

ANDREA FREIDUS, MPH, PHD ASSISTANT PROFESSOR, DENA SHENK, PHD PROFESSOR EMERITA OF ANTHROPOLOGY, AND CHRISTIN WOLF

UNC Charlotte-Anthropology (E-mail: dshenk@uncc.edu, cwolfj@uncc.edu)

Integrating Praxis Through the Research Process: Caregivers for Older Americans During the COVID-19 Pandemic

While applied anthropological research is sometimes envisioned as a linear process, we present an alternative view based on our research with frontline workers providing long-term care (LTC) for older adults during COVID-19. We completed a rapid qualitative assessment in central North Carolina from May to November 2020. We conducted data analysis as we continued to collect data and implemented activities and interventions along the way. We report emerging findings that included the deleterious effects of isolation on older adults in both congregate and community-based LTC, the value of creatively using technology as an avenue for communication and engagement, the importance of leadership and flexibility, as well as an abundance of mental health struggles LTC workers faced in caring for older adults during COVID-19. We present how we were able to address these in a variety of ways during the inductive research process because of iterative analysis that occurred alongside continued data collection. [rapid qualitative assessment, long-term care workers, COVID-19]

Introduction

In this article, we present a case study of a rapid qualitative appraisal focused on frontline workers' perceptions and experiences providing long-term care (LTC) during a global pandemic. We also include how praxis occurred throughout the process of the research itself. We include this to demonstrate the impactful aspects of applied research that may occur alongside data collection if we are sensitive to, and acutely aware of, what the issues are as the data are being collected and emerging findings become apparent. With this awareness, applied scholars can address ongoing community-based issues through the mobilization of networks created through the research process.

In this discussion, we draw on a rapid qualitative assessment of the impact of COVID-19 on the provision of care and support for older Americans in North Carolina, in both congregate LTC communities and in-home and community-based programs and services. Next, we examine staff perceptions and experiences including (1) issues of social isolation and the deleterious effects on residents and clients, particularly people with dementia (Shenk and Freidus 2020); (2) the importance of technology as an avenue to addressing social isolation; (3) mental health impacts on staff; and (4) the essential ways particular kinds of leadership, communication, and flexibility were useful and effective in helping meet the needs of staff, residents, and family members. In addition, we demonstrate how our research team was able to identify and facilitate interventions to address each of these findings during the data collection.

ANNALS OF ANTHROPOLOGICAL PRACTICE, Vol. 45, No. 2, pp. 162–174, ISSN 0094-0496, online
ISSN 1548-1425. © 2021 by the American Anthropological Association. All rights reserved.
DOI: 10.1111/napa.12166

LTC in the United States

In the United States, LTC for older adults was originally developed based on a medical model following the medicalization of everyday life. It is well established that medicine has become a powerful institution of social control able to determine as well as direct cultural and social values (Zola 1972). An effective way of exerting this control is by applying medicine, health, and illness concepts and approaches to ever-expanding ranges of daily living activities, processes, and states of being including aging and disability (Zola 2009). Historically, aging Americans have primarily been defined and managed by their physical and biological needs and limitations. As a result, models of care for this population have focused heavily on the physical self and quantity of life with less attention paid to the whole self, overall quality of life, or quality of care, broadly defined.

Since the early 1960s, but gaining substantive traction in the 1980s, multiple models have developed to implement culture change and person-centered care of older adults in LTC communities to address these issues. Person-centered care is commonly recognized as a core concept guiding a change of philosophy from a traditional medical model to a more humanistic approach to care (Junxin and Porock 2014). Culture change requires a reorientation of institutional values, attitudes, and practices (Koren 2010). For example, instead of a model focused on “nursing” an emphasis was placed on “homes” prioritizing quality of life as well as resident agency (Koren 2010). Other linguistic shifts ensued in an effort to capture this conceptual change. “Patients” were now referred to as “residents,” and “facilities” were termed as “communities” or “residences.” Through sustained advocacy, residents in congregate settings were to be afforded individualized services to support their mental and psychosocial needs in addition to their physical requirements. Despite inroads to provide person-centered care, the cultural orientation of the medical model remains pervasive (Rahman and Schnelle 2008) along with its focus on the physical needs of residents. This focus was exacerbated during the COVID-19 pandemic and is evident in the data presented below. For a more extensive history of the development of LTC in the United States, see, for example, McLean (2007).

While COVID-19 has centered attention on congregate care, 94 percent of older adults actually receive their care in their own homes and most older adults prefer to remain within the community. Much like the transition to person-centered care, many advocates focus their attention on encouraging more “aging in place” because it has been shown to prevent much of the depression and helplessness associated with congregate living and results in a higher quality of life and more independence (Iecovich 2014). To sustain older adults in the community, a panoply of services is required ranging from food delivery, management of medicine and special medical equipment, in-home aides, home-health aides, and transportation services to adult day cares and senior centers (Buch 2018; Iecovich 2014). Unfortunately, these services are largely underfunded, fragmented, understaffed, and unable to meet the level of community demand (Iecovich 2014).

Caring for older Americans requires a committed and well-trained workforce sensitive to their evolving needs. Long-standing challenges in caregiving of older adults in both congregate and community-based care include inadequate staffing, high staff turnover, low pay, insufficient benefits, and lack of a career ladder. Estimates of annual turnover in direct care health care occupations range from 40 to 166 percent in various agencies and facilities (Seavey 2004). Specifically, the direct care workforce is dominated by undereducated, immigrant, and minority women who often live in poverty while working full time (Coe 2019; Potter, Churilla, and Smith 2006) perpetuating their immobility on the “sticky floor” (Smith and James 2002), that is, jobs that provide few options for promotion. Their working conditions generally include low wages, poor benefits, and staffing shortages that increase the possibilities of physical and emotional injuries (Potter, Churilla, and Smith 2006). As Stacey (2005) summarizes from the limited literature on home care work, the tendency is either to romanticize the importance of the emotional ties between the caregivers and clients, or to emphasize the exploitative nature of the relationship. Our findings demonstrate how these issues have been highlighted and exacerbated during the COVID-19 pandemic.

Complex Health Emergencies and Rapid Qualitative Assessments

The value of qualitative data to direct or inform evidence-based public health responses to complex health emergencies, in general, and infectious disease outbreaks, in particular, is becoming increasingly visible although it is still marginalized compared to other research designs (Vindrola-Padros et al. 2020b). Rapid assessments are valuable tools during these kinds of emergencies because they are carried out expeditiously, are participatory in nature, involve mixed methods, are iterative or grounded as data analysis and collection occur simultaneously, and are team-based, which provides accurate and actionable data useful to policymakers, funders, and program developers (Beebe 1995, 2014; Vindrola-Padros et al. 2020b). According to Sams et al. (2017), social scientists conducting this kind of work are especially attuned to capturing local perceptions and knowledge, identifying shortfalls and limitations associated with public health messaging, and addressing or challenging the pathologizing and scapegoating of cultural practices and understandings in relation to outbreaks (see also Abramowitz et al. 2015). They are also helpful in attenuating public health messaging to more accurately account for a diversity of sociocultural contexts (Abramowitz et al. 2015).

Proponents of rapid qualitative research acknowledge the key critique of this methodology in its relationship to praxis. This concern is centered on the validity and accuracy of data analysis because it is an iterative process that begins in the early stages of the assessment (Vindrola-Padros and Vindrola-Padros 2017). There is concern about actionable preliminary findings being insufficient, underdeveloped, or incomplete because the research process has been at times labeled as “quick and dirty” (Vindrola-Padros and Vindrola-Padros 2017). While “quick” is appropriate because of the time-sensitive nature of the research during an ongoing global health crisis, the notion that these data are “dirty” is easily challenged within the research design with the selection of the research team and purposive recruitment of research participants, which can lead to “deep and valid ways of knowing” (Pink and Morgan 2013, 351).

The current study used a rapid qualitative assessment focused on the frontline caregivers of older

Americans in central North Carolina during the COVID-19 epidemic because these methods are particularly useful in identifying social structures, immediate needs from community perspectives, as well as drawing out local knowledge and expertise (Brennan and Rimba 2005; Williams and Boland 2008)¹. We present our findings as well as illuminate the value of implementing localized applications that emerged alongside the data collection to encourage social scientists who will be undertaking these kinds of assessments to continue to be cognizant of and amenable to engaging in applications that seem tangential to the research process itself, to not miss opportunities for engagement and application along the way.

Methods

This is a mirror study conducted as part of the global efforts spearheaded by the Rapid Research, Evaluation and Appraisal Lab (RREAL) at University College London (Vindrola-Padros et al. 2020a, 2020b). At an early meeting of the global teams, a team from another country talked about studying the experiences of frontline workers in a nursing home. Early attention in the United States focused on the high rates of COVID-19 infection and severe impact on older adults, particularly those in LTC communities. The first author contacted the second author for assistance in identifying initial participants in order to study caregiving of older adults in LTC in central North Carolina.

The formation of a knowledgeable and dedicated team is an essential step in ensuring the best possible results and enables the collection of quality data. Having an expert of both topical and geographical areas of focus leading the team is indispensable to the process. Shenk is the former Director of the Gerontology Program at UNC Charlotte and has worked in the field of aging in North Carolina for 30 years. Once recruited, she utilized her extensive professional networks in the region and knowledge of the aging field to map the LTC net-

¹ This approach differs from participatory action research that integrates community partners in the process of research design, data collection, and analysis, and sometimes in the implementation of relevant interventions that result from the project (McIntyre 2008). Our work purposefully tried to avoid placing too many demands on the research participants who were already stressed and overworked.

work and recruit research participants. Freidus is an applied medical anthropologist who has worked extensively on health-related disparities among vulnerable populations in the United States and overseas. The third member of the research team, Wolf, is a graduate assistant who conducted interviews, coded, and participated in organization and analysis.

We began by interviewing former students and colleagues of Dr. Shenk who are currently working at the regional and state level. She envisioned the sample as a puzzle and each piece provided a specific perspective on the situation of caregiving for older adults in central North Carolina during the pandemic. Shenk's intimate knowledge of the landscape was essential in conducting this project because she crafted a purposive sample that was not random but rather allowed for some degree of representativeness to be built into the design that we argue led to more reliable, valid, and actionable data from the onset (Vindrola-Padros and Vindrola-Padros 2017).

This three-phase rapid qualitative assessment is focused on the perspectives of workers providing LTC to older adults in central North Carolina during the pandemic.² We conducted interviews with 76 people from June to November 2020. We included participants from all types of congregate LTC communities and also workers providing in-home and community-based services. Phase 1 focused on administrative and nongovernmental advocacy groups that work with LTC communities, including residents, families, and the direct care providers within these homes, as well as providers of in-home and community-based aging programs. Phase 2 included a sample of administrators of LTC communities as well as the workers providing hands-on care in 15 congregate care communities. We included workers in Continuing Care Retirement Communities, nursing homes, assisted living communities, adult care homes, and memory care for people with dementia. Participants included dining staff, housekeepers, chaplains, marketing staff, certified nursing assistants, medical technicians (Med Techs), activities staff, nurses, nurse practitioners, and administrators. Phase 3 focused on community- and home-based care workers who provide services and assistance to older adults living in the community, including managers and

² Residents, clients, and family members were not interviewed for this project.

staff providing information and referral, staffing adult day cares, providing home care and home health care, distributing home-delivered meals, running senior centers, and providing transportation and some medical care. Due to the ongoing nature of the pandemic, we continued data collection beginning in January 2021, organizing three focus group discussions with administrators of congregate care, activities coordinators and in-home and community-based care professionals to obtain updates and share information among participants.

In addition to rapid qualitative assessments being team-based, they also often involve collaboration with community leaders, political officials, and/or interested nongovernmental or governmental organizations that request information to improve policy and programming (Johnson and Vindrola-Padros 2017; Vindrola-Padros et al. 2020b). Early in our process, we worked with staff of the regional Area Agency on Aging (AAA) who provided feedback on research protocols. We also interviewed a county commissioner, advocates for residents of LTC, and the facilitator of a regional group of aging service providers in order to be responsive to their needs for data.

Interviews were video-recorded using a web-based platform and were transcribed verbatim. Similar questions were posed in each phase in semistructured interviews ranging from 23 to 145 minutes. We asked these workers about the overall impact of the epidemic on their provision of care as well as their key concerns. We recorded a total of 67 hours of interviews with the 76 participants and generated codes for these data through an ongoing, inductive approach. In order to protect anonymity, we use only a participant number in reporting our findings.

Rapid assessments demand that data analysis be an ongoing iterative process in order to distribute findings quickly so that decision makers can act on them expeditiously, especially in times of crisis. Therefore, we started developing preliminary codes based on the data from the onset. Initial coding went through three phases. Using an inductive approach that avoided the use of preexisting codes, the second author reviewed all the interviews as they were conducted, and generated a master list of themes that she refined with each interview reviewed. This allowed for analysis to be driven by the narratives of the participants to capture their unique perspectives. As the senior scholar generated the initial codes, the other two scholars reviewed the interviews and contributed missing themes as well

as condensed themes when overlap was identified. The research team convened at minimum once a week, but often met multiple times a week depending on the pace of interviewing to review emerging findings and discuss themes and subthemes to build consensus. The first and third authors independently coded interviews using NVivo software at three different times throughout the process to organize data around the key themes. We then compared these data for accuracy. In an effort to maintain a rapid timeframe, data collection, analysis and write-up had to occur simultaneously. IRB approval was received from UNC Charlotte.

Caring for Residents Experiencing Social Isolation

A key finding that emerged beginning with Phase 1 was the impact social isolation was having on both staff and residents. Most congregate LTC communities across the United States were shuttered in March 2020 as older Americans were being disproportionately impacted by the virus. As a result, residents were forced to stay in their rooms instead of congregating for meals, engaging in social activities, and visiting with family and friends. Older adults living in the community were generally isolated in their homes. The impact of this isolation was noted by regional AAA staff, administrators, and LTC workers in both congregate and in-home and community-based care (see Freidus, Shenk, and Wolf 2020). Participant #10 explained:

I'm just getting frustrated, I think, because I feel like this is not a sustainable way to handle this type of issue. And this is not going away, and it won't be the only virus that affects people like this, and ... this is not gonna disappear. And so, I feel like those conversations... need to be had about "how are we going to handle this in a sustainable way that is not affecting, I think the mental health of everyone?"

Our data reveal that residents of congregate care communities, especially those with cognitive impairments and dementia, are experiencing both mental and physical decline related to their isolation (see Shenk and Freidus 2020). Research participant #74 who works in a memory care unit stated definitively, "100 percent of our residents have de-

clined" noting that one resident who weighed only 170 pounds to begin with had lost 30 pounds over the course of 6 months. Participant #74 stated: "We underestimate how quickly isolation does its damage." They went on to explain: "Dementia cases progress the fastest when in isolation. When they're not being challenged. When they're not being engaged. When they don't have the ability to choose."

Staff struggled to find ways to keep residents engaged during an unprecedented period of isolation within an environment of group living. Activities staff in particular were challenged to address the ramifications of residents being isolated in their rooms or socially distanced in small groups. Participant #41, an activities coordinator, expressed:

Since the COVID, there's been a decline in [all social activities/gatherings], and I've been limited on what I can do. At first, they told me, "Well, you can't have more than eight people." And so, during my exercise class, I'd have to cut it to eight people... And then it was like, "You gotta have less than that," and that's hard to do, and then it's like, "You can't have any group settings." So, I was like, "What do I do? Do I even have a job?"

What has not emerged consistently, even when guidance and direction were needed early on, was an adequate way of communicating across individual LTC communities and community-based programs to share ideas, experiences, and innovations to address the impacts of social isolation. Professional organizations including the NAAP (National Association of Activities Professionals) and National Certification Council for Activity Professionals (NCCAP) hosted open meetings in the early months of the pandemic. Some staff utilized social media and personal and professional networks to commiserate and share information, but there did not seem to be sufficient safe spaces. Safe spaces are defined here as places within which professionals can safely share thoughts and process their emotions with others going through similar experiences—without experiencing harassment, criticism, or conflict. The research team reached out to an activities professional who works for NCCAP. Using social networking platforms, they organized a focus group of activities professionals from across the United States. The original purpose was to share the research project goals and methods in an effort to recruit participants. While this occurred, the most

valuable aspect of this focus group was the subsequent social networking and program sharing that occurred between activities staff. At the end, the focus group participants #31 and #41 expressed to one another who they had never met: “I would love to, after Covid is gone, ... I would love to meet with you sometime. I would love that. Certainly this has been a pleasure.” This focus group meeting created a space to share ideas and innovations and some of these conversations proved invaluable in regards to information sharing. Equally important, many also expressed appreciation for the ability to connect with and share their experiences with other activities professionals in a safe space.

The obvious need to facilitate communication between various congregate care communities and aging programs led our research team to start sharing resources with activities professionals as we became aware of them. For example, beginning in September, we encouraged activities staff to join in a North Carolina-based Family and Caregivers support program’s virtual sing along. Similarly, in November we circulated information about a free, live, virtual music concert meant to promote democracy. These are just a few examples of how the networks we created through the research process allowed us to both become aware of emerging opportunities for creating innovative engagements but also allowed us to redistribute information and opportunities as they arose. We also realized the need to purposefully create safe spaces for these workers to connect and share experiences that were independent of data collection. Next, we highlight our efforts at building these spaces, for example, in our coordination of a group discussion with LTC administrators.

While seemingly outside the research process itself, this kind of engagement signals that application of findings can be ongoing throughout the research process if researchers are attentive to the needs that become evident through the data as well as the emerging resources that are created to address those needs. During the lockdown, visits with family and supporters in the larger community were stopped leading to the need for new and creative approaches to share resources and engage residents and clients.

Use and Availability of Technology

Related to the issues of social isolation discussed above, data collected in the early stages of this work

revealed that the use of technology to address social isolation was an issue for most LTC communities and home and community-based programs. The use of tablets, smartphones, baby monitors, and headphones to aid in connecting families with their loved ones has proven invaluable although often insufficient. Participant #31 explained:

I was worried about them not wanting to be alive anymore, I really was worried about some of the residents just being in a pit of sadness and starting to see their families more, and ... doing the distance visitation helps so much to see them and have them come inside or just sit across at the conference room with them and visit... It was amazing. And they would cry and cry afterwards and saying how that just felt like years to them, they haven’t seen their family.

Community-based programs turned to making telephone contact with their participants who were now stuck at home. They were able to identify clients who were isolated and those in need of support and assistance, and work with other programs to be sure these needs were addressed. Some LTC communities were well equipped to make this adjustment and used available resources to stream programming to residents in their own rooms through their in-house systems. However, many LTC communities did not have this type of access. Our data revealed that it was not uncommon for workers to use their own cell phones to facilitate video calls between residents and their loved ones. As participant #20 explained: “I’d take my cell phone in the room and just put it on speaker phone. I did a lot of Facetimes with families with it.”

For dementia residents, this type of technology was less useful even though they were the most vulnerable to the effects of isolation. Participant #9 explained:

These window visits are so sad almost, sometimes you can’t orient them to who it is, and it’s just really, really, really hard and they can’t hear. That’s a huge thing, even with the phone or baby monitor, they still can’t hear, and they just get confused...

Interfacing with technology whereby loved ones attempted to communicate with them was often disorienting. The research team was particularly concerned about this issue. Previous interviews with

the AAA staff revealed a program that targeted the disorientation and anxiety felt by older Americans with dementia that lived at home through the use of robotic cats and dogs. Robotic pets are known to provide positive interaction for people with dementia (Peterson et al. 2017), but this resource was not extended to residents in congregate care communities. Participant #5, the Aging Specialist who was distributing the animatronic pets, explained:

...social isolation has been a major concern of ours. So through my Family Caregiver Program, I actually purchased some animatronic pets... We've actually had a lot of calls from people in nursing homes asking for one because they are lonely... Unfortunately, the funding source won't let us do that, which is one of the most frustrating things because while the funding coming down from the federal government is very flexible, it's still [segmented]... This is for facility-based, this is for community. And so, right now we can't provide any to the nursing homes, but I hope that we can, but that's been one of the hardest things is saying, "I'm sorry, you can't have one." But they've been in social isolation, and risk of depression.

The need for enhanced use of technology has been exacerbated by the pandemic and many congregate care communities and aging programs need support in tapping into resources that are being made available. Barriers include the fact that busy staff have been forced to take on additional responsibilities, may not have the skills and experience to know how to write up a small grant proposal or may not be aware of the effectiveness of particular types of resources such as animatronic pets. When we were made aware of a grant program at the county level that earmarked CARES Act funds to address issues of mental decline and social isolation of older adults, we reached out to our research participants at congregate care communities. We encouraged them to apply for funds for purchasing these pets, tablets, and sound-enhancing headphones. The tablets and wireless headphones are effective in facilitating conversations with family members, and accommodating interactions with special interest groups, such as Bible Study and other individual interests. We offered to work individually with these communities to assist in writing the grant proposals and help them get submitted. Three communities applied and all three of them

received funding. We assisted a fourth community that applied for funding but were informed that they would be contacted if additional funds become available.

Participant #21 whom we assisted in the grant writing process told us, "...I am so clueless to this process and we are so, so grateful that you've been kind enough to make this effort on our behalf." The other communities that we assisted were also incredibly grateful that we took the time to make them aware of these opportunities as well as help draft the necessary materials. Participant #44 told us in an email:

Words cannot express how thankful and appreciative I am for your efforts, time and focus in composing this grant for (our community). I am extremely humbled that you thought enough of our community and especially the residents to share this opportunity... Again, my sincere gratitude to you and your team for presenting this opportunity for [our] community. You are a true angel!!!

While this might initially seem to fall outside the scope of the rapid assessment itself, it is in actuality a major purpose of it if the goal is to have a positive impact and affect change.

Mental Health Impacts on Staff

Early into our study, the mental and emotional impact the epidemic was having on administrators and workers in congregate LTC was evident (see Freidus and Shenk 2020). In our data analysis, we began to code for affective engagements in the interviews. Participants registered fear, grief, frustration, anger, trauma, numbness, and exhaustion (Freidus and Shenk 2020). At times, these emotions were noted in their narratives and at other times they were expressed more viscerally through crying, raised voices, faces turning red, sighing heavily, or pausing to collect themselves. They often expressed fear regarding risking infecting themselves, their residents or their family members. As participant #23 explained:

I have four kids at home and a husband. So I was really worried that I'd take something back home to them, but I was very cautious. Every time I went home, I undressed outside. I had

to apologize to my neighbors, but I undressed on my back porch every day, put my clothes in a plastic bag. They immediately went to a wash machine. I went to the shower. When I got out of the shower, my towel, everything that I touched went to the washing machine and got washed.

Grief and sadness were expressed for residents that died. Participant #38 shared:

We have a memorial board where we list deaths This morning, three of our culinary employees, they kind of work in assisted [living] and skilled [nursing], serving meals there, so they really get to know the residents, because they served meals when residents could eat together in those dining rooms. But they saw a name on the board and one of them just burst into tears and began to cry, because she really loved that resident and she had served her for many years, in assisted and then in skilled.

Frustration and anger focused around frontline workers not being heard when expressing concern about policy and programming to administrators or anger at the broader community for politicizing a public health crisis. Participant #10 explained:

I feel like a lot of people have a lot of opinions, but no one knows what to do. No one really is able to solidify on a solid plan. And again, like I said, I'm in a tough spot because I really don't have a say. I can voice my opinion and they're very respectful of it, but at the end of the day, this is not my facility, I don't run this facility, and it's not my decision on how they decide to deal with it.

Trauma was registered when participants said they that could not sleep and they were haunted by the suffering of dying residents. Everyone, it seemed, was exhausted and participant #38 lamented: "I think we're gonna have staff that is traumatized by what they have been through in this. And I think we have some staff who are traumatized even just by the idea of the virus."

These were not discrete emotions, but rather often experienced simultaneously. Participant #38 went on to explain: "I think there's stories of loss and grief all over this building. And then, they're like me, they're dealing with things in their own

home, it's not like they're living in a vacuum, and so life is just a big stress pot."

We forewarned participants that these could be emotional interviews and encouraged them to not answer questions they felt were too difficult. We assured them that they could stop the interview at any point if they felt it was too emotional or difficult to continue. Yet everyone fully participated and it was very common for us to hear at the end of each interview how thankful they were to be included in the project.

There are therapeutic aspects of being interviewed for research projects that have emotive dimensions. The few studies that have attempted to capture the impact interviewing can have on participants suggest that they are often healing or cathartic because participants appreciate being heard and having someone who is neutral and nonjudgmental listen to them relate their experiences (Bourne and Robson 2015; Lowes and Paul 2006; Snyder 2016). This clearly was the case for participants in our project with many of them telling us that they enjoyed and appreciated the experience. During this particularly stressful and isolating time, it was essential to provide a range of opportunities as mental health services were scant and/or underutilized. As researchers and applied anthropologists, we rarely discuss the reflections of participants about the research process itself. In this project, we regularly discussed this and acknowledged that we would and should mindfully allow participants the space to tell their stories in whatever way they wanted. This meant allowing them to follow whatever tangent they chose, often leading to interviews lasting over an hour, with one lasting 2.5 hours. We should note that we are not trained in mental health or psychology so no advice was given. Participants were heard and given nods of acknowledgment, words of admiration, and often sympathetic facial expressions along the way.

During an interview with one administrator at a nursing home that suffered a major outbreak and subsequent loss of lives of residents (Freidus and Shenk 2020), for example, they did get emotional and explained how the experience was emotionally and physically exhausting and they continued to be haunted by the experience. They expressed gratitude for us taking the opportunity to listen to their experience and acknowledged its cathartic nature:

Researcher: We'll get feedback from everyone to make sure we really captured to the best of our

ability, the lessons learned, the thoughts moving forward, issues to consider, those kinds of things.

Participant #56: Excellent. Well I appreciate your time; that was almost like a little therapy session. It was cool.

The participants' responses to the interview process demonstrated that having someone actively listen was therapeutic and gave them a safe space to share emotions. Participant #44 expressed at the end of their interview: "This has been good for me. I guess I needed to cry a little today, so you got it out from me." Participant #65 similarly stated:

I thank you for digging into these questions and interviewing the different perspectives, because none of us have all the answers, but we're gonna get a good cross-section. And I really do look forward to learning, and maybe some actions being taken due to the learnings.

Participant #24 also expressed the following:

I hope you realize that when you're doing this, you're giving us a chance to just talk that we don't normally get... We can talk to our co-workers, but they're also feeling all of this craziness, and I just... Thank you for just talking for an hour and a half. I really appreciate it.

We were reminded regularly of the value of the active listening we provided in these interviews for these stressed workers who were experiencing the pandemic both professionally and personally. In terms of praxis, we urge applied scholars to continue to be cognizant of the interview process itself as a form of application, because allowing a safe space for participants to be heard can be just as valuable as the actual data collected.

Leadership, Communication, and Flexibility

The role of strong, sensitive leadership has been crucial throughout the trajectory of this pandemic. We came to recognize the importance of effective communication that incorporates flexibility as key to navigating the challenging situations facing staff,

residents/clients, and families. The managers and administrators who were particularly successful in guiding their staff and programs through the evolving pandemic demonstrated these skills.

Leadership

Structured leadership within each congregate care community and community-based program was essential to responding effectively and pivoting rapidly to continue to meet the needs of clients and residents. Effective leaders had the respect of their staff, residents/clients, and family members. Participant #60, an administrator, explained:

Yes, at the beginning, when we started, and I mentioned we started three weeks before it'd become more public, we got serious pushback from families. I have pretty much very good relations with most of the families.... They were unhappy, but I was very... I was stern about it, and I smiled sometimes, but I didn't smile, whatever it takes. You see, my position with family, and they know that I never hide it, families are not my clients, residents are my clients.... It's my responsibility to protect them.

This administrator alludes to the struggle faced in delicately balancing keeping residents safe while also meeting the needs and desires of their families. This was a particularly difficult position for administrators because of the changing nature of the epidemic including the way knowledge about the virus and its spread evolved. Participant #46 observed:

When the COVID first started, this is no lie, all the directors, man, they was meeting every day, every day, all day. That's what changed with them. They started meeting more. They was coming up with stuff every day, every day changes, every day. "How can this work? Well, if this don't, we gonna do it this way." Making sure each department head was on the same level. "What you need? Which y'all don't have? Why I can't get hand sanitizer? Well, let us try to see if we can get it." They was all coming together, working together.

Our data reveal that a key element of effective leadership during the pandemic is assuring adequate avenues of communication.

Communication

Effective communication was essential between administrators, managers, and their staff, administrators and their corporate offices, staff and families and residents, as well as administrators and managers and the regional AAA. These various avenues of communication were all discussed at length by participants. LTC communities with the most effective, consistent, and transparent avenues of communication seemed to more effectively stave off the worst impacts of COVID-19 outbreaks. Participant #44 explained: “You want to maintain that level of trust. You’re trusting us to take care of your loved one and we need you to trust that we’re doing that and we’re being very open and honest.”

The staff of congregate LTC communities and community-based programs faced huge challenges in assuring adequate communication with their residents or clients and their own co-workers. A particular challenge was communicating effectively with family and enabling them to keep up to date on their loved ones’ situation and engage with them. Participant #44, for example, talked about the difficult communication with families and their firm but caring leadership style:

Sometimes you have to be open to disagree with the family members because they’re just going to see it one way, but you have to get them to understand the big picture. It’s not one single person I’m having to protect... You sometimes just have to take a hard stance... I’m running this show. Be very open and honest... They’re receptive to that... That’s how I lead - over-communicate.

In-home and community-based programs were able to pivot most successfully by utilizing their relationships with other programs and service providers in the aging network. Participant #40, a manager of one program that was closed and calling participants to identify their needs, shared:

Getting people food is a big deal...[the nutrition program quickly pivoted] for those individuals who [usually] go to congregate sites, to have them getting their meals delivered while also responding to us when we were identifying new individuals who needed meals delivered. They did a phenomenal job. Turning on a dime and getting that incorporated into their routes.

This manager illuminates the reciprocal relationship between communication and flexibility that proved key in responding quickly to the changing needs of clients and residents. This kept many older Americans food secure that might have otherwise struggled to meet their basic needs.

Flexibility

Managers and staff demonstrated impressive flexibility in pivoting to meet the needs of their residents and clients during the pandemic. Participant #52, an aging program manager, explained: “So what we did is we split up the list and we started calling people saying, we’re closed. We need to figure out how we’re going to do things differently.”

While they emphasized the importance of protecting all of their residents or clients, they also had to incorporate elements of person-centered care, which requires an element of flexibility to respond to specific individual needs and situations. For congregate LTC, guidelines for “Compassionate Care” were generally understood to be appropriate to allow family to visit with residents who were transitioning (i.e., the terminology used for dying), but had to be enacted by each LTC community. Participant #44 described, for example, how they made exceptions for the family of a resident who was dying:

We knew she was starting to transition (starts crying). We made arrangements for her family to come in for a porch visit and made it possible for them to hug her, knowing it might be the last time they’d see her. This job is not easy. You have to make hard decisions sometimes but you do it from “how would I feel if that were me?” So you make exceptions. I swear I hate Covid.

Most congregate LTC communities worked within their corporate structure to function through the early stages of the pandemic, but as Participant #44 went on to describe: “at first we were reactive instead of proactive.... I had trouble understanding what I was facing.” While corporately owned nursing homes and assisted living communities received guidance and direction from their corporate leadership, independently owned communities and programs had to interpret national, state and county guidelines. From our perspective, it seemed there was insufficient sharing of ideas and solutions between congregate communities outside their corpo-

rate silos. We invited the administrators who had participated in our research to a virtual meeting to update us about their situation and share ideas. Four agreed to participate, but two were dealing with active cases of COVID and two showed up for the scheduled discussion.

These two administrators who had never met welcomed the opportunity to share their experiences since March 2020 and discussed their plans and mutual concerns. They freely shared lessons learned and discussed their individual situations, challenges, and plans for reopening to indoor visitation. Participant #44 cried while describing the experience:

So this Covid has taught us a lot just about life, dealing with people, your emotions, 'cause it can be very internalized and for us, and very depressing sometimes. Some days I go home, I'm drained.

The other participant supported her in this safe space we had provided. These two administrators shared openly about the specific challenges and decisions they were facing in the moment, agreed to share resources and meet in the future. They were both appreciative of the opportunity and acknowledged the need for expanded social and professional networking. While there are conversations going on across various professional groups, we identified a clear need for more discussions in real time and on a more personal level (see Freidus and Shenk 2020).

Conclusion

We have presented findings regarding staff perceptions and experiences focusing on issues of social isolation and the deleterious effects on residents and clients, particularly people with dementia, as well as the importance of technology as an avenue to addressing social isolation. In addition, we noted the mental health impacts on staff and the ways particular kinds of leadership, communication, and flexibility were useful and effective in helping meet the needs of staff, residents, and family members. We have also discussed interventions we were able to implement during the research process.

It is worth noting that the impetus for this article developed when a graduate student inquired during a presentation on our project: "how do you imagine your work impacting the lives of your participants? What is the application?" Our initial re-

sponse focused on our dissemination to date (see Freidus, Shenk, and Wolf 2020; Freidus and Shenk 2020; Shenk and Freidus 2020). We also described future reports and other modes of dissemination (i.e., posters, PowerPoints, infographics, blogposts, presentations, and articles) that would be sent to RREAL at UCL as well as all our participants, the AAA, the advocacy group we had been consulting throughout the research, and a concerned county councilwoman we had interviewed for the project. However, as the discussion continued we began to talk about the aspects of the project we were most proud of and realized that we had been engaging in praxis all along and that our participants were benefiting from these seemingly tangential engagements.

These, we realized, were central to the project and potentially invaluable to the communities we were trying to serve. In teaching about applied research and its methodology we do not always speak or write about this kind of praxis, which might seem inconsequential to some people and as a given to others. This article is our effort to remedy this shortfall and alert applied anthropologists, especially those just embarking on their careers, to be alert to the possibility of engaging with the communities where they work in ways that may seem outside the scope of their research methods and objectives. Collecting data is not simply a precursor to the application of the knowledge we produce, but rather an integral component of creating change along the way.

Our end goal is still to develop reports and share the findings broadly with policymakers, service providers, and academics. The journey has taken on a life of its own, however, and we have followed the various threads and explored and availed ourselves of the possibilities we came across. A key lesson we want to share is that researchers can be key stakeholders and decision makers throughout the research process. As applied anthropologists involved in a rapid qualitative assessment, we are part of the action plan as it is unfolding in front of us and are helping to create solutions as they emerge from the research itself. We hope these lessons learned can be useful to applied scholars as they engage in similar rapid research.

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