Tackling Grief and Bereavement in Nursing Home Settings

Findings from WellbeingTREE Learning and Action Network Roundtables

This report provides an overview of the **WellbeingTREE Learning and Action Network (LAN)**, details of two roundtables conducted that focused on grief and bereavement practices and policies to support Michigan nursing home staff and residents, and a summary of findings and recommendations shared during the roundtables.

Background

Grief and bereavement are universal experiences for most individuals. Grief is the emotional process of reacting to a loss, and bereavement is the objective situation one faces after a loss. While individuals experience grief and bereavement differently, when left unaddressed they can negatively impact one's health and productivity (Buckley et al., 2012; Carey et al., 2014; Wilson et al., 2020). For those who work and live in nursing homes, death is a common and often frequent occurrence, therefore presenting increased potential for experiences of grief and bereavement. The COVID-19 pandemic exacerbated this problem, as nursing homes experienced disproportionate losses compared to the general population (Cronin and Evans, 2022). Further, staff working in nursing homes not only experience loss within the home but also loss in their personal lives outside of work. Residents living in nursing homes experience grief and bereavement of loved ones, fellow residents, loss of abilities, as well as feelings of loss associated with transitioning into a nursing home setting. Nursing homes can help reduce the negative impacts of grief and bereavement by addressing them directly and building supports in the home that promote resident and staff wellbeing.

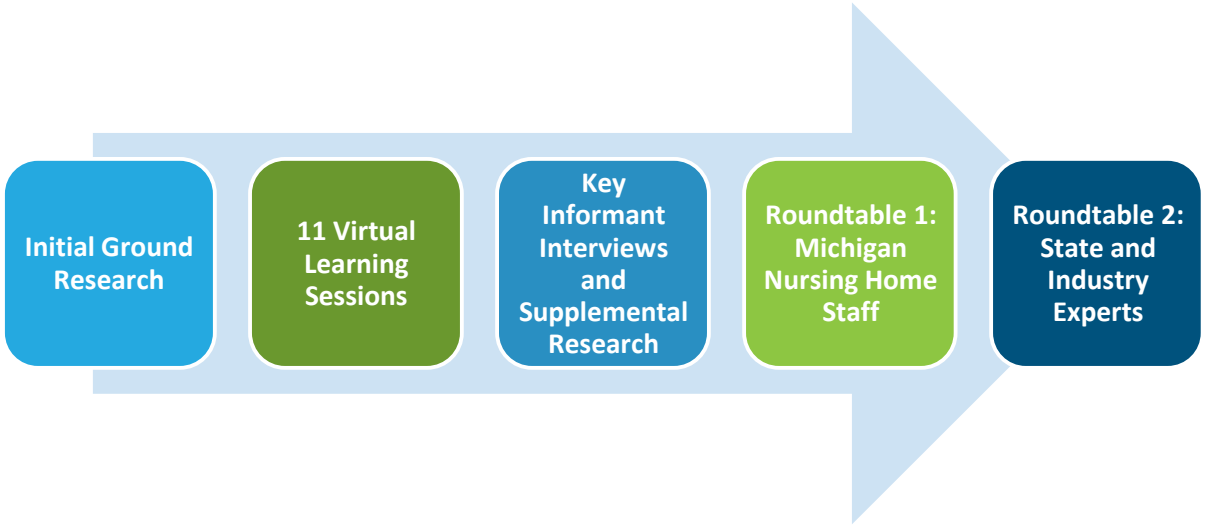
Overview of Project Activities

With funding from the Michigan Health Endowment Fund, Altarum established WellbeingTREE, a learning and action network that provided Michigan nursing home leadership and staff-tailored education and evidence-based strategies to address the grief, bereavement, social isolation, and loneliness that nursing home communities experience. Participants were encouraged to share person-centered strategies they implemented to improve emotional well-being among their staff and residents. Between May 2022 and August 2023, WellbeingTREE offered eleven (11) total virtual learning sessions, six (6) focused on *Grief and Bereavement* and five (5) focused on *Social Isolation and Loneliness*.

Following learning sessions, Altarum facilitated two roundtables to engage in conversations with stakeholders and supplement feedback from the G*rief and Bereavement* series around supports, practices, and policies for supporting nursing home staff and residents experiencing grief and bereavement. The first roundtable session brought together Michigan nursing home staff to discuss the types of support for staff and residents in Michigan nursing homes and where support gaps currently exist. The second roundtable brought together grief and bereavement and long-term care subject matter experts to identify solutions and recommendations to help nursing homes better support bereaved and grieving staff and residents. Key details, including the focus, participants, and objectives of each roundtable session are outlined in the next section.

A roadmap of WellbeingTREE activities leading up to roundtables is outlined below.

WellbeingTREE Activity Roadmap:



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Key Roundtable Details

Roundtable 1

LTPAC Staff Discuss Grief and Bereavement Support Needs

Topic

Types of grief and bereavement support for staff and residents and where are the gaps in support.

6 Participants

Five staff from Michigan nursing homes, including a social worker, CNA activities director, Quality of Life Manager, case manager, and chaplain.

One program manager from a state agency.

Objectives

- Discussed and provided feedback on how their teams support bereaved teammates and residents in their community.
- Contemplated what they might take away from the session to benefit their community.
- Brainstormed on what actions could be taken at the facility, local, state, and/or national level to support bereaved nursing home staff and residents.

Roundtable 2

Subject Matter Experts Discuss Solutions and Recommendations

Topic

Solutions and recommendations to help nursing homes support bereaved and grieving staff and residents.

11 Participants

Four subject matter experts on grief and bereavement, social isolation and loneliness, mental health, and culture change, respectively.

Seven Michigan long-term care experts working in state industry associations, a quality improvement organization, and a state agency.

Objectives

- Identified existing state resources or programs that could help address grief and bereavement in nursing homes (e.g., grants and other funding, training programs, evidence-based practices).
- Provided policy and practice recommendations at the individual home, and county and state levels.
- Planned for ongoing collaboration and dissemination of roundtable findings.

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Information Gathering

Support Themes

Prior to the first roundtable, Altarum staff interviewed roundtable participants as well as representatives from 10 additional Michigan nursing homes to gain a better understanding of what grief and bereavement supports exist in nursing homes. Common themes arising from those discussions reveal that:

- Memorials are being used to both honor residents who have died and as a supportive ritual for the living in some but not all homes.
- Policies directing care and emotional support for residents when death is imminent are inconsistent.
- Care and emotional support practices when staff/coworkers die are inconsistent.
- General bereavement policies are inconsistent, offering different amounts of eligible leave time and inconsistent definitions of eligibility. Eligibility is based on the home's definition of "immediate family."
- Staff can take unpaid bereavement leave based on coverage availability.
- Some homes allow staff to donate their paid time off to coworkers.
- Most homes do not employ chaplains and of those that do, not all the employed chaplains are certified.
- Bereavement support and education provided by hospice partners vary.
- Some homes shared anecdotally that in bereavement, staff support each other by bringing food or helping to complete tasks.

Roundtable One participants shared their practices for supporting residents and staff. The practices fell under four categories of support: emotional, physical, spiritual, and financial.

Emotional Support	Physical Support	Spiritual Support	Financial Support
•Bereavement leave •Sympathy cards, texts, etc. •Counseling •Presence	•Flexible scheduling •Daily wellness check-ins •Covering shifts •Providing child care •Providing meals/groceries	•Chaplain referral •Praying for or with •Taking residents to memorial services or resting places •Culturally appropriate rituals	•Support funds •PTO donations •Increased days off •Allow non-consecutive use of bereavement leave

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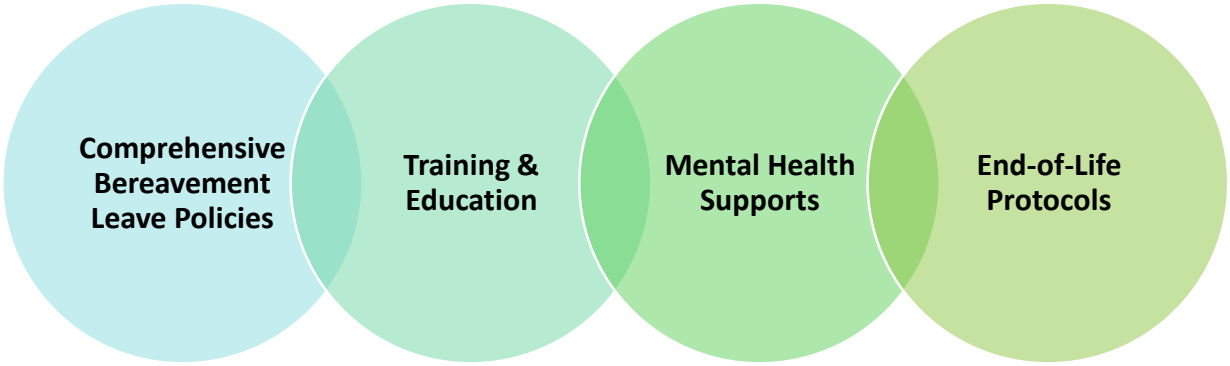
Summary of Roundtable Discussion

The roundtables focused on four areas of need for homes to better support grieving and bereaved residents and staff. Those areas have been categorized as the following: comprehensive bereavement leave policies, training and education, mental health supports, and protocols for end-of-life.



Roundtable Two brought together nursing home industry leaders in Michigan and national subject matter experts on culture change and grief and bereavement to identify solutions to the needs discussed in the first roundtable. Guiding questions were used to initiate discussion around each of the four categories of need that were identified during Roundtable One. The themes identified during Roundtable Two are summarized below.

Bereavement Policies and Procedures

In Roundtable One, nursing home staff identified inconsistent or deficient bereavement leave policies and procedures as a gap needing attention. Examples of needs include an increase in the number of paid bereavement days offered, broadening eligibility guidelines for those who leave may be used for, and offering leave days that can be taken non-consecutively over a longer period. With these needs in mind, attendees in Roundtable Two were asked the following guiding questions:

- ***What is preventing homes from offering a more comprehensive bereavement leave?***
- ***Should there be bereavement leave for staff who lose a resident whom they cared for over a long time?***

First, it is important to note the challenges that nursing homes face daily. Ongoing staffing shortages, ever-changing regulatory requirements, and the trauma staff and residents experienced during the

pandemic have left nursing homes in a compromised state. Several attendees noted the importance of acknowledging that nursing homes are in need of support and that it may be difficult for homes to focus on addressing grief and bereavement when they are faced with such challenges. However, CMS's recent guidelines surrounding person-centered care planning and trauma-informed care prioritize both resident and staff empowerment to create an environment of respect and autonomy. Addressing grief and bereavement in nursing homes goes hand in hand with **creating a culture of person-centered care**. Attendees agreed that those homes supporting grief and bereavement initiatives, including comprehensive bereavement leave, have a culture that emphasizes person-centered care.

Participants shared several thoughts about homes' challenges in providing **more comprehensive bereavement leave** for their staff. It was noted that homes might not be offering more comprehensive leave because they are not aware of the long- and short-term benefits. Similarly, another attendee noted that it is important to know the impact of not providing bereavement benefits and whether there are adverse outcomes associated with it. Participants mentioned how demonstrating the return on investments of providing greater bereavement support to staff might sway those concerned about the financial costs. Similarly, it was noted that there is a lack of data on outcomes associated with providing more comprehensive bereavement leave, and it should be an area for research to explore further.

Other attendees discussed the relationship between nursing homes' staffing shortages and bereavement leave. There may be a fear of losing staff for extended periods of time, as well as the financial cost of paying staff who are not working. Attendees also noted that, like other industries, there may be some homes operating from a punitive mindset with a culture of not believing in or trusting employees. Leadership may erroneously believe that by offering more time off and more flexible parameters for qualifying for bereavement leave it will be abused, and staff will not show up for work. The group discussed a need to encourage leadership to continue to "**lean in with compassion**" when considering bereavement.

> *"This comes back to making sure that the culture we create, even if the policies don't come together exactly as needed for the person needing the support, allow for staff regardless of position (scheduler, administrator, HR, etc.) to creatively figure out how to support people as individuals."*

When asked about the possibility of staff being able to use bereavement leave when losing a resident they worked with closely, one attendee shared that it is important for homes to have **flexible bereavement leave policies** depending on an employee's situation rather than a one-size-fits-all policy. It is not always an immediate family member that people need to grieve the loss of. Some nursing home staff care for people for several years, growing to care for them deeply. In many cases, staff find out about a loss on the job and then must continue with their workday.

Related to flexible bereavement leave policies, it was noted that even when an employee loses a family member, the rigidity of many standard policies does not account for the nuances that occur. One attendee told a story of an immigrant CNA who needed to travel to her home country for her father's

funeral. The home's bereavement policy did not cover her being away for a month, so the scheduler worked with the administration to cover her pay for as long as they could and made sure that she had a job to come back to when she returned. On this topic, one attendee stated, "This comes back to making sure that the culture we create, even if the policies don't come together exactly as needed for the person needing the support, allow for staff regardless of position (scheduler, administrator, HR, etc.) to **creatively figure out how to support people as individuals**."

Training and Education

Another area of need identified in Roundtable One was more training and education for nursing home staff, including training for direct care staff around providing care for the dying, self-care for staff, and training for new administrators on providing emotional support to staff. Two guiding questions were used to lead this portion of the roundtable:

- ***How can we train and educate a workforce that is physically and emotionally exhausted without creating more burden?***
- ***Are there existing training or education resources?***

Nursing homes already have numerous required trainings they must take every year, ongoing staffing shortages that make it difficult to pull nursing staff from the floor, and managers with competing demands. With that, roundtable attendees acknowledged that any training recommendations should aim not to create more burden for homes. One approach to lessen the burden is by **incorporating** grief and bereavement training **into other existing trainings**, such as required dementia and mental health training. Modules could also be added around grief and bereavement in CNA and Nursing Home Administrator training and licensing as well as into new hire orientation.

Several attendees mentioned the challenges that new administrators face. Attendees noted that in their experience, new administrators are often younger with less on-the-job experience, many coming straight from college rather than working up to an administrator role after working in other roles in the home. One attendee said, "There is nothing to prepare a young administrator for death, dying, loss, bereavement, mental health issues, or anger (that grief and bereavement can commonly manifest as)." This feedback emphasizes the need for mental health support and training to preserve existing administrators as well as to bolster those new to the role and field.

Attendees felt that it is just as important for administrators to understand the soft skills it takes to run a nursing home in addition to the regulatory requirements. One attendee said, "Sometimes running a business gets in the way of treating people with compassion." It was suggested that a way to help those newer administrators could be to **pair them with a veteran administrator mentor**.

Several attendees mentioned **Mental Health First Aid (MHFA)** as a potential training that staff of any level in nursing homes could take. MHFA is often offered for free or at a low cost (as a result of grant

funding) through The National Council for Mental Wellbeing. MHFA introduces the risk factors and warning signs of mental illness, provides an understanding of the impact mental illness can have on an individual, and overviews various supports available. One attendee noted that this kind of training is important for teaching basic mental health concepts to staff who do not work in mental health roles, especially for those in rural areas who may have limited access to mental health professionals.

Another attendee suggested homes have **"nudges" or frequent reminders about training topics**. This attendee was concerned that one-off trainings may not always stick with people who do not get opportunities to practice or apply the content. For example, a staff member who takes training on culturally appropriate end-of-life care but does not have a resident die for several months may lose sight of particular or all training concepts. **Daily or weekly reminders of pertinent training topics are a way to keep the content fresh in staff members' minds and convey to staff that this is an issue the home cares about.** Roundtable attendees discussed incorporating these into existing meetings, bulletin boards, texts, or other forms of communication.

Mental Health Supports

The third area of need identified by Roundtable One was mental health support for residents and staff. This can include supports such as increased access to chaplains and pastors certified in death counseling and building proactive, consistent, and genuine mental health support into the workplace. Roundtable Two sought to identify solutions by answering the following questions:

- ***How can we better support all staff, including administrators, who are juggling multiple competing priorities? What is the role of corporate offices?***
- ***In what ways can we provide support to residents who are experiencing grief?***

When asked about how to better support staff in nursing homes, one attendee mentioned the importance of not putting too much of the onus on administrators to be the main source of support for staff in the home. While administrators have a responsibility to support staff, the attendee noted that administrators are also burning out due to the competing priorities of the job and being expected to emotionally support the entire staff. The same consideration should be held for the building social worker. They should not have the sole role of providing support to residents and the entire building staff. One attendee noted corporate leaders' role in developing comprehensive bereavement leave and emphasized the importance of corporate involvement in these conversations.

Attendees also noted the importance of acknowledging that people grieve differently. Not all staff may want to talk about their feelings about grief and bereavement. People grieve and cope in different ways. **There are multiple ways to support staff besides offering therapy**. Attendees discussed the importance of considering the diverse needs of all staff. Sometimes, **providing food** can be a source of support for those who are grieving, while others may desire more **direct emotional support**. Encouraging or

providing time for **physical activity like walking in nature/green areas/spending time outdoors, wellness check-ins, and training in basic self-care** are other recognized methods of support.

Attendees agreed that **support groups for residents, led by residents,** could benefit those who want them but noted that as all staff have different preferences for how they receive support, so do residents. One attendee noted that in her experience, residents typically preferred **one-on-one support** from someone in a comparable situation as opposed to a group setting. Another attendee shared her experience with grief and bereavement support groups for residents. The attendee noted that while the social worker helped to facilitate the support group, it was primarily driven by the residents and was a highly attended group. Grief and bereavement support groups can help residents who are experiencing the loss of a loved one but also allow residents to share about the grief they experience moving into a home and dealing with potential changes in their abilities.

Several attendees discussed the importance of vetting potential support group facilitators. For example, some faith-based approaches to grief and bereavement may advise residents that grief is the result of not having strong enough faith, rather than a normal response to loss. Facilitators should also have experience working with older adults, and preferably older adults in congregate living, if possible. Several attendees discussed the importance of having a person-centered environment that empowers residents to advocate for and start their own support groups, and even lead groups themselves if they choose.

One attendee noted again that it may be necessary to **provide the business case for providing more mental health support for staff and residents**. It would be valuable for administrators to have insight on the financial cost and any return on implementing more support. For example, it could be helpful to know if implementing more support can lead to higher retention among staff or an increase in the quality of care. Unfortunately, there is a lack of research in this area and, therefore, a lack of data connecting support for grief and bereavement with any outcomes.

Protocols for End-of-Life

The last area of need identified by Roundtable One was improved protocols for end-of-life. Attendees in Roundtable One stated they wish they had **more time when a resident passes**, noting that they feel rushed to remove the body and fill the bed with a new resident as soon as possible. Other needs included more **standardized processes after death occurs**, a **team or community debrief after death**, **staff trained on the rituals surrounding death in the cultures** applicable to the residents they are caring for, and **private rooms for those who are transitioning.** Roundtable Two sought to identify solutions by answering the following questions:

> *"There's not a way for people to be informed [of a resident death] in a way that is respectful, heartfelt, and understanding. It is important to inform people in a way that matters, to show that they matter and that staff matters."*

- ***What are some ways we can allow family, staff, and residents the time and space to grieve when a resident passes or is passing?***
- ***How can homes and hospices improve partnerships to better support residents, families, and staff when a resident passes?***

Hospice can support nursing home staff by providing training and offering support to staff experiencing grief and bereavement. However, support provided by hospice is often inconsistent. One attendee mentioned that partnerships between nursing homes and hospice could be strengthened by **asking hospice to provide grief and bereavement EAP-type services to nursing home staff**. The hospice philosophy means that most hospices are willing to engage more with nursing homes and provide more support to staff through training, education, and counseling where it is needed, but may need that invitation from the home to engage further.

One need that was highly voiced during Roundtable One was the need for more time when a resident passes. Attendees in Roundtable Two discussed how rituals can give staff and residents the time and space to grieve. For example, one attendee discussed how the task-oriented nature of nursing homes means things move quickly when a resident passes and does not allow time for staff to grieve. One way to address this is by **building rituals into the processes after death** so there is built-in time for staff and residents to acknowledge the passing of a resident, even if only briefly. Examples of rituals include playing a special song when a resident passes, laying a quilt on the resident's bed, bringing staff and residents together for a procession out of the main entrance of the home, memorials, legacy activities for residents, memory bulletin boards, or memory ornaments for holiday trees, among other examples. Some homes light a candle to indicate when a resident is transitioning. Rituals serve several purposes in that they provide comfort to the living residents by demonstrating what will happen in the event that they die, allow staff to show their respect to the departed, and are an avenue for both groups to begin the grieving process. Residents are acutely aware of what is happening in their home. Implementing a process that allows residents and staff to prepare emotionally for the passing of their friend and for subsequent inquiries about their absence. Attendees noted that residents, along with the help of empowered staff, have come up with great suggestions for rituals.

Attendees also discussed the need for communication protocols that include staff, family, and residents for when a death occurs. One example that was provided was having a protocol in place for those who need to know of a death first, such as the spouse/partner/primary family before other friends or family post about the death on Facebook or other social media outlets. Individual preferences for communication should be understood and documented. One attendee noted that it is also important to consider staff preferences for notification of a resident death, particularly those who closely cared for a resident. She stated, "There's not a way for people to be informed [of a resident death] in a way that is respectful, heartfelt, and understanding. It is important to inform people in a way that matters, to show that they matter and that staff matters."

Conclusion

Roundtable Two attendees shared perspectives, ideas, and solutions for addressing the needs identified in Roundtable One. Attendees shared similar gaps that were discussed in Roundtable One but also identified additional gaps, such as a lack of research and data to support the need for more bereavement leave and additional mental health support. Attendees noted several systemic challenges that nursing homes face, such as low staffing, that may be a barrier to homes addressing grief and bereavement. However, participants discussed many solutions that are low or no cost, support person-centered care and culture, and could be combined or built into existing policies, education, and processes. Nursing homes can consider these suggestions and subsequent recommendations outlined in the next section for practices and policies aimed at reducing the negative impacts of grief and bereavement and building supports in the home to promote resident and staff wellbeing.

Recommendations

Several recommendations were developed in response to the solutions discussed during Roundtable Two, and many of the homes the team spoke to are already taking these steps. This section highlights actions that can be taken by:

- Nursing Home Administrators
- Social Workers, Activity Directors, and Chaplains
- Nursing Home Owners and Organizations
- Educators
- Advocacy Organizations and Associations
- Researchers
- Hospice Providers
- State and National Government Agencies

Target Audience	Recommendation	Category
Nursing Home Administrators	***Create a culture of open communication.*** Administrators can set the stage by starting a dialogue about grief and bereavement in the home. Seeing a leader open up may signal to staff that it is okay for them to do so as well.	*Culture Change/Person-Centered Care*
	Create a culture of trust where people can take time off when needed regardless of the reason. Work with schedulers and human resources to examine policies on time off and allow managers the latitude to work creatively and with flexibility to accommodate time off. Consider testing unlimited leave policies with administrative-level staff.	*Culture Change/Person-Centered Care*

Target Audience	Recommendation	Category
Nursing Home Administrators	***Implement clear and emotionally supportive post-mortem protocols.*** Examples of areas to consider include the retrieval of a resident's personal items, communication protocol, and process for who gets notified at what intervals when a resident is dying, and structuring formal post-mortem debriefs with staff.	*Policies/ Procedures*
	Train staff in grief and bereavement-related topics. To lessen the burden of training on staff, training can be offered as in-service topics and during new staff orientation, including training on language usage around death and dying and support and how staff should communicate about it. Grief and bereavement topics can also be included in other training topics such as dementia. Use weekly reminders or nudges during daily huddles or meetings on grief and bereavement-related topics.	*Training & Education/ Mental Health Supports*
	Train select managers to recognize mental health needs. Training such as Mental Health First Aid is often offered for free, is brief (8 hours), and has been used in long-term care to identify and support staff who are struggling with mental health issues.	*Training & Education/ Mental Health Supports*
	Evaluate contracts with hospice partner organizations and consider building the provision of support and education components for staff into them. Strengthen relationships with hospice providers by leaning on them for more support around training and educating staff about end-of-life care and self-care.	*Training & Education/ Mental Health Supports*
	Work with hospice partners to create a standardized communication plan/process for when a death occurs. Hospice can provide guidance on developing a standardized plan and process for notifying family and staff when a death occurs, including who is notified first, how, and when.	*End-of-Life Protocols*
	Implement a Grief & Bereavement or Mental Health Employee Resource Group (ERG) and/or employee support group. Identify if there is interest among staff by conducting a survey or through informal conversations. The group could be led by staff with the support of leadership.	*Mental Health Supports*

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Target Audience	Recommendation	Category
Social Workers, Activity Directors, and Chaplains	***Implement grief and bereavement support groups for residents.*** Identify if there is interest among residents in support groups. Groups could be facilitated by the social worker or an outside professional, but resident-led groups (supported by staff) are ideal.	*Mental Health Supports*
	Communicate with residents about grief and bereavement. Have open conversations with residents when a death occurs in or out of the home. Not all residents may be interested in talking about grief and bereavement, but opening the door lets them know they have someone to talk to should they change their minds.	*Mental Health Supports*
	Identify and implement preferred post-mortem rituals for when a resident passes. Ask residents and staff how they would like to honor residents. Ideas for rituals include playing a special song, having a procession out the main entrance, or laying a quilt on the resident's bed.	*Policies/ Procedures & Mental Health Supports*
	Hold memorials for residents who have passed. Survey residents to learn how they would prefer to memorialize others, and how they would like to personally be memorialized if they pass. There are different approaches for holding memorials. Some homes hold a memorial for each resident that passes, while others may hold one for all residents who have passed over a specified amount of time.	*Policies/ Procedures & Mental Health Supports*
	Communicate with residents about end-of-life wishes extending beyond POLST/Advanced Directive criteria. Other areas that may be considered are whether they have any wishes for being memorialized in the home.	*Policies/ Procedures & Mental Health Supports*
Nursing Home Owners and Organizations	***Make culture change and person-centered care a strategic priority for all homes within the organization.*** Including culture change in strategic planning ensures that it becomes an ongoing, long-term goal, and holds all employees accountable for its success.	*Culture Change/Person-Centered Care*
	Develop flexible bereavement policies to reflect the needs of modern workers and update them when needed. Assess current policies for person-centeredness and whether managers have the leeway to act creatively to support staff in the best way possible. Bereavement leave should be broadly covered beyond the immediate family and allowed to be taken non-consecutively to accommodate the needs of the	*Policies/ Procedures & Mental Health Supports*

Target Audience	Recommendation	Category
Nursing Home Owners and Organizations	bereaved. If more paid leave is not currently an option, increase the flexibility in which staff can take unpaid leave. Consider the needs of staff who are from other countries and may need to travel for extended periods of time.	*Policies/ Procedures & Mental Health Supports*
	Incorporate training around grief and bereavement in onboarding for all staff. Training should be tailored to the position (administrators and managers vs direct care staff) and address the home's approach to end-of-life care and how the home processes the loss of a resident.	*Training & Education*
	Consider developing a mentorship program for new nursing home administrators. Mentorship for administrators is not a new idea, but there could be room to expand mentorship programs to include a focus on mental health support and self-care for those who are interested.	*Training & Education/ Mental Health Supports*
	Seek feedback from staff working in the homes. Identify and understand staff experiences related to grief and bereavement in the home and learn if they are receiving the support they need. Some potential avenues for receiving feedback are listening sessions with staff or anonymous surveys.	*Training & Education/ Mental Health Supports*
Educators	***Inclusion of culture change/person-centered care as part of the education curriculum for Health Care Administrators and other similar degrees.*** Culture change places emphasis on supporting and empowering staff. Prepare future administrators to move away from the institutional model of care while still working within regulations.	*Training & Education/ Mental Health Supports*
	Inclusion of grief and bereavement, mental health/burnout risk, and self-care in the Health Care Administration degree programs. Self-care is typically addressed in nursing and social work degree programs, but it is important to address it for health administrators as well. Administrators are juggling multiple roles while trying to support and retain staff, thus at risk for burnout.	*Training & Education/ Mental Health Supports*

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Target Audience	Recommendation	Category
Advocacy Organizations and Associations	***Continue to advocate for increased mental health funding and support for nursing home staff and residents.*** In general, there continues to be a lack of mental health resources, particularly in rural areas. With the pandemic still fresh in the minds of policymakers, now is the time to advocate for increased resources.	*Training & Education/ Mental Health Supports*
	Raise awareness of and continue to identify needs about grief and bereavement. Industry associations can use their members to spread awareness about grief and bereavement through monthly communications. Associations can also help to bring awareness to the needs of nursing homes by surveying members on grief and bereavement.	*Training & Education*
Researchers	***Evaluate the impact of increased mental health support for nursing home staff.*** There is a lack of data demonstrating the impact of increased support, such as robust bereavement leave policies, on nursing homes. Areas of interest may be the financial costs and returns of implementing more supports, and the impact on retention.	*Data*
State and National Government Agencies	***Designate culture change as a priority.*** Create incentives for nursing homes to implement culture change and provide guidance on implementing culture change in accordance with other regulations.	*Culture Change/Person-Centered Care*
	Include a more robust grief and bereavement module in the Nurse Aide Training and Competency Evaluation Training Program curriculum. Michigan currently has a broad module on end-of-life care, but there is room for more on self-care topics and dealing with grief and bereavement working in the nursing home setting.	*Training & Education/ Mental Health Supports*
	Add a module on bereavement to the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS data is used in two-thirds of states to support health-related legislative efforts. In 2019, Georgia added a three-question module on bereavement to the BRFSS. Including a bereavement module could help states evaluate the impact bereavement has on public health and, more specifically, front-line workers.	*Data*

References

1. Buckley, T., Sunari, D., Marshall, A., Bartrop, R., McKinley, S., & Tofler, G. (2012). Physiological correlates of bereavement and the impact of bereavement interventions. *Dialogues in Clinical Neuroscience*, *14*(2), 129-39. doi: 10.31887/DCNS.2012.14.2/tbuckley.
2. Carey, I.M., Shah, S.M., & DeWilde, S. (2014). Increased risk of acute cardiovascular events after partner bereavement: A matched cohort study. *JAMA Internal Medicine, 174*(4), 598-605. Doi: 10.1001/jamainternmed.2013.14558
3. Cowles, K. V. (1996). Cultural perspectives of grief: An expanded concept analysis. Journal of Advanced Nursing, 23, 287294. (R)
4. Levesque, D.A., Lunardini, M.M., Payne, E.L., Callison-Burch, V. (2023). Grief in the Workplace: Challenges and Solutions. American Journal of Health Promotion. https://doi.org/10.1177/08901171221145217d
5. Li, Changle & Miles, Toni. (2024). Bereavement & Health-Related Quality of Life: Population Data Pre-Pandemic 2019 Georgia. 10.2139/ssrn.4668823.
6. Miles, Toni & Li, Changle & Khan, M. & Bayakly, Rana & Carr, Deborah. (2023). Estimating Prevalence of Bereavement, Its Contribution to Risk for Binge Drinking, and Other High-Risk Health States in a State Population Survey, 2019 Georgia Behavioral Risk Factor Surveillance Survey. International Journal of Environmental Research and Public Health. 20. 10.3390/ijerph20105837
7. Murphy, K-, Hanrahan, P., & Luchins, D. (1997). A survey of grief and bereavement in nursing homes: The importance of hospice grief and bereavement for the endstage Alzheimer's disease patient and family. Journal of the American Geriatrics Society, 4f, 1104-1107. (R)
8. Rando, TA. (1984). Grief, dying and death; Clinical interventions for caregivers. Chicago: Research Press. (L)
9. Rosenzweig, A., Prigerson, H., Miller, M.D., & Reynolds, C.F. (1997). Bereavement and late-life depression: Grief and its complications in the elderly. Annual Review of Medicine, 48, 421-428. (R)
10. Wilson, D.M., Rodríguez-Prat, A., & Low, G. (2020). The potential impact of bereavement grief on workers, work, careers, and the workplace. *Social Work in Health Care, 59*(3), 1-16. https://doi.org/10.1080/00981389.2020.1769247.
11. Won Y., Kim, H.C., Kim, J., Yang, S.C., Park, S.G., & Leem, J.H. (2022). Impacts of presenteeism on work-related injury absence and disease absence. Annals of Occupational and Environmental Medicine. 10.35371/aoem.2022.34. e25