

### **Funding Issues**

Lack of funding coverage specifically attributed to RT services in nursing homes plays a significant role in present and future sustainability. While identified as a distinct service from activities and identified as a key discipline in Programs for All-Inclusive Care of the Elderly (PACE), RT does not financially impact a nursing home or a PACE program (National PACE Association, 2020). CTRs are trained and competent to deliver services to nursing home residents; however, due to the lack of funding, administrators are not incentivized to hire them. However, Buettner and Legg (2011) wrote, “research has demonstrated a significant return on investment (ROI) from hiring a recreational therapist” (p. 39). Improvements in fall prevention, survey results, and quality of life are documented outcomes (Buettner & Legg, 2011) of CTRs working with nursing home residents.

Another issue facing nursing homes is the underpayment of services through government funding, specifically Medicare and Medicaid. Long-term services for long living adults are a significant component of national health care spending (National Health Policy Forum, 2014), yet funding has remained stagnant (Mohl, 2019). The prioritization of in-home care services, along with Medicaid reimbursement rates from a 2007 cost data report, have contributed to chronic underfunding (Mohl, 2019). For example, in Massachusetts 69% of nursing home residents’ costs are covered by the state’s Medicaid program (Mohl, 2019). The Massachusetts Senior Care Association estimates that facilities are reimbursed at a rate of \$38 per resident per day (Mohl, 2019). This is significantly less than the daily cost to provide appropriate resident care (Mohl, 2019). Without significant investment in each state’s Medicaid program, the nursing home industry as a whole, has an uncertain future.

## **Social Isolation and Recreational Therapy in a COVID-19 World**

COVID-19 has dramatically changed life since its entrance on the world stage in December 2019. Nursing home residents are particularly susceptible to COVID-19 due to chronic conditions, being affected with respiratory virus due to aging changes, frailty, congregate living, and high contact with people who have been outside of the facility (CDC, 2020; Markowitz, 2020; Wu, 2020).

Nursing homes have experienced significant and complex changes including: large numbers of COVID-19 outbreaks and deaths among residents and staff; insufficient amounts of personal protective equipment; staffing shortages due to illness and changes in family responsibilities (i.e., children not able to go to school or daycare); reductions in hospice visits; regulatory restrictions of visitors or volunteers; and increases in mental health issues (particularly anxiety and depression) among frontline workers and residents (CDC, 2020; Chidambaram, 2020; Quilter, 2020). Nursing home residents account for about half of COVID-19 related deaths but are receiving less than half of the country's resources and attention (Godfrey, 2020).

Social isolation appears to be one of the most negative effects of COVID-19 on residents. It is defined as "the objective state of having few social relationships or infrequent social contact with others" (Wu, 2020, p. 1). Prior to COVID-19, researchers had found that "nearly a quarter of older adults were socially isolated and about one-third of middle-aged and older adults experienced loneliness" (Daley, 2020, para. 6). Obviously, social distancing and visitor restrictions have significantly increased the risk of social isolation. Social isolation contributes to chronic diseases, mental health issues, and poor coping with outcomes of obesity, declines in cognitive functioning, increased mortality, and lack of physical activity (Advancing States, 2020; Aten, 2020; Daley, 2020; Wu, 2020). As the COVID pandemic continues, long-term effects of social isolation on residents remains unknown.

The restrictions on visitors including family, friends, and volunteers (CDC, 2020) has affected residents' feelings of loneliness. Reductions in group activities and interactions have contributed to residents' lonesomeness and stress. A nursing home advocate stated, "It's heartbreaking to hear about the increasing number of residents whose health has declined or who have died over these past two months as a result of the loneliness and isolation" (Soergel, 2020, para. 19). The American Psychology Association pointed out that "being separated from someone you love goes beyond isolation; it's a loss of something that can't be substituted" (Abramson, 2020, para. 5). While staff can offer socialization and support, "... staff, no matter how caring and skilled, can never substitute for the love of a relative" (Jackson & Hall, 2020, para. 7).

Virtual visits have become the norm for families and friends with loved ones in nursing homes. Zoom, FaceTime, and Skype are some of the platforms that have allowed families to stay connected with nursing home residents. However, for residents and families, there is nothing like holding a hand or kissing a cheek to feel connected (Bair & Czink, 2020). Families have been encouraged to engage in video chats and virtual activities together like watching a movie or sharing a meal together (Eaton, L., 2020; Markowitz, 2020). Non-technological activities like sending mail, photos, or treats, creating a jigsaw puzzle from a picture of one's family, playing games, and creating theme boxes (Abramson, 2020; Eaton, L., 2020; Markowitz, 2020) have been suggested as ways to meaningfully engage with residents.

Based on research and author observations, RT is playing a key essential role in facilitating person-centered, meaningful activity engagement and non-pharmacological behavioral interventions. Virtual visits are encouraged with some states providing funding to purchase technology to help combat loneliness with the goal of keeping nursing home residents connected. In Pennsylvania, tablets and phones were purchased for 49 nursing homes (Soergel, 2020). Alaska and Texas are working on similar

funding for nursing homes, and Oregon is drafting guidelines for virtual visits (Soergel, 2020). Some states allow socially distanced visits such as window visits, outdoor visits, and drive-by parades (Jackson & Hall, 2020).

Not only is technology assisting with virtual visits, it is providing cognitive stimulation and a means of programming. Some nursing homes offer organization specific TV channels in which programming such as exercise and bingo can be done with people in their rooms physically distanced. Other facilities are providing services like *It's Never 2 Late (iN2L)*, a program available on computers and tablets. The program offers a variety of health applications ranging from physical exercise like arm exercises where participants conduct the classical music and chair yoga. There are also programs within iN2L to address spiritual needs, social needs (like Free Rice which donates rice to help others for each question answered), and cognitive needs (through games like cost estimates and trivia) (<https://in2l.com/U.S. Census Bureau>, 2018). A director of operations at a senior living community said, "From the word games in memory care to a trip around the world, iN2L has truly given some residents a new lease on life. They know they can be transported to new things without leaving the comfort of their home" (iN2L, n.d., p. 6). While COVID has created many restrictions and limitations, it has also offered opportunities for engagement, the use of technology, and creativity that might not have been explored in "typical" times.

## **Trajectories of the Nursing Home Industry and Recreational Therapy**

Professionals can anticipate changes in the nursing home industry post-COVID-19. AARP Vice President of Government Affairs for State Advocacy stated, "This pandemic has made us painfully aware that we can't ignore our most vulnerable people. Americans always respond to a crisis. And there is hope that, with innovative ideas and bold actions, they will again" (Eaton, J., 2020, para. 33). One possible change is expanding aging in place options (Eaton, J., 2020). Changing living arrangements to allow for more individual rooms has been growing in popularity and may be expedited to reduce the spread of infections (Eaton, J., 2020). Creation of less institutional environments and smaller communities like that of the Green House Project (The Green House Project, 2020) may also become more common (Eaton, J., 2020).

Additionally, with increasing life expectancy throughout the world, there are implications for all of health care; and in North America (and as RT grows around the world), in the United States, there will be implications for RT in both the community and nursing homes (Genoe et al., 2017). In Massachusetts alone, 5% of the state's 420 nursing home facilities closed their doors in 2018 (Mohl, 2019). These numbers directly relate to poor reimbursement levels. As the oldest members of the "Baby Boomer" generation reached 73 years of age in 2019, the mere numbers indicate that the nursing home industry will soon have a demand that outpaces the supply (Mohl, 2019).

The financial uncertainties coupled with active older adults will influence RT practices (Genoe et al., 2017). The COVID-19 pandemic leaves many unanswered questions about the future of nursing homes and the role of RT in these settings. As a leading employer of CTRs, the RT profession must contemplate the status of nursing homes and their services to residents.

## Recommendations

The global and U.S. population is forecasted to age significantly, which will impact all areas of society (Genoe et al., 2017). The COVID-19 pandemic will continue to change practices and policies in RT and nursing homes (Dwolatzky, 2020; Genoe et al., 2017). While much is unknown, it is likely that all CTRSs will work with an older population at some point in their career. RT educators may want to rethink curricula related to serving an aging population. NCTRC certification standards may need to include required coursework on the nature of aging, ageism, bereavement, and federal funding for services that benefit the aging population (Buttigeig et al., 2018).

RT scholars frequently advocate for increased evidence-based research on the benefits of RT with older adults. This research needs to be disseminated within nursing homes, nursing organizations, and geriatric health care outlets in addition to the RT profession. The sharing of research will not only introduce other professionals to RT, it will help them understand the scope of practice and how the RT standards of practice support their work. Visibility of RT in other professions can spur efforts to be recognized and reimbursed by CMS (Skalko, 2012). A specific emphasis on interventions and outcomes of RT services during COVID-19 could be explored. For example, a research study might consider if residents who worked with CTRSs experienced less loneliness and social isolation during COVID-19?

New evidence-based research can explore the outcomes of interventions specific to RT during COVID-19 in nursing homes. Learning more about the impact of virtual visits, distancing during activities, and in-room interventions is needed. Another example is the use of legalized medicinal and recreational marijuana. Since the World Health Organization now recognizes cannabis as a therapeutic treatment, it may be prudent to research the potential for cannabis-assisted therapy with nursing home residents (Rosner, 2019).

RT and CMS both share a vision of providing quality services with older adults in nursing homes. It is clear that RT evidence-based outcomes fall within the definition of person-centered care adopted by CMS. Yet, RT is considered unnecessary and remains unrecognized as a reimbursable service by some nursing home administrators. If this perception of RT remains, and CMS continues to underfund nursing homes, it is possible that RT could disappear from nursing homes. It is clear that CTRSs will need to do more to demonstrate their value in addressing specific health and behavior outcomes related to cost effectiveness to gain the attention of CMS and nursing home industry leaders. The presence of COVID-19, brings to the forefront the urgency of CTRSs to design and implement a strategic plan that includes research initiatives and intervention protocols on the relationship of RT and nursing home residents' care and well-being.

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