

**COMBATING SOCIAL ISOLATION
AND LONELINESS DURING
THE COVID-19 PANDEMIC**

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THURSDAY, JUNE 11, 2020

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:35 a.m., in Room 253 Russell Senate Office Building, Hon. Susan Collins, Chairman of the Committee, presiding.

Present: Senators Collins, McSally, Braun, Casey, Gillibrand, Blumenthal, Jones, and Rosen.

**OPENING STATEMENT OF SENATOR
SUSUAN M. COLLINS, CHAIRMAN**

The CHAIRMAN. The hearing of the Special Committee on Aging will come to order.

Good morning, everyone. COVID-19 has claimed the lives of more than 110,000 Americans, about 80 percent of whom were 65 or older. Older adults have been disproportionately affected by this health crisis, but they are not the only group.

Last week, the CDC reported that black Americans make up 23 percent of COVID-related deaths in this country. That is despite representing only 13 percent of the U.S. population.

In Maine, 20 percent of diagnosed COVID cases have been black Mainers, although they represent less than 2 percent of the population in our State.

COVID-19 has shed a light on long-standing health disparities in this country, and this Committee will hold a hearing next month to examine these racial disparities among older Americans and the health care that they receive.

Today's hearing focuses on a danger that affects older adults of all races and ethnicities in this pandemic, and that is social isolation and prolonged loneliness.

In 2017, this Committee held the first congressional hearing on the impact of social isolation and loneliness on older adults. We found that the silent epidemic has devastating physical and emotional health effects by increasing the risk of stroke, heart disease, depression, and dementia. One expert testified that prolonged isolation for seniors is comparable to smoking 15 cigarettes a day.

Since March, the CDC has instructed us all to stay at home and to social distance, with the exception of essential workers. For the past 3 months, the ability to visit loved ones in hospitals, nursing

homes, and senior facilities has been severely restricted or banned in most States. While such measures may have been necessary, they have also intensified the isolation and loneliness that were already an everyday struggle for many older Americans, and there is surely nothing sadder than a beloved parent or grandparent dying alone or with just a compassionate health care provider rather than with family members by their side.

Before COVID, about a quarter of seniors reported being isolated, and 40 percent reported being lonely. A Tivity Health survey published last month indicates that since the pandemic began, the number of adults who feel isolated and lonely has tripled.

Maine is the oldest State by median age. It is aging the fastest, and it is among the most rural. One in six Mainers lives in a rural area, and about 30 percent of the seniors in our State live alone.

As the pandemic continues and the epidemic of loneliness and isolation worsens, we run the risk of an infectious disease causing a mental health crisis. Already, calls to Maine's mental health support line have increased an estimated 40 percent since the beginning of the pandemic. I have heard from countless Mainers about the pain of talking with a much loved spouse, parent, or grandparent only by telephone or through a computer screen or waving through a nursing home window.

While technology allows many families to stay connected, it is not the same as the human touch. I am asked again and again: When will my grandparents be able to hug their grandkids?

In addition to the human costs I have just described, isolation and loneliness also have a fiscal cost. According to a 2017 paper published by AARP's Public Policy Institute, isolation among older adults increases Federal spending by an estimated \$6.7 billion annually, as isolated people are often sicker and have to rely more heavily on skilled nursing care.

Since our initial hearing on this subject, we have taken steps to combat isolation. In March, the President signed into law the Supporting Older Americans Act of 2020 that I authored with Ranking Member Casey and other members of this Committee. This law reauthorizes critical Older Americans Act services, such as nutrition, home care, health promotion, and caregiver support. In this year's reauthorization, we added grants specifically to combat social isolation and improve multigenerational collaboration.

With congregate meal sites closing in the pandemic, we have also taken action to bolster the Meals on Wheels program, which provides more than a meal but social connectedness too.

Through the CARES Act, I have worked to ensure that funding could be transferred from congregate meal sites to home-delivered meals and to expand the definition of homebound so that older adults who are quarantined or observing social distancing could also receive meals.

Overall, Congress has provided \$1.2 billion in relief for nutrition and other community programs as part of our COVID-19 response.

Recently, a Meals on Wheels driver in my hometown of Caribou, Maine, posted online about her volunteer experience. She noted that when she asked seniors on her route what they needed help with in this difficult time, many said that they were running low on toilet paper and were worried about going to the store amidst

the pandemic. Another member of the community saw that post and brought 96 rolls of toilet paper, which she donated and gave to the driver to distribute with the next meal delivery. The seniors on that route not only got a necessity but also confirmation that someone cared about them. This story illustrates perfectly the social value of the program and of that strong sense of community.

We must continue to do more to support our seniors during this pandemic. Today we will hear from a geriatrician, a public health researcher, and two Area Agency on Aging directors, one serving a large rural area and the other an urban area. All of these individuals are on the front lines of reducing social isolation and loneliness among older adults. We will learn today about promising research, innovation, and technology that can make a big difference. It is imperative, now more than ever, that we find solutions.

I am now pleased to turn to our Ranking Member, Senator Casey, for his opening statement.

**OPENING STATEMENT OF SENATOR
ROBERT P. CASEY, JR., RANKING MEMBER**

Senator CASEY. Chairman Collins, thank you for this hearing on social isolation and loneliness.

I wanted to start today with a reference to the American family, so many families in our country are hurting right now. For them, it is a dark night. We are over 3 months into a pandemic that continues to rage, and in some areas, as we know, it is re-intensifying.

COVID-19 has claimed the lives of over 113,000 people in the United States, over 113,000 people dead, including well over 6,000 in the Commonwealth of Pennsylvania.

Across the country, people continue to experience grievous suffering in hospitals, nursing homes, and at home, isolated and alone, away from their loved ones.

Millions more are suffering extreme economic hardship. There are about 21 million Americans unemployed. In Pennsylvania, over 976,000 people are out of work, and yet that data does not even paint the full picture. The impact of this terrible virus has not been evenly felt across this country.

By all accounts, you know this from what we have been witnessing the last number of weeks. By all accounts, people of color, particularly black Americans, are disproportionately impacted. Over 23,000 black lives have been lost to COVID-19 to date.

African Americans account for 13 percent of our population, as Chairman Collins noted, but 24 percent of the deaths from COVID-19 where the race of the individual is known. This means that black people in America are dying at a rate nearly two times higher than their population share.

The unemployment rate for the overall population is 13.3 percent. It is 16.8 percent for black Americans. Consider this. For black men age 20 and older, only 54 percent are working, a 10-percentage-point drop just since February.

The murder of George Floyd was described by one NAACP leader as, "A murder that shames us before the world." The only way—the only way to even begin to attempt to right all of these terrible wrongs is to take action. This action is demanded of all of us.

The African American community, however, is not the only community demanding of action in Washington. Seniors are suffering disproportionately as well. As our hearing will explore today, seniors are living and dying, often scared and alone due to this virus.

In Pennsylvania, nearly one third of COVID-19 cases have occurred among people over age 65. Even worse, most of the deaths, the deaths that have occurred in my home State, are among older Pennsylvanians.

As I mentioned during our last hearing, people living in nursing homes represent a fraction of 1 percent of the population, yet more than 40 percent, 40 percent of all deaths nationwide have been either residents of long-term care settings or the workers in those long-term care settings.

Those who have recovered from the virus or who are trying to remain healthy are isolated from their family and friends, their sons and daughters, granddaughters and grandsons. It is interaction with our loved ones that sustains all of us. We all understand that. Instead, the social isolation and loneliness that older adults are experiencing is causing greater cognitive decline.

Experts tell us that it is contributing to greater difficulties accessing proper nutrition and wellness services for our seniors, and it is leading to a deterioration in both physical health as well as mental health.

Before COVID-19, millions of seniors faced social isolation and loneliness every day. We know that. Now they are looking at relatives through windowpanes.

In March and April, I met with 51 out of our 52 Area Agencies on Aging in Pennsylvania to discuss the needs of seniors during the pandemic. These AAAs are working double overtime to combat social isolation in the community.

This work is being supported by over \$1 billion in both the Families First Bill and the CARES Act to address the needs of seniors. Much of that funding stems from a bill I introduced back in March, Senate Bill 3544, the Relief for Seniors and People with Disabilities Act. This is an important first step, but we cannot not stop there.

Since the start of the pandemic, I have proposed over a dozen policies to help seniors and to combat social isolation, policies ranging from dollars for nursing homes to institute better practices and to more funding for meal and grocery delivery services. These are sound policies with broad stakeholder support and support from Democrats in both chambers.

Instead of passing these bills or any bills to address the pandemic, the U.S. Senate spent the month of May doing nothing but nominations except for one exception, the Foreign Intelligence Surveillance Act. Everything else was nominations the entire month.

We cannot sit around in the Senate and just lament the impact of the pandemic. We cannot simply lament the deaths and the illness that have been caused by the virus, nor can we simply lament the devastating economic toll on our families. We cannot simply lament social isolation that people are experiencing, and finally, we cannot simply lament the racial injustice and police misconduct taking place all across this country.

We have to take action. We have got to legislate.

That is what the U.S. Senate is supposed to do. It is not supposed to be a nomination machine. It is supposed to be a legislative body, a body where we deliberate serious urgent issues, instead of just voting day after day and week after week on nominations.

The Senate must continue to act to support our seniors and to support our families and to support all communities impacted by the virus.

Chairman Collins, thank you very much for the hearing. I want to thank our witnesses.

The CHAIRMAN. Thank you, Senator Casey.

I would note that it has been the Senate that has been in session while the House has not been in session during this time. I think it is unfortunate if this Committee, which has always operated in a bipartisan manner and which is focusing on a very important issue today, to disintegrate into partisan squabbles, and I hope that can be avoided and that we can be respectful to our great panel of witnesses.

I want to acknowledge, because it may not be evident to C-SPAN or those who are watching, that we have excellent participation by Senators here today. Many of them are coming in remotely, but here in person, Senator Braun and Senator Blumenthal, and I very much appreciate your efforts. You both are extremely diligent members of this Committee, and I appreciate the efforts you make to be here.

Our first witness today, Dr. Perissinotto, joins us from the University of California San Francisco School of Medicine, where she is an Associate Professor and Associate Chief for Geriatrics Clinical programs. Dr. Perissinotto oversees inpatient and outpatient clinical programs, and her research is focused on reducing social isolation among older adults.

She has served on the committee that authored the National Academy of Sciences, Engineering, and Medicine report on Social Isolation and Loneliness in Older Adults, which was published in February.

I would now like to turn to Senator Rosen to introduce our witness from her home State.

Senator ROSEN. Thank you, Senator Collins and Ranking Member Casey. I want to really thank you both for holding this hearing on COMBATING social isolation and the loneliness of older adults, and I especially want to thank all of the witnesses for being here today and for their work.

I am so pleased to introduce one witness in particular, Dr. Peter Reed. Dr. Reed is the director at the University of Nevada, Reno School of Medicine's Sanford Center for Aging.

In a rapid response to the unfolding crisis, Dr. Reed helped to convene a team of aging services providers in Nevada, and he developed a Nevada COVID-19 aging network, or Nevada CAN. This is a new initiative with the ambitious goal of mobilizing all the available resources to ensure that every elder Nevadan has access to medical, to social, and to daily essentials in their home.

As we are going to hear today, this effort has just been a tremendous success, and we look forward to hearing about the great work that Dr. Reed and Nevada CAN that they are doing in our State.

I just want to take this time on a personal note. I was a caregiver for my parents and in-laws as they aged and at the end of their lives, and I wish that I would have had access to something like Nevada CAN at that time. It was often difficult to find where to go to get the resources, who to talk to, and I am so grateful that it is there for anyone who is now going through some of the things that I went through.

Thank you, and we look forward to hearing everyone's testimony. The CHAIRMAN. Thank you, Senator Rosen.

Next, we will hear from Betsy Sawyer-Manter, who serves as the CEO of SeniorsPlus, an Area Agency on Aging based on Lewiston, Maine. She has both, Maine's second largest city as well as many very rural areas around it under her purview. For the last 11 years, Ms. Sawyer-Manter has overseen vital aging network services that have allowed our seniors to age independently in our communities. She is the president of the Maine Association of Area Agencies on Aging and serves on the board of the Maine Council on Aging. She has been leading efforts to combat isolation among seniors during this pandemic.

We are very pleased to have Betsy joining us today.

Next, I will turn to Senator Casey to introduce Mr. Orr, our witness from the Commonwealth.

Senator CASEY. Thank you, Chairman Collins.

I am pleased to introduce Najja Orr. He is from Philadelphia, Pennsylvania. He has served as president and CEO of the Philadelphia Corporation for Aging and the Philadelphia Area Agency on Aging. This is the largest AAA in the State and serves the most diverse population in our State.

Mr. Orr will share with us the work that the Philadelphia Corporation for Aging is doing to combat social isolation and the important role of nutrition programs, in preventing isolation, and sustaining mental and physical health. Prior to his current role, Mr. Orr worked for the Bucks County Area Agency on Aging for 15 years, serving as that agency's director since 2011.

Thank you, Mr. Orr, for being with us today and for sharing your expertise with the Aging Committee.

The CHAIRMAN. Thank you, Senator. We will start with Dr. Perissinotto.

**STATEMENT OF CARLA PERISSINOTTO, MD, MHS,
ASSOCIATE CHIEF FOR GERIATRICS CLINICAL PROGRAMS,
ASSOCIATE PROFESSOR, SCHOOL OF MEDICINE,
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CALIFORNIA**

Dr. PERISSINOTTO. Chairman Collins, Ranking Member Casey, and distinguished members of the Committee, thank you for the opportunity to testify today on the topic of social isolation and loneliness during the COVID-19 pandemic, and thank you for allowing me to testify remotely, given these unprecedented times.

I am a geriatrician and a palliative medicine physician at UC-San Francisco and have devoted my career to the clinical care of older adults, many of whom, as you noted, are underserved, vulnerable, and homebound.

I am also a first-generation American of Mexican and Italian descent who cares deeply about the care of our older adults, those

who have diverse backgrounds, and I profoundly respect the immigrant roots of our Nation.

In addition to providing clinical care, I have been researching the health effects of loneliness and isolation in older adults specifically over 10 years. In 2012, I published a seminal paper demonstrating that older adults who are lonely have a 59 percent increased risk of losing their independence and a 45 percent increased risk of death.

Most recently, my work is focusing on incorporating loneliness and isolation assessments to health care systems in evaluating community-based programs.

Indeed, loneliness and isolation are a national and global public health problem whose widespread effects may be even more pressing now in the midst of this COVID-19 pandemic.

As my friend and colleague, Julianne Holt-Lunstad, previously reported to you in 2017, being connected to others is widely considered a fundamental human need, crucial to both well-being and survival. Yet as described in the National Academy of Sciences consensus report, which is titled “The Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults,” prevalence rates for loneliness and isolation range from 20 to 50 percent cross the United States, and the corresponding health effects are disquieting, thus, raising this to the level of a public health crisis.

Prior research formed the justification for this report. There are five key outcomes from the report that are worth bringing to this Committee’s attention: 1) develop a more robust evidence base for effective assessment, prevention, and intervention strategies for both loneliness and isolation; 2) translate current research into health care practices; 3) improve awareness; 4) strengthen ongoing education and training; and 5) strengthen ties between health care systems and community-based networks.

Given the findings from this research and the National Academy’s report, like many, I have been incredibly concerned about the downstream effects that we would see during the COVID-19 pandemic. Seemingly overnight, we saw our social structures dissolve as we were all forced to socially or, rather, physically distance ourselves.

The challenge is that to protect our lives now, we have had to subject ourselves and others to the potential of worsening our health and shortening our life expectancies in the future by enforcing isolation.

To some extent, we are actually in a data-free zone right now, where we do not know how long we have to be lonely or isolated or how severe this must be for us to have lasting negative consequences, either economic or health-wise.

Unfortunately, it is even more apparent that ageism runs deep, and the needs of older adults and the health effects of COVID-19 on older adults has largely been an afterthought, so together with my colleague, Dr. Ashwin Kotwal, we have rapidly designed a study to understand the experience of loneliness and isolation over time during the pandemic. As geriatricians, we are also interested in understanding where physical distancing has had other unintended consequences.

Our study is currently ongoing and, sadly, unfunded, but I will share some preliminary findings, so far, our sample is remarkably ethnically diverse, given that it is predominantly in San Francisco. It is also predominantly women, and 64 percent of our sample lives alone.

What we have found is that a high percentage of participants in our study had loneliness at a baseline up to 73 percent, which is higher than it has been reported in other studies, and during the pandemic, 41 percent have experienced a worsening because of COVID-19. We have also seen a worsening of both depression and anxiety at 33 percent and 29 percent worsen respectively.

Not surprisingly, we have seen reduced socializing and community participation, and most concerning is that we have seen a decrease in the number of volunteers supporting people and case management during the pandemic.

Eighty percent of participants had difficulty obtaining medications, and there are unmet functional needs such as with activities of daily living and transportation. Surprisingly in our sample, food security was not a predominant concern, and also interesting to this Committee is that 77 percent of our sample had video contact - zero to two times a week, and 29 percent of the sample did not use the internet at all.

Though our findings are preliminary, there are some areas that are already giving us evidence of what may be happening across the country and where we might expect to see downstream effects.

There are three key findings which are in line and can be addressed by some of the recommendations from the National Academy's report: 1) social isolation and loneliness are worse, yet 67 percent of older adults that we sampled are not concerned or are only somewhat concerned about their health worsening because of not being able to see their health care providers. This highlights the importance of the National Academy's Recommendation 8.1 and 8.2, which suggest including measures of social isolation and loneliness in large-scale health strategies, including more public awareness; 2) the effects of unmet needs are concerning, especially the functional needs and medication access. This highlights another recommendation from the report, which states that there is a need for health care systems to partner with social service organizations and promote tailored community-based services; and 3) a large proportion of older adults may not have access to technology, video or internet, and this highlights another recommendation from the National Academy's report that states that those who are developing and deploying technology and interventions should be sure that technological innovations related to social isolation and loneliness are properly assessed and tested so as to understand the full range of benefits and potential adverse consequences in order to prevent harm.

This last point is concerning because, as has been noted by the Committee, physical distancing policies have forced many health care and social programs to shift to technological solutions, and this may be leaving out many older adults who do not have access to these technologies and these may be more difficult for those with vision and hearing impairments.

We also know that underrepresented minority groups and other marginalized people already were at risk for loneliness and isolation and poor health outcomes prior to the pandemic, and these are the exact groups that are disproportionately being affected the most by COVID-19.

There are still many gaps in the evidence, predominately around telephone-and computer-based programs, but it is understanding of how to rapidly scale some of these because of the urgency, but we still do not know what the long-term effects are.

There are some areas drawing directly from the report that will help us learn from the pandemic. A couple areas for us to move forward on are thinking about funding, which includes ensuring adequate funding not just on some of the solutions, but on ensuring that research and evaluation of these programs occur so that we understand the lasting effects.

We also need to ensure accountability. Again, this means clearly evaluating and ensuring that the solutions that are proposed actually do what they propose to do and have a focus on improving the lives of older adults.

Last, with education and learning, we may have opportunities to learn from our colleagues abroad and see what has worked and consider the concept of assessing social isolation and loneliness and of social prescribing.

Understanding the needs of marginalized populations is one of the largest areas of gaps, and this is an area for us to continue our national discourse.

The solutions ahead of us may not be readily apparent, but starting with addressing the underlying ageism and other discrimination will need to be part of our response. Our challenge will be in making systematic changes that are evidence based, equitable, and timely.

I am incredibly grateful that a topic and population that I care deeply about is being recognized by this Committee. I welcome any opportunity to further advance to knowledge base and improve the care of older adults.

Thank you again for the opportunity to testify before you, and I will welcome any questions.

The CHAIRMAN. Thank you very much, Doctor.

Dr. Reed?

**STATEMENT OF PETER REED, Ph.D, MPH, DIRECTOR,
SANFORD CENTER FOR AGING, PROFESSOR, COMMUNITY
HEALTH SCIENCES, SCHOOL OF MEDICINE,
UNIVERSITY OF NEVADA, RENO, NEVADA**

Dr. REED. Good morning, and thank you, Chairman Collins, Ranking Member Casey, and members of the Senate Special Committee on Aging.

My name is Peter Reed of the Sanford Center for Aging at the University of Nevada, Reno, School of Medicine. I am a public health gerontologist dedicated to enhancing the quality of life of older adults. Throughout my career, I have never seen a crisis with the potential to cause as much harm to older adults as COVID-19.

To enable older adults to stay home and stay safe, while remaining connected to needed resources, the State of Nevada launched Nevada CAN, or the Nevada COVID-19 Aging Network Rapid Re-

sponse. It is the story of Nevada CAN that I will share today as an example of ways that we can mobilize community and State resources to enable elders to stay home.

In mid-March, a group of aging services leaders came together with grave concerns over the health and well-being of Nevada's older adults, who had all become homebound. We expected a dramatic increase in demand for aging services from the already-strained providers; therefore, we set out to mobilize the statewide network in a coordinated effort to identify and respond to elder needs by targeting three priority focus areas: one, daily essentials such as food and medication; two, telehealth services; and three, social support.

Under the leadership of Dena Schmidt, the administrator of Nevada's Aging and Disability Services Division, each of Nevada CAN's priority focus areas is supported by its own action team: the Food and Medication Action Team, led by Jeff Klein of Nevada Senior Services in Las Vegas; the Telehealth Action Team, which I lead; and the Social Support Action Team, led by Dr. Jennifer Carson of the Dementia, Engagement, Education, and Research Program at the University of Nevada, Reno, School of Community Health Sciences.

On April 1st, after a rapid planning process, Nevada CAN launched its new website, connected to Nevada 2-1-1, through which older adults can request help using a simple elder needs survey. Aging and Disability Resource Center case managers then connect elders to the appropriate action teams for support. The Food and Medication Action Team engages a network of county- and community-based agencies in delivering food, medications, and other essential items to the doorsteps of older adults. The Telehealth Action Team brings together existing health care and social service providers into an integrated statewide telehealth network, offering geriatrics, social work, primary care, and other services.

This telehealth network includes training efforts to bolster capacity of primary care providers to deliver telemedicine, with support from Nevada's two HRSA-funded Geriatrics Workforce Enhancement Programs.

Finally, the Social Support Action Team, led by Dr. Jennifer Carson, launched the truly innovative NEST Collaborative. Standing for "Nevada Ensures Support Together," the NEST Collaborative recruits volunteers, including many college students, who are committed to delivering social support to reduce social isolation.

After a background check and 7 hours of training, volunteers offer one of four social support programs: one, calling older adults twice weekly to have a friendly conversation and monitor their needs; two, convening a virtual peer group of older adults for regular group discussions; three, offering technical assistance to enable existing groups of friends to come together; or four, providing technical assistance to enable older adults to effectively use technology to access telehealth services or to connect with family members across the country.

Each of these volunteer services is designed to reduce social isolation and build reciprocal support, embracing the idea that elders are themselves a valuable resource to the community. These opportunities help fulfill one of the most basic needs in an elder's life:

the need to be known by and meaningfully connected to other people.

Clients of NEST have stated that they are grateful for the services, saying that because without someone calling to check on them, no one would know if they are even still alive. Further, as the pandemic continues, the NEST collaborative, in partnership with the State long-term care ombudsman program, is extending virtual social support opportunities to reduce isolation among skilled nursing home and assisted living residents.

In the first 2 months of Nevada CAN, there were 757 requests for help, resulting in 1,235 referrals to services. These included 448 referrals for food delivery, 148 for social support, 89 for telehealth services, as well as 550 other general services requested from the Aging and Disability Resource Center, including emergency financial assistance.

In addition to the requests through Nevada CAN, Nevada has seen a 57 percent increase in requests for assistance due to the COVID-19 pandemic. Nevada CAN reflects the true spirit of the “no wrong door” philosophy of aging services.

This time of social and physical distancing does not mean elders must be socially isolated. Nevada CAN and the NEST Collaborative are examples of how to help elders stay meaningfully engaged and connected to their communities during this pandemic.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Reed.

We will next turn to Ms. Sawyer-Manter for her testimony.

**STATEMENT OF BETSY SAWYER-MANTER, MSW,
PRESIDENT AND CEO, SENIORSPLUS, LEWISTON, MAINE**

Ms. SAWYER-MANTER. Thank you.

Good morning, Chairman Collins, Ranking Member Casey, and members of the Special Committee on Aging.

I am Betsy Sawyer-Manter. I am the CEO of Western Maine’s Agency on Aging, SeniorsPlus. I appreciate the opportunity to speak before you today.

Maine has a very old population, as Senator Collins said earlier. The COVID-19 pandemic disrupted the service delivery system that older Mainers have come to rely on for services and answers on aging. I can assume this is reflected across our entire Nation.

We have continued to provide services since our public closure in mid-March. We have quickly moved to adapt our services to telephonic and a virtual platform.

Many of our clients rely on the friendly volunteer who delivers their meals or the class in our education center that gives them purpose and socialization or the home visit with a care coordinator checking in to ensure that their home care services are still intact.

I would like to share with you some of what we have done to address the service delivery needs and to combat social isolation.

A hallmark program for us is Meals on Wheels. We cannot deliver meals virtually, so we needed to keep our meals on the road. We instituted a drop-and-go strategy to avoid direct contact and began making reassurance calls to all the clients to ensure that they are doing well and they still feel connected.

Our kitchen went into overdrive and produced an extra 3 weeks of shelf-stable and frozen meals for every client in case our kitchen

went down due to illness. We also produced 2,000 extra meals but found we needed additional freezer space. We contacted our local Walmart distribution center, and they dropped off a freezer trailer for us to use, which we are continuing to use.

UnitedHealthcare came through with additional food products, but just as importantly, pet food. We deliver the food along with the meals so that they do not give their people food to their pets, as we know pets are incredibly important companions for older isolated people.

Our home-delivered meal count is up 46 percent right now and climbing.

We have been inundated with calls on our helpline. Our staff is fielding around 100 calls a day, and that is climbing.

We have three administrative staff answering the phone live, and they report receiving calls from folks who just really want to chat. They are lonely. They are reaching out, and we have identified these clients and we have volunteers who are doing friendly visitor calls, checking in with them to make sure they are okay.

Our Community Services staff are pretty tech savvy, and they immediately went into the mode of how do we use Zoom to delivery our services. They are offering Zoom 101 training every week to clients and staff.

One client recently called after taking a class. He was very grateful for all the work we put into changing how we do business, and that he just wants to stay connected with other people. He feels that he is able to do this because now he has learned how to use Zoom, such a testimony to the power of lifelong learning.

We are offering many Zoom services using Zoom technology. Some of these include caregiver support at a time where caregivers are more isolated than ever, a grief support group at a time when we are deferring services and do not have the ability to say goodbye and get that closure, and an all-important Coping During COVID support group.

A client recently shared that she started taking a class. She was struggling with depression and spending most of her day in bed. The weekly class has brought so much positivity into her life. She has been walking, spending time outside, and has been so much happier.

In addition to our work in Western Maine, we are a statewide service coordination agency working to support over 4,400 Mainers who remain at home. We are part of the long-term services and support system in our State.

Our care coordinators are based throughout the State, and our 10 Zoom accounts are in frequent use as we conduct virtual home visits with clients. We also have the ability to get eyes on some of our most vulnerable clients.

One care coordinator shared that people are wanting to talk longer, and they have a lot of disinformation that we help them unravel. They appreciate the time we are taking with them.

We have found our clients to be receptive and welcoming of new ways of doing business. For those with technology and connectivity, it works well, but many do not have it. To that end, we have secured some private funds from the Maine Community Foundation and we are using some of our CARES Act funding to purchase tab-

lets and hotspots. We have found tablets to be easier and less threatening technology for older people who are not used to using technology.

Social isolation is detrimental to our health. We can feel the need for human interaction in every call and virtual contact that we have. We will continue to look at our business model to see how we can enhance it and enhance the opportunity to serve people in new ways.

I live in a State with many rural and even frontier areas. This new normal could serve as a means to help us reach those underserved areas and further combat social isolation in the future.

I thank you for the opportunity to speak with you today, and I would be glad to take questions when we get to that point.

The CHAIRMAN. Thank you very much. I very much appreciate the work that you do in the State of Maine.

Mr. Orr?

**STATEMENT OF NAJJA ORR, MBA, PRESIDENT
AND CEO, PHILADELPHIA CORPORATION FOR AGING,
PHILADELPHIA, PENNSYLVANIA**

Mr. ORR. Good morning.

I would first like to thank Senator Collins, Senator Casey, and the remaining members of the Special Committee on Aging for convening this hearing. I would also like to extend my gratitude for the reauthorization of the Older Americans Act and several bills that increase supports during COVID-19.

Philadelphia has the second highest proportion of impoverished older adults and is the poorest overall of the 10 largest cities in the United States. As the Area Agency on Aging for Philadelphia County, PCA has been coordinating a broad range of services for more than 140,000 older Philadelphians annually for nearly 50 years.

According to the National Institute on Aging, isolation increases risk of decline in cognitive impairments, depression, comorbidities, nutrition, and physical activity. Approximately 40 percent of Pennsylvania's linguistically isolated households are in Philadelphia, and I appreciate that Senator Casey has been championing increased funding to Area Agencies on Aging to support seniors with limited English proficiency.

As focal points in the community, senior centers play an integral part in engaging active older adults. As a result of the pandemic, senior centers have had to make significant adjustments to their services. Staff have had to make more than 9,000 wellness calls to ensure safety, provide information and resources, encourage response to the Census, and complete nutrition screenings.

Many centers have also transitioned health and wellness programs to online platforms and social media outreach. Unfortunately, due to the high rates of poverty in Philadelphia, many older adults do not have access to the technology required to participate in online programming.

It is also important to note the impact of isolation on elder abuse. PCA operates the Older Adult Protective Services Unit for Philadelphia, and unfortunately, our numbers of investigations have nearly doubled since 2013.

As pandemic-related restrictions ease, we are concerned about an increase in allegations of abuse, neglect, financial exploitation, and abandonment.

Many older Philadelphians live on fixed incomes and struggle to pay for food. According to the Public Health Management Corporation, of the approximately 301,000 older adults in Philadelphia, more than 56,000 are unable to shop for themselves, 32,000 need assistance preparing a meal, and 36,000 report skipping a meal due to lack of money.

Senior nutrition programs like home-delivered and congregate meal programs provide isolated seniors with a regular form of social engagement through safety checks and a friendly neighbor to engage with.

During the pandemic, the senior center network has risen to the challenge by providing grab-and-go meals and partnering with community organizations, including fire and police stations, to make deliveries to older adults who are unable to pick them up. Since March 18th, PCA has provided over 110,000 meals through the senior centers. As restrictions are lifted and people are returning to work, we do anticipate a decrease in available volunteers and a possible increase in need due to less availability from family members.

Through PCA's meal distribution center, nearly 1.9 million meals were delivered to homebound older adults last year. The agency has worked closely with a variety of organizations also addressing the nutritional needs of older adults during the pandemic, but the need in Philadelphia is great.

I was grateful to learn on Friday, Pennsylvania SNAP recipients now have the flexibility to utilize online purchasing for grocery delivery or curbside pickup. This benefit adds another option for isolated Philadelphians in need.

We are fortunate for a strong community and the organizations dedicated to serving the most vulnerable among us. PCA is proud to be counted among those organizations and are grateful for the support of Senator Casey as a champion of older Pennsylvanians and the continued support from the Senate Special Committee on Aging.

A few recommendations to enhance services to older adults during the pandemic as it relates to social isolation include, one, the pandemic has expedited the trend of moving programs and online services, and the coming generations of older adults will now have familiarity and expectations of digital platforms. However, current older adults, particularly in low-income communities, do not have access to technology needed to stay connected. Increased funding and education is needed to bridge the digital divide.

Number two, COVID-19 has taught us the importance of agility to meet evolving needs of older adults. Providing States and AAAs the ability to be more flexible with Older Americans Act funding. For example, reimbursement for meals of consumer choice including ethnic meals, rather than strict adherence to one-third registered daily allowance, this will create the opportunity for innovation and the capacity to meet the needs specific to their community, and number three, incorporating additional funding for AAAs in the next relief package will allow the provision of essential Older

Americans Act services to be adapted to telephonic or online options. This will keep older adults socially connected, safe, and as independent as possible while unexpectedly homebound.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Orr, for your excellent testimony.

We will now turn to questions. I want to thank all of our witnesses for provocative and interesting statements.

Dr. Perissinotto, I would like to start my questions with you. Many hospitals have instituted no-visitor policies in order to reduce the spread of COVID-19. While such policies have helped to mitigate the spread of the virus, this experience can be isolating for those with long hospital stays.

In addition, for patients with Alzheimer's disease or other forms of dementia, having a family caregiver in the room can be a critical part of the effectiveness of the care team.

As a doctor on the frontlines, can you speak to the impact of these restrictive visitor policies on vulnerable older adults' health? and, in particular, do you have suggestions for dealing with patients with Alzheimer's or other dementias?

Dr. PERISSINOTTO. Senator Collins, thank you for the excellent question, and it is incredibly relevant to the work that I do because, literally, in the last 2 weeks, I have faced these issues with my patients.

I had a patient who was monolingual, Spanish speaker, hospitalized, and where, unfortunately, even though the hospital policy had changed, this was not made clear to the family that they could be present because he had cognitive impairment and severely delirious.

This is such an important topic, and I do think that there are some things we need to think about. Number one, it returns to this idea of ageism. Many hospital policies have actually still allowed children to be at the hospital with a parent, and if we wanted to be equitable across age groups, it does mean thinking about dependent adults and allowing a family member to be there exactly in the cases you describe, which are patients with dementia and in patients who are having severe delirium, where we know that presence of a family member and familiar environment actually help reduce lengths of stay and as you know from the research that you quoted, length of stay is one of the reasons why Medicare costs are rising for people who have isolation and loneliness.

Other ideas to think about are, there is actually pretty widespread evidence of the benefits of hospital at home nationally. One idea is to think about how can we expand these services, which could also think about reducing the number of people that are exposed and of PPE use.

Other things that I am hopeful for, I am hopeful that as we get improved point-of-care testing, which right now unfortunately has been problematic, as many of you know, we will be able to test more rapidly so that we can test family members and caregivers so that they allow visitors to be more present.

The other two ideas are, as I spoke earlier in my testimony, the use of video is a little bit problematic because we do not exactly know how helpful it can be, but in the absence of nothing, it may

be something that is reasonable. We have to think about what are the resources that hospitals have to facilitate the telemedicine or the video visits with family members. It is not just having the device, but what is the staffing need?

Then, last, I am hoping that as we think about understanding the science better, as we understand transmission, I am hoping that these visitor policies will start to be lifted some. At our own institution at UCSF, we are seeing changes in the policies. Thankfully, we have a different level of pandemic here, and so we have been able to create exceptions, as I noted, for people with dementia and other situations.

We do know that there is, for example, a paper in *The Lancet* a week or two ago that demonstrated a reduction, a pretty significant reduction in transmission, as little as 3 feet, so that that starts to make us think a little bit about how we can think about space between people.

The CHAIRMAN. Thank you very much for those very interesting and helpful suggestions.

Ms. Sawyer-Manter, in addition to providing \$750 million in the Federal COVID response packages for the AAAs to expand senior nutrition programs, Senator Casey and I worked to expand flexibilities in the Older Americans Act, as Mr. Orr mentioned, to ensure that AAAs can meet the growing needs during this pandemic.

In the brief amount of time that I have left for my questions, could you expand on how this increased flexibility has enabled your agency to better meet the growing nutrition and social connection needs of the seniors you serve?

Ms. SAWYER-MANTER. Thank you. Absolutely.

We found that the flexibility was incredibly important to us. We have been able to continue to serve those congregate meals through home-delivered meals now. Those folks needed the nutrition just as well, but obviously, we could not be doing congregate sites and we do not know when we will ever get back to that for a number of months.

Additionally, the ability to reach people who were socially isolating, that did not necessarily meet the traditional Older Americans Act restrictions. What we found is we have really discovered that the need out there is so much greater than what the traditional resources were able to cover. We are finding that it is about doubling everybody's caseload in terms of who needs our assistance with nutrition, and what we are also finding is that many of them could actually meet the traditional Older Americans Act guidelines.

I think what we are really doing is discovering the true size of the population that really needs nutrition assistance, so it has really opened doors in ways that we would not have been able to do in the past.

The CHAIRMAN. Thank you.

Senator Casey?

Senator CASEY. Thank you, Chairman Collins.

I wanted to start my questioning with Mr. Orr. Mr. Orr, in your testimony, you shared that senior nutrition programs like Meals on Wheels are important not only to decrease hunger and food insecurity in seniors but also to alleviate social isolation and loneliness.

As I mentioned, part of the provisions of my bill was included in the CARES Act and the Families First bill. Those two bills combined provided over \$730 million for nutrition programs and getting new flexibilities.

Many older adults, as you and others have noted, are afraid to leave their homes to go to the grocery store, so they are buying groceries online. For most seniors on SNAP throughout the country, this is not an option. Traditionally, SNAP just does not support delivery.

As you noted as well, Pennsylvania announced participation in the online purchasing option that allows participating retailers to accept SNAP for online purchases. We know this is a good step in the right direction, but it only accounts for one State and only for retailers that are participating in the program.

I have introduced a bill, 3563, the Food Assistance for Kids and Families during COVID-19, and the separate bill, Senate Bill 3736, which is Increasing Access to SNAP Delivery. Both of these would provide the Department of Agriculture with the funding to expand access to delivery options for all SNAP recipients and support independently owned and operated retailers, so here is the question. Based on your experience, Mr. Orr, how would expanding SNAP delivery options help keep seniors both well nourished as well as how it would address social isolation?

Mr. ORR. Thank you, Senator Casey, for your question.

As I mentioned earlier, the Older Americans Act funding that we are utilizing has gone toward supporting our nutrition programs during the pandemic, ensuring that we are getting home-delivered meals and grab-and-go meals to older adults. We are also using it to ensure that we have PPEs for the staff that are on the frontlines and making sure that it has appropriate resources to our Older Adult Protective Services unit.

However, regarding nutrition services, we knew that one meal a day is really not enough to support an older adult, so any additional supports that could continue to add to the supports and services that we are providing is tremendous.

We know that statistics tell us that about 60 percent of older adults that report to the hospital are at risk for malnutrition, and that also increases hospital stays by 4 to 6 days, so any additional supports that can carry forth the supports from the Older Americans Act nutrition programs like the SNAP program, especially during the pandemic where there could be delivery, is tremendous for older adults that are sheltering in place.

Senator CASEY. Thank you very much.

I wanted to in my remaining time get one question in about limited English-proficient seniors. You highlighted in your testimony the diverse makeup of seniors that you serve in the Philadelphia Corporation for Aging, and we know that the Census Bureau tells us that over 25.5 million individuals who speak English, less than, very well, that there are that many in the country.

I want to applaud your efforts to ensure that every senior, regardless of the language they speak at home, has access to timely, accurate information.

Accessing translation services, as you know, can be challenging and costly. I have introduced a bill to focus on this that would pro-

vide Area Agencies on Aging funding to partner with the relevant community-based organizations to help limited English-proficient seniors.

If you would just tell us—and I know we only have about 30 seconds left—how could this funding enhance your ability and the ability of AAAs to assist seniors in this fashion?

Mr. ORR. Thank you.

I would say that language translation is a significant support and service for Philadelphians. We know that 57 percent of older Adults in Philadelphia come from a diverse background, and 14 percent have limited English proficiency.

Having the opportunity to expand collaboration of partnerships with those organizations that are within the community is a tremendous support to us. This allows us, once again, to make sure that we are using our resources and stretching our resources with shared partnerships, making sure that we are collaborating with people that are also within the community, and ensuring that we are expanding nutrition programs, for being able to provide shelf-stable meals, and older adult protective services to those older adults, so expanding our reach through collaboration of partnerships really is an extension of the services that we are able to provide, and it provides greater need to the community.

Senator CASEY. Thank you, Mr. Orr.

Mr. ORR. Thank you.

Senator CASEY. Thank you, Chairman Collins.

The CHAIRMAN. Thank you, Senator.

Next, I am going to call on Senator Braun, who was the first person here. After him, I will be calling on Senator Gillibrand, just so people can start getting ready who are remote. Thank you.

Senator Braun?

Senator BRAUN. Thank you, Madam Chair.

First of all, I want to commend all the witnesses for dedicating your careers to such a noble pursuit. It also sounds like if there is any good news out of this that we are going to have enhanced communication technology and tools and telehealth, which I am one who has been so out front in trying to reform health care. That is not needed not only for the care of elderly but across the board.

I am going to reminisce back to 2004 and 2007 when I had a mother and father, respectively, the last 3 to 4 months of their lives in a nursing home, and I had the benefit of living in my hometown where they were. I cannot imagine how frustrating it would be today to where you have family members that are in the area of a nursing home with a mother or father or a close relative and you cannot visit.

I would like each witness to tell us, Since COVID, what best practices have come along? How many nursing homes have found ways to actually let close relatives in safely, and if that has not occurred, if you think here in the next few months, if we have a resurgence, that will be there to where you eliminate that most frustrating thing, where you have people in their own communities that cannot see a loved one? I would like each witness to weigh in maybe with a minute or less to tell me what you think.

Dr. PERISSINOTTO. This is Dr. Perissinotto.

I think that there is a couple things we need to think about here, and I want to broaden the discussion a little bit, not just to nursing homes, which has been the predominant discussion nationally, but we need to think about long-term care facilities in general.

As Senator Collins noted, I believe, only 1 percent of the population is nursing homes, but there is an even greater population of people who live in assisted living, supporting care, and who are homebound and are receiving the care from direct workers and it is understanding the risk in all of these situations.

What I anticipate that we need to be able to move safely into the next round of the pandemic and to keep both our workers and our family members of patients safe is better understanding the epidemiology, which means better tracking symptoms.

One of the things that has been challenging is that we have probably missed cases because we did not originally include in the definition of COVID symptoms many of the geriatric symptoms we see in older adults, which are falls, change in cognition, weakness, so that is part of it, and it is also again really understanding better the transmission that would safely allow visitors and safely allow such workers.

Dr. REED. If I may, I would like to share first just a quick disclosure that long-term care is an area of passion of mine, and I currently serve on the Governing Board of the National Consumer Voice for long-term care as well as the board of directors for Eden Alternative International. Those are two nonprofit organizations focused on resident and long-term care advocacy, training, and education.

Drawing on that experience, I can tell you in terms of social isolation within not just nursing homes but, as Dr. Perissinotto said, also assisted living and group home communities, any congregate or residential care community.

Loneliness, helplessness, and boredom are extreme challenges. In fact, those three concepts were described by the Eden Alternative founders, Drs. Bill Thomas and Jude Thomas, as the plagues of elderhood and the manner in which we can combat those plagues is by fostering and forming authentic, meaningful, proactive relationships with all elders irrespective of their cognitive or physical limitations.

I think it is important that we find ways to keep elders connected to their families as well as communities. Technology is obviously a solution for that, and as I mentioned, the NEST Collaborative within Nevada CAN is working with our Ombudsman Office to leverage getting tablets into nursing homes so that we can have volunteers connect and provide social engagement to residents.

I want to comment that as I think was mentioned earlier, there is no substitution for person-to-person contact with humans, and I think that it is incumbent upon CMS and the States while protecting elders and maintaining their safety to also find the right guidelines and procedures that they can require for nursing homes to be able to begin allowing families and community members to engage with elders and that might include requirements such as wearing masks, using hand sanitizers, using separate areas within the communities, maintaining social distancing with family members, but doing so really in a safe way.

I will say nursing homes have experience with this. They are infection control experts and have been for many decades, and this is just another challenge that while we leverage technology to address social isolation, we can also start to provide the guidance and the guidelines from the Federal and State levels to enable visits to begin happening again in a safe way that protects elders.

Ms. SAWYER-MANTER. This is Betsy Sawyer-Manter.

I heard yesterday here in Maine that—can you hear me? I think so. Things with creating spaces that are safe, but that family members and the older adult can come together with some kind of a created barrier between them that makes that safer for them, so that is one idea.

Of course, during warm weather, they are looking at doing outside social distancing activities between family members and older people, so those are a couple ideas that I have heard here in Maine.

Senator BRAUN. Thank you.

Mr. ORR. I would agree with the previous comments related to there is no substitute for face-to-face contact; however, as we continue to looking at ways to increase supports and ensure that we are connecting with folks that are at risk for social isolation, I think that resources available to ensure that people have the appropriate technology is going to be critical.

Just looking at Philadelphia alone with the digital divide, our statistics tell us that about 82 percent of white households have access to the internet, the older adults in Philadelphia. Whereas, 67 percent of African Americans in Philadelphia have access to the internet, so making sure that we are doing our part and having flexible resources in there to support technology during this time and ensure that doing something to tackle the digital divide is going to be important.

Senator BRAUN. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Gillibrand?

Senator GILLIBRAND. Thank you, Madam Chairwoman for this hearing.

I would like to talk about the intersection between social isolation and nutrition. We have amazing organizations in New York that are delivering food to our older adults. Meals on Wheels deliver both goods and visit seniors, so it creates that social contact.

We took steps in the CARES Act, the Families First Coronavirus Response Act to provide \$1.2 billion specifically for older adults living in community, including specific funding for nutrition programs and home delivery.

I believe we need much more funding for nutrition. We need to prioritize nutrition for our older adults in needs. Food banks, as you have seen in the news, are experiencing skyrocketing demand. You have seen photographs and pictures of cars lined up for miles just to get a bag of food. We have seen pressure at food banks in every part of my State, and we need to close this meal gap.

I did introduce legislation called Closing the Meal Gap that would increase the baseline for SNAP benefits by 30 percent.

Dr. Reed, I wanted to ask you. Given this growing need for nutrition programs, how important is it from your perspective that we raise the baseline of SNAP benefits, and what other policy ap-

proaches should we be considering to address food insecurity for older adults?

Dr. REED. Well, thank you, Senator Gillibrand, for that question.

There is no doubt that this pandemic has shined a light on the challenges of food insecurity among older adults and the questions about where the eligibility criteria should be set for how people can access those benefits, and certainly, the flexibility that has been provided through the emergency funding bills and the Administration for Community Living for the nutrition programs has been extremely helpful to communities and being able to serve a larger number of people.

I think that one of the important innovations that we have seen is popup organizations throughout. At least in Nevada, we are seeing that very much so and I think probably across the country as well, where to supplement and complement the SNAP-Ed and other nutritional program funding that is available through our county agencies as well as through the States, there are private and non-profit organizations and restaurants that are forming collaborations to come together to deliver meals to people's homes in ways that can help to address that. I think that is really critical in supplementing it during this pandemic, but to your point, I think that it is possible many of those pop-up agencies that are committed or interested in supporting this now may start to fade away over time as the crisis begins to abate, and it is going to be important that we recognize the need for sustained and increased financial resources to ensure that all people have food available to them.

Senator GILLIBRAND. Do you know what the impact of the USDA SNAP online purchasing pilot has been on food insecurity in older adults, and how do you think we could improve this program to be more effective?

Dr. REED. I am not aware of the specific details of that bill or the impact that it may be having. I can tell you that in Nevada, we have delivered almost 400,000 meals just in the months of March and April to older adults, and that does not include the organizations that have been stood up to provide services particularly in the urban areas that have delivered tens of thousands of other meals as well.

There is a lot of activity that is happening, but I would defer to particularly my colleagues from the AAAs in terms of the impact of that bill on food security.

Senator GILLIBRAND. I would like to address access to technology as well. Obviously, before this pandemic, we knew that there was about 65 percent of older adults who used the internet overall, but about half of older adults did not have access that they needed. Many rely on computers in senior centers or community centers or the libraries, a lot of which are closed now and they are not able to access.

Improving access to telehealth visits to increase support would help protect older adults from being at risk of COVID while still receiving the care they need and connecting with families and friends. During this pandemic, CMS has provided telehealth waivers in an effort to make telehealth more accessible.

Ms. Sawyer-Manter, what are the most benefits on health outcomes of older adults by closing the broadband access gap?

Ms. SAWYER-MANTER. Thank you, Senator.

I will just say that we are doing telehealth on our agency. We are a care coordination agency under Medicaid to ensure that people living at home are getting the care that they need and that they are getting their needs met.

What we are finding is only about 20 percent of the population that we are reaching even wants to be connected through computers. I think some of that is the era of technology, and that can be overcome with education.

The other piece is much like my colleague in Philadelphia. Folks do not either have broadband—there is an inequity in terms of the rurality of the State of Maine, for example—and also that the poverty rate is pretty high among older adults, and they just simply cannot afford the fees. It is not just getting them the technology, but it is keeping them connected because there is a monthly cost for people to have internet. I think sometimes we think just about getting out the equipment is the way, but it is really beyond that and we are trying to think through how do we support people by more than just giving them the equipment that they need so that they can get the telehealth they need, but also how do we help them stay connected.

Senator GILLIBRAND. Thank you.

Thank you, Madam Chairwoman. Thank you, Mr. Ranking Member.

The CHAIRMAN. Thank you.

Senator ROSEN?

Senator ROSEN. Thank you, Madam Chairwoman. Thank you, Ranking Member again. Thank you to all of the witnesses for being here.

You know, with the emergency of the novel coronavirus earlier this year, public health officials instructed Americans to stay home and social distance in order to prevent the spread of the disease. These guidelines have been especially important for adults age 65 and older, so for Nevada, this means that approximately half a million elder Nevadans are now primarily homebound and at a risk of experiencing social isolation, a figure that makes Dr. Reed's goal to ensure that every elder Nevadan has access to medical, social, and daily essentials to their home all the more critical.

Dr. Reed, as you have noted, our State's Aging Services Organization, Nevada's Aging and Disability Services Division, the Sanford Center for Aging, UNR's Dementia Engagement, Education, and Research program quickly came to launch together, Nevada CAN, that integrated service response we are so proud of, working to ensure that our senior service providers can collaboratively support every older Nevadan who is now homebound, so like we have been talking about, social isolation, so we have to think about getting essential services to our seniors. Dr. Reed, I know you have leveraged everything you can to help create that Nevada—or work with the Nevada 2-1-1 hotline to make Nevada CAN a COVID response section as well as all the other services, but how do you think these new relationships and integrated approach can be beneficial in the long term after the coronavirus crisis abates, and how can we bolster the success and then export it hopefully to other States that can use our model?

Dr. REED. Thank you very much for that question, Senator Rosen, and also, thank you for your advocacy on behalf of older Americans as well as elder Nevadans. Your engagement with this Committee and the hard work that you do is impacting lives every day, and we in Nevada are grateful for your hard work.

I will say that the relationships that we formed really are the central, sustainable component of what we have done with Nevada CAN. We stood up this statewide integrated coordination of efforts in order to address the pandemic.

However, by bringing together our State unit on aging with community-based providers, with county providers, and thinking about how to triage requests for help from elders directly through a centralized program to those providers, there is now a new network of support that has been created, and that network of support can be sustained in the long term. I will say that resources are going to be required to help to achieve that at multiple levels.

The first relates, as you mentioned, to 2-1-1 and what is called the “no wrong door” approach to providing services to elders through aging and disability resource centers. We have to have the funding necessary to ensure that no matter what an elder needs or where they access the aging services system, they are able to get connected with the broad range of services that can help them to meet their needs, so that entry point and that triage to those other services becomes critical at the highest level.

The next level are the individual functional areas, so thinking about how we can put resources specifically into addressing social isolation, resources specifically into bolstering the technology and the connectiveness for telehealth, and resources obviously into food security and continuing to provide nutritional assistance. Those core functions of this network also need to be sustained at their own individual level, so it is the connectedness between all those different elements and the relationships that we have created that—I guess you could call this as a silver lining to come out of this because we have always tried to work together, but this pandemic has forced us to really streamline and coordinate efforts in an efficient manner.

Senator ROSEN. How exciting. I just cannot wait to keep telling everyone about it and let your In Box be full so people can copy our model.

I want to speak briefly about—Senator Gillibrand talked about the digital divide as it relates to broadband, but we know that seniors oftentimes have difficulty even using equipment because of their eyesight. They might have a hand tremor, just the physical limitations of sometimes being a senior.

What do you think are some of the new and innovative ways that we can help seniors use the technology if we are going to provide them telehealth, et cetera, et cetera? How do we overcome those physical limitations?

Dr. REED. Right. I think that issue is important, both in terms of providing social support as well as through telehealth.

I am going to speak very briefly about telehealth first. It is interesting. The Sanford Center for Aging at the School of Medicine at UNR has been providing telemedicine services for several years, but that was a telemedicine cart talking to a telemedicine cart in

a rural clinic and that is no longer possible because very few elders have telemedicine carts sitting in their living rooms.

What we have been able to leverage are new online platforms, and also, we are able to potentially get tablets to people that do not have the technology, but that does not address the barrier of people not being able to use technology. If you hand an iPad to an older adult who has never held an iPad, they are not going to know what to do with it. We have tried to stand up our back-office support within the clinics to provide pre-visit technical assistance to ensure that they are able to access the technology, get online, before connecting them directly with our providers and some of that work, as I mentioned, is being supported by the CARES Act emergency funding that went to the Health Resources and Services Administration to support the Geriatric Workforce Enhancement Programs nationwide and bolstering their telemedicine and telehealth services.

On the social isolation side, it is a similar situation, and so what we have done through the NEST Collaborative is to engage volunteers in reaching out and specifically just providing technical assistance to older adults to connect with their existing groups of friends as well as to learn how to use technology to be able to access telehealth and have social connectedness.

It is essentially IT support for elders to learn how to use the technology effectively in addition to providing the technology and providing the services via technology. All three of those elements have to be present. Thank you.

Senator ROSEN. I am so grateful for your innovation. We have all had our challenges with the Zoom calls. That is for sure, but we look forward to seeing you back home in Nevada and continuing supporting the good work that you do.

Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Jones?

Senator JONES. Thank you, Chairman Collins, and thank you for holding this hearing, you and Ranking Member Casey. This is an important hearing, and I appreciate all the witnesses not only for being with us today but also your dedication to seniors across the country.

Ms. Sawyer-Manter, I would like to ask you a little bit, a question about personal protection equipment. You mentioned in your testimony that you had difficulty finding PPE during the beginning of the pandemic in order to safely serve clients.

I have heard that across Alabama as well, and I have a bill pending to try to get more PPE manufactured in this country, to give tax incentives, because I firmly believe that we are going to need more going out of this than we had coming in. In other words, it may not have been as much on your radar heading into this pandemic.

My view—and I would like for you to address whether I am right or wrong. My view is that we are going to need more PPE coming out of this, that I think folks are going to be taking extra precautions even if this particular crisis abates, so if you could address how we see going forward the use of PPE with your agency?

Ms. SAWYER-MANTER. Thank you, Senator, for the question.

I believe that PPE is going to be standard operating procedure from this point forward for the foreseeable future, anyway, and I do think that one of the things that we do is we have statewide home-based care in our State, where many, many personal care workers are in homes all the time helping people with activities of daily living. Those folks need personal protective equipment, as do the clients that they are serving. It is a two-way street, so it is not only getting it to the workers, but it is also getting it to the clients. We do not see that we will see people in our physical office space without PPE, and so I think that is going to be an ongoing issue.

We have had a really hard time getting masks. Gloves have been a little easier, but masks have been a real issue. I recently was able to place an order and get some of just the surgical masks, so it is an ongoing issue, and I do not see it going away anytime soon.

Senator JONES. Thank you. Well, that is kind of the way I see it. I hope we can get some support for this bill I have got that would give incentives to businesses to make that in the United States and not be so dependent on foreign vendors in foreign countries for the manufacturer.

I would like to kind of ask the panel. It is a general question, but I am just going to be candid about this. Each one of you have dedicated your lives to working for seniors, and I so applaud that. You have made it your life's work.

I will be honest that at some point during this pandemic, we have seen as people got frustrated and wanted to open back up and get out into the world—and rightly so—and so things, there seemed to be to me upon not a few public officials but also some in the general public that had more of a cavalier attitude about the health of our seniors, the potential expendability of our seniors. I have heard it over, “Well, they are going to die anyway. They have got these preexisting conditions. We need to live our lives,” and that has been very troubling to me, having lost a dad in December, having a mom who just turned 89 years old.

I would like for each of you to address that a little bit to see what can we do as we get toward the end of this, hopefully this health care crisis, but about the attitude for our seniors in general and if anybody has any thoughts on that, I would sure like to hear it because it has been very troubling to me.

Dr. PERISSINOTTO. This is Carla.

I can touch on a few topics, where we are essentially discriminating against ourselves, because we are all aging, and we will all be in this place at some point, so it is fascinating to me the discriminatory language that we have used.

I said this a couple times during my testimony. Ageism is a huge part of this, and so it does require a reframing and a national focus on how we talk about respect and how do we bring back value to older adults.

If that does not work, which is a culture war which does not always work, it is also thinking about the finances. Older adults are costly, and if we do not focus on some of the things that we know prevent costs down the line, that ultimately affects all of us, so it is not just about dying. It is the people that lose their independence and become more dependent and end up in nursing homes and other places which are costly to Medicare.

Senator JONES. Thank you.

My time is almost out. Anyone else that wants to add to that?
Ms. SAWYER-MANTER. This is Betsy Sawyer-Manter.

I had the same conversation a couple days ago with someone. In a time when we are really talking about social justice in this country, it seems to me that ageism has to enter into that conversation as well, and that there is this Dixie Cup mentality that older people are expendable and we need to stop that, and we need to address it, and we need to confront it when we hear it.

Dr. REED. I would say that is exactly right. Ageism is one of the preeminent issues in the field of gerontology and geriatrics, and it affects our society, our communities, as well as our health care delivery system.

I think what is critical is that we start to educate the public as well as health care providers about ageism as a form of discrimination, just like the other forms of discrimination that are so socially unacceptable. For some reason, making jokes about older adults is perfectly fine, and it is a socially acceptable form of discrimination right now and that is what needs to be addressed.

As has been said, people are discriminating against their own future selves, and to get them to recognize that there really is no age at which they would choose to be diminished in their value or their abilities to self-determination and decisionmaking in their own lives.

I would just add that discrimination against people living with dementia is also a form of discrimination that needs to be addressed as well. It is judging people based on their cognitive abilities and making assumptions about what they are and are not capable of doing for themselves, and both ageism and dementia-ism are forms of discrimination that we should try to educate the public about because I think if they knew about these to a greater degree, they would be less willing to engage in that discrimination so readily.

Senator JONES. Great.

Mr. ORR. I would also agree that ageism and reframing aging is absolutely critical.

We continue to stress the importance of following the guidelines of the CDC and health department for our older adults because they are some of the most vulnerable in the community.

I think back to a time when one of my predecessors wrote an article—this is probably about 10, 15 years ago—in how we view ageism in the United States, and when we think about aging things in other areas of our lives, we talk about vintage cars and we talk about aged wine, it tastes better, but when we talk about older adults, you hear things like “geezer” and “old fogey,” so we really have to think about how we frame ageism and reframe it in our society.

Senator JONES. Great.

Well, thank you all. Thank you, Madam Chairman. I know I went over my time a little bit, but I think that those were very, very important comments from our panelists today, so thank you for that indulgence.

The CHAIRMAN. I agree.

I know that there is at least one other Senator who wants to be here. I am going to go to my second round and give Senator Casey the opportunity for his second round in the hope that the Senator will be able to get here before we wrap up the hearing.

There are so many important issues that we covered today. Mr. Orr, you touched on one that I want to explore more with you. You noted the potential increase for elder abuse scams and exploitation during this pandemic. We have already seen one COVID-related scam in which individuals were called, particularly seniors, and told that they had to pay now to get a vaccine against COVID-19.

Well, of course, while there is a lot of research that is promising and under way, there is not currently a vaccine even available for the coronavirus.

Seniors who are socially isolated are particularly vulnerable to scams. We know that from more than 20 hearings we have held exploring various scams that target our seniors.

As scammers seek to prey off the most isolated and vulnerable seniors during this pandemic, during a time where they may be more isolated, not have people to consult with, what preparations is your agency doing to help protect this truly vulnerable population?

Mr. ORR. Thank you for your question, Chairman Collins.

I would say that we are ensuring that we are adding the appropriate resources to our Older Adult Protective Services unit so that we can address abuse and neglect, financial exploitation, and abandonment.

We also want to make sure people know other resources that are available to them, like the Ombudsman Unit which supports those individuals in long-term care, receiving long-term care services, but we are also continuing to work with collaborative partners and with our local legislators like Senator Casey who has continued to stress the importance of educating older adults on scams and what resources are available to them, so just making sure that we not only have resources available to investigate and try to mitigate abuse and support people with resources, but also connecting them to opportunities to become educated.

The CHAIRMAN. Thank you for that very important work that you are doing.

I want to turn back to Dr. Reed and an issue that I raised earlier about Alzheimer's disease. How does your portal or does your portal help those with Alzheimer's and their caregivers to connect with social supports? Do you have any special program there that would help people who are living with dementia and particularly their caregivers?

Dr. REED. Right. Thank you, Senator Collins, for that question and, again, I feel I am full of disclosures. I should say that I do serve as the chair of the Nevada Task Force on Alzheimer's Disease and have also been involved with the Alzheimer's Association in one way or another for over 20 years, including currently serving on the board of directors for the Northern California and Northern Nevada chapter of the Alzheimer's Association.

The Nevada CAN effort has taken great steps to try to ensure that people living with dementia are able to access and benefit from the services as well as their family caregivers. That started

in the social isolation element by connecting with people living with dementia themselves who helped to develop the portal that we offer, helped to develop and review the website to ensure that it is dementia friendly.

The NEST collaborative, as I mentioned, is housed within the Dementia Engagement Education and Research Program at our School of Community Health Sciences, and Dr. Jennifer Carson, the director of that center, also leads Dementia Friendly Nevada. She has connected our Nevada CAN social support efforts with both volunteers and participants living with dementia from our rural Dementia Friendly communities around the State that has gone to great lengths to ensure that all of the services that we offer are supportive of people living with dementia.

I think that a critical component is the input and the advice from people living with dementia. As I said earlier, we often make assumptions about what people with dementia can and cannot do, and in our initiative in Nevada, we recognize the value that elders bring into the discussion, and recognize the value that people living with dementia bring in sharing their own perspectives on what will and will not be best to help to support them in the community.

The CHAIRMAN. Thank you so much for the good work that you do.

In the interest of full disclosure to you, I founded the Alzheimer's Task Force in the Senate. Hillary Clinton was my first co-chair. Mark Warner is my current co-chair. I worked over the years with Evan Bayh and others. We have been able to gravely increase the funding for research, and that is something that I have been very proud of. There is a long ways to go, but I am so pleased that you are so active in that area. I think it is really critical.

Senator Casey?

Senator CASEY. Chairman Collins, thanks very much.

I wanted to turn my attention to Dr. Reed for a question about nursing homes. As we know, we have seen the horror unfold in COVID-19 where, as I mentioned earlier, just about 40 percent of all deaths are in long-term care settings when you combine the number of resident deaths—and, of course, that is the higher number, unfortunately, but when you combine resident deaths and the deaths of workers in those settings.

We know that just as the pandemic has isolated seniors living within communities across the country, it is also, of course, isolated seniors in nursing homes. They have been locked down, in essence, for months now without outside visitors and family members, as I mentioned, seeing them through windowpanes that we have all seen over and over again.

I had an opportunity with Senator Klobuchar and Senator Capito to introduce Senate Bill 3517 called the ACCESS Act. It was pretty simple, but it would just provide help to nursing homes so they can purchase the technology to ensure residents can stay connected. It complements a new pilot program, actually, a Pennsylvania program, the Department of Aging in Pennsylvania and AARP in Pennsylvania, giving cell phones and tablets to nursing homes for residents in about 40 counties in our State.

My question, Dr. Reed, do you agree that efforts like these are necessary to help nursing home residents stay connected to both

family and friends and to reduce the incidence of both social isolation and loneliness?

Dr. REED. Thank you, Senator Casey.

Absolutely. I think one of the benefits of the ACCESS Act that you have proposed is not only that it enables nursing home and assisted living communities to gain the technology that they need in terms of the tablets and computers, but also that the language is broad enough, at least as I understand it, that it can provide support for homes to get internet services, so it is not just the hardware, but it is also the connectiveness as well, which I think is another really important component of this, and opening that up so that the internet is available along with the technology and then I mentioned earlier, I think also it is important to provide the technical assistance to older adults for them to be able to effectively use the technology, which is another leg to that stool.

Gaining access to technology and the services necessary are an essential step toward reducing social isolation in long-term care communities, and I would mention again that it is also important for CMS to begin providing guidance on how to engage in effective infection control within those communities, so that they can start to have person-to-person visits in a way that is cautious and protective of the elders. Bringing those two things together can, I think, have a meaningful impact in reducing social isolation between the technology and the cautious protected visits.

Senator CASEY. Doctor, thanks.

I think one thing the Senate should do is to consider legislation. I happen to have a bill, but I am not referring just to that bill. We have got to provide, I think, more resources to nursing homes, even as we want to hold them accountable, as we have to for violations. We also have to help them with resources so they can separate, so-called “cohorting,” separate residents with COVID-19 from residents that do not have it, and that cohorting works and it should be in place in every single nursing home in addition to the costs of PPE and other expenses they have to incur.

We should not allow another group of nursing home residents and workers to die because we do not have the strategy and a funded strategy to help nursing homes across the country, so I hope we can act in the Senate on that.

Thanks, Dr. Reed.

Chairman Collins, I will go back to the other questioners.

The CHAIRMAN. Thank you.

Senator McSally?

Senator MCSALLY. Thanks, Chairwoman Collins. I appreciate you holding this important hearing. Thanks to all of our panelists.

We are all experiencing, our constituents are experiencing the challenges of the isolation that we have been talking about today. My mom is in independent living. I know she does not like me talking about her on Capitol Hill, but just trying to stay connected with her and help her through the process and getting eyes on her virtually, she is again in independent living but has been basically isolated for months now.

I did a window visit with a mentor in assisted living in Tucson, and just the challenges are very real in trying to stay connected with people, as we have been talking about, when the technology

is just not the same and sometimes the technology is overwhelming.

Then we had one constituent contact me whose mother was isolated, had dementia, basically felt totally cutoff, scared, and afraid, and she passed away in this timeframe. I think this is part of the cruelty of this virus that we have individuals who are already vulnerable, who are isolated, and if they get the virus or have some other serious health condition, they are alone and the nurses are doing amazing jobs to stay with them, but it is not the same as the face of your loved one, your family member.

As we move forward and we have increased our capacity for testing, I know there are concerns for bringing in visitors because we cannot have this population be more at risk.

I feel like we cannot afford not to have the ability for visitors and family members to be tested so that they can be with their loved ones and have that human touch as they go visit them.

I also think there is an element of preventing elder abuse. It is underreported. The number of cases that are reported is a shocking number in America, and one of the best oversight mechanisms in addition to inspections in the government is the family showing up and being able to check in on their loved one and see how they are doing and focus on their care and see any signs and symptoms where there may be neglect happening, so if you could all share. It is not just about isolation. I think it is also about preventing elder abuse and just providing that there is a humanity of a loved one being with you. There is nothing that replaces that. Can we not get to that place where we can safely allow people to visit and hug with high situational awareness while protecting these most vulnerable from this awful virus?

Dr. PERISSINOTTO. This is Carla Perissinotto.

Thank you, Senator, for bringing up these topics. I had two things. Related to the elder abuse, one of the challenges has been around our understanding of cognitive impairment and how we define that and how our local agencies respond.

There is often this assumption that people have the right to decline services and the right to self-determination. Self-determination goes out the window with the cognitive impairment, so part of this going forward as we understand elder abuse is understanding the interplay of cognitive impairment and giving our agencies room to work with that.

Related to assisted livings or independent living, thank you for bringing that up. Where we are here is that, as I mentioned earlier in my testimony, we are in a data-free zone, and we need to work nationally to provide better guidance to these locations because they are having to go to extreme measures because of fear of what families are going to say if someone is infected, fear of the media, and no guidelines, so the work ahead of us is really to develop those guidelines so we can safely allow you to see your mother, not just through a window.

Where that policy came from is a little bit beyond me. I think it has been fear-based. We have had to do that to keep people safe, but there is a middle ground. I hope in these couple months if we see a little bit of downtrends of transmission, we will have some time before the next pandemic starts.

Senator MCSALLY. Great.

Any other panelist want to share your perspectives?

Dr. REED. This is Peter Reed.

I would just share I think it goes back to that sort of ethical or philosophical tension that exists in really all areas, but balancing physical safety with personal autonomy and thinking about how we can maintain safe environments for elders while also enabling them to engage with family and friends, as you said, to get hugs, which are so critical. Physical touch is so important.

Senator MCSALLY. Yes.

Dr. REED. This is true not only in long-term care communities but also in community-based supports and services and this is a really challenging situation with the pandemic because we have heard the data. This has a dramatic impact on older adults, and as a public health professional, my advice is for all elders to continue to stay home, no matter what their States are doing, in opening up opportunities to go out and to take advantage of the technology and the services and resources that are being provided in their communities to help to maintain access to all of those essentials of everyday life that they need, but bringing families together in a safe and appropriate way, providing guidance on how to do that can help us to balance that need of autonomy and personal safety and connectedness and physical safety. It is a challenge, though.

Senator MCSALLY. Great. Thank you.

I do not know where the time clock is here. I do not know where I am, but I do want to also just ask really quick about the issue of telehealth.

Senator Jones and I will be introducing legislation today. This is again a pilot project to increase the access, especially in rural areas, to remote patient monitoring. I mean, we have seen the benefits of telehealth. That keeps you isolated, but it still gets access to the health care, but even people with diabetes and other things, if they can have that remote monitoring and it is under 2G or 3G or cellular coverage to be able to do that, just having that additional situational awareness to be able to keep the senior healthy and monitored, so any comments on expanding telehealth to include remote patient monitoring like our bill has?

Dr. PERISSINOTTO. This is Carla Perissinotto.

Two things real quick. One, it is thinking about is that technology accessible for older adults. Has it been tested? Has it been adapted to them?

Two, over-monitoring can be somewhat dangerous in older adults, so it is the balance between what are we monitoring for and what are our goals, and then just keeping autonomy and privacy in mind as we develop these things. There is a lot of room, and it is great to be thinking about this moving forward.

Senator MCSALLY. Great.

Anyone else?

Mr. ORR. Sure. I would say that making sure that we do our part too to try to eliminate the digital divide.

Earlier, I shared some statistics in Philadelphia that with the older adults in my community who have access to the internet, it is about 82 percent, and those in the African American community,

it is 67 percent. That does not even touch on those that are impoverished.

We are looking at people who are in Philadelphia that are at the 100 percent of the Federal poverty level. They have about 52 percent internet connectivity, so anything we can do to make sure that we break that digital divide so more people can have access to telehealth at this time would be tremendous.

Senator MCSALLY. Great. Thank you.

I am pretty sure I am over my time, even though I cannot see a clock. Thanks a lot, Madam Chair. I appreciate it.

The CHAIRMAN. Thank you.

I want to thank all of our witnesses today for their research, their work, their commitment to serving our seniors and for joining us today. Considering the technological constraints we had to work with, I think it went extraordinarily well, and I want to thank both our technical staff as well as the Committee staff for their hard work on this hearing.

Today's hearing has highlighted the stark reality that while social distancing has become a core tool in our effort to save lives and to help flatten the curve of COVID-19, social isolation cannot become the new normal, especially for our older adult population. We know that social isolation and loneliness creates significant but underappreciated health risks for older adults. The pandemic has only magnified these detrimental effects.

While the issues related to social isolation affect people of all ages, older adults are more susceptible due to physical ailments or life circumstances such as living alone or having a smaller social network.

As we work to understand and reduce the impacts of this silent epidemic, today's witnesses certainly provided us with valuable insights, practical solutions, and reasons for hope that we can overcome some of the strict restrictions and carefully and safely unite families with their loved ones in hospitals and nursing homes and particularly those who are living with Alzheimer's or other dementias.

Three years ago, I wrote a column for a Maine newspaper in which I wrote, "The anecdote to isolation is connection," and that is even truer today during this pandemic. Solutions to this issue come in many forms. Technology clearly is important, but the common thread is human connection.

We will continue to search for meaningful ways to listen, learn, and connect with older adults to help give them the assistance that they need and to make their lives more meaningful and more enjoyable, and so that we too can learn from them.

I would like to now yield to Senator Casey for his closing remarks.

Senator CASEY. Chairman Collins, thank you very much for the hearing. I think it was a critically important set of topics to be able to explore at this time, especially when we consider the challenges faced by seniors and their families in the aftermath of the spread of COVID-19 as well as the economic crisis on top of it.

I hope that we can do more beyond this hearing. I hope that the Senate in the next couple of weeks will act on a whole range of issues, but if we just focus on these senior issues, there is still a

long way to go. As much as we came together with the virtually unanimous consensus to pass what now I think is five pieces of legislation, there is still more to do. The Senate still has work to do to help seniors.

I would just mention one issue, and that is food security, which we know is directly connected to the issue of social isolation.

Mr. Orr mentioned just in the—consider this, just in the city of Philadelphia, one city, 56,000 people in that city who happen to be seniors who cannot shop for themselves, so food security in and of itself is a huge issue directly related to social isolation.

I hope that we do not go through the rest of June and the rest of July—we have a break in July, as everyone knows—without taking action on a whole range of issues, but I will limit it to just food security and issues that can better assist our seniors and their families with social isolation.

I think there are a lot of good ideas that our witnesses presented today, and I hope those ideas can be effectuated by way of legislation passing the U.S. Senate in the near term because I do not think families can wait months for this kind of support, but we are grateful. We hope that the spirit that undergirded the reauthorization of the Older Americans Act that Chairman Collins and I work together on, we hope that that spirit will animate and create some urgency behind near-term legislation to help seniors.

Thank you, Chairman Collins, and I want to thank our witnesses for their testimony. I want to commend and salute the work of the staff to make this hearing possible in this fashion. Thanks very much.

The CHAIRMAN. Thank you, Senator.

Committee members will have until Friday, June 19th, to submit additional questions for the record. If we get any, we will be sending them to our witnesses and appreciate their willingness to respond to them.

I want to thank our witnesses. You were absolutely terrific, and I appreciate your putting up with the technological challenges of today to join us.

I was thinking that prior to the pandemic, I had never heard of Zoom or WebEx, and now every single day, they rule my life, but at least we do have that technology to take advantage of.

One of you made a very good point that for her seniors, sometimes the ability to use that technology is limited by poor vision or by inadequate hearing, even if they have the access to the technology, and I think that is something for us to give some creative thought to as well.

I do want to again thank all the members of the Committee for participating in the hearing, and this concludes our hearing. Thank you.

[Whereupon, at 11:35 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

Testimony re: combatting social isolation and loneliness during the COVID-19

Senate Special Committee on Aging

June 11, 2020

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Introduction:

Chairman Collins, Ranking Member Casey, and distinguished members of the Committee, thank you for the opportunity to testify today on the topic of social isolation and loneliness during the COVID-19 pandemic. And an additional expression of gratitude for allowing me to testify remotely given these unprecedented times.

My name is Dr. Carla Perissinotto. I am an Associate Professor of Medicine at the University of California, San Francisco. I am a Geriatrician and Palliative Medicine Physician and have devoted my career to the clinical care of older adults, many of whom are underserved, vulnerable and homebound. I am a first Generation American of Mexican and Italian descent, who cares deeply about the care of our older adults who come from diverse backgrounds and I profoundly respect the immigrant roots of our nation. In addition to providing clinical care, I have been researching the health effects of loneliness and isolation in older adults for over 10 years. In 2012, I published a seminal paper in *JAMA Internal Medicine*, which highlighted the health effects of loneliness in older adults and demonstrated that older adults who are lonely have a 59% increased risk of losing their independence (as measured by Activities of Daily Living (ADL), mobility, climbing stairs and performing upper extremity tasks) and 45% increased risk of death. Most recently, my work has focused on the role of health care systems in understanding and measuring the health effects of loneliness and social isolation and incorporating this into clinical care. In addition, because of my own work in community-based settings I am interested in evaluating community-based programs that focus on loneliness and isolation. Indeed, loneliness and isolation are a national and global public health problem whose widespread effects may be even more pressing now, in the midst of the COVID-19 pandemic. Lastly, I have had the distinct pleasure of serving as a committee member for the National Academy of Sciences Consensus Report: *The Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults*.¹

Background on Social Isolation and Loneliness:

As my friend and colleague Dr. Julianne Holt-Lunstad previously reported to you in 2017, being connected to others is widely considered a fundamental human need—crucial to both well-being and survival. This need has been described extensively in the literature² and current day examples of harm exist and demonstrate what happens to us without social contact. These include the effects of solitary confinement, and separating infants from socialization, among others. Yet, as described in the National Academy of Sciences Report, there are increasing numbers of adults in the United States (and across the world) who are experiencing both loneliness and isolation at rates that are alarming and thus raising this to the level of a public health crisis. Anecdotally, the World Health Organization has recognized social isolation as a determinant of health. Prevalence rates for loneliness and isolation range from 20-50%³ and the corresponding health effects are disquieting. When the risks of loneliness and isolation are examined, both have dramatic effects on our health even after accounting for usual confounding factors such as depression, medical comorbidities and social economic status (SES). To remind the committee, loneliness is the subjective feeling of being isolated—or the discrepancy between actual and desired relationships; and social isolation relates to the quantifiable numbers of a relationships a person may have. These two can co-exist but they do not always.

The list of health effects include, but are not limited to the following:

- Both isolation and loneliness have an increased risk of all-cause premature mortality (risk variable by study)^{3,4}
- 50% increased risk of developing dementia⁵
- When people with heart failure experience loneliness, they have an almost four-fold increased risk of death, a 68% increased risk of hospitalization and 57% increased risk of emergency room use.⁶

Given these associated health care risks, it is not surprising that a study by AARP found that social isolation results in increased Medicare spending, by an estimated 6.7 billion dollars a year, thought to be due to increased inpatient care costs and skilled nursing home spending.⁷

Highlights from the National Academy of Sciences (NAS) Report:

These statistics and evidence form the justification for delving into the topic of loneliness and isolation in greater detail via the National Academy of Sciences Consensus Report. Ultimately, while I cannot encapsulate all the findings today, there are key outcomes that are worth bringing to this committee's attention. The committee formulated its final recommendations in accordance with 5 goals:

1. Develop a more robust evidence base for effective assessment, prevention, and intervention strategies for social isolation and loneliness;
2. Translate current research into health care practices in order to reduce the negative health impacts of social isolation and loneliness;
3. Improve awareness of the health and medical impacts of social isolation and loneliness across the health care workforce and among members of the public;
4. Strengthen ongoing education and training related to social isolation and loneliness in older adults for the health care workforce; and
5. Strengthen ties between the health care system and community-based networks and resources that address social isolation and loneliness in older adults.

Social Isolation and Loneliness during COVID-19:

Given the findings from prior research, and the NAS report, like many, I became concerned about the downstream effects that we would see during this COVID-19 pandemic. Seemingly overnight, we saw our social structures dissolve as we were all forced to socially-distance ourselves. Of note, the term physically distance may be more appropriate. The policies and recommendations regarding physical distancing are clear, as we saw evidence from across the globe that strict quarantine, isolation and minimizing human contact could alter the course of the pandemic. We saw this in examining neighboring provinces in Northern Italy and saw varying rates of transmission dependent upon whether enforced physical distancing was occurring. Yet, the challenge of all of this, is that to protect our lives and our health now, we have had to subject ourselves and others to the potential risks that we may be worsening our health and shortening our life expectancies in the future. The reality is that to some extent, we are in a data-free zone, where we do not know how long we have to be lonely or isolated, or how severe this must be for us to have lasting negative consequences—either economic or health wise.

Given these concerns and this heightened awareness of what could occur, together with my colleague Dr. Ashwin Kotwal, we rapidly designed a study to understand the magnitude of loneliness and isolation during the pandemic, particularly in areas of the country with shelter-in place orders. We postulated that for some, worsened loneliness would be probable because many of the policies that were put in place were specifically focused on isolation older adults because they have been experiencing the highest rates of morbidity and mortality from COVID-19. We also were concerned about worsened health conditions and functional status because many older adults already were experiencing limitations from prior medical conditions, cognitive impairment and functional limitations. As Geriatricians, we were also interested in understanding whether the physical distancing had other unintended consequences such as leaving our older adults with difficulty accessing health care services and other services related to maintaining independence. Our study is currently ongoing and unfunded at this time, but I wanted to share some of the preliminary findings as we suspect that our findings likely represent the experience of other older adults across the country. It is important to note however, that our study sample may be more diverse and more underserved than other areas of the country such that we may have to be careful with generalizability.

Preliminary Research Findings on COVID-19, Social Isolation and Loneliness: CO-PI: Ashwin Kotwal, Carla Perissinotto

By definition, shelter-in-place orders have isolated older adults from most in-person interactions, and this could be made worse for many who struggle to navigate any interactions that are not in person. We hope that our findings will help to guide evolving health policies and strategies for effective clinical and social support during pandemics and in general. Unfortunately, it is even more apparent that ageism runs deep, and the needs of older adults and the health effects of COVID-19 on older adults has largely been an afterthought.

We are conducting a mixed-methods study of community-dwelling older adults primarily in San Francisco during the shelter-in-place order, which started March 16th and our study recruitment started in mid-April and is ongoing. Our objectives are to: 1) investigate the experiences of loneliness and social isolation over time, and 2) examine unmet health needs and psychological distress related to deficits in social interactions.

Who is in our sample:

- Fairly diverse sample, though not quite reflective of the US (Latinx, African-American under-represented; Asian and multi-ethnic over-represented):

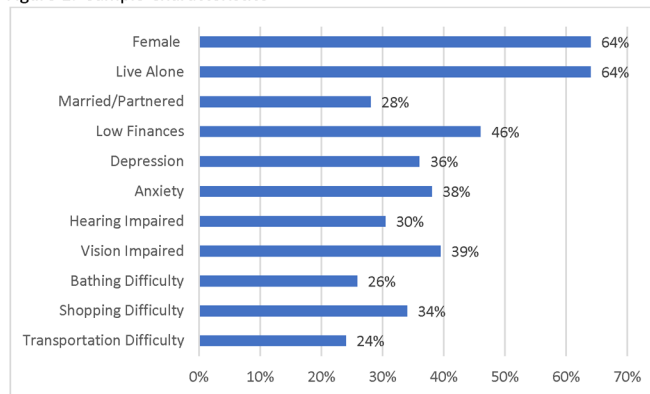
Table 1: Ethnic Composition

Race/Ethnicity		
AA		8%
Latino		5%
Asian		8%
White		70%
Multi-ethnic		6%

Other 3%

- Primarily women
- 64% live alone (this is higher than the average across the United States)
- Almost half report low finances
- Quarter to a third experiencing functional impairments at baseline, depression, anxiety, and visual or hearing impairments.

Figure 1: Sample Characteristics



Highlights from our Preliminary Findings:

- High percentage of loneliness at baseline (73%), **41% experiencing worsening because of COVID-19**
- Depression and anxiety also worse (**33% and 29% respectively**)
- Overall poor self-efficacy related to health, social life and finances (Table 2)

Table 2: Perceptions of Coronavirus and Impacts on Well-Being		All Baseline
Loneliness	Any loneliness	73%
	High loneliness	30%
Change attributed to coronavirus:	Worse	41%
	Same	55%
	Better	5%
Anxiety	High Anxiety	29%
Change attributed to coronavirus:	Worse	29%

	Same	68%
	Better	4%
Depression	High Depression	23%
	Worse	33%
Change attributed to coronavirus:	Same	63%
	Better	4%
Self-Efficacy		
Control over Health	Little (0-4)	18%
	Neutral (5)	20%
	A lot (6-10)	62%
Control over Social Life	Little (0-4)	42%
	Neutral (5)	20%
	A lot (6-10)	38%
Control over Finances	Little (0-4)	26%
	Neutral (5)	10%
	A lot (6-10)	64%

Social Connection Summary (Table 3):

- Most have reduced the socializing and community participation
- Most concerning regarding cancelled activities: decrease in volunteers and case management
- Only highlighted items change over time

Table 3. Social connections and personal activities **All Baseline**

Measure		
Overall Impact on socializing	More than usual	3%
	Same	12%
	Less	46%
	Rarely or stopped	39%
Community Participation	None	88%
	1-2 times	7%
	3 or more	5%
Cancelled Activities	Community centers	55%
	Social Activities	53%
	Social Gatherings	73%
	Volunteering or Caregiver	33%
	Worship service	35%
	Classes or Education	42%
Continued activities	Pray privately	36%
	Reading	79%
	Watching television	80%

Word games	40%
Playing Games (e.g. chess)	19%
Writing	40%
Using computer	73%
Home or car maintenance	34%
Special Baking or cooking	26%
Making clothes, knitting	11%
Hobbies	33%
Playing Sports	43%
Walking >20 mins	49%
Online Classes	15%
Other	21%

Summary of Unmet Needs and Social Contacts:

- 80% had difficulty obtaining medications
- Food security was not as big of a concern in our sample (18%)
- There were unmet functional needs (bathing, medications and transportation in over 30% of the sample)
- 77% of sample had video contact 0-2 times a week, and 29% did not use the internet at all

Figure 2: Unmet Needs

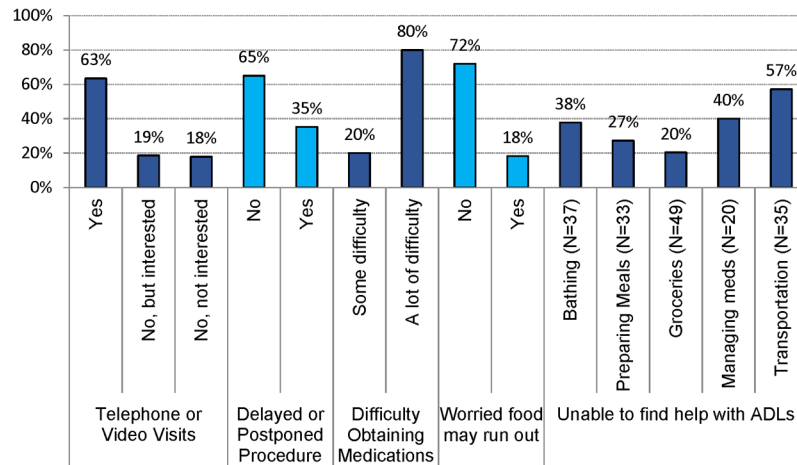
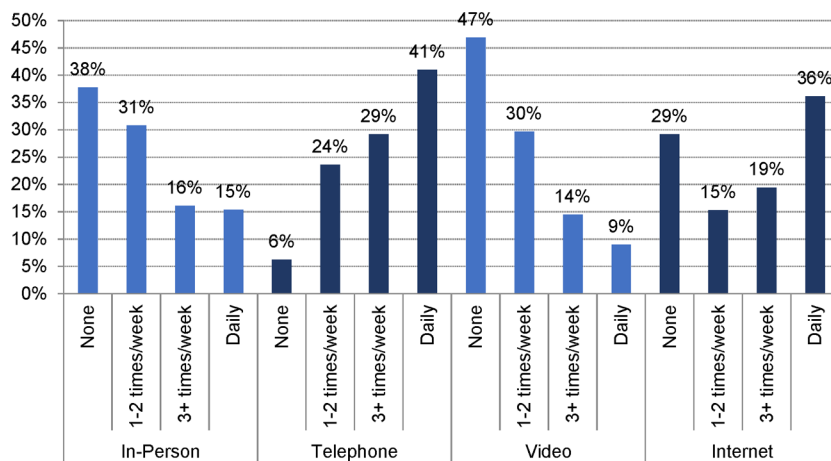


Figure 3: Types of Social Contact:



Overall Summary of Preliminary Findings and what we have learned:

Though our findings are preliminary, there are some areas that are already giving us evidence of what may be happening across the country and where we might expect to see downstream effects. These 4 key findings are in-line and can be addressed by some of the recommendations put forth by the NAS report.

For example:

1. Social isolation and loneliness are worse (even after adjusting for depression and other factors) during the pandemic as early as one month into shelter in place and persisting into month two.
2. 67% of older adults are not concerned or only somewhat concerned about their health worsening because of not being able to see their health care providers.

See Recommendation 8.1 and 8.2:

- *The U.S. Department of Health and Human Services should advocate for including measures of social isolation and loneliness in major large-scale health strategies (e.g., Healthy People) and surveys (e.g., National Health Interview Survey).*

- *Health and aging organizations, relevant government agencies, and consumer-facing organizations should create public awareness and education campaigns that highlight the health impacts of social isolation and loneliness in adults.*
3. Effects on unmet needs are concerning—especially functional needs and medication access
See recommendation 9.1:
- *Health care providers, organizations, and systems should partner with social service providers, including those serving vulnerable communities, in order to create effective team-based care (which includes services such as transportation and housing support) and to promote the use of tailored community-based services to address social isolation and loneliness in older adults.*
4. A large proportion of older adults may not have access to technology (video or internet).
See recommendation 9.6:
- *System designers as well as those who are developing and deploying technology in interventions should ensure that technological innovations related to social isolation and loneliness are properly assessed and tested so as to understand their full range of benefits and potential adverse consequences in order to prevent harm, and they should work to understand and take into account contextual issues, such as broadband access and having sufficient knowledge and support for using the technology.*

What is also concerning is that because of physical distancing, many health care and social programs have shifted to technological solutions, and this may be leaving out many older adults who do not have access to these technologies and these may be more difficult for those with vision and hearing impairments (in our sample approximately 30% of the sample).

We also know that underrepresented minority groups and other marginalized already were at risk for loneliness and isolation and poor health outcomes prior to the pandemic, and these are the exact groups that are disproportionately being affected the most by COVID-19.

Gaps in the Evidence:

During the pandemic and before, we have seen a sudden rise in telephone-based outreach programs or video-based programs both on the non-for-profit and private-for-profit sector. These have been scaled quickly, yet as the NAS report concluded: we do not yet have the evidence to support the scaling of these interventions as the majority have not been rigorously studied or implemented. This means that we must be cautious as we trial and scale some of these programs. Yet during the urgency of this pandemic, and given the likelihood that we will have another surge in the Fall, it seems reasonable to outreach to older adults because as we can see, through research and asking pointed questions, there are unmet needs that are identified and where health care systems, community organizations and our government could intervene. But we do not know if this will ultimately have lasting positive effects or introduce any harms or risks.

Additional gaps in the evidence include knowing which programs or which interventions will work for specific populations. For example, it is important to understand that if an individual is experiencing loneliness, does the program proposed meet the needs of the individual and address the underlying

reason for the loneliness? A paper by Masi et al, provides a helpful framework for how we understand the types of interventions that are possible.⁸ This means that even as we try to apply population health principles, there is a degree of individualization that needs to occur. In essence, is it the right intervention for the right person or population at the right time. It is equally important to understand what the intervention is trying to accomplish. Are you trying to help the person feel more connected, or help them have more opportunities for connection? Or trying to decrease mortality and health care costs. All of these have an impact on how the intervention or program needs to be designed, implemented, funded and scaled. This also means that the length of time of an intervention matters. For example, what if programs develop during COVID-19 and temporarily help but then end post-COVID. What happens post-pandemic? Will these programs still exist if effective?

Conclusions and Next steps:

Our experience thus far with COVID-19 echo the NAS report recommendations (shared above) such that some of the key recommendations are relevant and can help us move to the next steps. I would like to provide clear examples of what has worked during the pandemic, but the truth is that we do not yet have an evidence base to draw conclusions and it would be incorrect to support programs and interventions prematurely. However there is hope. Drawing directly from the report, some of the key findings that can help us learn from this pandemic and help older adults both during and outside of pandemics include:

- **Funding:** Ensuring adequate funding for research and evaluations of proposed programs and interventions so that we can know what works, what should be scaled, what the return on investment is, and how it should be funded. Given the large public health impact, this will require a national approach.

See Recommendation 9-2: Given the public health impact of social isolation and loneliness, the U.S. Department of Health and Human Services should establish and fund a national resource center to centralize evidence, resources, training, and best practices on social isolation and loneliness, including those for older adults and for diverse and at-risk populations.

- **Accountability:** As noted above and in recommendation 9-6 this means clearly evaluating and ensuring that solutions that are proposed actually do what they propose to do and have a focus on improving the lives of older adults.
- **Education and learning:** We may have opportunities to learn from our colleagues abroad and see what has worked and consider the concept of “social prescribing” and we have an opportunity to educate the health care sector on the importance of incorporating assessments into practice.

See recommendation 7-2: Health care systems should create opportunities for clinicians to partner with researchers to evaluate the application of currently available evidence-based tools to assess social isolation and loneliness in clinical settings, including testing and applications for specific populations.

- **Understanding the needs of marginalized populations:** The evidence base for these groups is even more scant, and this gap is even more important now given the current national discourse

and the awareness that this pandemic is unequivocally affecting older adults and minority populations at alarming rates.

The solutions ahead of us may not be readily apparent, but starting with addressing the underlying ageism and other discrimination will need to be part of our response. Our challenge will be in making systematic changes that are evidence-based fair and timely.

I am incredibly grateful that a topic and population that I care deeply about is being recognized by this committee, and will further bring this topic the attention it needs given the magnitude of the public health implications. I welcome any opportunity to further advance the knowledge base and improve the care of our older adults.

Thank you again for the opportunity to testify before you and I will welcome any questions.

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Testimony of Peter Reed, PhD, MPH
Director, Sanford Center for Aging
Professor, Community Health Sciences
University of Nevada, Reno, School of Medicine

Before the United States Senate Special Committee on Aging

Combating Social Isolation and Loneliness During the COVID-19 Pandemic

June 11, 2020

Good Morning Chairman Collins, Ranking Member Casey and members of the Senate Special Committee on Aging.

My name is Peter Reed. I am a public health gerontologist dedicated to enhancing the quality of life of older adults. Throughout my career, I have never seen a crisis with the potential to cause as much harm to older adults as the COVID-19 pandemic. To enable older adults to stay home and stay safe, while remaining connected to needed resources, the State of Nevada launched Nevada CAN, or the Nevada COVID-19 Aging Network Rapid Response.

In mid-March, a group of aging services leaders came together with grave concerns over the health and well-being of Nevada's older adults, who had all become 'homebound'. We expected a dramatic increase in demand for the services of the already-strained aging service providers. Therefore, we set out to mobilize the statewide network in a coordinated effort to identify and respond to elder needs by targeting three priority focus areas: 1) essentials of daily life such as food and medication; 2) telehealth services; and 3) social support.

Under the leadership of Dena Schmidt, Administrator of Nevada's Aging and Disability Services Division, each of Nevada CAN's priority focus areas is supported by its own action team: The Food and Medication Action Team, led by Jeff Klein of Nevada Senior Services in Las Vegas, the Telehealth Action Team, which I lead, and the Social Support Action Team, led by Dr.

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Jennifer Carson of the Dementia, Engagement, Education and Research Program at the University of Nevada Reno, School of Community Health Sciences.

On April 1st, after a rapid planning process, Nevada CAN launched a new website, connected to Nevada 2-1-1, through which older adults can request help. Aging and Disability Resource Center case managers connect elders to the appropriate action teams for support. The Food and Medication Action Team engages a network of county and community-based agencies in delivering food, medications and other essential items to the doorsteps of older adults. The Telehealth Action Team brings together existing healthcare and social service providers into an integrated statewide telehealth network, offering geriatrics, social work, primary care and other services. This telehealth network includes training efforts to bolster capacity of primary care partners to deliver telemedicine, with support from the state's two HRSA-funded Geriatrics Workforce Enhancement Programs.

Finally, the Social Support Action Team, led by Dr. Jennifer Carson, launched the truly innovative "NEST Collaborative". Standing for "Nevada Ensures Support Together", the NEST Collaborative recruits volunteers, including many college students, who are committed to delivering social support to reduce social isolation. After a background check and seven hours of mandatory training, volunteers offer one of four social support programs: 1) calling older adults twice weekly to have a friendly conversation and monitor their needs; 2) convening a virtual peer group of older adults for regular group discussions; 3) offering technical assistance to enable existing groups of friends to come together in virtual gatherings; or 4) providing technical assistance to enable older adults to effectively use technology to access telehealth services or to connect with family members across the country. Each of these volunteer services is designed to reduce social isolation and build reciprocal support, embracing the idea that elders are themselves a valuable resource to the community. The check-in calls and peer groups help fulfill one of the most basic needs in an elder's life: the need to be known by, and meaningfully connected to, other people. Clients of NEST have stated that they are grateful for the services, because without someone calling to check on them, no one may know if they are even still alive. Further, as the pandemic continues to evolve, the NEST collaborative, in partnership with the

state long-term care ombudsman program, is extending virtual social support opportunities to reduce isolation among skilled nursing home and assisted living residents.

In the first two months of Nevada CAN, there were 757 requests for help, resulting in 1,235 referrals to services. These included 448 referrals for food delivery, 148 for social support, 89 for telehealth services and 550 for other general services from the ADRC, including emergency financial assistance. In addition to the requests through Nevada CAN, Nevada has seen a 57% increase in requests for assistance due to the COVID-19 pandemic. Nevada CAN reflects the true spirit of the 'no wrong door' philosophy of aging services.

This time of social distancing does not mean elders must be socially isolated. Nevada CAN and the NEST Collaborative are examples of how to help elders stay meaningfully engaged and connected to their communities.



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Testimony of Betsy Sawyer-Manter, LMSW, SeniorsPlus President and CEO
Before the United States Senate Special Committee on Aging

Re: COVID-19 - Social Isolation and the Aging Population

Good Morning Chairman Collins, Ranking Member Casey and members of the Special Committee on Aging.

I am Betsy Sawyer-Manter, the CEO of Western Maine's Agency on Aging – SeniorsPlus. I appreciate the opportunity to speak before you today.

Maine has a very old population. The COVID-19 pandemic disrupted the service delivery system that older Mainers have come to rely for services and answers on aging. I can assume this is reflected all across our nation.

We have continued to provide services since our public closure in mid-March. While we could no longer serve clients face to face, we quickly moved to adapt our services to a telephonic and virtual platform.

Many of our clients rely on the friendly volunteer who delivers their meals, or the class in our education center that gives them purpose and socialization, or the home visit with a care coordinator checking to insure that their home care services are intact. With the impact of COVID-19, we knew that we needed to find ways to connect and stay connected.

I would like to share with you some of what we have done to address the service delivery needs and combat social isolation.

A hallmark program for us is Meals on Wheels. We cannot deliver meals virtually so we needed to keep our meals on the road. We found adequate PPE to keep our clients and volunteers safe. We instituted a drop and go strategy to avoid direct contact and began making reassurance calls to all the clients to insure that they are doing well and feeling connected.

Our kitchen went into overdrive and produced an extra 3 weeks of shelf stable and frozen meals for every client in case we were unable to get meals out to them. We also produced 2000 extra meals but found that we needed additional freezer space. Our local Walmart distribution center dropped off a freezer trailer at our kitchen and we just have to keep the diesel engine going to keep it cold.

United Health Care came through with additional food products, but just as importantly, pet food. We deliver the food along with the meals as we know pets are incredibly important companions for older isolated people.

Our home delivered meal count is up **46 %** since mid-March and still climbing.

We have been inundated with calls on our helpline. Our small staff is fielding nearly 100 calls per day. Older people reach out for help with issues such as Medicare counseling, food insecurity, information on how to get groceries or pharmacy deliveries, etc.

We have 3 administrative staff answering the phone live and they report receiving calls from folks who really just want to chat. They are lonely and reaching out. We have identified these clients and we have a group of volunteers who are doing friendly visitor calls to check in and chat with them.

Our Community Services staff are pretty tech savvy and immediately went into the mode of "how do we use ZOOM to deliver our services?" They are offering ZOOM 101 training every week for clients and staff.

One client recently called after taking a class. He shared that he's very grateful for all the work we've put into changing how we do business, and that he just wants to stay connected with other people. He feels that he is able to do this because now he has learned how to use Zoom! Such a testimony to the power of lifelong learning.

We are offering many services using ZOOM technology. These include:

- Medicare Counseling
- Caregiver support groups. Caregivers are more isolated than ever and need support
- Grief support group – especially during this time of deferring services and the inability to say goodbye.
- Evidenced Based classes such as living well for better health
- Chair Yoga and Tai Chi, and other exercise classes, and
- An all-important, Coping during COVID support group!

We just began offering Trivia as a means to engage people in a light hearted activity to build more interaction.

A client recently shared that before she started taking the class she was struggling with depression and was spending most of her day in bed. The weekly class has brought so much positivity and motivation into her life that she feels like a completely new person. She has been walking, spending time outside, and has been so much happier.

In addition to our work in Western Maine, we are a state wide service coordination agency working to support over 4400 Mainers to remain at home. We are part of the Long Term Services and Support System that coordinates in home care.

Our care coordinators are based throughout the state and have typically used a combination of telephone and in home visits to insure that quality services are meeting the needs of people enrolled in the programs. Our ten ZOOM accounts are in frequent use as we conduct virtual home visits with clients. Seeing a face instead of just a voice is so important to making strong personal connection. We also have the ability to get "eyes on" some of our most vulnerable clients.

One care coordinator shared that people are wanting to talk longer and have a lot of disinformation that we can help unravel. They are afraid to venture out at all. We brainstorm with them and offer suggestions such as inviting friends and family for an outside social distancing get together. They appreciate the time we are spending with them.

We have found our clients to be receptive and welcoming of new ways of doing business. For those with technology and the connectivity it works well but many do not. To that end, we have secured some private funds and are using CARES funds to purchase tablets and hotspots to get out to those who are open to learning new technology. We have found tablets to be easier to use and less threatening technology for many of the older people we serve.

Social isolation is detrimental to our health. We can feel the need for human interaction in every call and virtual contact that we have. We will continue to look at our business model to see how we can enhance the opportunity to serve people in new ways. I live in a state with many rural and frontier areas. This "new normal" could serve as a means to help us reach those underserved areas and further combat social isolation.

I thank you for the opportunity to speak with you today.

Philadelphia Corporation for Aging Testimony

United States Senate Special Committee on Aging Hearing
Combating Social Isolation and Loneliness During the COVID-19 Pandemic
June 11, 2020

Presented by:

Najja Orr

President and CEO

Philadelphia Corporation for Aging

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Good morning. My name is Najja Orr and I am the President and CEO of the Philadelphia Corporation for Aging, also known as PCA. I would first like to thank Senator Collins, Senator Casey and the remaining members of the Special Committee on Aging for convening this hearing regarding some of the impacts of COVID-19 on older adults. I'd also like to extend my gratitude for the reauthorization of the Older Americans Act (OAA), and several bills that increase supports during COVID-19.

Philadelphia has the second highest proportion of impoverished older adults and is the poorest overall of the 10 largest cities in the United States. As the Area Agency on Aging (AAA) for Philadelphia County, PCA has been coordinating a broad range of services for more than 140,000 older Philadelphians annually for nearly 50 years.

Social Isolation

Before the pandemic, 36 percent of Philadelphia's older adults were living alone and at risk of social isolation. According to the National Institute on Aging, isolation increases risk of decline in cognitive impairments, depression, comorbidities, nutrition, and physical activity. Approximately 40 percent of Pennsylvania's linguistically isolated households are in Philadelphia, and I appreciate that Senator Casey has been championing increased funding to Area Agencies on Aging to support seniors with limited English proficiency. Additionally, neighborhood accessibility and safety concerns can further isolate older adults.

As focal points in the community, senior centers play an integral part in engaging active older adults. Approximately 20,000 of Philadelphia's older adults attend centers to connect socially and recreationally, engage in programs that support physical and mental wellbeing, and receive a nutritionally balanced meal. As a result of the pandemic, senior centers have had to make significant adjustments

to services; staff have made over 9,000 wellness calls to ensure safety, provided information and resources, encouraged response to the census, and completed nutrition screenings. Many centers have also transitioned health and wellness programs to online platforms and social media outreach. Unfortunately, due to the high rates of poverty in Philadelphia, many older adults do not have access to the technology required to participate in online programming.

It is important to note the impact of isolation on elder abuse as well. PCA operates the Older Adult Protective Services Unit for Philadelphia, and unfortunately we have nearly doubled the number of investigations since 2013. As pandemic related restrictions ease, we are concerned about an increase in allegations of abuse, neglect, financial exploitation and abandonment.

Nutrition

Many older Philadelphians live on fixed incomes and struggle to pay for food. For seniors with inadequate support and limited mobility, cooking and shopping for groceries is challenging or impossible. According to the 2018 Public Health Management Corporation's Household Health Survey, of the approximate 301,000 older adults in Philadelphia (age 60+), more than:

- 126,000 live alone,
- 56,000 are unable to shop for themselves,
- 32,000 need assistance preparing a meal, and
- 36,000 report skipping a meal due to lack of money.

In the United States, 24 percent of adults ages 65 and older are socially isolated while 43 percent of adults ages 60 and over report feeling lonely. Senior nutrition programs, like home-delivered and congregate meal programs, provide isolated seniors with a regular form of social engagement through safety checks, and a friendly neighbor to engage with.

Along with opportunities for socialization and education, over 540,000 congregate meals were served in Philadelphia senior centers last year. During the pandemic, the senior center network has risen to the challenge by providing grab-and-go meals, and partnering with community organizations, including police and fire stations, to make deliveries to older adults who are unable to pick them up. Since March 18th, PCA has provided over 110,000 meals through the senior centers. As restrictions are lifted and people are returning to work, we anticipate a decrease in available volunteers, and a possible increase in need due to less availability from family members.

Meal and Grocery Delivery

PCA has also strengthened our traditional home delivered meal program. Through the agency's Meal Distribution Center, nearly 1.9 million meals were delivered to homebound older adults last year.

PCA has worked closely with a variety of organizations also addressing the nutritional needs of older adults during the pandemic, but the need in Philadelphia is great. I was grateful to learn on Friday, Pennsylvania SNAP recipients now have the flexibility to utilize online purchasing for grocery delivery or curbside pick-up. In Philadelphia, Amazon, Walmart, and three large grocery store chains are participating in this pilot phase, and we hope to see more stores participate to increase available resources. This benefit adds another option to isolated Philadelphians in great need.

We are fortunate for a strong community and the organizations dedicated to serving the most vulnerable among us. PCA is proud to be counted among those organizations and are grateful for the support of Senator Casey as a champion for older Pennsylvanians and the continued support from Senate Special Committee on Aging.

A few recommendations to enhance services to older adults during the pandemic include:

1. The pandemic has expedited the trend of moving programs and services online, and the coming generations of older adults will have familiarity and expectations of digital platforms. However, current older adults, particularly in low income communities, do not have access to the technology needed to stay connected. Increased funding and education is needed to bridge the digital divide in communities.
2. COVID-19 taught us the importance of agility to meet evolving needs of older adults. Providing States and AAAs the ability to be more flexible with OAA funding; for example, reimbursement for meals of consumer choice including ethnic meals, rather than strict adherence to one-third registered daily allowance. This will create the opportunity for innovation and the capacity to meet the needs specific to their communities.
3. Incorporating additional funding for AAAs in the next relief package will allow for the provision of essential OAA services to be adapted to telephonic or online options. This will keep older adults socially connected, safe, and as independent as possible while unexpectedly homebound.

Thank you.

Questions for the Record

U.S. Senate Special Committee on Aging
Hearing: Combating Social Isolation and Loneliness During the COVID-19 Pandemic
June 11, 2020
Questions for the Record from Senator Elizabeth Warren

Carla Perissinotto, MD, MHS

Access to Hearing Aid Technologies

Hearing loss affects approximately 20 percent of Americans, including two-thirds of adults in their seventies. Despite the prevalence of hearing loss, a minority of Americans in their seventies had a hearing test in the past four years, and only about 14 percent of people with hearing loss use assistive hearing technologies. Hearing loss can play a significant role in social isolation.

1. In your experience, can challenges with loneliness and social isolation be exacerbated by older adults with hearing loss that cannot access assistive hearing technologies?
2. Medicare covers a range of hearing health services, including hearing and balance assessments. However, under current law, Medicare does not recognize audiologists as providers of most hearing health-related services. Instead, Medicare only allows audiologists to receive reimbursements for a narrow set of tests to diagnose a hearing or balance disorder, and only if patients first obtain an order from a physician or nurse practitioner. During the pandemic, CMS has allowed audiologists (among other providers) to provide certain telehealth services to Medicare beneficiaries. However, it has not eliminated the requirement that patients receive a referral before receiving certain audiologist services. I have introduced bipartisan legislation, the *Medicare Audiologist Access and Services Act of 2019*, to expand access to hearing services for seniors.
 - a. Do you believe that expanding older Americans' access to hearing aid technologies could help reduce social isolation and loneliness among seniors?
 - b. What steps do you believe Congress should take to expand seniors' access to hearing aid technologies and other hearing health-care?

Equitable Access to Services for Older Adults

In your testimony, you state that “underrepresented minority groups and other marginalized groups already were at risk for loneliness and isolation and poor health outcomes prior to the pandemic, and these are the exact groups that are disproportionately being affected the most by COVID-19.”

1. What are the primary barriers facing older Americans that are members of underrepresented minority groups and other marginalized groups, including the disability community and non-English speaking communities, in accessing services? In your experience, where are those barriers most pronounced (for example, in accessing technology to receive services; in accessing medication and other medical services; etc.)? What specific policies and programs, if any, do you believe Congress should pursue in its effort to ensure equitable access to services for older adults?

2. In your testimony, you cite “gaps in the evidence” on older adults, including “knowing which programs or which interventions will work for specific populations.” You also note that the “evidence base” for marginalized populations is “event more scant.”
 - a. In your experience, what specific programs and interventions (or strategies used to develop specific programs and interventions) have been most useful in ensuring that marginalized populations, including communities of color, people with disabilities, and non-English-speaking communities, can access services for older adults? What lessons, if any, should the federal government take from these programs, interventions, and strategies?
 - b. How do you recommend that Congress help expand the evidence base on programs and interventions that support older adults who are members of marginalized populations?

Peter Reed, PhD, MPH

Equitable Access to Services for Older Adults

In your testimony, you discussed the Nevada COVID-19 Aging Network Rapid Response (Nevada CAN) program’s efforts to reduce social isolation and loneliness among older adults in Nevada. You noted that in the first two months of the program’s existence, nearly 800 people requested help from the program.

1. What racial and other demographic disparities, if any, did Nevada CAN observe in the requests for services it received? Did the requests match the demographic makeup of Nevada, or were certain demographic groups over- or under-represented? What are the root causes, in Nevada CAN’s view, of these disparities? Which of these causes are unique to Nevada, and which are applicable to the nation as a whole?
2. What specific strategies, if any, did Nevada CAN implement to reach different demographic groups, including communities of color, people with disabilities, and non-English-speaking people, with its programming? Were any strategies particularly effective or ineffective? What lessons, if any, should the federal government take from Nevada CAN’s outreach efforts in its effort to ensure equitable access to services for older adults?
3. What additional strategies would you suggest, based on the experiences of Nevada CAN, that the federal government consider in its effort to ensure equitable access to services for older adults?

At this time, responses are not available for printing. Please contact the U.S. Special Committee on Aging for further updates and to perhaps obtain a hard copy, if available.

Additional Statements for the Record



Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

**United States Senate Special Committee on Aging
Hearing on "Combating Social Isolation and Loneliness During the COVID-19 Pandemic"**

June 11, 2020

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Special Committee on Aging's hearing entitled "Combating Social Isolation and Loneliness During the COVID-19 Pandemic." The Association and AIM thank the Committee for its continued leadership on issues important to the millions of people living with Alzheimer's and other dementia and their caregivers. This statement provides an overview of specific policies that would help combat social isolation and loneliness in people living with Alzheimer's and other dementia during the COVID-19 pandemic and beyond, including long-term care policy recommendations, efforts to address the consequences of social isolation through Project Virtual Inclusive Technology for ALI (VITAL), and steps to ensure emergency preparedness in long-term and community-based care settings.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's sister organization, working in strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and development of approaches to reduce the risk of developing dementia.

The COVID-19 pandemic continues to create additional challenges for people living with dementia, their families, and caregivers including compounding the negative consequences of social isolation that many older adults already experience. Social isolation is an issue within the aging community as a whole, exacerbated due to the current public health crisis, and felt particularly hard in the Alzheimer's and dementia community.

Long-Term Care Recommendations

Nursing homes and assisted living communities are on the frontlines of the COVID-19 crisis, where 48 percent of nursing home residents are living with dementia, and 42 percent of residents in residential care facilities have Alzheimer's or other dementia. Across the country these facilities, their residents, and their staff, are experiencing a crisis due to a lack of transparency, an inability to access the necessary testing, inaccurate reporting, and more. According to some estimates, more than 28,000 residents and workers have died from the coronavirus at nursing homes and other long-term care communities. As long-term care facilities continue to restrict access to caregivers and family members, residents living with Alzheimer's and other dementias may experience behavioral changes which can be heightened during periods of isolation. The Alzheimer's Association recently released new policy recommendations, [Improving the State and Federal Response to COVID-19 in Long-Term Care Settings](#), to address the immediate and long-term issues impacting care facilities during the COVID-19 pandemic. Importantly, these recommendations include the need for all nursing

homes and assisted living communities to have full access to needed Personal Protective Equipment (PPE), testing equipment, training, and external support to keep them COVID-19-free. This specifically includes requiring nursing homes and assisted living communities to address social isolation and ensure people with Alzheimer's and other dementia are able to communicate with designated family and friends. As the Committee and Congress work to craft the next COVID-19 response package, we respectfully request that you include these policy solutions to help protect this vulnerable population during these challenging times.

Project VITAL: Virtual Inclusive Technology for ALI

Project VITAL, a new initiative from the Alzheimer's Association and the Florida Department of Elder Affairs, is designed to address the negative consequences of social isolation, creating a network for connection, engagement, education, and support of individuals with dementia and their families and caregivers to positively impact social isolation, stress, and well-being. Through the use of customized technology and resources, public-private partnerships will facilitate connections between individuals living with dementia in residential communities and their families; provide opportunities for individualized, person-centered engagement; and offer education and support for staff and families through video-based learning platforms. The initiative was launched in April in Florida, and we encourage Congress to include funding to expand access to Project VITAL to create and strengthen personal connections and support for persons living with dementia, families, and direct care staff during this time of physical isolation.

Emergency Preparedness in Long-Term and Community-Based Care Settings

One of the most important steps in providing quality dementia care is to know the person, the central tenet of the *Alzheimer's Association's Dementia Care Practice Recommendations*. In the event of a major disease outbreak, like COVID-19, or disaster, it may be more difficult for temporary staff members or those working in a new department or other health care setting to know the person. Ensuring staff, including temporary or substitute staff members, in long-term or community-based care settings have access to a personal information form for residents living with Alzheimer's or other dementia will allow them to quickly identify essential information about the person to help maintain a stable and comforting environment.

Additionally, people living with dementia may need help communicating with their families and loved ones during a crisis like COVID-19. Providers should consider developing a "What You Should Know" fact sheet to explain what families and friends and staff need to know in the event of an emergency. It should include information on how families can receive updates or talk to a care provider about the person living with dementia. Remember that each family is unique, and some people their closest supporters may not be biological or legal family members, but friends or community members.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Committee and its continued commitment to advancing policies important to the millions of families affected by Alzheimer's and other dementia. Thank you Chairman Collins and Ranking Member Casey for your continued commitment to supporting individuals facing social isolation. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance this and other policies that would help this vulnerable population during the COVID-19 pandemic, including long-term care policy recommendations, efforts to address the consequences of social isolation through Project Virtual Inclusive Technology for ALI (VITAL), and steps to ensure emergency preparedness in long-term and community-based care settings.



**Written Testimony of the
American Psychological Association
By Katherine B. McGuire
Chief Advocacy Officer of the American Psychological Association and
The American Psychological Association's Committee on Aging
Submitted to the Senate Special Committee on Aging
Hearing: Combating Social Isolation and Loneliness During the COVID-19 Pandemic
Thursday, June 11, 2020 – 9:30 am**

The American Psychological Association (APA), the leading scientific and professional organization representing psychology in the United States, numbering over 121,000 researchers, educators, clinicians, consultants, students and APA's Committee on Aging, applauds the Senate Special Committee on Aging for bringing attention to and addressing social isolation and loneliness during the COVID-19 national public health crisis. APA urges Congress to invest in programs which address social isolation through the recommendations below.

Key Research Findings

As described in the recent report from the National Academies of Sciences, Engineering, and Medicine ("*Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*" i), social smoking and obesity risks are being greatly exacerbated by physical distancing and psychological stress related to the COVID-19 public health emergency. Key findings from research include:

- Social isolation and loneliness (SIL) are closely interrelated, yet distinct, phenomena. People who are socially isolated lack social connection, close relationships, or contact with others- they live alone and infrequently engage with other people. Loneliness refers to feeling alone and disconnected from other people- it is a psychological, subjective experience. Research in this area can often be hard to untangle given overlap between social isolation and loneliness; people who are socially isolated are more likely to be lonely. The phenomena can each be measured separately, however.
- Roughly one in four community-dwelling U.S. adults aged 65 and older are considered socially isolated. Between 40-50% of older adults are at least occasionally lonely and roughly 20% frequently feel lonely. Some older people appear to be less lonely than younger people, but loneliness may exert a greater effect on older adults' health than on younger adults' health. Those older adults who are extremely lonely are at particular risk of psychological and physical health problems.
- Decades of studies have documented the long-term negative health outcomes of social isolation and loneliness. There is strong evidence that social isolation substantially increases mortality risk, and a growing body of evidence that loneliness increases mortality risk. Research finds SIL effects on mortality even after adjusting for relevant lifestyle (smoking, alcohol use, physical activity) and psychological (e.g.,



depression) factors. Social isolation and loneliness are also associated with increased risk of cardiovascular disease, stroke, dementia, and other conditions. Moreover, socially isolated individuals may not receive the support they need to prevent further decline, and may experience rapid deterioration and increased medical costs.

- Loneliness and social isolation are linked to both depression and anxiety. In one study just over half of individuals who frequently felt loneliness reported symptoms above the threshold for clinically significant depression. Social isolation and loneliness are risk factors for suicide and suicidal ideation, and this effect has been found independent of co-occurring depression.
- Research on geographic variation in SIL finds that older adults living in rural areas report having more relationships than older adults living in metropolitan areas, so they may not be as socially isolated. But older adults in rural areas do report feeling just as lonely as those in urban areas, and are more likely to report feeling left out. Non-Hispanic African-American residents in rural areas were found to have higher rates of perceived loneliness in particular. ⁱⁱ

Recommendations to help protect the socially isolated during COVID-19:

Access to Mental Health Services is Critical to Addressing Social Isolation and Loneliness- Support Mental and Behavioral Health Services

While health plans are beginning to screen and provide services to patients to address social isolation and loneliness and educate providers and enrollees about the importance of social connectedness, an effective response to SIL must ensure the aging community has adequate access to mental health services. Research on interventions to reduce loneliness finds that addressing maladaptive social cognition through psychotherapy is significantly more effective than improving social skills, enhancing social support, or increasing opportunities for social interaction, which are only modestly successful. ⁱⁱⁱ

Furthermore, during this critical time of COVID-19 when the need for mental and behavioral health services are rising, we urge Congress to support and expand access to psychological services and authorize an extension of Medicare telehealth flexibilities to the Centers for Medicare and Medicaid Services (CMS), including coverage of audio-only mental health services, for at least a one year transition period after the current public health emergency ends. Such services through audio-only telephones have provided critical care to isolated patients at home, in hospitals and in nursing homes who may have mobility issues, visual impairments, and be at elevated risk of COVID-19 transmission. Access to internet is particularly limited in rural areas, where needs are high. At least a one-year extension of current policies would enable the collection of data and analysis to determine the most appropriate policies for telehealth services going forward. Older adults have a lower rate of using smartphones and other technology and often live in areas without reliable broadband access.



Increase Investments in the Health Care Workforce to Serve Older Adults

To respond adequately to the needs of older adults during the COVID-19 pandemic address, additional investments are needed in the Title VII and VIII Geriatric Workforce Enhancement Program (GWEP) at the Health Resources and Services Administration (HRSA) to address the shortage of health care providers to care for older adults. As the only federal program dedicated to developing a health care workforce that maximizes patient and family engagement while improving health outcomes for older adults, the GWEP program integrates geriatrics and primary care to provide more coordinated and comprehensive care, and also develops providers who can assess and address the needs of older adults and their families/caregivers. GWEP grantees create and deliver community-based programs that provide patients, families, and caregivers with the knowledge and skills to improve health outcomes and the quality of care for older adults and also provide Alzheimer's disease and related dementia education to families, caregivers, direct care workers, and health professions students, faculty, and providers.

Additional funding for the Geriatrics Academic Career Awards (GACA) program is also needed to increase faculty development and the next generation of innovators to improve care outcomes and delivery. We urge Congress to provide:

- Supplemental funding of \$8.64 million (\$180,000 for each of the 48 GWEP sites) to support necessary staff, technology, training, and materials.
- Supplemental funding of \$1.7 million for current and prior GWEP sites in key COVID19 crisis areas to be determined by HRSA and
- Supplemental funding of \$650,000 for GACA awardees (\$25,000 for each of the 26 GACA awardees) many who are redirecting their clinical and education work to address solutions-based guidance for their institutions during the pandemic.

Support Older Americans Act Programs

Protect the Administration for Community Living (ACL) supported programs that offer many opportunities for older adults to engage in their communities. Programs include insurance counseling and providing transportation to seniors to enable them to help fellow seniors get to the doctor. The Older Americans Act nutrition programs provide home-delivered meals. Home-delivered meals provide social connectivity and daily informal check-ins.

Support Technology Adoption

Many social interactions today occur through technology, especially during COVID-19. Technology can also provide access to important information and resources for those who experience social isolation,



for example, through telehealth. However, there still exists a substantial “digital divide” with older adults adopting and using newer technology less often than younger adults. When considering policy, we recommend that Congress consider how technology can reduce social isolation and loneliness and also the barriers for the use of these technologies by older adults.

Transportation

Transportation is also key to the wellbeing of those suffering from social isolation. Reviews of driving cessation find that the negative consequences associated with isolation are nearly identical to those associated with driving cessation. This is another important issue we hope that Congress can address, as safe and accessible transportation options play an important role in protecting the mental and physical health of older adults.

Vulnerable Populations

Older adults are a diverse group. Older adults with lower household income, who are in poor health or have physical limitations and are not married, are at greater risk for loneliness. Evidence also suggests that the pattern of consequences resulting from isolation and social disconnectedness differs for White, Black, and Hispanic older adults. In Congress’ focus on these vulnerable and underserved populations, we also encourage Congress to devote attention to the growing number of LGBT older adults. They are more likely than their non-LGBT counterparts to live alone and are less likely to utilize services and to experience family support. LGBT older adults are especially at risk for the consequences of social isolation.

Thank you for considering our recommendations. We look forward to working with you to improve the lives of those suffering from social isolation and loneliness.

Contact

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i National Academies of Sciences, Engineering, and Medicine 2020. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. Washington, DC: The National Academies Press.

<https://doi.org/10.17226/25663>.

ii Henning-Smith, C., Moscovice, I., & Kozhimannil, K. (2019). Differences in social isolation and its relationship to health by rurality. *The Journal of Rural Health, 35*(4), 540-549.

iii Masi, C. M., Chen, H. Y., Hawkey, L. C., & Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review, 15*(3), 219-266.