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Evaluation of Partnerships in Preparedness (PiP): A Mentorship Program for Long-Term Care Facilities in the COVID-19 Crisis

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ABSTRACT

Long-term care facilities (LTCF) in the U.S. rank among the most profoundly affected industries by the Covid-19 pandemic. LTCF staff faced insurmountable challenges in their attempts to contain outbreaks and mitigate transmission. Changes in workflow processes were unprecedented, increasing stress on both providers and fragile residents. LTCF facility representatives, already overwhelmed with the facility's demands, struggled to interpret the latest and ever-changing recommendations and configure guidelines for their facility operations and infrastructure. Given the isolated nature of rural (and some urban) long-term care facilities, combined with the struggling industry, a one-to-one mentorship program seemed like a viable and welcome solution. Partnerships with professional associations were established to recruit facilities interested in establishing a mentor relationship. Mentors were given a short orientation to the program and then paired with a long-term care facility representative. Daily mentor meetings were conducted in the initial weeks of the program and then reduced to 3 times per week. Program evaluation was conducted mid-way through the program through focus groups with mentors and mentees in separate sessions. The qualitative results are the subject of this paper. Feedback from both mentor and mentees was overwhelmingly positive and concurred with systematic reviews of other published mentorship programs. Given that solutions for future planning should be based on lessons learned from previous crises, mentees in this program provided sound advice for measures that should be implemented regardless of establishing a formalized mentorship program. More comprehensive mentor orientation, mentee peer-peer interaction and engagement, consolidation of ever-evolving recommendations, and procedural templates were outcome program recommendations. This mentorship program serves as a national call to build infrastructure to provide valuable support for those who will dedicate their professional lives to protecting our vulnerable aging generation.

KEYWORDS: Long-Term Care; Mentorship; Pandemic; Preparedness.

KEY PRACTITIONER MESSAGE

1. Establish mentorship programs between long-term care facility representatives and subject matter experts in infection control and emergency preparedness.
2. Coordinate peer-to-peer mentoring support between long-term care staff in area facilities.
3. Coordinate and consolidate the sharing of concise and current information in public health emergencies.

INTRODUCTION AND BACKGROUND

Long-term care facilities (LTCF) in the U.S. rank among the most profoundly affected sectors by the Covid-19 pandemic. The infection rates among staff and residents have surprised even seasoned public health professionals, who are adept at outbreak containment and control and have a keen understanding of the vulnerability of this aging population. In the United States, there are approximately 1.3 million adults over 65 years of age living in nursing homes and approximately 1 million adults over 65 years of age living in assisted living facilities (Roy et al., 2020).

At the pandemic's peak, guidance from local, state, and national experts focused on outbreak mitigation, containment, and control with little regard for the collateral consequences to residents' wholistic well-being. It was difficult for providers to access Personal Protection Equipment (PPE). To facilitate the cohorting of resident care, guidelines for Covid-19 containment in Nebraska also include the reconfiguration of workflow processes in the long-term care facilities.

The Center for Medicare and Medicaid Services (CMS) requires all LTCFs to infection prevention follow the guidance provided by the Center for Disease Control and Prevention (CDC). Shortages of PPE jeopardized the health and safety of LTCF staff and residents. They violated COVID-19 protocols set forth by the CDC and often resulted in formal deficiency tags and financial penalties (D'Adamo et al., 2020). Increasing the overall challenge, some states' hospitals discharged patients to LTCFs with either positive COVID-19 tests or a lack of proof that returning residents tested negative. Other states, such as New York, implemented a moratorium on a facility's right to refuse a resident based on a positive COVID-19 test and required LTCFs to accept all patients (Ouslander & Grabowski, 2020).

LTCF staff faced insurmountable challenges in their attempts to contain outbreaks and mitigate transmission. Changes in workflow processes were unprecedented, increasing stress on both providers and fragile residents. The mental health toll on LTCF industry providers was palpable during State-wide calls with facility representatives and Infection Prevention Specialists working through organized ICAP (Infection Control and Prevention) programs. LTCF facility representatives, already overwhelmed with the facility's demands, struggled to interpret the latest and ever-changing recommendations and configure guidelines for their facility operations and infrastructure (Yen et al., 2020).

According to Gavin et al. (2020), healthcare workers on the frontline of the COVID-19 response experience high rates of anxiety, depression, and distress, while simultaneously having the usual avenues of adaptive behavior such as social interaction blocked due to social distancing and other infection control mitigation measures (Gavin et al., 2020). Given the isolated nature of rural (and some urban) LTCFs, combined with the struggling industry, a one-to-one mentorship program seemed like a viable and welcome solution. In a pandemic scenario, mentorship may enable the mentee to feel ready and able to use their practical knowledge and adapt as more empirical knowledge is obtained.

Mentorship programs are one way to increase social and peer-to-peer interaction (albeit limited) as positive adaptive behavior. At the same time, the mentee-mentor relationship can diminish healthcare workers' feelings of self-blame and deprecation by giving them an expert to lean on.

Professional mentorship encourages multidisciplinary collaboration and has been described as essential in personal and professional development (Burgess et al., 2018). Mentorship has been shown to increase a mentee's capacity to perform certain aspects of his/her job, but overall performance also increases significantly (Ghosh et al., 2020).

Additionally, a mentor can help a mentee feel important in their role in a prolonged healthcare emergency response. It can mitigate a mentee's potential feelings of loss of control and isolation by facilitating a consistent and trusting relationship. The mentee may express concerns and ask questions in a safe environment, free of judgment (Bhatti et al., 2020). In turn, mentors can support LTCF providers by shouldering the responsibility of knowledge transfer and helping facility representatives remain current on guidance and mandates from the local, state, and federal levels.

In the College of Public Health at the University of Nebraska Medical Center, the Center for Preparedness Education partnered with Leading Age Nebraska and the Nebraska Health Care Association (NHCA) to recruit LTCF facilities interested in establishing Partnerships in Preparedness (PiP) mentorship program. Mentors were recruited by invitation from long-time partners of the Center

for Preparedness Education and through the Association of Healthcare Emergency Preparedness Professionals (AHEPP). Among the requirements was expertise in emergency preparedness and infection control and prevention. Mentors were given a short orientation to the program and then paired with an LCTF representative. Daily mentor meetings were conducted in the initial weeks of the program and then reduced to 3 times per week. These "huddle" sessions were used to release new guidance information and provide a forum to discuss any items that arose from the mentee/mentor interaction. Mentors established a regular schedule to meet with facility mentees, but many were available for spontaneous consultation. At the height of program participation, there were 67 long-term care facilities and 21 mentors enrolled in the program.

Program evaluation was conducted mid-way through the program through focus groups with mentors and mentees in separate sessions. The qualitative results are the subject of this paper. Our goal is to demonstrate the value and purpose of such dedicated mentorship programs and provide operational and logistical guidance to those who wish to replicate this program across disciplines.

METHOD

We used a qualitative research approach since this is a new and novel program, and there were no existing evaluation data from the perspective of the PiP mentors or mentees. Data were gathered through 2 focus groups with mentors and 2 with mentees. A total of 10 mentors and seven mentees participated in the evaluation, and each focus group had between 4-7 participants.

The semi-structured interview guide was drafted through consensus among researchers and the PiP Mentorship leadership team. Inclusion criteria were mentors and mentees in the PiP program. The University of Nebraska Medical Center's Institutional Review Board (IRB) deemed that this study was classified as a program evaluation, and hence no further permission from IRB was needed. Focus groups were conducted via Zoom, recorded with permission from research participants, and transcribed verbatim.

Focus group sessions ranged from 45- 60 minutes, and all participation was voluntary. The main questions focused on mentors' and mentees' experience with the PiP mentorship program, including suggestions for improvement. Follow-up questions were based on responses from participants and allowed flexibility for the interviewer to delve deeper into issues (Huberman & Miles, 2019).

We followed a thematic data analysis process (Braun & Clarke, 2006). Transcripts were coded to organize the data into meaningful chunks or sections. The reliability of the coding process was established by having two researchers (Shireen S. Rajaram and Sharon Medcalf) independently code the same transcript. Next, they met to discuss and develop a consensus on the codes and determine the meaning or definitions for each code (Creswell & Poth, 2016; Miles et al., 2014). They created a codebook that was used to code the rest of the transcripts using NVivo® (QSR International Pty Ltd, 2015), a software program for qualitative data analysis. As clusters of meaning developed, these codes were combined into critical themes. The coding process was both deductive or topic-driven (top-down), based on the main focus areas relating to suggestions for improvement of the program, and inductive or data-driven (bottom-up), based on the meaning that emerged through the analysis and interpretation of the data (Creswell & Poth, 2016; Miles et al., 2014).

Field notes taken following each focus group that reflected insights and impressions of the process were used to interpret the data (Miles et al., 2014). We maintained credibility or validity through peer-debriefing, prolonged engagement, and rich, thick description (Lincoln & Guba, 1985; Patton, 2014). Peer debriefing between researchers occurred in drafting the interview guide and following each focus group. The PiP leadership team had prolonged engagement over the seven months of the project, and meetings occurred almost every day. The thick description of the results with details of the context of LTCFs and CAHs (Critical Access Hospitals) helped interpret the study data (Lincoln & Guba, 1985; Patton, 2014).

A total of 10 mentors and seven mentees participated in the focus groups. The majority of mentors were female, over 55 years of age, and had a college degree. All mentors were White-Caucasian and had public health or clinical care backgrounds. Six mentors were in the field of emergency preparedness. Five mentors worked with LTCF, while five worked with LTCF and CAH. Only two mentors worked with facilities that did not experience a COVID-19 case,

while the other mentors experienced COVID-19 cases in one or more of their mentees' facilities. No personal demographic data were collected on mentees to ensure the preservation of anonymity.

RESULTS

The results of the focus groups with mentors and mentees revealed five key themes: Assured Support, Building Relationships, Perceived Role of Mentor/ Mentees, Recommended Changes to the Program, and Alternative Programs. The names of people and organizations have all been redacted in the results.

Assured Support

Mentors shared that they were able to assure mentees that there would help and support them. Mentors indicated that they provided mentees with trusted advice and guidance on issues that were relevant to mentees. The support provided included informational support and esteem support that boosted the confidence and morale of mentees. Information shared mainly involved COVID-19-related issues pertaining to residents, facilities, employees, and family members.

Mentors supported with consultation in testing and screening strategies, personal protective equipment (gowns, disinfection wipes), contact tracing, documentation for CMS surveys, and more. For example, one mentor shared;

> "Some of the things I've directly done to help my mentees is providing forms for like symptom tracking, how to set up their screening process... checks with the isolation placement...are they using fire doors, do they have to set up plastic screening?"

Another mentor elaborated on contact tracing;

> "I have several sites who were grateful for the program since they were dealing with the COVID-19 in their facility, trying to do the contact tracing; they could just ask what was discussed to help guide them a little bit more."

Some COVID-19-related challenges involved employee HR (human relations) issues, including leave, travel, staffing exposure, and testing. One mentor shared;

> "they don't have an HR department except for the director of nurses and the administrator so they don't have the ability to ask some of those really deep questions from an HR perspective."

Mentees shared that it was difficult to get information, mainly since some of them lived in rural areas. They found mentors to be a;

> "...really good line of source of what's coming down from the state level and also a way to up-channel back to the state."

Mentee:

> "My mentor said that if we were surveyed and we did get a tag that was related to infection control...she would definitely be a support for our side of it and work with us on what we needed to do to correct it. And I think that that was very, very, very encouraging for me, that there was going to be somebody that was going to be helping me with a problem if we did have a tag."

Mentors shared notes from the daily/thrice weekly huddle session with their mentees. One mentee stated:

> "I have any questions at all, she goes and asks anybody that might have the answer if I need it right away. Otherwise, she'll put it out into her little group, to brainstorm and get back to me. And that's been beneficial. She sends notes from the meetings that she attends and that's been nice."

Another mentee stated:

> "We share information back and forth... so I've used some of the tools, some of the educational pieces, some of the competency training forms that she has shared with us, and I've also utilized her as a resource."

Mentors felt that the informational support helped mentees gain confidence in their ability to address their challenges. One mentor shared,

> "I, I really see that their confidence in what they're doing is, is really a boost for them. For us to say, yep, you're doing it right, you're doing exactly what you should be doing and your infection control plan is helping and you're doing you're on the right track, I think that's really beneficial to them -- that boost of confidence."

A mentee reflected similar sentiments:

> "When we...were getting ready to do our first gray room, it was very, very beneficial to have her and be able to go through -- Okay, we've got this, and we've got that... did you consider this? And do you have that? And, you know, it was just nice to have, kind of a second brain."

Mentors shared that mentees were often

overwhelmed with information and stated that the guidelines from different agencies such as ICAP (Infection Control and Prevention), NE DHHS (Nebraska Department of Health and Human Services), and CMS were constantly changing and contradicted each other.

One mentor underscored;

> "Frequently, more frequently than not, the target would move a bit, or the advice would change, and they really appreciated some breakdown of that or maybe a little bit of clarification."

Mentees concurred and stated that working with mentors helped them sort through a large amount of information that is often conflicting.

Building Relationships

Mentors indicated that providing technical support was crucial, and PiP was about building relationships with their mentees, providing emotional encouragement and support, and empathizing with and appreciating their mentees. They developed trust and mutual respect for their respective commitments to supporting the residents, family, and staff members in care facilities.

Several mentors emphasized that it was about relationships and;

> "...not just about a program. While sharing documents were important, it really does come down to the people and relationships for me just building those and learning from them."

Another mentor shared a similar perspective;

> "It was about building a relationship and a friendship with these people...even if it's just by email they know that somebody's listening and paying attention if they've got a question. I have had them actually get a hold of me at all hours of the day and night."

Developing a trusted partner to share information and confidentially was essential for building relationships. One mentor stated;

> "Not having that conversation go anywhere and developing that trust and relationship for them to have an outlet and get some questions answered."

Expressing gratitude and thanks was a key factor in building relationships.

Mentors empathized with their mentees and felt that the stress of keeping their facilities safe and complying with regulations was taking a toll on the mentees and their staff. One mentor wished that some support could be provided to the mentees in dealing with the stress. She expressed;

> "...just how much they're feeling right now and how much pressure and how much stress and all that is on them right now, I could just really hear that on my phone call so, any, any help that they could use...would be most beneficial to everybody."

Another mentor shared similar sentiments;

> "I have a few mentees crying on the phone for me because they're just so tired of all of the pressure and the requirements that they're having to meet and then having issues with testing and positives being false and then having to go back into Phase 1, and they're just really stressed."

Mentees felt that emotional support and encouragement were significant. Mentee:

> "When I was so upset, he was there to calm me down. There have been a couple of times I've been pretty upset with things that have happened either through state survey process or with trying to figure out...how long staff need the whole staff process of where what I need to do and stuff like that. And he brought me down. Let me get it off my chest. And then he brought me back down to reality, and that was really nice."

Mentee:

> "I think it's hard to replace that, that relationship quality that comes between the [mentor and mentee], or at least that I have with my mentor. Awesome!"

Mentee:

> "It was just really nice to have that person that I could call and say. Okay, you know, this came up. This is what I'm thinking that we're going to put in place. What's your take on this? And it was just a very nice relationship."

Mentee:

> "The underlying thing I agree with XX [name redacted] is that there was someone for you to talk to and to voice your concerns or frustrations and that that was so helpful. We all need that for our own mental well-being during this time of the pandemic."

One mentee stated:

> "I could just let it all off my chest. he'll just listen to me, and some days I just need that, I just need someone that will listen and let me get it off my chest."

Mentee:

> "For me, it was just nice. Someone cared and someone who's out there that I could talk to being like I said, Independent facility. It was just tough and it was nice that there was someone out there that would help me."

Mentee:

> "In some respects, sort of a counseling. The relationship is well, for those times that I was extremely stressed or frustrated or, or what have you? It was nice to talk to somebody that could say, okay, now take a deep breath. And let's break this down and look at it and, you know, and go on from there."

Mentors empathized with the challenges of their mentees and appreciated their ingenuity and hard work to maintain the physical and mental well-being of the residents, families, and staff. One mentor stated;

> "I remember one of the directors tell me, I think we're killing these people and she was talking about the residents with the social isolation, and it wasn't just the words, but it was the emotion behind the words, it was the frustration...at times she was so discouraged, so ready to quit."

Another mentor shared similar sentiments;

> "many of my mentees felt like their residents were being treated like prisoners in the very beginning because they were locked up in their rooms and had no human contact except for the staff. That was really heartbreaking."

Also, mentors were grateful for the positive feedback they received from their mentees, and it helped strengthen their relationship with their mentees. Mentors indicated that they especially appreciated the *"thank you."* One mentor revealed a similar perspective and mentioned that she feels appreciated when her mentees *"express their gratitude for the program."* A mentor shared that his mentee told him;

> "you know you are so amazing I don't know what I would do without you...I, I look forward to our call every day."

Overall, they felt that the *"mentees have been very receptive to our phone calls."*

Perceived Role of Mentor/Mentees

Mentors had varied perspectives on how they saw their role in providing support. Some of them saw their role as a coach while feeling that they served as a sounding board to each other. One mentor stated that he saw his role as a coach as helping his mentees problem solve and work through issues they experienced, such as interpretation of the guidelines.

Another mentor explained her problem-solving role;

> "kind of a back and forth like you know well what do you think are the positives on that, what do you think are the negatives on that, and just kind of helping them to go through [the issue]."

Other mentors stated that they saw their role as more of a *"supportive role than an active coaching role."* She stated that since a lot of the information was new and evolving, she felt that they were *"...kind of learning back and forth from each other."* A similar sentiment was shared by another mentor, and she indicated that it has been *"as much of a learning experience that is it has been helping them."*

Four mentors stated that they served as a sounding board;

> "...listen to what they had to say and if there were periods of frustration...just hear them out and help them out with their questions."

One mentee reflected similar sentiments:

> "I think for myself personally, my mentor was really the sounding board...It was just really nice to be able to visit with somebody that have some probably a little bit more or a lot more emergency preparedness, planning background than what? Also, a nursing background. And I know that she had filled several roles as a nurse."

Mentee:

> "It's nice to have him to be able to bounce ideas off of... Like if they're not recreating the wheel and just getting those other ideas on how to do it. Right?"

Some mentors and mentees saw each other as friends and felt they would continue staying in touch even after the PiP program ended. Mentee:

> "So he became a friend. You know, someone that quite honestly after the program...someone that I probably would very much so like to keep in touch with, I mean, because he helped me with more than just the covid pandemic."

Mentee:

> "You know, even if the funding would have went away, he still would have helped on his own time. And I think that's awesome."

Indeed, several mentors stated that they hoped to maintain the relationship with their mentees after the program was over. Mentee:

> "I still want to maintain those relationships and those friendships that are being built now so that's been really important."

Another mentor shared similar sentiments

> "Well I've thought about that myself and I'm actually gonna let my mentees know that [when] the program has ended, that doesn't mean our relationship has ended so if you have any questions at any time you've got my email you've got my phone call me and I'll try to help you out."

Recommended Changes to the Program

Overall, mentors and mentees were delighted with the program. One mentor stated;

> "I think the program was excellent. Whoever thought of it did a very, very good job. The mentees that I had were so appreciative of the program...kudos to you folks who put it together."

Mentee:

> "Personally, I like everything there is about the program. I think everything's working. Honestly, I have nothing but good things to say about the whole experience. I wish it was something that could go on 100% of the time."

Another mentee stated:

> "I don't want to think about the end [of the program]."

Suggestions for improvement of the program included mentee peer-mentoring/networking. Two mentors suggested to *"gather some of the mentees together"* since he felt they are *"experts on things like staff morale boosters or resident morale boosters."* One mentor felt that, *"allowing them to feed off each other and help each other would put them a little bit more in that helping role, and I think that always builds confidence."* Another mentor suggested to *"develop some sort of support organization,"* so they could assist each other.

Mentee:

> "I personally feel would be very useful would be resourcing for, like, networking. So, we're like, if we had a continual group thread, or chat, like our HR has it, our facility management has it. We have places we can go to where facilities like ours and people doing jobs like ours can voice and have this talk in between. So, during the times in between, we're gathering information. So, we might be able to see how other critical access hospitals are handling the situation. And then we might have more to bring back to XX [name of mentor redacted], after gathering that information from one another. So, I think that would be a great tool and a great resource."

The following are some other suggestions that mentors and mentee provided:

1. Include training/orientation of mentors via Zoom on mentorship and set expectations for the program.
2. Provide background information for each facility at the time of assignment to mentors, such as location and size, number of residents, nearest health department, COVID-19 spread in the county, etc.
3. Provide basic training for mentors on HR-related issues and Medicare and CMS survey requirements. One mentor explained that she did not expect to *"come out as HR professionals"* but felt that *"just the basics of HR would be helpful."*
4. Provide behavioral training and support for both mentors and mentees.

> "If nothing else...we give the tools to the people we are mentoring to recognize changes in the behavioral or mental status in these folks."

Another mentor suggested: He suggested that they could;

> "from time to time" spend a few minutes "...letting the mentors debrief to one another, because if was become pretty stressful, we have a lot on our plate."

5. Include formative evaluation with mentee feedback directly communicated to the PiP UNMC (University of Nebraska Medical Center) leadership team.

One mentor stated:

> "...it'd be nice monthly to get that loop coming back to us and having that documented [through] an official channel so if we're doing great we know that [and] if there's issues that we need to resolve."

He suggested that a short evaluation survey could be sent out to all mentees from the PiP leadership-team directly to mentees, *"bypassing us [mentors]"*.

6. Vary the time of huddle meetings during the week. For example, *"having one may be on a Monday morning and maybe a Tuesday afternoon."*

7. Having more flexibility in accounting for time spent in providing support to mentees.

Alternative Programs

Mentors were asked about alternative programs should the PiP program get discontinued due to lack of funding. Several mentors provided suggestions:

1. The mentor stated that since all facilities were connected to the Leading Age Nebraska and the Nebraska Healthcare Association, she felt that both these agencies could be used to support mentees if the PiP Mentorship program ended.

2. Two mentors suggested using the healthcare coalitions – to send the information to the healthcare coalition coordinator, and *"forwarded on to their partners and their members."*

3. A *"hotline program"* that people can call when they are "really up against the wall" can also get the needed assistance. One suggestion was to sort through the different and sometimes conflicting guidelines from the different entities such as DHHS, ICAP, and the Governor's office and send daily emails to the facilities so they could use them.

4. Clearing house for info.

Mentee:

> "It is so hard to keep up with what comes out from emergency preparedness. CMS, CDC, DHHS. If there was some ability for somebody to say, Here's everything that came out this week and it's all in chronological order and here is an easy way to find it all because when I go to CDC website or I go to CMS website, it's like going down numerous rabbit holes...if there was some way to cross reference the information that's out there and have a very easy link to it for facilities, for instance...I want the cohorting that the last cohorting information that CDC came out with it is so hard to find that information if you didn't save it somewhere. So if there was some type of a guide that says here's all of the information on cohorting and here's all the links for it. Here's all the information on PPE or extended use of PPE, and here's all the links for it. So it could be a quick guide to take people back and forth. They update those links so frequently that the average facility with one administrator or one nurse trying to watch all of this it's nearly impossible."

Mentee:

> "Maybe kind of like that list serve that I had where there's a group of people from each company that could just send that, you know, here we're dealing with this and how are you doing it?.....and just getting those ideas back."

5. Template for policies

Mentee:

> "Sample policies, just a basic sample policy to say, here's a policy to get started on with your testing plan. Here's a policy to get started on with your cohorting plan...you have to individualize it to each and every facility, but just a bones, bare bones, one to help somebody get started with, because I tell you the number of policies that I've done and the revisions to all of those policies that I have done since March is astronomical."

Mentee:

> "I wish there was some process for, um, all of those groups to sit down and talk and come up with a concrete plan and then take it out to the facilities, with something in writing, some type of template or some type of a training program that would help them understand. And if everybody were on the same page, and that hasn't happened. And I think that's probably the most frustrating thing for facilities. So if there was something on that order from at a higher level..."

DISCUSSION

The impact of COVID-19 on the LTCF industry will reverberate for years, if not decades. In an industry that has seldom experienced a sea change, the time has come to apply systems thinking to operations in normal times and planning for future public health disasters. Some predict a mass exodus of long-term-care professionals, and others demand a better-coordinated response at the state level across the nation (Behrens & Naylor, 2020). Either way, shifts in the operational paradigm will be imperative. This study makes a case for the addition of systematic mentorship as an outcome through the improvement matrix of after-action reports.

A systematic review of mentorships was conducted in 2019 and demonstrated interesting findings that explain many of the successes illustrated through our focus group (Liao et al., 2020). Mentor capability was determined to influence participant

experiences. Characteristics such as approachability, solid knowledge base, good communication skills, and clinical expertise were all valuable (Liao et al., 2020). Recommendations for competitively selecting mentors and improving their capacity through training and education are all features of our mentorship program. Mentors were selected from existing relationships and daily (eventually becoming thrice weekly) huddles, provided ample opportunities for collective education, peer mentoring of mentors, and information updates in an ever-evolving situation. Despite these touchpoints, mentors expressed concerns over their orientation to the program and their mentees while admitting that they were able to compensate for these drawbacks. We would recommend a more systematic orientation be developed for onboard mentors that include building capacity for softer skills such as communication and psychological first aid. Training should be provided before mentors engage with mentees to ensure that they are subject matter experts in the discipline necessary at the time. Foundational knowledge of infection prevention and emergency preparedness is imperative in a pandemic. As antibiotic resistance becomes a more pressing problem in any healthcare setting, infection prevention expertise will be sought far and wide. Given the more transient staffing nature of the LTCF industry, the consistent presence of subject matter expertise in infection prevention and control will become a top priority in the future.

Rural facilities often operate in isolation, so mentorship programs fill that void more consistently than professional organizations or agencies tasked with oversight or expertise.

The concept of peer-to-peer connectivity was also a recommendation and varied between involvement by professional organizations and healthcare coalitions. In essence, the oversight was not as significant as the opportunity to share experiences. Mentees in our program expressed the desire to be better connected to their peers in the region. We recommend incorporating a peer-to-peer mechanism into future mentorship programs. Lifelines through mentors were genuinely appreciated in our program. However, most professionals welcome a chance to connect to peers experiencing the same crisis in public health emergencies or challenges with ever-evolving accreditation requirements.

Methodically matching mentors to mentees was also a recommendation from the systematic review (Liao et al., 2020). Our PiP program only had one occurrence where a mentor was replaced for a better match. Fortunately, this occurred early in the program and emphasized early monitoring and intervention where needed.

Given that solutions for future planning should be based on lessons learned from previous crises, mentees in this program provided sound advice for measures that should be implemented without a formalized mentorship program. Consolidation of information seemed to be the most relevant. Chronological updates that highlighted the newest recommendations separate from previously provided were critical for most facilities. The time spent deciphering the latest updates became problematic in a world where guidance from expert agencies was evolving rapidly and confusing. Furthermore lastly, providing templates for policies and procedures (e.g., PPE, cohorting) would be a time-saving measure for an already overwhelmed facility.

The poignant testimony emerging from the programmatic evaluation of a project is proof that any investment in mentoring assistance to dedicated professionals managing LTCF provides significant returns. This program started as an idea borne out of a relatively isolated industry in crisis, then struggled for funding, but became a salvation for a few dozen facility representatives. This example serves as a national *"call to action"* for all facilities serving our aging and vulnerable populations. Build an infrastructure to provide valuable support for those who will dedicate their professional lives to protecting our vulnerable aging generation.

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