Courtesy of Bucksport Bay Healthy Communities Coalition

Reducing Social Isolation in Maine:

The Thriving in Place Experience

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February 2016

MeHAF

Maine Health Access Foundation

// 1. Acknowledgments

Reducing Social Isolation in Maine: The Thriving in Place Experience has been a collaborative effort among several partners. We are very grateful to the four TiP grantee communities whose staff, community partners, and community members shared their stories during interviews and group meetings. Special thanks to: Diane Nadeau and Steve Farnham, Aroostook Area Agency on Aging; Meg Callaway, Charlotte White Center; James Bradney, Bucksport Bay Healthy Communities Coalition; and Janet Lewis and Ann Schroth, Healthy Peninsula/Washington Hancock Community Agency.

This report would not have been possible without the support of the Maine Health Access Foundation and the dedication of its staff. We are especially grateful to Becky Hayes Boober, Senior Program Officer and the Thriving in Place project officer, and Barbara Leonard, Vice President for Programs, for their guidance and careful review of the case study.

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March 2016

2. Introduction

Isolation among older citizens with its associated adverse health outcomes is a national public health concern. In Maine this concern is elevated because one in four Mainers is expected to be over 65 by 2030[1]. For older adults, isolation and loneliness can be a predictor of poor health, especially depression, other mood disorders, anxiety, and alcohol and drug abuse.[2] Older persons are more likely to be lonely if they are not involved in volunteer work or community organizations, not a member of a faith community, and rarely or never contact friends[3]. A particular concern is people living in rural areas and on islands with limited access to services and social opportunities, especially after they discontinue driving. In recent years, models for creating community and social networks among older persons have been emerging, and there are now many such initiatives in Maine[4]. Although some early successes have been identified, much still needs to be learned about how best to address isolation in Maine.

A 90-year old woman lives in a 14-room house but can only afford to heat two rooms. **She says she doesn't need help.**

A 70-year old woman with chronic illness is widowed and has no children. Her house is at the top of a steep hill. **She only accepts help with laundry.**

An elderly man is seen **crawling over a snow pile** blocking the sidewalk.

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1 Maine Council on Aging (2014). **Blueprint for Action on Aging** (http://www.Maine4a.org/image_upload/SummitonAgingReport_Final.PDF)

2 Anderson, G. (September 2010). *Loneliness among Older Adults: A National Survey of Adults 45+*. Washington, D.C.: American Association of Retired Persons.

3 Ibid.

4 Maurer, J., Parham, L., and Kimball, P. (September 2013). *Building a Collaborative Community Response to Aging in Place: A Guide to Creating an Age-Friendly Maine, One Community at a Time.*

This case study explores the experiences of four Maine Health Access Foundation (MeHAF) Thriving in Place (TiP) grantees working in communities across Maine (Aroostook County, Piscataquis County, Bucksport area, and the Blue Hill Peninsula). They have completed community-based planning efforts and are now implementing new approaches to supporting and sustaining people with chronic conditions and their caregivers. This study focuses on ways in which these collaborative networks are identifying and reaching out to the most geographically and socially isolated people in their communities. The study is based on interviews with key partners, volunteers, and participants, site visits, and observation of collaborative phone calls among the four grantees.

MeHAF's TiP initiative supports community-based, cross-sector collaboration among health care, social services, community supports, and volunteer networks to improve and enhance services for adults with chronic health conditions and/or disabilities to keep them in their homes and communities. The focus of the initiative is not on the highest health care utilizers; it is intended to serve people with chronic conditions who may also be underserved or uninsured and who are at elevated risk for hospitalization or institutionalization. In most communities, many of those with chronic health conditions are older.

Rather than developing new programs, TiP communities identify and coordinate existing resources to increase support of those with health needs. Each grantee convenes a stakeholder leadership team that includes health care providers, in-home and community service and support providers, caregivers and consumers, and other key community leaders to gather extensive community input on needs and resources and to develop and implement a plan that builds on local resources in a more coordinated way to meet the individual needs of community members. Building collaboratively on each stakeholder's work, the TiP leadership team identifies people with needs, supporting them in the home so people avoid unnecessary hospital, assisted living, or nursing home stays. Cross training, streamlined referral systems, common care plans, and coordination across service systems are typically found in the implementation phase. The four grantees that are the focus of this study were initially funded in 2013 for a planning year and were then awarded three-year implementation grants based on the strength of their applications and work plans.

3. What does isolation look like?

MeHAF-funded communities are learning that people may be physically and/or socially isolated. Older people who are isolated live alone, often at a distance from towns and down long driveways that become impassible during snowstorms. Some are people who have lost their spouses or partners and are overwhelmed by home maintenance, financial pressures, and legal issues. They may be recently discharged from the hospital or transitioning from one service level to another. They may be younger but suffer from disabling conditions and live alone with little family support. They may be so disconnected and view themselves as so voiceless that they do not want to discuss their situations. They may be afraid that if they ask for help, they will be moved to a nursing home. In some towns, downward economic trends are exacerbating the problem of elder isolation. In Bucksport, the closure of the paper mill resulted in an exodus of young families to better jobs, in some cases leaving their elderly parents behind. Older people are having difficulty selling their homes to downsize and move into town.

Contrary to common belief, one community's assessment process revealed that access to health care was not the major problem that put people at risk of being placed in assisted living or nursing homes. Even those who had primary care providers, the right specialists and appropriate medications did not necessarily experience wellness that comes from being connected to others. The factors most likely to influence having to leave the home, as reported by community members, were maintaining living conditions (home repairs, heating oil, snow shoveling, lawn upkeep, and risks of falls), caregiver support, transportation, and social isolation. Social isolation especially was associated with depression and other health complications.

> *"Everyone is isolated—we think we're creating community digitally, but it's not true community."*
>
> *—Coalition member*

Community members describe many Mainers, particularly those who survived the Depression, as "ruggedly independent" people who will not ask for help until it becomes a crisis. Further, their reluctance to take "charity" and a belief that others have it worse than they do get in the way of asking for help. For some, the "rule of thumb is mind your own business and leave me alone." Finally, as people age, they sometimes become less future-oriented and have difficulty planning ahead, not addressing problems until they reach the critical stage.

4. What are the challenges associated with reaching and supporting very isolated individuals with chronic conditions?

Geographic Barriers

Geography is daunting in Maine. For example, Aroostook County covers an area the size of Rhode Island and Connecticut combined. Sharing a border with Quebec, the county has several French-speaking communities, requiring bilingual providers. Similarly, the population density in Piscataquis County is low enough to qualify it as a "frontier" county. Several areas are so remote that they do not have high speed internet, necessitating communication by phone. Some local projects considered using local mail carriers to check in on isolated community members, but carriers are now mostly independent contractors, so it is more challenging to engage them as partners. In the Blue Hill peninsula, villages are separated by inlets, and people don't want to "cross the bridge" to go to events in other towns. The TiP project has responded with a deeply localized approach, funding individual projects in villages across the county.

> *Models for alleviating social isolation that have been described in the literature are usually focused on urban areas and/or higher income elders; they need to be adapted for rural, lower-income communities.*

Reaching people who are isolated in larger towns is challenging enough, but smaller communities in distant parts of counties are the hardest to reach. People who retire to these idyllic communities are often taken by surprise that there are limited services for them once they become more dependent. Planning can be complicated by seasonal population shifts—a larger, wealthier summer population and a smaller, lower-income population in the winter.

Volunteers

Organizations serving individuals with chronic conditions most often do not have the capacity to identify, reach out to, and support people who are isolated and who do not actively seek assistance. Volunteers can fill those gaps; however, recruiting the numbers of volunteers communities need to meet all of the needs of their most vulnerable citizens is challenging. While individual needs are increasing, their volunteer workforce is growing older and is not being replaced by younger volunteers. Younger people are often unable to volunteer because of work and family responsibilities that leave little discretionary time. Some might be cobbling together a living from several part-time, minimum wage jobs. The problem is compounded in rural areas with small populations and vast catchment areas. A second area of concern is volunteer management. Volunteers must be recruited, trained, informed about expectations, and pass a background check. An organization must assume liability for volunteers and supervise them over time. Third, it is particularly difficult to find people with the skills and sensitivity to help with in-home care for seniors. These three challenges are exacerbated in rural or other isolated areas, such as islands.

Grantees make the most of the services already available in the community, but attending to all of the moving parts of these complex initiatives requires dedicated staff. The TiP coordinator is usually the only staff person with dedicated time to the initiative, and that individual is often the one who enrolls program participants and connects the participant to individualized supports and services. The same staff may also facilitate the network, recruit new partners, lead data tracking and reporting, write grants, and participate in statewide policy initiatives. Recognizing that this centralized approach is not sustainable, grantees are working on alternative approaches such as distributing these responsibilities across partners and increasing capacity with VISTA volunteers and Department of Labor workforce programs.

5. What strategies are proving effective in reaching people who experience social isolation?

Having the right organization take the lead. Thriving in Place grantee organizations have been serving their communities for many years and have long-standing reputations for being the trusted "go to" organization for community members. They have built strong relationships with civic organizations and health care providers and are experienced network facilitators. They respect the privacy and needs of community members without being overly intrusive, which has resulted in a high level of trust with their participants.

Conducting outreach. During their planning year, TiP grantees engaged a wide range of community members in their planning and community assessment processes, raising awareness of the initiative even before a specific program was in place. These outreach efforts continue as communities seek to reach their most isolated citizens. Participating in community events, hosting events such as an Annual Expo on Aging, displaying materials at voting sites, and airing public service announcements reminds potential participants, family members, and neighbors that help is available. These broad outreach strategies also help them to recruit volunteers, who are critical to the success of these initiatives. Grantees also target outreach to organizations that are most likely to have knowledge of or contact with isolated people. Any outreach approach needs to take into consideration the proud, independent nature of Mainers. For example, doing outreach at a food pantry could be shaming for community members; instead, Tip grantees convene community discussions around a "safe" topic like transportation to address isolation without labeling individuals as needy or alone.

> *"Families ask for help when they get tired or face a crisis, and they go to an organization that they trust. Some people who are isolated themselves initially call on behalf of a neighbor, learn that they can trust the organization as a resource, and eventually call on them for their own needs."*
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> *—Bucksport team member*

Ensuring multiple points of entry. TiP teams say that it should be as easy

> *"As in most rural areas, isolated elders need help with food, shelter, transportation, and help for their caregivers. With the loss of some support systems and shrinking communities, we need to engage schools, churches, businesses, and farmers to help with the basics."*
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> *—Aroostook resident*

as possible for people to ask for help, and this means welcoming people in through any doorway. Any partner organization, any "first contact" such as a transportation provider, senior center, emergency medical technicians (EMTs), or Meals on Wheels delivery person, should know how people can get help. For example, the Aroostook Area Agency on Aging (AAA) has daily phone coverage by staff or volunteers. They receive a high volume of calls (up to 75 calls an hour), especially during fall open enrollment season for Medicare, including Part D prescription drug coverage. People often start by asking for help with heat or food, and as they develop trust, they reveal other needs.

Transportation requests have become a primary point of entry into the TiP programs in Bucksport and Aroostook. The Community Action Resource Exchange (C.A.R.E.) transportation program in Bucksport (run solely by volunteers) takes all calls for transportation. The transportation coordinator, who is closely connected to the TiP collaborative, learns about residents' medical and other needs when assessing their eligibility for various transportation programs. Volunteer drivers often create trusting relationships with their passengers and become critical bridges to social connectedness.

Because TiP community collaboratives are diverse and inclusive, the TiP programs are becoming well known by potential referral sources that represent different "doorways." Families, caseworkers, town office managers, health care providers, EMTs, visiting nurses, and utility workers are just some of the sources for referrals in TiP communities. People also self refer, including some rural Maine Vietnam veterans who prefer to live alone in the woods. Volunteers in major programs such as senior centers know everyone in small communities and can be a great source of referrals. They also know when someone does not show up for a meal or a card game and can arrange for a volunteer to visit the individual or deliver food. Close connections among organizations are the building blocks for developing points of entry across entire counties to reduce social isolation.

Maximizing the effectiveness of existing community and in-home supports and services. Rather than building new programs, TiP grantees work to better knit together the services that exist, so that participants receive the right services in the

right locations. They also support coordination functions such as assessment, referral, and collating knowledge about program eligibility and availability across individual organizations. The following is a sampling of the range of supports and services that address isolation directly or indirectly in one or more TiP grantee communities. When operating in isolation, there are gaps or duplication of effort; when coordinated, they comprise a comprehensive system of care:

» **Fitness and wellness:** grantees report that health promotion, light exercise classes (e.g. Tai Chi, yoga), and evidence-based programs that reduce the risk of falling such as Matter of Balance[5] are appealing to vulnerable individuals and can have the added benefit of generating friendships among participants. A project director observed that "If you set out to give people a social experience, they may not come, but if you offer a health-related component (e.g. exercise, falls prevention), then they show up."

» **Check-ins with isolated elders:** in Aroostook County, volunteers visit and make reassurance phone calls to homebound elders. In Bucksport, a Sheriff's Department "Friendly Caller Program" has elders call in each day to report how they feel; if the elder does not call, law enforcement conducts a wellness check in the home.

» **Increasing access to needed services by enhancing the role of home visitors:** in Aroostook County, University of Maine Fort Kent's nursing school will train 85 nursing students to screen "well elders" for depression, fall risk, and instrumental activities of daily living; Aroostook Mental Health Center has trained Meals on Wheels staff and volunteers to use the PHQ-9[6] for depression screening of over 80 TiP participants. The plan is to re-assess the elders in 6 months. All depression screens go to the primary care provider (with permission from the participant). One TiP grantee is piloting a program that enables EMTs to address non-emergent needs in the home.

» **Reducing the risk of hospital readmission:** When individuals in fragile health with no family or other natural support persons are discharged, they are at elevated risk of returning to the hospital. In Aroostook, a nurse pays a "courtesy visit" within 72 hours of discharge and delivers meals for two weeks for the patient; if there is a caregiver, that individual also receives meals. Meals are contracted through the Area Agency on

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5 Matter of Balance is an 8-session evidence-based program designed to decrease risk of falls by emphasizing practical strategies like setting realistic goals for increasing activity, changing the environment to decrease fall risk factors, and increase exercises that improve balance (http://www.ncoa.org/resources/program-summary-a-matter-of-balance)

6 The Patient Health Questionnaire is a 9-item self-reported diagnostic and severity measure of depression. See Kroenke, K., Spitzer, R., and Williams, J.B. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. Journal of General Internal Medicine. 16(9): 606-613.

Aging. This program is reducing readmissions among those served.

» **Addressing structural impediments to connection:** Home repairs, snow removal and other barriers to socialization are sometimes alleviated with area high schools' community service volunteers and with advocacy, such as to make streets more walkable. After complaints of snowplows creating snow berms that made walking across streets difficult for elders, Bucksport purchased a small snow blower and hired part-time help to remove snow barriers for pedestrians.

A neighbor called a TiP grantee about a 70 year-old woman with no family who suffers from multiple chronic conditions. The woman did not answer her door, so the TiP coordinator called the sheriff (a partner) who reported that she was hospitalized. The TiP coordinator visited her at the hospital, set up home care, and enrolled her in Thriving in Place. In spite of her situation, she only wanted help with the laundry. A senior volunteer companion visits once a week and hopes to build trust over time.

» **Some communities explored models** such as naturally occurring retirement communities (NORCs)[7], but recognized that they are much more difficult to implement in rural, low-income areas where it is challenging to collect fees and raise the revenue for a coordinator to vet and manage services. One idea that is being considered is to ask wealthier members to make an additional contribution to support a lower income neighbor.

» **Expanding volunteer networks.** Volunteers are a linchpin of TiP's efforts to reduce isolation. Many of the needs grantees identified in their planning year were for services and supports that are not consistently provided by any agencies or providers, so their plans included efforts to recruit a cadre of volunteers to provide services to reach and assist isolated people in the community. Volunteers provide snow shoveling, home repair, home visits, meals delivery, transportation, and friendly visiting, among many

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7 Naturally Occurring Retirement Communities (NORCs) are communities not originally built for seniors but which have a significant proportion of older residents. Economies of scale make it possible to rethink the way services are organized and delivered, and some NORCs take full advantage of the skills and experiences of their residents to enhance services and support to one another (http://www.norcblueprint.org/norc).

other things. When people don't show up at the Senior Center, volunteers go to them. Communities employ creative strategies to expand the pool of volunteers to meet the diverse needs of their most isolated neighbors:

- Local advertising using colorful, marquis-like posters. People who volunteer comment specifically on the positive message the posters conveyed
- Creating a cross-organizational volunteer committee
- Recruiting volunteers in a voting line. Those who asked for more information received a follow-up mailing and a personal invitation by phone. Twenty people attended the training and 17 completed the process as a result of this recruitment in Bucksport.
- Joint training of volunteers from multiple agencies
- Finding one organization to manage volunteers. In Bucksport, the Methodist Church agreed to assume responsibility; in Blue Hill, Friends in Action, traditionally a volunteer transportation service, assumed responsibility for managing volunteers across the county. This arrangement is benefiting their organization by broadening its scope to include longer-term services.

While the above efforts have shown promise, the current TiP grantees agree that volunteer recruitment and management is a larger issue than any one community can address. The TiP implementation grantees have launched a joint media and strategic effort to maintain an adequate pool of volunteers. In addition, grantees recently called for a regional and/or statewide effort to inform the public about the value of volunteerism, the need for volunteers in rural communities, and to create a coordinated mechanism for screening, training, and supervising volunteers.

Starting with what people ask for. When TiP staff and volunteers meet someone with multiple and complex needs, it is tempting to offer a full array of services. However, they have learned to start with the request that is most pressing for the participant. Meeting concrete needs is a safe place to start, is responsive to the needs of very independent people, and builds trust. Helping with basic survival can be a springboard to more intensive services that engage people in the community. For example, one woman who lived alone needed a plow driver; the conversation and mutual problem solving that went into addressing the presenting issue ultimately engendered trust and a conversation about end of life preparation and communicating advance directives to her children.

6. What are communities learning about the most isolated people in their communities?

The real need is in-home services at all levels: Lifelines for isolated elders are fragile. If their caregivers become sick or leave town, there may be no one to check in on them and make sure they are safe, warm, and well fed. One TiP volunteer became involved when the family of an 88-year old woman with Alzheimer's who lives alone worried that she was not eating the meals they were delivering to her. The volunteer provides companionship at dinnertime to socialize and prepare dinner. Another woman with chronic fatigue syndrome receives a farm share but did not have the energy to freeze, chop, and store the food; her TiP volunteer delivers the farm share and helps her with this task. Professional providers such as visiting nurses observe enormous needs that they cannot meet; being able to refer people to TiP links them to needed home care, home maintenance, and companionship.

> *"You need to find people who know those who are socially isolated and then you have to convince them it's not charity."*
>
> *—Senior Resource Committee Member, Bucksport.*

Localized solutions work best. Physically isolated seniors are supported by bringing the people and programs to them in their towns and small communities and whenever possible, even to their living room. People who know those who are socially isolated can play a vital role by looking for the warning signs that someone needs help (e.g. unplowed driveway, no smoke coming out of the chimney). TiP partners are aware of the importance of honoring and respecting the limits seniors impose on helpers becoming involved in their lives, unless an emergency situation arises and corrective action is needed. Isolated seniors slowly become more connected through local people being aware of and building trust with one another.

7. Summary

MeHAF's Thriving in Place initiative is in the early stages of implementation, but its funded communities are already making a difference. They are demonstrating that investing in community-driven initiatives that address the most pressing needs of people with chronic health conditions including older, often isolated citizens is beginning to create changes in the way services are being coordinated and delivered at the local level. As relationships are strengthened among municipal officials, first responders, social services, health care providers, and community members, these communities are learning about which services are most acceptable and appealing to isolated elders, which outreach strategies work best, and where barriers and gaps exist in their systems of care. Over the next two years, these communities will continue to build out their systems of care and refine their approaches to strengthening community capacity. It is too early to predict which approaches will be the most effective and sustainable, but their willingness to work across organizational boundaries and across grantees will deepen their learning and help them adapt along the way.