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Assessing Social Functioning During COVID-19 and Beyond: Tools and Considerations for Nursing Home Staff

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Caroline Madrigal PhD, RN [a,b,*], Emily Bower PhD [c,d], Kelsey Simons PhD, LMSW [e], Suzanne M. Gillespie MD, RD [f,g], Kimberly Van Orden PhD [e], Whitney L. Mills PhD [a,b]

[a] Center of Innovation in Long-Term Services and Supports, Providence VA Medical Center, Providence, RI, USA
[b] Department of Health Services, Policy and Practice, School of Public Health Brown University, Providence, RI, USA
[c] VISN 2 Center of Excellence for Suicide Prevention, Canandaigua, NY, USA
[d] Pacific University, School of Graduate Psychology, Hillsboro, OR, USA
[e] University of Rochester School of Medicine & Dentistry, Department of Psychiatry, Rochester, NY, USA
[f] Canandaigua VA Medical Center, VA Finger Lakes Healthcare System, Canandaigua, NY, USA
[g] Division of Geriatrics/Aging, Department of Medicine, University of Rochester School of Medicine & Dentistry, Rochester, NY, USA

ABSTRACT

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Social functioning is defined as how a person operates in their unique social environment (ie, engagement in activities, connectedness with others, and contributions to social roles). Healthy social functioning is important for nursing home residents as they are at increased risk for loneliness and isolation. Social functioning has long been an underacknowledged aspect of nursing home residents' health, but now, with the COVID-19 pandemic, residents' risk for decreased social functioning is increased. Several reliable and well-validated tools are available to supplement routine care planning and delivery and track and improve changes in social functioning over time. The overarching aim of this article is to provide resources and recommendations for interdisciplinary team assessment related to social functioning for nursing home residents. We describe 2 domains of social functioning measures, care-planning measures and outcome measures, and provide recommendations for how to integrate said measures into practice. Healthy social functioning is needed to maintain nursing home residents' well-being and quality of life. Measures and recommendations outlined in this article can be used by nursing home staff to understand residents' social preferences and address social functioning during COVID-19 and beyond.
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Social Functioning in the Nursing Home Setting

Social functioning is an important aspect of a person's overall health that represents how they operate in their unique social environment, including managing social roles and responsibilities and engaging with other people and social activities.[1] It is sometimes referred to as "social health" or "psychosocial health." Social functioning is an essential component of care delivery, especially for nursing home residents who are at increased risk for loneliness and social disengagement.[2–4] Healthy social functioning includes engagement in social activities, connectedness to others, and contributions to the environment. Decreased social functioning (ie, disengagement, loneliness, isolation) has considerable negative effects on residents' health and well-being, including greater risk for depressive symptoms, anxiety, sleep disturbances, hospitalizations, cognitive decline, lower quality of life, suicidal ideations, and mortality.[2–6] This

is due, in part, to fewer opportunities for close social interactions in nursing homes, age-related changes in social networks (eg, widowhood and retirement), and physical and cognitive changes that may impede residents' abilities to fulfill their social needs.[7–9] Efforts to transform the organizational culture in nursing homes from provider-directed to person-directed practices (ie, "culture change") have begun to address social functioning,[10] with some nursing homes incorporating social functioning into interdisciplinary care planning and delivery in collaboration with residents. However, social functioning is still not commonly given the same level of attention in care planning (ie, treatment plan) or delivery as other aspects of health (eg, cognitive and physical function).[11]

Because of the known risks associated with decreased social functioning in the nursing home setting, significant concern exists regarding the impact of the COVID-19 pandemic and its potential for furthering trajectories of declining social functioning among residents. Nursing homes have been significantly impacted by the pandemic, with 32% of US COVID-19–related deaths occurring in the nursing home setting, affecting more than 180,000 residents.[12] Hong Kong nursing homes were impacted similarly during the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak. Beyond the physical toll of SARS, residents fell victim to declines in social functioning owing to visitation restrictions, limited social activities, health-related anxiety, loneliness, and feelings of abandonment.[13,14] In the case of COVID-19, US nursing home residents continue to experience the effects of social distancing implemented as part of infection prevention efforts.[15]

After more than a year of ongoing social distancing requirements, it is imperative that social functioning is included as a core component of nursing home care.[16] Researchers and staff have focused a great deal of effort on identifying and implementing ways for residents to safely connect with their peers, family, and friends within the confines of COVID-19 prevention guidelines and, now, reopenings.[2,8] However, there is a dearth of information on the assessment of social functioning in nursing home settings. Widely available, standardized, and highly validated measures exist to assess the domains of social functioning. But, despite availability of high-quality assessments, nursing home staff do not yet consistently integrate them into practice. This is likely due to little guidance on how to effectively use assessments and limited attempts at dissemination and uptake.[11] Accordingly, the overarching aims of this article are to review tools available for assessing social functioning in nursing home settings and to provide resources and recommendations for interdisciplinary team members to assess social functioning among nursing home residents. In alignment with the National Academies of Sciences, Engineering, and Medicine report on social isolation and loneliness in older adults,[16] we advocate for increased attention to the social needs of nursing home residents who have been gravely impacted by the effects of COVID-19.

Measures of Social Functioning

Reliable and well-validated tools for assessing important aspects of social functioning can be used to supplement routine care planning and delivery as well as to track and improve changes in social functioning over time. We describe a range of measures that can be used to plan and deliver care that promotes healthy social functioning. First, we discuss measures to plan care aligned with residents' social preferences. Then, we detail self and proxy report outcome measures of social functioning for residents with a range of cognitive abilities. In Table 1, we include additional information on the measures: (1) where to access them, (2) type of assessment (self, staff, or proxy report), (3) if it was validated in a nursing home setting, (4) number of items, (5) aim of assessment, (6) example questions from the assessment, and (7) recommendations for practice.

Care Planning Measures

Preference-based care planning measures aid in operationalizing person-directed care in practice. By understanding residents' preferences and what is important to them, staff can encourage resident autonomy and incorporate residents' priorities into care planning and delivery. Preference-based care planning measures span a variety of social functioning domains, including social engagement and connection, which can help with establishing resident preferences to aid in planning their daily routines as well as individual and group social interventions.

Self-, Staff-, or Proxy-Reported Care Planning Measures

Minimum Data Set—Preference Assessment Tool (Section F)
The Minimum Data Set (MDS) is an obvious starting point to consider social preferences and function as it is mandated in the United States for all nursing homes receiving Medicare or Medicaid reimbursement.[35] The MDS's Preference Assessment Tool (Section F; PAT) assesses some aspects of social engagement and connection via evaluation of residents' important daily and activity preferences and is validated for use in the nursing home setting.[17]

However, the PAT is limited in scope and does not include any assessment of fulfillment of preferences or outcomes related to social functioning. This hinders the utility of the PAT because it cannot capture key conditions associated with social functioning such as isolation or loneliness. The PAT and complementary tools outlined in this section are essential to planning social interventions that are important and highly individualized for residents; however, staff need to expand their approach of measuring social functioning beyond the PAT and its supplementary measures to include outcome measures of social functioning.

Self- or Proxy-Reported Measures

Preference for Everyday Living Inventory
One of the aforementioned supplementary tools to the PAT is the Preference for Everyday Living Inventory (nursing home version; PELI-NH) which expands on the MDS items across 5 domains, including social contact, to construct a comprehensive profile of residents' important preferences.[18] The PELI-NH is a well-validated[19] and useful tool throughout the care planning process to capture what is important to residents and to plan care and social activities reflective of residents' preferences.

Activity Card Sort
Card sorts provide an interactive alternative to assess social preferences and engagement. The Activity Card Sort[20] is a measure of activity preferences that involves sorting photographs of older adults engaged in a variety of social, instrumental, and leisure activities. Depending on the goal of the assessment, cards can be sorted according to the level of current, past, or desired future participation. Cards can also be used to guide person-directed care plans, set goals, and monitor progress toward goals. This type of assessment is validated in the nursing home setting and especially useful for residents with alternative communication patterns and abilities (eg, cognitive impairment, brain injury, Parkinson's, stroke recovery, spinal cord injury).[21,36]

Self-Reported Measures

Care Preference Assessment of Satisfaction tool
The Care Preference Assessment of Satisfaction tool (ComPASS) can be used with the MDS PAT or PELI-NH to assess how satisfied residents are with care related to their important preferences over time.

Table 1
Measures of Social Functioning for Nursing Home Residents

Tool (Citation) and Source	Type	Validated in Nursing Home Setting	Description of Tool	Example Questions	Suggestions for How to Use the Tool in Practice
Care planning measures					
Preference Assessment Tool (PAT; Housen et al 2009[17]) Available for free at cms.gov; preferencebasedliving.com	Self, staff, or proxy report	Yes (Housen et al 2009[17])	16-item measure of residents' daily routines and activity preferences	"How important is it… - To choose who you would like involved in discussions about your care - To do things with groups of people"	Typically administered by recreational therapy, social services, or nursing; can be administered by staff with assessment experience. Interdisciplinary care team should work together to implement resident preferences into care planning and delivery. Especially during COVID-19, consider the use of technology and how to meet preferences within social distancing guidelines.
Preference for Everyday Living Inventory (nursing home version; PELI-NH; Curyto et al 2016[18]) Available for free at preferencebasedliving.com	Self or proxy report	Yes (Curyto et al 2016[18]; Abbott et al 2018[19])	72-item measure of residents' important preferences across 5 domains (ie, self-dominion; enlisting others in care; social contact; growth activities; leisure and diversionary activities)	"How important is it… - To have regular contact with family - To spend time one-on-one with someone"	Typically administered by recreational therapy, social services, or nursing; can be administered by staff with assessment experience. Consider divvying up assessment among team members based on domains (eg, social function for psychology; leisure and diversionary activities for recreational therapy; self-dominion for nursing). Interdisciplinary care team should work together to implement resident preferences into care planning and delivery. Recreational therapy can use preferences to plan individualized or group activities. Especially during COVID-19, consider the use of technology and how to meet preferences within social distancing guidelines.
The Activity Card Sort (Baum and Edwards 2008[20]) Available for purchase at aota.org	Self or proxy report	Yes (Law et al 2005[21])	55-89-item (dependent on version) measure of residents' participation in social, instrumental, and leisure preferences that involves sorting photographs of older adults engaged in a variety of activities	Photo-based assessment	Typically administered by occupational therapy; can be administered by staff with assessment experience. Residents could be asked to sort pictures of activities into 2 categories: (1) those currently doing and (2) those stopped since COVID. They can also be asked to identify their preferred activities to aid in care planning.
Care Preference Assessment of Satisfaction tool (ComPASS; Heid et al 2019[22])	Self-report	Yes (Bangerter et al 2017[23])	Measure that accompanies the PAT and/or PELI-NH, which tracks residents' satisfaction	"How satisfied are you with this preference being met in the past week?"	Typically administered by recreational therapy, social services, or nursing; can be

Table 1 (*continued*)

Tool (Citation) and Source	Type	Validated in Nursing Home Setting	Description of Tool	Example Questions	Suggestions for How to Use the Tool in Practice
Available for free at: compass. linkedsenior.com			with care related to their important preferences		administered by staff with assessment experience. ComPASS is especially useful to understand how residents feel about the individualization of their care during COVID and beyond. Interdisciplinary care team should work with resident to adjust care delivery to meet their preferences, as needed.
Outcome measures					
World Health Organization measures - Disability Assessment Schedule (WHODAS) - Quality of Life Measure (WHOQOL) Available for free at who.int/tools	Self-report	Measures have been validated for use with a variety of specific populations of older adults (eg, specific conditions/cultures), but not nursing homes	Variety of measures that include domains/questions on a person's social participation and relationships	Items vary by measure: - "How much of a problem did you have in doing things by yourself for relaxation or pleasure?" (WHODAS) - "How satisfied are you with your personal relation-ships?" (WHOQOL)	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use these assessments to understand how a resident perceives her or his level of function (WHODAS) and quality of life (WHOQOL) both of which can be discussed with the resident to plan care and relevant social activities.
Patient-Reported Outcomes Measurement Information System (PROMIS) measures - Ability to participate in so-cial roles/activities - Companionship - Emotional support - Informational support - Instrumental support - Satisfaction with participa-tion in discretionary social activities - Satisfaction with participa-tion in social roles - Satisfaction with social roles and activities - Social isolation (Cella et al 2019[24]) Available for free at healthmeasures.net	Self-report	Some measures have been validated for use with older adults, but not nursing homes	Variety of measures focused on a person's social functioning and social health	Items vary by measure: - "I have someone who will listen to me when I need to talk" (Emotional Support) - "I am satisfied with my ability to do things for my friends" (Satisfaction with Participation in Social Roles)	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use PROMIS assessments to understand residents' perspectives on their social health. These measures could easily be used for longitudinal assessment because of their short and straightforward nature. Results should be considered in planning social activities and, also, in considering how staff can support residents.
UCLA Loneliness Scale (Russell 1996[25]) See citation for tool	Self-report	Validated for use in older adults, not nursing homes	20-item (dependent on version) measure of subjective feelings of loneliness and social isolation	- "I feel completely alone" - "I am unhappy doing so many things alone"	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use this tool to understand how lonely or isolated a resident may feel and identify areas to support their participation in social activities and social interactions.

Three-Item Loneliness Scale (Hughes et al 2004[26]) Available for free at: campaigntoendloneliness.org	Self-report	Validated for use in older adults, not nursing homes	3-item measure of subjective feelings of loneliness and social isolation	- "How often do you feel left out?"	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use this tool, especially when short on time, to screen for social isolation and loneliness. Then, staff can follow up with a more comprehensive assessment to identify areas to support residents' participation in social interactions and events and facilitate social connection with others.
Lubben Social Network Scale (Lubben and Gironda 2004[27]) See citation for tool	Self-report	Yes (Munn et al 2018[28])	6-18-item (dependent on version) measure of a person's size and type of social network	- "How many friends do you feel close to such that you could call on them for help?" - "How many relatives do you feel at ease with that you can talk about private matters?"	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use this tool to identify how residents perceive their social connections and relationships. Staff can use responses to identify areas residents might need support in fostering connection and relationships with others.
The Interpersonal Needs Questionnaire (INQ; Van Orden et al 2012[29]; Parkhurst et al 2016[30]) Available for free at https://psy.fsu.edu/~joinerlab/resources.html	Self-report	Validated for use in older adults, not nursing homes	10-25-item (dependent on version) measure of social functioning constructs (eg, belongingness and burdensomeness); shortened response version available that is recommended for use with older adults	- "These days, I rarely interact with people who care about me" - "These days, I have at least 1 satisfying interaction every day"	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use this tool to evaluate residents' self-perceived social deficits and use these as areas for goal-setting and planning care. However, this tool can also be used to assess residents' risk for suicide and, therefore, is an important multifaceted social functioning assessment for staff to consider using.
Questionnaire for Assessing the Impact of the COVID -19 Pandemic on Older Adults (Cawthon et al 2020[31]) See citation for tool	Self-report	No	17-item measure of social functioning in light of the COVID-19 pandemic; includes the 3-item loneliness scale	- "How often are you communicating with others?" - "How are you continuing to stay in touch with others?"	Currently used in research; can be administered by staff with experience in assessment and interpretation. During COVID-19, this tool can be used as a baseline to understand how the pandemic has impacted residents and their typical social roles and interactions. Some questions/wording of questions will need to be adapted for the nursing home population.

Table 1 (*continued*)

Tool (Citation) and Source	Type	Validated in Nursing Home Setting	Description of Tool	Example Questions	Suggestions for How to Use the Tool in Practice
Quality of Life in Alzheimer's Disease (QOL-AD; Logsdon et al 2002[32]) Available for purchase at apta. org	Self or proxy report specific to older adults with Alzheimer's disease and other dementias	Yes (Edelman et al 2005[33])	13-15-item (dependent on version) measure of physical health, mood, relationships, activities, and ability to complete tasks	- "How about your family and your relationship with family members? Would you describe it as poor, fair, good, or excellent?" - "How do you feel about your marriage? How is your relationship with (spouse's name)? Do you feel it's poor, fair, good, or excellent?"	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use this tool to assess a person's quality of life when living with Alzheimer's disease. Responses from resident or proxy will help aid in care planning that aligns with a resident's cognitive ability and functional status, specifically related to social activities and social interactions.
The Social Functioning in Dementia Scale (SF-DEM; Sommerlad et al 2017[34]) See citation for tool	Self- or proxy report specific to older adults with Alzheimer's disease and other dementias	Validated for use in older adults, not nursing homes	20-item measure of engagement in social activities and relationships	"Thinking about the past month, how often have you… - Contacted friends or family by phone or computer - Found you don't want to do things you would usually do"	Typically administered by social services, nursing, or mental health; can be administered by staff with experience in assessment and interpretation. Interdisciplinary staff can use this tool to understand the level of social functioning for a resident who lives with dementia—especially what types of social activities they might prefer and how well they or their proxy feel the resident connects with others.

ComPASS helps staff assess residents' self-rated social contributions and tailor future care delivery. ComPASS is validated for use in the nursing home setting.[22,23]

Social Functioning Outcome Measures

Although preference-based care planning measures help with incorporating residents' social histories and preferences into care, self and proxy report outcome-based assessments are useful for measuring baseline social functioning and tracking change over time. Outcome-based measures, although varied in their specific domain of social functioning (eg, engagement, connectedness, contribution), are essential tools to understand and improve residents' social functioning.

Self-Reported Measures

Patient-Reported Outcomes Measurement Information System

The Patient-Reported Outcomes Measurement Information System (PROMIS)[24] includes several measures that cover relevant domains of social functioning (ie, social isolation, companionship, emotional support; see Table 1) and are highly reliable and sensitive to change. PROMIS assessments are freely available in multiple formats and languages. Clinically meaningful score cut points are available, but measures were developed using samples from the general population and have not yet been validated for use with nursing home residents.

World Health Organization tools

The World Health Organization (WHO) developed and validated a variety of standardized measures for health professionals. These widely available tools are reliable, comprehensive, and culturally inclusive (available in a variety of formats and languages).[37] The World Health Organization Disability Assessment Schedule[38] and the World Health Organization Quality of Life[39] measures include domains specific to social participation and social relationships, respectively. Similar to PROMIS, these tools have not yet been validated for use with nursing home residents.

UCLA Loneliness Scale

For measuring loneliness, the UCLA Loneliness Scale[25] is validated for use with older adults and has been used in nursing home settings in several randomized controlled trials to measure loneliness.[40]

Three-Item Loneliness Scale

The Three-Item Loneliness Scale[26] is based on the UCLA Loneliness Scale, widely available, validated for use with older adults, and may be more ideal than the longer UCLA scale when brevity is required.

Lubben Social Network Scale

The Lubben Social Network Scale is also a measure of social isolation that can be used to measure the size and type of a person's social network.[27] A revised version[28] was developed for use in nursing home settings and demonstrated adequate internal reliability in preliminary testing.

Interpersonal Needs Questionnaire

The Interpersonal Needs Questionnaire (INQ)[29] is a self-report measure of 2 aspects of social functioning (perceived burdensomeness and loneliness) that are theorized to be proximal risk factors for suicide. A version with a simplified response scale is validated for use with older adults and may be more ideal than the original version for use in the nursing home setting.[30,41]

Questionnaire for Assessing the Impact of the COVID-19 Pandemic on Older Adults

A recently developed tool, the Questionnaire for Assessing the Impact of the COVID-19 Pandemic on Older Adults, is a measure that can aid staff in understanding how COVID-19 has impacted older adults' social relationships and functioning. The questionnaire includes items on older adult's actions related to social distancing and crisis response and could be especially useful in understanding residents' perceptions of their social functioning currently compared to pre-COVID. This measure includes the Three-item Loneliness Scale and may need to be further adapted for use in the nursing home setting as it was designed for community-dwelling older adults.[31]

Self- or Proxy-Reported Measures for Residents with Cognitive Impairment

Quality of Life in Alzheimer's Disease

For residents with cognitive impairment or dementia, the Quality of Life in Alzheimer's Disease (QOL-AD)[32] includes questions about the nature of relationships with friends and family members. The QOL-AD is validated for use in the nursing home setting[33] and can be administered to either the resident or a proxy.

Social Functioning in Dementia Scale

The Social Functioning in Dementia Scale (SF-DEM)[34] is an instrument used to assess engagement in social activities and relationships among adults with dementia. The SF-DEM is validated for use with older adults and can be administered by a health care professional to either the resident or a proxy.

Implications for Practice

This article presents well-validated care planning and outcome measures for staff to assess residents' social functioning. One of the advantages to the tools outlined in this article is that they can be used by "core" nursing home staff and do not rely on ancillary or contracted staff with specialized training. Although the entire interdisciplinary team can collaborate to administer the tools, recreational therapy (ie, staff responsible for activity development and coordination) and social service staff (social workers) with experience in assessment and/or interpretation can likely best integrate use of the tools into everyday practice. Nursing staff (ie, registered nurses, licensed practical nurses, licensed vocational nurses, and nursing assistants) are typically the residents' first point of contact, so they are also an essential component of and advocate for social functioning assessment and intervention. As nursing homes become versed in social functioning assessment, staff can work together to determine the most appropriate team member suited to assess residents' social functioning based on their unique home's staffing structure and availability.

All members of the interdisciplinary team have the potential to play key roles in assessing and addressing social functioning. Furthermore, understanding a resident's preferences and level of social functioning in the context of other required assessments and care goals can inform each discipline's approach to care. Assessment of social functioning can help inform social service staff of residents' unique social backgrounds and networks. Social functioning assessments can aid recreational therapy in designing and delivering individualized and group activities for residents based on their preferences and goals. Nursing staff can use information on residents' social functioning to tailor their everyday care interactions to meet residents' social needs. Physical, occupational, and speech therapy can use social functioning assessments to evaluate what supports may be needed for residents to participate in activities and social interactions effectively. Psychologists and members of the mental health team can

conduct and interpret social functioning assessments to design psychological treatment plans as appropriate. Ultimately, the optimization of residents' social functioning requires collaboration of all interdisciplinary staff [core, ancillary, and nonclinical (eg, dining, maintenance)] and commitment to residents' quality of care and life.

Perhaps the most challenging part of presenting a variety of tools in this article is how to choose which will be the most useful for nursing homes at varying levels of comfort and experience assessing residents' social functioning. Ideally, we recommend a 2-pronged assessment approach—use of a care plan measure and an outcome-based measure. Preference-based care planning measures offer roadmaps to inform relevant social activities and provide guidance on how to tailor activities to resident preferences and meet their unique cognitive and functional abilities. We describe the continuum of preference-based care planning tools above, but the PAT on the MDS is a logical place to start because it is required for all homes. Using the PAT to its fullest potential is essential, as this will help establish a baseline level of social preferences. The PAT can be used as part of a home's quality improvement efforts or activities to inform and guide individualized care planning and delivery. As homes are able to use the PAT and translate the assessment results into care, they can expand to use the ComPASS, which evaluates how satisfied residents are with their preferences and extend to a wider menu of preferences by using the PELI-NH or Activity Card Sort. Social preferences derived from these tools can be considered in activity planning and programming. These assessments can even be used as a form of social interaction for staff to determine subjectively how well residents are able to engage socially, especially during times when social activities are limited such as COVID-19.

In addition to a care planning measure to assess residents' social preferences, outcome-based measures are helpful to track residents' social functioning over time and monitor effectiveness of interventions and/or resident outcomes (eg, engagement, contributions, connectedness). However, choosing which social functioning measures are most appropriate for nursing homes and residents with highly varied needs is challenging. The National Academy of Sciences[16] recommends considering what related to social functioning a home is trying to accomplish (eg, identify an outcome of interest, compare groups, define a target population) so the most appropriate tool (or array of tools) can be identified. Another logical approach would be to evaluate the home's quality improvement goals and choose tools aligned with their needs. For example, if a home wants to focus on overall improvements in social or activities programming, they could pick measures aligned with their goals that assess change at the organizational level (ie, using a measure to track change in loneliness for residents over time). Whereas, if a home would rather assess clinical changes in individual residents (ie, increase engagement in activities for 1 resident), measures would be selected to align with individual care goals of the residents on an as-needed basis.

Shorter, more comprehensive social functioning outcome-based measures are a pragmatic place for homes to start. Especially useful tools for homes beginning their journey to address social functioning include the Three-Item Loneliness Scale, the Interpersonal Needs Questionnaire, and the Social Functioning in Dementia Scale. The Three-Item Loneliness Scale can serve as a starting point to investigate how a resident is functioning socially, especially when staff are short on time. The Interpersonal Needs Questionnaire is a good follow-up tool for those who screen positive for loneliness as it evaluates residents' self-perceived social deficits and risk for suicide. Finally, the Social Functioning in Dementia Scale is a useful alternate tool designed for and validated with residents living with dementia.

Other outcome-based measures include subscales of PROMIS and WHO, Lubben Social Network Scale, UCLA Loneliness Scale, Questionnaire for Assessing the Impact of the COVID-19 Pandemic on Older Adults, and Quality of Life in Alzheimer's Disease. Implementing 1 or more of these tools may help track changes in social functioning needs and aid in the early identification of residents who require additional social supports. Tools can be used as needed on an individual basis. For example, if a resident expresses feeling like they have no one to talk to, the Three-item Loneliness Scale and Lubben Social Network Scale would be an ideal pairing to understand residents' current social interactions and feelings about them.

Each tool described can be used independently or in tandem to provide a comprehensive social profile that captures both subjective and objective aspects of social functioning. Most of the tools discussed are available online or via paper but can also be administered orally and thus could be used by telehealth providers who may not have direct access to residents if social distancing restrictions are in place. Assessing social functioning can empower residents (and proxies) with the opportunity to contribute to care discussions and potentially make choices related to their care and social life, which may influence their satisfaction with care and overall quality of life.[23]

Conclusions and Implications

With the COVID-19 pandemic, nursing home staff are heroically attending to the critical physical and psychological needs of residents. However, it is likely the nursing home industry will be fundamentally changed by the pandemic and adaptations in practice will extend beyond COVID-19. With this shift comes an opportunity to re-envision how we approach the delivery of care in nursing homes. In particular, approaches to care planning and delivery should place the same importance on social functioning as other aspects of functioning (ie, physical, psychological, cognitive). In this article, we offer resources and suggestions to aid staff in assessing residents' social preferences and functioning with the goal of delivering person-directed care. Although this paper is a first step toward integrating social functioning assessments and related care into practice, future research is needed to understand the barriers and facilitators to using these tools effectively in practice, as well as policies and best practices for addressing social functioning consistently in nursing homes. We cannot underestimate the importance of assessing social functioning as a first step toward achieving optimal health and well-being for nursing home residents during the COVID-19 pandemic and beyond.

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