

November 29, 2019

SUBMITTED ELECTRONICALLY TO: Rural_Urban@mail.house.gov

RE: Ways & Means Committee Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady,

As members of the Rural Aging Advisory Council (RAAC), thank you for the opportunity to provide comments in response to your Request for Information (RFI) on health care issues impacting communities in rural and underserved areas. We support the creation of the House Ways & Means Committee's (Committee) Rural and Underserved Communities Health Task Force and stand ready to assist in the development of legislative solutions to improve health status and outcomes in rural and underserved communities.

Our comments focus on the aging population in rural America. Compared to their urban and suburban counterparts, older adults living in rural communities are at a disadvantage in terms of available services, resources and access to healthcare. Approximately 25% of Americans older than 65 live in small towns or rural communities. In some states, the percentage is significantly higher. For example, in Maine, 58% of adults older than age 65 live in rural areas.

Our comments below focus on addressing social determinants of health generally as well as social isolation and loneliness. We first provide background on the RAAC in order to provide context.

About the RAAC

The RAAC is an outgrowth of work that Tivity Health has been engaging in over the years concerning rural health, social isolation and loneliness and most recently, social determinants of health. Tivity Health, headquartered in Franklin, TN, is a leading provider of health improvement, nutrition, fitness and social engagement solutions to improve clinical outcomes, reduce health care costs and create opportunities to feel better, work better and live better. The organization's flagship program, SilverSneakers®, reaches over 16 million Medicare Advantage beneficiaries across the country. Tivity Health learned over the years that a significant percentage of its members live in rural communities and need support to actively engage in this program.

As a result, Tivity Health convened the first annual Connectivity Summit on Rural Aging, bringing together nearly 100 stakeholders from non-profit groups, faith-based organizations, health plans, government, rural experts, health leaders, and aging experts. This successful gathering was built on the importance of public-private collaboration and the strong belief that only through collaboration can we achieve success in solving problems. The summit kicked off a three-year "campaign" to raise awareness of the issue and to generate collaborative solutions. Summit participants also identified priority issues to address concerning rural aging including: 1)

public awareness; 2) housing; 3) transportation; 4) broadband/technology; and 5) social isolation and loneliness.

The second annual Connectivity Summit on Rural Aging was convened in August 2018 during which over 180 stakeholders collaborated to generate action steps needed to reverse social isolation. The RAAC also was created that year to provide guidance on these efforts and is committed to addressing issues surrounding seniors and their caregivers who live in rural America. This group of diverse stakeholders includes government, faith-based organizations, non-profits, academia and research groups, the business community, health plans, rural health experts and aging experts.

The third annual Connectivity Summit on Rural Aging was convened in August 2019 during which over 230 participants focused on better understanding social determinants of health, exploring how these factors impact the health of older Americans living in rural areas and developing solutions that can mitigate their impact. With a focus on delivering future actions and investments on this topic, summit participants also developed public policy recommendations to improve aging and social connectedness and addressing social determinants of health.

Social Determinants of Health

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

We appreciate that the Committee recognizes the significance of social determinants of health and how they should be addressed in order to ensure good health status and outcomes for patients in rural America. These social and economic factors have a profound impact on our health, longevity, and quality of life and include social connection, housing, health literacy, food security, social support, economic wellbeing, and transportation. In fact, it is well documented that factors such as these play a greater role on health status and wellbeing than direct clinical care.

Successful efforts have been underway at the local level to address social determinants of health and ensure good health status and outcomes for older adults in rural America. A collection of these success stories was recognized last August at the third annual Connectivity Summit on Rural Aging. These stories show that individuals, organizations and communities from across the country are able to mobilize and address a wide array of social determinants of health adversely impacting older Americans in rural areas. These success stories range from reversing social isolation and loneliness to ensuring adequate nutrition to making sure a senior has access to transportation. This collection of stories, entitled *Aging Well in Rural America: A Collection of Stories from the Heartland*, is attached and also can be accessed at:

<http://www.tivityhealth.com/connectivity-summit/2019/aging-well-in-rural-america-a-collection-of-stories-from-the-heartland/>.

We recommend that providers work more closely with member of the community and community and social service organizations like those showcased at the summit to identify social needs and ensure these needs are addressed. The importance of this coordination was reinforced by the CHRONIC Care Act, which is part of the Bipartisan Budget Act of 2018 (Pub. L. 115-123). For example, this legislation amended section 1852(a) of the Social Security Act to further expand the types of supplemental benefits that may be offered by Medicare Advantage (MA) plans to chronically ill enrollees. This includes supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees. We believe the intended purpose of this new category of supplemental benefits is to enable MA plans to better tailor benefit offerings, address gaps in care, improve health outcomes for the chronically ill population and address social determinants of health (e.g., transportation, food, housing modifications).

It is critical to promote the provision of these benefits along with community-based services. However, these expanded supplemental benefits were created without additional resources or funds. Incentives therefore need to be established to support the wide availability of these services along with outcomes-based research that examines rural and underserved area disparities in health status and outcomes.

Finally, we believe that more can be done to better address social determinants of health in Medicare. For example, CMS should explore ways to account better for social determinants of health and functional limitations in the risk adjustment model for MA plan payments, as well as to improve Star Ratings measures by reviewing new measures that include social determinants of health.

Social Isolation and Loneliness

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Services that promote social connection are especially important for older adults, especially in rural America. Social isolation and loneliness among this group is a growing epidemic in the United States, and the risk of social isolation increases as people get older due to factors such as living in a rural area, retirement, living alone, and loss of mobility. According to the U.S. Census Bureau, older Americans today increasingly live alone or on their own – with approximately one-third of those older than age 65 living alone and half of those over age 85 living alone.

The adverse impact of social isolation and loneliness has been well-documented and more acute in rural areas. First, social isolation increases a person's risk of premature mortality by 29 percent. Second, socially isolated individuals are at a greater risk of cognitive decline, including a 64 percent higher chance of developing clinical dementia. Third, loneliness may increase the risk of premature death by 30 percent—equivalent to smoking 15 cigarettes per day, and lonely individuals have a higher risk of developing coronary heart disease, stroke, or a disability. Finally, a study by the AARP Foundation found that Medicare spends an estimated \$1,608 annually on each senior who is socially isolated.¹ The lack of social contacts among older adults is associated with an estimated \$6.7 billion in additional federal spending on Medicare annually.²

As demonstrated in *Aging Well in Rural America: A Collection of Stories from the Heartland*, which is attached, social isolation and loneliness can be addressed at the local level by a wide array of activities conducted by individuals and organizations. Social isolation and loneliness can be addressed at broader level as well. For example, ensuring access to social connection through fitness programs have been shown to reverse the negative impacts and social isolation and loneliness. One study found that SilverSneakers® increased physical activity and self-rated health and decreased social isolation and loneliness.³ This type of intervention is not direct clinical care, but it is a cost-effective alternative to clinical interventions such as medications or invasive surgery.

We have included with our feedback the following background information and supporting data and research: 1) Results from the first annual Connectivity Summit on Rural Aging; 2) Summary of the second annual Connectivity Summit on Rural Aging: *The Power of Connection: Reversing Social Isolation in Rural America*; 3) Joint paper by the Healthcare Leadership Council, Tivity Health and Aetna on social determinants of health for the third annual Connectivity Summit on Rural Aging; and 4) *Aging Well in Rural America: A Collection of Stories from the Heartland* that was showcased last August during the third annual Connectivity Summit on Rural Aging.

Thank you for the opportunity to provide these recommendations. Please contact Vicki Shepard, Vice President, Government and External Relations for Tivity Health at Vicki.Shepard@tivityhealth.com should you have questions or need more information. We would be pleased to meet with you to elaborate on our recommendations or be of any additional assistance.

NAMES OF COUNCIL MEMBERS

Julianne Holt-Lunstad, PhD
Tivity Health
Health eVillages

¹ Lynda Flowers, et al., *Medicare Spends More on Socially Isolated Older Adults*, accessed at: <https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf>.

² *Id.*

³ Samantha Brady, et al., *Reducing Isolation and Loneliness Through Membership in a Fitness Program for Older Adults: Implications for Health*, *Journal of Applied Gerontology* (2018).

Sharecare
MIT AgeLab
Jefferson College of Population Health
Saint Joseph's College of Maine
National Association of Area Agencies on Aging
Valley Area Agency on Aging
National Association of Nutrition and Aging Programs
National Council on Aging
Grantmakers in Aging
Mercy Health Care
National Rural Health Association
National Minority Quality Forum
NashvilleHealth
Health Intelligence Partner
DoucetSolutions
Lois Drapin, The Drapin Group LLC
YMCA of Portage (Indiana)
Ashtabula County YMCA (Ohio)
Lyft
Better Medicare Alliance
American College of Lifestyle Medicine
Comcast
Carefully, Inc.
Motion Picture & Television Fund
AARP TN

cc: Representative Danny Davis
Representative Terri Sewell
Representative Jodey Arrington
Representative Brad Wenstrup



Aging Well in Rural America:

A Collection of Stories
from the Heartland

Presented by Tivity Health and Health eVillages

Interested in learning more about these organizations and how they are helping the aging population in rural America? Contact Tivity Health at RuralAge@TivityHealth.com or visit RuralAge.com.

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Introduction from Donato



All of us aspire to enjoy good health, prosperity and the comforts brought by our homes, families and local communities as we grow older.

Yet, the experience of aging can be vastly different depending on where you live – whether that's on the coast of Maine or in the urban heart of Los Angeles. Older Americans living in rural areas often face unique challenges. Caregivers and family sometimes live far away. Traditional transportation options can be sparse and access to healthy food may be limited. The challenges of loneliness and social isolation, which are associated with serious public health risks, may be more pronounced.

The good news is that many people, organizations and communities have recognized these challenges and are mobilizing solutions. Across the United States, there are stories of people who are working to promote healthier living and greater social connectedness among older Americans, examining solutions to address social determinants of health and creating innovative partnerships, particularly for those living in rural areas. Even with the challenges posed by geography, those living in rural America are resilient, resourceful and often have deep roots in the community, making community-based programs and approaches successful.

Several years ago, I wrote a book to share my own story of challenges, adversities and triumph. Throughout my book tour I learned that everyone has a story and the power of storytelling can help significantly to create a sense of connectedness at a time when people around the globe increasingly feel on their own. Hence, this collection of stories is designed to empower all of us to join the movement to address aging in rural America, social isolation and loneliness by learning about what others are already doing – and where they're finding success. Through the art of storytelling, our goal is to inspire action and new partnerships to tackle the most significant challenges facing older populations.

Our work here is just beginning. I genuinely believe that, by working together, we can empower our older friends, families and neighbors to live out their dreams in full health and prosperity.

Sincerely,

Donato Tramuto
CEO, Tivity Health
Founder, Health eVillages

There are stories of people who are working to promote healthier living and greater social connectedness.

Background & Acknowledgments

Several years ago, Tivity Health, in partnership with Health eVillages, launched a national campaign on rural aging to encourage everyone – from the private sector to the public sector – to take meaningful action around improving the health and well-being of older adults living in rural parts of the United States. Since launching this campaign, the focus has morphed from *what's going on* to *what can we do about it*. We've also broadened our focus to better understand how social determinants of health and the public health crisis of social isolation and loneliness, impact older adults.

In 2018, we convened nearly 200 people including public health experts, researchers and leaders from the private and public sectors for the annual Connectivity Summit on Rural Aging. What we heard is that people want to learn by example. And, we were missing a centralized resource that could serve as a “community playbook,” offering guidance, program ideas, and proven results that other stakeholders working in this space could replicate.

Nearly a year later, we are proud to unveil one such resource with our newest publication: **Aging Well in Rural America: A Collection of Stories from the Heartland**. This collection of stories offers more than a dozen examples of what various people and organizations are doing to promote healthier aging and social connectivity.

The development and production of this collaborative project would not have been possible without the help of our staff and partners on rural aging. Tivity Health thanks in particular the Rural Aging Advisory Council, which represents leading businesses, organizations and experts who are leading our national campaign on rural aging and social isolation. Special acknowledgment to Caroline Young, NashvilleHealth for chairing this effort. Caroline is a member of the Rural Aging Advisory Council and was instrumental in outreach for the stories and in supporting the development of this effort. We also want to acknowledge Justine Page, Ken Currey, Steve Phillips, Kimberly Janicak and Dominic Portalla, who spent countless hours working on this project, organizing the compilation of stories and production of this publication.

*What we heard is
that people want to
learn by example.*



AARP Livable Communities

America's historic downtown renewal

Livingston, Tennessee, has been a leader in downtown revitalization for more than a decade. The historic courthouse square, rich outdoor recreation, and Americana music heritage serve as the primary amenities and economic engines for tourism in the community. Livingston leaders saw the construction of a new downtown park and event space as an opportunity to connect and grow assets to improve residents' quality of life. In 2007, the city was selected as a Tennessee Courthouse Square Revitalization Act pilot project community.

The Livingston Downtown Revitalization Committee (DRC) led the Courthouse Square Revitalization program. Through this program, the committee has made strategic investments to establish the courthouse square as a vibrant home to many events that leverage the county's Americana music assets. Livingston was selected to participate in the Tennessee Department of Economic & Community Development Tennessee Downtowns program in 2016.

Central Park, located just off the historic courthouse square, is now bringing more people to downtown Livingston to shop, eat and play. In August of 2017,

the city hosted a Solar Eclipse event that brought thousands of visitors to Central Park. New community events at Central Park include tai chi classes, a new walking activity "Walk Livingston," two movies per month, "Live in Livingston" music performances and the community's biggest event "Fall-O-Ween in Livingston."

The Livingston Central Park has increased the number and size of community events that show immediate positive economic impact.

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AARP Livable Communities supports the efforts of neighborhoods, towns, cities and rural areas to provide safe, walkable streets, age-friendly housing and transportation options, access to needed services, and opportunities for residents of all ages to participate in community life.



American Heart Association

Gardening in the heart of Arkansas

People often associate rural America with rolling farmlands and a plethora of access to fresh fruits and vegetables. Unfortunately, many rural communities face a very different reality. In fact, 2.4 million rural households struggle with hunger. Small towns, given their potentially remote locations and limited populations, are often many miles from the nearest accessible grocery store.

Altheimer, Arkansas, is no exception. With less than 1,000 residents and no full-service grocery store, it is considered a food desert. Of its population, more than 65 percent are seniors living below the federal poverty line with limited access to reliable transportation. This community of dedicated seniors is committed to making Altheimer a better place to live. They are starting with an approach that has been a part of their community for many generations: farming.

2.4 million rural households face hunger.

The community is working together with the American Heart Association (AHA) and the Ben J. Altheimer Foundation, the family after whom the town is named, to address food access issues and increase community connectivity. Their first initiative is a community garden project.

The AHA worked with leaders to develop a plan and secure help from the University of Arkansas at Pine Bluff's small farm and garden program. Future steps will include connecting with the schools, offering educational cooking classes, and creating a more sustainable model by working with the town's corner stores to offer healthier options.

With the support of more than 22 million passionate supporters and volunteers, key partners and a global network, AHA delivers lifesaving information and programs into clinical facilities, businesses, schools and homes in over 80 countries.

Blue Zones Project – Albert Lea, MN

Creating a better future today

In 2008, Albert Lea, Minnesota, was suffering in the face of economic downturn. Businesses had closed downtown, and the city was plagued by high smoking rates and low activity levels. Local leaders were determined to transform the situation and teamed up with Blue Zones, LLC in 2009 to become the first Blue Zones Project. The first nine months of initiatives were born out of a partnership between Blue Zones Vitality Project and AARP, sponsored by the United Health Foundation.

“The Blue Zones Project initiative allowed our community to look at ourselves in a different light and build a better future by learning from our past,” says Vern Rasmussen, Jr., Mayor of Albert Lea.

Thanks to progressive tobacco policies, residents saw a 35 percent decline in smokers between 2010 and 2016 based on Well-Being Index data. This reduction equates to an \$8.6 million annual saving in health care costs for Albert Lea employers.

The addition of more than nine miles of new sidewalks and three miles of bike lanes led to a 40 percent increase in active transportation since 2014. More than a dozen businesses relocated downtown, with more than \$2.5 million invested in building permits since 2013. This investment created a 25 percent increase in property value in the downtown area, adding \$1 million to the tax base.

Freeborn County jumped to 34th place in the Minnesota County Health Rankings (previously 68 out of 87 counties).

Using secrets discovered in the original blue zones, community transformation programs help lower health care costs, improve productivity and boost national recognition as great places to live, work and play.



Blue Zones Project - Dodge County, WI - Moai

Making transformation a reality

After several preventable risks for serious health problems were identified in Wisconsin's Dodge and Jefferson Counties, the Beaver Dam Community Hospital formed a coalition of local leaders to explore solutions. In three years, Dodge county has seen a decrease in smoking and an increase in the number of residents who feel active and productive daily. Leaders have changed food policy and offerings in restaurants, grocery stores, schools, and workplaces. The addition of the Rotary Riverwalk Park has encouraged outdoor activity, healthy connections, and more community investment.

One of Dodge County's goals is to create a community where residents can – and want to – age in place. Like many other rural communities across the country, the population has begun to decline, with young professionals moving away in search of career opportunities.

Leaders have changed food policy and offerings in restaurants, grocery stores, schools, and workplaces.

To make transformation a reality, Dodge County leaders and Blue Zones Project experts identified key opportunities for impact through community design improvements, tobacco and alcohol policy initiatives. This provides more opportunities for residents to connect and build social networks through walking and healthy potluck groups.

According to Well-Being Index data, residents of Dodge County who are aware of and engaged in the Blue Zones Project have significantly higher well-being than those who are not engaged. Additional well-being shifts for those engaged in the Project include reductions in smoking rates, obesity rates, high blood pressure and high cholesterol, as well as increases in fresh produce consumption and those who feel active and productive daily.

Using secrets discovered in the original blue zones, community transformation programs help lower health care costs, improve productivity and boost national recognition as great places to live, work and play.

California Health Collaborative

Creating hope for aging in place

The California Health Collaborative (CHC) is involved in over 50 programs that target mental health, nutrition, diabetes, smoking cessation, early detection of breast and cervical cancer and much more. CHC serves 54 of the 58 California counties. The variety of public health services offered by the Collaborative are a testament to the power of partnerships in caring for the underserved.

The Collaborative successfully reaches out to where people live, work, learn, eat, spend their leisure time, and receive their health care. In doing so, they have

created a far-flung, multi-tiered network that addresses a host of health care challenges.

The variety of public health services offered by the Collaborative are a testament to the power of partnerships.

Ms. Brown is a participant in California Health Collaborative's Multipurpose Senior Services Program (MSSP), a state and federally funded Waiver program that serves low-income seniors in both the rural and urban communities of Placer, Sacramento, Yolo and Yuba counties. Ms. B, 81, lives with her daughter and has been an MSSP

participant for 1.25 years. Upon enrollment, she exhibited significant cognitive impairment with a Short Portable Mental Status Questionnaire of 9 out of 10, as well as indicating depression with a Geriatric Depression Scale score of 7 out of 15.

As a participant in the Multipurpose Senior Services Program, Ms. Brown's daughter received alarms to signal when she would attempt to leave her bed. A door alarm was also installed, allowing her daughter to respond quickly, creating a safer environment for Ms. Brown and her daughter.

The Collaborative addresses the needs of the underserved, especially those who have limited access to resources affecting their well-being, and face barriers related to culture, language, income, education, gender, geography or immigration status.

CareMore - Lyft

Lyfting experiences one ride at a time

In 2015, Lyft, the transportation network, partnered with CareMore Health, an integrated health plan and care delivery system, to explore ways to improve the patient experience and reduce costs through access to reliable, on-demand transportation.

Due to limited access to reliable transportation, millions of Americans are not able to access the health care they need each year. Transportation barriers primarily affect the elderly and chronically ill populations, for whom access to ambulatory care is necessary.

In 2016, CareMore launched a two-month long pilot program to assess the impact of adding Lyft for curb-to-curb (C2C) transportation. The pilot offered Lyft rides to 75,000 Medicare Advantage enrollees across California, Nevada, Arizona and Virginia. Within three months of the pilot launch, half of all C2C rides were Lyft-based. By the end of 2017, Lyft was providing 91 percent of all C2C rides accessed by CareMore members.

The encouraging early results from partnering with Lyft prompted CareMore to expand its partnership across all its Medicare Advantage markets nationwide.

Through the collaboration with Lyft, CareMore is helping thousands of patients

across their entire system enjoy better experiences getting to their medical appointments. With the addition of Lyft for CareMore members who need C2C transportation, patient experience has improved, wait times have reduced and efficiency of Non-Emergency Medical Transportation benefits has increased significantly.

CareMore is a health care delivery system built on compassion and fueled by innovation, treating patients and families with the care and dignity they deserve. Lyft aims to provide safe, reliable and affordable transportation that lowers barriers to care for those in need.

Due to limited access to reliable transportation, millions of Americans are not able to access the health care they need each year.



Eastern Band of Cherokee Indians

Investing in Cherokee's aging population

The Cherokee Indian Hospital is the primary care institution for more than 13,000 enrolled Cherokee Indians, with more than 35,000 primary care visits per year and 13,000 ER admissions.¹ Over the past five years, the Eastern Band of Cherokee Indians (EBCI) has invested more than \$50 million into their health services – focusing on access and quality of care. These investments have centered primarily on the aging population.

The Eastern Band of Cherokee has implemented several programs including geriatric, nutritional, wellness and prevention programs to improve the overall health of the aging population. Access to care in rural western North Carolina has been a major concern for the Cherokee, where they have added rural health care centers.

The Home Health program provides nursing care for homebound patients including skilled nursing, physical, occupational and speech therapy programs. Caring for the Caregiver offers support for family members who are looking after Tribal elders. This program works with the families and looks at short-term

Caring for the Caregiver offers support for family members who are caring for Tribal elders.

respite care based on the individual needs of each family. The Department of Health and Human Services provided the Tsali Care Nursing Facility, a 60-bed facility that is equipped to deliver quality nursing care for Cherokee senior citizens.

The Eastern Band of Cherokee's food distribution program, administered through the Public Health and Human Services

Department, in conjunction with the US Department of Agriculture, is designed to provide nutritious food to eligible citizens, including the aging and disabled population, to assist with supplementing the families' food needs for the month.

1. <http://cherokeehospital.org/>

With an emphasis on Cherokee history, arts, crafts and the unique healing aspects of Cherokee culture, CIHA addresses the health and wellness needs of the Tribe—and does so to the highest national standards of health care.

Louisiana Sheriffs' Association

Filling the gaps of elder care

Sheriffs across the country have initiated many community outreach programs that provide senior citizen assistance to “fill the gaps” and meet the needs of our aging population in rural communities.

Louisiana led the way in 1989, when St. Martin Parish Sheriff Charles Fusilier created the “The Right Information and Direction,” or Triad Program. Triad is a partnership among three groups: senior citizens, law enforcement and the community. The focus of the Triad Program is to reduce crime against senior

citizens and the crime-related fears older adults often experience by keeping them informed. By the early 2000s, with the backing of the American Association of Retired Persons (AARP), International Association of Chiefs of Police (IACP) and the National Sheriffs' Association (NSA), more than 800 counties and parishes signed Triad agreements. Currently, Triad programs are active in 47 states.

Whether it is through hosting community events, helping the elderly in their homes or providing meals for seniors in need,

Louisiana's sheriffs are proud to “fill the gaps” to assist the aging population. However, this is only possible with the help of other partners within each community who are willing to help bridge the gap. Through programs such as Triad, the elderly population can feel safer and more involved in the rural communities in which they live.

The Louisiana Sheriffs' Association's purpose is to maintain the powers of the sheriff as peace officer, ensure the delivery of first-rate services by sponsoring legislation to promote the administration of criminal justice and serve as a clearinghouse for information.

Through programs such as Triad, our elderly population can feel safer and more involved in the rural communities in which they live.

Lutheran Services in America

Collaborating to improve rural America



Lutheran Services in America is advancing solutions that support the healthy, independent aging of America's seniors, particularly those struggling with limited resources in rural, isolated settings. In 2015, the organization, along with Lutheran Social Service of Minnesota and Lutheran Social Services of North Dakota, launched its ongoing Great Plains Senior Services Collaborative.

The Collaborative has successfully improved the health and quality of life of over 1,550 low-income, vulnerable seniors in over 70 communities throughout Minnesota and North Dakota and has been expanded to include Montana. Its

Efforts have led to some of the highest-need older adults receiving services that contribute to improved quality of life.

efforts have led to some of the highest-need older adults receiving services that contribute to improved quality of life and having the freedom to choose where to live.

The Collaborative's services directly relate to social determinants of health - a key area of focus for Lutheran Services in America and its national network. Its services range from aiding with transportation to medical appointments and coordinating visits to friends and families, to assisting people

struggling with dementia, visiting as a needed companion and even helping with challenging household tasks.

Jeff, a Vietnam veteran who has struggled with post-traumatic stress, has cared for his wife, Sheila, since her Alzheimer's diagnosis at age 56. He says the stress of caring for his wife is the hardest thing he's ever had to face. "Day by day, you are faced with tremendous loss," he said. Through Remote Caregiver's respite care and counseling using the program's user-friendly technology, Jeff sees great improvement.

Lutheran Services in America is a nationwide network of 300 health care and human services organizations that work with one in 50 Americans each year. It is deeply embedded in the fabric of communities nationwide and works to transform the lives of people and communities.

Margaret Mary Health

Transitioning volume to value

Margaret Mary Health was founded in 1932 in the rural community of Batesville, Indiana, with only 7,000 people. After a sustained effort to understand the population's specific health needs, the hospital was formed by the community through support and firsthand input. Their main mission is to improve the overall health of the communities they serve.

Over time, Margaret Mary Health began to recognize an ongoing problem in hospital systems throughout the nation: hospitals were getting paid to do things for patients (such as perform surgeries, prescribe treatment and provide other necessary services), but not to keep them healthy after the fact. As a result, Margaret Mary Health made the commitment to focus on helping keep people in the community healthy, especially the elderly and isolated, beyond simply providing clean water and vaccines.

Margaret Mary Health is determined to be the one long-lasting hospital that is dedicated to helping their patients stay healthy and happy in the long-term.

Margaret Mary Health implemented the transition from “volume to value” in order to provide better health care coverage by understanding issues such as social isolation and loneliness.

The ongoing question for Margaret Mary Health remains, “What can we do to help the people in our community feel their best all while addressing social isolation?” To answer this, the community hospital is working with local churches, clubs and city centers to implement programs to keep residents involved and eradicate social isolation. Margaret Mary Health is determined to be the one long-lasting hospital that is dedicated to helping their patients stay healthy and happy in the long term.

Margaret Mary Health improves the health of its communities by being the best health care provider for the communities where people choose to go for services, where physicians choose to practice, and where team members choose to work.

Mercy Community Healthcare

Finding faith and health in rural Tennessee

Mercy Community Healthcare is now in its 20th year of operation and provides health care services to more than 10,000 people in four counties of central Tennessee, regardless of ability to pay.

Over the past two decades, Mercy has added critical services to their offerings, including mental health and social services, chronic care management, pediatric and adult primary care and care coordination. Mercy also maintains a strong footprint in rural areas of Tennessee, often being the insurer of last resort.

Wanda M. lived in a small rural area in Appalachia and cared for her terminally-ill husband for months. Years earlier, Wanda was diagnosed with atrial fibrillation, a condition that can lead to blood clots, stroke, heart failure, and other

heart-related complications. Her prescriptions included blood thinning medication and oxycodone, which led to addiction.

Her quiet battle with addiction empowered her to recommit to her faith, and when she was forced to move from Florida back to Tennessee, she adjusted more quickly. Thanks to the excellent care she was given at Mercy,

Mercy also maintains a strong footprint in rural areas of Tennessee, often being the insurer of last resort.

and the opportunities and activities available at her new home, the Brookdale Senior Living Center, Wanda's well-being has improved. She is very active as the garden club president and is a hostess for new residents coming into Brookdale.

Mercy Community Healthcare reflects the love and compassion of Jesus Christ by providing excellent health care to all and support for their families, regardless of ability to pay. Mercy provides compassionate, convenient and comprehensive services.



Motion Picture & Television Fund

Social connection a phone call away



Motion Picture & Television Fund's (MPTF) Daily Call Sheet (DCS) is all about creating social connections, addressing social isolation and loneliness affecting industry members, and creating a model for broader impact. The concept is simple: MPTF trains volunteers and matches them with industry members who are isolated and are suffering through loneliness through social telephone conversations. DCS participants live in locations across the U.S., including rural areas where geography and limited transportation options compound feelings of isolation triggered by health and aging challenges.

To expand the reach of this work, MPTF now trains other non-profit organizations in identifying and addressing social isolation and loneliness. With this, MPTF guides organizations in developing and deploying programs that directly address the unique needs of those they serve.

Over half the volunteers report that making the calls helps reduce their own sense of loneliness and isolation.

Participants, isolated due to caregiving duties, treatment facilities or other circumstances, may go many days without speaking to anyone. These recipients describe the calls as a “lifeline” that “lifts their spirits.” Of the recipients, 97 percent indicate that they would like to continue receiving calls and would recommend this for others. Over half the volunteers report that making the calls helps

reduce their own sense of loneliness and isolation.

Phillip, a 77-year-old retired prop manager, lives in a rehab facility in Ohio where he receives cancer treatments. He moved back to Ohio to be closer to family but found himself very isolated and feeling lonely. He reports, “I am so happy to have been connected to the Daily Call Sheet program. There were times I was so lonely, I thought I was dying. I truly look forward to Lisa’s calls and can’t thank MPTF enough for creating this program!”

MPTF supports the entertainment community in living and aging well, with dignity and purpose, and in helping each other in times of need, through a broad range of innovative programs and services across the lifespan - from childcare through end of life care.

National Council on Aging

Mastering aging as a joyful experience



Founded in 1950, National Council on Aging (NCOA) is a national advocate for every person's right to age well. Working with a nationwide network of partners, as well as directly with individuals, NCOA focuses on improving the health and economic security of all older adults, and has surpassed its 2020 goal of improving the lives of 10 million older adults with its next goal of improving the lives of 40 million by 2030.

NCOA delivered Aging Mastery® in 39 rural communities in Wisconsin, Minnesota and Washington. Aging Mastery is an innovative, fun approach to living that helps individuals take key steps toward making positive changes in their lives. In a three-year span, more than 4,000 individuals either participated in Aging Mastery Program® (AMP) classes or received the in-home Aging Mastery

Starter Kit. The lead state agencies were Greater Wisconsin Area Agency Resources, Inc. (GWAAR), Washington Association of Area Agencies on Aging (W4A) and Minnesota Recreation and Parks Association (MRPA).

Behavior change is a key metric for the AMP classes: 91 percent of participants reported that the classes improved the way they managed their

*Founded in 1950,
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health and 94 percent stated that AMP improved their quality of life. AMP participants most enjoyed its social component and the opportunity to meet new people. Participants often cited steps they took toward increasing gratitude and improving relationships.

Aging Mastery has transformed lives. As one participant said: "As a result of the Aging Mastery Program, I am now more aware of all aspects of aging. I take the time to recognize that small changes can make a big difference and actually make aging a joyful experience."

In addition, the program has transformed communities and NCOA has committed to growing the program over the next three years in additional rural areas in Wisconsin, Minnesota and Washington while focusing overall on improving the economic security and health of all older adults.

NCOA is a respected national leader and trusted partner to help people 60+ meet the challenges of aging. NCOA partners with non-profit organizations, government and business to provide innovative community programs and services, online help and advocacy.

Penn State Intergenerational Program

Bridging the gap between generations

The Penn State Intergenerational Program, an arm of the Penn State Extension, includes a broad base of scholars and practitioners who are interested in studying and employing diverse approaches to growing older across different age groups. They emphasize the development of new models and curricular resources that enrich people's lives and help address vital social and community issues.

Included in the 4-H Youth Development Program is the Generation Celebration Project.

One of their flagship programs, identified as FRIDGE (Food Related Intergenerational Discussion Group Experiences), is designed to help families communicate better

about food, learn about nutrition and work collectively to achieve personal healthy-eating goals.

Included in the 4-H Youth Development Program is the Generation Celebration Project. The objective is to help young people and older adults enjoy and learn from each other. The project consists of six sessions designed to aid young people and seniors to become more aware of stereotypes towards aging while having fun and getting to know each other.

Community and civic engagement, early childhood and environmental education are a few other key resources offered by the Intergenerational Program. Many revolve around training and development of intergenerational programs for those associated with each group. The Intergenerational Program acts as a guidebook, demonstrating strategies for children, adults and the elderly.

The Penn State Intergenerational Program is pioneering the development of new intergenerational initiatives, research around them and their impact on communities. Their work demonstrates how individuals can adapt to intergenerational lifestyles, build relationships and break through aging stereotypes.

Penn State Extension program develops initiatives and study their impact on communities, to provide leadership and resource support for organizations interested in establishing intergenerational programs.



Saint Joseph's College of Maine

Pioneering rural needs in Maine



Saint Joseph's College of Maine is taking an innovative approach to addressing the needs of its rural aging population. The newly created Institute for Integrative Aging (IIA) is committed to developing a variety of programs and activities geared toward wellness, social engagement and longevity.

Integrative Aging—a term coined by Saint Joseph's College President Jim Dlugos—seeks to advance the concepts of integrative medicine and health care by developing an understanding and approach to aging. Integrative Aging understands the multi-dimensional aspects of aging (physical, emotional, social, intellectual and spiritual) along with societal factors (socio-economic, urban vs. rural issues and cultural identity) that can negatively impact the health of a population.

Saint Joseph's College of Maine is taking an innovative approach to addressing the needs of its rural aging population.

The IIA is partnering with Tivity Health®, to bring SilverSneakers®, a nationwide fitness program focused on seniors, to campus. Three 45-minute classes are offered per week with a focus on

stability, muscle building and endurance. “We are working on the activities of daily life: bringing groceries in, getting in and out of the car and improving personal hygiene. We are working on things the senior community needs help with,” says Jenna Chase, Associate Director of Health and Wellness programming. More classes are being added due to an increase in demand and interest.

In addition to the physical benefits of the exercise program, strong social connections are forged, which addresses issues of loneliness and social isolation. IIA's commitment to social connectivity and community engagement is evidenced through the development and support of additional social events for older adults, such as Silver Lunches, Ukulele classes and a Silver Ball.

Saint Joseph's College of Maine is an intentional community committed to the practice and pursuit of wellness and sustainability, designed to provide new learning opportunities for a changing society while supporting the growth of Maine's emerging economies.

Texas A&M Center for Population Health and Aging

Lone Star State implements Texercise for seniors



On November 9, 2016, the Texas A&M Center for Population Health and Aging (CPHA) was formally recognized as a Texas A&M Board of Regents Center, building on more than a decade of aging-related research, education and practice projects. With a goal of making healthy aging the “new normal,” CPHA provides a centralized hub to address the challenges and opportunities of a rapidly aging world. Building upon evidence-based practices, CPHA activities focus on social, behavioral, economic, policy, environmental and technological innovations that positively affect aging individuals, their families, health care professionals, and communities.

CPHA works with local communities and partners to offer Texercise Select, a lifestyle program developed by Texas Health and Human Services, throughout the state. The Center worked with Amigos del Valle senior citizen centers and a faith-based coalition, Bienestar, to deliver Texercise classes.

CPHA provides a centralized hub to address the challenges and opportunities of a rapidly aging world.

Through public (e.g. Healthy South Texas initiative) and private funding (e.g. Knapp Community Care Foundation), Texercise Select has been implemented in Amigos del Valle senior centers in rural and underserved areas across South Texas such as Donna, Weslaco, La Joya, Mercedes and Elsa. The program provides fitness kits and light equipment to otherwise sedentary, inactive seniors. As a testament to the popularity and success of Texercise Select, many community centers continued to offer the program after its “official” end. That way, older adults living in rural and isolated areas could keep exercising in a safe environment, while also receiving social support for being active.

The Center for Population Health and Aging is leading a coordinated effort to promote research into, and understanding of, successful aging strategies. Specifically, the Center coalesces several distinct but related aging and health promotion-oriented research programs.

TN AARP - SMiles

Neighbors driving neighbors

Thanks to a team of 136 adult volunteers, 217 non-driving older adults in rural Blount County, Tennessee, now can make their doctor's appointments, go grocery shopping and visit with others.

Mrs. Smith lives in a remote area seven miles from rural Maryville, Tennessee. Until October of 2013, the options for Mrs. Smith were to call a taxi or schedule a ride with the local rural public transportation provider to get to doctors' appointments. For rural transit, she would leave her house at 8 a.m. and could be driven all over the county in a large van before being dropped off for her 10

a.m. appointment. Afterward, a call to the same provider arranges the pickup. Mrs. Smith would be home by 1:30 p.m., a round trip of five and one-half hours at a cost of six dollars.

The cost is still six dollars, but with the new benefits of efficiency, comfort and friendly socialization.

With SMiles, Mrs. Smith calls and schedules a ride, which is posted online through a special secure software program. A volunteer driver, Joy, assigns

herself to take Mrs. Smith to the dentist at 10 a.m. next Wednesday. The two of them have a friendly chat during the ride and while waiting at the office. After leaving the dentist, Joy takes her new friend to the store and then drops her back home by 11:30 a.m., helping bring in the groceries. The cost is still six dollars, but with the new benefits of efficiency, comfort and friendly socialization.

SMiles is a senior-friendly, door-through-door transportation service for Blount County, Tennessee, residents age 60+ who need rides for essential trips. The service enhances the quality of life and independence of older adults who no longer drive.

Valley Area Agency on Aging

Combating loneliness with SilverSneakers



The Valley Area Agency on Aging partnered with AARP to complete a Senior Needs Survey in 2016, in which seniors reported skin rashes, hair loss, anxiety, depression, feelings of isolation and loneliness, fatigue and other serious issues. These were all a result off the lead-contaminated water. Lack of transportation to water distribution stations and the inability to access information and assistance also became evident.

In 2017, the Valley Area Agency on Aging and Tivity Health established a formal partnership to collaborate on strategic ways to enhance engagement for low-income seniors in suburban and rural areas of Flint, Michigan. The goal of this effort was to improve their quality of life, and, by extension, to improve their health, independence and wellbeing.

The SilverSneakers classes continue to grow and have become a source of income for the Valley Area Agency on Aging.

Through this partnership, expanded evidence-based classes and SilverSneakers classes were introduced in area sites with a pre- and post-assessment survey to evaluate the impact of the programming on physical and mental health and loneliness. To date, 360 local seniors have participated in a class series, offered at 15 different locations.

The SilverSneakers classes continue to grow and have become a source of income for the Valley Area Agency on Aging. The ability to leverage support is a concept that can be adopted in other rural and suburban areas. The Agency has noted that the ability to be flexible at on-site locations for activity programs is critical for successful outreach, engagement and retention. Leveraging public-private collaboration is a great story for any community!

VAAA provides answers, action and advocacy on care for the elderly and disabled adults of Genesee, Lapeer and Shiawassee counties. It enhances lives, empowering choice, sustaining independence and supporting caregivers and families.



YMCA

Building healthy living in the community

In 2014, the Ashtabula County YMCA in Ohio, conducted a Community Needs Assessment that indicated a large portion of the county was not being supported with physical/social activities and healthy living opportunities, especially for older adults.

With a mission to put Christian principles into practice through programs that build a healthy spirit, mind and body for all, the Ashtabula County YMCA hired its first ever Outreach Director in 2015 and began a Community Outreach program.

Prior to starting senior group exercise classes, Carol, a 79-year-old from Andover, Ohio, was spending most of her time at home alone. In the

summertime, her friends were in town and she was significantly more active.

However, her friends would leave for Florida every Fall, and she would spend the next eight months in her house, alone and unmotivated.

After she read about the Andover outreach programs in the newspaper,

Carol attended an open house. She had SilverSneakers through her Medicare supplementary insurance but had never had an opportunity to use it. For the first time without her friends, Carol came out to the YMCA.

Carol no longer stays at home while her friends are away. She has made new friends through the YMCA outreach programs and has even started carpooling with them! She has also started attending senior luncheons and other social activities at the local Senior Center.

YMCAs throughout the country work side-by-side with neighbors to make sure everyone, regardless of age, income or background, has the opportunity to learn, grow and thrive, by focusing on youth development, healthy living and social responsibility.

For the first time without her friends, Carol came out to the YMCA.

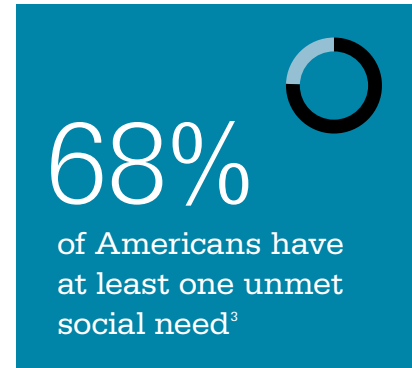




RuralAge.com

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Determined to Reduce Disparities: Solutions to Address Social Determinants of Health



SOCIAL AND ECONOMIC FACTORS have a profound impact on our health, longevity, and quality of life. They are the main drivers of health disparities in our society.

They include:

- Housing
- Health literacy
- Food insecurity
- Social support
- Crime & violence
- Economic wellbeing
- Transportation

Awareness of the critical role social determinants play is increasing, and organizations nationwide are working to find solutions to these difficult problems.

The need is clear.

Aggregate healthcare spending in this country is approaching 18 percent of gross domestic product, yet we lag other developed nations in health outcomes on such measures as obesity, chronic conditions, infant mortality, and life expectancy.⁴ Investment in social services is a stronger predictor of health outcomes than healthcare spending,⁵ so it's easy to see that addressing social determinants to improve population health can help slow the cost growth curve.

For example, states that provide higher levels of social services successfully reduced rates of obesity, asthma, mental health problems, cancer, myocardial infarction, and type 2 diabetes, representing significant avoided healthcare costs.⁶

There are many other positive indicators that awareness of the impact of social determinants is increasing, as stakeholders across the continuum are working to address their negative effects on health. Medicare Advantage, an option within Medicare that allows seniors to enroll in private plans offering wrap-around health coverage and benefits, now covers transportation services and nutrition counseling. And many states are receiving federal waivers to expand Medicaid programs to support initiatives in housing, employment, food access, and transportation.

Solutions: Keys to Success

Collaborations and partnerships are key to addressing social determinants of health. Public-private partnerships and multi-organization collaborations bring together the strengths of multiple players and maximize the contributions of all. We must work together to coordinate healthcare and social services outreach; bridge incentives across health services; integrate the voices of patients; and improve data strategies.

Coordinating Healthcare and Social Services Outreach

Providers and health systems must work more closely with community social service organizations that identify social needs and provide assistive services. These organizations have established local networks and credibility. When healthcare providers and organizations better understand specific community health needs, they can leverage community assets to meet those needs. These linkages and referrals can help surmount critical barriers to addressing social determinants, including vulnerability and distrust.

For example, social service organizations in Appalachia tailor outreach initiatives to link pregnant women struggling with opioid abuse with the appropriate health resources. Meals on Wheels programs provide beneficiaries with social

engagement and human contact, building the trust necessary for other social determinants interventions. Some colleges are opening their campuses and resources to senior citizens in their local communities for social engagement and stimulation. However, providers may be unaware of the rich assortment of programs available in their area.

Healthcare entities and social services providers have built-in incentives to seek collaboration.

Social service organizations that work with other institutions can broaden their reach and breadth of assistance. Healthcare payers and providers can, by working with community and social services organizations, keep individuals healthier through attention to social determinants and curb long-term health cost growth.

>> TO DO Collect and categorize community resources so healthcare providers can provide vital connections for patients with social needs.

Bridging Incentives Across Health Services

Addressing the social determinants of health presents significant financial challenges to patients and providers. Patients may be reluctant to seek care out of fear, distrust, or an inability to pay. Social safety nets are insufficient to link underserved populations with available services, and financial incentives may clash with family autonomy.⁹

Providers have concerns too. Not only are payment structures and effective metrics for non-medical solutions lacking, but healthcare leaders see slow patient adoption of solutions as a significant barrier as well. But there are many bright spots in innovation and payment reform. For example, the Social Determinants Accelerator Act, a bipartisan proposal for a federal grant program, would fund local programs developing silo-breaking interventions under Medicaid. Medical

providers are working with local ride-share businesses to address the four million missed medical appointments each year, and states are reforming ride-share reimbursement laws to advance this cooperative effort.

Creative payment policy solutions for addressing social determinants of health will be central to the current transition of healthcare to value-based models. New accountable and value-based care models, which integrate medical resources and global budgets, should align incentives for healthcare entities with those for social services and vulnerable patient segments. Integrated interventions can be pursued at all levels: federal, state, and local.

To realize the potential of those value-based models, we also must modernize the nation's healthcare fraud and abuse laws. Crafted to prevent improprieties in a fee-for-service environment, they are poorly suited for value-based care that emphasizes collaboration and the more robust care coordination needed to address social determinants of health.

>> TO DO Design new care delivery models to align incentives and integrate interventions to address the adverse effects of social determinants of health.

Integrating the Voices of Patients

Effective social determinants solutions give patients a voice, especially when the solutions are a co-creation between the patient and the community. Collaboration, information gathering, and information sharing can help beneficiaries feel invested and can help to build trust. Sharing their stories elevates their experience, gives it value, and helps forge connections with others in need. Viewing patients as critical stakeholders can help to overcome the vulnerability many feel when they come into contact with the healthcare system and can help alleviate distrust.



42%

of Americans say they would turn to their medical services provider when looking for information on community resources to help with social needs⁷



49%

of healthcare leaders cite lack of payment structures for non-medical activities as a barrier to addressing social determinants of health⁸



97%

of Americans feel that their medical provider should ask about social needs¹⁰

Barriers and Bright Spots

Common barriers can stand between people with social needs and the resources that can reduce disparities and improve their health:

- Vulnerability: economic insecurity, difficulty getting or keeping a job, food insecurity, unreliable or unaffordable transportation, broken familial relationships, insurance coverage gaps
- Distrust: a lack of trust in public safety and police, institutions, organizations; reluctance to share information, engage with the healthcare system, accept assistance
- Social isolation: loneliness, feelings of helplessness, crippling fear

Fortunately, there are bright spots: initiatives that have proven to break down (or leap over) those barriers and connect people to the resources they need.

For example, Tivity Health's SilverSneakers program uses group physical fitness activities to help participants maintain good physical health and age with vitality. The SilverSneakers program addresses multiple barriers. Its success underscores the importance of creating vehicles that enable greater social connectedness, the ability to create new friendships, and the sense of being part of a larger community. These initiatives enhance participants' physical, social, and mental health and well-being.

Similarly, Aetna works to build "healthy homes," from repairing rickety stairs and unsafe porches to installing equipment to help those with mobility challenges. The project has demonstrated how important it is to remove those physical causes of isolation. Safer housing enables people to interact more frequently with neighbors and community, and to be reached with nutritious meals and other essential services.

In addition to sharing their stories, patients should also share in the savings that result from their proactive participation in health programs. This, too, acknowledges their role as critical stakeholders.

>> TO DO Share patient stories and give them a voice in how a portion of shared savings will be spent.

Improving Data Strategies

While we may understand intuitively the value of addressing social determinants, we need data and evidence to engage and enlist the support of policymakers and stakeholders. By aggregating and refining data, we can develop analytical strategies that illuminate the effects of social determinants and make the case for proposed solutions. Data analysis is critical to bringing about systemic improvements in how social determinants are addressed at individual and population levels.

The relevant data resides in multiple repositories including private organizations as well as such public sources as Medicare and Medicaid. Although community service organizations collect data during patient interventions, they often lack the capacity and infrastructure to analyze it. Data integration is critical for informing healthcare delivery systems and governmental decision-making bodies and for assessing the effectiveness of possible solutions.

More systematic data collection and analysis on social determinants and aggregating it from a variety of public and private sources will improve care and service delivery to individuals and inform programmatic refinements through evidence-based population health strategies.

Marrying granular information with population-level data will enable its translation into new and improved solutions.

Inconsistent data collection, both in quality and frequency of collection, slows the broad application of social determinants solutions, while a shortage of methodologies to evaluate them frustrates potential adopters. To expand the resource flow into these solutions, we must find ways to demonstrate on a systemic level that these programs are generating positive return on investment in terms of greater access, better health, and improved outcomes.

>> TO DO Enlist key players in various health sectors to determine a strategy for incorporating methods for better data collection and integration and sharing of what works.



43%

of healthcare leaders say limitations on data sharing present a significant barrier to addressing social determinants of health¹¹

Determined

The sheer breadth of the social challenges that people face in their homes, stages of life, and communities can be daunting and make it difficult to get our arms around the idea of addressing social determinants of health. Whereas one person may live in an area plagued by crime, another may live in an isolated rural area that makes human contact all too rare. For every single male over 65 who has difficulty making interpersonal connections, there is a new mother struggling with health, nutrition, and transportation challenges.

Millions of people across the United States face significant disparities in health, quality of life, and lifespan for reasons that are within our power to address. There are solutions for each of these challenges, whether their nature is social, economic, or physical. The challenge lies in effectively applying these solutions for people and determining how to make the necessary investments in ways that will improve health outcomes.

There is significant reason for encouragement and optimism, given the progress seen in both the public and private sectors. These advances, though, are still largely episodic. The answer lies in developing systemic, data-driven, broad-scale approaches to social determinants of health that will make a lasting impact on population health and well-being.

Four Keys to Success



Coordinating
Healthcare and Social
Services Outreach



Bridging Incentives
Across Health
Services



Integrating the
Voices of Patients



Improving Data
Strategies

In May 2019, the Healthcare Leadership Council, an alliance of innovative healthcare companies from all health sectors, and two of its members, Aetna and Tivity Health, convened a roundtable forum in Washington, DC, involving more than 60 organizations from the healthcare, public policy, academia, non-profit, patient advocacy, and private industry spheres. The objective was to share ideas and build consensus around a common understanding of the importance of social determinants of health; identify the greatest barriers to addressing social determinants of health; and identify high-impact actions and solutions that both the private and public sectors could implement at the federal, state, and/or local levels. The solutions laid out in this document were generated by the roundtable participants.

1. [County Health Rankings model](#)
2. [Holt-Lunstad et al. Perspectives on Psychological Science, March 2015.](#)
3. [Kaiser Permanente](#)
4. [The Commonwealth Fund](#)
5. [Bradley et al. Health Affairs, May 2016](#)
6. [Ibid.](#)
7. [Kaiser Permanente](#)
8. [HealthCare Executive Group and Change Healthcare](#)
9. [Garg et al. Pediatrics, April 2019](#)
10. [Kaiser Permanente](#)
11. [HealthCare Executive Group and Change Healthcare](#)

For full reference citations, please see the online version of this document at www.hlc.org.

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RURAL AGING IN AMERICA: PROCEEDINGS OF THE 2017 CONNECTIVITY SUMMIT

Alexis Skoufalos, EdD, Janice L. Clarke, RN, BBA, Dana Rose Ellis, BA,
Vicki L. Shepard, MSW, MPA, and Elizabeth Y. Rula, PhD

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Population Health Management Supplement Policy

Population Health Management publishes supplements that (a) discuss new technologies, theories, and/or practice, and (b) serve as enduring materials to disseminate information from conferences and special meetings. Supplements that discuss new technologies, theories, and/or practices are subject to peer review.

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Rural Aging in America: Proceedings of the 2017 Connectivity Summit

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Vicki L. Shepard, MSW, MPA,³ and Elizabeth Y. Rula, PhD³

Editorial

Creating a Movement to Transform Rural Aging

*David B. Nash, MD, MBA, with Donato J. Tramuto,
and Joseph F. Coughlin, PhD*

Each day 10,000 people reach age 65 in the United States, a trend that is projected to continue through 2030.¹ As we strategize about how to address the needs of our country's aging population, we must redefine what it means to age well in the context of contemporary society. Today, healthy aging is not just about living *longer* but about living *better*. An individual's health and quality of life are influenced by many variables outside the traditional purview of health care services delivery (eg, accessible and affordable housing, healthy foods, reliable and convenient transportation, social opportunities, access to affordable quality health care and community services). These social and environmental determinants are the backbone of population health, and there is growing recognition of their vital importance. The consequences of neglecting these determinants can vary based on geography; in rural areas, the potential for a negative impact on quality of life is amplified, especially for older adults.

Compared to their urban and suburban counterparts, older adults living in rural communities are at a disadvantage in terms of available services, resources, and activities and the social "glue" these provide. Although it may come as a surprise to many people living in the country's more populous areas, approximately 25% of Americans older than age 65 live in a small town or other rural area.² In some states, the percentage is much higher; for example, in Maine, 58% percent of adults older than age 65 live in rural areas.

Rural communities have a higher prevalence of chronic disease, a higher disability rate, a lower prevalence of healthy behaviors,³ and a widening gap in life expectancy⁴ relative to the nation as a whole. Moreover, they face additional obstacles and challenges:

- Cash-strapped local governments.
- Difficulty forming community partnerships because of proximity challenges.
- Migration of younger individuals to cities for career and social opportunities, resulting in a smaller pool of potential caregivers.
- Struggling small businesses and dwindling economic opportunities.
- An aging housing stock that also may be unsafe (eg, in need of repairs, containing falls risks, inaccessible for a person with mobility challenges).
- A raging opioid crisis that has turned many grandparents into caregivers.
- Inadequate resources available to meet the broad range of needs among older adults.

How can we overcome these considerable challenges and build a strong foundation for improving the health and well-being of rural-dwelling older adults? A comprehensive solution is beyond the reach or resources of any single group or organization working in isolation. Progress in addressing the seemingly intractable problems in rural health will take strong leadership, recognition of the considerable power of communities, and creation of collaborative partnerships that leverage their combined resources and skills to develop meaningful solutions to difficult problems – something that has become known in the business world as "collaborative IQ."

Tivity Health and Health eVillages, the MIT AgeLab, and the Jefferson College of Population Health are committed to working together to identify strategies that will ensure the brightest future possible for aging Americans. To that end, we partnered to organize and convene the inaugural Connectivity Summit: A Catalyst for Change in Rural Aging on June 21, 2017, bringing together key stakeholders from multiple disciplines and sectors of society to share ideas and work toward implementing solutions to some of the most pressing problems described above.

Our mission was to initiate a movement that would elevate the importance of the critical situation facing rural-dwelling

¹Jefferson College of Population Health, Philadelphia, Pennsylvania.

²AgeLab, Massachusetts Institute of Technology, Cambridge, Massachusetts.

³Tivity Health, Franklin, Tennessee.

older adults. The Summit increased our original “collaborative IQ” (as experts from the fields of aging, technology, and health care) by 10-fold as it extended the conversation and connected with experts from government, business and academia, as well as nonprofit, faith-based, and community organizations.

“Coming together is a beginning.
Keeping together is progress.
Working together is success.”
Henry Ford

What follows are the proceedings of this dynamic meeting that brought together committed partners with diverse sets of talents and resources and a passion for making a difference in the lives of others. We hope that it inspires you to join us on this journey to help today’s older adults and future generations to age healthfully and live more fulfilling lives.

Introduction

Closing out the second decade of the 21st century, we have entered a new world of aging, one in which the image of retiring to a lounge chair has given way to a vision of healthy, active, socially-connected living. As the youngest members of the baby boomer generation quickly approach retirement age, the health care sector has been gearing up to accommodate their evolving needs and expectations. Wellness programs and activities (eg, SilverSneakers) and targeted education/support programs are widely available to help the growing population of older Americans achieve their optimal quality of life and successfully manage the age-related chronic conditions (eg, diabetes, heart disease, hypertension, arthritis, hyperlipidemia) that frequently arise during this stage of life.

With the anniversaries of Medicare (50th) and Social Security (75th) in 2015, the nation celebrated the great strides that have been made in addressing the physical health and financial security needs of older citizens. Although considerable progress has been made, it must not be permitted to overshadow the challenges that remain. In particular, there are substantial regional disparities that limit residents’ potential for vitality as they reach retirement age. Although the health care sector has anticipated the needs and expectations of the baby boomer generation and targeted initiatives accordingly, relatively few of these programs and resources are allocated to, or available in, rural areas.⁵

The term “rural” is used often, but there is no single standard for the designation, even under Federal government criteria; it is defined largely within the context of regional geography. The US Census Bureau defines rural as any population, housing, or territory that is not an urban area with a densely settled core.⁶ However, most of the rural population lives near one of 2 types of urban areas defined by the Bureau (“urban clusters” with populations of 2500 to 50,000, and “urbanized areas” with populations of 50,000 or more). The Office of Management and Budget uses an alternate, county-based definition of rural⁶ (ie, nonmetropolitan counties that are outside of a metropolitan or micropolitan statistical area). This description encompasses disparate areas – from small towns to frontier and remote areas – with different characteristics (eg, Native Americans have unique cultural needs

and reservations are often in very remote locations). Creation of a broad and unified definition of “rural” that is inclusive of the intensity and density of accessible activities and services also may help unify efforts to impact these communities.

The primary concerns that affect the health and well-being of all older Americans are access to health care and support services (including transportation and mobility support), nutrition, housing, and social isolation. For those living in rural areas these concerns are exacerbated by the geographic isolation that requires them to travel greater distances to obtain services of all types, the relative lack of infrastructure and connections (transportation systems, high-speed broadband, community centers), and the relative scarcity of resources because of economic constraints. The resultant social isolation can be an exceptionally challenging problem for rural-dwelling individuals who may also be trying to cope with food insecurity, mobility challenges and chronic health conditions.

There are approximately 10 million people ages 65 and older living in rural America today; in fact, 1 out of every 4 older adults lives in a small town or other rural area.⁷ Relative to their counterparts living in urban areas, statistics reveal that rural populations experience risk factors (geographic isolation, lower socioeconomic status, limited job opportunities) that contribute to health disparities and lower life expectancy. Rural residents receive lower Social Security and pension benefits than their urban counterparts, particularly rural-dwelling females with lower lifetime wages and greater longevity.⁸ In addition, they tend to have a higher prevalence of chronic disease, a higher rate of disability, a lower prevalence of healthy behaviors, and fewer health professionals available to provide the services they need.⁹

Geographic isolation requires rural residents to travel greater distances to fulfill basic needs such as quality health care, prescription medicines and healthy food. The number of physicians per 10,000 people is approximately 30% lower in rural communities than in urban areas,¹⁰ and travel to an urban center is often required for specialist services. Rural areas typically lack the infrastructure and connections required to transport people where they need to go, attract quality services to the community, and avail modern technology for in-home support. For example, 53% of rural area residents lack high-speed broadband (25 Mbps/3 Mbps of bandwidth) access compared with 4% of those living in urban areas.¹¹

According to the American Association of Retired Persons (AARP), 87% of people older than age 65 reported the desire to remain in their current homes and communities. However, aging in place is not a practical option for many older Americans living in rural areas because of limited access to preventive services, physical and behavioral health treatment options, and home health services. As younger generations move away, there are fewer caregivers to provide support and comfort. Moreover, the combination of proximity challenges and limited options for organized activities often results in significant social isolation for older adults who choose to remain in rural areas. According to the Gallup-Sharecare Well-Being Index, the widest gap between rural and urban communities across all aspects of well-being occurs with respect to social well-being.¹² In fact, social isolation is as predictive of mortality as clinical risk factors^{12,13}; older adults living in rural communities are more likely to be admitted to a nursing home because of a lack of the support necessary for aging in place.¹⁴

Many of today's rural communities struggle with challenges that stem from the root causes described herein. For example:

- Younger people tend to move away to seek better career opportunities and, in so doing, diminish the potential workforce pool and disrupt the family fabric that has traditionally provided support to the older population.
- The recent economic upturn has been slowest to take hold in rural America; in some cases, there has been no upturn at all.¹⁵
- In rural communities, the opioid issue often manifests in the form of elderly parents of addicted children caring for their grandchildren.
- It can be difficult to access culturally or linguistically appropriate services for rural populations who tend to be overwhelmingly non-Hispanic whites or, in specific regions, other minority groups.⁹ In particular, Native Americans have distinct needs.

In addition to evaluating the core issues of aging in rural America, it is important to consider the direct effect of associated policy decisions on the quality of life for older adults; eg, home- and community-based services versus institutional care, Medicaid funding, housing, transportation, communication infrastructure, and access to quality health care and social service programs. The current decade has been notable for ongoing controversy over how to make the best use of our health care resources. Regardless of the final resolution on the policy front, the likelihood is high that the focus will remain on population health management under value-based care delivery and reimbursement models.

Rationale for and goals of the Connectivity Summit

Despite their considerable challenges, rural communities have strengths that can be leveraged to improve the well-being of their residents. Although the Gallup-Sharecare Well-Being Index showed a significant overall deficit in well-being for rural-dwelling older adults versus their urban counterparts, it revealed relatively higher community well-being (pride in the community, feelings of safety and security) and a stronger sense of purpose among rural residents.¹²

Today, each organization and agency works independently to develop and implement interventions and programs that address a broad range of concerns. Achieving optimal health and quality of life outcomes for older adults living in rural America will require targeted, innovative, solutions-based thinking from a broad-based coalition of leaders from every sector: corporations, academia, health care, government, and nonprofit organizations (including faith-based institutions). Given the urgency of the issues, and the potential impact on society as a whole, there is an enormous opportunity to make a positive difference in the health and well-being of rural-dwelling older adults through collaboration (ie, information and resource sharing, program scaling, policy advocacy efforts to communicate these issues to governmental and public entities). To that end, Tivity Health, Health eVillages, and the Massachusetts Institute of Technology (MIT) AgeLab partnered with the Jefferson College of Population Health to organize the 2017 Connectivity Summit on Rural Aging, held on June 21, 2017, that brought together some of the country's leading experts

to focus on this important topic. The Summit was convened in Portsmouth, NH, which borders southern Maine, the state with the nation's highest median age and where the proportion of older adults is projected to almost double between 2000 and 2030.¹⁶ The 2010 US Census revealed that 61.3% of Maine's population lived in rural areas.¹⁷

In welcoming participants, Donato Tramuto (Chief Executive Officer of Tivity Health) conveyed the overarching goal of the Summit – to foster a nationwide *movement* by means of:

- Partnering to identify the unique challenges of rural aging,
- Using the participants' Collaborative IQ to create targeted solutions, and
- Sharing the outcomes to inform policy debates and educate industry leaders and consumers.

Joseph Coughlin, PhD, of MIT's AgeLab, served as the event moderator and opened the formal program with a brief anecdote to set the context for the morning's presentations. When asked by a reporter about why she still enjoyed life, 119-year-old Sarah Knauss replied, "I have my health and I can do things." Healthy aging is not simply about living longer, it is about living *better*. Coughlin noted that heightened awareness of an important issue and the related changes made to address it usually occur as a consequence of a crisis or an event that triggers action. However, policy change also comes about as a result of individual "issue entrepreneurs." To that end, Coughlin urged participants to be "issue entrepreneurs" in an effort to place the issue on the national agenda and drive change to improve the quality of life for older adults in rural America.

The focus was on developing interventions to enable people to age in a way that has meaning, and on maintaining connectivity with the community at large by leveraging the right combination of technology and hands-on services. The immediate objective was to identify and/or describe pilot programs and actionable items that the participants could work on to move forward, together, over time.

Each action-oriented session was designed to elicit ideas and stimulate conversation among participants to identify common needs for rural aging populations, with special attention to developing integrated strategies to improve access to health care and services and reduce social isolation.

Summit Proceedings

Roundtable 1: *The Power of Community – Enabling Social Connections and Access to Health Resources through Community-Based Programs*

To set the stage for discussion, several participants were invited to share information about their work in the rural aging field on the community level.

Brita Roy, MD, MPH, MHS (Assistant Professor and Director of Population Health, Yale School of Medicine), whose research focuses on identifying positive social and psychosocial factors that allow people to live healthier lives, has found that individuals who exhibit optimism and have strong social supports have a lower risk of cardiovascular disease. At the community level, she noted that individuals are greatly influenced by the places they live and the choices available to them – this includes the built (or physical) environment and social factors such as community resilience and social cohesion. Community-based participatory research shows that, by identifying and leveraging these assets

and resources, communities can be empowered to help lower costs and improve health.

Dr. Roy is also a participant in the 100 Million Healthier Lives (100M Lives) (100mlives.org) metrics workgroup. Recognizing the importance of improving quality of life for disadvantaged groups and older adults, 100M Lives is working to help communities build road maps to become Communities of Solution. These are characterized by strong relationships, an ability and willingness to address inequities, and a positive approach to change that supports vulnerable populations such as older adults. Leadership is key; Communities of Solution lead together, lead from within, lead for outcomes, lead for equity, and lead for sustainability. The initiative website houses an Aging Well Hub (www.agingwellhub.org/), a group of communities focused on improving the well-being of older adults. Any interested person or group may join the initiative or hub.

Sandy Markwood, MUEP (CEO, National Association of Area Agencies on Aging – n4a) stated that the overarching goal of n4a and its members is to support older adults to live with dignity and independence in their homes and communities for as long as possible through the provision of a broad range of community-based, on-the-ground services and supports. The Association's members include more than 622 Area Agencies on Aging and 250+ tribal aging programs that collectively engage and support millions of older adults and their caregivers in every community in the United States by offering services (eg, home-delivered meals, transportation, personal care, chore services, senior center and adult day programming) that promote wellness and combat social isolation.

More than 40% of agencies' programs explicitly serve Americans living in rural or frontier areas. Recognizing the unique nature of rural areas, n4a has a rural caucus that is convened by the Association to discuss and develop strategies to address the primary issues and challenges to health and well-being, especially assuring access to home care services and support and responding to increased needs for care coordination and mental health services in rural America.

Although it is estimated that 20% of the US population will be older than age 60 by 2020, in rural America the percentage will be higher. The fastest growing segment of this demographic is the population of older adults older than age 85,¹⁸ more than half of whom likely will need to rely on formal or informal supports to continue living independently. Statistics show that 1 out of every 3 people over age 85 struggles with Alzheimer's disease or a related form of dementia¹⁹; 60% of these people live in the community. Given that America is aging rapidly, there is a critical need for communities to value and support residents as they age by developing age- and dementia-friendly communities.

Despite the urgent need for aging services and supports, traditional governmental funding sources are not growing to meet the increasing demand. For that reason, the Aging Network is looking to partner with the health care, transportation, and volunteer/philanthropic sectors for the financial and human resources needed. Different approaches that leverage but do not rely on government funding must be found. For example:

- Through the National Aging and Disability Transportation Center (co-led by n4a and EasterSeals), n4a is supporting the development of expanded volunteer driving programs in rural communities.

- Working with the national coalition Dementia Friendly America, n4a is helping the community of Sheridan, Wyoming, support residents living with dementia and their caregivers by engaging businesses and faith-based and other volunteer organizations.

According to Gillian Sealy, MGPH (CEO, Clinton Health Matters Initiative, Clinton Foundation), the Health Matters Initiative (Initiative) views communities as the centers of innovation because they are best equipped to describe their own challenges and suggest solutions. The County Health Rankings uses a lens of social determinants of health (eg, built environment, community safety, sexual activity, alcohol/tobacco/drug use) to frame their work with 7 communities, 2 of which are in rural areas (Galesburg, Illinois and Adams County in southwestern Mississippi).

The Initiative addresses a variety of unique needs in each of the communities including: determining readiness for change, guiding communities to resources to meet physical and emotional needs, ensuring access and resources for health and well-being, promoting engagement in civic and social activities, and encouraging independence and empowerment via inclusion in discussions. Partnerships with purpose, policy review and change, and feasibility/sustainability over the long run are key elements in the Initiative's program.

Communities are beginning to realize that they must develop their own solutions. The Initiative functions as a neutral convener and facilitator in eliciting, cultivating, and implementing the communities' ideas.

Lori Parham, PhD (AARP State Director – Maine) described ways in which AARP works to enroll US communities in the international network of Age-Friendly Communities, a collaborative endeavor with the World Health Organization. Based on feedback from people ages 50 and older, WHO defined 8 domains for successful aging in place, including transportation, affordable housing, and civic engagement. AARP Maine works with 47 mostly rural communities across the state to provide technical assistance and support for local governments and community residents. Once a community is enrolled in the network, AARP focuses on community building and support at both the local and regional level. With AARP's guidance, communities conduct a thorough assessment to identify local assets and those of neighboring areas, with the goal of pooling resources if possible. They also identify local needs and areas for improvement. AARP has supported communities in developing local transportation programs, winter support programs, and age-friendly business programs. It also promotes local activities (eg, Free Coffee Fridays, walking clubs, gardening clubs).

Key outputs from the group discussion

Transportation. Transportation for medical and non-medical purposes was viewed as a necessity by many summit participants.

A primary focus for many volunteer organizations is helping transport older adults to their medical appointments. One challenge faced by these organizations is the volunteers' unease with requirements regarding background checks, personal insurance liability coverage, and bonding. To mitigate this issue, some local governments have enabled volunteers to be covered under their umbrella liability policies. Because the cost of group policies is generally high, some organizations/

agencies are beginning to work with state governments on legislation to protect volunteer drivers with a policy.

Ride-sharing companies such as Lyft and Uber are working with local governments and the Veterans Administration on a process to provide transportation services with billing directed to an entity other than the consumer. AARP Foundation described an upcoming pilot program with Lyft; payers have an incentive to support the initiative because it helps people get to their doctors. One caveat: Lyft may not be “rural” enough yet.

Some enterprising organizations are optimizing underutilized resources, which otherwise would be idle, to transport older adults to social or recreational activities or shopping. It is important to keep in mind that, for rural-dwelling older adults, travel to appointments itself often serves as a social event.

Power of community partnerships. Even in the face of a declining population base and employment challenges, community pride is strong in rural communities. One important opportunity lies in helping community-based organizations leverage the power of partnerships; for instance, partnering with Habitat for Humanity to work with volunteers on home repairs, partnering with the Masons to provide handyman services, or bringing older adults into preschools to foster intergenerational connections in communities. A compendium of success stories might serve as part of an evidence-based approach to solving some of these problems.

To help scale services throughout rural communities while preserving the uniqueness of each and accommodating their cultural differences, some organizations hire regional directors from the community. It is important to be culturally and linguistically appropriate with communication and educational materials. The 100 Million Lives Initiative is taking a similar approach, and regional leaders are now responsible for partnering with other nearby communities.

Roundtable 2: Technology and Rural Health: Innovative Solutions to Bridge the Distance, Improve Care, and Deliver Programs

Several participants were invited to share information about their work on technological issues in the context of aging in rural communities.

Anthony Versarge, MBA (Product Management Director - Connected Health, Comcast) stated that many cable companies began as connectivity companies for rural communities. An important goal for Comcast is to bring health and wellness options into homes (eg, leveraging platforms to enable adult children to check on their aging parents and to help ease the burden of care coordination). Technology can help improve the quality of life for older adults, their family supporters, and caregivers by increasing engagement and facilitating social interactions. For example:

- Partnered with academic medical institutions and retirement communities to create 150 three- to five-minute videos on healthy aging that are delivered via Comcast’s On Demand service.
- Low-Power Wide-Area technology can be employed in a device with a multiyear battery to facilitate low-power home monitoring.

Portia Singh, PhD (Research Scientist, Philips Healthcare) described the Active Care Solutions Innovation Center where 150 researchers look to the academic and advocacy communities for future direction. The population health management research division has a *hospital-to-home business unit* (telemedicine, prevention of readmissions) and a *personal health arm* (technologies for healthy living and wellness, home monitoring for chronic conditions). Examples include:

- Connected Aging examines how families and communities organize, then develops and implements initiatives to support this.
- Care Partners App provides a log and decision support for an individual.
- The Qualitative Research team works on ways to capture data sources that are not otherwise readily available. Caregiver anecdotal notes are collected over time to provide insights regarding care decisions.

However, technology is not always the answer. Although machine learning is often positioned as a replacement for humans, it is most useful in supporting and augmenting the data to improve care decisions.

Jim Firman, EdD (President and CEO - National Council on Aging) stated the overarching goal of his organization: achieving meaningful improvement in 10 million lives by 2020 by means of 4 core strategies: (1) facilitate collaborative leadership (government relations); (2) identify 2000 community not-for-profit organizations to deliver solutions; (3) develop and scale innovation; and (4) promote social enterprise (partnering with business). He provided an update on the Council’s work with regard to rural solutions as well as universal designs. With a major focus on improving access to benefits, the Council is rethinking how social services are delivered and accessed. The plan is to (1) employ people, (2) enlist friends/family, and (3) engage health care providers. For example, an evidence-based health promotion and fall prevention initiative involved partnering with Neal Kaufman, MD, to offer face-to-face and online diabetes prevention programs.

Using education and behavior change tools, the Aging Mastery Program encourages people to take actions that will improve their quality of life. The program operates in 200 communities, 55 of which are in rural areas. Public health solutions and social enterprise solutions (financial planning, socialization) are essential to help people make this major life transition over 20 years. There is an opportunity to meet people where they are; older people spend many hours per day watching television; this can be leveraged on a massive scale. For instance, a Washington State pilot uses community-based programming for digital devices, TV, and in-home monitoring. Now is the time to take responsibility for the inevitable challenges associated with a growing population of older adults.

Key outputs from the group discussion

High tech vs. high touch. It is not a matter of either/or but rather how to integrate them in a way that makes the best use of both. Technology is available but the connections needed are not happening on a large enough scale.

Consumer engagement in using technology. There is concern about the paucity of trust in this country, particularly

as we grow older. Technology is efficient but lacks the empathy of human interaction, and it is not necessarily a trusted medium when people are frightened. We must develop solutions to help to overcome this limitation.

State universities in rural areas might be helpful in recruiting younger people to connect with elders to provide support regarding technology use. One community college is offering the first associate degree program in gerontology in the state of Maine.

Focus on the end user. Codesign activities are crucial to successful technologies, yet users and their caregivers are only minimally involved in the design and development of the technologies created for them. Involve communities in the codesign of prototypes to be sure they are affordable, user friendly, portable, minimally intrusive, and stylish.

Broadband connectivity. If we think of connectivity as a basic utility, there is insufficient penetration in rural communities – and low-income older adults present the last frontier. Internet Service Providers (ISPs) must extend eligibility models to older adults (not just households with children). Copper wire maintenance must be replaced with substantial, affordable broadband. A potential immediate action might be an online exchange and marketplace to facilitate connections between groups. One caveat: it is expensive to keep a broadband product up to date, and an outdated product is useless to the end user.

Roundtable 3: An Integrated Experience: The Exponential Potential of a Collaborative Approach to Rural Aging

To set the stage for discussion, several participants were invited to share information about their work in rural aging with respect to leveraging collaborations.

John Feather, PhD (CEO - Grantmakers in Aging) reported that his organization works on the full range of aging – health, housing, arts, and rural aging. According to Feather, a paltry 2% of philanthropy in America is now focused on aging,²⁰ and only 7% of that amount is geared toward rural aging. The current concept of philanthropy for children as an investment and philanthropy for older people as an expense must be reframed in a way that articulates the return on investment on charitable giving to the aging in terms of its positive impact on services, economic security, and health care. Collaborations can be difficult because organizations rarely share the same vocabulary and the drivers are different. Grantmakers in Aging prefers to approach aging in a positive manner, and the contributions of partners can make a positive difference.

Bob Blancato, MPA (President - Matz, Blancato & Associates) spoke to the need for an advocacy strategy and closer examination of imminent threats to rural-dwelling older adults' access to resources. For instance, Medicaid cuts likely will have a more profound effect on rural communities where enrollment is higher than in urban centers. Although 11% of US physicians work in rural areas, 20% of the population lives there. There are budget proposals under consideration that would cut the community block grants that support the 7 state learning collaboratives in rural areas. A potential undercount in the upcoming 2020 census would

have serious consequences for rural communities. The current administration must be held accountable to the people who elected them, especially given that they predominantly represent rural communities.

David Nash, MD, MBA (Dean – Jefferson College of Population Health and member of the Humana Board) spoke to innovations in the way insurance companies are managing patient populations. He described ways in which Humana is working toward the Bold Goal, a 20% improvement in the health of the population served by 2020. The Medicare Advantage Program has grown by 40%, and Humana is experiencing per-member-per-month savings by means of electronic monitoring for members with chronic conditions. He noted that there is no shortage of physicians per se; rather, physicians are distributed inequitably in the United States, where there are 3 specialists for every primary care physician.

Key outputs from the group discussion

Workforce issues. A revolution in clinical care is taking place. Advanced practice nurses (APNs) trained in gerontology are obtaining independent practice licenses without the traditional requirement for physician supervision. APNs can be positioned to fill gaps in access and care management in rural communities by providing preventive care and overseeing coordinated care delivery.

In Maine, there are general workforce shortages that must be addressed. Even when they are able and willing to pay, older adults are unable to find people to help with tasks such as home maintenance, cleaning, and cooking, among others.

Role and future of critical access hospitals. Via Medicare reimbursement, the federal government covers 101% of costs at 1300 critical access hospitals.²¹ Some experts have forecasted that these hospitals will be forced to close within 40 years. Several important questions must be addressed:

- Should critical access hospitals be a safety net for acute care?
- What is the role of hospitals/health systems, and what is the incentive for these hospitals to manage care?
- Should there be a hub for activities that support at-risk populations?
- What is the role of the 55 US health systems that currently cover 28% of the population?

Following the presentations, the participants separated into small discussion groups and brainstormed collaborative follow-up actions to develop solutions to some of the challenges identified during the morning session.

General Discussion and Recommendations

The Summit represents the first opportunity for interested stakeholders to cut across sectors and work toward a comprehensive action plan. Two major focus areas emerged from the 3 roundtable and breakout sessions: (1) the need for access to improved broadband service for low-income older adults, and (2) creation of a web portal designed to share information, promote communication and collaboration among public and private organizations across regions, and to provide access to models of excellence and success stories.

Recommendation: broadband service to low-income older adults

Broadband can serve as a foundational tool for implementing interventions that target social connectedness, telehealth, and workforce development. ISPs can be helpful in bringing people together to form the business and policy case around extending eligibility to low-income older adults. Broadband service could become the highway for delivery of existing services and products (eg, telemedicine, remote monitoring, health education) as well as new ones. Products could be leveraged to help individuals monitor and manage chronic health conditions without requiring a high degree of digital literacy on the part of the beneficiary.

A potential downside is that such a program would be heavily dependent on the broadband service providers for delivery. From a financial perspective, even \$10/month may be too expensive for some people. Subsidies may be available for those meeting income eligibility criteria. Achieving 100% access will require a long-term policy solution.

Recommendation: create a Web portal to support the rural aging movement

Use a web portal to link Summit participants' and other organizations' resources and knowledge rather than creating new compendiums. The Tri-State Learning Collaborative on Aging's website might serve as a small-scale model for sharing success stories. The new portal would facilitate interorganizational communication and the formation of partnerships. Potential benefits might include shared data systems, consolidation of services and entities to resolve issues (nonprofit, government, for profit), intergenerational integration, and collaborative approaches to program funding and insurance.

The portal also could be useful as an educational platform (eg, sharing curricula designed to train providers in caring for older adults, sharing program designs for teaching college graduates how to care for rural dwelling older adults).

Post-Summit Debriefing

Strategy and objectives

Based on discussions at the Connectivity Summit and current research, the organizers identified the following potential strategies and associated objectives for future consideration:

Reduce social isolation and loneliness

- Collaborate with leading organizations to establish a consensus on measurement and guidelines for impacting social isolation
- Use technology to enable social connectedness
- Leverage the SilverSneakers model and network to increase rural engagement in group activities

Ensure safe, quality housing options

- Technology or in-person options for assessing home safety
- Health and safety monitoring and caregiver enablement
- Provide alternative options for independent living

Improve access to health care and other social and community-based services

- Expand broadband availability
- Increase transportation options
- Explore technology solutions to improve access to quality health care

Empower communities to identify local strengths to build on for proactive, tailored solutions

- Local strengths and needs assessments
- Involvement of local leaders and organizations to develop and enact solutions
- Identify and activate local ambassadors/volunteers

Improve nutrition and end hunger

- Ensure a balanced daily meal for the at-risk population
- Ensure availability of fresh fruits and vegetables at 1 or more community location(s)
- Distribute tablets to provide education on selecting and preparing healthy foods

6–12 month action plan

The Summit organizers committed to the following steps:

- 1) Assure the rural aging “movement” that began at the Summit continues via communication and prioritized action steps that engage participants in, and attract new organizations and key leaders to, the effort.
- 2) Establish a communication hub and strategy with a focus on timely updates; sharing best practices, community engagement tactics, and other resources; and facilitating the execution of activities.
- 3) Identify key policy issues from the Rural Aging Summit that can be communicated to Capitol Hill and other key stakeholder groups.
- 4) Facilitate the visibility of policy issues and create a change-focused agenda for action.
- 5) Review the 2017 Summit recommendations and identify 2–3 pilots that can report progress in 2018.
- 6) Engage stakeholders and strategic partners in scaling ideas and strategy.
- 7) Frame and move forward with plans for the 2nd Rural Summit in 2018.

Conclusion

Individuals living in rural areas frequently encounter unique challenges that impede their access to services and opportunities for meaningful social interaction. These issues take on even more importance in the context of the health and well-being of rural-dwelling older adults. Various local organizations and agencies have undertaken independent initiatives to address the unmet needs of older adults, but their impact has been limited.

Programmatic and policy solutions will not arrive quickly. The most effective way to resolve them is by gathering interested stakeholders, across multiple relevant sectors, to pool their resources and collaborative wisdom using a collective impact model to create long-term change. The Connectivity Summit was the first step on a journey forward. The participants left inspired by their colleagues, energized to begin the

hard work ahead, and committed to making a difference for older adults.

Author Disclosure Statement

Dr. Skoufalos and Ms. Clarke are employed by the Jefferson College of Population Health; Ms. Ellis is employed by AgeLab at the Massachusetts Institute of Technology; Ms. Shepard and Dr. Rula are employed by Tivity Health, one of the funders of the Summit.

References

1. Pew Research Center. Baby boomers retire. December 29, 2010. www.pewresearch.org/fact-tank/2010/12/29/baby-boomers-retire Accessed October 16, 2017.
2. Miller RB. The rural elderly: access to mental healthcare. https://www.aamft.org/iMIS15/AAMFT/Content/Advocacy/Rural_Elderly.aspx Accessed October 16, 2017.
3. Downey LH. Rural populations and health: determinants, disparities, and solutions. *Prev Chronic Dis* 2013;10:130097.
4. Singh GK, Siahpush M. Widening rural-urban disparities in all-cause mortality and mortality from major causes of death in the USA, 1969–2009. *J Urban Health* 2014;91:272–292.
5. National Advisory Committee on Rural Health and Human Services. Reducing health disparities in rural America: key provisions of the Affordable Care Act. Policy Brief, December 2011. <https://www.hrsa.gov/advisorycommittees/rural/publications/healthdisparities.pdf> Accessed October 16, 2017.
6. Health Resources and Services Administration. Defining rural population. <https://www.hrsa.gov/rural-health/about-us/definition/index.html> Accessed October 16, 2017.
7. Rural Health Information Hub. Medicare and rural health. <https://www.ruralhealthinfo.org/topics/medicare> Accessed October 16, 2017.
8. Dowd MW. Graying of rural America has policy implications. <http://news.cornell.edu/stories/2013/07/graying-rural-america-has-policy-implications> Accessed October 17, 2017.
9. Rural Health Information Hub. Rural health disparities. <https://www.ruralhealthinfo.org/topics/rural-health-disparities> Accessed October 23, 2017.
10. Jaffe S. Aging in rural America. 2015. <http://content.healthaffairs.org/content/34/1/7.abstract> Accessed October 17, 2017.
11. Federal Communications Commission. 2015 Broadband Progress Report. <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2015-broadband-progress-report> Accessed October 16, 2017.
12. 2015 Gallup-Sharecare Well-Being Index. www.well-beingindex.com Accessed October 23, 2017.
13. Pantell M, Rehkopf D, Jutte D, Syme SL, Balmes J, Adler N. Social isolation: a predictor of mortality comparable to traditional clinical risk factors. *Am J Public Health* 2013;103:2056–2062.
14. National Conference of State Legislatures. Home and community based services: meeting the long-term care needs of rural seniors. www.ncsl.org/research/health/home-and-community-based-services-meeting-the-lon.aspx Accessed October 23, 2017.
15. Taukersley J. A very bad sign for all but America's biggest cities. May 22, 2016. https://www.washingtonpost.com/news/wonk/wp/2016/05/22/a-very-bad-sign-for-all-but-americas-biggest-cities/?utm_term=.a6e832071a2c Accessed October 16, 2017.
16. Callahan C. Maine's aging population: a survey of potential economic implications. Maine State Planning Office. July 2007. http://digitalmaine.com/cgi/viewcontent.cgi?article=1010&context=spo_docs Accessed October 23, 2017.
17. Wickenheiser M. Census: Maine most rural state in 2010 as urban centers grow nationwide. March 26, 2012. <http://bangordailynews.com/2012/03/26/business/census-maine-most-rural-state-in-2010-as-urban-centers-grow-nationwide> Accessed October 23, 2017.
18. Ortman JM, Velkoff VA, Hogan A. An aging nation: the older population in the United States. U.S. Census. May 2014. <https://www.census.gov/prod/2014pubs/p25-1140.pdf> Accessed October 23, 2017.
19. Alzheimer's Association. 2017 Alzheimer's disease facts and figures. https://www.alz.org/documents_custom/2017-facts-and-figures.pdf Accessed October 23, 2017.
20. Pantell M, Rehkopf D, Jutte D, Syme SL, Balmes J, Adler N. Social isolation: a predictor of mortality comparable to traditional clinical risk factors. *Am J Public Health* 2013;103:2056–2062.
21. Critical Access Hospital Finance. National Rural Health Resource Center. June, 2017. <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&cad=rja&uact=8&ved=0ahUKEwir2c-3-r7XAhUBzmMKHSoMAo0QFghGMAQ&url=https%3A%2F%2Fwww.ruralcenter.org%2Fsites%2Fdefault%2Ffiles%2FCAH%2520Finance%2520101%2520Manual%2520June%25202017.pdf&usg=AOvVaw2zbOVGtHRQ2MpArJR9HnFK> Accessed November 15, 2017.

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THE POWER OF CONNECTION

Reversing Social
Isolation in
Rural America



Highlights of the 2018 Connectivity Summit on Rural Aging
August 7-8, 2018 | Portland, Maine

ACKNOWLEDGEMENTS

Tivity Health would like to express our sincere appreciation to our partners who played a leading role in supporting and ensuring the success of this year's Connectivity Summit on Rural Aging: Reversing Social Isolation. We commend our event co-sponsors, including Health eVillages, the MIT AgeLab, and Jefferson College of Population Health, for their continued engagement and dedication to this effort since our inaugural Connectivity Summit in 2017. We also recognize Lyft, Grantmakers In Aging, and St. Joseph's College of Maine, whose support and sponsorship helped ensure a robust and engaging program at this year's Summit. Our thanks to Isobar for their work on the new rural aging resource sharing website, **RuralAge.com**. We are also deeply grateful to members of our Rural Aging Advisory Council and our partners at Locust Street Group and Alston & Bird for their significant work planning and implementing this year's Summit. Lastly, special thanks to our speakers and attendees who fully engaged in the two-day event and are dedicated to actions to address rural aging and social isolation. The Summit is an event – the actions addressed in the document are the continuation of a movement.



About Tivity Health

Tivity Health, Inc. is a leading provider of fitness and health improvement programs, with strong capabilities in developing and managing network solutions. Through its existing three networks, SilverSneakers® - the nation's leading community fitness program for older adults, Prime® Fitness and WholeHealth Living™, Tivity Health is focused on targeted population health for those 50 and over. With more than 15 million Americans eligible for SilverSneakers, over 10,000 fitness centers in the Prime Fitness Network, and more than 25 years of clinical and operational expertise in managing specialty health benefits and networks, including chiropractic services, physical therapy, occupational therapy, speech therapy, acupuncture, massage and complementary and alternative medicine (CAM) services, the Company touches millions of consumers across the country and works directly with hundreds of healthcare practitioners and many of the nation's largest payers and employers. Learn more at www.tivityhealth.com.



About Health eVillages

Health eVillages collaborates to advance healthcare access and improve the quality of care by providing state-of-the-art mobile health technology including medical reference and clinical decision support tools, as well as other community-focused resources, to medical and public health professionals in the most challenging clinical environments around the world. Our partners include Robert F. Kennedy Human Rights, Tivity Health, Sharecare, the Tramuto Foundation, Skyscape, PCS Wireless, Global Impact, the Maternity Foundation, Medical Aid Films, and more. You can find more information at www.healthevillages.org and follow us on Twitter, Instagram and Facebook.



About the Massachusetts Institute of Technology AgeLab

The Massachusetts Institute of Technology AgeLab is a multidisciplinary research program that works with business, government, and NGOs to improve the quality of life of older people and those who care for them. The MIT AgeLab applies consumer-centered systems thinking to understand the challenges and opportunities posed by the longevity economy. To learn more, visit agelab.mit.edu.



Jefferson College of Population Health of Thomas Jefferson University

The Jefferson College of Population Health (JCPH) is the first college of its kind in the country. Established in 2008, JCPH is part of Thomas Jefferson University (Philadelphia University + Thomas Jefferson University), a leader in interdisciplinary, hands-on, professional education, and home of the Sidney Kimmel Medical College. JCPH is dedicated to exploring the policies and forces that define the health and well-being of populations. Its mission is to prepare leaders with global vision to examine the social determinants of health and to evaluate, develop and implement health policies and systems that will improve the health of populations and thereby enhance the quality of life. Jefferson College of Population Health provides exemplary graduate academic programming in population health, public health, health policy, healthcare quality and safety, and applied health economics and outcomes research. Its educational offerings are enhanced by research, publications and continuing education and professional development offerings in these areas.

ADDRESSING THE NEW CHRONIC CONDITION OF THE 21ST CENTURY: A MESSAGE FROM DONATO TRAMUTO



DEAR FRIENDS,

The verdict is in: To survive and thrive, we need meaningful connection with other people. These bonds are what make us human and give our lives purpose. But maintaining such connection is not always easy, and I believe we now need a national dialogue about the growing problem of social isolation.

Thanks to important new research, we now know that the little-discussed condition of social isolation increases a person's risk of premature mortality by almost 30 percent, making it a worse health hazard than obesity or smoking.¹ Yet many medical professionals and elected officials haven't heard about this, and neither has the public.

Social isolation is the new chronic condition of the 21st century. As CEO of Tivity Health, working with partners at Health eVillages, the MIT AgeLab, and the Jefferson College of Population Health, I invite you to read what experts, leaders, and practitioners from diverse backgrounds are doing to strengthen connectivity, remove obstacles to meaningful engagement with others, and ultimately reverse social isolation, particularly for older adults living in rural America.

CONTINUED>

CONTINUED LETTER FROM DONALD TRAMUTO>

No one is immune to the toxic effects of social isolation. However, millions of older Americans who live in rural or remote areas and small towns are at special risk of being affected by isolation or loneliness. At Tivity Health, we understand this intimately because almost half the people in our flagship SilverSneakers program live in rural places. We have seen how SilverSneakers has facilitated joyous and supportive social connections, providing meaning far beyond the physical benefits of exercise.

I speak from experience. When I lost my hearing as a child, I learned what it means to feel alone. Luckily, some of my hearing was restored, but I still use hearing aids and have never lost the desire to serve as a catalyst in creating a society where no one is neglected or forgotten. I also dream of the day when stigma no longer prevents anyone from seeking help. It is time to bring loneliness and isolation out of the closet.




I am grateful to the Summit attendees who spent the time to share ideas and action approaches to reverse this public health epidemic. They share my belief that through a “collaborative IQ” approach, we can bring better, more creative solutions to resolve this issue. You will read what our movement has undertaken to address the problem and our approach for future action. This document is a highlight from our Connectivity Summit on Rural Aging and is a commitment to continue to invest in this critical issue. As Senator Robert F. Kennedy once said, “Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope.”

Sincerely,

Donato J. Tramuto
Chief Executive Officer, Tivity Health
Founder and President, Health eVillages

THE RURAL AGING MOVEMENT: BUILDING MOMENTUM

The initiative to reverse social isolation builds on the significant record of accomplishment of the rural aging movement, including:

- Two leadership convenings: The 2018 and 2017 Connectivity Summits on Rural Aging.
- Two major policy events, at the Newseum (January 2018) and the Bipartisan Policy Center in Washington, DC (June 2018).
- Key partnerships, including formation of a distinguished Rural Aging Advisory Council  (see page 22).
- Thirty Capitol Hill visits with committee staff, including the Senate Aging, HELP, and Finance Committees and the House Ways and Means and House Energy and Commerce Committees, and staff of committee members.
- Two meetings at the Centers for Medicare and Medicaid Services (CMS), with Principal Deputy Administrator for Operations, and with the Co-Chair of the CMS Rural Health Council.
- Launch of a Rural Aging resource-sharing website at www.RuralAge.com.
- A national opinion survey of rural older adults  (see Box: The View from Rural America: Surveying Seniors on page 8).
- Support and publication of white papers, op-ed pieces, research reports on rural philanthropy, and a monthly e-newsletter.
- Multiple pilot projects with partners from leading stakeholder organizations to support older adults in rural America  (see page 20).

EXECUTIVE SUMMARY

Social isolation--a condition defined by the lack of meaningful relationships or social engagement and exacerbated by various physical and societal factors--is now recognized as actively dangerous to health and well-being. It can raise the risk of premature death by almost 30 percent, is as harmful as obesity or physical inactivity, and is a demonstrated risk factor in its own right.ⁱ

The feeling of loneliness is closely related to social isolation, with an important distinction: social isolation is considered objectively measurable while loneliness is considered subjective--the perception of being alone or having less connection than desired. Both are deemed harmful to health.

Social science researchers believe isolation is growingⁱⁱ and that the problem affects all age groups.ⁱⁱⁱ Living (and growing older) in a rural area is considered a primary risk factor.

TIVITY HEALTH AND THE CONNECTIVITY SUMMITS ON RURAL AGING

In August 2018, Tivity Health and co-sponsors Health eVillages, MIT AgeLab, and Jefferson College of Population Health convened the second Connectivity Summit on Rural Aging. This built on the work of the inaugural 2017 Connectivity Summit, which launched a collaborative movement to put rural aging on the national agenda and catalyze change.

The movement has included four major convenings, key partnerships, advocacy meetings on Capitol Hill and the Centers for Medicare and Medicaid Services (CMS), and several thought leadership publications.

The 2018 Summit added a special focus on social isolation and gathered health and rural aging experts and researchers and leaders from the private and public sector to share knowledge and propose action. This document presents key highlights of the 2018 summit.

COLLABORATION, ACCOMPLISHMENT, AND MOMENTUM

To stimulate collaboration and action, the Summit tasked participants with developing recommendations in four priority areas generated from a prior event co-chaired by Donato Tramuto and former Senator Bill Frist with the Bipartisan Policy Center:

- Raising awareness of social isolation;
- Building on existing resources and infrastructure;
- Promoting public policy improvements; and
- Reforming the health care delivery and payment system.

This report summarizes those suggestions. Also announced at the Summit were results of a national survey of older adults in rural America commissioned by Tivity Health, a series of pilot programs for older adults launching in late 2018, and the new Rural Aging resource-sharing website at www.RuralAge.com.

INTRODUCTION:

The Power of Connection

Our need to connect with one another is as old as time. Regardless of our age, address, or circumstances, we derive comfort, meaning, and purpose from strong connection with others in our families, workplaces, and communities. What is newer is the knowledge that the inverse is also true. In the last two decades, researchers have begun to measure the health consequences that arise in the absence of such connection, a condition often referred to as social isolation.

Social isolation—a condition defined by the lack of meaningful relationships or social engagement and exacerbated by physical and societal factors—is actively dangerous. It can raise the risk of premature death by almost 30 percent, according to a seminal 2015 meta-analysis by Julianne Holt-Lunstad of Brigham Young University.ⁱ The growing evidence base reveals that social isolation significantly increases health and disability risks including coronary heart disease (29 percent) and stroke (32 percent).^{iv} It is more serious than well-accepted health risks such as obesity, its harm has been traced to the neurochemical level^v, and it is a risk factor in its own right, not merely an associated phenomenon.ⁱ

Social isolation is not widely recognized, diagnosed, or targeted as a social ill, yet the stakes could hardly be higher, says Dr. Holt-Lunstad: “Social relationship-based interventions represent a major opportunity to enhance not only the quality of life, but also survival.” In fact, Holt-Lunstad’s research has established that social connection reduces the risk of premature mortality by 50 percent.ⁱ

THE 2018 CONNECTIVITY SUMMIT ON RURAL AGING: REVERSING SOCIAL ISOLATION

These factors set the stage for the 2018 Connectivity Summit on Rural Aging, a multi-sector gathering convened by Tivity Health and CEO Donato Tramuto, with co-sponsors Health eVillages, MIT AgeLab, and Jefferson College of Population Health.

Mr. Tramuto opened the Summit with a challenge: “We gather with a unique opportunity to be not transactional but transformative.” He also emphasized the power of storytelling, asking participants to elicit one another’s stories during the gathering.

The Summit built on work begun in 2017 and brought together leaders from government, academia, philanthropy, health care, transportation, advocacy, and the private sector, all with a shared commitment to improving the health and quality of life of people living in rural America. The 2017 Summit focused on the need to raise awareness of the issues of rural aging. During the year, problems associated with social isolation in rural America emerged, thus creating the theme for 2018. This document gathers the highlights of the 2018 Connectivity Summit on Rural Aging.



***Man is
by nature a
social animal.”***

—ARISTOTLE



MAKING THE CONNECTION, AT LAST

***Julianne Holt-Lunstad
Professor of Psychology
and Neuroscience,
Brigham Young University***

I've been studying social relationships and their connection to physical health outcomes for two decades. It's incredibly gratifying that there has been this surge of interest in last few years but it has also been a huge uphill battle to get anyone to recognize this as an important health issue.

To make progress, we need broader conversations between scientists and other stakeholders.

I've been thinking about how we might have consensus guidelines around social connection, as we do around physical activity and sleep. This could become part of medical education, well patient care, and K-12 health education. Guidelines would need to be evidence-based and subject to periodic review as the science progresses, but could have a cascading effect on public health.


Another key goal would be including social isolation as a domain in official protocols such as Healthy People 2030.

SETTING THE STAGE:

The Epidemic of Social Isolation

AN estimated 17 percent of older Americans experience social isolation^{vi} and social science researchers believe the problem is growing.ⁱⁱ

Among older people living in rural America, nearly one third (29%) say that they do not see friends or family most days, according to a 2018 poll commissioned by Tivity Health

 (see Box: The View from Rural America: Surveying Seniors on page 8).^{vii} Social isolation and loneliness also can and do affect all ages. In fact, the 18-22 age group was dubbed the “loneliest generation” in a recent survey for Cigna.ⁱⁱⁱ

The feeling of loneliness is closely related to social isolation, and both are deemed toxic and harmful to health. An important distinction: social isolation is considered objectively measurable, based on a lack of social contact, while loneliness is considered subjective--the perception of being alone or having less connection than desired. As MIT AgeLab founder and Director and Connectivity Summit participant Joseph F. Coughlin noted, we can be lonely in a crowd and isolated without feeling alone.



THE VIEW FROM RURAL AMERICA: SURVEYING SENIORS

For deeper insight on health status and social connectedness, Tivity Health commissioned a national poll of older people living in rural America.

Asked how they feel most days, many respondents were quite positive, describing themselves as “happy” (42%), “grateful” (30%), “active” (20%), and “hopeful” (14%).

On the other hand, the poll also revealed the prevalence of health problems that can contribute to isolation, such as vision loss (39%), hearing loss (36%), and loss of mobility (23%).

Nearly one third (29%) said that they did not see friends or family most days and even more (35%) have only two friends or less they can talk to about private matters.

Whether they said they felt isolated or not, a majority (64%) agreed with the statement that, “loneliness or social isolation usually has a negative impact on physical health.”

IN THEIR OWN WORDS

In a free-response section, seniors got specific about what they think elected officials should be addressing, citing concerns such as:

- “A lot of people live alone and don’t have the social network that they need to function properly.”
- “They seem to forget the older generation.”
- “I did everything I could do when my mama was living so she wouldn’t be lonely. Or did her hair or fingernails. Elderly people need things, too.”
- “If you can’t drive, you’re stuck.”

The telephone survey was conducted by Public Opinion Strategies from July 17-21, 2018 among 400 seniors living in mostly or completely rural counties across the United States as defined by the U.S. Census. The margin of error for N=400 is +4.9%.^{vii}

SETTING THE STAGE: The Epidemic of Social Isolation

Social Isolation and loneliness are not destiny for rural older adults.”

STRENGTH AND SUSCEPTIBILITY IN RURAL AMERICA

Living (and growing older) in a rural area is also considered a primary risk factor. One in five older people make their home in rural America, where health outcomes often lag those of the rest of the country.^{viii}

While rural communities are often tight-knit and supportive, there are also inherent challenges: long distances to social opportunities, shopping, and health care; few transportation options for non-drivers, including public transportation; resource shortages; out-migration of younger people; shrinking and aging populations; and a culture that has historically prized self-sufficiency. For some, asking for help still carries a stigma.

“One of the greatest strengths of rural America has always been the sense of community, but when that breaks, it breaks bad,” said Connectivity Summit panelist Alan Morgan, president of the National Rural Health Association. “In an urban setting, you might have social services to fall back on, but that’s nonexistent in rural.”

Still, as panelist Jennifer Weuve, granddaughter of farmers and a professor at Boston University School of Public Health observed, “Social Isolation and loneliness are not destiny for rural older adults.”

For more background and research, please visit www.tivityhealth.com/aging-in-rural-america.



FINDING PURPOSE IN HELPING OTHERS

Doesn't matter who you are – you have to be able to get up in the morning and feel like you are going to be able to do something for somebody else. Seniors have to learn what that is.

***Priscilla Farrell, Saco, Maine
Silver Sneakers Swanson Award Winner 2011***

RURAL VOICES

I only got one neighbor. Tell you the truth, I was shy and I never went out very much. My wife's been gone 15 years now and I just don't know what to do with myself sometimes.

Bobbie Farnsworth
Addison, Maine



Say you live in the city, you probably have public transportation or an automobile or something that you can drive to someplace that's not too far away. Many of our people in this area don't have that available to them.

Joyce Sawyer
Harrington, Maine

CULTIVATING COLLABORATION

A recurring Summit theme was collaboration. "We need to build on existing infrastructure," said Summit panelist Anand Parekh of the Bipartisan Policy Center. "Make sure health care providers are screening for isolation. Think about the important role of community-based organizations. The innovation here may actually be doing more and better with what we already have."

STAKEHOLDER COLLABORATION:

How the Private and Public Sectors Can Work Together



Rugged individualism has deep roots in the American psyche but social change is best achieved with a very different, more inclusive approach. As Alexis Skoufalos of Jefferson College of Population Health and a Connectivity Summit moderator pointed out, “As a nation, we made tremendous strides when government, industry, and citizens came together after World War II to leverage their collective impact.”

On the second day of the Summit, discussion turned to the importance of stakeholder collaboration and public-private partnerships in key areas.

OUR NEED FOR ‘THIRD PLACES’

Joseph F. Coughlin, founder and Director, MIT AgeLab

The “first place” is home. The “second place” is work. “Third places” are where we step out of our personal bubbles and collide socially. They used to be churches and faith-based centers, Rotary, Kiwanis, Lions, community clubs, and the VFW.

Today, the “third place” is Starbucks – where, as my MIT colleague Sherry Turkle says, we are alone together. In the same room, but still alone.

Boomers may love bowling, but they are bowling alone. The generation that said “trust no one over 30” didn’t join leagues, or much else. Those physical locations have gone. We have designed our physical communities in a way that has created a profound loss of social capital.

Without investment in institutions to connect us as we get older, the next cohort could be a train wreck. It’s time to revitalize, redesign, or replace our third spaces.

WHAT’S WORKING: REPORTS FROM MOBILITY, CHRONIC CARE, THE AGING NETWORK, AND PHILANTHROPY

A perennial challenge in alleviating social isolation is transportation. As Joe Coughlin put it, “Before you can do anything, you’ve got to get there,” and being unable to find a secure ride is typically a top obstacle for older people who have given up the keys, people without access to public transportation, people with disabilities, and people in rural America or anyone else who must travel long distances for shopping, socializing, or health care.

The recent ride-hailing revolution has made significant inroads, and promises even more as older people get comfortable with the technology and companies like Lyft and Uber continue to forge partnerships with senior centers, assisted living facilities, and health systems. Panelist Jake Swanton, senior federal policy manager at Lyft, joked that Lyft is, “no longer just a company that takes Millennials to and from bars,” adding more seriously that 95 percent of Americans now have access to Lyft services, the company is growing quickly in rural areas, and provides nearly 10 million rides per week, many of which are arranged by third parties such as caregivers.



Reducing social isolation among people who are chronically ill is part of what success looks like in the CareMore health system’s Togetherness Program. One key outcome, explained panelist and CareMore Chief Togetherness Officer Robin Caruso, is a near-doubling of the number of people in the program doing exercise, from 11 to 20 percent. It takes time, she said, but it’s powerful because of the personal connections it facilitates. “One man was embarrassed to have to use a walker, but six months later, he is at the gym, he has no pain, and he told me, ‘I haven’t had friendships like this since I was 14.’”

I haven’t had friendships like this since I was 14.”

In cross-sector collaboration, as in life, you can never predict where the next great idea will come from. That’s the rationale behind In Good Company: *The 2018 Optimal Aging Challenge*^{ix}, which seeks ideas from all over the world to reduce social isolation and loneliness and increase engagement among older adults. Multi-sector sponsors are GE Healthcare, Benchmark Senior Living, and MIT AgeLab, in collaboration with the Council to Address Aging in Massachusetts. “It’s part of our commitment to becoming an age-friendly state,” explained panelist Robin Lipson of the Massachusetts Executive Office of Elder Affairs. Winners will be announced in December 2018.

Quality of life is also a concern for the aging services network. “Without that social connection, seniors may be living, but they’re not really living well,” said Summit participant Sandy Markwood of the National Association of Area Agencies on Aging (n4a). This is why the recently launched EngAGED: National Resource Center for Engaging Older Adults will offer intergenerational programming, technology, participation in the arts, and lifelong learning and involvement in volunteerism.

Some of these solutions are national or even global, but in approaching philanthropy, it’s important to think local, added panelist John Feather, CEO of Grantmakers In Aging (GIA). “Eighty-five percent of foundations are community foundations,” he said, “so in asking them for support on social isolation programs, we want to make the point that investment can make a real difference in their own community – that this is not some huge, hopelessly complex issue that they couldn’t possibly address.”

CREATING RIPPLES OF HOPE: SILVER SNEAKERS AND THE YMCA



Whenever I come here and see the same people, it's like coming home. It's wonderful.

Jane Clough, Saco, Maine, Silver Sneakers member

I have bipolar, chronic fatigue syndrome, and fibromyalgia, and being part of a group helps me manage them so much better. When I was alone, I didn't always manage them. I'm not the same person I was 5 years ago.

*Fran Housing
Portland, Maine, YMCA Member*



COLLABORATING WITH POLICY MAKERS To Reverse Social Isolation

CULTIVATING COLLABORATION

In any major health care crisis, the role of government policy tends to come up quickly, and social isolation is no exception. But while researchers have established a compelling body of evidence, few policy proposals have taken shape and even fewer have received serious policymaker consideration.

Panelist Jennifer Weuve believes public health researchers can help by serving as intermediaries or “advocate whisperers” who express the evidence in terms most useful to policymakers. “The lingo can be so different between the two worlds, but the result when there is resonance can be millions of dollars for research and programs,” she said.

One strong argument for action is cost. The results of social isolation cost Medicare an additional \$134 per month per affected beneficiary, or an estimated \$6.7 billion in additional Medicare spending annually, according to the AARP Public Policy Institute.^x

The Summit addressed the question of how to adapt the massive U.S. health care delivery system so that it can diagnose, deliver, and fund care related to social isolation. The U.S. may never follow the lead of Great Britain and appoint a Minister for Loneliness, but other promising approaches could include:

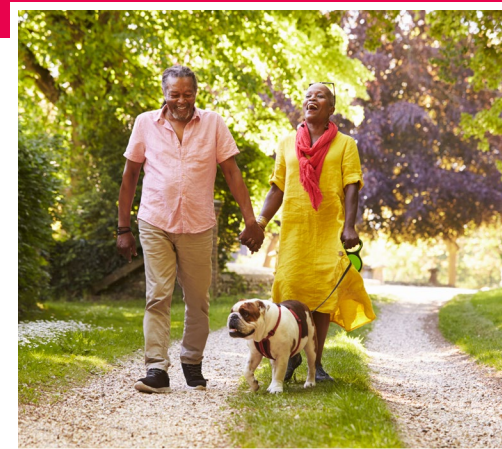
- Adopting a clinical screening tool for social isolation and including it in electronic medical records.
- Offering Medicare and/or Medicaid reimbursement for social support through waivers, Medicare Advantage, or innovation models funded by the Center for Medicare and Medicaid Innovation (CMMI).
- Global hospital budgeting and value-based care.
- Telehealth, online support, and other tech-driven care, supported by rural broadband expansion.
- More support for rural health systems.
- Including social isolation as a domain in official protocols such Healthy People 2030.



(See Box: Working to Achieve Health Equity in Rural America, on page 16)

Summit panelist Glenn Pomerantz, Chief Medical Officer and Senior Vice President for Care Management at Blue Cross and Blue Shield of Minnesota, suggested his industry could offer leadership. “If we’re going to improve health in this country, it really is about the social determinants of health. The problem is that we don’t link all these in a revenue model that is sustainable.”

“Perhaps the health plan is in the best position to be the convener on this,” Dr. Pomerantz added. “We see the longitudinal cost of care, we know to the penny how it works. It’s not about putting more money into the system; it’s about making the system more effective.”



COLLABORATING WITH POLICY MAKERS To Reverse Social Isolation



“GO TALK TO SENIORS”

Congressman Joe Kennedy III (D-MA)

A few years ago, when I was working on a campaign, I called my grandmother [Ethel Kennedy] for advice. She had seen a campaign or two and the first thing she said was, “Go talk to seniors. I promise you, you’ll learn something.” She was right.

Our seniors have too much to offer to be isolated from our communities and our country. But no journey is immune from heartache, so for even the most social, outgoing, vibrant senior citizens, isolation and loneliness can find a way to creep up.

Addressing this challenge begins, I believe, by strengthening the proven programs that touch the lives of seniors in every corner of our country.

When one in six struggles with hunger, Meals on Wheels helps feed and engage hundreds of thousands of elderly and needs to be expanded, not targeted. The Senior Corps program should be funded at levels such that any retiree who wants to service in their community has a role to play.

Thank you for being willing to confront a crisis that does not always gather headlines.

Seeing you all here gives me hope that we will reach the time when every senior will be able to enjoy their golden years with dignity, with laughter, and with fulfillment.



WORKING TO ACHIEVE HEALTH EQUITY IN RURAL AMERICA

*Cara V. James, Director, CMS Office
of Minority Health and Co-Chair, CMS
Rural Health Council*

As we work to achieve health equity in rural America, we must understand the diversity that exists within and across these communities. There is great variation from one rural community to another. Disparities exist between residents within rural areas as well as with their urban counterparts. To address these disparities, we must take into account the unique needs of these communities and be cognizant of the impact of social determinants of health.

We need to be equally cognizant of how we measure social determinants such as social isolation. Current tools like the PRAPARE protocol, Accountable Health Communities Health-Related Social Needs Screening Tool, and ICD-10 codes include different social determinants and vary in the way they're measured, making it harder to compare outcomes from one community to the next. Having standardized measures can improve our understanding of the problem and lead to better solutions. The path to health equity is not an easy one, but is obtainable if we work together.

ACTION PLANNING:

Improving Social Connectedness



The 2018 Connectivity Summit is a launching pad for greater social connectedness, but it's just a beginning. A top objective was to stimulate closer collaboration, new ideas, and more action, so on the final afternoon, all Summit participants joined breakout groups to brainstorm ideas based on four priority areas identified in an earlier roundtable event co-chaired by Donato Tramuto and former Senator Bill Frist with the Bipartisan Policy Center. Those priorities are:

- Raising awareness of social isolation.
- Building on existing resources and infrastructure.
- Promoting public policy improvements.
- Reforming the health care delivery and payment system.

The chart below shows the range of ideas that the workgroups presented.

We hope these ideas and this mission will prompt you want to get involved as well. We want to see more people participating in and championing the rural aging movement. We also want to hear your feedback. You are warmly invited to join our Rural Aging mailing list and to share your ideas and resources, all at our new Rural Aging website, **www.RuralAge.com**. Plan to join us at the 2019 Connectivity Summit, too!

FOCUS #1: ELEVATE THE ISSUE OF SOCIAL ISOLATION AND LONELINESS TO THE NATIONAL LEVEL

Program Idea: "Acts of Connection" -- a national, intergenerational awareness campaign

Approach	Launch a national multi-platform awareness campaign using positive framing ("connection") to avoid negative connotations of loneliness. Intergenerational focus may make accepting help easier by presenting involvement as "a gift to both parties." Informed by successful past campaigns against smoking and drug abuse.
Potential Partners	Schools and colleges, civic and faith-based organizations, the physical and mental health community, sports organizations, philanthropy (e.g., the Born This Way Foundation); corporate sponsorship (e.g., Facebook).
Other Tactics	Consider enlisting a celebrity brand ambassador.

Program Idea: Grassroots community-based campaigns to build awareness and trust

Approach	Select 10-20 communities to conduct local awareness campaigns. Establish common baselines for key metrics. Develop an action/implementation plan. Hold sponsored events such as a commemorative day, awareness-raising walks, and awards.
Potential Partners	Faith-based and community organizations, other trusted local organizations like Area Agencies on Aging (AAA) and senior centers, local media outlets, and foundations. Consider seeking partnership with federal Substance Abuse and Mental Health Administration (SAMHSA).
Other Tactics	Stigma surrounding loneliness and isolation may be an obstacle, so the local campaign might lag the national one by 18-24 months to allow time to build trust. Social media will be important.

FOCUS #2: BUILD ON EXISTING RESOURCES AND INFRASTRUCTURE

Program Idea: The Social Isolation Community Playbook

Approach	A toolkit to gather existing research and program options and make action and implementation easier. Launch in pilot communities. Standardized language and easy-to-understand metrics are priorities (might be customizable for certain communities or groups.) Some communities might develop their own best practices.
Potential Partners	Many, including senior centers, faith-based organizations, law enforcement and first responders, business and Chambers of Commerce, health care and pharmacy organizations, academia, government (including the Center for Innovation in Medicare and Medicaid), philanthropy, and volunteers.
Other Tactics	A tech partner will be important. Work should include stakeholder surveys and publication of findings and accomplishments of community work.

Program Idea: A pilot centralized organization or office to provide assessments, make referrals, and support social engagement

Approach	Coordinate services and collect learnings of social service organizations already working on aspects of social isolation. In client assessments, each participating organization would consistently ask three questions (to be determined) with a focus on eliciting personal stories.
Potential Partners	Community-based organizations, health plans and primary care providers, libraries, first responders and law enforcement, local media, faith-based organizations, and caregivers.
Other Tactics	Pilot programs would begin in three rural communities. Use surveys to collect data before, during, and after interventions to measure social engagement and patient-reported quality of life, capture service provider feedback. Other goals are publication and program replicability.

FOCUS #3: EMBARK ON PUBLIC POLICY IMPROVEMENTS

Program Idea: Ask the Secretary of Health and Human Services (HHS) to develop a national strategy with specific policies to assist people who are socially isolated

Approach	Increase action on social isolation within public programs by raising awareness and increasing funding to existing relevant programs. Specifically: add a requirement in the Older Americans Act to work on social isolation; require an inter-governmental working group and national advisory council; expand focus beyond older adults to garner support outside the aging network; seek prompt passage and implementation of the legislation. (In this working group, experienced Washington hands thought passage was a good metric, while those from outside Washington thought it was not rigorous enough.)
Potential Partners	Very broad cross-section of partners across the political spectrum, including the private and business sectors.
Other Tactics	Acquire bipartisan support and stakeholder endorsement. After passage, support with a grassroots advocacy campaign.

ACTION PLANNING:

Improving Social Connectedness

FOCUS #4: REFORM HEALTH CARE DELIVERY AND PAYMENT SYSTEMS

Program Idea: Design a simple social isolation/loneliness evaluation tool

Approach	The current lack of means for measuring levels of social isolation/loneliness makes evaluation of return on investment and resource coordination difficult. The tool should be sensitive enough to be validated for use in health care settings (including electronic health records) but simple enough to be deployed at community locations like ballparks.
Potential Partners	Health plans; large employers providing health care to retirees, among many others.
Other Tactics	Tool development should involve people it is designed to help (i.e., at risk for social isolation), as well as people outside health care. Tool could be modeled on existing diabetes screening questionnaire. Academic researchers and organizations like the National Quality Forum (NQF) should have a role in design, validation, and championing the tool. Seek inclusion in the interview protocol for Welcome to Medicare physicals.

Program Idea: Create a global benefit eligibility system to unlock resources for socially isolated beneficiaries

Approach	Consolidate information about state and federal benefits (e.g., Medicare, Medicaid, SNAP, etc.) so that eligible older adults can get information at any agency. Potential outcomes include better access to benefits, better health outcomes, and higher beneficiary satisfaction.
Potential Partners	Health plans, providers, government agencies and programs.
Other Tactics	Creating a one-stop database will require a new financing structure to support integrating federal and state agency databases, as well as navigators to assist.



CONCLUSION:

A Call to Action

Given all we have come to understand about the power of connection and the urgency of reversing social isolation, what is needed now is concerted action.

Looking ahead, the rural aging movement begun by Tivity Health and its partners, Health eVillages, MIT AgeLab, and Jefferson College of Population Health, will continue high-impact pilot programs to support aging populations in rural areas, carry on awareness efforts with government and key influencer groups, and expand the newly launched Rural Aging resource-sharing website (www.RuralAge.com) to ensure stakeholder utilization and engagement in sharing solutions. The Rural Aging Advisory Council will play a key role in reviewing the action recommendations.

Pilot programs, funded by Tivity Health, Health eVillages, and the Tramuto Foundation, and led by some of the top aging services organizations across the country, include:

- Reaching isolated seniors affected by the Flint, MI water crisis and the surrounding rural communities, with partners n4a and the Valley Area Agency on Aging.
- Establishing an intergenerational college campus-based Institute for Integrating Aging and senior housing project, in partnership with St. Joseph's College in Standish, Maine.
- Funding scholarships for professionals in rural population health through Jefferson College of Population Health.
- Expanding the work of Community Health Workers and the use of tablets for chronic disease management in rural America, in partnership with the National Rural Health Association.

A key action for 2018, leading to the 2019 Summit, will be the engagement of other stakeholders, such as the business community, philanthropic groups, and health partners, in investing in goals to overcome rural aging issues and find solutions to social isolation.

Helping older people in rural America achieve better health and quality of life by reversing social isolation will require the best of all of us. This document is offered in the hope that more individuals and organizations will wish to join this important movement.

IT'S WITHIN OUR TWO HANDS

The cure for loneliness is human connection. There's no drug. There's no injection. There's no infusion. There's no scalpel involved. It's about connecting with people. It's amazing. It's within our two hands.

Mary Flipse
Chief Legal and Administrative Officer, Tivity Health





END NOTES

ⁱHolt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. *Perspectives on Psychological Science*, Vol 10, Issue 2, pp. 227 – 237. <https://doi.org/10.1177/1745691614568352>. Accessed September 14, 2018.

ⁱⁱCacioppo JT, Cacioppo S. The growing problem of loneliness. *The Lancet*. Volume 391, Issue 10119, P426, February 03, 2018. DOI: [https://doi.org/10.1016/S0140-6736\(18\)30142-9](https://doi.org/10.1016/S0140-6736(18)30142-9). Accessed September 14, 2018.

ⁱⁱⁱCigna. New Cigna Study Reveals Loneliness at Epidemic Levels in America. <https://www.cigna.com/newsroom/news-releases/2018/new-cigna-study-reveals-loneliness-at-epidemic-levels-in-america>. Accessed September 14, 2018.

^{iv}Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 7(7): e1000316. <https://doi.org/10.1371/journal.pmed.1000316>. Accessed September 14, 2018.

^vMoriel Zelikowsky, May Hui, Tomomi Karigo, Andrea Choe, Bin Yang, Mario R. Blanco, Keith Beadle, Viviana Gradinaru, Benjamin E. Deverman, David J. Anderson. The Neuropeptide Tac2 Controls a Distributed Brain State Induced by Chronic Social Isolation Stress. *Cell*, 2018; 173 (5): 1265 DOI: 10.1016/j.cell.2018.03.037. Accessed October 2, 2018.

^{vi}AARP Foundation. Framework for Isolation in Adults Over 50, developed for AARP Foundation by Katie Elder, MPA and Jess Retrum, PhD. Revised Edition: May 30, 2012. https://www.aarp.org/content/dam/aarp/aarp_foundation/2012_PDFs/AARP-Foundation-Isolation-Framework-Report.pdf. Accessed September 17, 2018.

^{vii}Tivity Health: Aging in America: Polling on Social Isolation & Rural Senior Health. <http://www.tivityhealth.com/aging-in-rural-america/>. Accessed September 14, 2018.

^{viii}US Census: Percent of the Total Population Who Are 65 Years and Over - United States -- Urban/Rural and Inside/Outside Metropolitan and Micropolitan Area: 2012-2016 American Community Survey 5-Year Estimates. <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>. Accessed September 14, 2018.

^{ix}The 2018 Optimal Aging Challenge: In Good Company: Improving the experience of aging in Massachusetts through creative new solutions. <https://gex.brightidea.com/InGoodCompanyChallenge>. Accessed September 14, 2018.

^xInsight on the Issues Medicare Spends More on Socially Isolated Older Adults, Lynda Flowers, Ari Houser Claire Noel-Miller, AARP Public Policy Institute; Jonathan Shaw, Jay Bhattacharya, Lena Schoemaker, Stanford University; Monica Farid, Harvard University, (November 2017). <https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf>. Accessed September 14, 2018.

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