# Hello Maine

## Making Connections and Breaking the Silence of Social Isolation and Loneliness

DANIEL HANLEY CENTER for HEALTH LEADERSHIP

Many Thanks to the Davis Family Foundation for their support.



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## Social Isolation

Social isolation is an objective condition of physical isolation that prevents or limits the development and expansion of a diverse social network, resulting in minimal contact with other individuals and the community."

(NIA.NIH.Gov.)

## Loneliness

Loneliness is not necessarily about being alone. Instead, "it is the perception of being alone and isolated that matters most" and is "a state of mind". "Inability to find meaning in one's life", "Feeling of negative and unpleasant" and "A subjective, negative feeling related to the deficient social relations" "A feeling of disconnectedness or isolation." (NIA.NIH.Gov.)



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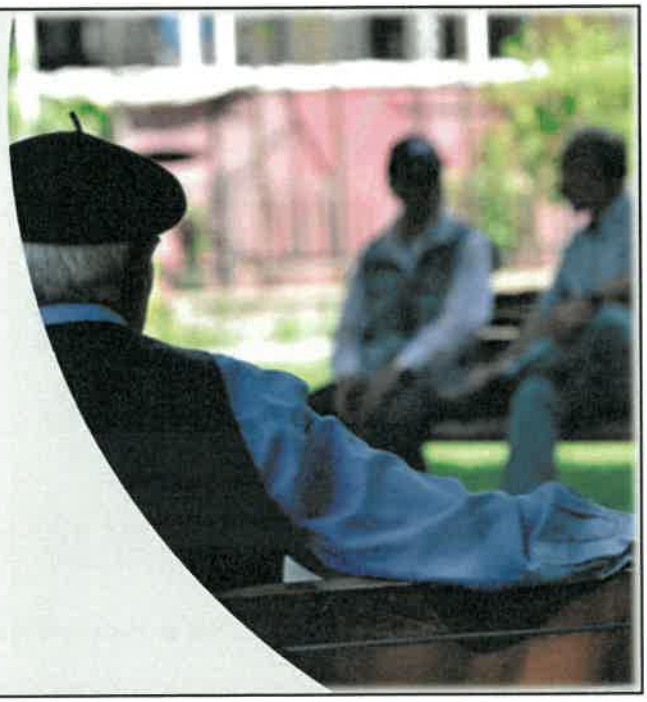
## Health Impacts of Social Isolation

- "The risk is comparable, and in many cases, exceeds that of other well-accepted risk factors, including smoking up to 15 cigarettes per day" (Holt-Lunstad et al., 2010).
- "Research has linked social isolation and loneliness to higher risks for high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death." (NIA.NIH.Gov.4.23.19)



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## Loss of Connections for Older Adults Can Have An Adverse Impact on Health and Well Being

"Nationally:

9% live in a rural area

20% of 65+ socially isolated

33% of 60+ experience intense loneliness

50% of 80+ report feeling lonely often

In Maine:

61% of the population live in a rural area

- 44% of those 65+ live alone, compared to 42%" U.S. Rurality, 65+ living alone. *American Community Survey*. Feelings of loneliness.

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## Understanding the Needs: Screening Tools for Social Determinants of Health (SDOH) and Social Isolation

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Age Friendly Health Systems 4M's "What Matters"
- Health Leads Social Needs Screening
- The Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities Screening

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## Making the Connections: Know Your Community Resources and How to Convene a Conversation

- Older adults often reach out to health care providers, town officials, and local community organizations, like churches and senior centers, for information and assistance in connecting to services they need
- Over 130 communities in Maine actively involved in creating and running locally-based volunteer initiatives that support healthy aging and "lifelong communities".
- EVERYONE benefits when someone in a region takes the initiative to convene a broad conversation about the core services and resources available in any area

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# Making Connections through a *Community Resource Guide* (Environmental Scan) Example from Mt Desert Island

| Purpose | Service delivery location | Target population served/ number served | Activities/ Services | Partnering agencies | Expected outcomes | Data | Contact | Funding source: (renewability? eligibility for alternate funding source?) |
|---|---|---|---|---|---|---|---|---|
| "Eastern Area Agency on Aging is the best source of information, options and services for seniors, adults with disabilities and caregivers." | 240 State St., Brewer, ME 04412 | many programs and activities are targeted to Bangor area | Aging and Disability Resources; Community Collaborations; Food and Nutrition; Wellness and Enrichment | Legal Services for the Elderly; Penobscot County | | | Phone: (207) 941-2865 or 1-800-432-7812 Fax: (207) 941-2869 Email: info@eaaa.org | |

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# Thank You!

**Hanley Forum 2019 Work Group on Improving Social Connections Among Older Adults**

**Work Group members:**

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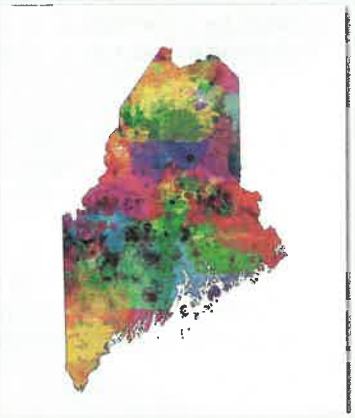

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# Screening Tools to Address Social Determinants of Health and Social Isolation

This guide has been prepared for use by healthcare and community based organizations seeking to screen for a variety of social determinants of health, but with a particular emphasis on social isolation and loneliness. There are many different tools available, and this guide is not intended to be an exhaustive list, but does offer some that demonstrate best practices or are evidence-based. Links are provided to individual program websites, which offer many more resources and are worth a visit and further review.

## The National Association of Community Health Centers PRAPARE Implementation and Action Toolkit:

## http://www.nachc.org/research-and-data/prapare/toolkit/

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' social determinants of health, transform care to meet the needs of their patients, and ultimately improve health and reduce costs. PRAPARE is both a standardized patient risk assessment tool as well as a process and collection of resources to identify and act on the social determinants of health. The PRAPARE Implementation and Action Toolkit is designed to provide interested users with the resources, best practices, and lessons learned to guide implementation, data collection, and responses to social determinant needs.

PRAPARE Electronic Health Record templates exist for eClinicalWorks, Epic, GE Centricity, and NextGen and are freely available to the public as part of our PRAPARE Implementation and Action Toolkit. For those who use an EHR where a PRAPARE template doesn't currently exist, we also have an Excel file template that allows you to collect standardized PRAPARE data in Excel until a PRAPARE EHR template is developed.

| | A | B | C |
|---|---|---|---|
| 11 | Category | Question | Text |
| 12 | Personal Characteristics | 1 | Are you Hispanic or Latino? |
| 13 | | 2 | Which race(s) are you? Check all that apply. |
| 14 | | 3 | At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income? |
| 15 | | 4 | Have you been discharged from the armed forces of the United States? |
| 16 | | 5 | What language are you most comfortable speaking? |
| 17 | Family & Home | 6 | How many family members, including yourself, do you currently live with? |
| 18 | | 7 | What is your housing situation today? |
| 19 | | 8 | Are you worried about losing your housing? |
| 20 | | 9 | What address do you live at? |
| 21 | Money & Resources | 10 | What is the highest level of school that you have finished? |
| 22 | | 11 | What is your current work situation? |
| 23 | | 12 | What is your main insurance? |
| 24 | | 13 | During the past year, what was the total combined income for you and your family members you live with? |
| 25 | | 14 | In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. |
| 26 | | 15 | Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all the apply. |
| 27 | Social & Emotional Health | 16 | How often do you see or talk to people that you care about and feel close to? |
| 28 | | 17 | Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? |
| 29 | Optional | 18 | In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility? |
| 30 | | 19 | Are you a refugee? |
| 31 | | 20 | Do you feel physically and emotionally safe where you currently live? |
| 32 | | 21 | In the past year, have you been afraid of your partner or ex-partner? |
| 33 | | | |

FrontPage MasterSheet

This is a modulized toolkit. The Toolkit's chapters focus on the major steps that are needed to implement a new data collection initiative on socioeconomic needs and circumstances. New users are advised to go through the entire Toolkit. Other users may wish to focus on certain chapters to build or enhance capacity in certain areas.

This Toolkit is based on the experiences, best practices, and lessons learned of our early adopting and pioneering health centers. We thank them for sharing their innovations and lessons learned with us so that others can advance their own social determinants of health journey.

## Age Friendly Health Systems Toolkit:

## http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf

### The "4Ms" Framework of an Age-Friendly Health System

In 2017, The John A. Hartford Foundation and IHI, in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), launched the Age-Friendly Health Systems initiative, which set the bold aim that 20 percent of US hospitals and health systems would be Age-Friendly Health Systems by December 2020.

The 4Ms Framework that emerged from the Age-Friendly Health Systems initiative is both evidence-based and able to be put into practice reliably in the health care setting. The 4Ms are:

- **What Matters:** Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.
- **Medication:** If medication is necessary, use age-friendly medication that does not interfere with What Matters to the older adult, Mentation, or Mobility across settings of care.
- **Mentation:** Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.
- **Mobility:** Ensure that older adults move safely every day in order to maintain function and do What Matters.

The 4Ms are the essential elements of high-quality care for older adults and, when implemented together, indicate a broad shift by health systems to focus on the needs of older adults. Reliable implementation of the 4Ms is supported by board and executive commitment to becoming an Age-Friendly Health System, engagement of older adults and caregivers, and community partnerships.

## "What Matters" as the Basis of Age-Friendly Care

In the Age-Friendly Health Systems initiative, "What Matters" to the older adult is the basis for the relationship with the care team and shapes the care that is provided. "What Matters" integrates care and decision making across care settings. "What Matters" is not limited to end-of-life planning. It is therefore essential to the older adult, the care team, and the health system that "What Matters" to each older adult is identified, understood, and documented so it can be acted upon, and updated across settings of care following changes in care or life events.

While fundamental to person-centered care, the practice of "What Matters" is the least developed of the 4Ms. Because of its importance, and the need for further development in practice, this "What Matters" to Older Adults Toolkit was developed by IHI with support from The SCAN Foundation. Bringing together the best available evidence from health systems around the world, the toolkit is a starting place and an invitation to learn together how to better understand and act upon "What Matters" to older adults and measure progress in doing so.

## The Health Leads Screening Toolkit

https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/?tfa_next=%2Fresponses%2Flast_success%26sid%3D1fa4d432ae4c037302b8401b35c065c2

When Health Leads launched our **Social Needs Screening Toolkit** in the summer of 2016, it stood as the lone comprehensive blueprint for health systems seeking to identify and screen patients for adverse social determinants of health. Though a number of basic screening templates were available at the time, the need for a fully-developed toolkit was clear. As the healthcare sector has come to embrace the need to address social and environmental factors that drive upwards of 70% of health outcomes, more and more healthcare delivery organizations have adopted patient-centered or whole-person care models. And through Medicare, Medicaid and other regulatory initiatives, federal and state governments have increasingly promoted alternative payment paradigms that incentivize comprehensive care and reward positive outcomes.

Combined, these developments have significantly increased demand for field-tested, up-to-date tools and resources to help health systems launch and scale effective social needs screening initiatives. As the sector advances and best practices evolve, so too have the recommendations put forward in our Screening Toolkit. The 2018 Edition includes a number of necessary updates based on the latest social needs research, lessons learned from long-standing screening programs, and feedback from front-line clinicians and healthcare providers.

**Essential Social Need Domains:** Representing the most common social needs impacting the health of patients today, these domains are based on findings from the Institute of Medicine, Centers for Medicare & Medicaid Services and Health Leads' two decades of on-the-ground experience. We recommend all healthcare systems include these domains in a screening tool for social determinants of health.

| SOCIAL NEED DOMAINS | EXAMPLES |
|---|---|
| Food Insecurity | Limited or uncertain access to adequate food |
| Housing Instability | Homelessness, unsafe or unhealthy housing conditions, inability to pay mortgage/ rent, frequent housing disruptions, eviction |
| Utility Needs | Difficulty paying utility bills, shut off notices, access to phone |
| Financial Resource Strain[2] | Inability to afford essential needs, financial literacy, medication under-use due to cost, benefits denial |
| Transportation Challenges | Difficulty accessing or affording transportation (medical or public) |
| Exposure To Violence[3] | Intimate partner violence, elder abuse, community violence |
| Socio-Demographic Information | Race and ethnicity, educational attainment, family income level, languages spoken |

## Depending on the goals of the initiative, these optional categories may be included on a social determinants of health screening tool.

| SOCIAL NEED DOMAINS | EXAMPLES |
|---|---|
| Childcare | Childcare, preschool, after-school programs, prenatal support services, kids clothing and supplies, summer programs |
| Education | English as a Second Language (ESL/ESOL), high school equivalency (GED), college training programs, health literacy |
| Employment | Under-employment, unemployment, job training |
| Health Behaviors[3] | Tobacco use, alcohol and substance use, physical activity, diet |
| Social Isolation & Supports[3] | Lack of family and/or friend network(s), minimal community contacts, absence of social engagement |
| Behavioral/ Mental Health[3] | Stress, anxiety, depression, psychological assets, trauma |

[3] *These categories will likely require a more highly skilled workforce than other types of social needs*

# MaineHealth 7 Social Determinant of Health (SDOH) Questions in EPIC

| Social Determinants of Health (SDOH) Standard Questions<br>Approved December 2016 [Updated: 05.24.17] | | | |
|---|---|---|---|
| **Question #** | **What is Being Assessed?** | **Question** | **Response** |
| 1 | Living Situation | What is your current living situation? | [Check Off: own home, apartment, assisted living, group home, homeless, skilled nursing facility, adult foster care, family member's home, temporary, multi-family, private residence, intermediate care facility, mental health residence] |
| 2 | Living Arrangement | What is your current living arrangement? | [Check Off: alone, children, family members, friends, parent, significant other, spouse] |
| 3 | Medication Affordability | In the past 6 months, have you ever taken your prescription medicines late, taken less than your doctor told you to take, or not filled your prescription because you couldn't' afford it? | [Check Off: Always, Often, Sometimes, Rarely, Never] |
| 4 | Food Insecurity | Do you worry whether your food will run out before you have the money to buy more? | [Check Off: Yes, No] |
| 5 | Health Literacy/Health Education | How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? | [Check Off: Always, Often, Sometimes, Rarely, Never] |
| 6 | Social Isolation | How often do you feel lonely or isolated from those around you? | [Check Off : Always, Often, Sometimes, Rarely, Never] |
| 7 | Transportation | Do you have difficulty arranging for transportation to or from your medical appointments? | [Check Off: Yes, No] |

## Institute of Medicine Questions on Social Connections

In a typical week, how many times do you talk on the phone with family, friends or neighbors?
Never Once a week Twice a week Three times a week More than three times a week Patient refused

How often do you get together with friends or relatives?
Never Once a week Twice a week Three times a week More than three times a week Patient refused

How often do you attend church or religious services?
Never Once a week Twice a week Three times a week More than three times a week Patient refused

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups or school groups?
Yes No Patient Refused

How often do you attend meetings of the clubs or organizations you belong to?
Never 1 to 4 times per year More than 4 times per year Patient refused

Are you married, widowed, divorced, separated, never married or living with a partner?
Married Widowed Divorced Separated Never married Living with a partner Patient Refused

# The Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities Screening Tool:

## https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

With input from a panel of national experts and after review of existing screening instruments, CMS developed a 10-item screening tool to identify patient needs in 5 different domains that can be addressed through community services (housing stability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety). Clinicians and their staff can use this short tool across a spectrum of ages, backgrounds, and settings, and it is streamlined enough to be incorporated into busy clinical workflows. Just like with clinical assessment tools, results from this screening tool can be used to inform a patient's treatment plan as well as make referrals to community services.

**Accountable Health Communities Core Health-Related Social Needs Screening Questions**

**Underlined answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.**

**Housing Instability**

1. What is your housing situation today?

□ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
□ I have housing today, but I am worried about losing housing in the future.
□ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

□ Bug infestation
□ Mold
□ Lead paint or pipes
□ Inadequate heat
□ Oven or stove not working
□ No or not working smoke detectors
□ Water leaks
□ None of the above

**Food Insecurity**

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

□ Often true
□ Sometimes true
□ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

□ Often true
□ Sometimes true
□ Never true

**Transportation Needs**

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that apply)

□ Yes, it has kept me from medical appointments or getting medications
□ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
□ No

**Utility Needs**

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

□ Yes
□ No
□ Already shut off

**Interpersonal Safety**

7. How often does anyone, including family, physically hurt you?

□ Never (1)
□ Rarely (2)
□ Sometimes (3)
□ Fairly often (4)
□ Frequently (5)

8. How often does anyone, including family, insult or talk down to you?

□ Never (1)
□ Rarely (2)
□ Sometimes (3)
□ Fairly often (4)
□ Frequently (5)

9. How often does anyone, including family, threaten you with harm?

□ Never (1)
□ Rarely (2)
□ Sometimes (3)
□ Fairly often (4)
□ Frequently (5)

10. How often does anyone, including family, scream or curse at you?

□ Never (1)
□ Rarely (2)
□ Sometimes (3)
□ Fairly often (4)
□ Frequently (5)

**SOURCE:** The above-noted health-related social need screening items are used with permission from their respective owners.

# Screening for social determinants of health in clinical care: moving from the margins to the mainstream

**https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6014006/#CR27**

Anne Andermann Public Health Reviews (2018) 39:19

While not a screening tool *per se*, Behforouz and colleagues propose that what is needed is to train health workers to take a more in depth social history on all patients that includes topics relating to individual characteristics, life circumstances, emotional health, perceptions of health care, health-related behaviors, and access to and utilization of health care

*Behforouz HL, Drain PK, Rhatigan JJ. Rethinking the social history. N Engl J Med. 2014;371(14):1277–1279. doi: 10.1056/NEJMp1404846. [PubMed] [CrossRef] [Google Scholar*

| | |
|---|---|
| Individual characteristics | Self-defined race or ethnicity<br><br>Place of birth or nationality<br><br>Primary spoken language<br><br>English literacy<br><br>Life experience (education, job history, military service, traumatic or life-shaping experiences)<br><br>Gender identification and sexual practices |
| Life circumstances | Marital status and children<br><br>Family structure, obligations, and stresses<br><br>Housing environment and safety<br><br>Food security<br><br>Legal and immigration issues<br><br>Employment (number of jobs, work hours, stresses/concerns about work) |
| Emotional health | Emotional state and history of mental illness (e.g., depression, anxiety, trauma, post-traumatic stress)<br><br>Causes of recent and long-term stress<br><br>Positive or negative social network: individual, family, community<br><br>Religious affiliation and spiritual beliefs |

| | |
|---|---|
| Perception of health care | Life goals & priorities; ranking health among other life priorities<br><br>Personal sense of health or fears regarding health care<br><br>Perceived or desired role for health care providers<br><br>Perceptions of medication and medical technology<br><br>Positive or negative health care experiences<br><br>Alternative care practices<br><br>Advance directives for cardiopulmonary resuscitation |
| Health-related behaviors | Sense of healthy or unhealthy behaviors<br><br>Facilitators of health promotion (e.g., behaviors among peers)<br><br>Triggers for harmful behaviors and motivation to change (determined through motivational interviewing)<br><br>Diet and exercise habits<br><br>Facilitators or barriers to medication adherence<br><br>Tobacco, alcohol, drug use habits<br><br>Safety precautions: seatbelts, helmets, firearms, street violence |
| Access to and utilization of health care | Health insurance status<br><br>Medication access and affordability<br><br>Health literacy and numeracy<br><br>Barriers to making appointments (e.g., child care, work allowance, affordability of copayment, transportation) |

## Additional Resources

### State Report from the Maine Shared CHNA, released April, 2019

### https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/final-CHNA-reports.shtml

### State of Maine Local Health Officers

### https://www.maine.gov/dhhs/mecdc/public-health-systems/lho/lho-contact.shtml

Maine LHOs role began in 1885 and have had a long and proud tradition of serving their communities. The "Local Health Officer" (LHO) is a term established by Maine Statute.

The local health officer work force has a unique knowledge about how to assist and protect Maine citizens and communities. They are "on the ground", working along with public health nurses, other local health officers, environmental health officials, and other professionals who share the common goal of improving and caring for the health of their communities.

The LHO monitors his or her community through identifying and/or responding to immediate and trends in health risks to individuals or the community through town resident queries and/or the sharp eye of the LHO. Maine Statute requires that every municipality in the state appoints and employs a local health officer. The link above offers a search tool to locate LHO's by municipality.

# Connecting Older Adults to Resources that Address Social Isolation & Loneliness

The causes of social isolation and loneliness are diverse, often interconnected, and impact people differently. It follows, therefore, that the solutions are equally as diverse. Some of the core causes of social isolation and loneliness include:

- **Poverty** – being unable to afford the basics means people often don't have sufficient resources for anything extra.
- **Lack of transportation** – while there may be many opportunities for social engagement and purposeful activities, you often have to drive to access these.
- **Lack of social connection** – this can be a complex issue caused by any other issues on this list, but can be specifically caused by the death of a spouse/partner.
- **Caregiving, especially for a person with dementia** – as caregiving becomes a full-time undertaking, hobbies, social engagements, and even basic appointments that yield social connection reduce significantly.
- **Fear of falling** – some people self-mitigate their fear of falling by reducing the number of times they go out.
- **Late in life onset of disability, particularly sight and hearing loss** – it may be that places they frequented are not accessible to people using a wheelchair or that they cannot hear to participate in a conversation or see to navigate or to participate in an activity they love (e.g. fishing or scrapbooking).
- **Language barriers** – this is not just an issue for new Mainers, many older French-speaking Mainers may lose their friends who spoke their language.
- **Lack of connection to a particular community** – for instance, native, LTBTQ, and new Mainers may experience loneliness for lack of connection to others like them. Some veterans may fall into this category as well.

While there are many statewide resources that can help a person overcome social isolation and loneliness, many solutions will be found at the micro-community level. This is because, beyond the traditional services network, every town in Maine has different resources available to assist residents with various needs, especially now that there are more than 130 communities in Maine actively involved in creating and running locally-based volunteer initiatives that support healthy aging – "lifelong communities".

As a trusted source of information and resources, older people often reach out to health care providers, town officials, and local community organizations, like churches and senior centers, for information and assistance in connecting to services they need. Sometimes information, a service, or a resource is readily available, and sometimes it isn't. Sometimes people answering questions think they "know" what's available, but really don't. Also, because of Maine's robust "lifelong community" movement, the services that are available are changing rapidly. Thus, everyone benefits when someone in a region takes the initiative to convene a broad conversation about the core services and resources available in any area

# Convene Stakeholders for a Conversation to Identify Core Local Supports for Older Adults

It doesn't matter who starts the conversation, but it's important that you take time to engage with each other about what services are provided in communities you serve, how best to access them, and where there are gaps in services.

**Environmental scan to get the right people/organization to the table:**

**Core Service Organizations:**

- Which Area Agency on Aging serves your community? This is always the first referral if there isn't a specific local referral. Know what services they provide and where they have waitlists.
- Which CAP (Community Action Program) serves your area and do they have any specific programs for older people?
- Do any of the municipalities in the area have resource coordinators/staff?
- Are there any volunteer initiatives in the communities you serve who are "age friendly," "aging in place," "villages," "cares communities," "lifelong communities," etc.?

**Transportation:**

- Do you have a volunteer transportation program that serves older people in the area?
- Who is your local transportation provider? Are there fee-for-service on-demand transportation options for people who cannot drive?

**Community Socialization Opportunities:**

- Are their regular community lunches or other meal opportunities available to older residents in your area? Can people attend from other communities?
- Do you have a senior center or community center that serves your community?
- Do any of your faith organizations host weekly socialization opportunities outside of traditional services (for instance, many cribbage leagues operate out of churches)?

**Purpose:**

- Are their opportunities for volunteering in your organization or in the community? Some people who are lonely lack purpose and would benefit from volunteering. Living a purposeful life reduces isolation and increases positive health outcomes.

## In-home Socialization/Support Opportunities:

- Is there a "friendly visitor program" that serves older people in your community? (Senior Companion or SEARCH or local volunteer program?)
- Is there a "good morning" program run through an organization or law enforcement agency that you can connect older people to for safety checks?
- Does your community have a parish nurse or community nurse who can make home visits to older residents?
- Is there a community paramedicine program that serves older people in your area?
- Do your fire, rescue, and law enforcement professionals proactively address health and safety issues they witness? E.g. do they refer to local resources or do falls assessments?
- Who are the local home care providers? Do they have any specialized community programming that might assist a person?
- Are there programs that help older people get online or access inexpensive broadband?

## Addressing Poverty:

- Do any of the communities you serve have any property tax relief options for older residents?
- Is there any heating assistance available to older residents beyond LiHEAP?
- Is there a local food pantry? Is there a mobile food pantry that serves your area?
- Do you know how to access programs to assist with prescription medications that you may be unable to afford?

## Community-Specific Needs

- Does your community include members that have specific engagement needs (language, LTBTQ, etc.)? Are there groups in your region that can provide connections?

- Host an initial conversation with these organizations, including all health and behavioral health services in your area. This will only work if the right people from each health organization are fully engaged. First question: are there organizations missing?
- Explore effective ways to make warm hand-offs to programs. Understand waitlists and other limitations of a program.
- Is there an organization who can host regular meetings?
- Host organization convenes group quarterly to keep relationships going and learn about new programs and initiatives that can help the people you serve.
- Explore ways you can increase how information about community supports is shared.

Making Connections through a
***Community Resource Guide***
(Environmental Scan)
Example from Mt Desert Island

| Purpose | Service delivery location | Target population served/ number served | Activities/ Services | Partnering agencies | Expected outcomes | Data | Contact | Funding source: (renewability? eligibility for alternate funding source?) |
|---|---|---|---|---|---|---|---|---|
| "Eastern Area Agency on Aging is the best source of information, options and services for seniors, adults with disabilities and caregivers." | 240 State St., Brewer, ME 04412 | many programs and activities are targeted to Bangor area | Aging and Disability Resources; Community Collaborations; Food and Nutrition; Wellness and Enrichment | Legal Services for the Elderly; Penobscot County | | | Phone: (207) 941-2865 or 1-800-432-7812 Fax: (207) 941-2869 Email: info@eaaa.org | |

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# Thank You!

**Hanley Forum 2019 Work Group on Improving Social Connections Among Older Adults**

**Work Group members:**

- Susan Ahl, Noble Adult & Community Education
- Ellen Freedman, MaineHealth
- Sue Guerrette, Aetna
- Vanessa Little, Mount Desert Island Hospital
- Jess Maurer, Maine Council on Aging
- Jo Morrissey, Maine Shared CHNA
- Catherine Ryder, Tri-County Mental Health
- Laura Tracy, MaineGeneral
- Sue Woods, HiTecHiTouch LLC

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## Understanding the Needs: Screening Tools for Social Determinants of Health (SDOH) and Social Isolation

- **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)**
- **Age Friendly Health Systems 4M's "What Matters"**
- **Health Leads Social Needs Screening**
- **The Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities Screening**



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## Making the Connections: Know Your Community Resources and How to Convene a Conversation

- **Older adults often reach out to health care providers, town officials, and local community organizations, like churches and senior centers, for information and assistance in connecting to services they need**
- **Over 130 communities in Maine actively involved in creating and running locally-based volunteer initiatives that support healthy aging and "lifelong communities".**
- **EVERYONE benefits when someone in a region takes the initiative to convene a broad conversation about the core services and resources available in any area**



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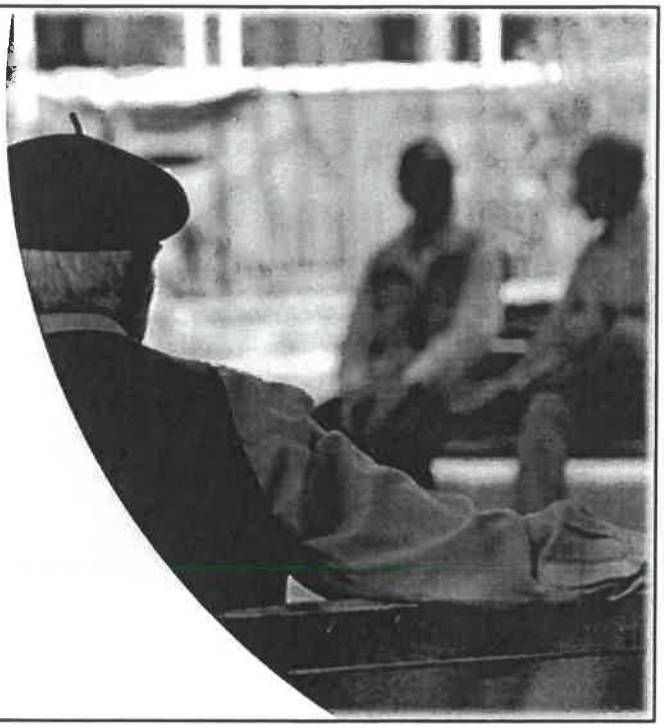
## Health Impacts of Social Isolation

- "The risk is comparable, and in many cases, exceeds that of other well-accepted risk factors, including smoking up to 15 cigarettes per day" (Holt-Lunstad et al., 2010).
- "Research has linked social isolation and loneliness to higher risks for high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death." (NIA.NIH.Gov.4.23.19)



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## Loss of Connections for Older Adults Can Have An Adverse Impact on Health and Well Being

"Nationally:

9% live in a rural area

20% of 65+ socially isolated

33% of 60+ experience intense loneliness

50% of 80+ report feeling lonely often

In Maine:

61% of the population live in a rural area

- 44% of those 65+ live alone, compared to 42%" U.S. Rurality, 65+ living alone: *American Community Survey*; Feelings of loneliness:

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# Hello Maine

## Making Connections and Breaking the Silence of Social Isolation and Loneliness

DANIEL HANLEY CENTER for HEALTH LEADERSHIP

Many Thanks to the Davis Family Foundation for their support.



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## Social Isolation

Social isolation is an objective condition of physical isolation that prevents or limits the development and expansion of a diverse social network, resulting in minimal contact with other individuals and the community."

(NIA.NIH.Gov.)

## Loneliness

Loneliness is not necessarily about being alone. Instead, "it is the perception of being alone and isolated that matters most" and is "a state of mind". "Inability to find meaning in one's life", "Feeling of negative and unpleasant" and "A subjective, negative feeling related to the deficient social relations" "A feeling of disconnectedness or isolation." (NIA.NIH.Gov.)



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