Harnessing the Power of Connection to Promote Healthy Aging and Social Engagement

Today's Speakers

- **April Young**

  – Senior Director of Strategic Initiatives, ADvancing States

- **Jeff Keilson**

  – Senior Vice President for Strategic Planning, Advocates, Inc.

- **Whitney Moyer**

  – Vice President of LTSS, Commonwealth Care Alliance

- **Dor Skuler**

  – CEO and Co-founder, Intuition Robotics

- **Greg Olsen**

  – Acting Director, New York State Office for the Aging

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Setting the Stage

Understanding Social Isolation and its Impacts

Impacts on Health and Wellbeing

- Social isolation can have negative impacts to older adult physical health, including early mortality, high blood pressure, and heart disease.

- The influence of social isolation on risk for mortality is comparable with well-established risk factors for mortality. (*Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review*, Perspectives on Psychological Science 2015, Vol. 10(2) 227 –237)

- Loneliness also has an impact on mental and emotional health, as older adults experiencing loneliness are at increased risk of depression and cognitive decline.

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Impacts on Expenditures and Service Utilization

- Social isolation and loneliness have personal and social costs.

- One study found that a lack of social contacts among older adults resulted in greater health care spending in fee-for-service Medicare, totaling over $1,600 more per beneficiary per year than beneficiaries with typical social contacts.

- Research also found that older adults living alone and experiencing loneliness were also more likely to need assistance from community programs.

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Growing Awareness of Social Isolation as a Social Determinant of Health

- With research documenting the health impacts of social isolation and loneliness, there is growing recognition that these conditions are social determinants of health.

- Loneliness and social isolation are experienced by adults across the age span.

- Life events/transitions might lead to decreased social connections for older adults. At the same time, life experience can foster resilience.

- The COVID-19 pandemic and public health emergency have created conditions that increase social isolation while also spurring new initiatives and approaches to addressing isolation and enhancing social connections.

ADVANCING STATES

Commit to Connect
Administration for Community Living

- To tackle the challenge of combatting social isolation and loneliness, ACL pulled together partners from across the federal government, the aging and disability networks, philanthropy, and industry.

- Some of the goals of this public-private partnership include:
  - Building a network of champions;
  - Collaborating on solutions to reach more people;
  - Developing an online, consumer-focused tool to match people to customized resources; and
  - Establishing partnerships in communities and across all levels of government to share successful initiatives.

- For more information: https://acl.gov/CommitToConnect

ADvancing States Resource

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

2. Consider tracking health care indicators in tandem with social isolation service

3. Foster partnerships with community resources, first responders, community health workers, and other stakeholders

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STATES

2023

**ADvancing States
Social Isolation
Report**

advancingstates.org
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ADvancing
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The Friendship Project

A Volunteer Initiative

Addressing Social Isolation and Loneliness

2023 Home and Community-Based Services Conference

Presenter

Jeff Keilson
Senior Vice President
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About Advocates

- Advocates is a private, non-profit agency

- Meeting the unique needs of elders, families, and individuals with a broad range of abilities for nearly 50 years

- Advocates and its affiliates employ over 2,000 staff and serve 40,000 people with mental health conditions, intellectual disabilities, brain injuries, and/or Autism and their families across eastern and central Massachusetts

www.Advocates.org

"To some people an afternoon of volunteering might not seem like much, but to my son, that afternoon represents friendship, independence, and kindness. That afternoon of him working out with his volunteer makes a world of difference in both of their lives."

Family caregiver

"I had so much fun. I never had so much fun."

Participant

"I love being a part of the Friendship Project! The connections we make with every person may seem small and quick, but these little moments genuinely matter. They create a little burst of happiness in your day and that trickless into other parts of your life! Positive human connection is the foundation for my mental health!"

Volunteer

Funding

- Initial grant from Administration for Community Living (2022)
- Two-year grant from the Office of the Attorney General in Massachusetts for an emergency room diversion initiative (2023)
- Advocates
- Managed Care Organizations (Commonwealth Care Alliance, United Health Care)
- Department of Developmental Disabilities
- Community Partners

Loneliness and Isolation

According to the Health Resources and Services Administration, the health risks of social isolation and loneliness can be "as damaging to health as smoking 15 cigarettes a day." Harmful impacts include elevated mortality rates and blood pressure, Alzheimer's Disease progression, depression, pain, failing immune systems, fatigue, and sleep loss.

The goals of The Friendship Project are to:

1. Reduce social isolation and feelings of loneliness among diverse older adults and adults with disabilities through friendly visits, sharing interests, texting, and connecting virtually.
2. Improve the well-being of diverse older adults and adults with disabilities through hands-on support with household tasks, community engagement and other activities.
3. Support decisions that impact the quality of life of the participants.
4. Increase the well-being of volunteers through a greater sense of purpose and connections to community.
5. Lessen the stress on family caregivers.
6. Diversion from emergency departments and hospitalizations.

Team

- Project Champion(s) and Project Lead
- Volunteer Coordinators
- Marketing and Communications Department
- Human Resources
- Program Staff
- Community Partners
  - Businesses
  - Faith-based organizations
  - Higher education
  - Management of subsidized housing
- Managed Care Organizations
  - Commonwealth Care Alliance
  - Tufts Unify
  - United Health Care

Expansion with
Commonwealth Care Alliance (CCA)

- CCA One-Care Program (Dual Eligibles)
- CCA team identifies members
- Care coordination delegated to Advocates
- Role of Advocates volunteer coordinator
- Quality of Life survey administered by Advocates
- Analysis of emergency room use and other expenditures by CCA
- First month: 7 participants have been matched or are in the process of being matched with volunteers.
  - Common experience in childhood which immediately bonded them
  - Shared interest

Components of Infrastructure

- Flyers
- Online sign-up sheets
- Onboarding procedure
- Background check procedure
- Volunteer training
- Online system for logging volunteer interactions
- Designed business cards with QR code for ease in logging interactions

Building Relationships

It is of utmost importance to build relationships with a broad range of stakeholders. We needed to build trust for people to take a chance with the initiative.

- Participants/members
- Volunteers
- Family caregivers and other family members
- Staff who support them
- Staff within each organization
- Community leaders
- Community organizations

Onboarding the Recipient

- Participant is nominated by themselves, their staff, or their family.
- The volunteer coordinator collects information from the individuals and/or their staff and family.
- The volunteer coordinator facilitates an introduction for the volunteer and participant, including key people who support the individual, if they desire.
- The volunteer and participant work out a plan to meet including time, activity, and how they will meet (phone call, text, zoom, in person).
- The volunteer coordinator follows up to ensure that the program is working for the participant and volunteer.
- Feedback to staff supporting the participant.

Volunteer Recruitment

- Personal network and connections to community
- Community members who have heard about the initiative
- Organizations that manage subsidized apartment complexes
- Retirees
- Faith communities
- Colleges and universities
- State employees
- Businesses with a commitment to support their employees to volunteer
- Advocates employees
- People receiving supports who want to give back
- Family members

Making the Match

- The volunteer coordinator will introduce the volunteer and participant (either virtually, in person, or through a phone call).

- The volunteer and participant will plan their first meeting.

- After each interaction, the volunteer will fill out a quick information log. The link to the log will be provided to the volunteer when they are onboarded. This information can also be emailed, texted, or called in to the volunteer coordinator.

- The volunteer coordinator will check in with both the volunteer and the participant to see how things are going. The volunteer can also contact the coordinator at any time.

18-Month Outcomes

- 46 volunteers connected with 90 participants, more than half with mental health conditions
- 25 family caregivers impacted (respite for families)
- Importance of supporting volunteers
- People with shared experiences
- People with shared interests making connections
  - Fishing
  - Animals
- Group Zoom chat
- Reduced isolation and loneliness for recipients, volunteers, and reduced stress on family caregivers

Tim and Paul

Tim is retired and was looking for a volunteer opportunity. Paul is a young man who had been living in a group home and was moving to a supported apartment. He was very anxious about the move, especially about how he would do all the errands that he was used to completing every week with the help of on-site staff.

Tim meets with Paul on a weekly basis to bring him to the bank, bookstore, and other community places that Paul has on his list.

Paul (as well as his staff) have reported that the move for Paul would never have been so successful if it were not for Tim.

Selena and McKenna

Selena is a student studying to be a social worker. She applied to become a volunteer for school credit.

McKenna is a young woman living in a supported apartment. She was identified by her staff for the Friendship Program to help alleviate loneliness and social isolation. Initially, she was resistant to the program, feeling bad that she couldn't make friends on her own. Selena quickly jumped in to say that she was also lonely and looking for a friend.

The two have mostly been communicating via phone calls and texts.

Selena completed her requirements for school, but has stayed on, as McKenna is now a friend.

McKenna had wanted to apply for a job but lacked confidence to apply. Selena helped talk her through the application process, encouraging her every step of the way, and now McKenna is working at a job she enjoys.

Abdullahi and Yaha

Abdullahi is a Boston community member who heard about the Friendship Project through an event at his mosque.

He was matched with Yaha, an elderly community member, who needed rides to community events. Abdullahi is an Uber driver, so this was a great match.

While the program is just meant for local travel, Yaha was invited to a family wedding in Maine. She had no way to get there, no family in the area, and no one was able to come from Maine to pick her up.

Abdullahi stepped in and took his day off to bring Yaha to the wedding and provide her with a family experience that would not have otherwise been possible.

Vicky and Evelyn

Vicky lives in a group living environment to support her mental health challenges. Due to her estrangement from her family and lack of friends in her life, she has become very lonely and isolated. Through the Friendship Project, she was introduced to Evelyn. They decided that Vicky would try going with Evelyn to her church on Sunday. This is something that Vicky had never done before.

Vicky now goes with Evelyn every Sunday. She says she has never had such a good time before and has never had someone take the time and spend the time with her.

Vicky also met Evelyn's sister Rachel at church. Seeing the success of this friendship encouraged Rachel to also sign up to be a volunteer with the Friendship Project.

The Power of Partnerships

Shaping Health Outcomes

"When you trace back to the causes of illness, in so many cases you see how our social fabric itself is in need of mending."
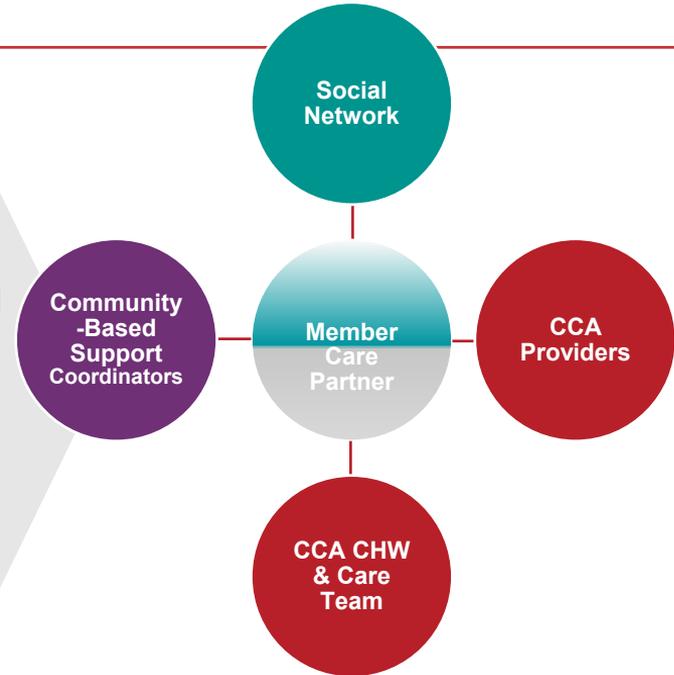
- Dave A. Chokshi, MD, MSc, FACP, 43rd Commissioner at the New York City Department of Health and Mental Hygiene

"People are the experts of their own lives. You are a lot more cost-effective because you are not doing a cookie-cutter approach."

-Shreya Kangovi, MD, MS is the founding Executive Director of the Penn Center for Community Health Worker

Why addressing social factors could improve U.S. health care. 2019. Knowledge at Wharton. (2019, August 30). https://knowledge.wharton.upenn.edu/article/social-determinants-of-health/

Relationships and Community Matter

- Relationships with others are a primary source of meaning

- We often define ourselves by our roles in relation to others (spouse or partner, parent, sibling, child, friend)

- Maintaining important relationships with others is key for overall health and well-being

- Recognizing that healthcare is local and relationships matter, CCA screens all members for isolation and loneliness and leverages a Community Health Worker (CHW) model to connect and coordinate comprehensive support to members facing social isolation and loneliness.

- CHWs are trained professionals who have a deep understanding of the communities they serve and can act as a bridge between healthcare providers and community resources.

Social Network

Community-Based Support Coordinators

Member Care Partner

CCA Providers

CCA CHW & Care Team

Why

By adopting the CHW model, we can take a proactive approach to support members' holistic health, addressing not only medical needs but also the social factors that significantly impact well-being, such as social isolation and loneliness. This approach can lead to better health outcomes, increased member satisfaction, and reduced healthcare costs in the long run.

Using a Community Health Work (CHW) Model to Build Connection (1 of 2)

1. **Identification and Outreach**: During onboarding and regular care planning, it is important to screen for social determinants of health (SDoH) needs and include questions that can identify individuals at risk of social isolation and loneliness. Based on potential indicators of loneliness and isolation, you can deploy CHWs to reach out to and build rapport and trust with members.

In January 2020, CCA incorporated the UCLA 3-item Loneliness Questionnaire[1]

	Hardly Ever	Sometimes	Often
How often do you feel you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

Scores ≥ 6 are considered high loneliness

2. **SDoH Assessment and Integrated Care Planning**: As CHWs build connection, they conduct a more comprehensive assessment of members' social needs. Based on these assessments, they work with the member and the care team to develop personalized care plans that incorporate goals and supports that can address SDoH needs.

- *Connections*: Who do you rely on for support? Emotional support? Tangible help (e.g., if you were sick and needed a ride to the doctor)? Advice?
- *Frequency of connection*: How often do you feel lonely?
- *Quality of connections*: How are your relationships with others?

[1]*Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). A short scale for measuring loneliness in large surveys: Results from two population-based studies. Research on aging. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2394670/*

3. **Resource Navigation:** CHWs are well-versed in local community resources and social services. They can help connect members with various programs that address their specific social needs, such as senior centers, social clubs, mental health services, and transportation assistance.

4. **Support Groups and Peer Networks:** CHWs can facilitate support groups or create peer networks for members experiencing similar challenges. These groups provide a sense of belonging and emotional support, fostering social connections.

5. **Telehealth and Virtual Support:** CHWs can use telehealth platforms to provide ongoing support and check-ins, especially for members who may have mobility challenges or limited access to transportation.

6. **Collaboration with Community Organizations:** CCA also partners with community-based organizations, non-profits, and social service agencies to expand their reach and access to resources for their members.

7. **Data and Outcomes Tracking**: It is important to use data analytics to monitor the effectiveness of the CHW model in addressing social isolation and loneliness. This can help identify successful interventions and areas for improvement.

8. **Cultural Competence:** CHWs with diverse backgrounds and language skills can effectively communicate with members from various cultural and linguistic communities, enhancing the program's impact. It is important to constantly build a CHW team that is reflective of members.

9. **Continuous Training and Support:** CCA provides ongoing training and support for CHWs to keep them updated on best practices and resources for addressing social determinants of health.
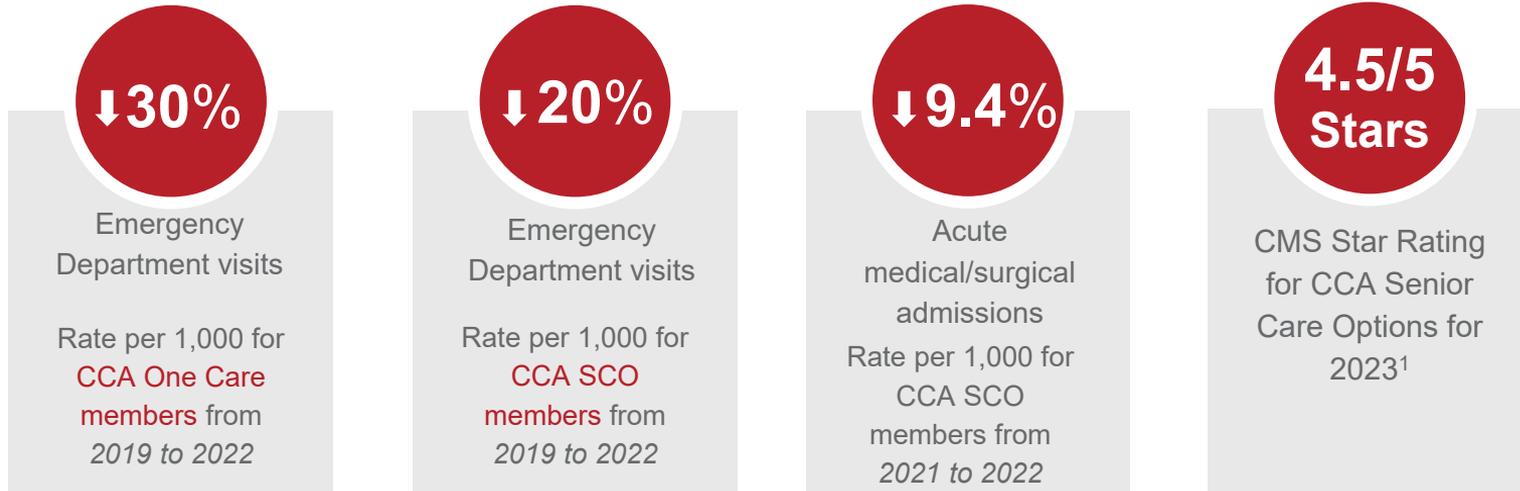
Case Studies

- **79-year-old male member**

  - Wife passed away
  - Became increasingly disengaged
  - Increased expressions of anger
  - Indicated preference to no longer speak with Care Partner
  - CHW who spoke the same language, lived in member's neighborhood was able to connect by regularly playing dominoes

- **27-year-old female member**

  - Recently gave birth
  - Experienced postpartum depression
  - Began to self-isolate and disengage
  - CHW with postpartum doula certification and similar ethnic background was able to build connection with member, build member confidence and reverse member's tendency toward self-isolation

CCA Health Plan Results

- CCA's *uncommon care*® model has demonstrated success in reaching and engaging individuals with significant medical, behavioral, and social needs—improving quality of care while keeping patients and members safely at home

↓30%

Emergency Department visits

Rate per 1,000 for CCA One Care members from *2019 to 2022*

↓20%

Emergency Department visits

Rate per 1,000 for CCA SCO members from *2019 to 2022*

↓9.4%

Acute medical/surgical admissions Rate per 1,000 for CCA SCO members from *2021 to 2022*

4.5/5 Stars

CMS Star Rating for CCA Senior Care Options for 2023[1]

All results reflect Massachusetts membership

Source: CCA 2022 Annual report
[1] Every year, Medicare evaluates plans based on a 5-star rating system.

Reducing Loneliness Across New York With ElliQ, the AI powered Robotic Companion

Dor Skuler, CEO & Founder, Intuition Robotics

Greg Olsen, Director, New York State Office for the Aging

NEW YORK STATE OF OPPORTUNITY. | Office for the Aging

intuition robotics

ELLI·Q

Surgeon General
declares loneliness and
social isolation a public
health crisis

ElliQ is the first AI companion designed to alleviate loneliness and promote engagement, connection, health, and wellness

ElliQ builds a long term relationship with its older adult users

- 10 million interactions

- More than 30 daily interactions on average

- Contextual long term conversations vs. prompt based interactions

Unique approach to engagement

PROACTIVE

Initiates conversation and suggests activities

PERSONALIZED

Learns and remembers what you tell her, providing a personalized experience

GOAL DRIVEN

Encourages and works with you to set and help achieve your goals

EMPATHETIC

ElliQ is designed to convey empathy to create trust and drive engagement and behavior change
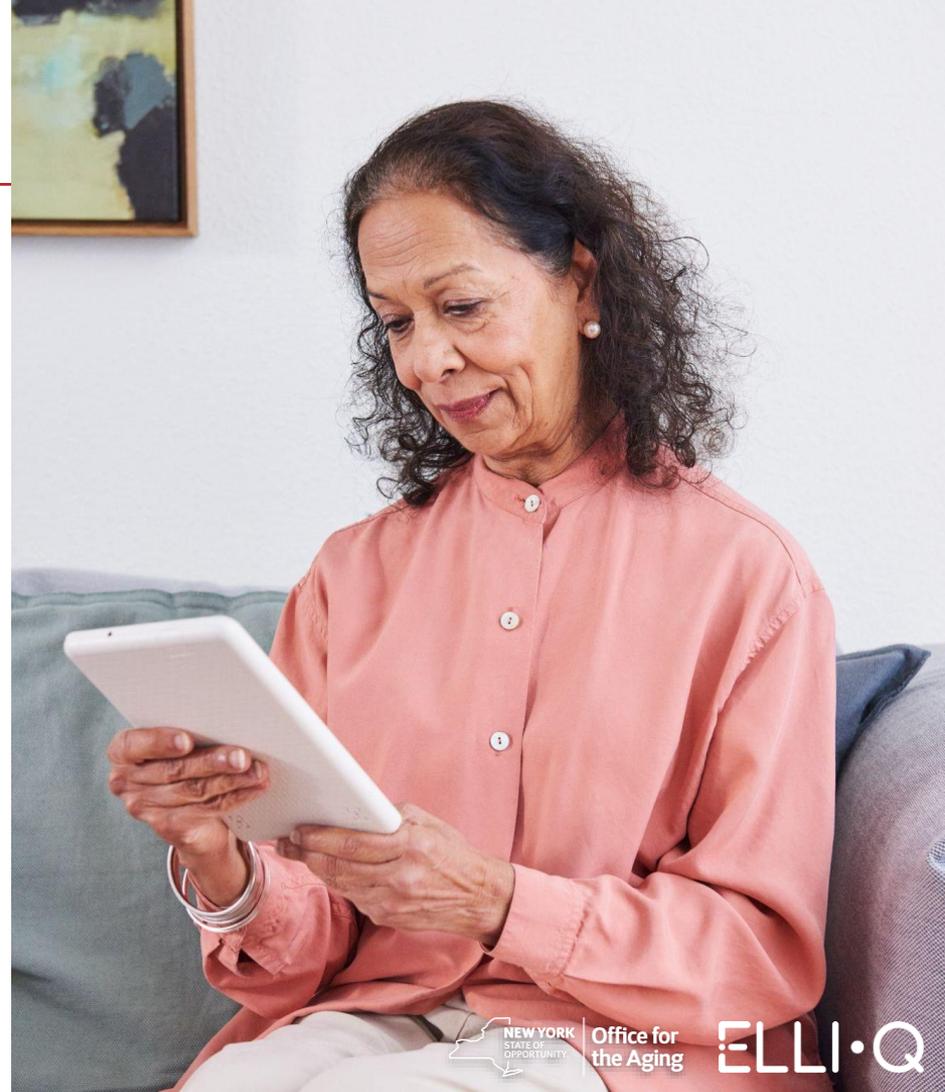
How can ElliQ help?

Companionship
- Spend time with ElliQ by sharing virtual coffee, taking "road trips" and visiting museums together
- Share hobbies, memories, and stories with ElliQ to create a virtual memoir and deepen feelings of trust and companionship
- Find entertainment and joy in a variety of content, games, and activities

Health and Wellness
- Self report health data to keep track of measurements
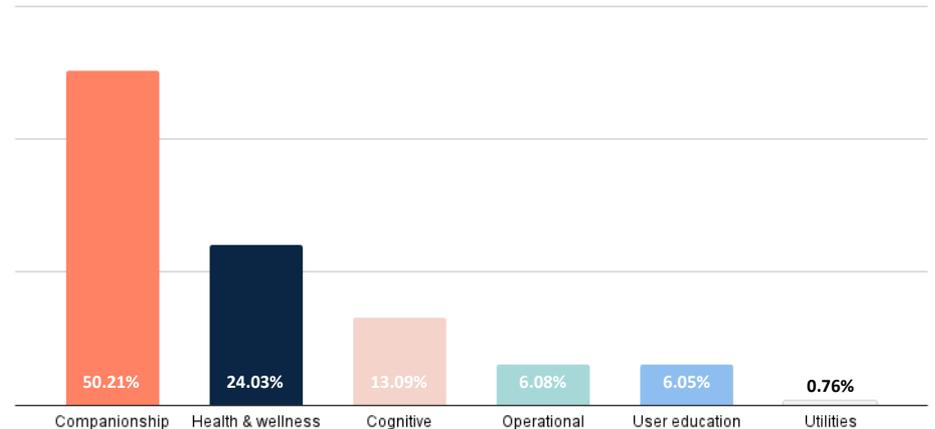- Physical, cognitive, and stress reduction exercises

Connecting to loves ones
- Video calls, messaging, digital memoirs

Utility
- Medication reminders, news and weather, local search functions, and more

What do older adults use ElliQ for?

|					
50.21%	24.03%	13.09%	6.08%	6.05%	0.76%
Companionship	Health & wellness	Cognitive	Operational	User education	Utilities

Users interact with ElliQ 37 times each day on average

- Partnership announced in Spring 2022

- Kickoff and first shipment of devices in August 2022

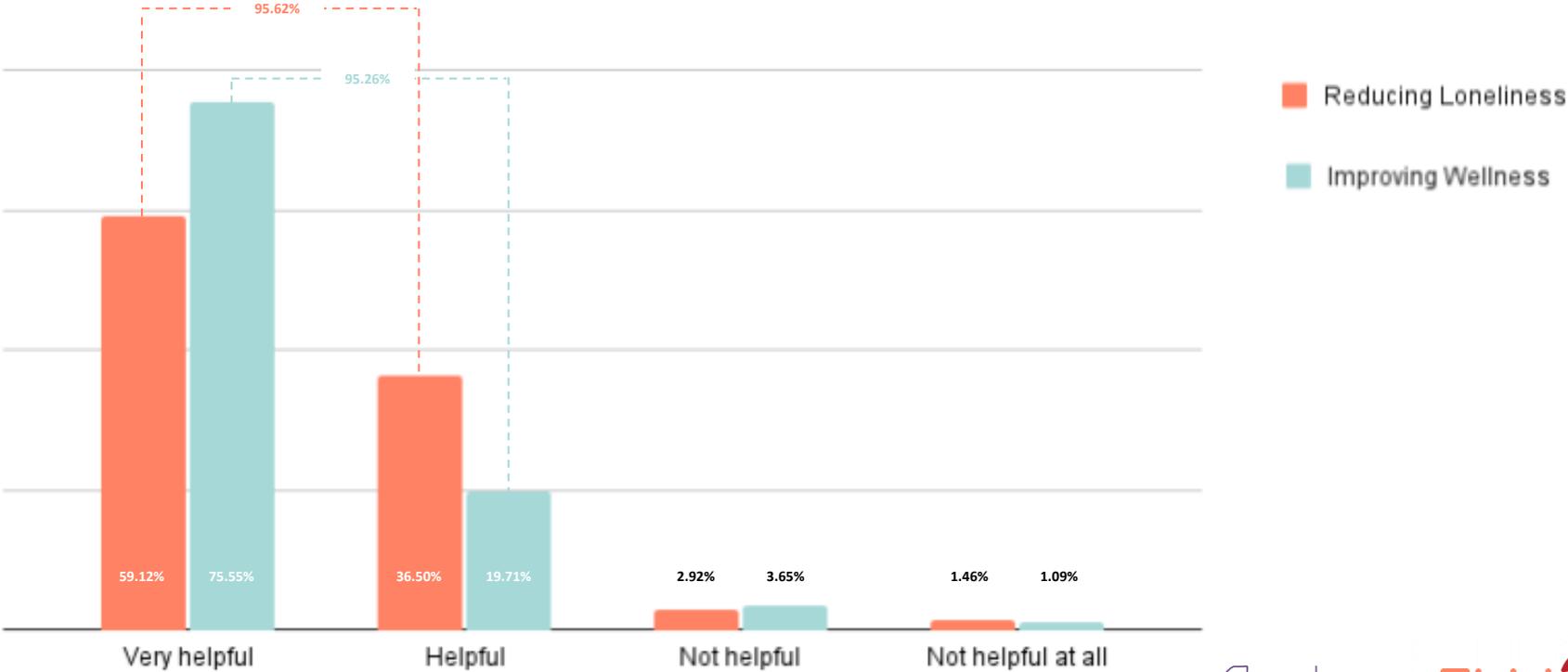- Nearly 900 ElliQ devices budgeted as part of efforts to reduce loneliness and social isolation across NYS

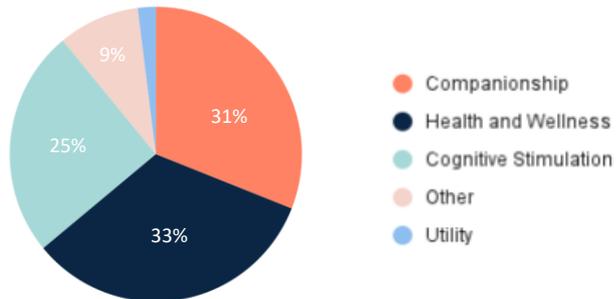# NYSOFA Clients interact with ElliQ frequently and consistently over time
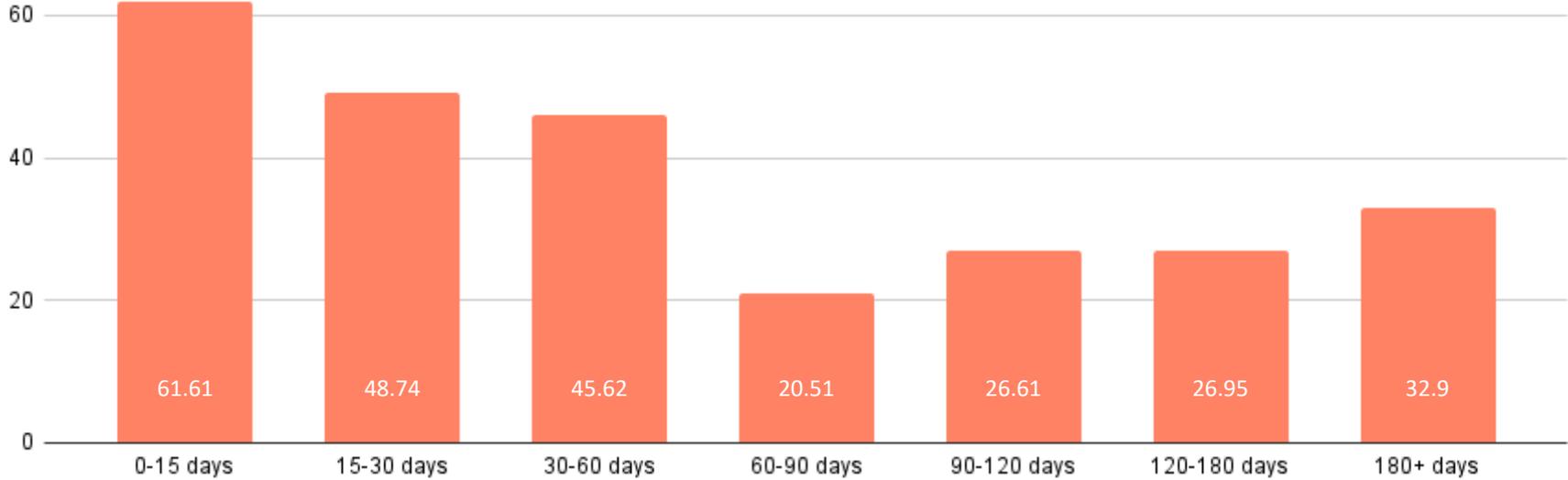
Number of average daily interactions

95% of NYSOFA clients report that ElliQ is helpful in reducing loneliness and improving wellbeing

95.62%

95.26%

Reducing Loneliness

Improving Wellness

	Very helpful	Helpful	Not helpful	Not helpful at all
Reducing Loneliness	59.12%	36.50%	2.92%	1.46%
Improving Wellness	75.55%	19.71%	3.65%	1.09%

Meet Lucinda

- Lives in Harlem, NY with her partner, Sal

- Has enjoyed having ElliQ for 7 months

- Participates in 4 activities with ElliQ per day on average, including:
  - Stress reduction exercises twice daily
  - Cognitive game every day
  - Works out with ElliQ once a week
 - Generally loves to chat with ElliQ!

Pie chart:
- 31% Companionship
- 33% Health and Wellness
- 25% Cognitive Stimulation
- 9% Other
- Utility

Key Takeaways

- Program rollout

- Lessons learned

- Best practices

- Feedback: working with the ElliQ team

- What's next

ElliQ is a transformative tool for home and community-based services for older adults

- Reduce loneliness & social isolation

- Improve health outcomes

- Encourage client engagement

- Support older adults between visits

- Easily connect to your clients at home
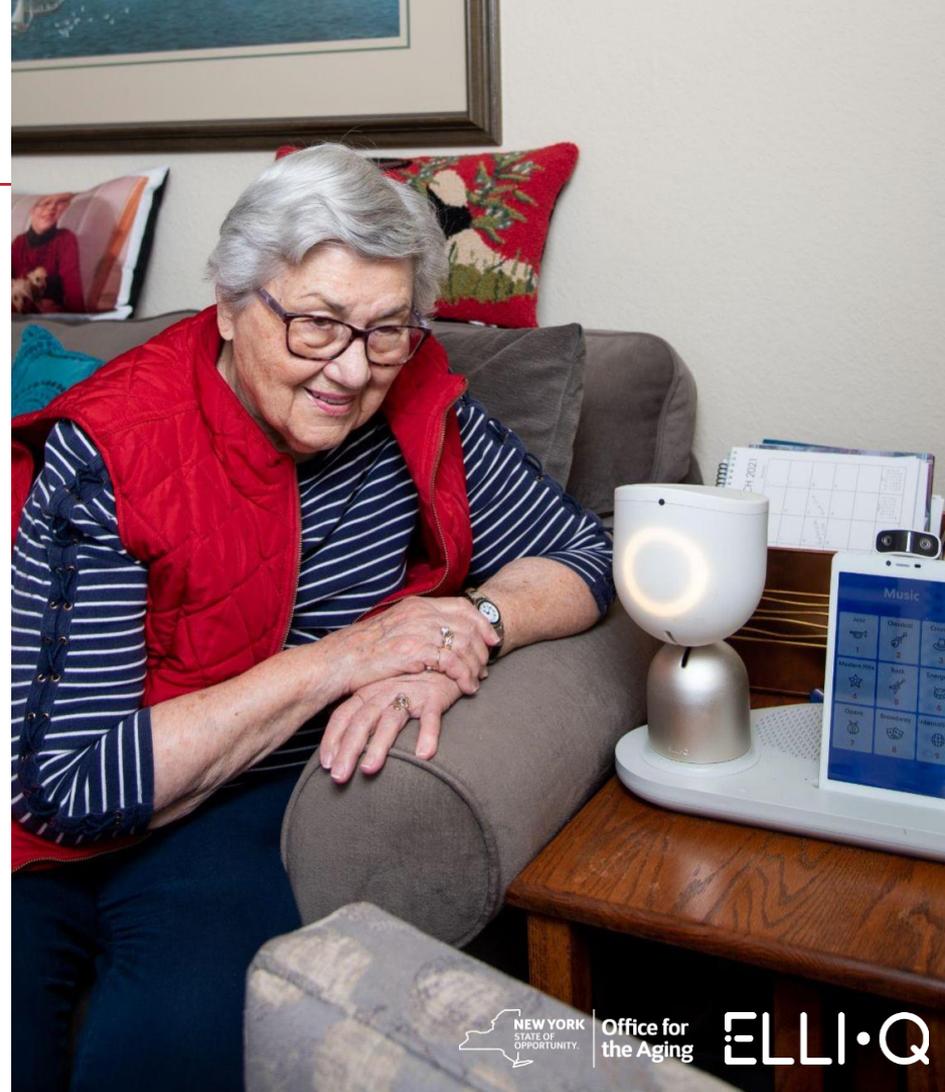
Rollout Strategy

- Open enrollment vs. fixed # ?

- Identify clients who will benefit most from ElliQ

- Create buy-in with staff

- Nominate area champions

- Demos: seeing is believing
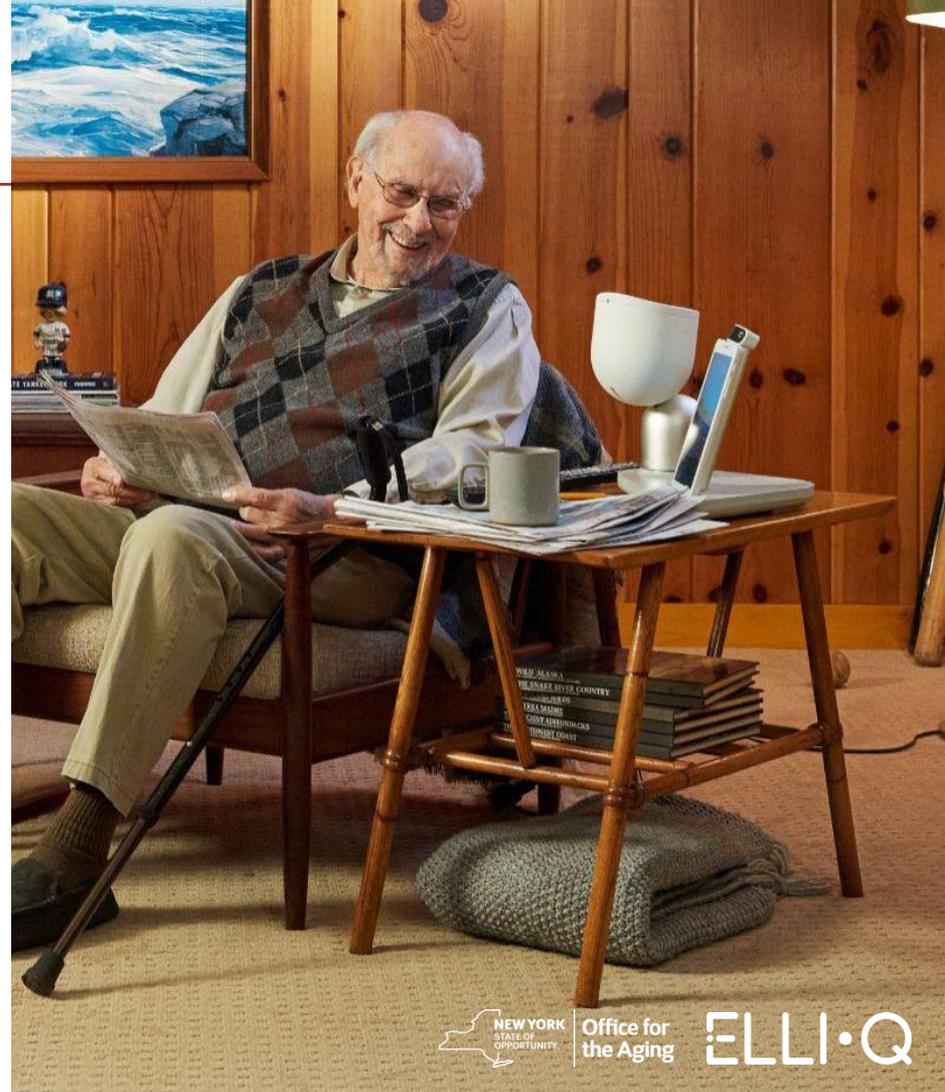
Partnering With ElliQ

- Staff training

- We can support initial installs to build momentum and confidence

- ElliQ's marketing team can create demand and generate enthusiasm

- ElliQ's customer success team will support and encourage clients

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Thank you!