SOCIAL ISOLATION & LONELINESS AMONG OLDER AMERICANS DURING COVID-19
EVIDENCE, POLICY, AND ADVOCACY
MAY, 20, 2020 – 12:00 TO 1:30 PM EDT
AGENDA

12:00 PM – Welcome and Coalition Introductions
   - Joel Miller, Chair, National Coalition on Mental Health & Aging
   - Andrew MacPherson, Co-Director, Coalition to End Social Isolation & Loneliness

   - Dr. Carla Perissinotto, Associate Chief for Geriatrics Clinical Programs, University of California San Francisco

12:30 PM – Biological Impacts of Social Isolation and Loneliness
   - Dr. Bert Uchino, Chair, Department of Psychology, University of Utah

12:45 PM – Promising Interventions to Address Social Isolation and Loneliness
   - Robin Caruso, Chief Togetherness Officer, CareMore Health
   - Maureen Feldman, Director, Social Isolation Impact Project, Motion Picture and Television Fund
   - Andrew Parker, CEO and Founder, Papa

1:10 PM – Policy Considerations and Current Legislative and Regulatory Action to Address Social Isolation and Loneliness
   - Brian Lindberg, Public Policy Advisor, Gerontological Society of America

1:25 PM – Wrap-up and Conclusions
   - Edward Garcia, Co-Director, Coalition to End Social Isolation & Loneliness
Coalition Introductions

Joel Miller
Chair, National Coalition on Mental Health & Aging

Andrew MacPherson
Co-Director, Coalition to End Social Isolation & Loneliness
Mission of the National Coalition on Mental Health and Aging (NCMHA)

- NCMHA was formed in 1991 by a group of organizational members representing the disciplines that work in aging and mental health fields.

- We are composed of 100 national and state associations and coalitions, and several governmental agencies are members such as SAMHSA and ACL.

- The Coalition provides opportunities for professional, consumer and gov’t organizations to work together toward improving the availability & quality of MH preventive and treatment strategies to older Americans & their families through education, research & increased public awareness.
About the National Council on Aging (NCOA)

- Respected national leader and trusted partner to help people aged 60+ meet the challenges of aging.
- Partners with nonprofit organizations, government, and business to provide innovative community programs and services, online help, and advocacy.
- **NCOA Mission**: Improve the lives of millions of older adults, especially those who are struggling.
NEW NCMHA SERIES ON “ADDRESSING DISPARITIES IN BEHAVIORAL HEALTH CARE FOR OLDER ADULTS”

- Following the May 20, 2019 National Older Adult Mental Health Awareness Day (OAMHD) events, NCMHA developed a plan to collaborate with interested government agencies, private sector groups, and experts to maintain the momentum and recommendations generated from OAMHD.

- We scheduled a series of webinars from July 2019 to April 2020 – targeting a specific topic and a practical focus and accompanying tools/resources to address the needs of older adults with mental health conditions, as well as state/local efforts best practices.

- In addition, a special feature of the webinars was that the sessions coincided with monthly, weekly and daily national mental health or aging observances.
Key Objectives of the NCMHA Webinar Series

- Identify specific approaches that address disparities in behavioral health care for older adults.

- Ensure that older adults with BH conditions are integrated within all BH awareness raising, policy, programmatic and research efforts going forward.

- Focus on topics that coincide with specific events and issues that effect older adults with mental health conditions and the opportunity to discuss these problems such as depression, trauma-informed care, and social isolation.
The stress and isolation from living in a pandemic are taking their toll on everyone.

It’s a concern voiced by leading experts, and no one will be hit harder than older Americans.

While we all are required to be physically distant in order to avoid the spread of the disease, a reduction in social contact will negatively impact those most vulnerable to social isolation and loneliness – exacerbating depression, anxiety, and myriad physical health outcomes.

NCMHA is incredibly proud to be collaborating with CESIL on this live web event to explore the causes and solutions to addressing social isolation and loneliness, during this critically important health care pandemic event.
What We Do...

In partnership with our diverse member organizations, The Coalition engages in a variety of areas in order to advance its mission; these areas include, but are not limited to:

- Disseminating research findings
- Developing and advocating for federal and state legislative and regulatory policy interventions
- Leading public awareness events in Washington, DC as well as across the nation.

The mission of the **Coalition to End Social Isolation and Loneliness** is to engage diverse stakeholders, increase public awareness, promote innovative research, and advocate for policy change that combats the adverse consequences of social isolation and loneliness and advances approaches that improve social connectedness for all Americans.
Coalition Activity

1. **Far From Alone Campaign**
   - Earlier this month, in partnership with Humana, Uber, Papa, and others the Coalition launched “Far from Alone,” a public health awareness campaign to address health-related social needs and to promote understanding of loneliness and social isolation issues that are exacerbated by the Coronavirus pandemic.

2. **“For the Health of It” Podcast**
   - This week, the Coalition hosted a podcast interview on COVID-19 and social isolation & loneliness featuring special guests Dr. Julianne Holt-Lunstad and Papa Pals Founder & CEO, Andrew Parker. The episode will air next Monday, May 25.

3. **Action Forum**
   - This summer, the Coalition will hold a virtual convening in order to publicly raise the visibility of the national crisis, identify key innovations, and promote its policy priorities.

4. **COVID-19 Resource Page & Infographics**
   - The Coalition has put together a compilation of resources and developed several infographics on the effects of physical distancing and how to stay connected with others while intentionally isolating oneself.

#isolatedNOTlonely #FarFromAlone
The **Coalition to End Social Isolation & Loneliness** has established a consensus policy agenda that takes a multi-sector approach at addressing the various risk factors and population impacts of social isolation and loneliness.

**In 2020 the Coalition has expanded** in both membership and scope and looks to advocate solutions that impact American's of all demographics. We continue to advocate for policy solutions that address the U.S. tech infrastructure, education systems, and financial systems, to address the risks and effects of social isolation and loneliness.
Magnitude, Prevalence & Impacts

Dr. Carla Perissinotto
Associate Chief of Geriatrics Clinical Programs
University of California San Francisco
Understanding Magnitude and Prevalence

MEASUREMENT AND DEFINITIONS MATTER
How do we estimate health risks for older adults?
• Every 19 minutes an adult age >65 dies of a FALL

• One in four adults fall each year
• 63% in people age >60

• Death rates: 14.3 per 1000
Loneliness

- 43% in people age >60 in the US
- 9% “ALWAYS” Lonely in UK

Victor 2015
Perissinotto 2012
Loneliness and age (USA, 2014)
### AARP Research:

**Loneliness and Social Connection: A National Survey of Adults 45 and Older**

<table>
<thead>
<tr>
<th></th>
<th>LONELY</th>
<th>NOT LONELY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 - 49</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>50 - 59</td>
<td>37%</td>
<td>63%</td>
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<tr>
<td>60 - 69</td>
<td>36%</td>
<td>64%</td>
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<tr>
<td>70+</td>
<td>24%</td>
<td>76%</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$25k</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>$25 - 49.9k</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>$50 - 74.9k</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>≥$75k</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS or less</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>Some college/assoc.</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>College graduate +</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>Widowed</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>Never married</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Living with partner</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>Black</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>Other</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td><strong>LGBTQ Identification</strong></td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>Non-LGBTQ</td>
<td></td>
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*Note: May not sum to 100% due to rounding error*
Social isolation affects nearly 1 in 5 older adults.
Intersection of Loneliness and Isolation

Loneliness
"Subjective" assessment that social relationships are lacking

~20 million older adults

Social isolation
"Objective" measure of connections to family, friends, or the community

r < 0.20

~9 million older adults

Figure from Dr. Ashwin Kotwal
Cornwell EY, Waite LJ. 2009;64(suppl_1):i38-i46
Understanding Impact

Measurement and Definitions Matter
Health Effects

- May be harmful at any age, and likely worse for older adults.

Social isolation and loneliness are associated with:

- Worsened Cardiovascular disease outcomes
- Frailty
- Alzheimer’s dementia
- Worse control of diabetes
- Poor Sleep
- Worsened depression
- Systemic inflammation
- HIGHER health care costs
1604 participants aged >60
Participants in the Health and Retirement Study
6 year study
Asked if they were lonely (UCLA 3 item loneliness)
  ◦ classified as lonely if responded “some of the time or often to any of the 3 questions”

Outcomes:
  ◦ Death
  ◦ Decline in Function
  ◦ ADLs
  ◦ Other mobility tasks (climbing stairs, upper mobility)

Perissinotto JAMA IM 2012
Variables Examined:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Lonely (N = 693)</th>
<th>Not Lonely (N = 911)</th>
<th>P-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (mean, SD)</td>
<td>71.3 ± 7.9</td>
<td>70.5 ± 7.2</td>
<td>0.041</td>
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<tr>
<td>Age Category, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-65</td>
<td>29.0</td>
<td>30.5</td>
<td>0.062</td>
</tr>
<tr>
<td>65-75</td>
<td>42.0</td>
<td>45.7</td>
<td></td>
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<tr>
<td>&gt;75</td>
<td>29.0</td>
<td>23.8</td>
<td></td>
</tr>
<tr>
<td>Female, %</td>
<td>67.1</td>
<td>53.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Ethnicity, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>76.2</td>
<td>85.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Black</td>
<td>14.7</td>
<td>8.6</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>7.8</td>
<td>4.8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Married or Partnered</td>
<td>62.5</td>
<td>83.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SES Measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;HS education, %</td>
<td>26.8</td>
<td>19.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Income, median (IQR)</td>
<td>28K (16K – 46K)</td>
<td>39K (24K – 65K)</td>
<td>&lt;0.001**</td>
</tr>
<tr>
<td>Net worth, median (IQR)</td>
<td>147K (46K – 375K)</td>
<td>245K (88K – 554K)</td>
<td>&lt;0.001**</td>
</tr>
<tr>
<td>Working for pay, %</td>
<td>19.1</td>
<td>28.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living in Urban Area, %</td>
<td>66.6</td>
<td>70.9</td>
<td>0.065</td>
</tr>
<tr>
<td>Living Alone, %</td>
<td>26.7</td>
<td>10.5</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
45% increased risk of deaths

<table>
<thead>
<tr>
<th>Functional Measure</th>
<th>Eligible for outcome</th>
<th>Outcome Frequency</th>
<th>Unadjusted RR/HR (95% CI)</th>
<th>Adjusted (^a) RR/HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLs</td>
<td>1233</td>
<td>24.8% 12.5%</td>
<td>1.98 (1.55, 2.53)</td>
<td>1.59 (1.23, 2.07)</td>
</tr>
<tr>
<td>Upper Extremities</td>
<td>1166</td>
<td>41.5% 28.3%</td>
<td>1.47 (1.25, 1.72)</td>
<td>1.28 (1.08, 1.52)</td>
</tr>
<tr>
<td>Mobility</td>
<td>1114</td>
<td>38.1% 29.4%</td>
<td>1.30 (1.10, 1.53)</td>
<td>1.18 (0.99, 1.41)</td>
</tr>
<tr>
<td>Climbing</td>
<td>1062</td>
<td>40.8% 27.9%</td>
<td>1.46 (1.23, 1.73)</td>
<td>1.31 (1.10, 1.57)</td>
</tr>
<tr>
<td>Death(^b)</td>
<td>1604</td>
<td>22.8% 14.2%</td>
<td>1.70 (1.35, 2.15)</td>
<td>1.45 (1.11, 1.88)</td>
</tr>
</tbody>
</table>

\(^a\) Adjusted for age, gender, and other relevant factors.

\(^b\) Death includes all causes of death.
Likelihood of mortality by type of isolation

<table>
<thead>
<tr>
<th></th>
<th>Odds of mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness</td>
<td></td>
</tr>
<tr>
<td>Living alone</td>
<td></td>
</tr>
<tr>
<td>Social isolation</td>
<td></td>
</tr>
</tbody>
</table>

Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015
Risk factors for loneliness
Losses predict increases in loneliness (and isolation)

- Death of spouse
- Death or other loss of relatives, friends
- Change in living arrangements (less likely to be living with others)
- Institutionalization
- Deteriorating physical health
- Impairment of mobility
- Impairment of vision and/or hearing
- Reduced social activity
- Other risks: lower SES, marginalized populations

Aartsen & Jylhä, 2011; Dykstra et al., 2005; Newall, Chipperfield & Bailis, 2014; Nicolaisen & Thorsen, 2014; Tijhuis et al., 1999; Victor & Bowling, 2012; Wenger & Burholt, 2004
Implications and Next Steps

THE ROLE OF HEALTH CARE
“All doctors soon learn that their patients consult them far less often for specific illnesses than because they are unhappy and seek relief from their loneliness and despair.”

- Goldberg, 2001
Primary Prevention: Identify patients at risk for loneliness and isolation
- Women, lower SES, older, LGBT
- Recent losses

Secondary Prevention: decrease the consequences for those who are lonely and or isolated
- Requires screening
- Knowing which interventions work
Pyramid of Vulnerability:

- **Isolated**
- **Disconnecting**
- **At Risk**

**Detection**

- Awareness Education
  - Identify and address risk
  - Build resilience

**Individualized and intensive intervention**

Jeremy Nobel, MD MPH

EA Casey
Frieden’s Health Impact Pyramid

Health Impact Pyramid

- Increasing Population Impact
  - Counseling and Education
- Clinical Interventions
- Long-Lasting Protection Interventions
- Changing the Context to Make Individuals’ Default Decisions Healthy
- Socioeconomic Factors

Loneliness

Frieden T. American Journal of Public Health | April 2010, Vol 100, No. 4
What We Know and Don’t Know

• There are many ways to measure social isolation and loneliness
• Loneliness and isolation are not routinely or systematically asked about in health care encounters
• There are no accepted US national guidelines on assessments in health care settings that have been systematically adopted
Social Isolation and Loneliness In Older Adults: Opportunities for the Health Care System
NAS Study Recommendations

- Develop a more robust **evidence base**
- Translate current research into **health care practices**
- Improve **awareness**
- Strengthen ongoing **education and training**
- Strengthen **ties** between the health care system and community-based networks and resources
Recommendation 9-5: Those who fund, develop, and operate programs to assess, prevent, and intervene in social isolation and loneliness should prioritize research on the following major gaps in the evidence base:

- Tailored interventions based on a public health framework of primary, secondary, and tertiary prevention.
- Approaches for assessments of and interventions among understudied groups of older adults (e.g., low income, LGBT) and those who face unique barriers to health.

Recommendation 9-6: System designers as well as those who are developing and deploying technology in interventions should ensure that technological innovations related to social isolation and loneliness are properly assessed and tested so as to understand their full range of benefits and potential adverse consequences in order to prevent harm, and they should work to understand and take into account contextual issues, such as broadband access and having sufficient knowledge and support for using the technology.
Biological Impacts

Dr. Bert Uchino
Chair, Dept. of Psychology, University of Utah
Understanding the Biological Impacts of Social Isolation and Loneliness

BERT N. UCHINO
UNIVERSITY OF UTAH
DEPARTMENT OF PSYCHOLOGY AND HEALTH PSYCHOLOGY PROGRAM
Overview

- What are the biological mechanisms linking social relationships to health outcomes such as cardiovascular disease and infectious illnesses?
  - Autonomic nervous system (ANS).
  - Neuroendocrine system.
  - Immune system.
- COVID-19 context
- A general model and evidence.
Setting the COVID-19 Context

- Relationships as structural or functional / subjective constructs.
  - Structural: Social integration/isolation.
  - Functional/Subjective: Social support, social negativity, loneliness, specific relationship quality).

- Risks: Isolation, loneliness, social conflict.

- Opportunities: Taking stock of positive online social interactions, Improving relationship functioning.
General Model Linking Social Relationships to Health

Relationship Structure and Function

Behavioral pathways: e.g., Health behaviors, Treatment cooperation

Psychological pathways: e.g., Appraisals, Depression, Quality of Life etc.

Biological pathways: Cardiovascular, neuroendocrine, immune function

Chronic / Acute disease morbidity

Specific and all-cause/disease mortality

Uchino et al. (2018)
## Relationships and the ANS

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Blood Pressure</th>
<th>Card. Reactivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Support</td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td>Social Integration</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>Relationship Quality</td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td>Loneliness</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Social Negativity</td>
<td>↑</td>
<td>↑</td>
</tr>
</tbody>
</table>

Selected references: Brown et al., 2018; Cacioppo et al., 2006; Cundiff & Matthews, 2018; Grewen et al., 2005; Hawkley et al., 2003; Holt-Lunstad et al., 2008; Norman et al., 2011; Manczak et al., 2015; Ong et. al., 2012; Robles et al., 2014; Shankar et al., 2011; Thorsteinsson & James, 1999; Troxel et al., 2010; Uchino et al., 1999; Uchino et al., 2016.
## Relationships and Neuroendocrine Function

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Cortisol</th>
<th>Oxytocin (less studies)</th>
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<tbody>
<tr>
<td>Social Support</td>
<td>↓</td>
<td>↑</td>
</tr>
<tr>
<td>Social Integration</td>
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<tr>
<td>Relationship Quality</td>
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<td>↑</td>
</tr>
<tr>
<td>Loneliness</td>
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<tr>
<td>Social Negativity</td>
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Selected references: Chang et al., 2014; Gerteis et al., 2016; Grewen et al., 2005; Heinrichs et al., 2003; Holt-Lunstad et al., 2008; Holt-Lunstad et al., 2015; Horsten et al., 1999; Hostinar et al., 2014; Norman et al., 2011; Robles et al., 2014; Seltzer et al., 2010; Stadler et al., 2012; Stafford et al., 2013; Steptoe et al., 2004; Steptoe et al., 2009; Uchino & Baldwin, 2017.
### Relationships and Immunity

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Inflammation</th>
<th>General Immunity</th>
<th>Vaccine Resp. (less studies)</th>
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</thead>
<tbody>
<tr>
<td>Social Support</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Social Integration</td>
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<td>Relationship Quality</td>
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<tr>
<td>Loneliness</td>
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<tr>
<td>Social Negativity</td>
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</tbody>
</table>

Select references: Bakermans-Kranenburg et al., 2013; Bosch et al., 2009; Cacioppo et al., 2015; Cole et al., 2007; Cresswell et al., 2012; Glaser et al., 1992; Hasselmo et al., 2018; Jaremka et al., 2013; Kiecolt-Glaser et al., 1993; Kiecolt-Glaser et al., 2005; Lee & Baldwin, 2019; Levy et al., 1990; Lutgendorf et al., 2005; Nersesian et al., 2018; O’Connor et al., 2015; Phillips et al., 2005; Pressman et al., 2005; Shankar et al., 2011; Uchino et al., 2018; Uchino et al., 2013.
Summary and Implications

- Relationships most conclusively linked to blood pressure, cortisol, and inflammation.
- These biological outcomes are linked to leading causes of morbidity and mortality.
- These risks might be exacerbated in older adults (Charles, 2010; Kiecolt-Glaser & Glaser, 2001)
- However, these risks are associated with more long-term relationships processes and less clear if shorter-term isolation has similar influences.
Implications

- What does this mean for the social context of COVID-19?
  - Prolonged isolation and conflict within families likely to negatively influence the biological health of individuals.
  - Social support, integration, and high quality relationships likely to have a protective influence.

- Helping socially isolated/lonely individuals (CBT, Mindfulness, Cresswell et al., 2012; Masi et al., 2011; Lindsay et al., 2019).

- Keeping in touch with high quality relationships and improving relationship perceptions/interactions (Clark et al., 2018; Holt-Lunstad et al., 2013; Miller et al., 2014).
Promising Interventions

Robin Caruso
Chief Togetherness Officer, CareMore Health

Maureen Feldman
Director, Social Isolation Impact Program, MPTF

Andrew Parker
CEO and Founder, Papa
Program Goals:
Build connections, increase socialization and re-engage in healthcare = *reduced loneliness and social isolation*

Profiles
- Lives alone
- Lives with others, but majority of their day is in isolation
- No social support (i.e. long distance caregiver, no caregiver)
- Self reports loneliness or isolation
- Members that are caregivers with little support
- Newly widowed with little social support

Approaches
1. We build connections
2. We increase socialization
3. We re-engage members with their healthcare

Actions
- Friendly weekly call from Phone Pal
  - Actively listen
  - Provide no judgment
  - Share personal experiences
- Screen for social isolation, loneliness and depression scores
- Stratify members into high, medium, low risk
- Evaluate social support and social activities
- Identify barriers impacting member’s well-being such as home safety, nutritional, and transportation needs
- Provide community resources to assist with eliminating barriers
- Connect to community based organizations for socialization
- Identify medical care needs
- Assist with medical care coordination
- Increase physical activity
  - Encourage Nifty After Fifty/Silver Sneakers participation
From the Member’s Perspective - A Human Approach

1. Learns about Togetherness
2. Referred to Togetherness
3. Welcome Call/Initial Assessment
4. Getting to Know You
   - Month 1
5. Connect You to Services & Introduce Social Activities
   - Month 2 - 9
6. Checking in on You
   - Month 10 - 14
7. Join Alumni Activities
   - Month 15
108,000 + Calls and visits
6,000 + referrals to resources & programs
57% ↑ participation in exercise programs
21% ↓ Hospital admissions

= Lives Changed

*Preliminary results based on internal and preliminary reporting, on 12 months of utilization, and subject to change as additional data is received. Participation in exercise programs increased by 56.6% for the program’s participants compared to those not involved in the program. Hospital admissions per thousand members among program participants are 20.8% lower than admissions among the intent to treat population.
The Power of Social Connectedness

Maureen Feldman
Director, Social Isolation Impact Project
MPTF was created by Charlie Chaplin, Mary Pickford, and Douglas Fairbanks who realized the need for reaching out to those in the entertainment industry who fell upon hard times.

The Motion Picture & Television Fund is a Charitable Organization

- MPTF offers assistance and care to those in the motion picture & television industries with limited or no resources serving over 150,000 individuals.

- Our mission is to support our community in living and aging well, with dignity and purpose, and to help each other in times of need through health and human services.
MPTF recognized the need to support those suffering from social isolation & loneliness in 2016 when they launched their successful social call program.

Impact

- 30,000 + outgoing calls
- 12,000 + Hours of conversations
- 500 + Industry members engaged
- 150 Active Volunteers
- 22 Volunteers have **become** recipients
- 12 Recipients have **become** volunteers
Solitary confinement was intended to be the harshest of punishments, yet many of our nations most vulnerable adults spend hours without human contact

- Based on the success of The Daily Call Sheet, MPTF created a tool kit to support other organizations wishing to launch social call programs
- To date they have trained thirty organizations ultimately affecting 100’s of individuals
- Currently MPTF is actively working with multiple organizations across the country providing training and support
MPTF’s Scalable Social Call Tool Kit
OUTCOMES

- Increased awareness of negative impacts from social isolation
- More programs being developed & executed nationwide
- Increase in # of older adults being reached
- More services being accessed
- Increased quality of life for older adults
Los Angeles Social Isolation & Loneliness Coalition

OUTCOMES

The Los Angeles Health Geriatrics Workgroup is integrating a SDOH screener with validated questions on social isolation & loneliness and expanded resources.

- LA LGBTQ Center, Jewish Family Services, L.A. Works, Jewish Federation, Valley Intercommunity Council, Project Angel Food, L.A. Falls Prevention Coalition, & Meals on Wheels are implementing friendly calling programs.

- Beach Cities trains local police on social isolation issues and resources for homeless individuals.

- Partners In Care added UCLA 3 question survey to their intakes and have started a friendly caller program.

- Fielding Graduate University is working to provide access to economical graduate education to older adults allowing them social connections and skills to age in place.

- Bet Tzedek Law Firm trained staff on indicators and risks of social isolation and is developing more comprehensive resources.
Barriers to Expansion

- Lack of federal awareness/focus on social isolation & loneliness has led to a fragmented and sparse public health effort, nationwide.

- Decreased federal funding leads to access barriers for the most underserved populations.

- Training and support for non-profits
Opportunities and Recommendations for Policy

1. **Improve federal focus and funding** on data collection and research initiatives measuring the impact of social isolation/loneliness—establish a central strategy to measure social isolation and loneliness, as well as a central strategy to assess programs addressing the impact of social isolation and loneliness.

2. Improve funding for, and access to, technologies and platforms that improve social connection and bridge gaps to service access for underserved and vulnerable populations.

3. Expand funding streams for those addressing social isolation and loneliness in Medicare, Medicaid, TRICARE, and other public coverage vehicles.
Family On-Demand

Andrew Parker, Founder and CEO
Papa connects older adults & families to Papa Pals for 

companionship, assistance, and transportation.

Health Plans send Papa eligibility files with eligible members

Members enroll in the program for weekly visits

The member and Papa Pals have a great visit!
How Do Our Pals Address Loneliness?

- Appointments & Trips
- Reminders
- Personal & Habitat Safety
- Fun & Mood
- Essential Assistance
- Community Engagement
Impact on Loneliness

**IMPROVED LONELINESS**

53%

**IMPROVED PHYSICAL UNHEALTHY DAYS**

16%

**IMPROVED MENTAL UNHEALTHY DAYS**

14%

- The average lonely patient used the ED 60% more than the average nonlonely patient. ¹
- Total medical costs were an estimated $1,608 annually greater for each socially isolated older adult. ²

¹https://www.mdedge.com/familymedicine/article/60985/loneliness-predictor-hospital-emergency-department-use/page/0/2
²https://www.aarp.org/content/dam/aarp/pbi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf
Support Families Throughout the Aging Journey

- Household organizational support, errand assistance, school pick ups
- Respite care for parents, grandparents and other relatives to alleviate workday distractions and distance challenges
- Yard work, errand assistance, lifting, house help
- Medical appointments, care gap reminders, community mobility
- Aging in place, personal safety, fall hazards, food insecurity

Solutions for: Medicare Advantage, Medicaid, Commercial Benefit, Provider Organizations
Policy Considerations

Brian Lindberg
Public Policy Advisor, Gerontological Society of America
Federal Response to COVID-19

1/29: COVID-19 Task Force is established; 1/31: HHS Secretary declares PHE.

1/29: CMS issues memo for providers treating COVID-19

2/6: Guidance issued to hospitals & nursing homes on infection control & prevention

3/13: President declares national emergency, frees potential $42B in federal aid for states and municipalities

3/17: HHS clarifies telehealth flexibilities for providers and programs

3/18: President signs “Phase 2” Families First Coronavirus Response Act into law


3/30: CMS releases first IFR for Medicare with subsequent blanket waivers

3/30: CMS releases first IFR for Medicare with subsequent blanket waivers

3/30: CMS releases first IFR for Medicare with subsequent blanket waivers

3/30: CMS releases first IFR for Medicare with subsequent blanket waivers

4/01-30: Congress passes Phase 3.5 – PPP and Health Care Enhancement Act

4/01-30: CMS releases second IFR for Medicare with subsequent blanket waivers

Reauthorizing the Older Americans Act

**On March 25th**, the President signed into law H.R. 4334 – Supporting Older Americans Act of 2020. H.R. 4334 includes several provisions that address social isolation and loneliness. These are highlighted below.

<table>
<thead>
<tr>
<th>Section</th>
<th>Provision Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 110</td>
<td>Adds “screening for the prevention of negative health effects associated with social isolation and coordination of supportive services and health care to address negative health effects associated with social isolation” as a “disease prevention and health promotion service” under the OAA.</td>
</tr>
<tr>
<td>Section 115 &amp; 126</td>
<td>Directs the Assistant Secretary of Aging to develop objectives, priorities, and a long-term plan for supporting State and local efforts addressing the effects of social isolation; submit a report to Congress highlighting the impact of current programs addressing social isolation.</td>
</tr>
<tr>
<td>Section 213</td>
<td>Establishes grant funding for services that screen for negative health effects associated with social isolation.</td>
</tr>
<tr>
<td>Section 214</td>
<td>Establishes grant funding for services that promote or support social connectedness and reduce negative health effects associated with social isolation.</td>
</tr>
<tr>
<td>Section 304</td>
<td>Establishes demonstration to address negative health impacts associated with social isolation.</td>
</tr>
<tr>
<td>Section 306</td>
<td>Establishes grant funding for multigenerational activities and civic engagement activities that reduce social isolation and improve participant social connectedness.</td>
</tr>
</tbody>
</table>
Key Actions Addressing SI&L in Older Americans During COVID-19

**Congressional:** Below are the key congressional actions that address social isolation and loneliness among older Americans, both during and after COVID-19.

- Passage of H.R. 4334 – reauthorizing the Older Americans Act
- Increased federal funding for: States and Medicaid programs; telehealth expansion among underserved and safety net regions; ACL and Aging Network services; geriatrics workforce training
- Expanded provider flexibilities for general telehealth and other virtual services; expanded home health practice flexibilities for non-physician practitioners (NPPs) as well as hospice flexibilities

**Administration:** Below are the key regulatory actions that address social isolation and loneliness among older Americans during the current PHE.

- Expanded flexibilities for telehealth and other virtual services (pursuant to congressional directives) – including mental and behavioral health services; broadened “homebound” designation
- (Codified and expanded key provisions passed by Congress)
Recommendations for Fourth COVID-19 Relief Package

On April 30th, the Coalition sent a letter to key members of Congress, providing policy recommendations that address the impact of social isolation and loneliness amidst the COVID-19 PHE.

The Coalition recommended the following overarching proposals:

1. Maintain and improve access to mental and behavioral health services that mediate the mental health implications of social isolation and loneliness for vulnerable populations;
2. Improve the public health response to COVID-19 and widespread social isolation and loneliness;
3. Provide for additional targeted funding for programs and services under the Older Americans Act (OAA);
4. Enhance supports for our Nation’s education
H.R. 6800 – the HEROES Act

*On May 12th,* House leadership introduced their fourth COVID-19 relief package—H.R. 6800. Many of the policies advocated by the Coalition were included in the final House bill.

- $100 million to ACL – $85 million specifically to Aging Network ($20 million for Title III B and $10 million for Title III D services)
- Substantial funding for SAMHSA and HRSA to improve access to mental and behavioral health services
- Establishes 9-8-8 National Mental Health and Suicide hotline
- Several provisions improving the funding and strategy for the public health response to all health complications of COVID-19 (including mental health complications)
- Funding for broadband infrastructure expansion/improvement

* A full side-by-side comparison of the Coalition’s policy recommendations and their status in HR 6800 can be found in the Appendices.
Immediate Policy Asks

The Coalition continues to push for the immediate policy solutions outlined below to address the impact of COVID-19, and widespread social isolation and loneliness.

❖ **Older Americans Act:** Further funding for OAA services/supports that address social isolation and loneliness, as well as funding to transition current evidence-based programs to virtual/telephonic platforms.

❖ **Service coverage/access:** Expand provider reimbursement and patient access to mental/behavioral health services that address social isolation and loneliness; establish funding for peer support services (and virtual peer support groups/aides); increase (fund) social isolation and loneliness screenings in Medicare/Medicaid/TRICARE.

❖ **Public Health Response and Infrastructure:** Continue to direct and improve funding for a more centralized, and targeted public health response to widespread social isolation and loneliness (research and intervention); continue to improve funding through the FCC and other relevant vehicles to improve broadband expansion and access for underserved/vulnerable populations.
Wrap Up

Edward Garcia, MHS
Co-Director, Coalition to End Social Isolation & Loneliness
“We all have a deep and abiding need to be seen for who we are – as fully dimensional, complex, and vulnerable human beings.

We all need to know that we matter and that we are loved. These are the deep-seated needs that secure relationships satisfy, and when they are met, we tend to live healthier, more productive, and more rewarding lives.

When they go unmet, we suffer.”

- Vivek H. Murthy, MD
19th Surgeon General of the United States

Together, The Health Power of Human Connection in a Sometimes Lonely World