



Rural Aging: Health and Community Policy Implications for Reversing Social Isolation

July 2018



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Bipartisan Policy Center

Donato Tramuto

President and CEO, Tivity Health

Founder and Chairman, Health eVillages

Anand Parekh

Chief Medical Advisor, Bipartisan Policy

Center

ACKNOWLEDGMENTS

The Bipartisan Policy Center would like to thank Tivity Health for support of this work.

Special thanks to Neleen Rubin, president of Rubin Health Policy Consulting, LLC, for her contributions to this roundtable discussion and summary.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

Background

In 2017, Tivity Health and Health eVillages, in partnership with the MIT AgeLab and the Jefferson College of Population Health, hosted the inaugural **Connectivity Summit: A Catalyst for Change in Rural Aging**. Key stakeholder groups from multiple disciplines and sectors identified ways to elevate the importance of the circumstances facing rural-dwelling older adults. At the summit, the impact of social isolation and loneliness on the health, health spending, and longevity of rural seniors emerged as a key issue.

Building on this effort, the Bipartisan Policy Center (BPC) hosted a roundtable titled “Rural Aging: Health and Community Policy Implications for Reversing Social Isolation” in Washington, D.C., on June 7, 2018. The roundtable discussion advanced the national conversation on reversing social isolation among rural seniors—with a focus on three key objectives:

1. Ensuring a **common understanding** of the impact of social isolation on the aging population, particularly in rural areas;
2. Outlining high-priority and **actionable solutions** that could have an immediate impact on reversing social isolation, especially in rural communities, and that could serve as a platform for further discussion at the second Connectivity Summit on Rural Aging in August 2018; and
3. Identifying ways to raise the **public profile** of the health and economic impacts of social isolation and loneliness.

Prior to the roundtable, BPC also developed a briefing document on social isolation (see Appendix A).

Summary of Findings

Roundtable participants comprised a diverse set of stakeholders actively engaged in improving social connectedness and preventing social isolation and loneliness as well as related experts in health care policy, including representatives from nonprofits, government, academia, the private sector, and community organizations. For a list of roundtable attendees, see Appendix B.

Developing a Common Understanding of Social Isolation

In a collaborative effort to reverse social isolation, roundtable participants first focused on developing a common understanding of factors that can lead to social isolation and loneliness, particularly among rural seniors.

DEFINING SOCIAL ISOLATION AND LONELINESS

Roundtable participants noted that the health care community and the public do not have a sound understanding of social isolation and the related issue of loneliness. Although social isolation can arise in many different contexts and people can experience it in different ways, one roundtable participant defined it simply as a “lack of contact with others.”

From a research perspective, evaluating whether an individual is experiencing social isolation is based on objective indicators, such as a lack of relationships or infrequent social contact. By contrast, loneliness is defined as the subjective perception of being alone. Further, loneliness results from the distressing feeling that arises when there is “a discrepancy between an individual’s desired level of social connection and their actual level of connection.”



Social isolation is based on objective indicators, such as a lack of relationships or infrequent social contact. Loneliness is defined as the subjective perception of being alone.

FACTORS THAT CONTRIBUTE TO THE PREVALANCE OF SOCIAL ISOLATION IN THE UNITED STATES

With these definitions in mind, participants discussed **specific factors that can increase the risk** of an individual experiencing social isolation. Participants noted that social isolation among older individuals is often higher in those who are living alone, who are unmarried, or who do not have a partner—often due to divorce or death; it can also result from diminishing social circles due to the loss of or distance to family and friend connections, reduced mobility, impaired hearing or vision, or poor health—all of which make it challenging to engage in activities and in the community. Other participants noted that inability to use technology to connect with others or with community services can reduce options for remaining socially connected.

The participants discussed surveys and studies that highlight the need to consider the stigma associated with social isolation and loneliness. Most isolated and lonely people will not identify themselves as such, which makes identifying these issues challenging and often requires the use of validated tools that ask more specific, situational questions. Given this, participants noted the need to develop evaluative tools in this area and the need to educate health care providers in their use.

The prevalence of social isolation in rural communities was also a roundtable focal point. One participant noted that improvements in life expectancy in rural areas have not kept pace with life expectancy gains in urban communities; curbing social isolation could help address this issue. Others highlighted recent statistics that show an increasing death rate in rural communities as a result of drug overdose, alcohol abuse, and suicide, and they suggested that social isolation in rural communities could be a contributing factor. In addition, participants noted the negative impact of losing a spouse in rural and farming communities and how this impacts the prevalence of social isolation. Finally, participants acknowledged that limited access to rural doctors, rural mental health care, and rural hospitals—as well as a lack of local community programs—are ongoing barriers to rural seniors remaining healthy and engaged in their communities.



Looking more broadly across the nation, a participant pointed out a recent study demonstrating that nearly 50 percent of Americans “feel alone.” This study also suggested that those ages 18 to 29 may be the “most lonely generation ever” based on the survey results of 20,000 Americans ages 18 and over. This has larger implications: The senior population may become even more isolated and lonely as these younger generations age and also face the health and mobility barriers that can further challenge their ability to socially engage. As a result, some participants noted that cross-generational programs that aim to improve social connectedness across a range of ages deserve further consideration.

SOCIAL ISOLATION’S IMPACT ON HEALTH OUTCOMES AND HEALTH SPENDING

Participants explored the significant impact of social isolation on health outcomes and health spending.

Their discussion examined research that found that both social isolation and loneliness **increase mortality** across age, gender, and country of origin. Specifically, one roundtable participant noted a recent meta-analysis based on a comprehensive literature search (a review of publications from 1980 to 2014 on 3.4 million subjects) that found a **29 percent increased risk of mortality** associated with social isolation and a 26 percent increased risk of loneliness, which were both consistent worldwide. Roundtable participants also explored other recent research that compared social isolation with well-established risk factors and that recognized that isolation could be an even bigger public health threat than smoking or obesity and that it could raise the risk of premature death by up to 50 percent.

With these statistics in mind, roundtable participants also discussed the significant impact of social isolation on **health care spending**. They noted a recent collaborative study by the AARP, Stanford University, and Harvard University that found the Medicare program spends an estimated \$134 more per person monthly (\$1,608 annually) for every socially isolated older adult, compared with those who were not socially isolated—a level of spending comparable to what Medicare pays for certain chronic conditions, such as high blood pressure or arthritis. In total, the study estimated that a lack of social contact among older adults is associated with an estimated \$6.7 billion in additional Medicare spending annually.

Given the significant health and economic impacts of social isolation and loneliness, roundtable participants agreed the time is now to develop collaborative solutions to improve social connectedness, particularly among the nation’s rural and aging seniors.

Identifying Action-Oriented Solutions to Reverse Social Isolation

After coming together to collectively identify the causes and impacts of social isolation, participants turned to the second objective of the roundtable: to identify high-impact actions or solutions to reverse social isolation at the federal, state, and community level. BPC facilitators encouraged participants to think big but also to identify areas where they can start small and execute. A robust conversation coalesced around tackling social isolation with four different actions.

ACTION #1: ELEVATING THE DISCUSSION TO THE NATIONAL LEVEL

First, and perhaps most importantly, roundtable participants identified the pressing need to elevate the issue of social isolation to the national level. Many highlighted programs that are making an impact at the local level. (See below for more on these programs.) However, others acknowledged that social isolation has not received adequate national attention. Relatedly, participants again noted the ongoing stigma resulting from a lack of understanding—and lack of public discussion—around the prevalence and health impacts of social isolation and loneliness.

To address these challenges, participants identified the need for a **coordinated, broadly focused national campaign** to raise public awareness of the prevalence of social isolation and to help reduce stigma.

Participants expressed hope that, over time, increased public awareness will help individuals become comfortable acknowledging—and hopefully seeking assistance to address—feelings of isolation and loneliness. Participants also emphasized the importance of ensuring any national campaign focus not only on the medical or clinical aspects of social isolation but also on the role that housing, transportation, community support and services, and other factors play in either increasing or reversing isolation. Finally, the group put forward a specific recommendation: “Engaged stakeholders should start simply with a national call to action, encouraging government, the private sector, and philanthropy to focus on this important issue.”

ACTION #2: BUILDING ON EXISTING RESOURCES AND INFRASTRUCTURE

In addition to embarking on a national public awareness campaign, roundtable participants stressed the need to **leverage existing community programs, partnerships, and resources**. Most participants agreed that utilizing existing resources—and not reinventing the wheel—is critical. Some noted that doctors and other medical providers may not be best equipped to help patients improve social connectedness, but they can play a critical role in connecting patients to local programs and services.

Roundtable participants specifically discussed encouraging rural seniors to tap into resources such as the YMCA, which operates in more than 2,700 communities across the nation and features programming that includes community and care navigators who can help put seniors in touch with needed resources. They also encouraged the promotion of Area Agencies on Aging, which are located in more than 600 communities, and they suggested that roundtable participants embark on efforts to build bridges between health care and community resources. Some noted that programs like Meals on Wheels can help identify isolated seniors as part of their broader interactions in the home or community.

Participants concluded this section of the discussion by noting the collective impact these and other health care, social, and community organizations could have if they joined together to identify—and support—those experiencing isolation or loneliness, particularly in rural or underserved communities.



ACTION #3: ADDRESSING SOCIAL ISOLATION THROUGH PUBLIC POLICY IMPROVEMENTS

The third area of action roundtable participants identified was embarking on **public policy changes** that could make a real difference in reversing social isolation.

Chief among the recommendations was the critical need to study and include social isolation explicitly among the **social determinants of health**. Related to this, one participant noted that the U.S. Department of Health and Human Services now recommends all electronic health records include social determinant information; yet, to date, most health systems and providers have not adopted this recommendation, which makes it another opportunity to increase awareness and intervention. Similarly, participants recommended requiring the upcoming **Healthy People 2030** report to explicitly acknowledge social isolation and loneliness. Highlighting social isolation in this report could help magnify the importance of the issue across the federal government and may heighten public awareness.

Participants also identified the **role of technology** as a key tool to avoid or decrease social isolation among seniors in rural areas, and they urged an additional public policy focus in this area. Technology can connect rural seniors to friends and family and to resources, such as transportation to doctor visits or activities. However, barriers around seniors' knowledge of and ability to use technology remain a concern as well as the ongoing lack of broadband infrastructure in rural communities.

Participants further noted the importance of prioritizing and executing plans to **leverage internet-based supports for health care, transportation, and education** purposes in isolated communities. Others noted the importance of recognizing that not all seniors are mobile, and many lack the ability to leave home. For these individuals, roundtable participants emphasized that it is critical to meet them where they are and to support policies to increase broadband access.

Finally, participants stressed the need to evaluate cost savings, study the effectiveness and quality impacts of any proposed public policy reforms, and look for evidence-based solutions. Some noted that interventions are generally less effective—and less cost-effective—when directed at the severely isolated and lonely. These data support the need for prevention and early intervention. Finally, some participants posited that policymakers should prioritize funding for innovation and research into models that address social isolation and that are also scalable and effective.

ACTION #4: REFORMING HEALTH CARE DELIVERY AND PAYMENT SYSTEMS

Finally, participants discussed the need for **targeted redesign of health care programs and financing**. Participants suggested that strengthening the rural health care infrastructure must be a cornerstone of the conversation on social isolation among rural seniors.

Participants pointed to recent work by BPC, titled “Reinventing Rural Health Care: A Case Study of Seven Upper Midwest States,” that highlighted the reimbursement, technology, and workforce challenges facing rural communities. The report specifically recommended that rural systems work together to secure appropriate funding mechanisms and to implement innovative models, which could include embarking on **global budgeting initiatives**. In a similar vein, participants noted that moves toward global budgeting could offer opportunities for the reimbursement of non-clinical services. This could include reimbursing health care providers for connecting socially isolated patients to community services or programs that promote social connectivity.

Participants also said that policymakers should consider reforms to programs beyond traditional, fee-for-service Medicare. Specifically, participants noted the role Medicare Advantage (MA) programs could play in addressing social isolation and in evaluating program flexibility and payment structure within the current MA programs. Others suggested that looking toward models with **state flexibility and innovation**—such as Medicaid waivers or the work of the CMS Center for Medicare and Medicaid Innovation (CMMI)—can offer important opportunities.

Participants highlighted the need to develop a reliable tool to screen seniors for social isolation; they recommended screening seniors during Welcome to Medicare preventive visits and annual Medicare exams. Finally, roundtable participants acknowledged that regardless of program reforms—whether within traditional Medicare, Medicare Advantage, Medicaid, or within programs at CMMI—there is little appetite among policymakers for new health care spending, which means reforms will have to harness existing federal dollars.

Raising the Public Profile of the Health, Spending, and Longevity Impacts of Social Isolation and Loneliness

The third objective of the session focused on raising the public profile of the impacts of social isolation and loneliness. A handful of recent news articles have highlighted the issue of social isolation in rural communities. For example, roundtable participants were aware of a recent *Politico* story that profiled the state of Maine, where nearly half of residents 65 years and older live alone. The article described local efforts to tackle social isolation resident by resident through programs that combine medical care with social support. Beyond this limited coverage, however, participants worried that the issues of social isolation and loneliness have not received enough widespread attention in the United States.

At the same time, participants looked abroad at the efforts of other governments to elevate the issue of the social isolation. For example, the United Kingdom recently appointed a **Minister of Loneliness** tasked with leading a government-wide effort to establish policies to reduce loneliness. Roundtable participants questioned **whether the U.S. government should also consider appointing a high-ranking official** charged with addressing social isolation and loneliness with effective programs.

Other participants noted the importance of ensuring that any national public-awareness campaign be **broad-based**. Campaigns should focus on the role of transportation, housing, nutrition, health, and other social determinants in preventing or reversing social isolation. Others suggested spotlighting **personal stories** to bring a face to the challenges of social isolation and loneliness in rural communities. One participant suggested that a celebrity spokesperson who self-identifies as isolated or lonely could help raise awareness and reduce stigma.

As the roundtable session came to a close, participants agreed that a key focus going forward should be to find an effective means to communicate the prevalence and impacts of social isolation and loneliness as well as ways to reverse these conditions.

For a recap of potential program and policy actions identified at the roundtable discussion, please see Appendix C.

Conclusion

Working together over the course of the recent roundtable on “Rural Aging: Health and Community Policy Implications for Reversing Social Isolation,” participants from nonprofits, government, academia, the private sector, and community organizations began charting a course to strengthen social connectedness across the nation.

Roundtable participants offered valuable insight regarding local and some nationwide efforts already underway to reverse social isolation and loneliness, but they also agreed that there is more to do to address this critical public health issue. To that end, they identified a host of actions and solutions that merit further discussion. These actions included establishing a broad-based national effort to reverse social isolation, leveraging existing resources and infrastructure to address social isolation at the local level, and addressing social isolation through targeted public policy, health care delivery, and financing reforms.

The groundwork laid out at the roundtable provides a strong backdrop to an upcoming event, “**Connectivity Summit on Rural Aging: Reversing Social Isolation**,” hosted by Tivity Health on **August 7-9, 2018**, in Portland, Maine. This upcoming summit will once again bring diverse stakeholders together to develop consensus for reversing and taking immediate actions to address social isolation in all aging communities, including in the nation’s most rural and underserved areas.



Appendices and Resources

APPENDIX A — SOCIAL ISOLATION: A BRIEF OVERVIEW OF RECENT WORK

May 2018

Over the last two decades, the issue of social isolation and its impact on health outcomes, health care spending, and longevity has emerged as a critical public health concern.

Academic research, a handful of recent media articles, and to a lesser extent policymaker interest has spurred a new focus on this issue, particularly as it relates to social isolation's impact on rural aging.

Social isolation can affect individuals across their lifespan and in all geographic areas. Although there are many ways to define—and many characteristics of—social isolation, one definition put forth by the [AARP](#) defines it simply as a “lack of contact with others.” Researchers and others have drawn a distinction between social isolation and loneliness, [defining social isolation](#) as “an objective and quantifiable reflection of reduced social network size and paucity of social contact” compared with [loneliness](#) as the subjective state of feeling alone, defined as dissatisfaction with the quantity and quality of one's social relationships.

Research suggests that the elderly experience higher rates of social isolation, compared with their younger counterparts. Social isolation among older individuals [can result from](#) diminishing family connections, reduced mobility, poor health, or an inability to use technology as a means of social connection, all of which make it challenging to engage in activities and in the community, among other reasons.

Unsurprisingly, social isolation is [more acute in rural and frontier areas](#) where physical distances, lack of public transportation, and fewer community resources pose particular barriers to social engagement. Rural seniors face these challenges as access to rural doctors, access to rural mental health care, and access to rural hospitals, which serve as vital sources of keeping seniors healthy and mobile, continue to decline.

Academics have studied social isolation from a variety of geographic, health policy, and health outcome perspectives. While most studies focus on wider geographies, some recent publications have included both short-term and longer-term, longitudinal reviews of social isolation among older people residing in rural communities.

For example, an [international study](#) published in 2004 followed roughly 500 individuals living in rural Wales over a 20-year time frame to study the factors associated with increased and decreased social isolation and loneliness. The study found that some respondents experienced no levels of social isolation, while others experienced varying levels. Key factors associated with both social isolation and loneliness in this rural area were recent widowhood; deaths of friends, relatives, or close neighbors; deteriorating health, including mobility, vision, or hearing impairment; and being home alone often and for long periods. Cases where individuals were not isolated yet still felt lonely often included primary caregivers to a spouse or those living with families who work full-time. In contrast, those who were long-term residences of a rural community, married or not otherwise living alone, or who had adult children nearby were consistently less socially isolated and lonely.

Other research has examined social isolation's link to general mortality and to specific disease states, such as the risk of heart disease and stroke. A [meta-analysis](#) based on a comprehensive literature search (reviewing publications from 1980 to 2014) found a 29 percent increased risk of mortality associated with social isolation and a 26 percent increased risk of loneliness, which was consistent worldwide. [Another study](#) found that social isolation is associated with a 59 percent increased risk of functional decline in activities of daily living and a 20 percent increased risk of losing mobility.

Regarding specific diseases, [other studies](#) have found that poor social relationships were associated with a 29 percent increased risk of coronary heart disease and a 32 percent increased risk of stroke. What's more, loneliness can increase the [risk of dementia](#) by 64 percent. Finally, other [newsworthy studies](#) have suggested that social isolation could be a bigger public health threat than smoking or obesity, and some studies report it could [raise the risk of premature death by up to 50 percent](#).

Against this backdrop and building on the research, organizations such as AARP, Stanford and Harvard have collectively explored how social isolation and poorer health outcomes impact health care utilization and spending. A [collaborative study](#) by these organizations found that Medicare spent an “estimated \$134 more monthly (\$1,608 annually) for each socially isolated older adult” compared with those who were not socially isolated—a level of spending “comparable to what Medicare pays for certain chronic conditions, such as high blood pressure or arthritis.” In total, the study estimates that “lack of social contacts among older adults is associated with an estimated \$6.7 billion in additional Medicare spending annually.”

Other organizations, including the Commonwealth Fund and insurers such as Cigna and Humana, have begun working to better define the problem of social isolation and to develop potential solutions and community resources. For example, Humana has released a [comprehensive tool kit](#) that offers plan members information ranging from understanding feelings of loneliness and social isolation to tips on how seniors can stay connected to their community. Cigna recently completed a [research project](#) that specifically spotlights loneliness and its root causes (across ages 18 and older, not just the elderly).

Stakeholders such as the AARP have also highlighted [specific proposals](#) to begin tackling the issue of social isolation. Proposals include developing a valid and reliable tool to screen seniors for social isolation, developing partnerships to identify evidence-based interventions, screening older adults for social isolation during Welcome to Medicare preventive visits and annual Medicare exams, elevating the discussion of social isolation in the public health community, and including social isolation among the social determinants of health.

At the same time, rural communities have begun working on the ground to increase focus on social isolation and to develop programs that support rural seniors. A recent news article in Politico highlighted the state of Maine, where nearly half of the residents 65 years and older live alone. The [article](#) profiles local efforts to tackle social isolation resident by resident through programs like Access Health that combine medical care with social support—like helping seniors replace hearing aids or providing assistance with household chores.

Finally, there has been some federal attention to the issue of social isolation and rural aging, but policymakers have demonstrated only limited engagement on the topic.

In April 2017, the Senate Aging Committee held a hearing to examine the mental and physical effects of social isolation and loneliness. A second hearing before the committee explored how age-friendly initiatives could reduce social isolation and loneliness in both rural and urban settings. Aside from these hearings, there has been no legislation introduced in the current Congress related to the issue of social isolation or specifically related to social isolation in rural areas. Also, there do not appear to be any initiatives underway at the U.S. Department of Health and Human Services related to social isolation.

Taken together, the research community has laid out a lot of the groundwork necessary to define the root causes of social isolation, including among the rural elderly. They have laid out less groundwork, however, on developing fulsome policy solutions; worse, proposals that have been put forward have not received serious policymaker consideration to date.



Social Isolation: List of Possible Solutions

<p>Individual Education and Resources</p>	<ul style="list-style-type: none"> • Educate seniors about loneliness and social isolation to raise awareness of what to expect and how to connect with resources. • Connect seniors with housing, medical, transportation, community, and other local resources to meet their particular needs. • Offer seniors access to professional help to work through individual stresses that can lead to isolation (e.g., widowhood)
<p>Clinical Interventions</p>	<ul style="list-style-type: none"> • Develop a valid and reliable tool to screen seniors for social isolation. • Screen older adults for social isolation during Welcome to Medicare preventive visits and annual Medicare exams. • Educate hospitals to ensure emergency room personnel can connect seniors to appropriate social supports (since the emergency room may be one of the few points of engagement for socially and geographically isolated seniors).
<p>Community Programs</p>	<ul style="list-style-type: none"> • Develop local programs, similar to Access Health in rural Maine, that offer individualized services, such as helping connect seniors to doctors through video calls and running errands to keep seniors healthy and mobile (such as medicine pickups). • Establish youth volunteer programs to increase intergenerational connections. • Ensure elderly have access to a telephone or other means of communication. • Provide low-cost computers and computer training to seniors to facilitate connections. • Develop websites with local support information to connect seniors to local services. • Survey local residents to determine what resources are available as well as the best ways to improve social engagement (e.g., is lack of transportation a key barrier?)
<p>Public Policy</p>	<ul style="list-style-type: none"> • Elevate the discussion of social isolation in the public health community. • Appoint a high-ranking official in the federal government to be responsible for developing interventions to address social isolation. • Study and include social isolation among the social determinants of health. • Support programs that provide local bereavement support and that ensure health care providers are educated on widowhood's impact on isolation. • Work with health care providers to develop systems to identify socially isolated individuals. • Develop respite services for caregivers to lessen social isolation among those caring for the elderly. • Age discrimination can lead to loneliness. Ensure public programs include anti-age discrimination rules and training.

APPENDIX B — LIST OF BPC ROUNDTABLE PARTICIPANTS

Debra	Whitman	AARP	Chief Public Policy Officer
Michael	Park	Alston & Bird, LLP	Attorney at Law
Jim	Capretta	American Enterprise Institute	Resident Fellow, Milton Friedman Chair
Ann	Mond Johnson	American Telemedicine Association	CEO
Latoya	Thomas	American Telemedicine Association	Director, State Policy Resource Center
Robin	Goracke	Better Medicare Alliance	Chief of Staff
Joann	Donnellan	Bipartisan Policy Center	Senior Advisor
Katherine	Hayes	Bipartisan Policy Center	Director of Health Policy
Bill	Hoagland	Bipartisan Policy Center	Senior Vice President
Caitlin	Krutsick	Bipartisan Policy Center	Project Manager
Anand	Parekh	Bipartisan Policy Center	Chief Medical Advisor
Neleen	Rubin	Bipartisan Policy Center	Health Team Consultant
Natalie	Weiner	Bipartisan Policy Center	Project Manager, Health Team
Julianne	Holt-Lunstad	Brighma Young University	Professor
Alice	Rivlin	Brookings Institution	Senior Fellow
Tracy	Frist	Centerstone	Board of Directors
Julian	Harris	CIGNA Corporation	President, CareAllies
Sarah	Heppner	Federal Office of Rural Health Policy	Director, Policy Research Division
Andrew	MacPherson	Healthsperien LLC	Principal
Alexis	Skoufalos	Jefferson College of Population Health	Associate Dean, Strategic Development
George	Suttles	John A. Hartford Foundation	Program Officer
Amanda	Austin Moorhead	Locust Street Group	Partner
David	Herrero	Locust Street Group	Partner
Alesia	Frerichs	Lutheran Services in America	Vice President, Member Engagement
Jake	Swanton	Lyft	Federal Policy
Adam	Felts	Massachusetts Institute of Technology	Technical Associate
Bob	Blancato	Matz, Blancato and Associates	President
L. Carter	Florence	Meals On Wheels Association of America	Director, Strategy and Impact
Bill	Frist	Nashville Health	Founder
Caroline	Young	Nashville Health	Executive Director
Sandy	Markwood	National Association of Area Agencies on Aging (n4a)	CEO
Vivian	Nava-Schellinger	National Council on Aging (NCOA)	National and Community Partnerships
Alan	Morgan	National Rural Health Association	CEO
Gail	Wilensky	Project Hope	Senior Fellow
Mary	Flipse	Tivity Health	Chief Legal and Administrative Officer



Elizabeth	Rula	Tivity Health	Executive Director and Principal Investigator
Vicki	Shepard	Tivity Health	Vice President, Govt. and External Relations
Donato	Tramuto	Tivity Health	CEO
John	Auerbach	Trust for America's Health	Executive Vice President
Chris	Coloian	Verscend	Senior Vice President, Revenue and Growth
Katie	Adamson	YMCA	Vice President, Health Partnerships and Policy
Daphne	Delgado	YMCA	Manager, Health Partnerships and Policy

APPENDIX C — BPC ROUNDTABLE RESULTS AND OTHER SOURCES

Summary of Possible Actions to Improve Social Connectedness	
Elevate the Issue of Social Isolation and Loneliness to the National Level	<ul style="list-style-type: none"> Embark on a collaborative effort to establish a coordinated, broad-based national campaign to raise public awareness about the prevalence and impacts of social isolation as well as ways to reverse social isolation. Specifically elevate the issue of social isolation in the public health community. Educate seniors about loneliness and social isolation to raise awareness of what to expect and how to connect with resources. Use a national campaign to specifically help seniors connect with housing, medical, transportation, community, and other local resources to meet their particular needs. Consider appointing a high-ranking official in the federal government to be responsible for developing interventions to address social isolation.
Build on Existing Resources and Infrastructure	<ul style="list-style-type: none"> Encourage rural seniors to tap into local programs, including community and care navigators who can connect seniors to needed resources. Further scale community health and well-being programs to prevent and control chronic disease and disability and to build relationships and social support. Encourage community and health care resources to work together to collectively address social isolation at the local level. Ensure local programs that connect with seniors in the home (e.g., Meals on Wheels) include screening for social isolation and loneliness as part of their interactions.
Public Policy Improvements	<ul style="list-style-type: none"> Study and include social isolation among the social determinants of health. Require the upcoming Healthy People 2030 report to specifically address social isolation and loneliness as a way to raise visibility across the federal government. Leverage internet-based supports for health care, transportation, and education to help rural seniors stay healthy and connected. Provide computer training to seniors and their caregivers to facilitate connections. Continue to place a priority on ensuring broadband access in all rural communities.
Reform Health Care Delivery and Financing Structures	<ul style="list-style-type: none"> Analyze whether it is appropriate to modify federal health care programs to allow payment for social support services that can improve social connectedness. Develop innovative models and funding mechanisms to shore up rural health care systems as a way to ensure the health of rural seniors. Develop a valid and reliable tool to screen seniors for social isolation. Screen older adults for social isolation during Welcome to Medicare preventive visits and annual Medicare exams. Analyze whether programs such as Medicare Advantage should be reformed to provide increased flexibility to address social isolation. Examine whether there are appropriate opportunities to address social isolation in Medicaid waiver or CMMI innovation models.

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