**Social Isolation and Loneliness: Access and Detection Work Group**

**Meeting 6/22/22: Screening Pilot Group**

**Present: Angie Sullivan, Barb Michaels, Sally Flashberger, Christine See, Allison Butler, Megan Timm**

* Developing an orientation for the pilot sites. Likely will have two trainings an hour each. Recommending recording the session.
* Currently in the process of recruiting partners until early August.
* Proposed sites:
  + ADRC of Brown County
  + ADRC of Sheboygan County (CHW)
  + ADRC of Dunn County (CHW)
  + Bayfield
  + ADRC of Portage County
  + Washington County
  + Green County
  + Oneida
  + LDF
  + Milwaukee
  + Casa Alba Brown County
  + Living Well Pilot Sites (Sally)
* Exploring translating documents

**Meeting 4/26/22**

1. **Welcome and Introductions - Carleigh Olson (WCESIL Coordinator 😊)**
2. **Update on SIL Screening Tool pilot**
   1. The group has made progress and they are deciding what sample size they will want to use. They want a variety of settings for the pilot.
   2. They have taken time to zoom out and consider what they are trying to measure. They’ve decided that they are trying to understand how the tool incorporates into ADRCs and Aging Units.
   3. They’ve been considering the time window to do the pilot as well.
   4. They will be creating a 1 pager for those in the pilot so they can incorporate it into their resources.
   5. They are currently looking at the Aging Unit 3-year plans and have identified the ones who have named something related to social isolation and loneliness.
   6. Angie created a map to show were all the Aging Units/ADRCs are that are interested.
   7. Sheboygan and Brown Counties have already confirmed their interest in the pilot.
3. **Work Group Restructuring**
   1. Frequency and structure of meetings
      1. We don’t have any future meetings on the books. We have been meeting every three weeks.
      2. Many groups are moving to a working meeting format. Angie and Sara are proposing keeping meetings every three weeks or every month. The meeting will be 15 minutes together at the beginning and then moving into the sub-goal areas in breakout rooms for 30 min and then convene for the last 15 min to report out.
      3. The group has decided to move to the monthly cadence with the proposed format.
      4. The group will focus on a Tuesday at 9am call, likely the third or fourth of the month.
   2. Co-Chair discussion
      1. We are looking for a new co-chair. Angie will be shifting roles a bit. Sara will continue as co-chair.
      2. Sally will consider.
   3. Member expectations
   4. Sub-Committee designation
      1. Pilot Screening Tool
      2. SIL WI Resource Guide Updates/Website updates
      3. SIL Evaluation – Evidence-Based Health Promotion Programming
4. **WCSIL Website Review**
   1. The group reviewed the website and discussed how they will use it as a group.
5. Next Meeting?

**Meeting 3/15/2022**

1. **Welcome** 
   1. Introductions –
      1. Amy Zellman – intern w/ UW-Health at UW-Wisconsin
      2. Emma G – intern at UW-Health – working with Pam at GWAAR
2. **WCESIL and Other Work Group Updates** 
   1. Larger coalition meets every other week – workgroups report out and steering committee addresses any issues workgroups identify
   2. Carleigh starting this week – Angie & Sara plan to meet with her
   3. Coalition is growing really fast – lots of people want to be part of the workgroups
      1. Good problem but we want to make sure everyone is in the right place – Steering Committee needs to weigh in on a process for adding people and ideally Carleigh will be able to centralize and organize this onboarding process
      2. Lots of PH departments and hospitals have identified SI/L as strategies and are hearing about the coalition
      3. We’ll be talking a bit more about this
   4. Policy WG – finding it’s impossible to map out the entire landscape of organizations working on things related to SI/L policy. Currently putting together a white paper to draw attention to SI/L in the policy community
   5. Equity/Inclusion WG – pulling together first meeting date/time for this group. Sally Flaschberger representing from this workgroup.
   6. Awareness WG – really exciting; they’ll be launching the website next week; currently running the website through an accessibility screen to make sure everyone can see the site
   7. Measurement – having a guest speaker and also working on a graphic/image that will contextualize some of the risk factors for isolation and loneliness
   8. Reviewing website – not live yet but will go live next week. We’ll be able to change it as needed.
      1. All workgroup members will have access to both public and private parts of the website
      2. We’ll make sure everyone has the link and information to enter the internal site
   9. Reviewing one-pager – can use this for reference for outside conversations and groups
   10. Definitions, goals for each workgroup, and updates on current status
       1. Does mention we’ll be piloting the UCLA screening tool
       2. Comment about the one-pager – as far as our workgroup (third-to-last paragraph) recommending UCLA tool – once we start to circulate people might ask why we selected the UCLA tool. Would be helpful to explain why we chose this one. Great point – we did spend a lot of time reviewing the scales/screenings that are available. It would be great to show how we did that and show rationale.
3. **Evaluation SIL data (StrongBodies & AMP)**
   1. We’ve entered the UCLA questions into the two StrongBodies and AMP programs
      1. We know there aren’t many programs looking at SI/L, but these two programs are connecting people and we’ve added these questions.
      2. UW worked with evaluation specialist to develop these questions and evaluate the impact of WiseWisconsin program. Really started that program so that we could connect people around the state during COVID and Winter months.
         1. We’ve been adding these questions to many of our virtual programs
      3. We’ll continue to monitor and see data – can show that these two programs are proving to connect people (and to what extent they’re doing so).
      4. Questions have been vetted with evaluation specialist at UW-Extension
      5. If an Aging Unit or ADRC is implementing health promotion programs, they can apply these questions as well. A lot of Aging Units in their three-year plan indicated they want to do something around SI/L.
      6. Starting out small but hopefully will really be able to start collecting a lot of data. Brown County is doing this already – asking different questions but very similar to this tool. Great example.
      7. Questions in Brown are very similar – once data was collected it was surprising to see how programs were affecting the survey results. Really helping to have programs that are having a clear impact.
4. **UCLA Screening WI Nutrition Data**
   1. GWAAR does an annual satisfaction survey for home-delivered meal program
   2. Had over 5K responses to the latest survey (during COVID)
   3. Ask a few questions, including the three UCLA questions. Emma, Amy, Pam looked at data for GWAAR service area (not including Dane and Milwaukee).
   4. In the results about half of people report isolation/loneliness sometimes or often. Indication in home-delivered meals and carry-out is that rural areas report equal or lower frequency of SI/L compared to S/SE portion of the State. Next step is to look at why – what services are available in the area and how are people connecting?
      1. 70% of responses said the meal driver gave the person something to look forward to; 50% said it gave them someone to talk to (even with social distancing); 33% said it was an avenue to other programs and services
      2. Also took write-ins. Lots of personalized responses; sense of safety and security was very meaningful. Helpful to be able to ask the driver to do some basic tasks around the house and specific compliments to the drivers.
   5. There’s an opportunity for participants to give back to the community. We do have an avenue here to get resources and ideas out.
   6. Important for this group to know about that information and see what kind of data is collected and what outcomes it can have. Also highlights the importance of storytelling – we need to incorporate that into data collection too.
   7. How can our group assist Pam and other nutrition consultants?
      1. Maybe this group could put together a training for drivers – help raise awareness about social isolation and loneliness.
5. **Screening Pilot Work Group Progress**
   1. Quick overview – one of our strategies is to pilot the three-question UCLA tool
      1. Decided it would be cumbersome to move forward with the whole group
      2. Sounds like a simple strategy to do this, so the breakout group talked through this and had a good conversation. Discussed whether we’re trying to tackle screening, intervention, and evaluation? Would have to have all the interventions ready, but really what we’re trying to do is more simple right now. Simply see how the tool can be embedded in the Aging Units and ADRCs programs and whether they’re able to do it. % of Aging Units that use the tool; % of participants that agree to be surveyed; % of Aging Units that refer results and data up to use in developing programs. Really trying to see how Aging Units/ADRCs are able to use this.
      3. Want to make this as easy as possible rather than create a new process. Some will be self-administered or by interviewer – that might be an option/choice for Aging Units/ADRCs
         1. UW-Extension offered to use Qualtrics
         2. Once we work through questions we can look at Aging Units/ADRCs
         3. Don’t want them to see these as questions they need to add but instead as support and filling a gap they’ve identified
         4. Also need to consider what qualitative information we can get from open-ended questions. Do we need informed consent or to recruit a researcher to review information as we go along?
         5. One other important thing is that we’ll conduct a focus group with Aging Unit and ADRC staff to hear about how using the tool works.
         6. Dream is for all Aging units and ADRCs to use this but first just want to pilot with a few and see how it works. Dane and Milwaukee need to be incorporated too.
         7. Being sensitive to everyone’s time, hopefully this group will be able to meet every two weeks for 30 minutes.
6. **Future meeting logistics**
   1. Frequency of meetings
      1. Won’t start until May, but at that point we may take the overall group to once a month
   2. Inviting new members process
      1. Refer up to Steering Committee

**Meeting 2/22/2022**

* **Welcome**
  + Tori Lamar – Marshfield Clinic/Americorps
  + Reviewing agenda and plan for today’s meeting
* **Updates from WCESIL**
  + DHS hire for full-time position – Carleigh Olson, starts March 14
  + A new workgroup has been created to focus on equity/inclusion – Sally volunteered as the liaison from this group
    - Will invite Katherine Cullinan to this workgroup meeting later to present on next steps, ideas for how equity/inclusion workgroup will get involved
  + Policy workgroup has been focused on a goal of broadband and getting older adults connected. Initial thinking is that we want direct involvement in different groups, but there’s a huge quantity of groups active in each space.
  + Creating a one-pager about the work the Policy group is doing – would go on the website and give a summary of the workgroup
  + Measurement group – NorthLakes talking to the workgroup about their program. Speaking at the Measurement workgroup on March 24.
* **Evaluation of High-Level Evidence-Based Health Promotion Workshops around the state**
  + One of our agenda items was to add an SI&L question to a WIHA survey
  + The current question is “how often do you feel isolated from those around you?” Doesn’t tell us that much and doesn’t help us determine whether people feel more connected to others.
  + Sara: Early on UW worked on a number of initiatives to combat isolation and loneliness. Created a WiseWisconsin series – had 260 people register. Were doing a virtual program and there were people feeling isolated and lonely. Worked with evaluation specialist to come up with questions.
    - Intended to evaluate after people attended a session. By week 4 of the current cohort, 85% of people who attended have felt more connected and felt they had more tools to connect with others. Numbers were also very high last year.
    - Barb: Questions are very similar to what we’ve used in Brown County and similarities in responses as well.
    - Thought was to use this with aging mastery programs throughout the state. StrongBodies program is another option. Big sample size, things we can do without much effort. In our initial goals and objectives we had 3-5 aging units and ADRCs do this as well. A bit duplicative though because ADRCs are already doing the aging mastery and strong bodies programs. Maybe don’t focus on pushing this to ADRCs if we’re able to get a large sample size elsewhere.
    - Over 2,000 participants in StrongBodies statewide. Would be a large number of people evaluated.
    - AMP and Strong Bodies has plenty of people to get us a base to start with. Agree it would be clunky to ask ADRCs to do additional work independently. Once WIHA grant goes away could we adjust a bit?
      * What if we included the WIHA question at the beginning to find the type of classes, then after the class find the measurable increase. Setting a baseline and then measuring.
    - How many questions are on the UW evaluation tool? Were they added to other questions or are these independent? It’s a one-pager, not more than 20 questions.
    - Sally can also talk to WIBPDD staff to see if the questions could be added to their survey. Slightly smaller sample size but would be very interesting to see if programs are reaching the audience and the impact.
      * Great! Aging Mastery and StrongBodies are quite open to participation. Other programs (Stepping On) are more restrictive and do exclude people with disabilities to some extent.
      * We might miss the disability community by just focusing on ADRC and older adult services. This will really speak to older adults but there are ways Inclusa, BPDD, and others might be able to pilot different things
      * We’re really piloting a lot of this to see if it works in detection – it may not but then we’ll know.
      * Does UW-Ext survey ask demographic information? Yes, some.
    - Several of these programs are done across a broad area (population of focus), so we’re not just talking about aging units and ADRCs. We will catch some of the disability community with this. Middle-aged adults are a big focus for the UW-Ext programs.
    - What things are out there that we can be sharing? Lots of programs exist. People get very individualized services – they participate in community day services, may be working, etc. BPDD has been working on a lot of these issues (rights, neglect and abuse, etc.). BPDD can pilot some of these questions within it’s’ grant.
    - Where are other places that people are receiving training? Thinking through this might provide other places we can survey.
  + When we talk about evidence-based programs, when do we add other tools to get a wide range of answers? The idea was that we could add to WIHA, but that’s not the case. We won’t be able to do that for at least a few years.
  + Sara/Angie and Angie F can start doing this and looking at data – fairly simple to add to some of the surveys.
  + Will include in the notes a list of ADRCs and Aging Units that identified SI&L as priorities
* **Small Group Development to pilot UCLA tool**
  + We identified this as the tool to use
  + It will be a lot to examine and develop a strategy for using it.
  + We talked about doing a template for each county to use for local resources – we might need to create a small workgroup where we can work though this more quickly
  + Pam VanKampen has volunteered to be on that small group as well as Barb and Sally. **Let Angie know if you’re interested in participating.** Meeting just to get things going, then taper off after a while. Maybe pull in someone from the larger coalition too.
* **WCESIL Website – review**
  + Looking at draft website right now
    - [**https://wihealthyaging.org/wisconsin-coalition-to-end-social-isolation-loneliness**](https://wihealthyaging.org/wisconsin-coalition-to-end-social-isolation-loneliness)
  + Awareness group has been working on pulling this website together.
  + A password-protected section and a public section
  + Each workgroup has its own public section to post materials
  + Member section would have all co-chairs and steering committee listed – will need to build out parts of this.
  + What can go public?
    - Maybe some information about the UCLA tool could be made public? Final version of the questions we’re asking. WIHA is asking this question – other units are asking this – UCLA used here – we’re taking all of the data to do x.
    - Need a bigger disability focus – pictures, organizations that are mentioned
    - Another thing might be to make more clear what the access/detection pieces mean? Maybe use “Identifying and Connecting”?
    - Updating the isolation and loneliness guide? Maybe something Carleigh can take on?
    - Our goals and objectives can be public
  + What should stay private?
    - List of aging units/ADRCs that are working on SI&L would be helpful to add. Created a document when reviewed ADRC/Aging Unit plans? Yes, but could be better and could have more detail before sharing.
    - Meeting notes and other group files can go in this section
* **Action Items**
  + **Email Angie with comments on the website by March 1**
  + **Email Angie if you’re interested in being involved in the small group developing a template for counties to use the UCLA tool**
  + **Angie & Sara to update StrongBodies and Aging Mastery Program survey tools**
  + **Sally to review whether BPDD grant can incorporate survey questions**

**Meeting 2/1/2022**

* Welcome and Introductions (New Work Group Member)
  + Emily Dieringer, Marshfield Clinic – Center for Community health Advancement; Beaver Dam/Dodge County – working in policy and systems change, have experience in transportation and a lot in social connectedness space. Social connectedness was in Winnebago’s plan and Fox Valley was working with regional partners. Center serves entire Marshfield Clinic system and there are similar roles in other Marshfield hospitals. Dodge County is a bit unique re: blue zones w/ lots of social connection work. An effort is being made to try to connect isolation/loneliness work to MH; strategy is “promote protective factors that build a sense of belonging”. Don’t personally work with patients but possibly could connect us to those who do. From the Center standpoint, have a very specific BH strategy to improve social connectedness in rural communities. This year/next year really want to improve social connectedness in counties Marshfield serves. Hoping to help with this group; build those connections.
* Group Discussion on the Work Group Goal and Objectives Document
  + In Goal #2 it felt like Objective 1 and 2 were repetitive. Wondering if Obj 1 should be deleted or combined with #2.
    - Maybe Obj 2 is a strategy?
    - Seems appropriate to take one of those out. As we identify organizations and primary care providers the next step would be piloting
    - Many HC organizations are going full steam ahead on these surveys and data collections and screening tools – many have questions related to social connection and use of tools
      * Likely lots of questions about SDoH screening tools, etc.
      * That’s something we could find out in this group is what screening tools people are using already – what are they referring people to if someone screens positive
      * Section starting in WPHA looking at this specifically. Another connection we could make is to WPHA.
      * At least 5 or 6 systems using some kind of tech-based tool to screen folks. Their question won’t be what tool to use, maybe not how to use it, but will likely have questions about what to do after screening positive.
    - Just a wording thing too – maybe Goal #2 is finding information and building connections and Goal #3 is to increase access and push information
    - Would be unrealistic for this group to tell HC organizations what to do
      * So maybe we’re trying to find out what they are doing, then looking across organizations to find trends
      * HC organizations have anecdotal information about each other; WPHA has coordination role between HC organizations so that’s not likely a role for this group either
    - This group might have a role in advising on ‘now what’ after screening tool is used. HC organizations may not be as good at handing off to social service agency after using a screening tool
    - Maybe we say “Increase collaboration and coordination between primary care/health care providers with Community Based Organizations”.
  + Goal Statement at the top – says “sense of belonging” but we could say “sense of belonging and purpose”.
  + Under Goal #4 we know there are workshops happening and that they are making a difference. Want to collect data on programs across the state; be able to show a collection of impactful activities that are happening and results if possible
    - From a collective impact/shared measure standpoint our shared measure collecting programs could show what orgs are doing and measure – fixed this problem, moved this needle
  + Looking at Goal 4, Objective 2; it’s not clear who is going to do that or who is going to add those questions.
    - Program managers would be responsible for reporting up; can’t add anything to WIHA but local entities could adjust their evaluation form; UW, GWAAR have ability to change things
  + In the template, adding a column saying who is heading different things; make it clear who is taking on a specific task.
* Aging Unit 2022-2024 Aging Plan – SIL Goals
  + Went through all 72 counties that GWAAR oversees – created a summary document to see which counties are addressing this in their plan.
  + To receive OAA funds, every county in the state has to do a 3-yr aging unit plan. Have to write goals around services in OAA; nutrition, health promotion, local goals, etc.
  + Broke this down into where they put a social isolation goal. That helps indicate the county’s focus
    - Includes Caregiver, Community Engagement, Health Promotion, Local Prioity, Nutrition, Person-Centered Services, Racial Equity, Supportive Services, Transportation,
    - Nothing on people with disabilities?
      * There are some aging units that are integrated with ADRCs, which would indicate that disability services are covered.
      * Send to Tim to indicate which ones are integrated
      * One county that we know of has deployed a social isolation and loneliness survey during COVID-19
        + Started doing response programs immediately based on results
      * ARPA funding – each county also has an ARPA plan as does each city. Are we seeing counties devote funding towards this? Also seems like an area where people might be putting resources toward this.
  + Next time we’ll start to identify people to assign to various objectives.
  + Propose we move forward with recommending UCLA tools for aging units and ADRCs
    - Acknowledge capacity issues everywhere and ‘sell’ that the three question survey would be easier to implement
    - Adjusting the survey might lead to collecting different data – maybe the way to do it is to create a training for survey delivery (without changing the survey), or collecting data on how trainings were delivered (in person, paper survey, using tech, etc.) and how much explanation was provided to respondents.

**Meeting 1/11/2022**

* Updates from the Wisconsin Coalition to End Social Isolation and Loneliness
  1. New person joining our group! Emily Derringer (?) – community benefits coordinator for Marshfield Clinic. Marshfield has been implementing Blue Zone project – very interesting – correlates to isolation and loneliness. Marshfield has written a goal related to older adults and Emily felt it would be a really good fit to be part of this coalition. Has great ideas and will start attending in February.
  2. Website housed on WIHA website; timelines and calendar; starting a new DHS person with the Coalition
* Review and finalize goals and objectives
  1. Go through and see if there are any changes needed;
  2. Goal #6 – Health Equity; three objectives: 1) recruitment to add people “representative of population we aim to serve”; 2) all WG members attend/view health equity training; 3) conduct AMP in Spanish and collect screening tool data in Jefferson County.
     1. #1 seems really good – ideally the Equity/Inclusion advisory group will be able to assist with this.
     2. Maybe use Jefferson County as an example in #3? Not an exclusive focus on Jefferson County. Also maybe not just Spanish – maybe Hmong, ASL, and others?
     3. Lots of Aging Units doing health promotion – not always diverse representation, but some are.
     4. Whether it’s truly a social activity or not – maybe we encourage groups to integrate a screening tool rather than encourage specific activities.
     5. Other question – do we have culturally appropriate screening tools yet? Not sure if UCLA scale, for example, is appropriate for all groups.
     6. Maybe another objective would be to research screening tools that are meant for minority groups?
     7. Need to be careful with how much we do. We don’t have control over what local entities do so our role is more to provide education and examples for locals to implement. We could set up tracking to see the results of our work but can’t actually do direct work ourselves.
     8. Brown County example – doing an event specific to a minority population but not sure what screening tool they would use. This workgroup could support by highlighting a screening tool that would be culturally appropriate in different situations.
     9. Maybe as we recruit more people representative of population we aim to serve (obj. 1) we can ask what tools they’re using.
     10. Possible starting point: <https://journals.sagepub.com/doi/full/10.1177/10731911211034564>
  3. Want to make sure we’re considering situations where people may not want to speak out to say they’re isolated or lonely. Isolated or lonely people might be reluctant to do that.
* Develop a work plan for 2022 – what are the priorities?
  1. Pam – have some preliminary data but noticing that those who identify as isolated, lonely, left out (UCLA Scale) are typically <15% for population surveyed. Collected demographic/race data though most responses will be Caucasian.
     1. Will share data once it’s all in.
     2. Overwhelming response was that meals were something to look forward to for older adults.
  2. Goal #1 needs to be a major priority – next meeting we need to settle on which tools we’re going to use. Home-delivered meal program is already using UCLA scale – makes sense for aging units and ADRCs to be consistent with that.
  3. Goal #2 – likely this will unfold as our coalition grows. Marshfield clinic and other healthcare developing objectives and awareness about this is an example of how this will grow. Not an immediate priority.
  4. Goal #3 – Build out community resources – have guides (from Pam, Sally, and Sara) that we can look at quarterly and update, maybe as a group. New person at BADR could take the lead on this. As we all hear of new resources we could have a process for communicating and updating this. [Resource from GWAAR](https://gwaar.org/api/cms/viewFile/id/2006074).
     1. Ideally the new DHS person will be able to update some of the existing resources regularly. Will check with Steering Committee to see if that’s an option.
     2. Maybe an opportunity to share resources at grocery stores or other public places where minority or other groups might be more apt to visit, rather than just primary care where some people might not typically visit until they’re sick or isolation and loneliness are not the central purpose of the visit to PCP.
        1. Great point – one thing that might unfold over the next year or so is work with community partners.
  5. Angie going through County Aging plans to see if they have goals related to isolation and loneliness – so far quite a few have access/detection or goal related to isolation as related to nutrition. Lots of opportunities to engage with counties.
  6. Goal #5 – maybe someone from this group involves a conversation with WIHA about what pre- and post-surveys are expected to be delivered.
  7. Goal #6 is also a major priority in 2022
  8. Next meeting is 2/1 9-10 so we’ll get notes out and updated goals/objectives and any action items.

**Meeting 12-14-21**

* **Welcome to Cory!**
* **Coalition updates for equity/inclusion, resources, and website/file-sharing update**
* **Goal/Strategy Template**
  + Angie/Sara met to go over call discussion and thoughts shared around action steps based on google form
  + On the form we have goal statement and strategies, then action plans
    - Reviewing format – are we following the typical federal grant format?
  + Strategy 1 –
    - Sub-strategies around piloting the tool in Strategy 1
    - Thoughts or suggestions around these?
      * Replace “suffering” with “experiencing”
      * Loneliness and isolation for people with disabilities is really about health effects
      * Remove “health” and leave “effects of loneliness”.
      * “…that are experiencing health and safety effects of isolation and loneliness.”
    - Strategy 1(a) and 1(b)?
      * 1(b) – Living Well can definitely pilot this but may not do it with all partners.
      * Christine – need to see if ADRCs are willing, but would like to do this to capture people with disabilities.
      * Barb – maybe be more SMART goal frame for both of these? We talk about piloting but could we add “learnings and recommendations” and be more specific?
      * Could do a focus group after pilots – Living Well has done this and gets great feedback from focus groups. Is this working? How was it received/delivered? When building a guide this will be helpful to roll it out in a larger format.
      * Maybe focus group/feedback is a good action step for all three sub-strategies?
      * Provide learnings and recommendations off of 1(a)
      * Probably isn’t a question right now, but are we piloting one tool, or are those involved in pilot each picking their own tool?
        + Haven’t completely decided, but don’t want to spin wheels and keep looking at tools – ideally we would be able to adjust for each population.
        + It would be good to see if UCLA *gets* people with disabilities. Is that one enough or do we need something different?
        + Not wanting to changing things mid-way through
        + Piloting out in a few different populations would be very informative
        + Would it be helpful if 3-5 ADRCs tested this with adults with disabilities, would it make sense for different ADRCs to try different tools?
        + It could – depends on how many tools we want to try. Ideally not try too many at once.
      * Is there an opportunity to pilot with participants from Inclusa?
        + Ann – yes, definitely think so; something Inclusa could do.
        + Ok, add a generic description mentioning want – use “explore”
        + Maybe do a joint Living-Well and Inclusa pilot
      * Action Steps would go toward all strategies
      * Conduct focus groups for all four strategies
        + This would be a great outcome measure
      * Two other things identified as important –
        + Recognize primary care as important since almost everyone has one. Challenging as most PC resources are pulled toward COVID right now. This would be a long-term goal, don’t want to lose track of primary care.
        + The other piece is after we build out screening, then what? Want to make sure we identify tools to deploy at the post-detection stage. If the survey score is low don’t want to leave them.
        + Kaitlin shared in Awareness group LivingWell tool
        + Maybe these are more action steps than strategies? They might be separate, at least for the primary care one.
        + Barb – only have one of three health systems reporting right now; might be able to identify more that are using the tools. Are we building a template for community use? Same categories and processes are being used for mental health; local communities could plop in their resource. UW also drafted a model early in the pandemic for communities to localize.
        + The thing we’re creating is a plan – action plan they can put in place. Can give someone resources but do they know what to do with them? When we’re thinking about moving forward, do people know what to do next? Person might need more than just community resources. Who’s going to do that?
        + Agreed – that should maybe be a whole separate strategy. Person-centered plan with action steps.
        + Similar to evidence-based healthy ideas program. Working with an identified individual. Resistance in aging network because of staff/time limitations.
        + Will work on person-centered approach; making this a whole separate strategy. Pathways approach – could be an action step. Maybe Pam can help build out action steps. Will keep Primary Care under first strategy; build out community resources to be a separate strategy.
  + Strategy 2 –
    - Is there a guide already for SI&L? Yes, early on the Dane County AAA created one – Pam recently updated it. On GWAAR’s website and it has all sorts of resources for people. This group can take the guide and figure out a way to make it better. Will be great to have additional input. (<https://gwaar.org/api/cms/viewFile/id/2006074>).
    - Maybe highlighting some of the resources that are in the guide? Pull them out as a resource at various meetings? Maybe make it more of a living document?
    - Thinking about the communications side – maybe work with Awareness workgroup on this? Created some stuff and can continue to grow that as we go forward.
    - Need to target professionals for some of these – webinars and other resources can be shared out to state/local partners.
  + Strategy 3 –
    - Aging Mastery Programs – is there a similar program for people with disabilities?
    - Strategy 3 feels like a role CAARN and WIHA play in promoting evidence-based workshops. Action steps kind of feel duplicative of what the Aging Mastery Program already does.
    - With CAARN Angie is on Exec Committee and this group could add a strategy to have someone on that committee so we know what they’re doing. They primarily look at WIHA programming; they don’t always look at stuff developed/researched by WIHA.
    - Average timeline is 4 yrs for a program to be researched. What we found early on is that most evidence-based programming isn’t available for isolation and loneliness. Have to go through the whole process of control groups and research.
    - Adding it to Aging Mastery Program will give us the ability to see impact on WI. Know from Brown County that good information is coming in – how can we replicate that data in other parts of the state. How can we show that evidence-based health promotion helps?
    - [https://www.ncoa.org/article/what-is-the-aging-mastery-program](https://secure-web.cisco.com/13qc3FQMmHDOHcc3tWWO9JZLIbEmOLU4oleJicVRXFhxIXTjfYH3-DJGgOeDfcdv1PbiLl0ILFnTtF04Czv0nPW7kUXlC2RtWn_swEZ3C__KgIWKc0PATUkyrkFRwZtt3Pafcdw3UP6dnltaxCKwhlhlwYFOO-_mRfJn6fJfwW6MCewC4mJGdjhtxSgjW5NTgri3rtkdazhXw8srgpu9BxTcUZRYmsCHbUF)
    - Health promotion workshops – aging mastery is considered one of those. Not sure what parallel is in disability area. What would health promotion workshops be in disability community. Is there a list we’re thinking of?
    - Research WG realized early that there aren’t a lot of research-based programs. OAAs have $ that they have to use for some of this. We were looking at replicating existing programs but didn’t find much.
    - UW-Ex has tenured faculty that have to do research to keep faculty status. Do have one person interested in facilitating this – have opportunities to do work with some of these programs. Have ability to tap into some of these resources.
    - LivingWell is also going to pilot their toolkit – going to do that later in 2022. Did it with a COVID toolkit and it went well.
    - Adjust language to remove “Research” and replace with “Evaluation”.
    - How is Brown County using data they’re collecting?
      * Really drove aging plan goals to include isolation and loneliness. Still gathering data but it will impact strategies for aging goals.
      * Has it been helpful for Brown to do this? We want to find similar places that would do this program. Would it be helpful to have access to a larger pool of data?
      * People coming to classes were thought to be more connected but they aren’t. That piece was enlightening and is an example of a ‘lesson learned’ from data that could help others.
      * We would assume that people being assessed would be less lonely.
      * Pam: Identify the role that EB Programs play in addressing Social Isolation and Loneliness as the strategy. Evaluation could be one action step. ANother action step would be to identify barriers why people don't attend. The classes are a door or opportunity for socialization but we need to know why people do or do not enter thru this door and identify barriers for those that don't.
    - There aren’t programs known that have an impact – if we can prove impact that would be helpful for research, policy, and the rest of the coalition too.

**Meeting: 11-23-2021**

* **Welcome and Introductions**
  + Angie Sullivan, Sara Richie, Tim Wellens, Dan DeValve, Ann Sheahan, Deb Shepro, Sally Flaschberger, Martha Bechard, Barb Michaels, Christine See
* **Updates from WCESIL SC and Workgroups**
  + As a larger coalition decided to put together a status update document to give people a good idea of what’s happening.
  + Steering Committee
    - Reviewed populations of focus - working on targeted universalism approach (podcast from Sally [https://belonging.berkeley.edu/podcast-targeted-universalism-john-powell](https://www.ta-community.com/media/download/m2fhd4/Social_Connectedness_Screens_Matrix_Oct_2020_FINAL.pdf?url=https://belonging.berkeley.edu/podcast-targeted-universalism-john-powell&data=04|01|janet.zander@gwaar.org|4fba615a431042432e3408d9aded44d5|8e087664409d4c4ca6b47aa01020d6ea|0|0|637732056835803141|Unknown|TWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0=|3000&sdata=cgjdQkqxgsj4k2r1N22gKHd+WtEjgPNwlzC3X60CGKQ=&reserved=0)
    - Also discussed inclusion and equity
    - Coalition progress – are we moving forward discussion; yes and no was our answer – lots of logistical things in the first year but working groups just now getting objectives and strategies down.
  + Awareness WG – looking at strategies for generating awareness and some media connections. Looking at dividing into multiple workgroups too. Governor’s Proclamation – Kris working on that. Options for awareness – in process and making sure messaging is appropriate.
  + Research WG – shifting to focus on measurement rather than interventions. Intervention conversation shifting to the Access/Detection group.
  + Policy WG – they’re at the stage where they’re looking at strategies under a specific objective. One thing to add – really need assessment of people’s needs when it comes to tech. People might need some type of assessment to see where they’re at when it comes to technology – wanted to see what this group is able to do when it comes to identifying what an assessment would look like.
* **Discussion on Screening Tools from the last meeting**
  + Learned that GWAAR added UCLA tool to nutrition screenings
    - Reached out to their team to see how they decided on UCLA tool and what results looked like.
    - Email – said they didn’t put as much effort into it as this group but because it was a validated tool and had potential to do larger surveys they went with it. Just in the process of collecting the data right now. Wasn’t a big long process but they wanted to choose a validated tool.
    - Now that they’re collecting data they’re getting really good data. Case study from NH where they used UCLA on nutrition screening. If someone had 6 or over on scoring then they received further resources for loneliness. Used full 20-Question UCLA tool?
    - WI nutrition isn’t using the full 20-Q tool. Didn’t do a lot of research (Angie to share ppt). Used it on annual anonymous customer satisfaction survey. First time using it so it was a goo
    - +d tool to start with. Analyzing data now, more to come on results.
    - Very specific population they’re using it with.
  + NH used it as a screening tool.
  + Strategy: *Identify screening/detection tool(s) that can be used to assess prevalence of isolation and/or loneliness in specific service delivery programs or communities.*
  + *Collect data on results of tools findings around detection of isolation and loneliness*
  + *Recommend use of specific tools in specific situations or circumstances (toolkit, presentation)*
  + Setting strategies for ourselves and collecting data, once we find tools we can access.
  + Goal for today – select one tool to pilot and discuss next steps.
    - Will probably have to select two tools for different audiences. Will have to look into two different tools. RN want to discuss UCLA tool and USIRS and EPIC screening tool. Those are the three tools we selected out of the six that were discussed at the last meeting.
      * UCLA loneliness scale is attractive because it is being used by some programs around the state right now.
      * Sally – from my perspective it’s going to be how the people who are asking questions educated on the tool. Thinking about people with disabilities, explaining the three UCLA questions is important. Would need to create a guide.
        + Getting people to change their systems isn’t a very good use of time – EPIC won’t change what they’re doing, for example.
        + Not as concerned with selecting just one – more about communicating what we’re looking for and letting folks know what we’d like to see.
        + Really like the idea of having a guide to use tools
      * Might be good to identify people who *aren’t* using a tool and identifying a place we could try it and see if it’s working.
      * Thinking about connectedness too, but holding off until a tool is identified.
      * Could pilot it through the Living Well grant. Could probably add it to annual data collection efforts.
    - If anyone has a contact with EPIC to find out what questions they’re using that would be helpful. If there is any information about how they did their tool and what research they used it would be helpful.
      * Link to the EPIC tool with the last set of notes
      * Not sure if there’s background on this yet.
  + Lots of ideas and tools floating around that we can utilize – maybe transition to discussing action steps.
    - Three to five action steps we can do over the next year. Many ideas shared using Forms – what can we get a start on and do moving forward? Having some projects and getting traction is helpful!
    - ADRCs record instances when customers are identified as loneliness. This group could create materials to help identify appropriate tools.
      * Pam updated Dane county tool/guide to build capacity. UW-Extension also created a tool. Had more of a build-your-own tool for people to localize. Allows people to adjust it. Something we could have on our website.
      * Asked Brown County information and assistance ADRC staff about this – they said there’s a step before this: they need training, know how to record it, need to know what to do with response. Won’t do a screening without this piece. Need to be trained before they can do things like this.
      * Christine – ADRC Program Manager – I’d do training and information. Notified them last month that this information is being added and more info would be coming about all of this. Information will definitely be in Christine’s plan.
    - Another idea is to create a WI Innovations Hub – collect best practice case studies and produce an informational document. Rural ADRC or org could find out what others in WI are doing and emulate.
      * For those who are local units/ADRCs, would this be helpful? Don’t want to create something that wouldn’t be used.
      * Some ADRCs would use this, some won’t as much. Information is helpful but need to engage in conversations to communicate the benefits of this. Strategy for aging units (at GWAAR) to include this in meetings, promoting tools, etc.
    - Also goes to idea of creating ‘monthly office hours’ – could have a regular time to talk about screening or a resource guide.
    - Connecting indigenous health officers to tools.
      * Stuff we could do pretty easily to get word out and build the program.
    - Surveys – media blitz to provide information to people, neighbors, etc. Not just identifying older adults, persons with disabilities but also caregivers and supports. Paper distribution, mailers, etc. Would need support from the Awareness WG.
      * School of Nursing has elder tree app – connects older adults with chronic conditions with each other. Another app for caregivers but that’s something different. We should invite someone from CARES (at UW School of Nursing).
      * Neighborhood app – help people connect to help each other.
    - Work on training for sites – with FRIENDS model about building social connectedness and building full lives. Being used around the states for persons with disabilities and service providers. Had a conversation about model – works for anyone bc it’s about a person’s strengths and what they enjoy doing and then building a community around that.
      * Resources are good but we have a select group of people who need that next step. Strength-based, interest-based. Help people build community around that.
  + Have identified some tools we can build on. Home-delivered meals, Living Well grant, other pilots we can use? Need to determine how we do this, action or strategy. ADRC/Aging pilot? Barb measuring already using tool they’ve identified.
    - * We can add questions to evals for evidence-based programs.
      * There are a lot of people who feel isolated who are taking classes, have identified program opportunities for themselves.
      * Build on some things that are already happening across the state. Bolster what’s happening.
      * Anne-thinking of UCLA tool – getting nursing interns all the time and looking for projects for them to do. Looking at who we’re identifying at Inclusa who falls into that scale. Nursing students could help by following up.
      * Members of Inclusa who might be in the same building – looking at how to connect them too.
    - A lot depends on who is asking questions – seniors would definitely benefit. Trainings and having a way to educate and having consistency and fidelity with the tool. Inviting people to answer questions.
* **Action Steps/Strategies and Opportunities for Screening**
  + From a logistical standpoint it would be helpful to have goal/objective/strategies and then activities under that. Would be helpful to have that visual to focus on what we want to do.
    - Have that in a template already – just have action steps/strategies blank right now. Have been working on a lot of these but don’t have them in writing yet. Have a lot of things, just now pulling them together.
  + Would this workgroup collaborate with other workgroups to support webinars to inform the state? Could we do that to raise awareness around the state to communicate?
    - Yes, something we need to put on their radar. Lots of education needed so having a consistent way to do that is crucial. WPHA conversation in Dec. and trying to get more members from public health to join.

* **Identify Next Steps**
  + Looking forward to putting it together in action plan
  + Sara/Angie to meet, condense strategies and action steps, send it out to the group for feedback, by Dec. 14 strategically focus.
  + Moving to Zoom so we can use blackboard tool for productivity.

**Meeting: 11-2-21 Notes**

* **Welcome and Introductions** (Angie & Sara)
  + Angie Sullivan, Sara Richie, Barb Michaels, Ann Sheahan, Stephanie Birmingham, Deb Shepro, Alyssa Marie Sanford, Tim Wellens
* **Updates from WCESIL Mtg. on 11-1-21** (Angie & Sara)
  + Policy workgroup – looking at goals from California Aging Mastery Plan, looked at goals broadband issue for rural partners, dementia-friendly model, multigenerational volunteer opportunities, sustain issues for prevention
    - Policy is driven by funding, so we need the funding in order to have the policy exist
  + Research workgroup – is there to help support the other workgroups, finding successful interventions after access and detection is complete, looking at population-level evaluation
* **Discussion on Screening Tools from Last Meeting**  (Sara & All)
  + Social Connections Epic Screening Tool (Barb)
    - Epic Foundations – questionnaire/survey to help understand social determinants of health and social connections
      * About 40% of their patients are filling this out during their annual physical and Medicare wellness visits
      * Barriers to not filling it out = length of the questionnaire; some refuse to answer because it’s too personal
  + Link to notes on screening tools: <https://docs.google.com/document/d/1SJFlUkYkIRRS-81cp7gxjeV5DMALrF2dcn8uDlor-j4/edit?usp=sharingb>
  + Discussion on strengths and limitations of each screening tool (<https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf>)
    - UCLA Loneliness Scale:
      * Strengths: Already being used for aging units; pilot with Nutrition program; questions can be added to this; good tool for population measurement
      * Limitations: Is it measuring what we want it to?
        + Not a way to start conversation for people hesitant to talk about SI&L
        + Need for training in health literacy and motivational interviewing
        + Not a good scale for individual measuring, if anonymous
    - De Jong Gierveld Loneliness Scale:
      * Strengths:
      * Limitations:
    - U-SIRS <https://www.u-sirs.com/>
      * Angie will do some research into the shortened version of this tool
    - Campaign to End Loneliness Tool
    - Single-Item Question
  + Should we focus on the tools that are already being used (UCLA Loneliness Scale and Epic)?
    - Are we overthinking all of this?
* **Full-time WCESIL Position is Now Posted**
  + Human Services Program Coordinator position housed within DPH/BADR
  + People can apply through the end of November
* **Action Steps/Strategies & Opportunities for Screening** (Angie & All)
  + Review of notes and ideas that workgroup members responded to using the Microsoft form [https://forms.office.com/Pages/ResponsePage.aspx?id=DQSIkWdsW0yxEjajBLZtrQAAAAAAAAAAAAEcKEmtUrdUMkExOU9NWVI5RkNGSkVSRDJaNE9aOEtLUS4u](https://secure-web.cisco.com/13qc3FQMmHDOHcc3tWWO9JZLIbEmOLU4oleJicVRXFhxIXTjfYH3-DJGgOeDfcdv1PbiLl0ILFnTtF04Czv0nPW7kUXlC2RtWn_swEZ3C__KgIWKc0PATUkyrkFRwZtt3Pafcdw3UP6dnltaxCKwhlhlwYFOO-_mRfJn6fJfwW6MCewC4mJGdjhtxSgjW5NTgri3rtkdazhXw8srgpu9BxTcUZRYmsCHbUFhpkBv6Gy42tU_9xNVwHCNTUhlYZ8DuUd2YtsnXYJndX53g6dc8n-uK9qgT4qA2Mdg53vnW1k5cH4H1L3a65LeNECzeubN4xuUzbtNYKczjNwDq0VcOKg/https%3A%2F%2Fforms.office.com%2FPages%2FResponsePage.aspx%3Fid%3DDQSIkWdsW0yxEjajBLZtrQAAAAAAAAAAAAEcKEmtUrdUMkExOU9NWVI5RkNGSkVSRDJaNE9aOEtLUS4u)
    - Please list any action steps/strategies that will help us accomplish our goal.  For reference here is our working goal: **Detect all adults who are at risk of health and safety concerns due to the effects of social isolation and loneliness.  The group will provide connection and resources to create meaningful, authentic engagement opportunities to create a sense of purpose and belonging.**
    - Where are opportunities to detect social isolation and loneliness?
* **Identify Next Steps** (All)
  + **Next Meeting:** Tuesday, November 23, 9a-10a

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**Meeting: 10-21-21 Notes**

* Welcome & Introductions for New Members
  + Tim Wellens (DHS)
  + Alyssa Sanford (UW-Madison)
  + Ann Sheahan (Inclusa)
  + Review of group rules
  + Review of agenda and plans for this meeting
* Coalition Updates
  + Review Definitions
    - Definitions for isolation, loneliness, and social connection
    - Wanted to keep these relatively simple as core definitions
      * We can add more in-depth and workgroup-specific strategies under these definitions
      * Lots of discussion went into these but that’s what we have right now.
    - Reaction?
      * Suggestion would be to not use both ‘social contact’ *and* social connection. What is the definition of social contact? Or definition of social connection? Maybe doesn’t align well?
      * Sara: could we say “infrequent social connections” in the definition of social isolation?
      * Angie: very valid comment
      * Sara: definition of social connection could be simplified a lot and then maybe expanded on by each group?
      * Barb: Feels like the first two are more definition-related but the one for social connection is not a definition. First sentence of the social connection seems to be more of a definition.
      * **Decision:** we’ll take this back to the steering committee for final discussion.
  + Website
    - On DHS site, under development right now and will be transferable to a non-state site at some point
  + Equity Tool
    - Under development by DHS
  + DHS Staff Position
    - Soon to be posted; will take on many of the project management responsibilities and coordinate with potential WIHA person
* Review workgroup goal:
  + Sally: One thing that keeps getting dropped is safety – steering committee talked about this a lot – policy team is talking about that a lot
  + **Action Item:** Angie to put in a note to add safety, adjust duplicative language in workgroup objective
* Review Screening Tools --[https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf](https://secure-web.cisco.com/1-1YDC_g8OcjKvie2GcrTM1Hw7QKz2lTQDbUByEfRSy21GdWdJ08uUCxA23kLr_H08sWoeiSpYAvtDRnzcW6y-zTeVH7Yp-swjmxU0WEzRS3GgCFCc4yXSp0nkZoQr_iomSGOAcrpUwubzr2MfM5BYaN74HcOx2YKmqBWiG4Ae64EwqlaRv8LSZAfKBxHnvEVpkp9ehTj4rcsP0OkWSa_ako_OR79OxhphRL6QlEueb2_2MBgpwIdgrBXNCLDmtJ3s441uYDeQwwJ3dzlWzS_nhh-MEwBzGN1cUuuU0SLur6lPN0m-1lD3PffV8Xf5r-W/https%3A%2F%2Fwww.campaigntoendloneliness.org%2Fwp-content%2Fuploads%2FLoneliness-Measurement-Guidance1.pdf)
  + **UCLA Loneliness Scale (Barb Michaels)**
    - Advantage is that it’s short
    - Negatively phrased but very quick to use.
    - Need to be mindful of whether we’re surveying people too much.
    - From personal experience – when collected generically we get 100% filling it out but when connected to identity some people do feel it’s too personal.
    - Angie: from research it seems like this is the most widely used assessment tool
    - Barb: We are using it with some classes
    - Pam: Also use it with meal survey – anonymous and just using it for baseline.
    - According to Dr. Jane Mahoney – common theme is that this is used widely.
    - Barb: Timeslips program has used UCLA scoring
    - Term companionship doesn’t seem like a word that would make much sense to a younger adult with disabilities
      * Caution against utilization of this assessment – not a huge fan of this one. Questions are leading and wording not defined really well. Almost too generic when thinking about younger folks with disabilities.
      * Sara: Great feedback! It’s very vague
      * Sally: Definitely agree – this one may not be good, particularly for people with disabilities.
    - Angie: Mentions it is for ages 58+
      * Barb: It was originally developed with students though. Maybe students didn’t include disabilities as a consideration?
    - So what is the full UCLA scale? 20 questions in the full scale and the three questions make more sense in context.
  + **The De Jong Gierveld Loneliness Scale (Barb)** 
    - Six questions
    - Teases out different types of loneliness
    - Doesn’t scream out negativity because of mixture of questions
    - You can’t see a pattern of responses which forces people to read each question.
    - Length is a negative – personal experience is that this test takes quite a bit longer to answer because of how the response is recorded.
    - A positive is when researchers are using other quality of life data this seems to fit in well.
    - Tested with both younger and older adults and can be used in either setting
  + **USIRS (Pam V.)** [**https://www.u-sirs.com/**](https://www.u-sirs.com/)
    - Developed in MD by Matthew Smith
    - Conservative approach to capture multiple levels of risk
    - 13 questions – length is a negative; maybe a follow-up to a shorter screen
    - Also tested only with adults age 60+
    - Lots of the questions are similar to the other scales but break down some of the questions into more detail
    - In MD have a scoring system that results in high- medium- or low-risk. Comes out with individualized print-out and generates recommendations.
    - Not sure about the cost of this – we’d have to build out customized referrals for counties and tribes down to a very local level.
    - Results found that most people were medium- or high-risk.
    - Person-centered plan of care is a really good feature.
    - But our group is looking at the access/detection piece. Is there another group focused on next step after access/detection? Maybe developing something like this could be a recommendation or area for workgroup collaboration.
    - So when does someone get referred to this assessment? After detection? Not sure but testing of the tool was the first step - not triggered by detection or any preliminary tests.
    - Seems like there are abbreviated versions but not clear if the shorter one is a validated tool.
    - Really like the trigger to interventions – in MD if they were high-risk they automatically went to PEARLS program
    - Marty: Even though it’s longer the person may feel like we want to help them at the point of asking questions
    - Sara: The challenge I see with the U-SIRS is localizing the resources and potential cost of building the database for Wisconsin, updates, etc.
  + **The Campaign to End Loneliness Measurement Tool (Angie)**
    - Short evaluation tool – three questions
    - Has a scale to interpret the results; scoring mechanism
    - Gives an idea of where they are on the continuum
    - Main purpose is to measure impact of a program
    - Does have positive language – so people might be more apt to answer
    - Short and has undergone academic tests to make sure it’s reliable
    - Best used face-to-face; not a screening tool to establish eligibility for various programs
  + **National Core Indicators (Sally)**
    - National level
    - In-person interviews so no recent data after 2019
    - Significant number of questions in various domains.
    - It is voluntary (only 900 people interviewed in WI last time)
      * People who complete it are people who are engaged and want to answer questions, not necessarily people who might be most at-risk.
    - Does ask some granular questions to see if people are using community resources, or have connection to friends/family
    - Disability community might interpret things differently – difficult to make determination of what community engagement even means. Might result in lots of yes answers - for example, someone might go into community through day services – not necessarily where they want to go or who they want to go with.
    - Is there a different way to do this? Three questions (other surveys) might not be enough or go into enough detail about people’s lives and connectedness.
    - No questions in the functional screen that fit this criteria.
    - It’s very medical and about daily living skills
    - When examining all of these options it’s very important to have a system to be able to do something with survey results.
    - The other things about core indicators is that they can add 10 questions in every state every year. There is an opportunity to do a little more work to add more questions. Also think about how we can get more people involved.
  + **Single-item Questions (Angie)**
    - Obvious advantage is that this is just one question.
    - Gets right to the heart of the issue. Are you lonely?
    - Limitation is that this asks a question that is time-limited. People can interpret this in different ways.
* Next step is to discuss what to do after detection/access
  + We can advocate for ADRCs to add questions to their surveys. Brown County has already done some of this.
  + Inclusa has done a depression screening (Ann to talk more about that on the next call)
    - Question for Inclusa - Do you use a modified version of the Beck Depression Inventory?
    - Wondering if you use PHQ-9 depression scale?
      * We use the PHQ-9, yes
  + Where is the biggest value/impact possibility? Maybe as simple as adding question to foodshare survey.
  + Barb: I can forward to you Angie (for team) the scale used within Epic on "social connections" ....6 questions as part of Social determinants of health questions, and can we learn statewide how many health systems are already using this scale that have Epic
  + Stephanie: I wonder if it would be possible to include some questions on the general application for Medicaid? I'm trying to think where we might be able to capture a larger audience.
  + **Action Item:** we’ll have to focus on this at the next meeting on Nov. 2
* **Action Item:** Angie will create a forms option for people to share ideas and potential action items
* Also think about idea for communities – when should individuals or family members decide to intervene

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**Meeting: 9-20-21 Notes**

1. Welcome and Introductions - - Angie Sullivan
   1. New introductions
      1. Christine See (BADR) ADRC specialist program manager. Work directly with ADRCs, hopefully will be able to learn and share and help ADRCs understand SIL and what they can do – excited to be part of this group.
      2. Clara – dietetic intern (with Pam) with UW Health – excited to listen in and join.
      3. Intros from others in the group who have been here before.
2. Updates for the larger Coalition - - Angie Sullivan
   1. Review agenda for today
   2. Review of larger coalition updates
      1. All workgroups are starting to meet
      2. Some overlap between this group and others – especially Research, which is diving into interventions. Not necessarily a bad thing to have some overlap. We’ll keep communicating through steering committee and occasionally having people attend both WGs.
      3. Discussed a joint format for measurement/goals/objectives.
      4. Shortened engagement survey
      5. Job description set for project coordinator; going to group meetings, taking on backbone role – will be great to have a person for this.
      6. DHS creating a website so we’ll have a landing page to refer people to.
      7. Definitions of SIL – interesting that other groups were talking about the same thing. We’ll finalize what our thoughts are and then we’ll submit it to the larger group and other workgroups so that we’re working off the same definition.
3. Definitions & Work Group Goals Discussion – All
   1. Review Definitions
      1. Are these for internal and public use? May want to consider one in more plain language to share with the public. Yes, let’s create a version that works for public.
      2. Level of social integration – what does that mean. Might not be quite as relevant to older populations – are we sure people have any meaningful work and volunteer opportunities?
      3. Loneliness
         1. Important to note the feeling of distress as a result of loneliness.
         2. Pretty common in definitions – common perception of loneliness is that it’s a lack of relationships but that’s not necessarily the case.
         3. Negative feelings – should that be part of the definition? Talking about feelings of distress might not be good to include.
         4. “Perceived” is a tricky word – you’re just perceiving it that way… “Subjective experience” is more neutral.
            1. When we look at interventions ok, but then at some point it can become more of a mental health issue where we need additional resources.
         5. Use of “enough” focuses on the number of connections, not the depth of connections.
         6. Will replace first sentence with highlighted portion.
         7. What if we say “loneliness can be defined as the subjective experience of distress over not having the quantity or quality of social relationships that an individual desires or expects for themselves”. That would help address both quantity and quality of relationships.
         8. Will change to “subjective experience of distress over not having [quantity/quality] of relationships that an individual expects.” Wordsmith a bit.
         9. One other thought – in terms of SI, in addition to access to tech, access to reliable transportation is important regardless of age. Older adults, disability population all need transportation. Not being able to drive is a big issue.
   2. Going forward if we have a new member come on Angie will meet to brief person and bring them up to speed
      1. Sally – reach out to non-driver task force (DOT)? We already have some GWAAR (and other) connections to this. Maybe not need a person to join us, maybe just have information from the people we know are already in that group.
      2. We have people in other coalition workgroups as well
      3. Also need recruitment from underserved communities
   3. Parking Lot
      1. Angie to create a list of nuggets of information/things that come up that we need to monitor.
   4. Identifying groups at risk
      1. Suggestions for more – adults with disabilities as a main bullet point; adults at risk – there’s a difference (adults at risk may not capture everyone)
4. ADRC intake process   -- Jennifer Speckien/Christine See
   1. Last time Pam talked about Nutrition assessment – every individual receives a survey and would be a great point to detect loneliness
   2. Christine – many initiatives ADRCs have been working on during the pandemic – doesn’t look at this specifically. Started to develop ‘customer outcome screening’. Trying to identify SDoH and risk factors. Pilot group did test this but wasn’t widely implemented because COVID-19.
   3. ADRC might not directly ask these questions (they could) but more indirectly bringing this up in conversation. Asking very basic questions.
   4. Might be not just asking the question but could also try to identify some other key factors.
   5. A home visit might be offered, the ADRC could do a more in-depth interview or follow-up. Make sure a person receives services and is connected.
   6. Evaluate if the ADRC helped the customer in a way that was valuable and reduced the risk.
   7. It’s a process – with the pandemic it wasn’t completely rolled out at a wide scale. Might need to go back and retool a little bit.
   8. Is this for anyone who connects with an ADRC? Yes, anyone who needs any kind of assistance.
   9. Are there any questions right now being asked about SIL? They do have to answer a question if they live alone. Nothing diving into detail. Part of it is the database system they use – not a lot of flexibility to change the questions.
      1. Lives alone might be a risk factor, but it’s only one measure.
   10. Pam – on nutrition we currently do ask three UCLA questions (not required to complete it and it’s anonymous). Don’t use the survey for everyone.
   11. So there are some opportunities within ADRC for detection, perhaps even more opportunity within Nutrition on the aging side to detect.
   12. What measures to use, what are we going to do about this?
   13. Brown county also asking questions related to health promotion. Do we want to measure people already doing evidence-based programs since they’re already quite social? Actually findings from Brown showed that people still were having difficulty connecting. Brown is planning to keep current questions in and to continue to measure this.
       1. Have started asking questions on the front end – to set a baseline and see how programs are working.
       2. Trying to get a measurement system embedded more in other programs.
       3. Did forward an email with questions that are asked as part of ‘options counseling’. Not sure how well data can be pulled out of the system.
       4. Pulling the information out of the system is a real barrier. Enter all the scores but it’s very difficult to get those questions out individually.
   14. Questions
       1. Do all ADRCs use same data system? No – all aging units use WellSky and about 85% of ADRCs use it as well. The two collect different information based on roles. ADRCs that don’t use this data system are required to conform to standards/WellSky changes. Barrier is that we don’t have ability to add thigs to WellSky. There are a few areas that are flexible – if we come up with something in the next month or two we might be able to add it.
          1. Talk to policy about this. Might need to advocate for a system using state funds (some available?). Could be happening – this is recognized as an issue.
   15. How do we detect?
       1. We can help refine WG goal and get some strategies down.
       2. At the next meeting we should dive deeper into screening tools that are being used – help us decide what questions to ask –
          1. Review screening tools:
             1. UCLA Loneliness Scale (Barb to do this)–

Will find a document with an overview of some of these scales. Would be easy to pull out the pages we want to look at.

* + - * 1. The De Jong Gierveld Loneliness Scale (also Barb)
        2. The Campaign to End Loneliness Measurement Tool (Angie)
        3. Single-item questions (Angie)
        4. U-SIRS (Pam)
        5. National Core Indicators (Sally) –

People with disabilities focus – already has something built in but we could advocate for adding more.

* + - * 1. Reach out to disability network to see if there are any others (Sally)

1. Next Steps – All
   1. Report out on tools – look at what’s happening and develop strategies on what tools to use/how to use them

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**Meeting: 8-31-21 Notes**

1. Meeting goals, welcome, introductions (10 minutes)
   1. New member joining – Jennifer Speckien
   2. Group/meeting expectations
   3. Definitions of SI and L
      1. Adjusting L so that it’s not just a reference to older adults. Adjust so that harm or personal injury are included. Mention health equity and define what is meant by social relationships – also how does technology fit with this.
         1. Strategies – technology, health equity, positive frame of connections
         2. Excellent to include disability community
      2. Might also feel more broad-based to mention rural and minority communities.
         1. Some of these might include those who live alone, mobility of sensory impairment, major life transitions or losses, low-income or with limited financial resources, caregivers, psychological or cognitive challenges, inadequate social support, rural or inaccessible neighborhoods, transportation access challenges, language barriers, age/racial/ethnic/sexual orientation discrimination
2. Review (35 minutes)
   1. Decisions made at last meeting
   2. Discussion on the Access and Detection Work Group survey that was sent to work group members
      1. What organizations or individuals are not represented that you think should be included in this work group?
         1. Healthcare is a big group missing from the discussion here. Primary health. Medical colleges would be a good connection too. Primary health can tell us what they already screen for, what wouldn’t work. Area health education centers are also a good connection.
            1. Also thinking Balance of State (large association of all different continuum of care in counties wrt homeless services). Lots of folks who fall into older adults/disabilities experiencing homelessness and probably loneliness.
         2. A few people who filled out the survey and wanted to be engaged or informed. Consider reaching out to them as needed.
         3. Minority communities and LGBT older adults.
         4. Connection and ‘join this group’ might be a good way to approach people.
         5. Sally – happy to reach out to LGBT community connection in Milwaukee. MCO and Inclusa are great connections.
         6. Could also add social isolation loneliness questions to the National Core Indicators survey. <https://www.nationalcoreindicators.org/states/WI/>
            1. If we can jump on to an existing process to detect and screen that would be great.
         7. What about the faith community?
         8. Maybe don’t need to add everyone right away.
      2. Identify any resources (screening tools, interventions, etc.) that you would like this group to explore?
         1. So many tools and resources out there. What are good ones to explore?
         2. Nutrition and Home-Delivered Meals are a good resource.
            1. Survey accompanies this – identify root causes and effects of nutrition risk to address it. Have to do an annual nutrition assessment. How many people complete it statewide? – A lot☺
            2. Maryland has a similar program and added questions to directly address social isolation/loneliness. Five questions that really try to identify loneliness/isolation. Incorporating several measurement scales.
            3. Our nutrition infrastructure can be a feeder into the system.
         3. Evidence-based health promotion group (Angie):
            1. Everyone in this work is doing evidence-based health promotion programs. Several elements of data collection are active and the group is debating including SI&L questions there. Those participating in programs do tend to be social people, not necessarily those most at risk so questions here could miss people or skew data.
         4. Brown County – haven’t landed on one specific tool yet. One tool in use does give both screening questions and education (<https://eldercare.acl.gov/public/resources/brochures/docs/Expanding-Circles.pdf>). Have done a measurement of isolation – not loneliness as part of a class.
            1. Started using it – thought they would be measuring less isolated people, but finding it’s much more prevalent than thought. Half of class reported less isolation after class.
            2. Looking to thread this information into other classes and center outputs.
            3. Get better data when they don’t ask for identification. Challenge is in connecting with individuals without asking for identification (or tradeoff with asking for ID knowing response rate might not be as good.)
         5. Living Well grant
            1. Survey and many questions allude to SI&L. MN has been doing research on building social networks. Will be offering a training on building social circles.
            2. ACL screening tool ([https://www.ta-community.com/media/download/m2fhd4/Social\_Connectedness\_Screens\_Matrix\_Oct\_2020\_FINAL.pdf](https://www.ncoa.org/article/what-is-the-aging-mastery-program)) that might be useful.
         6. Besides national core indicators, not sure if there is a standard assessment that really gets down to individual.
            1. Can’t recall much related to this on the LTC Functional Screen (more of a medical model – seems to be method to identify most at-risk individuals). Seems to be based on who care managers are and how empowered individuals are. If someone doesn’t know what questions to ask then this tool is less useful.
            2. Disability community is almost even more at-risk here, especially in winter.
         7. Matthew Smith – doing a lot of work with Maryland. 13-item questionnaire for community-dwelling older adults. Not sure if there’s anything for disability community? Questionnaire labels as red, yellow, green and provides location-specific options to engage. Red result connects people with engagement program and other resources.
            1. Seen a lack of evidence-based programming in communities that have depression. Maybe not applicable to cognitive disabilities. Tool can be used by case managers, health educators. Set personal goals for individuals and help identify resources. ADRCs can use OAA $ to implement this. A way for ADRCs to screen and detect. (<https://healthyideasprograms.org/>)
            2. Fear is that we identify people and not provide resources. Screening is only half the process.
         8. Have a research workgroup and have a connection to ADRCs in each community. Most are doing some type of evidence-based health promotion.
         9. Are we looking at this from internal or external factors? Is social isolation a result of exterior factors or internal ones (lack of transportation, communication challenges, not understanding available resources, etc).For example, the term homebound – is that by choice or because there are too many barriers to engagement so that label is by default?
            1. It would be interesting to see what policy workgroup is doing on this. Definitely lots of external issues that affect this definition/issue. Doesn’t stop us from looking for resources like transportation or to identify resources that help people who are screened.
            2. Conversation for the policy group (make sure they’re thinking “policy” along these lines – probably not quite to this point yet).
         10. Getting awareness out there independent of tools is crucial.
             1. Communications group is heading up something in this area. Within a few months we hope to have an awareness campaign that can be deployed at the local level.
             2. More geared toward getting back into your community – not so much a focus on negative impacts of social isolation and loneliness.
      3. Any other thoughts on the direction you would like this work group to take?
         1. Challenge will be how to get resources and tools out to people. How to promote them.
3. Data Discussion (25 minutes)
4. Goal and Strategies Discussion (15 minutes)
   1. Review initial goal and strategy
      1. Really will be community implementing things, not us. How can we provide resources and support? Make this our own.
      2. Not focus on older adults. Not focus just on health effects. Maybe focus on screening/identification for social isolation here.
      3. Would have to adjust an approach for each target group if we name more than one – maybe defining a timeline through more specific objectives. We can use our strategies to define this more.
      4. Wordsmith a little and then specify adults, safety component is important for older adults and those with disabilities and that encompasses caregivers.
      5. Keep the goal broad instead of pulling in and mentioning specific groups.
      6. Provide engagement? Maybe better to say “connecting people to” meaningful engagement. Yes, a large part of this WG is just connecting people to existing resources and people who are doing existing work.
         1. Hopefully new project management person will really be able to map out the network of what else is happening in WI and nationally.
      7. One strategy coming through is fostering connections at the local level. Develop a strategy toward that.
      8. One text option – “Detect all adults who are at risk of health and safety concerns due to the effects of social isolation. The group will provide connection and resources to create meaningful, authentic engagement opportunities to create a purpose and belonging for the person.”
5. Set a standing meeting time (every 3 weeks, 1 hr)
6. Next Steps (5 minutes)
   1. Develop strategies and wordsmith overall group goal (Angie)
   2. Develop updated definitions of SI&L (Angie)
   3. Share definitions of SI and L with larger coalition for agreement, posting to website, etc. (Dan, when ready)
   4. Angie to reach out to SSM, others to reach out to Sage, Inclusa, MCHO

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**Meeting: 8-5-21 Notes**

1. **Introductions – Members Present**
   1. **Angie Sullivan** – Older Americans Act (OAA) Consultant for GWAAR in the area of evidence-based health promotion. Provides technical assistance for 70 county Aging Units and 11 tribal aging unit. Co-Chair
   2. **Sara Richie** – Life Span Manager, UW Extension (Co-Chair) on maternity leave until Oct. 2021.
   3. **Debra Shepro** – Director of Volunteer Services ADVOCAP Inc. Over sees a Retired and Senior Volunteer Program, a Foster Grandparent Program, a volunteer transportation program and a Senior Friends Program (volunteers visit those who are isolated and/or lonely) serving Fond du Lac, Winnebago and Green Lake Counties.
   4. **Pam VanKampen** – OAA Consultant/Nutrition Services/Senior Center Representative. Little Brothers Friends of the Elderly Pilot with 7 counties in WI. Sip & Swipe training and work with Generations online to help get older adults connected to the virtual world. Compile the Social Isolation Resource Directory in collaboration with Dane AAA.
   5. **Sally Flaschberger –** Wisconsin Board for People with Disabilities. Currently the BPDD – Living Well project manager. The grant focuses on quality home and community based waiver services for people with disabilities. Focus on healthy, safe and connected lives. One charge of the grant is to be sure that people are free from abuse and neglect. Sally has a strong public policy background, and experience with writing legislation. She also is a parent of a young adults with a developmental disability, she not only brings professional but personal experience.
   6. **Stephanie Birmingham** – is self-employed; Options for Independent Living. She is an individual living with a physical disability who brings a combination of experience and education that includes a Master’s degree in Counseling, knowledge of the Independent Living philosophy, and experience working with multi-group stakeholders. She is also a volunteer legal guardian to two people with developmental disabilities and has witnessed the effects of social isolation personally.
   7. **Martha Bechard** – Caregiver Coordinator for Waushara County/Waushara County Department of Aging. Previous work experience includes working in the long-term care. She presently works with caregivers, and has witnessed and spoke with individuals who have suffering from social isolation and loneliness. Personally, she has taken on the caregiving duties for her mother and see first hand her struggles with isolation and loneliness.
   8. **Barb Michels –** Prevention Coordinator for Brown County ADRC. Currently using screening tool to identify social isolated and lonely adults who are participating in their prevention programs. Creating a consistent way to measure. Included a goal in their 3 year Aging Unit Plan.
   9. **Gayatri Raol** – Program and Policy Analyst for the Division of Public Health. Works with a variety of data sets including data for Caregivers and Social Determinant’s of Health. Personally, is a part of the immigrant population and has seen firsthand how living in social isolation can affect one’s health.
   10. **Dan DeValve** – Federal Grants Coordinator, Office of Policy Initiatives and Budget, Department of Health Services. Current project manager of the Social Isolation and Loneliness Coalition – attends all work groups meetings to create a sense of cohesiveness.
   11. **Group Ground Rules –** Angie reviewed a set of group ground rules (see attached PowerPoint). A recommendation was made by a group member to send any materials that needed to be reviewed prior to the meeting, so everyone would have a chance to educate themselves prior to the meeting discussion. Great addition.

**Other work group members not present:** Please reach out to Angie Sullivan at [angela.sullivan@gwaar.org](mailto:angela.sullivan@gwaar.org) to indicate if you would still like to be a part of the group and receive meeting notifications and notes. Thank you.

1. **Coalition and Model Overview**
   1. Angie provided an overview of the WI Social Isolation and Loneliness Coalition, insight on all four work groups, the collective impact mode and the Access and Detection tentative goals and objectives. Please see the attached PowerPoint.
2. **Next Steps**
   1. We had such a great discussion that we ran out of time to address the rest of the agenda. Please complete the attached survey so we can gather some information before our next meeting.
   2. The group decided to meet every other week to get some of the preliminary work complete, and then meet less as we get further along on projects. (see link in the body of the email)
   3. Angie will send out a doodle for our next meeting, which will be 1.5 hrs long.

Thank you for attending and sharing your passion and expertise.