ADVANCING STATES

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Services to Address Social Isolation: Findings and Recommendations

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Introduction & Background

Millions of Americans are experiencing social isolation and loneliness, which has a significant impact on health and wellbeing. Studies have demonstrated life longevity, physical, and mental health conditions are all negatively impacted when an individual is socially isolated or lonely.[1] Social isolation and loneliness are also costly issues, with significant economic impacts. A 2017 study identified an estimated $6.7 billion in additional annual federal spending for Medicare due to a lack of social contacts among older adults.[2] For these reasons, social isolation is emerging as a preeminent health and social policy issue.

It is important to frame social isolation in the context of research and work in the field more broadly to better understand the issue. Social isolation and loneliness are related concepts that fall under the broader umbrella of social connection. While these terms are often used interchangeably, they are distinct concepts. For purposes of this report, the following conceptual definitions will be used:

- Loneliness is subjective- it is the perception of social isolation or the subjective feeling of being lonely. It is the perceived discrepancy between actual and desired levels of social connection.
- Social isolation is objective- it is identified as a few or limited social relationships, roles, or group memberships. Social isolation is measured by infrequent social interactions. It refers to social contact and social network ties.
- Social connection is an umbrella term that identifies the extent to which an individual is connected socially. It depends on multiple factors and encompasses the structural (marital status, social networks, social integration, living alone, social isolation), functional (received support, perceptions of social support, perceived loneliness) and quality (marital quality, relationship strain, social inclusion or exclusion) aspects connection with each other.[3]

One final note on these terms- some studies have shown that social isolation and loneliness are not highly correlated.[4] Someone who is lonely may not be socially isolated and vice versa. From a policy standpoint - it is important to consider these distinctions when considering approaches related to assessment, intervention(s), and evaluation.

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[1] National Academies Science, Engineering Medicine. (2020). *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System.* https://nap.nationalacademies.org/download/25663

[2] AARP Public Policy Institute (2017). *Medicare Spends More on Socially Isolated Older Adults.* https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf.coredownload.pdf

[3] National Academies Science, Engineering Medicine. (2020). *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System.* https://nap.nationalacademies.org/download/25663

[4] Decade of Health Aging: Advocacy Brief. *Social Isolation and Loneliness Among Older People.* https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2021/08/SocIsolationLonelinessOP.pdf

Social Isolation Health Outcomes, Prevalence and Risk Factors

There is growing longitudinal large-scale study that demonstrates a strong association between social isolation and loneliness with the following health issues:

- Diminished physical health - such as cardiovascular disease, stroke, type 2 diabetes, and immune and respiratory illnesses;
- Mental and behavioral health - such as depression and anxiety, suicidality, addiction; and
- Cognitive health - such as cognitive decline, depression, and dementia.

Social isolation is associated with a significantly increased risk of premature mortality - with some evidence indicating that the magnitude of this effect is comparable to or greater than other risk factors, such as smoking and obesity. Loneliness poses an increased risk for earlier death by 26 percent; social isolation poses an increased risk for an early death by 29 percent; and living alone poses an increased risk for an earlier death by 32 percent. Conversely, evidence also documents that being socially connected significantly reduces risk for premature mortality from all causes.[5]

The prevalence of social isolation and feelings of loneliness in the United States are well documented. The National Health and Aging Trends Study found that 24 percent of community-dwelling older adults are considered socially isolated with that percentage increasing as we age[6]. During the peak of the COVID-19 Public Health Emergency, one half of older adults reported that they sometimes or often felt isolated from others.[7]

There are many risk factors for social isolation, including living alone, loss of family and friends, chronic illnesses and sensory impairments. These risk factors are also more prevalent with individuals in certain populations, including older adults, people with disabilities, immigrants, and marginalized groups. Health care and community organizations are well-positioned to identify risk factors and provide education, interventions, and support for high-risk groups. The 2019 National Academies consensus study report emphasizes the importance of integrating health care and social care, reducing risk for social isolation by providing assistance and connecting patients with relevant social care resources.[8]

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[5] Holt-Lunstad, J., Robles, T. F., & Sbarra, D. A. (2017). Advancing social connection as a public health priority in the United States. *American Psychologist, 72*(6), 517–530. https://doi.org/10.1037/amp0000103

[6] National Academies Science, Engineering Medicine. (2020). *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System.* https://nap.nationalacademies.org/download/25663

[7] Michigan Public Health News Center. (2020). *Loneliness Doubled Among Older Adults in Early Months of COVID-19.* https://sph.umich.edu/news/2020posts/loneliness-doubled-among-older-adults-early-months-covid-19-poll-shows.html

[8] Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. Washington (DC): National Academies Press (US); 2019 Sep 25. https://www.ncbi.nlm.nih.gov/books/NBK552593/

Measurement Tools and Evaluation

There are a variety of research tools measuring social isolation and loneliness; however, most of the tools have been used for research purposes. Less information is available on the application of tools for clinical use and outcome assessment. In general, tools that measure loneliness tend to be based on subjective questions and those that look at social isolation and social networks look at objective measures.

A comprehensive list of assessment tools is included below:

Tool Name	Description	Pros	Cons
Berkman-Syme Social Network Index	Composite measure of four types of social connection	Validated Tool, focuses on general adult population, recommended for inclusion in EHR by Institute of Medicine Committee, straightforward questions.	Measures social integration rather than social isolation
Campaign to End Loneliness Measurement Tool	3-item tool to measure loneliness.	Main purpose of tool is to measure the change that happens as a result of an intervention to address loneliness.	
Connect 2 Affect	3-minute assessment tool- online or call-in	Self-use, directs to local resources after use	AARP owned and managed, must agree to terms to get assessment info
Cornwell Perceived Isolation Scale	9-item scale that combines indicators of perceived lack of social support and loneliness. Incorporates the UCLA 3-item.	Expands on UCLA 3 item to capture social support.	
De Jong Gierveld Loneliness Scale	11-item questionnaire. Measures emotional and social loneliness with six statements, three measuring social loneliness and three measuring emotional loneliness.	Widely used and robust tool measures feelings of missing an intimate relationship (emotional loneliness) and missing a wider social network (social loneliness). Useful for identifying reasons behind feelings of loneliness.	

Tool Name	Description	Pros	Cons
Duke abbrev. 11-item scale	11-item tool. Abbreviated measure for social interaction and subjective measure of social support.	Abbreviated version that captures the essential components of social support related to mental health outcomes and use of health services in treating elderly individuals with nonpsychiatric medical illness.	Clinical health service approach, research is specific to older adults.
Duke Social Support Index (includes stress scale)	35-item measure of dimensions of social support	Research based	Original version is lengthy
Eldercare Locator	13 question self-assessment for social isolation	Developed for self-use	Developed for self-use
Italian Loneliness Scale	20-item self-reported scale. 18 items are adapted from the UCLA loneliness scale and De Jong Gierveld Loneliness scale. Scale evaluates perceived loneliness. Scale is broken into three subscales: social loneliness, emotional loneliness and general loneliness answered on a 4-point Likert scale.	Like the De Jong scale, includes emotional and social loneliness, but also includes general loneliness.	Lengthy
Lubben Social Network Scale	12-item measure. Adaptation of Berkman-Syme with focus on older adults.	Validated tool, well researched.	Focus specific to older adults
Lubben Social Network Scale-abbrev. 6- item	6-item measurement of social connection with family and friends	Validated tool, well researched, looks free	Focus specific to older adults
Multidimensional Scale of Perceived Social Support (MSPSS)	12-item scale broken into three factors of social support (family, friends and significant others). Scale is rated on a 7-point Likert scale.	Shorter instrument (12 questions). Widely used and validated. Free to use. Translated into multiple languages.	

Tool Name	Description	Pros	Cons
Revised Social Support Questionnaire (SSQ6)	6-iitem measure of social support. Respondents indicate the number of people they feel they have available in six areas. Incudes a follow-up scale of satisfaction with support given.	Tool is brief and has ability for follow-up on interventions	
Revised UCLA (R-UCLA) Loneliness Scale	20 item, self-administered questionnaire, standard assessment for loneliness	Well researched/validated tool	
Social Interaction Anxiety Scale (SIAS)	Instrument assesses commonly feared social situations. It consists of 20 items rated on a 5-point Likert scale.	Supported by psychometric data with good test-retest reliability.	Specific to social anxiety, which is not the only factor in social isolation and loneliness
Social Provisions Scale	24 statement scale split into six sections (attachment, social integration, reliable alliance, guidance, opportunity for nurturance, and reassurance of worth). Scale from 1-4 to indicate degree of perceived support.	Focuses on broad array of social engagement. Straightforward assessment tool.	Lengthy
Steptoe Social Isolation Index	Index of social isolation with 5-point scale and people with score of 2 or more defined as socially isolated	Simple to administer and focuses on social isolation- would be easy to administer pre and post	Research focus/validation with older adults
UCLA 3- Item Loneliness Scale	Measures self-perceived isolation and relational connectedness. Developed for use over the phone	Simple and easy to administer, utilized by MCOs, has wide use in research and clinical settings.	

In 2020, The National Academies of Sciences, Engineering and Medicine published a comprehensive "Social Isolation and Loneliness in Older Adults" Consensus Study Report (Consensus Report).[1] The Consensus Report devotes an entire section to measurement and assessment of social isolation and loneliness. The Consensus Report provides general recommendations to consider when selecting and designing an evaluation approach which include:

- Use a validated tool rather than using parts of existing tools or creating new, unvalidated tools.
- Use a tool that measures the research question.
- Seek a tool that can be used both before and after an intervention for comparison.
- Consider the amount of training required to administer the tool.
- Consider whether the tool can be used by clinicians, other staff, or be self-administered.
- Amount of time to administer the tool.
- Availability of the tool in other languages.

One other general recommendation from the Report is to periodically perform an assessment using one or more validated tools to identify older adults experiencing social isolation and/or loneliness. When individuals who have elevated risks due to social isolation and loneliness are identified, those issues can be mitigated by providing specific interventions.

Intervention Approaches and Evaluation

Overall, the quality of evidence for specific interventions for social isolation in older adults is limited. Researchers are only beginning to understand the correlation between approaches, populations, risk factors and outcomes. There is also some indication that interventions and approaches may need to be different to address social isolation versus loneliness.

One key recommendation from the Consensus Report is the importance of keeping the individual, family, and community at the center of the intervention when implementing evidence-based practices. The delivery of an intervention approach must address the values, characteristics, and contextual factors that are important to the individual. A common factor of many successful interventions for social isolation and loneliness is a person-centered planning approach that places the individual at the center of the conversation and actively engages them in the design of the intervention. Experts describe the importance of tailoring services and programs to an individual's unique preferences.

There is limited information in the literature on best practices for addressing social isolation and loneliness in the clinical arena. Research has focused, instead, on identifying risk factors and estimating the social and health impacts- less on the effect of individual interventions.

All State Survey Findings

To supplement research findings and our environmental scan on social isolation, ADvancing States deployed an all-state survey for Medicaid LTSS and Aging staff that included questions about specific services to address social isolation, assessment tools used, service authorization processes, service delivery, and service evaluation and quality. ADvancing States received 65 responses. Nearly 40 percent of those responses came from Medicaid LTSS staff (as opposed to Aging). Roughly two-thirds of Medicaid respondents shared their states offered services to address social isolation and loneliness, while 20 percent offered services to address only social isolation, not loneliness. An overwhelming 92 percent of respondents also shared their Medicaid LTSS programs offered more than one service to address social isolation.

Specific services

The survey asked states to name the most utilized or main service offered to address social isolation. Many states responded that adult day programs were their most utilized service, however, State C and State E described services that were slightly more comprehensive and complex.

State C's Community Integration Support Services/Community Participation services "coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation."

In State E, a service called Meaningful Day "provides a person-centered approach to designing and delivering meaningful activities for eligible DSHS clients. Providers participating will utilize tools and approaches to assist clients to manage stresses and personal actions that pose a barrier to successful community living. One of these tools is the facilitation of activities that the client has identified as personally meaningful. Activities may be directly led by the Adult Family Home provider in a one-on-one format or a group format, or the client may be assisted through set up and coaching to engage in the activity independently." ADvancing States staff followed up with State C and State E about these services during our state interviews, shared later in the report.

Settings, populations, and funding

The survey asked in what Medicaid LTSS program settings social isolation services were provided. Adult day services were the most common response at 64 percent, followed by community-based settings at 54 percent, and personal or private homes at 45 percent. Aging and mental health populations were the most common populations eligible for social isolation services. Respondents shared that services to address social isolation were most commonly funded through 1915(c) waiver programs, followed by 1115 demonstration waivers. Two states responded their social isolation services were also available through a 1915(k).

Assessments

ADvancing States asked which assessment tools were most commonly used by states as well as whether they were home grown or more formal, validated assessment tools. Eight states responded they use a specific assessment tool to identify individuals who are socially isolated or at risk for social isolation. When asked what specific assessment tools were used, many states shared they included questions related to social isolation in state-specific program assessment tools; in fact, it was the most common response. Three other states shared they used the InterRAI. Most states shared there was some sort of training involved in using the state-specific assessment and InterRAI tools. All states responded the assessment was administered at initial assessment, annually, or when there was a significant change. Most responding states shared there was one combined assessment for both social isolation and loneliness.

States varied in how they billed the assessments to Medicaid. One of the more common responses was to bill the assessment through case management service codes (as a Medicaid administrative function). One state shared a certain percentage for staff time was billed to Medicaid while another percentage was billed to state general revenue. Another state billed per assessment while another included the assessment as part of their case management daily rate.

As previously mentioned, ADvancing States also sent the survey to state Aging offices. It was more common for Aging offices to use a homegrown assessment that included questions about social isolation; however, the most often-cited formal tool was the UCLA 3-Item Loneliness Scale. In their feedback, states shared the UCLA 3-Item Loneliness Scale was used because it is validated and offers a “simple, streamlined option.” ADvancing States would offer that even though state Aging offices reported that they assess for social isolation, what they shared in terms of assessments was targeted at assessing loneliness. ADvancing States staff would like to acknowledge that even though the survey specifically asked about social isolation, not loneliness, many states still responded with information related to loneliness. We concluded that it may be difficult for states to only address one over the other without strong parameters or scope of service in place.

Length of time and modality

There was consensus among state Medicaid agencies on how long a service to address social isolation could be provided, with all states responding there was no strict time limit to the service. One state clarified the provider must submit detailed quarterly reports about the member's progress toward their goals and what specific activities and methodologies were used to aid the member in this process.

Unsurprisingly, most Medicaid agencies responded the service was available in person. In general, the impact of the pandemic on service delivery seemed to increase availability of remote and virtual options for HCBS, but only three states shared there was a virtual social isolation service option available to individuals. ADvancing States staff expected this number to be higher.

Evaluation and quality

ADvancing States also asked about how states evaluated their service(s) to address social isolation. Four Medicaid agencies responded they evaluated the service at the individual level. The frequency of evaluation varied from annually to quarterly to monthly. The only specific evaluation tool provided was the InterRAI Home Care (HC); the rest of the respondents shared some variation of capturing feedback through a person-centered care plan or via communication with a support coordinator. ADvancing States would note the InterRAI HC is not an evaluation tool but rather an assessment tool that, once completed, can inform an individual's comprehensive service plan.[9] States responded the evaluation was most often completed by case managers and/or state employees.

Seven Medicaid LTSS respondents shared they had methods to evaluate the quality of the service to address social isolation. States shared a variety of methods, including quality assurance reviews by HCBS Quality Improvement Organizations, individual follow up by case managers, and independent surveys. One state also referenced the National Core Indicators (NCI™) surveys for a systems-level monitoring perspective. The survey asked which specific assurance standards were used; however, none were provided. The survey also asked about monitoring for specific health outcomes data related to social isolation, but none of the states reported tracking this data.

Two Medicaid LTSS respondents shared they track aggregate data on the quality of the social isolation service. One state shared this is accomplished via residential assessment, case plan review, and member monthly contacts, and the other through the NCI™ surveys. Specifically, the two community integration measures used by that state for their quality strategy are:

[9] https://catalog.interrai.org/content/interrai-home-care-hc-assessment-form-and-users-manual-standard-english-edition-912

- NCI-AD: Increase the percentage of older adults and adults with physical disabilities who report being able to do things outside of their homes as much as they want to.
- NCI-IDD: Increase the percentage of individuals with I/DD who report being able to go out into the community and do the things they like to do.

ADvancing States wanted to know how states ensured the service to address social isolation is effective. Five Medicaid respondents shared their state did not have data available or did not measure effectiveness. Two states mentioned the NCI™ surveys in their response; one of those states went into more detail and shared they include a participant choice statement that advises the person to notify the state with satisfaction or quality concerns with their provider. ADvancing states staff speculate this might have been added as a state-specific question on the NCI™ survey. Other states mentioned feedback from members, natural supports, and/or case managers.

State Interviews

ADvancing States reviewed state survey responses to identify which states to interview for more in-depth information about their services. Staff included the same questions for each interview but also customized conversations according to each state's situation and who was on the call. Summaries of the interviews are provided below.

State A Interview Takeaways

- State A does not include a specific service targeted only to address social isolation. Case managers incorporate goals into the service plan if social isolation is identified as something the person wants to address. The person must indicate to the case manager or self-identify as being socially isolated; there is not a specific trigger in the assessment that would make that connection. This speaks to the importance of the training and skill of the case managers to pick up on social cues that someone may be socially isolated.
- The closest service to address social isolation offered is the adult day program for people with physical disabilities or mental health conditions. For the IDD population, day habilitation is offered. Both of these services are mostly delivered in a group setting where community integration serves as a main focus.
- Technology plays a small part in the personal care benefit and could be another example of how social isolation is addressed. The individual can receive prompting, cueing, and guidance for assistance that does not require in-person help. PERS were also provided as an example of a benefit where companionship was somewhat of a component. The state shared these were minimally utilized and had just recently been approved within the last year.
- State A has a new person-centered planning process that will be rolling out soon. There are some questions included in voluntary assessment modules that address social isolation, loneliness, and depression. These questions are included in the psychosocial module. The state shared they started by reviewing what other states had done regarding assessment tools, and that they had also incorporated an extensive multi- year stakeholder engagement process.
- The state does not track health care data related to social isolation but did reference the NCI™ survey tools as one way to track the issue systemically.

State B Interview Takeaways

- State B emphasized person centeredness in all aspects of the planning and referral process to address social isolation. ADRC counselors and AAA options counselors all play a role in assessing and referring individuals for services.
    - Counselors are trained in how to have authentic conversations around social isolation and loneliness.
- The state utilizes two assessments. The first assessment, the Six Item Lubben Scale, is triggered if the person lives alone.[10] This assessment was chosen because it is user friendly and takes relatively little time to administer. As a follow up to the Lubben Scale, the UCLA 3-Item Scale assessment is administered to gauge the person's perception of loneliness. The state mentioned it has been helpful to use these two assessments to provide a more complete picture of the person's needs. The referral process is then initiated in a person-centered manner and with input from the person. The two assessments mentioned above are only administered if the person is comfortable with them.
    - The Lubben Scale can be administered by phone or in person depending on the person's preference.
- The person receiving services to address social isolation is assessed at the beginning, middle, and end of the service to determine if the service is having the intended effect. AAAs enter data into a system that documents and guides their work. AAAs can give permission to others to view the system data. They also have the capacity to pull percentages on how many people take part in the assessments, who is being served, and for how long.
    - The state shared that keeping good data can be a great tool to leverage expansion of social isolation programming.
    - The state also suggested developing a workflow process that includes collaboration and feedback about how the service is having an impact, as this can be useful for determining effectiveness.
- The state described the effort and focus that is needed to identify alternative options for people who may need an intervention outside of the typical congregate meal or senior center options. Connections and partnerships with local communities via faith-based organizations, recreation centers, and neighborhood groups were all promoted as a good strategy to offer as many options as possible to individuals. Flexibility in services offered was mentioned as necessary, but also a challenge to addressing social isolation.

> *"We need each other to do this work because it is so personable."*

[10] https://www.brandeis.edu/roybal/docs/LSNS_website_PDF.pdf

- The importance and usefulness of community partnerships was emphasized for rural areas.

- State B is contracting and collaborating with a health policy center for a two-year grant using CARES Act funds to help spearhead this work. Stakeholder engagement has been a constant throughout the project.
- The state emphasized variety in funding, sharing that over-reliance solely on state funds is not the best approach. Financial commitments outside of state funds can be helpful in continuing services. This can sometimes be accomplished by fostering diverse community partnerships.

State C Interview Takeaways

- Similar to State A, State C does not have one singular service to address social isolation, but shared that person centeredness, independence, and community integration are part of the overall goal and philosophy of their programs. Examples of services that can help to address social isolation include community living support, adult day care, personal care, supported employment, and volunteerism. Programs are designed to promote maximum participation in the community in a person-centered fashion.

> *"It's not just that "Oh, I'm getting the care I need," it's that "I've become who I wanted to be."*

- Community integration support services are offered in a waiver program – centered on adults with intellectual/developmental disabilities - and are designed to promote community participation, friendships, social networks, and connection with people without disabilities that share the same interests. This is how social isolation is addressed through the program's goals. These are provider services, not peer supported.
- The MCOs in State C are contractually required to provide person centered planning, and to train support coordinators in person centered thinking, including assessing member strength and goals for accessing the community. The state set expectations for the MCOs and also promoted consistent language around PCP. This has helped to ensure PCP is effective, everyone is using the same terms, and all have the same understanding around what forms are used.
    - Questions are designed to help the member self-reflect, generate ideas, and visualize opportunities, including community integration. The assessment questions and care coordinator help the member to see what they might need to enhance day to day living. State C developed the person-centered support plan in collaboration with

the MCOs and it includes questions about social isolation and loneliness. The PCSP is now aligned across all HCBS programs.
    - State C explained the language in the MCO contracts should be as prescriptive as possible to prevent MCOs from all taking a different approach to person centeredness. The contract language in State C even specifies the kind of training care coordinators should have.
    - State C keeps in regular contact with MCOs, meeting monthly and sometimes weekly. Keeping the dialogue open has helped to promote good collaborative relationships.
- State C does not pull individual level data but did mention using NCI™ surveys for aggregated data. MCOs also share success stories with the state.
- Key relationships between MCOs, AAAs, and the state help to provide more than one perspective on needs of members and gather information from across the state. Hearing from different partners on what is being seen in the state can provide a more comprehensive picture and help to forecast/identify what issues might be bubbling up.
- In October 2022 State C started using Pyx Health for waiver members. This is the same app identified during MCO interviews (more below) that addresses social isolation and loneliness.
- The state also shared they are aligning their quality monitoring across programs and will include indicators related to community involvement and development of meaningful relationships.

State D Interview Takeaways

- State D began a statewide coalition to address social isolation in fall 2020. The state obtained funding to support a full-time coordinator position. Health care, ADRCs, hospitals, community programs, clinics, and aging professionals are all part of the 400 coalition members across the state. They are working to secure funding to host a standalone website.
    - The coalition works to provide information and raise awareness about social isolation. The main populations the coalition focuses on are older adults and people with physical disabilities.
- State D piloted the UCLA 3-Item Loneliness Scale assessment with eight ADRC sites last fall with a goal to implement the scale into daily work. Most assessments were completed for those 60 and older (83 out of 97) to identify socially isolated individuals and refer them for services if they scored within a certain range. State D was pleased with the pilot and plans to expand the assessment statewide upon completion of analysis.

- Four other tools were considered but State D chose the UCLA 3-Item Scale because of ease of use, the length of the assessment, and use of non-invasive questions. Community health workers were familiar with the scale as well and could use with marginalized communities.

- State D's coalition has a Measurement and Research Workgroup that has compiled data from Behavioral Risk Factor Surveillance System (BRFSS) responses and created charts and graphs to show trends over the last few years. This resource was the most impactful visual ADvancing States identified during our state interviews.

State E Interview Takeaways

- State E has a relocation service available to Medicaid LTSS recipients called Community Choice Guides. This intensive case management service assists with the person's transition out of a facility back to a home environment and in addition to finding housing, goods, and services, can also include facilitating connection to a community. Training for the Community Choice Guides is intensive and focused on person centered practices, in addition to minimum Medicaid provider qualifications.

> *"These first responders already know, they've been doing this for years. They might be the only person who sees somebody over the course of 3 or 6 months"*

  - These services were so successful when used for people moving from a facility that the AAAs started using this service for people moving from one AAA catchment area to another area. The service helps the individual get connected to a new community and resources. Availability depends on whether the AAA is contracted with a Community Choice Guides provider.
  - A small percentage of people use this one-on-one service but it is highly impactful. Often individuals have been isolated and need assistance gaining connection and fostering relationships once out of the facility.
  - Quarterly meetings with guides, state partners, and AAAs facilitate expertise sharing and discussions about difficult cases.

- Peer to peer support is a service offered through the Older Americans Act. It is not statewide. This is more of a social support that uses a person-centered action plan to create tasks and address goals. This service requires intensive, 40 hour training.

- State E staff shared, like other states and MCOs, that community partnerships were key to addressing social isolation. Staff suggested reaching out to communities first to determine

what services were needed that were unique to the area and included first responders in that consideration. Other suggested entities to reach out to were home delivered meal providers as well as phone reassurance providers.

- State staff also discussed technology and the Get Set Up platform, where older adults can attend online classes. Quarterly reports from the platform show which classes were attended and for how long.

MCO Interviews

ADvancing States wanted to capture information and strategies from managed care organizations (MCOs) and spoke with three national health plans. Questions included which tools MCOs used to address social isolation, when and how members were identified for a screening, what interventions were used when a need was identified, and how the health plan tracked effectiveness.

One of the main themes all three MCOs mentioned was the need to be as person-centered as possible in the assessment and delivery of services. Two of the health plans talked about how to approach the discussion around social isolation and loneliness and training care coordinators and case managers on how to ask about and screen for social isolation. MCOs shared if questions and screenings are conversational in nature, it was more likely the member would share openly about their needs and day-to-day living. MCOs emphasized training to develop this skill. Using a natural approach, engaging the member on their level, and utilizing motivational interviewing techniques were all provided as examples of how to obtain information from members on what can be a sensitive, personal topic.

Building and gaining trust from members and the community at large (non-profits, community-based organizations, etc) was also commonly discussed across all three organizations. Many of the interventions mentioned were somewhat dependent on what services were available to the member in their community. By having good working relationships with CBOs and non-profits in the area, the MCOs were more likely to be able to refer the member to an appropriate intervention or service.

Tools/Assessments

The MCOs varied somewhat in how they approached assessing members for social isolation. One MCO shared they do not rely on one assessment tool, but rather take a multi-pronged approach to help provide a more comprehensive picture. This included utilizing the UCLA Loneliness Scale Version 3, incorporating relevant questions into assessment tools and health screeners, and data mining other clinical tools that may have already been administered.[11] This particular MCO also offered they have the ability to review electronic health records (EHRs) from primary care physicians that conduct screenings for loneliness, depression, and social isolation. By utilizing information that is already available, the member is not subjected to multiple assessments and screening fatigue is minimized.

[11] Russell, D. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. Journal of Personality Assessment, 66, 20-40.

Predictive analytics were also referenced from two of the MCOs. One health plan shared they were already using predictive analytics tools to identify members that may be at high risk for social isolation. This was done for members in the community as well as in facility settings. Another MCO shared they were working on predictive analytics software to identify people who might be suffering from social isolation but could not share specifics of the program due to its proprietary nature.

The frequency of assessments for social isolation were often dependent on the member's needs. MCOs shared assessments were completed at onboarding, annually, quarterly, and whenever there was a change in condition. One MCO also shared members could self-refer for social isolation screening.

Services and Interventions

MCOs were asked about available services to address social isolation. Health plans shared these services were varied and customized to the individual according to their needs. There were some commonalities across all three MCOs, including an emphasis on the importance of person centeredness, the use of technology, and extending partnership with communities.

When asked about services to address social isolation, MCOs first and foremost discussed person centeredness and finding interventions and services that would meet the needs of each specific person. There was no "one size fits all" approach taken by any MCO. One MCO shared the care planning process included questions to set goals, such as combatting isolation. The service or intervention was then planned and individualized to meet the needs of the person. The care manager would be responsible for checking in with the member to determine if the service support was working and if not, what could be tweaked to meet their needs in a more effective way. None of the MCOs thought there should be time limits on addressing social isolation, but that the service would be available for as long as needed with ongoing check-ins and assessment.

MCOs also discussed remote methods for addressing social isolation. The MCOs ADvancing states staff spoke with discussed one app in particular, called Pyx Health.[12] Commonly referred to as Pyx, the phone app provides a method for members to interact with others from the comfort of their own home or anywhere the member prefers. One MCO shared they found older adults and people with disabilities were hesitant to use the app at first, but once comfortable with how to use the technology they were active for long periods of time. For one MCO, members could self-refer for the Pyx service and Pyx would enroll that member in the program if appropriate. The ability to self-refer was noted as a best practice by ADvancing States staff. Doing so can be an empowering way for

[12] https://www.pyxhealth.com/

individuals to engage in their own well-being while also decreasing the time in between identified need and referral. A Personal Emergency Response System (PERS) was also mentioned as a way to address isolation by one MCO because it could be used for friendly check-in calls as well as for members to use in emergencies.

One MCO emphasized technology more than the others and shared they often turned to technology first as a method to address social isolation and loneliness. They incorporated consideration for technology into their philosophy and approach to helping members achieve their vision for day-to-day living. That same MCO also described utilizing personal care to the fullest extent under program scope to address social isolation. The MCO described thinking about personal care staff as a "bridge" to connecting members with surrounding communities.

All MCOs identified local community-based organizations and community members as partners in addressing social isolation. Often, MCOs would share the services available to the member were heavily dependent on what resources were available in the community. One MCO spoke about the mental health benefits to the member and had focused some of their efforts on community partnerships and supporting resources like memory cafes. Another MCO shared they were constantly looking to connect with community resources to address social isolation and believed the "peer to peer function and human element" were more effective than some technology-driven options. That MCO was looking at ways they could target outreach to trusted community members, such as community health workers, using their own case management workforce.

Effectiveness

While two of the MCOs shared they continually assessed for effectiveness via conversation with the member and adjusted services and goals as necessary, none of the MCOs had a formal way of tracking and trending health care data related to evaluation of social isolation services.

ADvancing States staff also asked MCOs about bio markers as they relate to social isolation. MCOs did not share methods for tracking specific health care data on an individual level as it related to the intervention for social isolation; however, one of the health plans did share they had reviewed preventive care information pre- and post- intervention for social isolation, depression, and loneliness. The MCO shared members were more likely to take care of preventive doctor visits once their social isolation needs had been addressed as compared to a control group. Since health plans mentioned access to EHRs and medical records in their interviews, ADvancing States staff believe it is likely MCOs could pull medical information (such as blood pressure) and track or trend that data along with the intervention's progress to identify any improvements or changes in health status.

Recommendations

Based on the environmental scan, nationwide survey results, MCO interviews and state interviews, ADvancing States identified promising practices and offer the following recommendations for successful implementation of a state social isolation service.

1. **Ensure comprehensive and thorough training for case managers to identify individuals who may be socially isolated.**

Training should include strategies for keeping discussions as authentic and organic as possible to promote the most comfortable environment and honest responses from individuals. Almost every state and MCO mentioned weaving this conversation into the person-centered planning process, maintaining social connectedness and community involvement as a priority in all planning and assessment activities.

2. **Frame service interventions using a person-centered practice lens.**

ADvancing States' research and state conversations revealed the importance of an individualized plan to address social isolation. Currently, there is no definitive research study that identifies the single best approach to address social isolation. Rather, current practice, as revealed in the state survey and interview findings, is a multi-faceted intervention strategy that provides the individual with an opportunity to lead the discussion and generate ideas for services and supports that meet their goals for increased social connection.

3. **Require MCOs to allow individuals to self-refer for services to address social isolation.**

During some of our interviews, ADvancing States learned individuals were encouraged to self-refer for certain services, such as the PERS and Pyx Health services, if interested. ADvancing States believes this option should be made available to members and shared with individuals at the initial assessment and at minimum every reassessment to encourage self-empowerment and to promote increase access to services. There is still a stigma around social isolation and loneliness, the impacts of which many people may not want to discuss with others. If the ability to self-refer is an option for these types of services, they may be utilized more often.

4. **Consider asking health plans to track certain health care indicators in tandem with the social isolation service.**

Research overwhelmingly shows when people are connected to others and feel part of a community, their emergency room utilization decreases and their blood pressure may decrease.[13] [14] While none of the interviewees ADvancing States spoke with shared they were engaging in this type of data tracking, we believe this could be one way to help further support of and promote services to address social isolation. For MLTSS states, ADvancing States suggests including a contractual requirement for MCOs to track this information.

5. **Foster partnership and connection with community resources, first responders, community health workers, and other stakeholders.**

One of the most common topics interviewees discussed was the importance of community connection and partnership to address social isolation. MCOs and states alike shared that often the services available to individuals were dependent on local resources. Maintaining good working relationships with local communities can help expand options for individuals to address their goals to decrease social isolation. This seems important since the staff we spoke with stressed the importance of ensuring the services to address social isolation were customizable to each person's needs. Fostering connections with community provider networks at the local level to provide broader service intervention options to individuals at risk for and/or identified as socially isolated is recommended as a best practice.

State and MCO staff should – as much as possible - remain up to date and knowledgeable about what resources are available. Consider mechanisms to set up a quarterly meeting for case managers and other staff/workers to share difficult cases for others to help work through and foster exchange of ideas.

6. **Offer clear and distinct service definitions.**

If your state is trying to address only loneliness, or only social isolation, be aware that clear and distinct service definitions will most likely be key. The state and MCO staff ADvancing States spoke with often used social isolation and loneliness interchangeably, even though ADvancing States was primarily asking about social isolation. Social isolation, loneliness, and social connection are all interconnected. It was difficult for staff to discuss one without the other.

7. **Explore measurement tools in conjunction with current assessment and planning processes in the state to build on system strengths and ensure effective implementation.**

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[13] Mosen, D.M., *et al.* (2020) Social Isolation Associated with Future Health Care Utilization. *Population Health Management.* doi.org/10.1089/pop.2020.0106.
[14] Kamiya Y, Whelan B, Timonen V, Kenny RA. The differential impact of subjective and objective aspects of social engagement on cardiovascular risk factors. *BMC Geriatrics*. 2010;10(1):81. doi:10.1186/1471-2318-10-81

ADvancing States believes there is great value in pursuing implementation of a standardized measurement tool to identify individuals who may be experiencing social isolation and to measure effectiveness of social isolation interventions. We spoke with a few states that had effectively used measurement tools in conjunction with their assessment process to implement a standardized tool to identify risk for social isolation and/or loneliness. In conversations with these states, it was apparent they had deployed a dynamic process to evaluate and research multiple tools prior to determining which one(s) would work best. The states also developed implementation strategies in conjunction with their stakeholders and worked to ensure that the state's community resources and service delivery systems were embedded in the implementation strategy. The results of these efforts proved successful, as these states conveyed a strong sense of purpose when describing the implementation benefit of the measurement tool in conjunction with service assessment and design.

Based on state survey results and MCO and state conversations, condensed measurement tools (i.e., less than 10 questions) appear to be the most consistently used in both the Medicaid and Aging service arenas. According to our research, the UCLA 3-Item Loneliness Scale is the most sited. While it doesn't strictly identify social isolation, it does provide measurable scoring and is simple to administer. For these reasons, the UCLA 3-Item tool is worth exploring as one facet of identifying loneliness and social isolation. For states looking to target assessments and services only for social isolation, ADvancing States staff suggest reviewing the following:

- The Cornwell Perceived Isolation Scale, a measurement tool that incorporates the UCLA 3-Item within a 9-item scale (aging focus);[15]
- The Multidimensional Scale of Perceived Social Support (MSPSS), based on a seven-point Likert scale (all populations);[16] or
- The Lubben Social Network Scale 6-item assessment, measuring social connection with family and friends (aging focus).

These tools are validated, well-researched tools that target social isolation, are simple to administer, and could be administered pre- and post- service intervention.

[15] See Table 1 for a list of indicators included in the scale: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756979/? hstc=3584879.1bb630f9cde2cb5f07430159d50a3c91.1523577601954.1523577601955.1523577601956.1& hssc=3584879.1.1523577601957& hsfp=1773666937

[16] Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment 1988;52:30-41.