FINAL REPORT

Process Program Evaluation for Illinois Aging Services

DATE:
June 30, 2022

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Acronyms

AAAs	Area Agencies on Aging
ACS	American Community Survey
CITI	Collaborative Institutional Training Initiative
CLTB	Caring Together, Living Better
IAS	Illinois Aging Services
IDoA	Illinois Department on Aging
IRB	Internal Review Board
MSC	Most significant change
NAPIS	National Aging Program Information System
NIH	National Institutes of Health
OAA	Older Americans Act
PI	Principal Investigator
PII	Personally identifiable information
SFTP	Secure File Transfer Protocol

1. Executive Summary

Study Background and Purpose

The COVID-19 pandemic has affected the needs of older adults across myriad domains of life, and social contact and interaction were among the most salient areas of need during this time. The Illinois Department on Aging (IDoA) and the Area Agencies on Aging (AAAs) have long recognized this need and have offered a range of programs to address this need, but the constraints of the pandemic limited the means by which older adults could be provided with these offerings. To avoid in-person contact, much of the programming needed to change gears to other modes of contact, and new programming was launched to help fill the gap when prior types of programming were disallowed. This pivot in programming was supported by an infusion of funds designated by the State of Illinois specifically for social isolation programming for older adults. The overarching objective of the present evaluation is to provide the IDoA and the AAAs with a robust characterization of programs as they were designed and implemented in response to both the social isolation initiative and the evolving needs related to the COVID-19 pandemic.

With funding from the Retirement Research Foundation, Illinois Aging Services (IAS) contracted with NORC at the University of Chicago and CJE SeniorLife (CJE) to conduct the research with a subset of five AAAs who indicated they have the capacity to partner on this research project. This subset includes Area 2 (AgeGuide), Area 5 (East Central Illinois Area Agency on Aging, Inc.), Area 7 (AgeLinc), Area 8 (AgeSmart), and Area 13 (AgeOptions).

The project included an assessment of changes from before to during the pandemic in (1) the characteristics of the programs, and (2) the characteristics of the older adults who availed themselves of AAA programs.

Collectively, these assessments illustrate the flexibility of the AAAs in adjusting programs in response to the pandemic, identify which isolation programs have not been able to continue under current restrictions, and reveal which populations are being reached (or not) in this era relative to before the pandemic, thereby informing future isolation programming strategies. These new insights will equip the IDoA, Illinois Aging Services (IAS), and the individual AAAs with a better understanding of where to target their resources during the pandemic and beyond.

In addition, this project entailed a novel text-message-based data collection strategy with the goal of developing a means of assessing program impact in a measurable way, by monitoring loneliness levels within individuals and over time. Lessons learned will guide the modification and testing of this approach in the future.

Pilot Agency: AgeOptions

The process evaluation procedures were tested between March and September 2021 in collaboration with one of the five agencies identified above, AgeOptions. AgeOptions was the preferred pilot AAA because its staff had an established relationship with the NORC and CJE research team. In carrying out the pilot evaluation phase with AgeOptions, we encountered a number of challenges with regard to the overall project, quantitative components, and qualitative components. We describe these challenges and the actions we took and/or the information gleaned related to these challenges in Appendix I, which has been updated to include challenges encountered over the course of the rest of the evaluation study. Findings from the Pilot were documented in an interim report, which was shared with Illinois Aging Services in October 2021. The report presented quantitative findings that were specific to AgeOptions and its

programming, preliminary qualitative findings relevant to all five agencies, and informed data collection protocols for the remaining AAAs.

Objectives

This evaluation study addressed three overall objectives to set the stage for next steps to improve programming and rigorously evaluate program effectiveness in reducing social isolation and loneliness in the ongoing era of COVID-19. The following research questions for each objective guided the study:

Objective 1: Program Description

How did AAAs address the goals and specific objectives of the social isolation initiative? How did the AAA programs adapt their services to respond to the challenges posed by the pandemic? More specifically:

1a. Describe programs intended to be implemented before the pandemic forced a shut-down.

1b. Describe changes in programming triggered by the pandemic.

Objective 2: Program Reach, Use, and Impact

To what extent did AAA social isolation programs address social isolation among older adults amidst the pandemic?

2a. Program reach: Methods, challenges, new strategies

2b. Program use: Characteristics of participants using social isolation program services

2c. Program impact: Participant and staff perspectives

Objective 3: Program Assessment Methods

Physical distancing requirements required shifting data collection procedures from in-person to remote to obtain information on participants' feelings of loneliness and isolation, as well as their satisfaction with social isolation programming and other outcomes of interest to the AAAs and services providers.

3a. Data collection practices: Current methods and their effectiveness

3b. Pilot test of novel methods: Feasibility of text-messaging survey methodology

Key Findings

Objective 1: Program Description

Based on information provided by AgeOptions, programming pivoted away from at least three planned programs to reduce social isolation because they relied on in-person contact that was no longer possible. When recruiting older adults for interviews, other AAAs in this study indicated that planned intergenerational programs, singing events, and other programs that would require in-person community gatherings were not implemented during the pandemic. In their stead, other existing programs were rapidly reconfigured by changing the mode of contact from in-person to video or phone contact. Some programs (e.g., Mather Telephone Topics) expanded from only

phone contact to the option of video contact. Video contact replaced in-person contact for programs such as Memory Cafes and Thrive with Pride Cafes. In other instances (e.g., Friendly Phone Visits), the volume of phone calls increased dramatically to meet a much greater demand. Congregate Meals became "pick-up" meals. Daily home delivered meals remained an in-person offering and continued to serve as a daily security check that simultaneously assured recipients of at least one social contact, albeit socially distant and masked. Top Box was launched during the pandemic as an alternative to congregate dining and delivered culturally-modified boxes of groceries on a weekly basis, thereby also providing recipients with evidence that they had social value and had not been forgotten. Qualitative findings provide other examples of changes such as conducting programs outdoors and providing isolated older adults with activity kits. These program changes reveal the flexibility that was needed to accommodate a rapidly changing landscape, both in protecting older adults' health and in taking advantage of new developments in the content and mode of service provision.

Objective 2: Program Reach, Use, and Impact

Objective 2a. Program Reach.

Three focus groups were conducted to solicit and discuss their insights, opinions, observations, and experiences. These groups were constituted of staff members representing five AAAs and service provider staff contracted by the AAAs to provide services to older adults and/or caregivers. Discussions in these focus groups revealed that, during the pandemic, staff enhanced their usual outreach strategies by making more phone calls to older adults, which older adults noticed. Staff also made efforts to share with older adults information about programs where they lived, and sometimes reached out to older adults who they might not have been in contact with prior to the pandemic. Older adult and staff suggestions for outreach emphasized the importance of disseminating program information in the community in ways that would maximize word of mouth referrals, such as through peer-to-peer networks.

Objective 2b. Program Use.

Administrative data. Data from the Census and the American Community Survey were used to produce estimates of the target population in each of the AAA's geographic areas. By comparing the demographic characteristics of the target population with the characteristics of the population enrolled in each AAA, it is possible to identify subpopulations that are not using AAA services.

In summary, the general pattern of program use was one in which men are consistently underrepresented. Black older adults are relatively consistently overrepresented among program users, whereas Hispanics are underrepresented. These findings highlight a need to understand the reasons behind under-utilization of programming, including failure to reach these populations, cultural barriers, preferences, or other reasons.

Staff focus groups and older adult interviews. Older adults in this study were referred from diverse programs across the five AAAs, with equal proportions of older adults who used one-on-one versus groups programs, but many older adults also used other programs. A few interviewees were part of programs to introduce tablets or devices, some of which came with group training. Some older adults accessed programs in more than one way over the course of the pandemic. Approximately 40% of older adult study participants accessed programs by phone, 48% used programs in person such as meal delivery, friendly visits, or congregate dining, and 35% used programs provided through an online application or were accessing programs via an online platform.

Those who used group programs that moved online and those who had attended centers or dining sites experienced significant changes in their program experiences. Both staff and older adults cited examples of older adults missing in-person interactions, feeling disconnected from their communities of older adults, and missing usual program and volunteering routines. Those who chose to use online groups observed declines in participants or different participants. The benefits of using programs online included convenience, being able to see faces during the pandemic, having some way of staying connected to their fellow program users, trying new things, or even interacting with new people, but online group programs did not meet needs for social interaction for others. Some older people stopped participating in groups that went online or have not returned to dining sites. Older adults, program providers, and online group facilitators all had to learn new skills, and some older adults needed more time and confidence to learn new skills. Technology barriers such as not having computers or smart phones, access to the internet, and slow internet speeds were cited by both staff and older adults, confirming that more significant resources are needed to build a viable infrastructure for effective delivery and use of online programs.

Objective 2c. Program Impact.

Loneliness levels: Aggregate results.
Area Agencies had initiated a practice of collecting loneliness data from older adults at their intake and/or in the course of program delivery. These data consisted of older adults' responses to three items that constitute the brief UCLA Loneliness Scale. The UCLA Loneliness Scale scores (range = 3-9) among program participants in each agency are summarized here. In most instances, loneliness data are summarized at the aggregate and loneliness levels and cannot be validly compared over time since a different group of individuals contributed to the data at each time point. These data are useful, however, to understand broad trends in loneliness over the course of the pandemic.

In summary, loneliness levels decreased over time from the beginning of the pandemic lock-down period in 2020 through the later months of 2021. Some of this decrease is likely attributable to individual coping strategies, acclimating to different ways of socializing, and revising expectations about necessary levels of social activity; however, some of the decrease may also be attributable to participation in programming offered by the Area Agencies on Aging. The design and results of the Uniper program are consistent with this possibility. Ideally, repeated assessments of loneliness from individuals during the time they are active in a program would be obtained for each program type to better understand the impact of social isolation programming on loneliness.

Loneliness levels: Repeated online survey results.
To move beyond aggregate data, an online survey was administered on two occasions in an attempt to quantify the magnitude of the change in loneliness over time in a single cohort. Among 36 participants who completed an online survey at baseline, only 11 participated at the 3-4 month follow-up. In this small sample, loneliness levels remained constant over time at an average score of 3.82

The online surveys also probed other aspects of older adults' lives relevant to their experience of social isolation. These included questions about their use of the internet, self-reported physical and mental health, perceived availability of tangible and emotional support, the frequency of participation in a range of social activities, barriers to social participations, and interest in various types of community events and activities.

Program impact: Staff and older adult perspectives.
Staff and older adults in this study identified similar program benefits related to social connections, social support and mental well-being. The qualitative findings suggest that reducing

social isolation requires *an array of programs that can meet a continuum of social needs*. By giving older adults choices for socially connecting, they can build on the social experiences that they already have and gain new social skills. In this study, programs had positive impacts when they met local or cultural preferences for socializing (e.g., rural, LGBTQ+, ethnic, racial and faith-based communities). Qualitative findings confirm the value of seeking input from older adults, staff and program innovators.

Objective 3: Program Assessment Methods

Physical distancing requirements necessitated remote data collection procedures to obtain information on participants' feelings of loneliness and isolation, as well as their satisfaction with social isolation programming and other outcomes of interest to the AAAs and services providers. Moreover, reliable and consistent data collection are necessary to conduct valid evaluations of program effectiveness. Text-based surveys could be a means to achieve this end while minimizing burden on service providers who would otherwise be tasked with obtaining those data. After conducting interviews and focus groups to obtain input from staff and older adults, a text-based survey was developed and implemented to consenting older adults at the rate of one text message survey/month for 3 consecutive months. Of the 32 older adults who participated, half completed all three surveys, and all of them started at least one survey. Among the 27 older adults who completed at least one survey, the average completion rate was 2.3 surveys. These preliminary data suggest that this method is feasible.

Conclusions and Recommendations

Taken together, findings from the program descriptions, and their reach, use, and impact provide information that could inform the IAS as it seeks to further address older adults' need for social connection. Opportunities posed by these findings include: (1) expanding the range of strategies used to locate older adults at risk for social isolation; (2) developing programming that is sensitive to the unique needs of racial, ethnic, cultural, and other subgroups; (3) exploring and addressing barriers to participation by men and some racial/ethnic subgroups, who tend to be underrepresented in social isolation programs; (4) integrating a robust technology support system into service offerings to facilitate older adults' use of this mode of communication; and (5) implementing a systematic and reliable data collection strategy to permit monitoring of program effectiveness at reducing individuals' social isolation (e.g., for whom is it effective? What duration and frequency of engagement are needed to elicit a benefit)?

Text-based surveys lend themselves well to the latter opportunity while minimizing staff burden. Although our results indicate this is a feasible strategy in terms of response rates, uptake needs improvement. That is, work is needed to develop an approach to text-based messaging that gets greater buy-in on the part of older adults who do not release their phone numbers to AAAs or providers (a major obstacle to our being able to use the text-messaging approach). We recommend considering the use of text messaging to provide resources, information, and emergency alerts (for example) alongside the delivery of surveys. An approach to data collection that "gives" as much as it "takes" may be seen more favorably and may garner greater participation. This is an empirical question and could be tested and compared with other means of securing participation.

2. Introduction

Study Background and Purpose

The COVID-19 pandemic has affected the needs of older adults across myriad domains of life, and social contact and interaction were among the most salient areas of need during this time. The Illinois Department on Aging (IDoA) and the Area Agencies on Aging (AAAs) have long recognized this need and have offered a range of programs to address this need, but the constraints of the pandemic limited the means by which older adults could be provided with these offerings. To avoid in-person contact, much of the programming needed to change gears to other modes of contact, and new programming was launched to help fill the gap when prior types of programming were disallowed. This pivot in programming was supported by an infusion of funds designated by the State of Illinois specifically for social isolation programming for older adults. The overarching objective of the present evaluation is to provide the IDoA and the AAAs with a robust characterization of programs as they were designed and implemented in response to both the social isolation initiative and the evolving needs related to the COVID-19 pandemic.

With funding from the Retirement Research Foundation, Illinois Aging Services (IAS) contracted with NORC and CJE to conduct the research with a subset of five AAAs who indicated they have the capacity to partner on this research project. This subset includes Area 2 (AgeGuide), Area 5 (East Central Illinois Area Agency on Aging, Inc.), Area 7 (AgeLinc), Area 8 (AgeSmart), and Area 13 (AgeOptions); see map below to view locations.

Illinois Area Agencies on Aging

The project included an assessment of changes from before to during the pandemic in (1) the characteristics of the programs, and (2) the characteristics of the older adults who availed themselves of AAA programs.

Collectively, these assessments illustrate the flexibility of the AAAs in adjusting programs in response to the pandemic, identify which isolation programs have not been able to continue under current restrictions, and reveal which populations are being reached (or not) in this era relative to before the pandemic, thereby informing future isolation programming strategies. These new insights will equip the IDoA, Illinois Aging Services (IAS), and the individual AAAs with a better understanding of where to target their resources during the pandemic and beyond.

In addition, this project entailed a novel text-message-based data collection strategy with the goal of developing a means of assessing program impact in a measurable way, by monitoring loneliness levels within individuals and over time. Lessons learned will guide the modification and testing of this approach in the future.

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Objective 1: Program Description

How didthe AAAs address the goals and specific objectives of the social isolation initiative? How did the AAA programs adapt their services to respond to the challenges posed by the pandemic? More specifically:

1a. Programs intended to be implemented

i. What are the types and characteristics of programs that were intended to be implemented by each AAA before the pandemic forced a shut-down?

1b. Changes in programming

i. How have programs changed during the pandemic? What new programs were launched?

Objective 2: Program Reach, Use, and Impact

To what extent did AAA social isolation programs address social isolation among older adults amidst the pandemic?

2a. Program Reach

i. What methods are being used to identify vulnerable older adults in the community?
ii. What are the challenges to reaching the target population or sub-population?
iii. What new programming is in the pipeline and being considered as a means of reaching a broader population of older adults needing alleviation of social isolation and/or loneliness?

2b. Program Use

i. Who is participating in social isolation program services, and with what frequency? Conversely, what are the characteristics of non-participants (e.g., are any subgroups more or less likely to participate in social isolation program services)?
ii. How have demographic characteristics of participants (i.e., age, gender, race/ethnicity, socioeconomic status) changed during the pandemic?

2c. Program Impact

i. Participant perspective: To what degree are participants satisfied with various types of programs? What are their biggest concerns about their social needs during the pandemic? Do participants recommend any changes to programs that have been re-tooled to accommodate physical distancing restrictions?
ii. Staff perspective: To what degree are service providers satisfied with their ability to deliver programming, and do they perceive that the programming is making a difference? Do staff recommend any changes to programs that have been re-tooled to accommodate physical distancing restrictions?

Objective 3: Program Assessment Methods

Physical distancing requirements required shifting data collection procedures from in-person to remote in order to obtain information on participants' feelings of loneliness and isolation, as well as their satisfaction with social isolation programming and other outcomes of interest to the AAAs and services providers.

3a. Data Collection Practices

i. How are AAAs and/or service providers collecting data during the pandemic? How effective are these methods of obtaining data, and do certain methods work better than others, and for certain sub-populations?

3b. Pilot Test of Novel Methods

i. What is the feasibility of a novel, text-messaging based methodology for collecting these data? If feasible, this methodology may be implemented in later work to regularly quantify program impacts on loneliness and social isolation with an eye for participant safety during the pandemic.

3. Methods

Data Collection Preparation

Advisory Groups

To address the specific research questions described above, the research team first formed and consulted with three advisory groups. These groups, comprised of staff, program participants, and community members, respectively, met with the NORC and CJE research team multiple times to advise on data collection instruments and protocols. This included recruitment processes

and scripts, informed consent approaches, preferred data collection modes, and instrument design and clarity. The research team incorporated this feedback and revised study materials accordingly. We discuss this feedback in the Results Section for Objective 3.

Research Ethics and Study Authorization

This study was conducted in line with human subjects research guidelines. NORC follows established protocols for gathering informed consent, protecting anonymity and identifying information, and ensuring ethical data collection, including from vulnerable populations such as older adults. To ensure compliance with our high ethical standards, all research involving vulnerable populations much pass through formal Institutional Review Board (IRB) review prior to data collection and all research staff must complete a certified course in Protecting Human Research Participants through the National Institutes of Health (NIH) or Collaborative Institutional Training Initiative (CITI).

NORC sought and received approval in May 2021 from its internal IRB (exempt status; IRB Protocol 21-01-095). NORC's internal IRB follows a formal process for ensuring all research projects are conducted in accordance with the U.S. Federal Policy for the Protection of Human Subjects. NORC's IRB is registered with the U.S. Department of Health and Human Services Office of Human Research Protection and has a Federal-wide assurance (FWA 00000142). The IRB takes an active role in helping guide protocols to meet the highest standards for human subject protections. NORC's IRB requires that research protocols provide sufficient detail to ensure that (1) the selection of subjects is equitable, subjects' privacy is protected, and data confidentiality is maintained; (2) informed consent is written in language that study participants can understand and is obtained without coercion or undue influence; and (3) appropriate safeguards to protect the rights and welfare of vulnerable subjects.

Quantitative Data Methods

The quantitative component informed all three objectives described above—program description; program reach, use, impact; and program assessment methods—using secondary and primary data, specifically: 1) administrative census data; 2) programmatic data (e.g., demographic data of service recipients); and, among older adults receiving services, 3) online survey data; and 4) text-based survey data.

Administrative Census Data

The research team obtained publicly available Census and American Community Survey (ACS) data in June 2021 to describe the characteristics of older adults in the areas served by the selected AAAs in terms of their racial/ethnic, gender, and age composition, and socioeconomic/poverty status.[1] To the extent possible, researchers also obtained key social isolation risk factors, including living arrangements (% living alone), marital status (% married or not), percent living in poverty, and percentages disabled and experiencing independent living difficulties. These data addressed research questions regarding *program use.*

[1] See map for complete list of counties covered by Areas 2, 5, 7, 8, and 13: https://www2.illinois.gov/aging/forprofessionals/Pages/aaa_map.aspx.

Programmatic/AAA Administrative Data

The team reviewed a range of programmatic and administrative data collected by the five select AAAs as well as their implementing partners/service providers. These data came in two forms: descriptive, textual documents and quantitative data files.

Desired documents included descriptive text on programs related to social isolation and loneliness that were administered prior to or during the pandemic in the service areas covered by selected AAAs, including the nature (e.g., meal delivery), mode (e.g., in-person), and frequency (e.g., weekly). These informed our responses to research questions related to *program description*. These documents also included select AAA's Area Plans in response to the statewide initiative, which provided an overview of the strategies for identifying and reaching socially isolated older adults, both before and after the start of the pandemic. This informed our descriptions of *program use.*

Quantitative data files from the service providers, as well as select AAAs, also informed our responses to research questions regarding *program use.* At intake, each agency is required by the National Aging Program Information Systems (NAPIS) to obtain limited demographic data from each participant to monitor performance and collect information on Older Americans Act (OAA) Title III, VI, and VII programs. Participants who receive "non-registered" services (e.g., transportation, legal assistance, friendly visiting, telephone reassurance) are required to provide only their race-ethnicity and information to determine poverty status. Participants who receive "registered" services (e.g., housekeeping, home-delivered meals, in-home respite, congregate meals) are required to also provide date of birth, gender, rural status, and live alone status.

NORC sought to obtain these data from select AAAs and, to the extent possible, their service providers, to summarize the number of unique participants, participant demographics, the number of services provided and patterns in frequency of service use by participants as an aggregate by agency. To the extent possible, NORC sought to use these data to examine whether demographic characteristics (i.e., age, gender, race/ethnicity) are linked with greater response rates for certain AAA data collection/assessment methods. In addition, drawing from estimates produced using Census and ACS data, NORC used the programmatic/AAA administrative data to describe participants who are *not* receiving services, both before and during the pandemic Finally, some of these quantitative data files contained 3-item UCLA Loneliness Scale scores, informing our assessment of *program impact* from the perspectives of participants. These data from participants were used to assess changes in loneliness over time.

To obtain these data, NORC provided a Secure File Transfer Protocol (SFTP) to the select AAAs in April 2021 to ensure all identifiable data remained confidential; only the project team had access to the data, which were securely stored. NORC worked with AgeOptions to identify relevant documents described above between March and September 2021, and with the remaining AAAs through May 2022. The AAAs reached out to their service providers who obtained the data and, either directly via email or indirectly via the SFTP, shared them with NORC. Ideally, these data would be at the individual-level, enabling analysts to link individuals' demographic information with their service receipt, program participation, and their loneliness scores over time. However, conversations with AgeOptions during the Pilot Phase clarified that AgeOptions and their service providers typically do not collect individual-level data but rather data at the aggregate-level. Therefore, researchers adjusted their analysis plan and used the data provided to them to address research questions as best possible for the Pilot Phase, and subsequently used a similar approach with the remaining AAAs.

Online Survey

Primary data collected among older adults receiving social isolation-related programming included an online pre/post survey to inform our assessment of *program impact*. This survey was administered to older adults in July-September 2021 (among those covered by AgeOptions) and in October 2021-Feburary 2022 (among those covered by the remaining AAAs) and supplemented programmatic (described above) and qualitative interview data (described in detail in the sub-section below). The survey collected various information, including the UCLA Loneliness Scale, social isolation, social engagement, relationship quality, social support, and demographic information at two time points: baseline and 3-4 months later. NORC designed the online survey using the Qualtrics platform. Excluding two respondents who took more than 8 hours to complete the survey, respondents took between 3.3 minutes and 19 minutes to complete the survey (see Appendix II for the online survey questionnaire).

During multiple conversations with various stakeholders (including the advisory groups and with the AAAs), it was determined that the most efficient recruitment method for the online survey was through older adults' personal email. NORC worked with the select AAAs and, where possible, their service providers, asking them to identify the email addresses they had on file for all older adults with normal cognitive functioning who were currently receiving social isolation-related programming in the AAAs' geographic areas. NORC provided the AAAs a script for service providers to revise as needed and to send to older adults in their area. This script described the purpose of the study, emphasizing how findings will inform programs targeting older adults like themselves with the goals of improving their health and well-being (see Appendix III for the script). The email then included a hyperlink that interested adults could follow to the Qualtrics online survey, which began with a display of the informed consent form for both the online survey and the text-based survey described below (see Appendix IV for informed consent). Interested older adults provided their mobile phone number to be used in the study. They were informed that, by providing their phone number and electronic signature, they were providing informed consent to participate in the study and may be contacted by the research team. Interested adults were assigned a numeric subject ID upon enrollment to the text-based survey and online survey data collection to ensure data were anonymous.

It is difficult to estimate the response rate to recruitment emails from staff partners to their program's older adults across the five AAAs. For example, AgeOptions noted that they have no participant email addresses on file and were unable to provide an estimate of the number of email address that their partners have, although noted that it is likely limited.

Text-Based Survey

A second primary data collection activity included a text-based survey. This informed research questions related to *program assessment methods* and was implemented to test the feasibility of a text-messaging based method to systematically and regularly acquire and share data on participants' service use, social isolation, loneliness, social support, social connectedness, and program satisfaction. NORC again designed the text-based survey in consultation with the advisory groups. NORC collaborated with a third-party vendor to program the survey using an online platform that automates text-based surveys to maximize efficiency, randomize the timing or window of survey administration to identify ideal times for survey response, and allow for complete security of personally identifiable information (PII), including phone numbers. Researchers piloted the text-based survey for usability and clarity.

Recruitment for the text-based survey was linked directly to the online survey and took place in July-August 2021 (AgeOptions) and in October-November 2021 (remaining AAAs): interested older adults provided their phone number on the Qualtrics platform, which was stored securely with our third party vendor and used to administer the text-based survey.

The text-based survey was designed to assess older adults' loneliness, program participation, program satisfaction, and social interactions (see Appendix V for the survey). Brief versions of the social measures to be collected were developed and tested to help shorten the overall burden on respondents. In consultation with the advisory groups, it was determined that the survey should be sent once a month for a period of 3 months to maximize participant response rates and minimize burden. To maximize response rates, the survey was programmed to send reminder messages to respondents who had not yet submitted respondents to all survey items. These reminder messages were sent 2 and 4 hours after the initial message was sent out. After 48 hours, respondents were sent a text informing them that the window to complete the survey has closed.

Qualitative Data Methods

The qualitative component of the project explored program users' and program staff members' perspectives on program *reach* and *impact* through interviews and focus groups. Three advisory groups and the steering committee provided input on participant recruitment, qualitative data collection methods and tools, and challenges encountered while collecting qualitative data. As part of the qualitative analysis process, these groups also participated in the Most Significant Change Technique, which involves selecting 'most significant' stories for all stories that were elicited during each interview.

Progress on the qualitative component of the study was impacted by recruitment challenges, as well as actions CJE took to overcome those challenges, summarized in Appendix I. In addition, the primary interviewer had to leave the project in March due to personal reasons and the Qualitative Principal Investigator (PI) (Berman) took over her role for the remainder of the data collection period, completing all remaining recruitment and interviews. There were no significant modifications to the original qualitative protocol for this evaluation study.

Older Adult Interviews

Two qualitative researchers conducted a total of 60 telephone interviews with program users, which were up to 45 minutes in length. The qualitative PI trained a research assistant in qualitative interviewing and systematic note-taking methods using assigned readings, coaching, and role-playing, along with review and discussion of interview notes as they were completed. The PI also conducted interviews.

Interview participants were recruited using a purposive sampling strategy. The qualitative PI developed a sampling framework and eligibility criteria, with input from the Steering Committee and Staff Advisory Group, to ensure the sample included diverse program users of different types of programs. The framework included rough target numbers for subgroups of participants by the type of program they use (e.g., one on one vs. group) and mode of delivery (e.g., online, in person, phone). It also tracked participants' demographic characteristics (age, race/ethnicity, gender, etc.). Participants were eligible for an interview if the participant used one or more programs funded as part of Illinois' Social Isolation Initiative and were able to participate in a 45-minute conversational interview in English (based on knowledge/judgement of provider staff). Initially CJE also had an eligibility criterion of age 60 or older, but because the AAAs serve caregivers as part of the social isolation initiative, two caregivers who were slightly younger than age 60 were included in the sample.

Each AAA designated a recruitment coordinator to interface with grantee/provider staff who contacted the older adult to ask permission for a researcher to call and explain the project. Staff involved in recruitment were provided with a recruitment script and referral form that included a list of the types of programs that were funded under the Illinois Social Isolation Initiative in their

AAA and eligibility criteria for participating in an interview. Once a program user assented to be contacted by a researcher, the grantee/provider staff person completed the referral form with contact information, a basic description of which social isolation program(s) the person used, how long he/she/they had used the program(s) and whether participants were using the Community Care Program for in home services. A sample Qualitative Recruitment Script and Referral Form for Older Adult Interviews (for AgeOptions) is included in Appendix VI. Recruitment coordinators emailed completed forms to a researcher on the qualitative team. The qualitative PI was in regular email communication with recruitment coordinators to provide suggestions for types of programs to recruit from next.

A qualitative researcher called each participant to secure verbal consent to participate in the interview, using the Qualitative Statement of Informed Consent for Older Adult Interviews, which describes the project, the purpose of the interview and the participant's role in the evaluation study (Appendix VII), after which an interview was scheduled and conducted. Before starting the interview, the interviewer verified participation in the program that was identified in the referral form and the person's age.

The interview guide began with open-ended questions about how the interviewee learned about the program or service and why they decided to use that program. It then elicited a story of 'most significant change' by asking "What has been the most significant change in the quality of your day-to-day life as a result of using [program]?" The Most Significant Change (MSC) Technique is a participatory method for monitoring and evaluation that is especially helpful for identifying unexpected changes, important values, rich descriptions of participant experiences, and differences in stakeholder perspectives (Davies & Dart, 2005). Elicitation of stories of change from interviewees aimed to increase the likelihood that this study contributes relevant knowledge from the perspective of those who use the aging services network. The interview guide (Appendix VIII) and the MSC story prompt were developed with input from the Steering committee and all three Advisory Groups. After the person's initial response to the MSC questions, the interviewer then prompted for additional details and examples regarding how the program(s) changed their social life or connections and what they found to be useful or socially satisfying.

The rest of the interview included open-ended questions about what the older adult did not like about the program, how his/her experience with the program changed (e.g., due to the pandemic), reasons for continuing or not continuing to use the program, what might have improved the program, any barriers to accessing or using programs, how he/she connects with the world (socially or in other ways), and interest in other social opportunities or programs (e.g., to address unmet social needs). At the end of the interview, the interviewer also asked open-ended questions to gather demographic information (e.g., type of community, type of housing, household size, age, race/ethnicity, and gender/identity). This open-ended question format was suggested by the Advisory Groups as being more comfortable for older adults in a phone interview setting, especially when asking questions about gender. Interviews were documented with detailed notes, which were expanded after the interview. Interviewees responses to open-ended demographic questions were grouped into categories. A researcher mailed or emailed the interviewee a copy of the Statement of Informed Consent that was verbally discussed. Illinois Aging Services provided older adult interviewees with a $25 gift card after completing the interview.

Staff Focus Groups

The qualitative PI from CJE facilitated three focus group discussions on Zoom with service provider and AAA staff in August, October, and November of 2021. The Steering Committee and the Staff Advisory Group Participant provided input on recruitment strategies, types of staff to recruit, informed consent procedures, and the focus group question guide.

Focus group participants were recruited via convenience and snowball sampling strategies. A researcher sent an email to the leadership of all five AAAs, as well as to staff who had been involved in recruiting older adults for interviews or who were members of the Staff Advisory Group. The email included the Statement of Informed Consent for Staff Focus Groups, which described the project, the purpose of the focus group and the participant's role in the evaluation study (Appendix IX). These individuals were then encouraged to share the focus group invitation with other staff. CJE asked that staff have at least three months of experience with some aspect of programs for reducing social isolation (e.g., design, delivery, outreach, assessment, etc.), speak English, and provide services in one of the AAAs included in the study. Staff registered for a focus group using an emailed or an online form (Appendix X). The form indicated that providing their contact information served as consent to participate in the focus group.

The focus group guide (Appendix XI) included questions about staff views of social isolation and the social needs of older adults, how they reach, identify, and assess older adults at risk of social isolation (i.e., social isolation or loneliness), the types of program strategies that can address social isolation, how delivering such programs changed during the pandemic, challenges to delivering such programs, and suggestions or advice for improving such programs in the future. Before starting the discussion, the facilitator confirmed that everyone had reviewed the Statement of Informed Consent for Staff Focus Groups, provided an opportunity to ask questions about the project or their role in the focus group, and then secured verbal assent to record the discussion on Zoom. At the close of the discussion, participants were asked to voluntarily email a written MSC story about impact of programs on program users and/or collect MSC stories from other staff. The MSC prompt and instructions for writing the story to maintain the program interviewees' confidentiality were emailed to focus group participants immediately after the focus group. However, CJE only received one story and did not include it in the qualitative findings. Focus group discussions were transcribed.

Qualitative Analysis

Interview notes and focus group transcripts were coded using QDA Miner Lite™ (QDA) a qualitative analysis software package that facilitates search, retrieval, and identification of themes by applying codes to segments of interviews. The QDA codebook feature allows the creation of overall categories which cannot be applied as codes within which codes are developed to capture subtopics or themes. The qualitative PI developed a codebook (i.e., codes and code definitions) using a combination of deductive and inductive approaches. Pre-determined categories were created that reflected the topics related to the questions in the interview guide and codes captured themes (topics, ideas, and patterns of meaning) that emerged across participants' responses to *any* of the open-ended questions. In other words, thematic codes could be applied to any response, regardless of which category they were organized under.

A draft list of thematic codes was developed after reviewing 25 interviews. The two qualitative researchers used an intercoder reliability procedure to improve the coding scheme (O'Connor & Joffe, 2020), which involved engaging in reflective dialogue about codes and how to apply them with the goal of maximizing consistency in the application of codes. To do this, they separately coded three interviews; these three interviewees used different types of programs and raised different themes. Consistency in the application of codes was determined by recording the presence or absence of a code within a response to an interview question or follow-up prompt question. The responses and applied codes were entered into a spreadsheet to facilitate comparison across the two coders. When both coders had applied a code within a response, this was recorded as agreement. Any discrepancies in the application of codes within a response were recorded as disagreement. After coding each interview, the coders discussed instances of disagreement and resolved discrepancies in coding by clarifying or expanding code definitions, merging or splitting codes and/or improving the clarity of code labels. A rough measure of

intercoder reliability was determined by dividing the total number of agreements by the sum of the total number of agreements and disagreements (Miles & Huberman 1994). After coding the first interview, intercoder reliability was 39% across all codes. After revising the code book and coding the second interview, intercoder reliability was 80%. After coding the third interview with a further revised codebook, intercoder reliability was 81%, which falls above the 80% level suggested by Miles & Huberman (1994). Codes were used for both the interviews and focus groups but a few additional codes and code definitions that were specific to the focus groups were developed as those focus group transcripts were coded.

When multiple passages in an interview repeated the same theme, the code was applied at least once for that interview but not all passages were coded (i.e., coding was not exhaustive). Each interview was also assigned variables (using QDA) based on responses to the open-ended demographic questions (see above, p.2). Analysis involved search and retrieval of all coded segments by codes and/or variables. Coded passages could be viewed in the context of the interview but also downloaded as an excel sheet to facilitate sorting by codes, code categories, or variables.

Based on the repetition of themes through the 60 interviews, the qualitative findings reflect a high degree of data saturation across the sample. For this study, saturation was defined as a process in which there was increasing degree of redundancy in themes, with few if any new themes emerging in later interviews (Saunders et. al. 2018).

Qualitative analysis was also informed by The Most Significant Change Technique (MSC), which directly engages stakeholders in the interpretation of qualitative data by asking groups of stakeholders to select stories that represent "the most significant changes" in a domain of interest and then discuss why they selected those stories. This process allows stakeholders to participate in generating themes or domains of change and select examples that best illustrate those themes. Each of the three advisory groups was asked to review 30 stories in two different meetings. Each story was assigned to a set of stories (as suggested by Lennie, 2011) based on similarities in issues that interviewees mentioned first and/or more often. Group members were asked to select one or two stories from each set that they felt reflect the most significant changes (depending on how many stories were in that set) and then explain their reasons for selecting particular stories. The advisory groups also discussed themes across all stories that they felt were important. The qualitative PI reviewed all reasons and themes mentioned by these groups and verified that the codebook captured those issues.

A total of 18 members of the three advisory groups were involved in one or two rounds of story selection: four older adults participated in the first round of story selections and three participated the second, eight staff participated in the first round and five participated in the second, five community members participated in the first round and three participated in the second. Stories that received the most or second most votes in each thematic grouping were included in a subset of 27 MSC stories that were then reviewed by the Steering Committee. The six committee members were instructed to select up to 10 stories that they felt were 'most significant of all' with regards to reducing social isolation. A total of eight stories are designated as "most significant of all," defined as being selected by 3 or more Steering Committee members (see Appendix XII). Each member selected between two and nine stories.

4. Results

Objective 1: Program Description

Results for Objective 1 are limited to the pilot agency (AgeOptions), as information from the remaining four AAAs was not available for this report.

1a. Programs Intended to be Implemented

Before the pandemic began, AgeOptions planned to make the following changes in response to the state-wide initiative:

1. **Reframe outreach for congregate meal sites**

   Given that many clients prefer to attend meal sites to connect with other people (rather than to just receive a nutritious meal), AgeOptions planned to work with their existing meal sites to primarily promote the sites as an opportunity for socialization and programming, instead of making the meal a main focus (but still offering the meals).

2. **Expand network capacity for dementia friendly communities**

   Dementia Friendly America defines a dementia friendly community as, "a village, town, city, or county that is informed, safe, and respectful of individuals with the disease, their families and caregivers, and provides supportive options that foster quality of life." AgeOptions planned to pilot their efforts in this area with Tinley Park, working with partners and communities already interested in the initiative to learn best practices and build upon their existing materials. AgeOptions also planned to use materials provided by Dementia Friendly America to ensure all sectors are represented, educated, and prepared to support people with dementia and their family/caretakers in the community.

3. **Encourage the concept of memory cafés**

   Building upon their dementia-friendly efforts, AgeOptions planned to encourage the concept of memory cafés to be established at their congregate meal sites. Memory cafés were intended to enhance current programming/activities and socialization efforts of congregate meal sites, encourage others to attend for a nutritious meal, and connect participants to other AgeOptions programs and services.

1b. Changes in Programming

Based on focus groups and interviews, we found that both staff and older adults described dramatic declines in social connections among older adults and made observations about changes in older adults' mental and physical health during the pandemic in general. However, older adult interviews revealed that not everyone experienced significant change in their social worlds. Indeed, people who had robust social connections prior to pandemic felt acute changes in their social worlds during the pandemic, but other older adults who were isolated before the pandemic and continued to use the same programs, such as friendly visiting, experienced little change in their social worlds. Likewise, older adults who had already had to cope with retirement, loss of a spouse, family or friends, changes in health, or reduced mobility talked about using those same coping skills to adjust to changes in social routines during the pandemic. The pandemic also shaped experiences with program reach, use and impact, which are described in the qualitative findings from staff focus groups and older adults interviews.

As an example of how programming changed, Table 1 below contains information about each program offered by AgeOptions that aims to address social isolation, including: a program description; any sub-population target(s); how the program responded to the challenges of the COVID-19 pandemic; and the nature of the mode(s) of delivery, social context(s), and frequency of programming during the pandemic. Similar changes occurred in the other AAAs. For instance, when recruiting older adults for interviews, several AAAs indicated that intergenerational programs, singing events, and events that require in-person community gatherings were not implemented during the pandemic. Qualitative findings from staff focus groups and older adult interviews provide other examples of changes such as conducting programs outdoors and providing isolated older adults with activity kits. Staff focus groups also reviewed and discussed a consolidated list of types of programs that were intended to address social isolation, derived from the area plans of the five AAAs (see qualitative findings).

Table 1. Characteristics of Programs Addressing Social Isolation During the Pandemic – AgeOptions

Social Isolation Program	Program Description	Sub-Population Target(s)	Response to Pandemic	Modes(s) Before Pandemic	Mode(s) During Pandemic	Social Context During Pandemic	Frequency During Pandemic
Mather Telephone Topics	Participants call a toll-free number or join online to access a wide range of discussions and programs for wellness, education, fitness, music, and live performances.	Isolated older adults	Partnered with Mather Lifeways Telephone Topics to provide presenters in both English and Spanish to provide social engagement programming. This program was discontinued in Spring 2022, with users being converted to the Uniper program as much as possible.	Phone	Video, phone	One-on-one, group	Daily on-demand
Friendly Phone Visits	Calls are made to older adults to check on their well-being and mitigate the effects of social isolation.	Isolated older adults	Increased the number of calls made to older adults.	Phone	Phone	One-on-one	On demand or as older adults prefer
Memory Cafés	Social gatherings at congregate meal sites for people with dementia and their caretakers that provide them with an opportunity to feel welcome and engaged in their own community.	Black, low-income older adults	Moved to a Zoom platform and deployed a technology specialist to trouble shoot Zoom challenges. Caregiver specialists had more one-on-one “check-ins” and counseling calls.	In-person	Video	One-on-one, group	Monthly
Thrive with Pride Cafés	Creates safe “gathering spaces” for LGBT+ adults. Partners with affirming churches and community organizations to delivery programming and create social opportunities for LGBT+ adults.	LGBTQ, low-income older adults	Moved to be entirely online, including website offering online follow-up. Added an additional four new partner sites throughout Suburban Cook County.	In-person	Video	Group, independent	Monthly

Social Isolation Program	Program Description	Sub-Population Target(s)	Response to Pandemic	Modes(s) Before Pandemic	Mode(s) During Pandemic	Social Context During Pandemic	Frequency During Pandemic
Congregate Meals	Older adults meet in groups to eat provided nutritious meals and socialize with others.	Food insecure, isolated older adults	Congregate dining sites closed temporarily. Home delivered meal efforts were increased (e.g., see new Top Box service below) and meals were offered "to-go" from the sites.	In-person	Pick-up	Group	Monday thru Friday
Home Delivered Meals	Offer nutritious meals and act as a daily security check. Provides comprehensive in-home assessment, nutrition education, and referral to other social and health-related services. Provide social contact to reduce loneliness.	Older adults who may be homebound, disabled, lonely or isolated, frail, recovering from acute illness/injury, unable to prepare meals or go to a grocery store, lack food preparation knowledge, low-income	Ensured that clients have a minimum of 3 days of shelf-stable meals. Offer ethnic meals (kosher, vegetarian meals for Hindi and Pakistani older adults) in some areas.	In-person	In-person	One-on-one	Daily
Top Box	Food box delivery program.	Those who are unable to shop or go to a food pantry or congregate meal, but have the ability and desire to cook	Top Box sent food boxes for creating 42 meals with simple preparation. Boxes are modified to meet different cultural/ethnic needs (e.g., Arab American, Korean, African American). This program was implemented in large measure as a result of temporary closure of congregate dining sites.	Non-existent	In-person	One-on-one	Weekly

Social Isolation Program	Program Description	Sub-Population Target(s)	Response to Pandemic	Modes(s) Before Pandemic	Mode(s) During Pandemic	Social Context During Pandemic	Frequency During Pandemic
Uniper System	An online service accessed through a TV, computer, smartphone, or tablet. Allows people to keep in touch with family, loved ones, and friends and to maintain physical activity.	Older adults living in low-income areas	Demonstrated the Uniper system to combat social isolation in low-income areas.	Video	Video	One-on-one, group, independent	Daily on-demand
National Family Caregiver Support Program	Caregiver Resource Centers throughout the service area supporting informal/unpaid caregivers with counseling, support, and training.	Informal/unpaid caregivers	Supported Caregiver Resource Centers as they moved their caregiver support groups and other programs for caregivers to web-based platforms. Partnered with WellMed to offer three training opportunities for caregiver specialists to make their in-person workshops go virtual. Caregiver Specialists are now using TCare, an assessment took designed to examine key stressors for caregivers, which has been proven to delay institutionalization of care recipients.	In-person	Video or phone	One-on-one, group	Daily on-demand
Caring Together Living Better (CTLB)	A collaboration of local non-profit organizations and faith communities to support family and informal caregivers of older adults.	Low-income Black and Latinx caregivers in grass-roots and faith-based communities	Loaned a library of hardware so that older adults could attend faith-based services remotely. Offered friendly phone visits, care packages, online support groups, economic assistance though covid-response funding	In-person	Video, phone	Group, individual	Weekly

Social Isolation Program	Program Description	Sub-Population Target(s)	Response to Pandemic	Modes(s) Before Pandemic	Mode(s) During Pandemic	Social Context During Pandemic	Frequency During Pandemic
Sing-Along Café Sessions	Provide sing-along sessions with others.	Caregivers and those with dementia	Partnered with Sounds Good Choir, NFP to provide 15 virtual sing-along café sessions.	In-person	Video, phone	Group	Weekly

Objective 2: Program Reach, Use, and Impact

2a. Program Reach

Summary of Staff Focus Group Discussions

Three focus group were attended by a total of 27 staff members representing five AAAs (eight from AgeOptions, seven from ECIAAA, seven from AgeGuide, four from AgeSmart and one from AgeLinc). Five participants were AAA staff and 22 were service provider staff (i.e., grantees of AAA's that provide services to older adults and/or caregivers). Participants included people who had experience working with racial and ethnic communities, the LGBTQ+ community, and caregivers. Focus group findings provide insight into staff perspectives regarding social isolation and social needs of older adults, reaching and assessing those at risk of social isolation, effective program strategies, and how to improve program reach and impact. Focus groups also discussed current data collection practices and the challenges, which are reported as results for Objective 3. Each theme included in this summary was raised by one or more participants of the three focus groups. Themes are indicated in bold font in each section below. Phrases in quotation marks and examples in boxes are direct quotes from staff. (It should be noted that focus group discussions happened in 2021, which may have affected the types of pandemic-related challenges they discussed.)

Staff conceptualization of social isolation and social needs

As a warmup activity, each focus group participant was asked what comes to mind first when they hear the term "social isolation." The responses from participants of all focus groups are summarized in the word cloud below; larger font size represents more frequently mentioned words or phrases.

When asked about the social needs of older adults, staff noted that older adults' needs can be different due to a variety of factors. Overall, staff discussed needs such as a sense of connection, companionship, brief social contacts as part of day-to-day routines, and acceptance and support. Staff observed that experiencing a pandemic heightened older adults' needs for face-to face interactions and revealed other needs.

Focus group attendees generally agreed that older adults have **diverse social needs that can be shaped by different factors** such as class, education, income levels, and personal backgrounds. One staff attendee noted that regardless of these differences "everyone can feel some loneliness, everyone can be isolated." One attendee noted that older adults may experience the "feelings" of social isolation or loneliness (the subjective experience) but may also experience different levels of social support (the objective experience). Staff cited a variety of other factors that can shape social needs and experiences with isolation including loss of people in their social world, loss of daily connections due to retirement, language or cultural differences, mental health (e.g., depression, anxiety, mental illness), dementia, disability, incontinence, and other health conditions that make it harder for older adults "to get out as much as they'd like to."

A prevalent theme was that older adults need a **sense of connection**, which many lost during the pandemic. Staff noted that older adults connect through both one-on-one conversations and/or groups. Just being able to talk with someone is a way to socially connect. One attendee observed that older adults are looking for *any* way to stay socially connected, even if it is just hanging out and having fun (such as at a dining site). Staff explained that older adults use social connections to be "part of their tribes," give them a "sense of purpose", create a "chosen family." Several staff agreed that having a "safe space" to interact with others and being "around people who accept them just as they are" was especially important for some subgroups (e.g., for the LGBTQ+ community). One person explained that older adults also connect with staff: "they can come in here, they feel welcomed, they see staff, but to them we are their friends, someone that they know, they can come in and kind of express themselves." Staff noted that in groups of people in similar situations, participants (e.g., caregivers) benefit from **mutual support** or no longer feel alone.

Lost Connections

As their friends die, they can't go out, and reengage and continue on with the ones that they have, because they feel like they need to stay home for health reasons, for safety. So I don't know how to put it, other than COVID has really played an effect in exasperating their social isolation.

Staff noted that for some, finding **companionship** is a priority, including older adults who are looking for a friend or a partner. However, staff also noted that inappropriate and unwelcome advances made by an older person to another person is sometimes a problem that staff feel they must manage.

Staff also explained that even **brief contacts** with people as a part of day-to-day routines can be very important for meeting basic social needs. Staff noted that for some older adults their primary or sole social contact is seeing people at the grocery store or talking to a driver or fellow riders from a transportation service. Staff observed that the people that older adults see in these daily settings can become their friends. They suggested that transportation that gives older adults freedom to choose when and where they go may be especially helpful for maintaining everyday routines that put them in contact with others. They also observed that home-delivered meals, telephone reassurance calls, and wellness checks also provide brief social contact, even if for a few minutes at day. These programs, along with friendly calls were seen by staff as important sources of social contact during the pandemic (see below). As one staff attendee noted, "communication is key" because "with social isolation there's so many moving parts." Staff also noted those who went to congregate dining sites were a "whole new group that suddenly were isolated" because they were cut off from their usual social routines. Staff noted that for some, their only connection to their usual social routines (prior to the pandemic) was a meal delivery or pick up. They also observed that older adults who benefited from social contacts while grocery shopping or taking transportation may have also suffered from more isolation.

One person noted that brief contacts with service providers (e.g., through telephone calls or in person) may also meet older adults' needs for **acceptance and support.** One person noted that providing support could be as simple as helping someone who is having problems with their phone. Another felt that such contacts provided a sense of validation explaining, "it's sort of in that same theme of feeling comfortable and knowing that people accept them." One person explained that some people do not participate in any social activity

Support from Staff or Volunteers

… so just, being able to come in and express that they have a problem, and for us to at least attempt to resolve their problem, but also knowing that you know, we may not be able to fix everything that's happening, but they know that they can at least come in and inquire and that we're not going to turn them away....

…having someone maybe to sometimes do a little research for them because they don't have that internet ability.

programs but "will come down and speak to social services" for help with phone or email issues, which at least provides "some type of human connection." Another person mentioned that friendly visitors or callers can play a similar supportive role. Staff also felt that brief and repeated contacts can also help older adults identify other social needs, even when an older person states that he/she is not lonely (also see reaching and assessing socially isolated individuals below).

Staff expressed strong feelings that older adults need **face-to-face interactions** with people, and during the pandemic, the lack of in person contact many older adults experienced that as a loss, "disconnect", or the "silence" of being alone. For instance, one person observed that if groups stopped meeting and older adults or caregivers lost those connections, some became "listless," felt isolated, or experienced anxiety and depression. Staff mentioned that some older adults did not realize what they were experiencing as a result of pandemic-related social isolation. Staff speculated that those who had attended support groups prior to the pandemic may have experienced deeper depression if they were not able to join those groups (e.g., online). Another person speculated that absence of face-to-face contact may have diminished the benefits of a particular group program. Staff had heard from both staff and volunteers that they also missed being in person.

Absence of Face-to-Face Contact

And this is a group that has really relied on one another over the years almost like a chosen family kind of a way. They help each other in getting to appointments, dealing with the day-to-day issues of life, and to not have that core group be able to come together and, and kind of problem solve and support each other has made it more difficult. We're trying to do things virtually connections, phone trees, all that but it's just not quite the same as being able to all come together and make that human connection.

Staff also felt that **other areas of need increased during the pandemic**. For instance, some older adults were reluctant to go to the doctor or allow people to come into their homes to provide services that would help them be more independent in their home. One person believed that the health of some previously well seniors likely declined due to staying home and being less mobile during the pandemic. In addition, some staff noted that older adults of color who experienced social trauma over their lifetime may have re-experienced that trauma during the protests of George Floyd's killing.

Reaching socially isolated individuals

The focus group discussions highlighted a variety of challenges to reaching older people and caregivers at risk of social isolation. Themes included how providers determine who is experiencing social isolation, reaching subgroups of older people who are at risk of social isolation, strategies that providers already use or could use to reach socially isolated older adults, and how those strategies changed during the pandemic (themes indicated in bold below).

Service providers shared that it is difficult to **identify who is experiencing social isolation** because only some individuals explicitly tell staff they are lonely or feeling isolated. Staff believed that older adults are more likely to tell friends or family how they are feeling, especially when they are "in crisis." For instance, they explained that friends, family, or another agency may report that an older adult or caregiver is isolated, frustrated, or depressed. Staff felt that during the pandemic older adults were even more unlikely to tell someone they were lonely because some people may not have recognized what was happening to them as a result of self-isolating. Staff also believed that even if older people do not report feeling isolated and turn down a friendly call or other program, they often identify some other need (e.g., needing in-home help) or welcome a service that provides social contact (e.g., enjoying the company of a grocery delivery person). Staff felt that service providers who have the skills to "delve a little

deeper" through probing conversations with older adults to discern what else is happening are able to encourage an older person to express their feelings about being lonely or sad. However, older adults need to be comfortable with their relationship with a staff person. Staff also felt that what they learn from these conversations sometimes contradicted older adults' responses to standards assessment tools. (See focus group findings under Objective 3 for a summary of staff experiences with formal assessment tools.)

Focus group discussions highlighted several circumstances that make it **difficult to reach older adults**, especially those who live alone or are homebound. It became even more difficult to assess social isolation for such individuals during the pandemic, since some service staff did not have any connections homebound individuals and the group of older adults who stayed home and socially distanced grew rapidly. On the other end of the spectrum, staff noted that people who see themselves as self-reliant and independent or do not want to be labelled as a senior, old, or lonely can also be difficult to reach. One staff person commented, "I have a lot of clients who are very independent and really want to continue that way despite their [being] lonely." One person noted that older adults from earlier generations, particularly men who may not be comfortable talking about feelings, may neglect their own social needs. Staff also noted that some people do not prefer socializing groups. Finally, staff mentioned subgroups of older adults that need social opportunities that fit their unique circumstances, such as those living with dementia, caregivers, and LBGTQ+ older adults.

Staff shared examples of a variety of effective **strategies that can be used to reach the socially isolated**, as well as older adults in general. Later in the focus group discussion, groups were also asked to suggest ideas for outreach strategies (see Brainstorming List of Outreach Strategies below in Exhibit 1). Some staff noted that the primary way older adults hear about their programs is through word of mouth from neighbors, family members, friends, pastors, and others in the community. One person explained that they reach many of their people through faith-based programming at churches. Another mentioned providing group events to increase awareness of programs for socializing and provide opportunities to ask about resources. One person commented on their success with reaching people by doing a story-time in a laundromat. Another noted that pharmacies have partnered with dementia-friendly community projects to include a resource list when picking up medications for people with dementia. One staff person explained that other service providers are an especially valuable "network" for reaching homebound seniors, "not only just hearing from the senior that they're lonely" but also "to hear from somebody else that yes, you know, this senior is super lonely." That person went on to explain that volunteers can also "coach" seniors to seek support if they are prepared to do so by staff.

Relying on Volunteers for Outreach

…teaching our volunteers resources in the area I think is really big, because each senior is lonely for a different reason. It might be chronic pain, it might be lack of transportation, family and friends so having those resources on hand for them to kind of empower the senior to make those changes is always a big help.

When focus groups were asked to share ideas for improving outreach, they confirmed the value of doing more of what already works but also suggested connecting with mental health organizations or mental health coalitions to reach those with mental health issues, human resource departments to reach people transitioning into retirement and employee assistance programs to reach caregivers. Two people talked about using older adults or existing clients to explain the types of programs offered, ether as liaisons or through an older adult phone tree. Staff also mentioned the importance of having a talented marketing director or innovative marketing team.

Exhibit 1. Outreach Strategies to Reach Socially Isolated Older Adults: Focus Group Brainstorming Ideas

Outreach strategies that staff have used
Promoting word of mouth through existing clients, family and community members
Phone calls (e.g., calling users of existing programs, cold calling clients who have been out of contact etc.)
Referrals from staff who are in the field (drivers, volunteers, meal deliverers, site managers)
Educating volunteers about resources
Mailings
Flyers
Notices in newspapers
Bookmarks sent out with every mailing that can be shared with others
Agency newsletter
Billboards
Websites and Facebook sites with informational videos, examples of services options for users to ask for information
Delivering programs or group events where older adults live
Open house events at the organization
Speaking engagements at churches, libraries, community organizations, etc.
Partnering with and sending information to libraries, home health agencies, hospitals, churches, other agencies, etc.
Relationships with community leaders and legislators
Coordinating with in home service providers
Advertising in senior buildings (e.g. flyers)
Regular communication with senior housing resident service coordinators
Providing information to doctors' offices (e.g., for referrals to a senior fitness center)
Disseminating information or having activities where people go or congregate (e.g., grocery stores, laundromats, restaurants, bus stops, etc.)
Advertising on placemats in restaurants
Placing flyers in utility bills
Providing resource lists with medications at pharmacies
Hosting or participating in clinics in the community
Disseminating information through senior citizen councils or senior resource centers
Having volunteers share information and resources
Ideas for outreach strategies
Sharing resources with mental health organizations and coalitions
Connecting with employers to reach retirees and caregivers
Using older adults to contact other older adults (e.g., phone trees)

Staff also cited examples of how their **outreach strategies changed during the pandemi**c. Making more phone calls was the most frequently mentioned change. More than one staff person commented that when programs' physical locations closed, agencies started making wellness checks (i.e., reassurance calls) or offering friendly calls or visits to those receiving meals or who had been senior center members. Another person commented that they when the realized older people may not be getting or reading their newsletter, they started "cold calling" people that they only see every couple of years when they would come in to apply for something and some of those people joined their programs. One person mentioned relying more on electronic copies of things that had been previously sent out in a print format and utilizing social media. Staff gave examples of calling people who used to come to programs in person to offer them home visits or

lunch excursions. Staff also called people who did not come back to congregate dining or centers to let them know they had re-opened or that group programs or outings had started again. Staff also tried other new ways to expand reach by offering services to more people. One staff person said that they started providing pamphlets to all residents of a senior building instead of just their clients. Similarly, another staff person said that their program had typically relied on older adults coming to them, but during the pandemic they decided to try going to where older adults lived. Another person described how they held discussion groups at senior residential buildings about "anything that's going on in the world" just to "get our foot in the door with a lot of people we may not have previously connected with." One staff member gave an example of offering individual virtual programs or referring the older adult to a friendly caller program.

Reaching Out Where Older Adults Are

There's a senior housing complex that we can get to and we're planning on bringing our services there, including our technology help…. And there is no, like, there is no community room at this place, so we're going to be setting up outside in their little courtyard, but um … weather permitting. But … also, there's a meal distribution site, so we're planning on going there also.

Focus group discussions also provided examples of how pandemic-related funding or activities gave them an opportunity to reach out to older adults to offer new technologies. For instance, one person noted that funding for tablets and technology support provided an opportunity to shift their approach from having to "find" socially isolated people and instead respond to and support people who wanted a device. The funding also gave staff a reason to call older adults to check in with them regarding their technology needs, providing another way of reaching out. Participating in vaccination events was another example of how outreach changed. For instance, one person said that hosting a clinic for vaccinations helped to recruit people into their program and another person noted they collaborated with a clinic to helped recruit seniors to get the vaccine. Another staff person provided vaccinations at bus stops.

Program strategies and impact

Focus groups reviewed a list of program strategies for reducing social isolation that was based on the content of the area plans for the five AAA's included in this study.[2] They were asked to comment on which strategies have the most impact with regards to enhancing social connections and add any effective strategies that they felt were missing. Their discussion touched on program strategies they used both before and during the pandemic including congregate meals, calls and visits, meal delivery, transportation, group programs, opportunities to interact virtually, entertainment or things to do for those who cannot get out, outdoor activities, support with technology, programs that address mental health, and volunteer opportunities. The benefits of these programs for older adults identified by staff included opportunities to socialize, one on one interactions, relationships between individuals, something to look forward to, connections with a group of people (especially during activities such as music, exercise, and dance), a sense of belonging or community, entertainment or something to do, and connecting to family. Focus groups also reiterated the importance of targeting specific subgroups or those who were at particular risk of social isolation. Staff also discussed the challenges of implementing various program strategies during the pandemic that were identified by staff and their ideas and hopes for future programming.

[2] The list that the staff focus groups reviewed included friendly visiting, check ins and reassurance calls; meals; transportation; creative activities; technology classes; providing technology; group discussions; lectures, presentations, films, etc.; health management education; exercise and fitness; life enrichment programs that offer a variety of options; interactive games; wellness or aging empowerment programs; caregiver education; and intergenerational activities.

Staff noted that congregate meals are an especially effective strategy because it gives older adults an **opportunity to** "**hang out" and socialize**. During the pandemic, when many of these individuals received home delivered meals instead, staff felt they were particularly vulnerable to becoming "disconnected," especially if they did not have internet access and/or computers. As noted previously (see discussion of reach above), providers reconnected older adults by increasing wellness or telephone reassurance calls, connecting people to friendly callers and referring people to online programs.

Others noted that volunteers involved in meal delivery and transportation provide valuable **one on one interactions**. In fact, one person speculated that the bonds people make with those who provide transportation, meals, or calls may be more effective at promoting social connection than some programs that specifically aim to reduce social isolation. As noted previously in the focus group findings, staff felt that friendly calls and visits can be particularly effective for fostering **relationships between individuals** and giving an older adult **something to look forward to**. Staff observed that by finding they have things in common or developing a relationship, the callers and the people being called both experience social benefits. One person mentioned how they used an activity box to give the older adult and caller something to talk about, assisting with the development of a relationship, but not all older adults enjoyed the activities. Again, staff felt that any phone contact, including brief calls from social services staff, volunteers, or other older adults was effective for maintaining social connections during the pandemic. One staff person said that texting and chatting features, which they recently started using, have been valuable for communicating with older adults who have hearing or speech impairments.

Staff said that during the pandemic some group programs stopped meeting altogether, other programs shifted to online formats, and new online classes and activities were offered. With regards to online activities, staff cited small group programs (discussions, book groups, conversations, etc.) as being a good strategy for fostering **social connections within a group of people.** Other staff observed that programs that include music that older adults are familiar with tend to bring in larger numbers of people. Others observed that group exercise programs (e.g., Whats Workout and Bingocize) and dance (e.g., parties and Zumba) can offer a combined connection of movement, socialization, and laughter. Staff believe that some people come to dance parties without a dance partner "looking for that connection." The value of singing together or being part of a choir was also mentioned as an effective strategy. Another example was an evidenced-based program that had an added intergenerational component, where high school students interviewed older adults with memory concerns and created a play list for them. Staff believe that evidenced-based music programs trigger memory, stimulate non-communicative people to engage with the music, and foster empathy from the students.

Staff observed that being able to meet virtually allowed program participants the option of maintaining connections. For instance, one person commented, "for some, I think that has been a good space to keep that connection and sense of belonging and interaction with their peers." Staff believed that intentionally building in opportunities to interact virtually could help foster a sense of community. Examples included allowing program users to log on early to chat or check on each other, creating opportunities for laughter and having discussions or conversations.

Staff felt that for older adults who were not getting out, online programs provided **entertainment or something to do** other than watching TV. Some of these new online programs attracted new users. For instance, one provider started an English conversation class, and another opened up an educational program for professionals to the general community and found that some older adults began attending. Another program that went virtual was expanded into eight counties, substantially increasing reach. One agency provided travel programs that allow older adults to engage with the world through virtual 'visits' to national parks and aquariums and a second agency created television shows that aired on two public television stations with episodes

on garden tours, a recorded jazz festival, and filming families sharing recipes from grandparents. Another agency had student volunteers deliver activity kits (craft supplies, musical instruments, or recipes) and then meet with older adults on zoom to do the activity together.

Providing online activities during the pandemic was not the only new strategy mentioned. Some staff mentioned providing outdoor activities during the pandemic. Examples included playing bingo in parking lots, providing the option of socially distanced friendly visits, or starting an outdoor garden bed project to promote gardening as a social activity.

Opportunities to offer technology support to older adults, such as providing devices through the CARES (Coronavirus Aid, Relief, and Economic Security) Act and classes to build their skills or overcome reluctance to using new technologies, not only enhanced reach (see above) but also offered new ways for older adults to connect to programs and other activities. One staff participant noted that libraries provide hotspots, tablets on loan, and large screens, along with showing older adults how to use the technology. Older adults could check out a "technology kit" and these kits were also loaned out to an assisted living facility. They also provided one on one support to help older adults learn how to use online technology. Another staff mentioned providing such technology in assisted living facilities and providing accessible features for those with hearing or speech impairments (e.g., texting, chatting, computer apps, etc.) as being helpful strategies that could facilitate older adults' use of online technology for a variety of purposes. Another organization provided older adults with Grandpads. One staff participant also noted that the pandemic had significantly increased demand for a smart speaker program they had started before the pandemic. Prior to the pandemic they were having difficulty finding people who were willing to use the device. One person felt that having access to such technologies gave people access to more things to do during the pandemic and another person believed that fostering the use of technology may help older adults **connect to family** during the pandemic. However, staff were not certain how the technology was actually being used by older adults or if it helped them stay socially connected.

Staff felt that strategies that address mental health needed to be added to the list of program strategies that can foster social connections. Examples included grief support, support for mental illness or depression that may be triggered by the pandemic, and other support groups. For example, one staff person noted that it was important to be attentive to potential stressors, such as actively reaching out to those who may be experiencing or re-living trauma related to racial violence.

Being Attentive to Mental Health

I was very intentional about calling, personally calling these individuals and saying, I'm calling you because of the situation that's going on across the country and finding out if you need to talk about these, if they're triggering childhood experiences for you.

The potential benefits of being a volunteer were only briefly discussed by staff. Their examples of opportunities for older adults to volunteer were usually described as a part of other program strategies (visits, calls, transportation, meal delivery, etc.). Additional examples included older people who volunteered to help others with technology or delivered at home activity kits.

In their review of the list of program strategies, focus groups felt that programs targeting specific groups deserved special mention. Several staff commented on the positive impact of programs that provide **connections for caregivers and persons with dementia** through support groups, dementia education, stress management programs, and Memory Café. Staff believed that such programs offer opportunities to socialize or learn new social skills. Staff also observed that programs for caregivers that shifted to an online format are sometimes better attended, since there is no need to find respite care or programs are offered at more flexible times for them. One

person also noted that by going online they were able to offer a program to more people by expanding availability to eight counties. Others mentioned a need for programs for ethnic communities in their language that also accommodate **cultural differences** (e.g., Latinx, limited English speaking) and programs that create **a safe space for LBGTQ+** participants, mentioned faith-based programs, and accommodating the social needs of persons with disabilities or limited mobility.

Focus groups also raised a variety of challenges to implementing some of the program strategies they used during the pandemic. With the sudden shift to online formats, staff encountered **technology barriers** and improving the technology skills of volunteers or staff had to be quickly accomplished. They gave examples of barriers for older adults, such as not having a smart phone (or any phone), laptops or other needed technology, not having high speed internet, and discomfort with devices or the internet. They described technology adoption as a "slow process," even when older adults are provided with devices (e.g., through the CARES Act). Many older adults declined such offers of devices. Among those who accepted a tablet, some "gave up" when broadband access was found to be a challenge (i.e., due to regional variations in high-speed access). Staff commented that making broadband cheaper was not enough to increase older adults' use of online technologies. Staff also learned that even their own internet capacity could be a barrier when they discovered that they could not have too many people being trained online at the same time.

Focus group participants also speculated about potential **changes in participation** for both online and in-person programs due pandemic experiences. They cited difficulties related to planning for the restart of in-person programs and having to shift back and forth between in-person and virtual and then sometimes going hybrid (see below). Some staff wondered whether all of those who became used to connecting virtually would come back to in-person programs or centers, especially if they have lingering fears of COVID-19. However, other staff noted that other participants were not using any virtual programs and may not come back to any programs until they are offered in-person. One person mentioned that older adults who were using an online application for activities during the pandemic started transitioning back to local offerings because they "prefer a local spin" and "that sense of community."

Having to adjust to a **decline in resources** during the pandemic was mentioned by some providers. Examples included not having enough volunteers or lower donation levels that impacted their operational budget. To compensate for lack of resources, one agency had their receptionist make calls that volunteers would have normally made. To maintain individualized transportation during the pandemic when they were short of volunteers, one organization partnered with a limo company so they could still provide transportation.

When asked **what programs might look like in the future**, staff noted that virtual programs may be more prevalent. They observed that older adults are more likely to use online activities that both seem "familiar" and promote engagement. Staff also discussed whether a "hybrid" of online and in-person programs would be more acceptable in the future, particularly as currently employed people who already use technology retire. Some staff observed that it may be easier to use such hybrid approaches with programs that do not have many restrictions (e.g., hobby-related activities) as opposed to evidenced-based programs. One example was book clubs that have successfully gone hybrid during the pandemic. Staff noted that an advantage of providing some programs virtually is that participants can use them even when temporarily residing in another state. However, focus group participants questioned whether their organizations have adequate technology to use a hybrid approach. Some staff suggested looking to other organizations who have successfully used a hybrid approach, such as churches and educational institutions. Staff felt the biggest challenges to moving most programs into a hybrid mode were having enough funding to set up the technology infrastructure to ensure that the online mode is "effective and

seamless," and the inequities in access to technology or broadband for program users and the organizations offering programs. Expanding internet accessibility across the state will be critical.

Staff also had **new ideas for programming**, some of which were inspired by things they tried during the pandemic. For instance, one staff person wanted to expand their parking lot so they could continue having outdoor activities and another mentioned creating age-friendly parks that would foster intergenerational connections, as other countries have done. Others commented on the having more creative ways to eat meals together, especially for homebound individuals. One person was familiar with a program that had students call older adults and eat together at lunch time. Another person suggested small groups or "pods of lunch bunches" so that people could eat together in smaller groups or even bring their own lunch. Another person described a one-on-one activity that involves cooking with an older adult as a great experience that could be scaled up to a group level, but it would require some work to do that. Other ideas included pet walking services for older adults or pet visiting programs in senior buildings. One person felt it will be especially important to have more social workers and community health workers as a way to address wellness in a more holistic way. Finally, one person suggested creating a think tank to generate new strategies for socially connecting older adults. Overall, focus groups recognized that service providers need to be creative and resilient when designing programs that both promote and nurture social connections.

2b. Program Use

Characteristics of Older Adults in the AAA Constituencies Versus their Program Recipients

To assess program use, we first analyzed Census and ACS data to produce estimates of the size of the target population. We next used these data in conjunction with any available programmatic data to describe the characteristics of older adults served by each AAA (and/or their provider partners) to identify potential subpopulations that may not be sufficiently reached. The AAAs and their provider partners do not collect data for some of the Census and ACS characteristics (e.g., marital and disability status); nevertheless, we include this information to assist with characterizing each AAA's broader geographic population. Furthermore, because the Census and ACS data do not map directly onto AAA and provider partner programmatic data in some instances (e.g., age categories), we present the available data and make comparisons to the extent possible.

Descriptive statistics of older adults in each of the five AAA geographic areas are presented in Table 2. While the five AAA locations varied substantially with regard to their distribution of several demographic characteristics (e.g., racial and ethnic groups, spoken languages, proportion living alone), several other characteristics were quite similar across locations. For instance, among those age 65 and older, constituents are most often female (55-58%), from the youngest older adult age group (65-74), and married (52-58%).

AgeOptions

Table 3 displays demographic characteristics of older adults served by AgeOptions' library partner providers before and during the pandemic. Compared to the demographics of their geographic area, AgeOptions library program participants from January to March 2020 appear to have less representation from the following the groups than expected: Hispanic individuals (21.48% vs. 5.92%), Asian/Pacific Islander individuals (8.00% vs. 4.57%), male older adults (42.46 vs. 16.45%), and those age 65-74 (the largest age group of those age 65+ in the geographic area, but the second-most represented age group among the library program participants (83.56% were age 75-84).

These trends were similar when comparing the demographics of the geographic area to AgeOptions library program participants from the most recent data point of April to June 2021. The latter group appears to have less representation from the following the groups than expected: Hispanic individuals (21.48% vs. 9.37%), Asian/Pacific Islander individuals (8.00% vs. 3.05%), and male older adults (42.46 vs. 12.48%). Data in Figure 1 from Uniper participants also suggest an underrepresentation of male older adults in programming throughout the pandemic.

AgeGuide

Table 4 displays demographic characteristics of older adults served by AgeGuide in 2020 and 2021. Compared to the demographics of their geographic area, AgeGuide program participants from 2020 and 2021 appear to have less representation of Hispanic older adults (17.16% vs. 6.14% and 6.15% in 2020 and 2021, respectively) and male older adults (44.79% vs. 27.21% and 24.55%) than expected. However, AgeGuide program participants have greater representation than expected based on their geographic area for Black older adults (11.52% and 12.84% vs. 6.54%) and Asian older adults (12.61% and 10.13% vs. 4.58%).

AgeLinc

Table 5 displays demographic characteristics of older adults served numerous AgeLinc partner providers before and during the pandemic. Compared to the demographics of their geographic area, AgeLinc program participants from before and during the pandemic appear to have less representation from the following the groups than expected: Hispanic older adults (3.19% vs. <1% in 2018-19 and 2020-21, respectively) and male older adults (44.28% vs. 41.91% and 39.36%). However, AgeGuide program participants in 2018-19 and 2020-21 show greater representation than expected based on their geographic area for Black older adults (10.46% and 13.56% vs. 3.31%) and older adults with an income below the poverty level (91.46% and 89.38% vs. 6.70%).

AgeSmart

Table 6 displays demographic characteristics of older adults served by the CRIS Healthy-Aging Program in 2021. These data suggest that compared to the broader population in the geographic area, this program is reaching a greater proportion Black older adults (8.64% vs. 40.90%) and older adults with income below the poverty level (7.29% vs. 66.67%) than expected. However, representation of male older adults is lower among program participants than found in the broader constituency (23.90% vs. 44.41%).

ECIAAA

Demographic program data were not available from ECIAAA for comparisons.

Table 2. Demographic Characteristics of Constituents of the AAA Locations (American Community Survey 2015-2019)

	Estimates Among Constituents of each AAA Location				
	AgeOptions	**AgeGuide**	**AgeLinc**	**AgeSmart**	**ECIAAA**
Population Sizes					
Size of whole population (all ages)	2,488,741	3,446,295	445,827	661,858	826,359
Size of population age 65+	404,305	473,357	82,029	108,390	132,685
Race/Ethnicity (of the whole population)					
% Hispanic	21.48%	17.16%	3.19%	2.87%	3.33%
% White only	52.10%	69.76%	91.27%	86.16%	89.42%
% Black only	16.41%	6.54%	3.31%	8.64%	4.02%
% American Indian/Alaska Native only	0.10%	0.09%	0.20%	0.20%	0.16%
% Asian/Pacific Islander only	8.00%	4.58%	0.56%	0.81%	1.50%
% Other race identity/identities	1.93%	1.87%	1.46%	1.33%	1.55%
Gender (of those 65+)					
% Male	42.46%	44.79%	44.28%	44.41%	44.26%
% Female	57.57%	55.21%	55.72%	55.59%	55.74%
Age Composition (of the whole population)					
% 65-74	9.12%	8.12%	10.46%	9.63%	10.14%
% 75-84	4.84%	3.81%	6.01%	5.50%	5.64%
% 85+	2.28%	1.63%	2.71%	2.39%	2.70%
Living Arrangements (of the whole population)					
% Households with someone 65+ living alone	16.58%	9.44%	14.34%	12.72%	13.44%

	AgeOptions	AgeGuide	AgeLinc	AgeSmart	ECIAAA
Socioeconomic/Poverty Status (of those 65+) [a]					
% With income below poverty level	8.00%	6.73%	6.70%	7.29%	7.33%
% With less than a high school diploma	14.19%	12.03%	12.14%	13.95%	12.54%
Language (of those 5+) [a]					
% Speak a language other than English	34.47%	19.72%	3.69%	3.89%	5.64%
Marital Status (of those 65+) [a]					
% Never married	7.70%	4.72%	4.02%	4.76%	3.48%
% Now married, except separate	51.99%	57.76%	54.58%	55.58%	54.87%
% Separated	1.19%	0.92%	0.44%	0.75%	0.63%
% Widowed	26.10%	22.99%	26.37%	25.15%	26.21%
% Divorced	13.02%	11.38%	12.19%	12.28%	12.28%
Disability Status (of those 65+) [a]					
% With a disability	30.80%	30.02%	35.33%	35.48%	35.61%
% With a hearing difficulty	11.12%	11.75%	15.06%	16.75%	16.27%
% With a vision difficulty	5.18%	4.94%	5.94%	6.80%	5.07%
% With a cognitive difficulty	7.20%	6.77%	7.27%	7.91%	6.69%
% With an ambulatory difficult	20.26%	18.76%	22.25%	21.73%	21.40%
% With a self-care difficulty	7.81%	7.16%	7.53%	6.76%	6.25%
% With an independent living difficulty	14.48%	13.52%	13.32%	13.16%	12.35%

Note: Census estimates were derived from the American Community Survey at the County and Place level. Many of these variables have a fairly large margin of error, and should be interpreted with that variance in mind. [a] indicates variable for which we have no AgeOptions data to compare. We include them here to provide context.

Characteristics of Program Participants Over Time

Library program participants (AgeOptions).
Table 3 presents characteristics of library program participants over time. Compared to the first three months of 2020, participation in library programming increased during the pandemic for older adults who were Hispanic, White, female, and of a younger age group (i.e., under age 60 or age 60-74). In contrast, participation decreased from before to during the pandemic for older adults who were non-Hispanic, Black, male, age 75-84, and living alone.

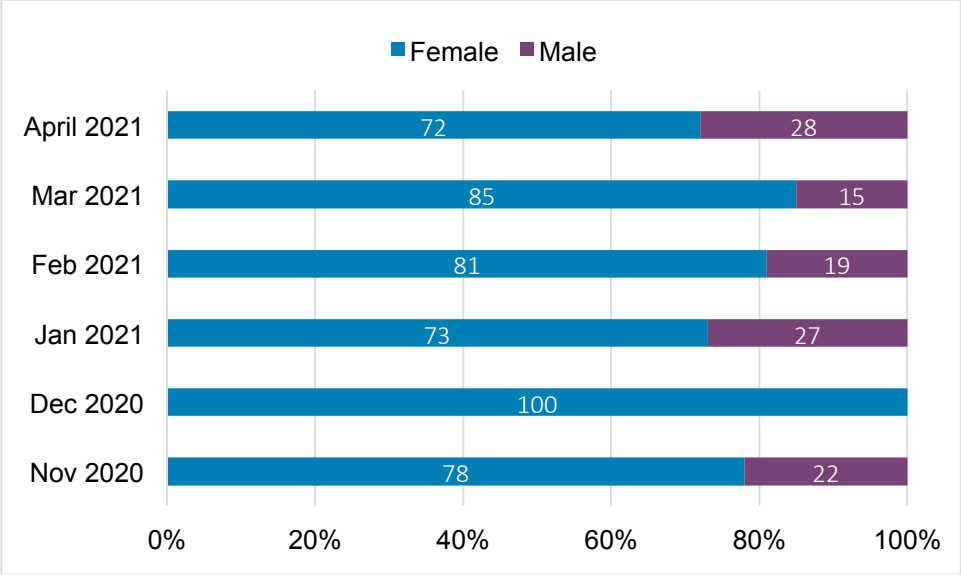
Table 3. Demographic Characteristics of Library Program Participants Before and During the Pandemic - AgeOptions

Demographic Characteristic	Pre (to Early)-Pandemic: Jan – March 2020[a]	During Pandemic: Oct – Dec 2020 (N=187)	During Pandemic: Jan - March 2021 (N=304)	During Pandemic: April – June 2021 (N=594)
Ethnicity				
Hispanic	5.92%	8.38%	33.21%	9.37%
Not Hispanic	94.08%	91.62	66.79%	90.63%
Race				
White only	69.04%	92.53%	88.21%	89.96%
Black only	22.34%	2.87%	3.93%	5.38%
American Indian/Alaska Native only	0.00%	0.00%	0.00%	0.00%
Asian/Pacific Islander only	4.57%	2.30%	5.00%	3.05%
Other race identity or two or more race identities	1.02%	2.30%	2.86%	1.61%
Gender				
Male	16.45%	13.74%	11.30%	12.48%
Female	83.55%	86.26%	88.70%	87.52%
Age Composition				
Under 60	1.39%	19.67%	18.00%	17.06%
60-74	13.30%	55.19%	57.67%	58.87%
75-84	83.56%	22.95%	23.00%	21.84%
Above 85	1.75%	2.19%	1.33%	2.22%
Living Arrangements				
Live alone	56.71%	39.87%	44.31%	48.22%
% Live with someone who provides care	13.41%	34.18%	6.67%	7.51%
% Live with someone who does not provide care	29.88%	25.95%	49.02%	40.71%

Note: [a] Sample sizes for characteristics collected pre-Pandemic (Jan-March 2020) vary by characteristic: ethnicity N=181; race N=200; gender N=232; age composition N=1085; living arrangements N=222.

Uniper participants (AgeOptions).
Figure 1 below displays the gender of Uniper survey participants at various time points during the pandemic. The gender distribution remained relatively stable with a few exceptions: 100% of participants were female in December 2020, and women's participation also reached a high point in March 2021 (85%).

Figure 1. Gender of Uniper Participants During the Pandemic (N=115) - AgeOptions



Social isolation programming.

AgeGuide. Table 4 below presents demographic characteristics of older adults receiving social isolation programming, collected by AgeGuide in 2020 and 2021. The ethnic distribution remains near identical across these two time points, with a large majority reporting as being non-Hispanic (94%). This is similar for race as well, with a majority reporting at White (approximately three-fourths in both time points. The gender distribution also remains relatively stable, with approximately three-fourths identifying as female. Notable differences emerge for age composition, although it is unclear if data on individuals under 60 years old was collected pre-pandemic. Nevertheless, more than 40% of AgeGuide's Social Isolation program participants during the pandemic were younger 60 years old between January – November 2021, whereas less than 1% were above 85 years. This is in stark contrast to early pandemic months, when 21% were older than 85. Regarding living arrangements, participants living alone with an identified caregiver increase from early (1.8%) to during the pandemic (8.2%).

Table 4. Demographic Characteristics of Social Isolation Program Participants Before and During the Pandemic – AgeGuide

	Pre (to Early)-Pandemic: Jan – Oct 2020		During Pandemic: Jan – Nov 2021	
Demographic Characteristic	**Percent**	**N**	**Percent**	**N**
Ethnicity		553		717
Hispanic	6.15%		6.14%	
Not Hispanic	93.85%		93.86%	
Race		547		701
White	75.50%		76.89%	
Black	11.52%		12.84%	
Asian	12.61%		10.13%	
American Indian/Alaska Native	0.37%		0.14%	
Gender		555		721
Male	27.21%		24.55%	
Female	72.79%		75.45%	
Age Composition		555		721
Under 60	0.00%		42.44%	
60-74	49.55%		33.98%	
75-84	29.91%		22.61%	
Above 85	20.54%		0.97%	
Living Arrangements		228		681
Live alone	19.74%		21.59%	
Live alone, have identified caregiver	1.75%		8.22%	
Live alone, no identified caregiver	78.51%		70.19%	

AgeLinc. Table 5 below presents demographic characteristics of older adults collected by AgeLinc from 2018-2019 and 2020-2021. Similar to AgeGuide, the race and ethnic composition of program participants remained relatively stable across these two time points, with the majority reporting as White (between 85-89%). Similar patterns exist for gender (roughly 59% female), age composition (approximately half are between ages 60-74 years), living arrangements (slightly more than half living alone), and poverty status (approximately 90% have income below poverty level).

Table 5. Demographic Characteristics of Program Participants Before and During the Pandemic – AgeLinc

	Pre-Pandemic: 2018-2019		During Pandemic: 2020-2021	
Demographic Characteristic	**Percent**	**N**	**Percent**	**N**
Race and Ethnicity		8,227		7,553
White	89.13%		85.12%	
Black	10.46%		13.56%	
Hispanic	0.13%		0.24%	
Other race	0.28%		1.09%	
Gender		8,006		7,551
Male	41.91%		39.36%	
Female	58.09%		60.64%	
Age Composition[a]		1,741		1,872
Under 60	2.07%		2.40%	
60-74	50.83%		55.61%	
75-84	29.35%		28.04%	
Above 85	17.75%		13.94%	
Living Arrangements[b]		7,095		6,568
Live alone	55.93%		59.39%	
Live with others	44.07%		40.61%	
Socioeconomic/Poverty Status[c]		562		885
Income below poverty level	91.46%		89.38%	

Note: Percentages shown above represent averages across several programs affiliated with AgeLinc: Care Coordination Unit, Daily Bread, Elder Assistance Services, and Senior Transport. Sample sizes for each of these four programs at the time that data were collected before and during the pandemic are: *N* = 6,570 and *N* = 5,683; *N* = 1,179 and *N* = 987; *N* = 478 and *N* = 743; and *N* = 84 and *N* = 142, respectively. Data were collected from July 1, 2018 through June 30, 2019 (pre-pandemic) and from July 1, 2020 through June 30, 2021 (during pandemic) for the Elder Assistance Services program; data from the remaining programs were collected from October 1, 2018 through September 30, 2019 (pre-pandemic) and from October 1, 2020 through September 30, 2021 (during pandemic).

[a] Age composition estimates do not include data from Care Coordination Unit, because this program only collected information on the percent of older adults age 75+ (61.45% pre-pandemic and 53.81% during the pandemic).

[b] Living arrangement estimates do not include data from Care Coordination Unit and Daily Bread; these programs did collect complete data at one or both time points.

[c] Socioeconomic/poverty status estimates do not include data from Care Coordination Unit and Daily Bread; these programs did not collect this type of data at one or both time points.

AgeSmart. Table 6 presents demographic characteristics of older adults participating in programming with the CRIS Healthy-Aging Center—a provider partner of AgeSmart. Slightly more than half of participants identified as White, followed by 41% as Black), three-fourths identified as female (76%), two-thirds were between 60-74 years old (62%), 57% lived alone, and two-thirds reported having income below the poverty level.

Table 6. Demographic Characteristics of CRIS Healthy-Aging Program Participants (N=161) During the Pandemic – AgeSmart

	During Pandemic: 2021	
Demographic Characteristic	Percent	N
Race and Ethnicity		161
White	55.90%	
Black	40.99%	
Hispanic	1.24%	
Other race	1.86%	
Gender		159
Male	23.90%	
Female	76.10%	
Age Composition		159
Under 60	0.00%	
60-74	62.26%	
75-84	26.42%	
Above 85	11.32%	
Living Arrangements		159
Live alone	57.23%	
Live with others	42.77%	
Socioeconomic/Poverty Status		159
Income below poverty level	66.67%	

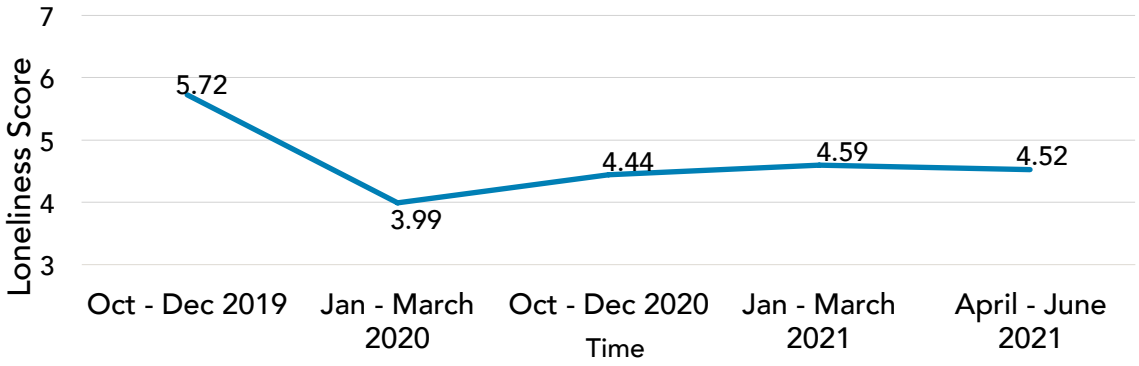
2c. Program Impact

Loneliness Findings from Programmatic Data

UCLA Loneliness Scale scores among library program recipients before and during the pandemic

AgeOptions Library Program: As shown in Figure 2, among library program participants, UCLA Loneliness Scale scores initially dropped from the end of 2019 to January to March 2020. Loneliness scores increased from early 2020 to October through December of 2020 and appeared to remain relatively stable from this time through the first half of 2021. Loneliness scores from April to June 2021 were lower than they had been before the pandemic started. Sample sizes for the five fiscal quarters (data points) shown from left to right are: $N = 79$, $N = 266$, $N = 180$, $N = 268$, and $N = 577$.[3]

Figure 2. UCLA Loneliness Scale Scores: Library Program - AgeOptions



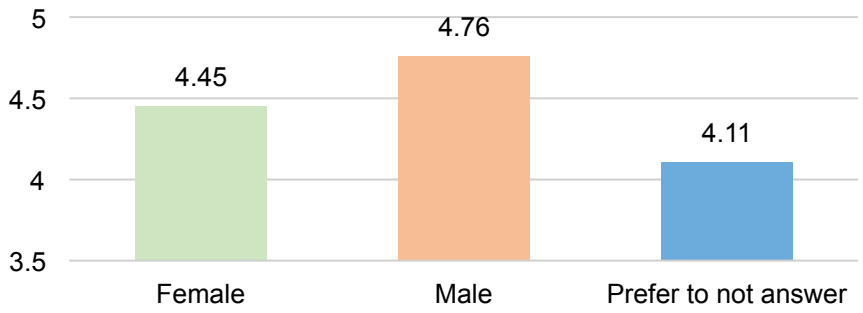
Note: 3-Item UCLA Loneliness Scale scores may range from 3-9.

Figures 3-5 below display UCLA Loneliness Scale scores collected among library program participants ($N = 592$ from 20 libraries) during the pandemic from September 2020 through July 2021. Loneliness scores are presented as a function of gender, race/ethnicity, and age group.

[3] Estimates of loneliness scores are less reliable in the first quarter due to the small sample size, and should therefore be interpreted cautiously (i.e., data from a larger sample may have revealed a significantly lower or higher average loneliness score).

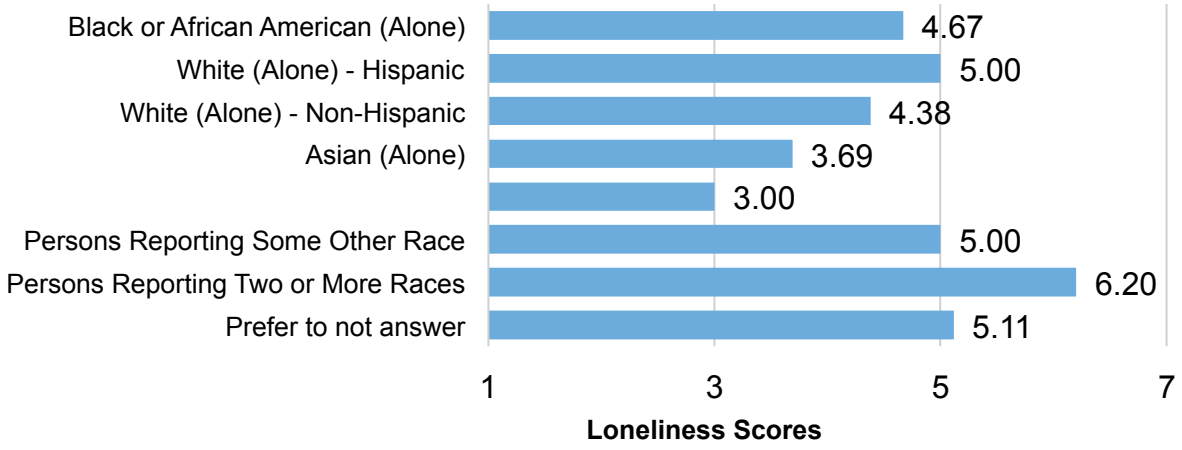
As shown in Figure 3, for library participants, loneliness scores during the pandemic were higher among men than women, and lowest among those who preferred not to answer the question about gender.

Figure 3. UCLA Loneliness Scale Scores During the Pandemic by Gender Among Library Program Participants (N=592) - AgeOptions



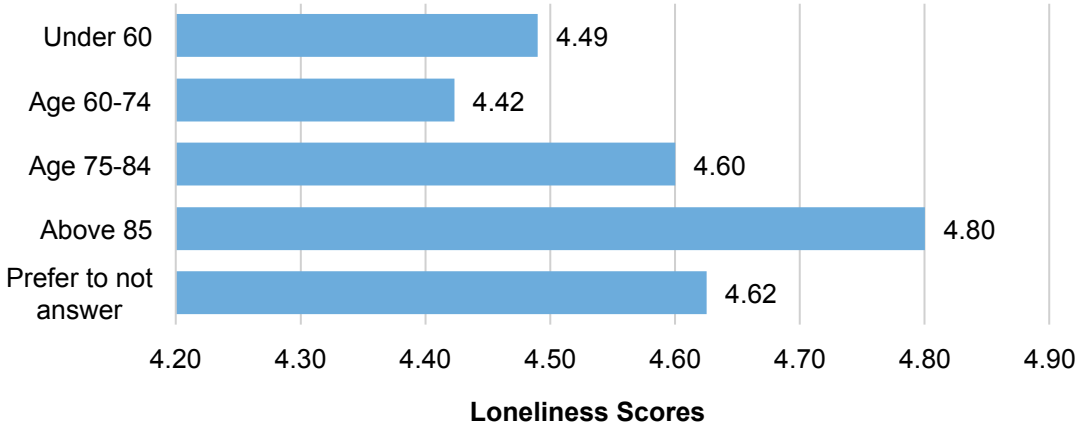
As shown in Figure 4, loneliness scores were the highest among older adults who reported two or more races ($N = 11$), followed by those who preferred not to answer the question about race ($N = 38$) and those who identified as Hispanic Whites ($N = 28$) or as some other race ($N = 2$). Groups with lower loneliness scores included older adults who identified as Black or African American ($N = 25$), non-Hispanic White ($N = 471$), Asian ($N = 16$), or Native Hawaiian or Other Pacific Islander ($N = 1$).

Figure 4. UCLA Loneliness Scale Scores During the Pandemic by Race/Ethnicity Among Library Program Participants (N=592) - AgeOptions



As shown in Figure 5, loneliness scores were highest among those above age 85 ($N = 10$), followed by those who preferred not to answer this question ($N = 9$), and those age 75-84 ($N = 128$), under 60 ($N = 103$), and 60-74 ($N = 342$).

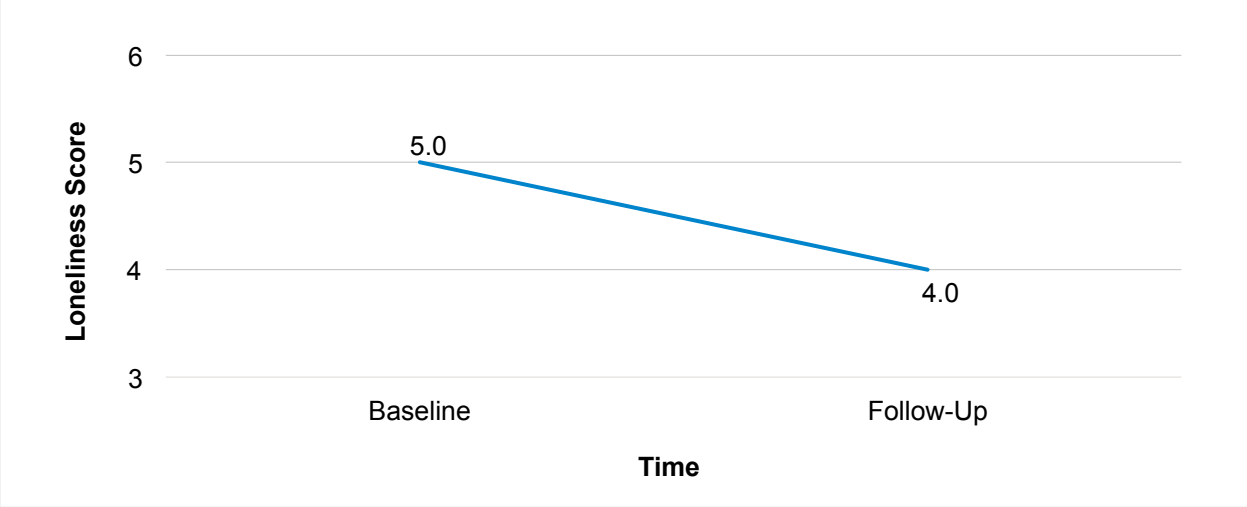
Figure 5. UCLA Loneliness Scale Scores During the Pandemic by Age Group Among Library Program Participants (N=592) - AgeOptions



UCLA Loneliness Scale Scores Over the Course of the Pandemic Among Uniper Program Participants

AgeOptions Uniper Program. Figure 6 below presents UCLA Loneliness Scale scores collected via Uniper from the same group of older adults at baseline and a follow-up assessment ($N = 77$). The dates of baseline assessments ranged from November 2020 through July 2021, and the dates of follow-up assessments ranged from June through September 2021. As shown in Figure 6, on average, those receiving Uniper programming who participated in this pre-post survey showed a decrease in loneliness scores from baseline to follow-up.

Figure 6. UCLA Loneliness Scale Scores: Uniper (N=77)



UCLA Loneliness Scale Scores During the Pandemic Among Memory Café Program Participants

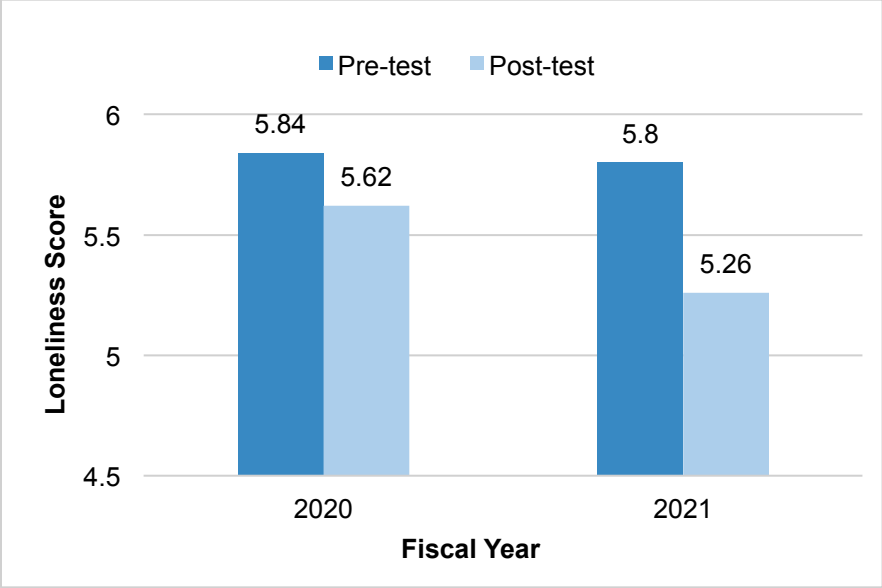
AgeOptions Memory Café Program. UCLA Loneliness Scale scores among Memory Café participants increased from 5.72 at pre-test to 6.69 at post-test.

UCLA Loneliness Scale Scores Over the Course of the Pandemic Across Program Recipients.

AgeGuide. Figure 7 below presents UCLA Loneliness Scale scores collected among older adults by AgeGuide in fiscal year 2020 (from October 1, 2019 through September 30, 2020) and fiscal year 2021 (from October 1, 2020 through September 30, 2021). Scores were collected in each fiscal year at two time points: a pre-test assessment ($N = 422$ in FY 2020; $N = 352$ in FY 2021) and a post-test assessment ($N = 297$ in FY 2020; $N = 344$ in FY 2021).

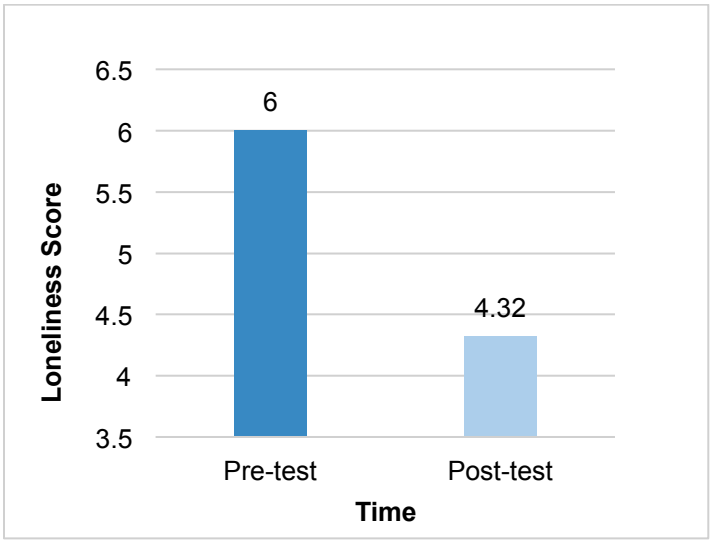
As shown in Figure 7, on average, loneliness scores at pre-test for fiscal years 2020 and 2021 were similar, with values of 5.84 and 5.80, respectively. In both fiscal years, loneliness scores showed a decrease from pre-test to post-test; however, a greater reduction in loneliness scores over time was observed in fiscal year 2021.

Figure 7. UCLA Loneliness Scale Scores in Fiscal Years 2020 and 2021: AgeGuide



AgeSmart. Figure 8 below presents UCLA Loneliness Scale scores collected among older adults (N = 159) by AgeSmart in 2021 during the pandemic. Scores were collected at two time points: a pre-test assessment and a post-test assessment.

Figure 8. UCLA Loneliness Scale Scores in 2021: AgeSmart (N=159)



Findings from the Online Survey

Demographic characteristics of survey participants

A total of 102 individuals clicked on the link to the baseline online survey from July 2, 2021 through February 9, 2022. Of these individuals, 51 (50%) answered at least one survey item and 30 completed the entire baseline survey. Demographic characteristics of baseline survey respondents (including the number of respondents with data for each characteristic) are presented in Table 7 below.

Only 11 of the baseline survey participants also participated in the 3-4 month online follow-up survey from October 28, 2021 through February 24, 2022. Nine of these participants completed the entire follow-up survey. Of follow-up survey participants, all were White (n = 8) or Black (n = 1) and most were women (n = 8). None of the follow-up respondents reported being divorced, never married, or having a non-coresident partner.

Table 7. Demographic Characteristics of Participants in the Baseline Surveys

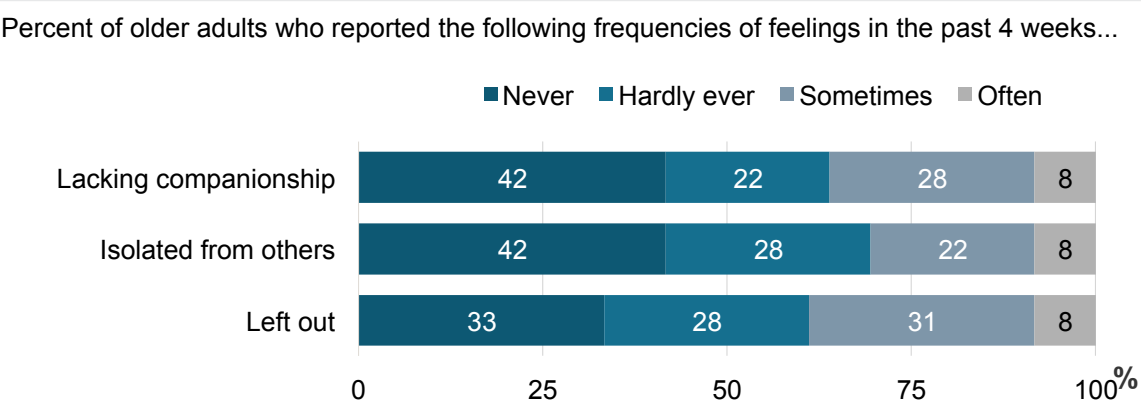
Demographic Characteristic	Percent or Mean	N
Race/Ethnicity		34
% Hispanic	5.88%	2
% White only	82.35%	28
% Black only	8.82%	3
% American Indian/Alaska Native only	2.94%	1
% Asian/Pacific Islander only	0.00%	0
% Other race identity/identities	0.00%	0
Gender		35
% Male	11.43%	4
% Female	88.57%	31
Marital Status		34
% Married	47.06%	16
% Living with a partner	2.94%	1
% Have a partner, and not living with them	5.88%	2
% Separated	2.94%	1
% Divorced	17.65%	6
% Widowed	20.59%	7
% Never married	2.94%	1
Age (years)	71.12	34

Loneliness

Among the 11 older adults who participated in both the baseline and 3-4 month follow-up surveys, average UCLA loneliness scores were the same at the 3-4 month follow-up ($M = 3.82$) as they were at baseline ($M = 3.82$).

Among the overall total of 36 baseline online survey participants, the average UCLA loneliness scale score was 4.31. Figure 9 below presents baseline responses to the three items comprising the UCLA loneliness scale. As shown there, 30% or more of older adults reported sometimes or often lacking companionship (36%), feeling isolated from others (30%), or feeling left out (39%) during the latter half of 2021 and the beginning of 2022.

Figure 9. Responses to UCLA Loneliness Scale Items Among Baseline Online Survey Participants Between July 2021 and February 2022



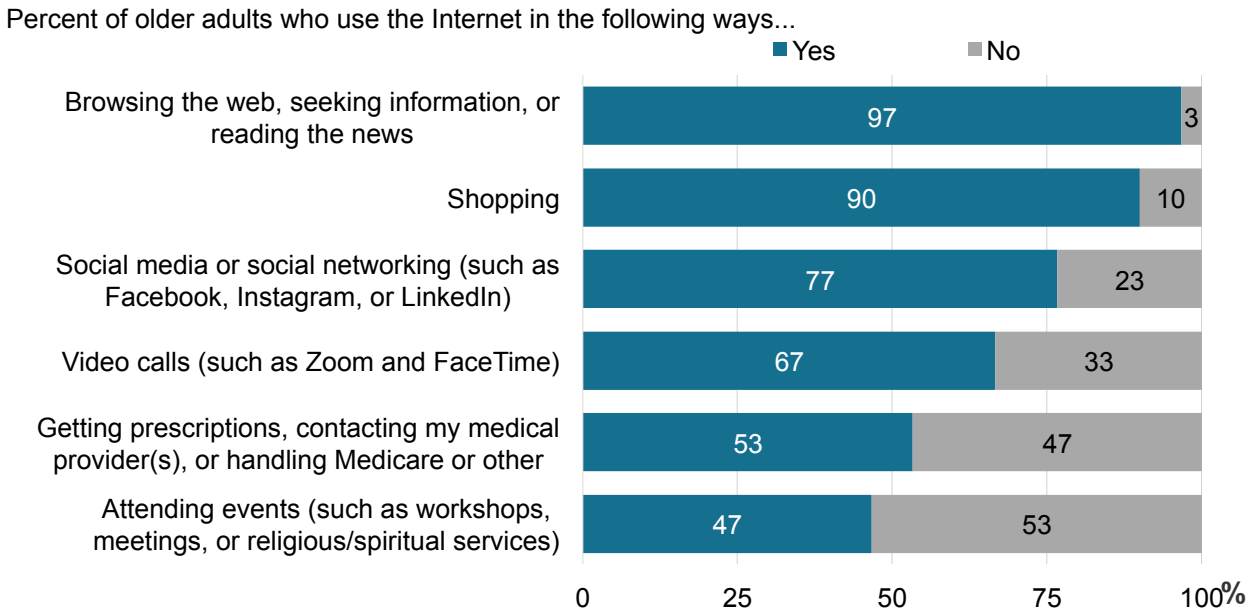
Questions: How often in the past 4 weeks have you felt that.. [you lack companionship, you are isolated from ohters, you are left out]?
Source: Baseline online survey among 36 older adults who completed these questions.

Internet use and modes of social contact

A majority of older adults in the baseline survey said they were very confident in their ability to use the Internet (54%), with fewer reporting having moderate or only a little bit of confident (31% and 14%, respectively). Of the 30 older adults who answered this question, none reported having no confidence at all.

Figure 10 below presents the percent of baseline online survey respondents who report using the Internet for various purposes. The top three most commonly reported uses were for seeking information, shopping, and using social media or social network platforms.

Figure 10. Reported Types of Internet Use Among Baseline Online Survey Participants Between July 2021 and February 2022



Question: In what ways do you use the Internet? Select all that apply.
Source: Baseline online survey among 30 older adults who completed the full survey.

When asked how much in the next 4 months that they would like to socialize with others in-person, compared to other ways of socializing (such as by phone, video calls, text messages, or online), an equal percentage of older adults (47% for each) preferred socializing mostly in-person as endorsed a preference for an equal amount in-person and other ways (not in-person). In addition, a small and equal percentage of the sample (3% each) preferred socializing only in-person versus not at all in-person.

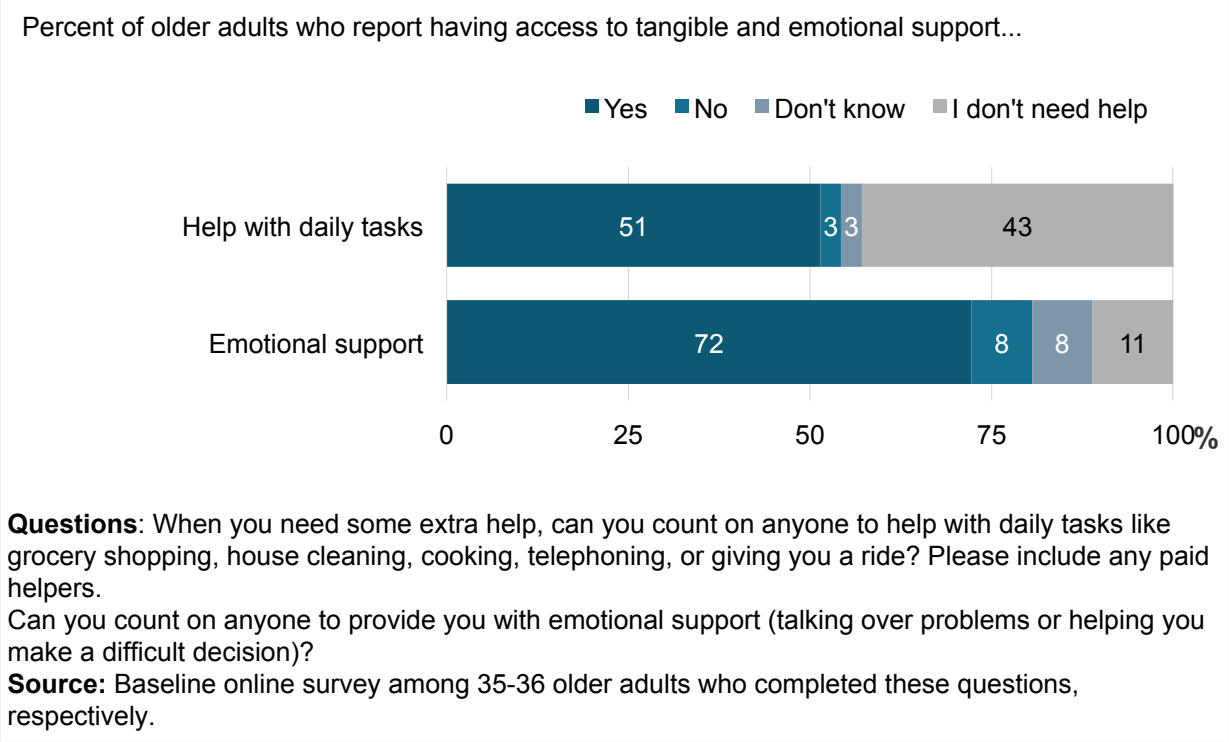
Physical and mental health

Of 35 baseline survey participants, a majority rated their physical health as very good (46%) or excellent (17%) during the period from July 2021 to February 2022. One in five rated their physical health as good, with fewer older adults rating their physical health as fair (11%) or poor (6%).

Tangible and emotional support

Figure 11 below displays the baseline survey responses regarding the availability of tangible and emotional support. Fifty-one percent of participants can count on someone for help with tasks like grocery shopping, house, cleaning, cooking, telephoning, or getting a ride. Nearly three-fourths of respondents can count on someone for emotional support.

Figure 11. Tangible and Emotional Support Among Baseline Online Survey Participants Between July 2021 and February 2022

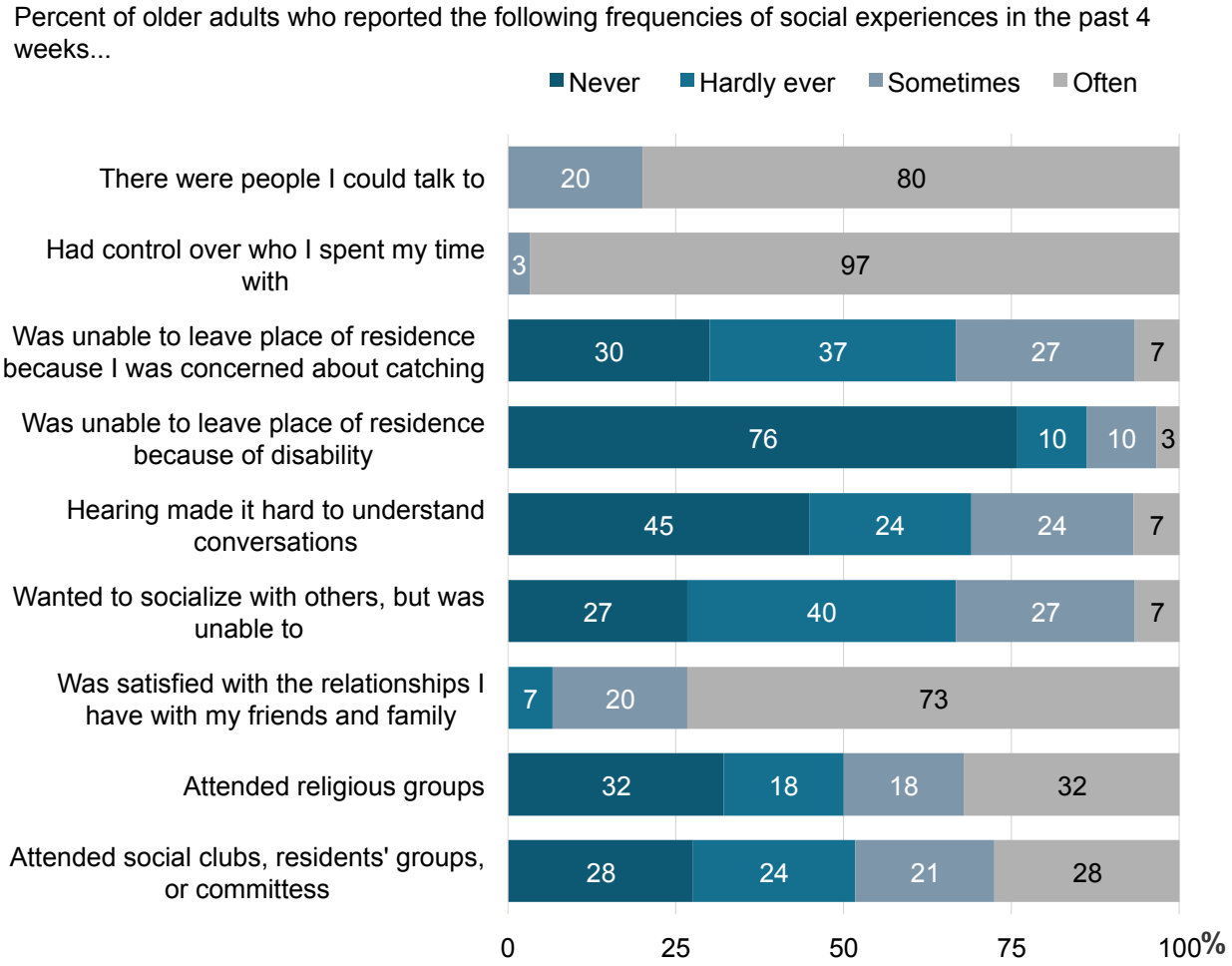


Questions: When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, house cleaning, cooking, telephoning, or giving you a ride? Please include any paid helpers.
Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?
Source: Baseline online survey among 35-36 older adults who completed these questions, respectively.

Social activities

Figure 12 below presents data from older adult participants in the baseline online survey regarding the frequency at which they had various social experiences. All participants reported sometimes or often having people they could talk to and having control over who they spent their time with. About one-third of older adults reported being unable to leave their place of residence due to concern about COVID-19, and 13% were sometimes or often unable to leave because of disability. Approximately one-third of older adults sometimes or often had difficulty understanding conversations because of their hearing, or wanted to socialize but were unable to (31% and 34%, respectively). Nearly three in four older adults were often satisfied with their relationships with friends and family. Regarding frequency of attending religious services and attending social clubs, resident's groups, or committees, an equal percentage of older adults reported attending these never versus often (32% and 28%, respectively).

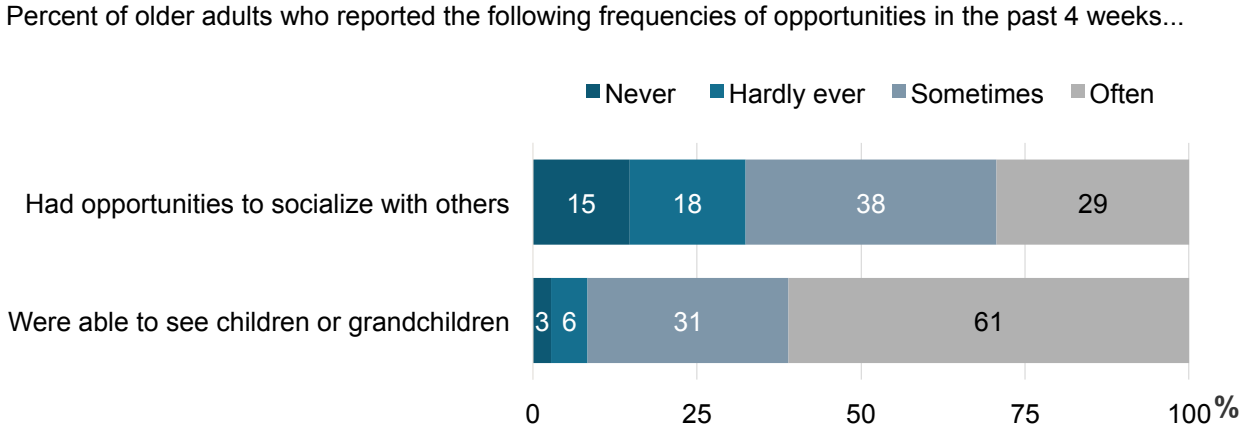
Figure 12. Reported Social Activities/Experiences Among Baseline Online Survey Participants Between July 2021 and February 2022



Questions: People differ in how often and how easy it is for them to socialize. Thinking of all the ways you interact with others--whether in-person or by phone, video calls, text messages, or social media--how often in the past 4 weeks have the following statements been true for you?
Source: Baseline online survey among 28-30 older adults who completed these questions.

Figure 13 below displays the percent of baseline survey respondents who reported various frequencies of social opportunities in the past 4 weeks. About two-thirds (67%) of older adults reported having opportunities to socialize with others sometimes or often, and only 9% of older adults reported never or hardly ever being able to see their children or grandchildren.

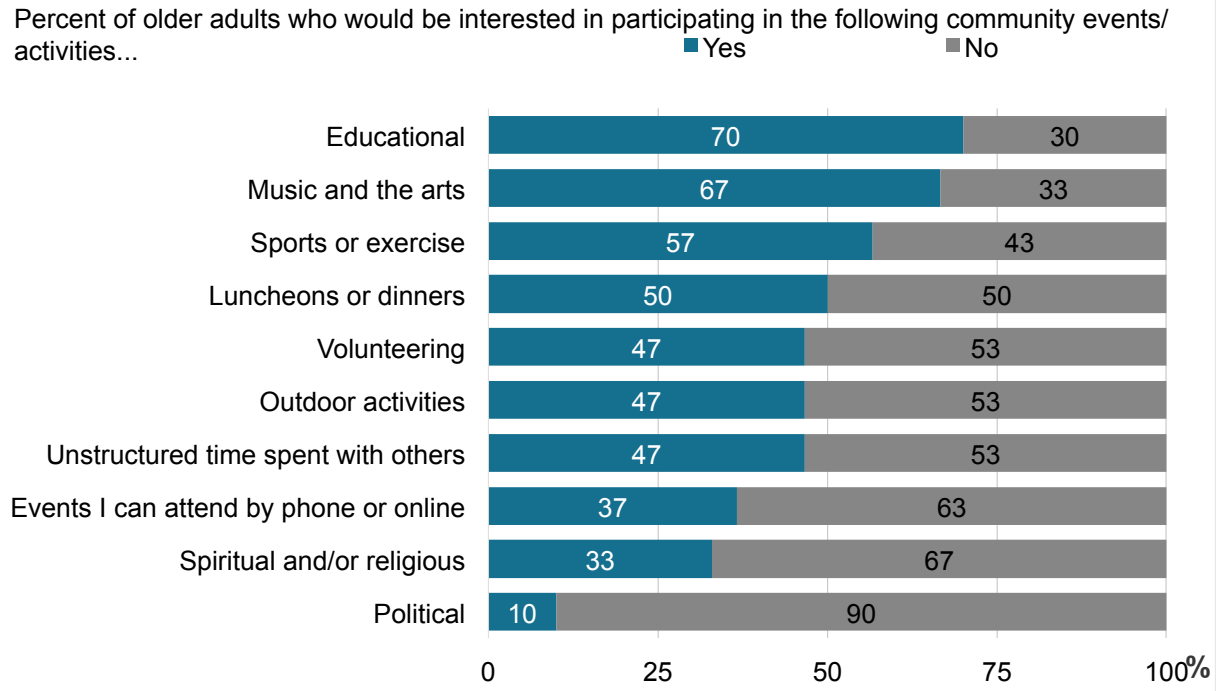
Figure 13. Frequency of Social Opportunities Among Baseline Online Survey Participants Between July 2021 and February 2022



Questions: How often have you had opportunities to socialize with others in the past 4 weeks?
How often have you been able to see your children or grandchildren in the past 4 weeks?
Source: Baseline online survey among 36 older adults who completed these questions. Two older adults were not included in the percentages for the child/grandchild percentages above because they reported that they do not have children or grandchild.

Figure 14 below displays the percent of baseline survey participants who expressed interest in various types of community activities/events, should they be available. The three types of activities that attracted the most interest among older adults were those focusing on education, music and the arts, and sports/exercise.

Figure 14. Interest in Community Activities/Events Among Baseline Online Survey Participants Between July 2021 and February 2022



Question: If your community were to offer the activities/events below, which ones would you be interested in participating in? Please select all that apply.
Source: Baseline online survey among 30 older adults who completed the full survey.

Findings from Older Adult Interviews

After a description of the characteristics of interviewees and the types of programs they used, the qualitative findings summarize themes from the interviews.

Interview characteristics and program use

Qualitative researchers for this project contacted at total of 102 older adults who were referred by social service providers from a wide variety of programs intended to reduce social isolation. Interviews were completed with 60 program users (59% of those who were contacted). In each AAA, anywhere from 41% to 86% of those who were contacted completed an interview. Interviewees included 12 older adults or caregivers. Reasons for not participating in an interview included: not being able to reach the person or the person blocked our phone number (25), the person refused to participate (7), the person could not confirm they were using the program (4), the person did not show up for the interview (4) or the phone number did not work (3).

Interviewees included 51 older adults and 9 caregivers (seven of whom were over the age of 60). Demographic characteristics and living arrangements of interviewees are summarized in Table 8. A majority of interviewees were between the ages of 60-74 (43.3%) or 75-84 (38.3%). Over

three quarters self-identified as female (78.3%), 20% self-identified as male. Only one interviewee identified a sexual preference although there were at least three people who used programs that target LGBTQ+ communities. Nearly a third of interviewees (28.3%) self-identified as Black or African American, 56.7% as White or Caucasian, 3.3% as Asian, and 6.7% as Latino or Hispanic. Two people chose not to answer this question.

Table 8. Interviewees' Demographic Characteristics and Living Arrangements (*N* = 60)

Demographic Characteristic	Percent	N
Age (years)		
50-59	3.3%	2
60-74	43.3%	26
75-84	38.3%	23
85+	13.3%	8
Did not answer	1.7%	1
Gender		
Male	20.0%	47
Female	78.3%	12
LGBTQ	1.7%	1
Race and ethnicity		
Black/African American	28.3%	17
White/Caucasian	56.7%	34
Asian	3.3%	2
Latino/Hispanic	6.7%	4
Did not answer	5.9%	2
Living arrangements		
Lives alone	71.7%	43
Type of residence		
Own house, mobile home, or condo	56.7%	34
Rental apartment or house in community	20.0%	12
Senior housing, assisted living, or retirement community	20.0%	12
Another person's home	1.7%	1
Did not specify	1.7%	1
Type of community		
Suburban/urban setting	50.0%	30
Rural area/small town	50.0%	30

Nearly three quarters (71.7%) lived alone. Over half (56.7%) lived in and owned their home, 20.0% lived in a rental apartment or house in the community, and 20.0% lived in senior housing, assisted living or a retirement community. Two people either lived in someone else's home or did not clearly specify their type of residence. Half lived in a rural area or small town and half lived in an urban or suburban setting.

At the time of the interview, 65% (39) were using one on one programs and 63% (38) were using group programs. Many (63%,38) used multiple programs, including programs other than those they were referred from. One on one programs included friendly visits, friendly calls, telephone reassurance calls, home delivered meals, activity packets, and transportation. Group programs included educational activities related to aging, caregiver support programs, activities for persons with dementia and their caregivers, discussions, cooking activities, choirs, bands, and activities at congregate dining sites. Interviewees who used centers or online applications that provided a variety of activities participated in exercise classes, mind/body activities, craft or art classes, and a wide variety of entertainment activities. Participants of centers or dining sites also engaged in informal socializing and volunteered. A few interviewees were part of programs to introduce tablets or devices, some of which came with group training.

Some people were accessing programs in more than one way. Overall, 40% (24) accessed programs by phone (either receiving one on one calls or calling in to an online group program), 48% (29) were using programs in person (such as meal delivery, friendly visits, or congregate dining), and 35% (21) were using programs provided through an online application or were accessing programs via an online platform. In this report, the term "application" is reserved for accessing multiple programs through the same online source and "platform" refers to using a single program that was provided through Zoom or Webex.

Most interviewees (88%, 53) had been using the program(s) they were referred from for at least three months; only three had been using those programs for less than three months. Of these, 46 had been using one or more programs for over 9 months and one had been using a program for 7 months. Some interviewees had been using a program for years.[4]

Interview themes

After a discussion of interviewees' experiences with the COVID-19 pandemic, the qualitative findings summarize themes related to how interviewees heard about programs, their reasons for using those programs, accounts of the benefits or impacts of programs, changes in programs and technology during the pandemic, potential barriers to using programs, and suggestions for improving programs. This section closes with a summary of how interviewees connect with the world and examples of 'most significant change' stories that illustrate how programs fit into the social lives of people living in different situations.

Themes are indicated in bold and percentages included below are based on the number of interviews in which a particular code was applied to at least one passage (i.e., a *rough* estimate of the frequency of some of the more prevalent themes).[5] Text in quotation marks is an excerpt from interview notes that captured the interviewees words and items in brackets clarify what an interviewee was referring to. Appendix XIII includes additional excerpts from notes for selected themes (where indicated below).

<u>Experiencing the COVID-19 Pandemic</u>

A dominant theme in the interviews was **how the pandemic changed people's daily routines,** but those changes varied depending on their living circumstances and personal situations. For example, the routines of those who were unable to go out without assistance changed little or if at all. In contrast, people who lived in senior residences that implemented stringent limitations were no longer able to take advantage of usual activities and social connections in their building. Others who were living at home had socially distanced visits but some strictly adhered to

[4] In four cases, we did not have information for using a program for at least three months and for six cases we did not have information about longer term use (more than 9 months).

[5] Although there were some differences in how often issues were mentioned by different subgroups (e.g., rural vs. urban), we do not report those differences because they could be due to any number of factors including the type of programs used in these settings.

recommendations to self-isolate and stopped nearly all face-to face contact with friends and family.

Interviewees talked about **how well they adjusted to changes in their social routines**. A few people felt they were able to adjust to changes that came with the pandemic, noting that they had always "been able to adjust" or "survive", were used to living alone, or had "learned how to entertain themselves." Some people did not find it hard to adjust because they had always been a "bit of a loner" or did not socialize a great deal. Interviewees who had very active social lives had more difficulty adjusting to changes in social contacts and, as one person noted, "COVID changed everything." A number of interviewees experienced grief due to the loss of family and friends, and some lost multiple people over the course of the pandemic. Many felt they were not able to handle all the "bad news" about the pandemic, police violence or racial tensions. Experiences during the pandemic are discussed in relation to the impact of programs on mental wellness and changes in programs during the pandemic (see below).

Interviewees gave examples of **what they did to adjust**. Most relied on their phones to stay in contact with friends and family, attend meetings, listen to church services or to participate in group programs. Some created schedules or projects to keep them occupied at home. Others used text, email, and online platforms to stay in touch. Others found creative ways to socialize while keeping distance. Interviewees used variety of technologies to keep themselves occupied at home (see below for themes related to using programs and technology during the pandemic). Appendix XIII provides examples of interviewees' experiences with the pandemic.

How interviewees heard about programs

Over half of interviewees (56%) mentioned hearing about programs from **organizations or staff members that provide those programs** or while using other programs offered by that same organization, and 35% learned about programs from other people or through **word of mouth** (from family, friends, neighbors, people who had used or volunteered for the program). Some interviewees told others about a program or brought friends along. Thirty-two percent learned about a program **from other community organizations or resources** such as notices and flyers in senior or township newsletters or local newspapers or at libraries, churches, doctors' offices, and senior residences. Three mentioned hearing about a program through **local government**. Two caregivers mentioned doing **"research" on the internet** to find programs.

Why interviewees use programs

Most interviewees (57%) mentioned **particular benefits** as reasons for using or continuing to use programs and often restated those benefits several times during an interview. Such reasons included wanting to meet people, socialize, make friends, get out, have something to do, try new things, get information or resources, learn something, have someone checking on them. Some interviewees **alluded to social needs** as reasons such as being isolated due to the pandemic, being alone, having a condition that limits their ability to go places or do things for themselves, caring for another person, not wanting to impose on family, having fewer friends available (due to death, decline, moving, etc.), needing to compensate for COVID restrictions on their usual social life, or needing help, services, or resources. Positive **attributes of staff or volunteers** were mentioned as reasons for using programs by 42% of interviewees. For instance, program providers were described as friendly, knowledgeable, skilled, patient, or generally being "good people." A few interviewees mentioned having respect for the person leading the program. Other reasons included that the **program was well run** or **convenient**. A few people mentioned their **prior connections to a program** (e.g., someone they knew had used it or they had volunteered or worked for the program in the past). Finally, a few people were simply **curious** about a new program (such as new technology).

Benefits and impacts of programs

Interviewees mentioned both specific benefits as well as broader impacts on their day-to-day lives when describing significant changes due to using programs. Interview themes were related

to social connections, social support, mental well-being, and non-social benefits. Appendix XIII includes brief examples from interviews for some of these themes.

Social connections

Most interviewees (73%) appreciated opportunities for **social interaction** and **having conversations**. Those who had few social contacts or were isolated due to the pandemic benefitted from having another person or a group of people to talk to. Homebound individuals appreciated seeing drivers or meal delivery people and opportunities to interact with other riders, even if for a limited time. Those who attended centers or dining sites (in person) benefitted from people to talk to or having informal conversations. People who participated in online group programs liked being able to talk to others online during the pandemic.

About a third (35%) explicitly mentioned the benefit of having more opportunities for **social contact** or **meeting people**. Interviewees explained they were able to meet new people, people in similar situations as themselves, people with similar interests, or a wider variety of people.

Some interviewees (20%) explicitly mentioned feeling a **sense of community**, comradery, commonality, coming together, acceptance, openness, or mutual respect among participants of a program or people at a center. Some people noted that they had brought friends to the program or already knew some of the other participants. A few mentioned that participating in a program was a way to know **what is happening in the community** (e.g., in a small town) or that meeting people they knew from the past gave them a **sense of history**. Over a quarter of interviewees (28%) specifically mentioned enjoying program activities that involved **eating together** such as a meal, snack, coffee time, or cooking together.

Half of interviewees (50%) mentioned opportunities to **develop relationships** as a significant benefit. This included getting to know someone, making a friend and looking for other types of relationships. Those who had visitors or callers especially valued having things in common with another person and described relationships with a visitor or caller as being "companionship," or a "friendship." Some noted their relationships were "two-way" in that their visitor or caller also gained a lot. One caregiver noted that participating in a group program helped to sustain a relationship with the care recipient, who lives with dementia.

Social support

Nearly two-thirds of interviewees (63%) benefitted from some kind of social support. These interviewees described group leaders or participants as caring, attentive, helpful, or supportive and gave examples such as providing guidance, advice, or suggestions. Some people explained that being called, being visited, getting their problems addressed, or receiving care packages during the pandemic made them feel as if **someone cares**.

Interviewees felt that programs gave them opportunities to **share personal experiences** by listening to and learning from others, empathizing, or feeling accepted. Some interviewees noted that the impact of having this experience in a group setting was realizing that **they are not alone**.

Just over one-third of interviewees (37%) specifically mentioned having **someone check on them** as a benefit. Many of these individuals received home delivered meals or telephone calls from volunteers or staff. One person noted that a smart speaker program made it easier for a family member to check in every day. Others talked about how receiving calls or home delivered meals where people check on you provides "peace of mind" for their family. For some, additional benefits of being checked were having **someone to advocate** on their behalf or **connect them to resources or information**. This was often mentioned by those who received one on one programs such as calls, visits or home delivered meals. Some of the interviewees were volunteers who checked on others.

Mental well-being

Over half of interviewees (68%) discussed either positive or negative aspects of their mental well-being. Roughly 40% of interviewees mentioned or alluded to experiencing loneliness, isolation, depression, or anxiety. Such individuals referred to being isolated during the pandemic and missing their prior routines or social connections. Some had experienced multiple deaths of friends or family. At least one person felt the loss of not being able to be with someone before they died, due to pandemic restrictions. Interviewees also talked about hearing too much "bad news" about the pandemic and racial violence, not wanting to watch TV anymore, and needing other activities to distract themselves from negative thoughts. Some explicitly mentioned that they experienced anxiety or depression during the pandemic. Some had managed such feelings in the past, but those feelings returned or were exacerbated by not being able to get out and see people. Other interviewees stated that experiencing the pandemic did not affect their mental well-being. Such individuals described themselves as being comfortable alone, did not experience a change in their routines (e.g., because they unable to get out before the pandemic), or found ways to adapt to the pandemic.

Some people described how using a program helped to **reduce feelings of isolation or loneliness** or deal with other negative feelings. For instance, interviewees felt that the programs they used gave them a **more positive outlook** or cheered them up. Others described how participating in programs helped them to **cope or manage** negative feelings such as sadness, fear, anxiety, grief, or stress. Several individuals also talked about how they **care for themselves** by using mind/body exercises, physical exercises, or stress management activities. Some interviewees specifically mentioned exercise programs that included opportunities to socialize. A few people described how a program gave them the opportunity to **focus on spirituality or mindfulness**. Finally, several interviewees felt that they gained or practiced **social skills** by participating in programs. For instance, one person reluctantly volunteered to lead a class for others and then found it "exciting" to both prepare for the class and lead discussions with an engaged group of participants. A few people talked about how they were making more efforts to socialize and meet people than they had in the past, either to overcome personal tendencies to not socialize, to address mental health issues or to deal with isolation during the pandemic.

Non-social benefits

Interviewees mentioned benefits other than socialization. Nearly half (47%) liked that the program was a way to have **something to do**, gave them a place to go or provided a **reason to get out**. Twenty percent of interviewees explicitly stated that they **look forward to** attending a program or getting a call or visit as part of their day-to-day routines. Some interviewees explained that participating in programs was part of a general strategy to "stay active," "keep busy," or create some "structure" in their day-to-day life. Others commented that they liked having **options to choose from** or being able to do a variety of things or that they enjoyed trying new things. During the pandemic, people who tired of watching TV or seeing bad news were happy that programs offered "something different" to do or a way to "pass time." A few people who gained access to tablets or other electronic technologies talked about being able to participate in online meetings (other than programs) during the pandemic or finding "new things to do".

Some interviewees (38%) simply **enjoyed** the activities offered through programs. For instance, they described activities as being "fun" or "entertaining," or talked the benefits of laughter or "having a good time." Nearly half of interviewees (45%) said that they **learned something** or received useful information. Some interviewees (35%) more specifically commented that they liked being able to **do something interesting** or stimulating. For instance, one person participated used programs as part of a general strategy to do things that "require me to think to see if it helps my brain cells."

Over a third of interviewees (37%) brought up issues related to **physical wellbeing** as a benefit. Exercise, mind/body activities and health were frequently mentioned as programs they used at a

center or through an online application. A few people mentioned that due to attending a meal program they were eating better and no longer had to deal with physical or other difficulties cooking. One person found using a new technology device was especially helpful for getting medication reminders. Interviewees often gave examples of how such programs also impacted their mental wellness (see above and examples in Appendix XIII).

A variety of other benefits were mentioned, such as regaining **independence** due to getting a transportation service. For instance, one person felt that the most significant change in her life was "a lot of independence back because if there is some place I want to go….I can do it ." Caregivers talked about how a program **gave them a break** from their daily responsibilities. For instance, one person said that because the program was now on Zoom "…I don't have to get up and take [care recipient] anywhere…and I can actually sit down and relax."

Using Programs and Technology During the Pandemic

A majority of interviewees (73%) described how their experiences with programs changed during the pandemic. Appendix XIII includes examples from interviews notes that reflect the themes described below.

Some interviewees talked about **safety during the pandemic,** such as feeling safe due to precautions that staff or volunteers took. For instance, one person said, "they're trying so hard to keep everybody safe" and "cheer us on." Interviewees examples of what staff or volunteers did to make them feel safe such as wearing masks, visiting outside, staying at the door to deliver a meal, and providing outdoor activities. A few people wished that other program participants would have taken COVID-19 more seriously by adhering to recommended mask and vaccine guidelines. Many interviewees noticed and appreciated that service providers or volunteers were calling more often to check on them and other older adults during the pandemic (see section on benefits and impacts of programs).

Regardless of whether interviewees used one-on-one or group programs, many people **missed i**n-person contact with participants, volunteers and program staff in person. This was especially the case for those who used group program or centers or whose friendly visits had shift to calls. Those who were regulars at centers or meal sites were eager or happy to return to seeing people and participating in more activities (depending upon the status of programs at the time of the interview). Those who participated in group activities that went online also missed interacting in person. Volunteers missed their work and in-person meetings with other volunteers.

Program experiences changed during the pandemic in different ways, depending on the type of programs they used. Interviewees' accounts captured the shifting and varied landscape of program delivery in response to changing pandemic restrictions and repeated outbreaks. Some people experienced transitions from in-person to online or phone formats, others experienced programs being shut down, re-opened, and shut down again, and some had just joined a center or program and were disappointed that could not start by attending in person. Some people felt they were able to adjust to the changes, but the fluctuating situations created a sense of uncertainty for others. Experiences with one-on-one programs changed for some but not all interviewees. Some people who had friendly visitors started getting calls instead, while others still visited in person with masks and social distancing. More people started receiving brief phone calls to check on them (see benefits of social support above). A few interviewees decided to use meals deliveries more often because they were less able to prepare meals on their own; this change was not necessarily attributed to the pandemic but likely happened during that time period. People who used transportation had to schedule transportation farther ahead or were not able to go as many places. A few people speculated that having fewer volunteers affected transportation and other programs. Some people who were receiving telephone reassurance calls during the pandemic noticed that they had become less frequent as the pandemic subsided.

Interviewees' **experiences with group programs that went online** varied. Some people attended more or less often. Interviewees observed that the number of participants declined or

increased in some groups or that the group did not grow as expected. They speculated that people who were not able to or not comfortable with attending online dropped out or were waiting for things to re-open in person. Others noticed the participants in a group or center changed. For instance, when people could attend online from anywhere, some new people joined the group. In one instance, two different groups merged into one. People who attended groups or centers started receiving more calls during the pandemic; one person felt that these calls kept people connected to their groups or centers. Those who attended centers for dining or activities noted that when they re-opened with social distancing and limited activities, some people never came back. Interviewees who used dining sites speculated that some people chose to continue receiving home delivered meals, or others may have experienced health problems or passed away. Interviewees also observed that because everyone had "gotten older" during the years of the pandemic, new seniors joined.

Some interviewees noted **benefits of online programs** such as convenience, being able to see faces, joining from anywhere, and not missing sessions when they are travelling or living out of state. For these people, participating in a program online was better than nothing and provided a way to stay connected with a group. But interviewees also encountered a number of **limitations of online programs**. Examples provided by interviewees included not having enough time to socialize during the program, no way to connect with people before or after a program, conversations or discussions being dominated by a few people, and problems getting a technology to work consistently. One interviewee mentioned trying online exercise programs but felt that were not safe for them to use. Some people mentioned using **new programs** that provided them with something to do during the pandemic such as outdoor activities, activity packets, online applications, or access to devices.

Roughly 32% of interviewees talked about their positive or negative experiences with using various technologies. Interviewees who participated in online programs or received devices talked about **adjusting to using new technologies**. Some had difficulty learning how to use Zoom in the beginning, which became easier over time. Others said positive things about the technical support they received that expanded their access to virtual activities (e.g., setting up a device in their home or an application on their TV) or gave them another way to contact other people (e.g., via a smart speaker or tablet). Those who received training on how to use new technology often mentioned that they were continuing to learn how to use different features. A couple of interviewees had helped other older adults learn how to use a tablet or computer.

A significant subgroup of interviewees was **open to using new technology** in their day-to-day lives. Some had used such technology prior to the pandemic but others started using it during the pandemic. The variety of devices and technologies used by interviewees included flip phones, smart phones, tablets, smart speakers, computers that were used for texting, video calls, social media (such as Facebook), and online platforms (e.g., Zoom or Webex). When asked how they use these technologies to connect with the world they described staying in touch with family, friends, and neighbors, keeping up with what others are doing, attending family events, church services, a funeral, or meetings and, as noted previously, simply having something to do. For instance, one person decided to learn how to text to be able to communicate with younger family members and was glad to have gained that skill before it became "mandatory" due to the pandemic. Some wanted to learn how to use more features of Zoom (e.g., chat), a tablet, a device, or an online program application. A few people mentioned that family members got them a smart phone or set them up with video phone apps such as Facetime or Duo. Interviewees sometimes mentioned that they were already familiar with computers due to a prior job or had always been interested in learning new technologies.

Others were **reluctant to use new technology** due to lack of confidence, discomfort, or privacy concerns. For example, some interviewees had difficulty typing text on phones or hearing on mobile phones. A few people worried they might do something wrong or break something (e.g., on a computer). Other examples included discomfort with using computers or smart phones with too many features or zoom. Others preferring talking by phone or writing to people (e.g., email

or letters) as opposed to texting. Some were not at all interested in having a computer or spending more time on a computer screen, even if they were familiar with computers. A few had concerns about getting hacked or privacy. Most who had Facebook accounts did not want to post their personal lives on Facebook and only used it to see what others were doing. One caregiver stopped participating in a group program when it went online because the person they were caring, who had dementia, refused to participate on zoom. Another noted that other older people did not like the idea of other people on Zoom seeing their homes.

Some people **did not have access to technology**, such as a computer, internet access or high-speed internet which may have affected their options for joining programs. For example, one person who did not have a computer tried to attend church services over the phone but found it hard to participate without seeing people. (See above for changes in program experiences related to technology and the limitations of online programs).

Barriers to using programs

Interviewees talked about what made it harder and/or easier for them or other older adults to use programs (i.e., potential barriers to using programs). Themes included the **schedule or the frequency** of a program (mentioned by roughly 42%), **limited mobility, sensory impairments, speech impairments, or health conditions** that make it difficult for them or others to either travel to or participate in programs (mentioned by 47%) and having or not having access to **transportation** (mentioned by about 37%). With regards to the latter, some interviewees noted that they were able to get to programs because they still drive or can still use public transportation. People used transportation services for reasons such as not having a car, no longer being able to drive, finding it difficult to drive long distances, and having difficulty getting rides from other people. Other issues that were mentioned as potential barriers or facilitators included the convenience or characteristics of a **program location** including the availability of parking, not being able to attend in person programs due to **weather or seasonal conditions**, the **affordability** of a program, or the **neighborhood safety**. A few commented that some older adults do not want to participate in programs because they feel they **aren't old yet or don't need help.** For some, **caregiving responsibilities** or preferences of the care recipient limited the types of programs they could participate in or when or how long they can participate. Finally, some people pointed out that **lack of funding, staff, or volunteers** is likely to limit older adults' access to some programs, while others noted that many people cited that **older people are unaware** of available programs.

Suggestions for and Interests in Programs

Overall, interviewees did not have many suggestions for improving the social aspects of the programs they use and instead expressed positive feelings about those programs. They were also prompted for suggestions to improve programs for other older people. As noted above, they were mostly concerned that many older adults are not aware of programs and getting more people to participate. Several observed that providers need to "build groups up again" that had become smaller during the pandemic. A few people noted that advertising should not be limited to senior centers and senior buildings, noting that they or others typically learn about programs through word-of-mouth referrals (see section on how interviewees heard about programs above). Suggested strategies for "getting the word out" include:

- Advertising in the community (i.e., "the right spots") where older adults, neighbors, friends, co-workers, and family go such as grocery stores, workshops, faith-based organizations (e.g., bulletins, flyers, church groups), libraries, and youth centers
- Disseminating printed advertisements for those who are not on the internet or computers (e.g., newspaper announcements, mailed newsletters or pamphlets, flyers in utility bills, bank statements)
- Reaching out to senior building residents beyond people already using particular programs
- Asking current program users to identify other older adults who need the program

- Encouraging people to join senior centers (e.g., re-opening campaign, advertising the variety of activities)
- Publicizing/recruiting earlier for programs with specific timeframes
- Providing events, seminars, or conferences for sharing resources
- Having a place or booklet with information on resources
- Having staff/case managers from a program share information about other programs

A few people noted the importance of seeking input from group participants on topics they were interested in and others had ideas for improving online program experiences such as allowing more time before, during, or after sessions to talk, meet people and share ideas. Others felt that some online programs could have shorter lectures or presentations with more time for discussion or that online sessions needed to be longer (e.g., more than an hour). Some observed that it was important to have a group leader who could effectively facilitate online discussion, "nudge" things along, and use the time effectively.

A few people observed that programs that rely heavily on volunteers (e.g., transportation, meal delivery, visiting, etc.) may need more funding or resources to support the volunteers and possibly expand access. One person wished that meal programs would use biodegradable packaging. We also asked interviewees what other types of programs they or other older adults would be interested (listed in Table 9).

Table 9. Older adults' interests and suggestions for programs or activities

Entertainment in social settings
Playing games Concerts Watching movies, film screenings with themes Affordable outings to museums, theatre, movies cultural events, local sites Travel clubs Doing projects or activity kits with others Cooking classes with entertaining themes More social opportunities at libraries (to add to what is already there)
Creative expression (groups)
Story sharing or telling (about past/shared generational experiences) Art classes or groups Craft and hobby groups (quilting, sewing, baking, cooking) Creating music (bands, choirs, singing) Dancing
Learning or discussion (groups)
Intellectually stimulating activities and "learn for learning sake" (lectures, classes) Bible study groups Events that provide information on local services in your community Tea or coffee get togethers with a discussion topic Classes on wellness or health issues (nutrition, self-care, brain health, medications) Book clubs or reading groups
Exercising with others (groups)
Group exercise classes Fitness centers Outdoor locations for physical activity (walking areas, activities in parks)
Supporting mental wellness (groups)

Opportunities to share experiences with overcoming mental health issues (not just what do or where to go) Group counselling to deal with pandemic related stress/experiences Opportunities to share, learn how to relax, and see life more positively during the pandemic, which could also help families Faith based groups to deal with grief or similar issues Art therapy groups Self-care, stress management, mind/body activities
Programs for people with different abilities or limited mobility
Phone calls and cards for those who live alone or are homebound Senior lunches (groups) for people who can't drive Exercise or walking options or walking for people who have lost their vision Activities for people who are homebound (projects, things to watch or listen to, book delivery service, exercise programs) Outings (plays, movies, theatre) for people who need both transportation and someone to assist them More activities that persons with dementia can enjoy; programs for younger people with dementia

Ways to meet a companion
Opportunities to find companions or significant others (e.g., quick dating events with criteria for participating, such as being widowed) Opportunities to volunteer (e.g., in senior programs, medical settings, helping others)
Technology education and support
Training on: Computer skills Understanding the internet; how to "find your way" (without being afraid) Using web sites (such as Social Security) Paying bills Using smart phones Google searches How training could be structured to ensure that older adults learn: Regularly offering small group technology classes (e.g., monthly) Follow-up instruction from people who are familiar with the technology the older adult is using (e.g., the type of tablet) Hands on practice "until they learned it" (not just telling them what to do) Ongoing support such as being able to schedule one on one appointments for tech assistance (e.g., at a library)

*In addition to groups, affordable counseling that is culturally appropriate.

Program Use within the Context of How Interviewees Connect with the World

The older adults in this study often described the benefits of programs within the context of their other social connections, regardless of whether those were limited or more extensive. Near the end of each interview, we also asked older adults to describe how they connect with the world outside of the programs they use (other social activities, volunteering, helping others, and other activities that were important or meaningful for them). To better illustrate this, the most significant change stories portray brief, holistic snapshots of how program use fits within individuals' unique circumstances, social needs, and other activities they engage in as part of their day-to-day lives and social worlds.

Below, we showcase four most significant change stories for: 1) a caregiver who met people in similar situations, 2) a socially active person, 3) someone dealing with loss, and 4) someone who looks forward friendly calls.

Meeting People in Similar Situations
(Story 1, Appendix XII)

JA cares for his/her/their partner and lives in a home in a suburban community. JA participates in a **caregiver group** that has shifted to Zoom as a result of the pandemic and has also taken advantage of **one on phone calls for caregivers**. JA has also used training for caregivers and participated in other caregiver groups and feels that the organization that provides the caregiver program has "real great caregiver groups" that are "well run" and provide "excellent help." JA mentioned that meeting virtually works great because they live in another state part of the year and can now participate from wherever they are.

The most significant change for JA, besides learning "what to do and what's going on" is "meeting other people that are in similar situations and being able to talk to them and relate to their experiences. You're not alone, and you can learn so much more from other people who have more experience with this and who have been dealing with similar situations for longer." JA also values "hearing the guidance that [the program] is providing to other people." JA added that the one-on-one sessions are "more for when you have something that's really bothering you" were helpful for getting "advice and suggestions" on how to deal with a particular problem or issue.

Since the pandemic JA has not done much socially. He/she/they stays connected to the world by reading news and articles on the internet and emailing people. JA misses the "hanging out and talking to people" in person and explained that "the social aspect is really hurting for me. It's better for my [partner] [because he/she/they has access to a program], but "I just have the caregiver. Before the pandemic he/she/they participated in clubs and activities, went to a fitness club regularly, hiked trails and enjoyed meals and activities at center with his/her/their partner. They were just starting to return to in person activities at the center.

Staying Socially Active
(Story 4, Appendix XII)

BL lives alone in his/her/their condominium in an urban neighborhood and attends **a group that provides activities and discussions**, which met at a building before the pandemic. BL started participating because of an interest in a class, the convenience of the location, and the variety of other interesting activities available at that site. BL described his/her/their self as "very active." BL has regular daily exercise routines, takes walks, talks to neighbors in public spaces in his/her/their building, attends board meetings in the building, frequently visits with a wide variety of family members, and tutors a grandchild.

For BL, the most significant change in his/her/their day-to-day quality of life due was socializing. Before the pandemic, BL enjoyed participating in the variety of classes and activities and celebrating occasions with food and music, while also making "so many friends and socializing." BL likes "anything that keeps my brain active… anything that has to do with the brain and the mind." Since the pandemic, BL has been joining all classes and activities on Zoom, which he/she/they had not used before. BL prefers Zoom over joining by phone because then he/she/they can see the instructor and other participants. BL feels there are still some social benefits to participating online. "I get to hear a lot of other people who join in on our conversations, or during meditation, or this or that, so it's kind of a social thing. And there's a lot of people from...other cities.... we all join for a great cause." BL especially enjoys a meditation class, which "taught me to not worry… not having any negative thoughts." BL also feels that he/she/they 'sees a lot of improvement with myself" as a result of attending exercise classes. BL feels that using such programs helped him/her/they stay physically and socially "busy" and adjust to the limitations of the pandemic.

When the program shifted to online, BL decided to learn new things. "I said, 'Well I'm locked up, but I'm going to do all these things,' … it's not the same, but it's still the same. But it's still kind of socializing a little, because talking to the instructor and this and that and whatever. Through them, I learned a lot too! Even though I'm locked up, I have Zoom." BL still keeps in touch with nearby friends that also participate in the program, socializing outdoors on their terraces. BL has told others about the online activities. BL misses events and activities that cannot be easily replicated on zoom such as special occasion gatherings, chess, dancing and movies. He/she/they is eager to get back to in person activities, but for now, "I'm not stressed, I'm happy … even though it's not the same, but it's quite a bit better than nothing." BL repeatedly mentioned the importance of making friends and "who knows, maybe fall in love! Again!" However, BL is worried about finding a new program to go when the pandemic is over because he/she/they believes that the physical location is permanently closed and stated that when it closed, "I was crying because it wasn't there anymore and I was missing learning ...and all the socializing we did."

Dealing with Loss and Loneliness
(Story 8, Appendix XII)

EE lives alone in his/her/their own home in a suburban community. EE participates in a variety of activities that are available through an **online program platform**, and a **phone-based discussion group**. EE found Zoom "difficult" but people from the program came to install some equipment and explain how to access programs. EE **used to go to the center** that was closed down during the pandemic and became "lonesome but this helped a lot. I'm not lonely anymore."

One of the most significant changes EE experienced was being able to "mentally relax" because "I've had a lot of deaths in the family, so this helped me during the grief and relaxed me." The bible classes and opportunities to "laugh" also helped EE cope with stress. EE prefers listening to these online programs "instead of listening to the news, when everything was so bad all the time you get down and you lose hope." EE also enjoys seeing faces of other participants and discussing things with people from all over the country. EE finds the online yoga class especially valuable "because going through all this death, not being able to move around, I'd be stiff and tired all the time, and have no energy. And this gave me energy…and, because of the mindfulness, I can improve my thinking a little better now, instead of thinking of all the death I've had and feeling sorry for myself." EE also noted that the online programs focus on positive things. "You don't want to fill yourself up with things that are going to put you down. This brings you up! This brings your spirits up. This is constructive. It gives seniors hope." EE observed that sometimes family members do not have time, but seniors can support each other. "We can get here with each other, we can identify each other's aches and things and when you're talking, you become like friends and identify needs and shared experiences." Once He/she/they also values "being able to talk and see other people, see their faces, their expressions, their smiles, their personality and compassion. It's like family, like a new family." EE describes the program leaders as caring people who listen and "have patience with seniors," which "helps them grow more, see other people going through, trials and tribulations too. You're not alone. Other people are facing it too and just taking their minds off of it for a bit." For her, participating online was like participating in the community from the TV. EE also started doing more exercises and noticed both mental and physical improvements.

During the winter weather and the pandemic, EE felt the online programs were "very handy for talking to people," and learning. "So this was like learning it all over again, you know as you get older, if you don't use things, they go away, so this was bringing them back. And I needed that." Using online programs inspired EE to learn more about technology. "I want to learn, because this is the new way." In the past, EE socialized with a group of friends, going to each other's home to dance, sing, cook, or pray or going to a restaurant or movie. These friends still got together from time to time prior to the pandemic. EE also participates in groups at his/her/their church.

Looking Forward to Friendly Calls
(Story 12, Appendix XII)

NS lives alone in his/her/their own home in a small town. NS receives **friendly calls** and heard about the program from a staff person at a senior service organization. NS says he/she/they decided to accept calls "because I was pretty much isolated at that time" due to the pandemic. NS noted that a nearby family member would not come visit because of NW's health conditions and the doctor had told NS to stay home. NS noted, "It was very hard to be here by myself all the time. So the calls, it came at the right time."

When asked about significant changes in his/her/their day-to-day quality of life due to the calls, NS responded, "I look forward to the calls. I actually think I look forward to the future more than I did, because I know [the caller] is going to be calling and we have a lot in common! And we always enjoy visiting with each other, so … it really helps to take your mind off of what's going on." NS said that they tried to arrange an in person visit but haven't yet succeeded in finding a time that is convenient. NS went on to describe the experiences and hobbies he/she/they and the caller have in common and what they talk about. The calls also gave NS something to do when he/she/they had to stay off his/her/their feet due to health issues "and it *still* gives me something to do. When [caller] calls, it's like visiting with a good friend." NS later noted that the friendly calls may have helped him/her/they deal with the death of a family member and the passing of several neighbors, noting that "This has been a year of goodbyes." "And I've always been somebody who knows everybody, so to see the group getting smaller like this … it's been hard."

NS is familiar with computers from his/her/their past career. NS connects with neighbors and family both in person and on the phone. One neighbor has been particularly helpful when NS has emergencies. He/she/they also uses Facebook to stay in touch with friends and former students, is not Facebook friends with the person who calls. During the pandemic, NS adjusted to not seeing people in person, explaining, "I missed that one on one contact an awful lot, but I still was able to do some things. Our church started having their services online, so I could watch it online until they decided we would have it in the parking lot...We did find ways to do the things we do in-person. It was just different!" NS has also participated in craft programs through a library and received an Ipad and internet connection device from them "that was handy when I was so cut off." He/she/they learned how to do more shopping on the internet. NS describes him/her/their self as an "outgoing person." NS also does a "card ministry" for his/her/their church and sits and visits with neighbors.

Together, the 27 stories selected by the Steering Committee and/or Advisory Groups (Appendix XII) demonstrate how a wide variety of programs can meet older adults' needs for social connections, including programs we may not think of as explicitly being "social" in nature. First, some older people in this study explained that they were comfortable spending time alone or had limited desires for social contact (e.g., stories 11, 15 and 25). These individuals, who were limited by health conditions or disabilities, appreciated the social contact they had with staff or volunteers in transportation programs, home delivered meals, or those who provide other resources. In another set of stories, older adults did not necessarily express interest in expanding their social connections and appeared to be satisfied or even fulfilled by the social opportunities they currently had through programs, contacts with family, friends, and neighbors and other groups or organizations (e.g., 2, 3, 5, 7, 8, 9, 10, 14, 16, 17 and 18). These individuals used a variety of programs including caregiver groups, choirs, educational groups, discussion groups, various activities at a center, at dining sites, or via an online application, tablet, or zoom, library programs, transportation (to get to a desired activity), and volunteer programs. In another set of stories older adults expressed interest in or preferences for seeking out more social opportunities, staying socially active, developing relationships, or expanding social connections in some other way (e.g., 1, 4, 6, 12, 13, 19, 20, 21, 22, 23, 24, 26, 27). They also participated in groups, centers, dining sites, and volunteer programs, used transportation to go where they prefer, or developed relationships or expanded their social network through friendly visits or calls.

In short, the ‘most significant change’ stories confirm that different types of programs can effectively provide social connections, and likely reduce social isolation, in different ways for different people. In addition, the most significant change stories show how older adults made decisions about how to use programs during a period of unexpected change (i.e., the pandemic), but also in response to retirement, losing friends or family, moving, and other changes in their lives. In response to those changes, they chose programs that allowed them to exercise the social skills that they already have, but also sometimes took advantage of programs that gave them opportunities to build new social skills.

Objective 3: Assessing Program Data Collection Practices

3a. Data Collection Practices

Physical distancing requirements have necessitated remote data collection procedures to obtain information on participants' feelings of loneliness and isolation, as well as their satisfaction with social isolation programming and other outcomes of interest to the AAAs and services providers.

Findings from Staff Focus Groups

During the focus groups, staff were asked to discuss issues related to data collection and use. Themes from that discussion are summarized below (themes highlighted in bold).

Some staff shared their **experiences with formal assessment tools and data collection**. During discussions, staff mentioned conducting assessments by phone, mail, online, or as part of outreach activities at locations where they provide group programs. The type of data staff collect depended on the types of services they provide. A number of staff mentioned using the short version of the UCLA Loneliness Scale and one person described using a "brief questionnaire" on loneliness as being part of their intake process (which may have been the same tool). One person did not think their agency was asking any questions about loneliness. One person described administering a pre- and post-assessment of outcomes using a set of tools (Geriatric Anxiety, PHQ9, and the UCLA3) and a second person also mentioned using the PHQ9. Another person mentioned an online self-assessment tool but did not specify what it was for. For caregivers, some staff use "Tailored Caregiver Assessment and Referral (T-Care)", a comprehensive assessment tool and data collection system that gives agencies "quantifiable data." Some staff mentioned using longer assessment tools to determine needs for transportation and other home and community-bases services. Staff also mentioned collecting data on how people heard about programs or where they were referred from, asking about participants' interests as a way of assessing needs, and conducting satisfaction surveys. One person felt they were "getting better" at collecting pre- and post-outcomes data for an online dementia education program.

Staff cited a variety of challenges to **getting responses or accurate information from older adults**. One person noted, "We've been asked to collect data through a link, which a lot of seniors just don't follow through and either they can't, or they don't'." Staff observed that not being able to get older people to call back impedes their ability to conduct assessments. Some also felt that administering the UCLA Loneliness scale over the phone was difficult. One person noted, "there's a little finesse where you have to make them feel comfortable with the questions you're asking..." One person explained,

> Because you don't get to see their reactions to comments or questions, and I feel like when you're over the phone it's probably harder, easier for them to kind of change their results, and like, tell you something that may not be a hundred percent true, and you can't see that in their face. But I feel like sometimes if you're able to see them in person, and kind of see the way that they're processing, you might be able to pick up on things and kind of dive into it a little bit deeper than you can when you're on the phone with them.

Someone else observed that when asking a question about being lonely the person may instead say something like, "I haven't been able to get out to my church that I usually visited." Another person speculated that an older adult could be embarrassed to admit being lonely or isolated, thinking that there is something wrong with them and "….that pride may be a barrier to really teasing who are the truly lonely, isolated people." As noted above many staff described informal discussions with older adults or caregivers as being most useful for them (see assessing and reaching socially isolated older adults). One person explained that if social service staff ask questions *without* using the term lonely or isolated "the truth will come out." At the same time,

some staff commented that older adults' reactions to the short version of the UCLA are "better" than when they used the longer form in the past.

Focus groups were also asked **how they use data**. Overall, staff explained that they are required by their AAA to collect data from their clients, which they primarily use for reporting to their AAA and their board. As one person explained, "I collect data and I pass it on." Others mentioned using data in proposals to a foundation or for fund raising, while others agreed it can be useful to share data with the community or community partners. Staff mentioned using results from satisfaction surveys or using outcomes data to seek more funding. However, one person noted that they do not have any way of collecting data from people who are not their clients and that the data they receive from the AAAs only gives them an overview of all data from all agencies in their communities. That person was not sure how they could use better data to find or "keep track of" people at risk of social isolation or loneliness.

When prompted for ideas for how to overcome data collection or data use challenges, some staff cited the problem of duplication of data, noting that they are entering the same data into different software systems and spreadsheets. Staff felt it would be helpful to have a more streamlined system for reporting data to different audiences for different purposes. One person did not believe that many other staff see the importance of data. No one suggested how to overcome this challenge, but they did have ideas for how to make data collection more feasible or useful. Other staff felt that agencies need help with developing surveys, scripts for administering tools, a better understanding of how to appropriately administer tools or surveys, and translation when working with different language groups. Other staff hired researchers to do data collection when they have an interest or need for certain kinds of data.

3b. Pilot Test of Novel Methods

Feasibility of a Text Message-Based Survey Method

At the initial stage of study conception, we planned to conduct one focus group with up to 10 older adults who had participated in the text message survey to seek their input on the feasibility of using this new methodology. The focus group was planned to address topics such as older adults' prior experience with technology, what they liked/did not like about this data collection method, potential barriers or challenges to accessing and/or responding to the text-messaging based survey, reasons why other older adults might not respond to text-messaging based surveys, and suggestions for improving feasibility for older adults.

In lieu of conducting this focus group, we collected feedback on these desired topics from two other sources. First, information about older adults' experiences with technology was collected via the ongoing online survey. These questions asked about respondents' confidence in their ability to use the Internet, ways respondents use the Internet, and how much respondents would like to socialize with others in-person versus other ways of socializing (by phone, video calls, text messages, or online) in the next 4 months. Responses to these items were collected from additional AAAs through Spring 2022, which we then analyzed and used to further contextualize and/or make suggestions for improving the text message-based survey method.

Second, in two meetings with the Older Adult Advisory Group prior to launching the text message-based surveys, we presented to the group our first draft of the text message surveys—as well as the online survey—for their input and suggested improvements. Table 10 below summarizes the group's feedback regarding these surveys, as well as suggested modifications that were implemented in the revised survey materials prior to data collection in the field. In summary, feedback on the online survey focused on themes of question wording and ordering, whereas feedback on the text-based survey focused on reducing burden and potential for respondent concerns about text messaging itself.

Table 10. Feedback on Online and Text Survey Materials and Methods from Older Adult Advisory Group and Implemented Improvements

Material	Feedback	Implemented Improvement
Recruitment Email	"You may be eligible if proficient in English" sounds exclusionary.	Language changed to, "This survey is only offered in English at this time."
Online Survey	Starting off with the UCLA Loneliness Scale isn't ideal because it is too personal, too fast and the questions are difficult and emotional in nature.	The online survey now begins with three more neutral questions that do not ask about loneliness or social isolation. These questions ask about respondents' confidence in their ability to use the Internet, ways respondents use the Internet, and how much respondents would like to socialize with others in-person versus other ways of socializing (by phone, video calls, text messages, or online) in the next 4 months.
Online Survey	Technology use is noticeably missing from the survey—it would be good to include some questions about this.	We have added questions about technology use (see preceding row above).
Online Survey	For the survey item asking about tangible support, any support from paid helpers should also be included because those can be important relationships as well.	This item was edited to add paid helpers and now reads, "When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, house cleaning, cooking, telephoning, or giving you a ride? Please include any paid helpers."
Online Survey	Is there a way to remove the word "sexual" from, "Do you currently have a romantic, intimate, or sexual partner?"	This item was combined with the marital status item and edited to remove the word "sexual." It now reads, "Are you currently married, living with a partner, have a partner who you do not live with, separated, divorced, widowed, or have you never been married?"
Online Survey	After the more difficult questions in the middle of the survey about loneliness and social isolation, it would be nice to have near the end a few additional questions about socializing and the kinds of activities folks would want to do in their community.	We have added near the end of the survey these questions suggested by the group: 1) "How often have you had opportunities to socialize with other in the past 4 weeks?" 2) "How often have you been able to see your children or grandchildren in the past 4 weeks?" 3) "If your community were to offer the activities/events below, which ones would you be interested in participating in? Please select all that apply." (11 activity choices)
Online Survey	It would be nice to end the survey with an open-ended question inviting respondents to share anything else that is on their mind. This would ensure that we don't miss anything important that comes up for people.	Near the end of the survey, a question asks, "Is there anything else you would like to tell us?" in a free-response format.
Text Message Survey	It seems too overwhelming to participate once per week in a text survey for 4 months. Can the expected level of participation be reduced?	We have changed the survey frequency to be once per month for a total of 3 months (3 surveys) rather than once per week for 4 months (~16 surveys).

Text Message Survey	A total participation commitment of 3-4 months seems like a long time. It could be helpful to remind respondents that their participation is voluntary and they can participate as much or as little as they would like to.	We have kept in the consent form information about: 1) how participation is voluntary, 2) that respondents have the right to skip any question that makes them uncomfortable, and 3) that respondents may end their participation at any time. In addition, the text message surveys let respondents know that they can text the word "STOP" at any time if they no longer wish to receive text messages for the study.
Text Message Survey	Respondents should be informed that they might be charged by their cell phone plan to receive the text messages.	We have added to the consent form a sentence about this, which reads, "Note that standard text messaging rates may apply, following your own particular cell phone plan."

During the pilot phase, AgeOptions submitted a request to a select group of their service provider partners who aim to address loneliness and social isolation, asking them to send out the study recruitment email to any older adults for whom they have an email address on file. For the remaining AAAs, NORC worked directly with service providers, rather than via the AAAs, to send out the same study recruitment email.

Text Message-Based Survey Results

Thirty-two consenting older adults received one text message survey per month for a total of 3 consecutive months. Of these 32 older adults, all of them started at least one survey (*M*=2.9 surveys started/participant, out of a possible 3 surveys). Among the 27 older adults who completed at least one survey (submitted responses for all survey items), the average completion rate was 2.3 surveys.

A total of 93 text message-based surveys were returned by respondents between July 14, 2021 and April 19, 2022. Of these 93 surveys, 62 (66.7%) were completed.

As far as response rates, older adults completed 65% of all possible surveys (i.e., 62 surveys were completed out of 96 possible surveys). Half of respondents completed all three surveys. Of the surveys that were completed, older adults took an average of 73.6 minutes to complete the survey, although this ranged significantly from 1.7 to 1174.3 minutes (19.6 hours). Half of these surveys were completed in under 8 minutes, with 75% within approximately one hour (61.5 minutes). Times of the day at which respondents completed surveys ranged from 8:34am to 11:14pm, although times were relatively evenly distributed throughout the day with an average time of around 1pm.

Table 11 presents summary statistics of text message-based surveys started and completed among older adults.

Table 11. Summary Statistics of Text Message-Based Surveys Started and Completed Among 32 Participants Who Consented to the Text Message Survey Protocol.

	N / % / Mean	Standard Deviation	Range
Total unique respondents that started ≥1 survey	32		
Total unique respondents that completed ≥1 survey	27		
Total surveys administered	96		
Total surveys returned	93		
Total completed surveys returned	62		
% surveys completed out of total possible surveys	65%		
% respondents who completed all 3 surveys	50%		
Mean surveys started / respondent	2.9	0.7	2-6[a]
Mean surveys completed / respondent among those who completed ≥1 survey	2.3	0.9	1-3
Mean time to submit completed survey (minutes)	73.6	174.9	1.7 – 1174.3
Mean time to submit completed survey (hours)	1.23	2.9	0.03 – 19.6

[a] One respondent started a text message-based survey twice in response to three separate text prompts, each prompt spaced one month apart. In each case, the respondent only completed one survey. Excluding this respondent, older adults started and/or submitted between 1 and 3 surveys.

5. Conclusions and Recommendations

Taken together, findings from the program descriptions, and their reach, use, and impact provide information that could inform the IAS as it seeks to further address older adults' need for social connection. Opportunities posed by these findings include: (1) expanding the range of strategies used to locate older adults at risk for social isolation; (2) developing programming that is sensitive to the unique needs of racial, ethnic, cultural, and other subgroups; (3) exploring and addressing barriers to participation by men and some racial/ethnic subgroups, who tend to be underrepresented in social isolation programs; (4) integrating a robust technology support system into service offerings to facilitate older adults' use of this mode of communication; and (5) implementing a systematic and reliable data collection strategy to permit monitoring of program effectiveness at reducing individuals' social isolation (e.g., for whom is it effective? What duration and frequency of engagement are needed to elicit a benefit)?

Text-based surveys lend themselves well to the latter opportunity while minimizing staff burden. Although our results indicate this is a feasible strategy in terms of response rates, uptake needs improvement. That is, work is needed to develop an approach to text-based messaging that gets greater buy-in on the part of older adults who do not release their phone numbers to AAAs or providers (a major obstacle to our being able to use the text-messaging approach). We recommend considering the use of text messaging to provide resources, information, and emergency alerts (for example) alongside the delivery of surveys. An approach to data collection that "gives" as much as it "takes" may be seen more favorably and may garner greater participation. This is an empirical question and could be tested and compared with other means of securing participation.

6. Limitations

Limitations of the Qualitative Interviews and Focus Groups

The findings from interviews are not generalizable to those who were not interviewed or to other adults not living in the areas of Illinois included in the study. The sample was limited in several ways. Only twelve people from each AAA were interviewed and sometimes more than one person was referred from the same program, which may have limited the diversity of program experiences reflected in the sample. The interview sample overrepresents the experiences of women as opposed to men or other gender identities. Although the sample included some African Americans and a few people of Latinx or other ethnic backgrounds, no limited English-speaking older adults were included. Due to challenges with recruitment, such as unwillingness to answer phone calls, older adults who agreed to be interviewed may have included those who were more willing to share personal experiences. In addition, older adults were referred by those who provided the programs and therefore may have been more compelled to say positive things about those programs.

The findings from focus groups are not generalizable to other staff in the five areas of Illinois included in the study and may not represent the experiences and views of staff who were familiar with the full range of programs used by older adults in this study. The focus groups may not have included representatives from staff who were more familiar with some programs. In addition, there were more participants from some AAAs than others (and only one participant from one of the AAAs).

Limitations of the Online Survey and Text-Based Messaging

Findings from the online and text-based surveys are not generalizable to those older adults who did not participate in these surveys or to or to other adults not living in the areas of Illinois included in this research. Findings also may not generalize to older adults who do not use computers or text messaging due to lack of interest, access, or technological knowledge. Overall, those who participated in the surveys were more often women (vs. men) and non-Hispanic White (vs. non-Hispanic Black, Hispanic, and those of other races). Furthermore, findings may not generalize to those who are not fluent in English; given the pilot stage nature of this research, surveys were only available in English. In addition, given that only some AAA partner providers collected information from program recipients about email addresses, some older adults with Internet connectivity and email were not able to be invited to participate by the partner providers. Finally, given that we did not follow-up with participants in the online or text-based surveys to inquire about their experiences with these surveys, we do not have user experience or other data to assist with identifying potential reasons why individuals did or did not complete all surveys in their entirety throughout the total course of the pilot.

List of Appendices

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Appendix I. Challenges Encountered and Lessons Learned

In carrying out the pilot evaluation phase with AgeOptions as well as the remainder of the project with additional AAAs, we encountered a number of challenges with regard to the overall project, quantitative components, and qualitative components. In the table below, we describe these challenges by topic area, including the actions we took and/or the information gleaned related to these challenges. These lessons learned informed the evolution of the program evaluation.

Challenges Encountered by Topic Area and Corresponding Actions Taken and/or Information Gleaned

Topic	Challenge	Actions Taken/Information Gleaned	Lessons Learned
Program Evaluation Budget	We found that the required effort for carrying out all of the proposed study components (i.e., advisory groups, programmatic data, online survey, text messaging survey, interviews, focus groups) took longer than originally anticipated, in part related to the challenges noted within this Table.	We did not carry out the proposed "virtual community white board" component that was originally proposed. In addition, we did not conduct a focus group with participants of the text messaging survey. Instead, we gleaned a significant amount of older adult feedback on this survey from the Older Adult Advisory group, described herein (see Table 4).	In future research, it may be prudent to estimate that study components will take more time to complete than anticipated and to keep the scope of work to a realistic number of components given the time frame. Consulting with junior staff to estimate time/effort required prior to finalizing scope could be beneficial. A stipend for AAA/program partner staff (existing or hired specifically for a project) may be advised to reflect the effort undertaken.
Communications with AAAs and their Program Partners	NORC and CJE SeniorLife had originally thought we could avoid overwhelming AAA staff with work related to this project by introducing the various components (e.g., focus group, interviews, online survey recruitment) one at a time, over time. However, this may have instead created confusion.	Moving forward in communications with the remaining AAAs, NORC and CJE SeniorLife provided an introductory overview of all program components from the start to provide a more comprehensive overview for collaboration and task completion.	In an introductory/orientation meeting, provide an overview of the overall project, components, and timeline. The earlier that this meeting can take place, the better this may be to allow all parties to begin planning while balancing other commitments (e.g., preparing annual AAA report).

Forming and Convening of Older Adult Advisory Group	Some members of the older adult advisory group were difficult to reach via their only mode of contact provided (phone).	We continued to recruit more members to the group until we had a sufficient quota with successful contact. For one individual without Internet, we mailed him the required meeting materials and arranged a test call for him to practice calling into a Zoom meeting.	This did not slow our progress on the project. Some individuals became more likely to respond to phone calls after the first 1-2 meetings. Attempts at collecting alternative modes of contact should be made; however, we expect that there will always be some older adults who do not have email/Internet.
Convening of Advisory Groups	Over the course of the project, we observed attrition in members of all three of the advisory groups.	We continued to convene the advisory groups with the remaining members. At times, this was only 3-4 members at a given group meeting.	It may be beneficial to provide financial or other incentives to group members to keep them engaged and prevent attrition. Payment could be delivered in 2-3 installments after individuals have attended a certain number of meetings. Sharing brief progress updates via email could also demonstrate how their input has been used and maintain interest over time.
Programmatic Data	Many AgeOptions program partners did not start collecting UCLA Loneliness Scale data until after the pandemic began, and these data are sometimes only available at the aggregate (rather than the individual) level.	We have analyzed any available loneliness score data, even if for some programs it was only collected during the pandemic and/or at the aggregate level of organization (precluding linkage of scores with demographics).	Before establishing the scope of work for future research, all parties involved should have clear communication and investigation into the extent to which desired existing data are indeed available and the level of detail that is available in the data.
Programmatic Data	We do not have programmatic data for some key demographics (date of birth, gender, living alone) for unregistered clients.	It was determined that having unregistered services staff begin to collect this information would be too much of a burden to implement at present. We have analyzed the data that are available.	Data may sometimes not be as complete as would be ideal, and adding to the list of data collected may be too burdensome for AAA and/or program provider staff.

Programmatic Data	Some programmatic data files were missing further information that would assist with contextualizing and understanding the findings. For example, it is sometimes unknown when pre-post loneliness data were collected, or what local factors might explain short-term fluctuations in program recipient demographics.	We are requesting this information from the AAAs; however, barring any additional information provided, we will not be equipped to deeply interpret findings beyond what is evident from the data available.	AAAs and/or program partners should collect records regarding when pre-post loneliness scores were collected (e.g., at intake and a standardized follow-up period; at standardized timepoints for all participants) and communicate that information to researchers. AAAs and/or program partners should also communicate any insights into local factors, trends, or changes that might explain program findings. Nevertheless, in observational research designs such as this, conclusions about causality will not be possible.
Recruitment for Surveys	Standard intake forms do not ask older adults for their email address and whether the phone number provided is a landline or cell number. It was unclear just how many email addresses are available, if any.	The AAAs asked their respective program partners to send out recruitment emails to any older adults for whom they have email addresses on file.	Expect that only a few program partners will have a large number of older adult email addresses; many others will likely have few to no email addresses on file.
Recruitment for Surveys	Even if email and type of phone number were to be added now to intake forms, this would only help us obtain this information for new program participants. Existing participants will not have this new data.	We discussed whether service providers (internal and/or external partner organizations) could begin to ask these questions at the time of service delivery. However, it was determined that this would be too much of a burden to implement at present.	Data may sometimes not be as complete as would be ideal, and adding to the list of data collected may be too burdensome for AAA and/or program provider staff.

Recruitment for Surveys	It was not immediately clear whether for recruitment a "mass email" would be possible from AAA perspective. That is, related to privacy, do they have the staff and the mechanism to sent out a mass email, to manage any replies, and to securely turn over the cases who consented without jeopardizing confidentiality?	We have found that it is indeed feasible to recruit via email while maintaining older adults' privacy. The recruitment message is sent by partner providers, and the recruitment materials provide NORC's contact information for any questions. All data collected from older adults for this research is stored on NORC's private server and no survey data go through the AAAs.	Partner providers can send out recruitment materials that include NORC's contact information for any questions. All data collected from older adults for research can be stored on NORC's private server and no survey data need to go through the AAAs.
Recruitment for Surveys	Older adults may be less likely to participate in the text message and online surveys without any form of compensation.	Given that part of the intent of these surveys is to—if feasible—include them as an unpaid part of regular intake and/or service delivery, compensation was not offered to provide the best test of feasibility.	Only half of those who opened the online survey ended up completing the first survey question after the informed consent section (which contained a sentence noting that participation would not be paid—information not included in the recruitment email). It is possible that lack of compensation for participation may have been one factor deterring participation.
Text Message Survey	It may be a bit too cumbersome to ask older adults about their frequency and duration of use and program satisfaction for every service that they receive	We speculated that most older adults are probably not participating in more than a few programs and thus, we ask them about whether they have used any of 6 different services in the past month and their satisfaction with any those that are reported.	It may be an efficient approach to ask first about participation in several different services in the past month and then only ask about program satisfaction for those that are reported.
Text Message Survey	We were not sure if friendly visit services are essentially the same as telephone reassurance services during the pandemic era.	In our text message survey, we combined the two as one program type, as they are conceptually very similar in their intent.	Researchers and AAAs should communicate early about program-specific terminology to clarify as needed.

Text Message Survey	Older adult participants may not respond to phone contacts when they do not recognize the phone number.	We standardized the phone number that the text messages came from and made a note in the recruitment materials to let participants know which phone number they can expect the messages to come from.	Standardize the phone number that the text messages come from and make a note in the recruitment materials to let participants know which phone number they can expect the messages to come from.
Text Message Survey	Older adults may wonder about costs of text messaging.	We included in the consent form a note that standard text messaging rates may apply depending on the individual's data plan.	Include in the consent form a note that standard text messaging rates may apply depending on the individual's data plan.
Online Survey	We will not be able to determine from each online survey response which AAA the participant was recruited from.	Before launching survey data collection for the remaining AAAs, we have added a question to the first online survey asking for the participant's zip code to then match up with AAAs.	We did not break down online survey results by AAA for the present research due to the small number of respondents. However, asking for zip code would permit matching of participants with AAAs in future research.

Recruitment for Interviews	Program Partner staff may not consistently understand or adhere to recruitment pro. For instance, staff sometimes referred older adults without going through the recruitment coordinator, did not complete a recruitment form, were uncertain which programs they could recruit from, and recruited people under the age of 60. Based on conversations with some older adults, it was not always clear if staff had confirmed than an older adult was willing to be contacted by a researcher.	We clarified that one person at each AAA should be designated as a recruitment coordinator, provided an overview of the recruitment procedure in a meeting with the five AAAs after they had begun recruiting, and tailored the recruitment form to each AAA by listing the programs funded under the social isolation initiative that were identified in their area plans. We periodically emailed the updated recruitment forms to all recruitment coordinators. We suggested target numbers by program types and demographic characteristics, to ensure a diverse sample. The interviewer instituted a screening process to verify participation in programs to reduce social isolation and age before beginning to verbal informed consent process with each participant.	Our initial plan was to designate one person at each AAA as a recruitment coordinator, providing those coordinators with orientation along with detailed written instructions on a form that they would then share with Program Partners who were in direct contact with older adults and caregivers. An introductory/orientation meeting to provide an overview of the overall project, components, and timeline (see Communications with AAAs and their Program Partners) should include explanation of recruitment procedures. Regardless, anyone involved in recruitment throughout the data collection period is likely to need repeated clarification of recruitment procedures. Future projects should budget extra time for communication with and support for AAAs/Program Partners.
Recruitment for Interviews	On a few occasions staff offered to ask the interview questions or translate interviews.	When such offers arose, we explained the research process and why it was important that staff were not involved in interviews, including the potential for biased responses.	A basic orientation to the rationale for data collection by researchers (as opposed to staff) and the concept of bias could be included an introductory/orientation meeting (see Communications with AAAs and their Program Partners).

Recruitment for Interviews	The pace of referrals was inconsistent over the course of the project. Sometimes referrals that had been identified were not immediately passed on to the interviewer.	We kept a log of all contacts with AAA's and Program Partners and recruitment coordinators if we had not received communications for several weeks and also sent thank you emails when we received referrals.	The ability of AAA and Program Partner staff to devote time to recruitment was impacted by their workload, especially during waves of the pandemic. In addition, normal staff responsibilities may not allow time for making extra calls to recruit evaluation project participants. In short, using direct service staff to recruit study participants may not always be a realistic method. Staff who do so will need support and/or time (as noted above) and evaluation projects will need to dedicate more project staff time to train and interface directly with staff involved in recruitment. Other options for recruitment that do not require Program Partner staff time should be considered as well.
Recruitment for Interviews	It was difficult to find older adults who were willing to be interviewed while also fulfilling target numbers for a diverse sample by demographic characteristics.	In the last six months of the recruitment period, to reduce burden on staff, we focused solely on target numbers for program type (one on one vs. group) to ensure that we would meet our goal of 60 interviews by the end of the data collection period.	Typical intake routines and other usual contacts with program users do not necessarily fit the sampling needs of a particular evaluation study. Recruiting a diverse sample requires more time for AAAs/Program Partners to make calls to a larger number of people.

Recruitment for Interviews	AAA/Program Partner staff identified recruitment challenges. They observed that older adults do not answer phone calls or respond to messages to avoid spam calls. They often ask for the name and phone number of the researcher and when they will be calling. They may be concerned about confidentiality of personal information and want to know what the interview questions were.	Program Partner/older adult concerns were addressed as they came up. We modified the recruitment form/process to include the name and phone number of the interviewer.	Staff involved in recruitment need to be able to explain to older adults that interviews in an evaluation study are confidential. They may need to clarify that the researcher will explain the study and answer their questions first, and will not be offended if they decide not be interviewed. Program Partner staff would benefit from a very simple explanation of these general aspects of evaluation research through an orientation meeting (see Communications with AAAs and their Program Partners). The recruitment script could also include more explicit language on these issues.
Recruitment for Interviews	It was time-consuming to reach older adults by phone. Some older adults blocked the interviewer's phone number. Program Partners also cited similar difficulties with reaching older adults by phone.	In order to complete 60 interviews, AAAs had to contact and refer over 100 older adults. A qualitative researcher/interviewer called and/or emailed each older adult referral at least three times or left at least three messages before discontinuing recruitment efforts. When qualitative research staff were available, a second person assisted the interviewer with making initial calls to schedule an interview. In the last three months of the project, we called potential interviewees more than three times and called them more frequently. We had had success communicating with the few older adults who had provided an email to a Program Partner, which may have helped to "legitimize" the source of a subsequent phone call.	Evaluation projects need to budget sufficient time for both staff involved in recruiting and interviewers to reach older adults by phone. They should anticipate a high rate of no responses to phone-based recruitment. In the future, it may be helpful if those who provide programs are able to consistently collected information from program users about their preferences for being contacted by email or text messaging (including for purpose of program evaluation).

Interviews	A few older adults may have consented primarily to get the $25 gift card. (One person was unable to verify that they received the program we called about.)	The interviewer changed the contact protocol by first confirming that the individual was receiving the program they were referred form (before consenting them to the study or mentioning the gift card).	We anticipated that this could happen and adjusted accordingly.
Interviews	Some older adults did not answer their phone when they were called for a scheduled interview.	We adjusted by making reminder calls a day or two prior to each interview. When someone missed an interview, we made at least two follow-up calls over a couple of weeks, to allow time for them to respond in the event that they had an unanticipated conflict or illness.	It is possible that because their first contact was with a person from the program they use, older adults may have been more inclined to agree to be called in part to please that person. It may have been more comfortable for some individuals to also agree to an interview, but then say "no" by simply not showing up.
Focus Group	A few staff may not have understood the purpose of a focus group. Some thought they were required to attend or would be asked to present information. Others thought the focus group would be providing them with information.	We required registration for a focus group to ensure that we had a way to provide each participant with a description of the project beforehand. When questions arose, we clarified the purpose and voluntary nature of a focus group. As planned, immediately before beginning the focus group discussion we reminded attendees that participation was voluntary.	Evaluation studies that collect data from staff need to be sensitive to staff perceptions of what is "required" as part of their job and their motivations for participating. Evaluation researchers need to remind staff of the purpose of data collection activities such as focus groups and their voluntary nature, even after they have provided them with study information.

Recruitment for Interviews	Program Partner staff may not consistently understand or adhere to recruitment pro. For instance, staff sometimes referred older adults without going through the recruitment coordinator, did not complete a recruitment form, were uncertain which programs they could recruit from, and recruited people under the age of 60. Based on conversations with some older adults, it was not always clear if staff had confirmed than an older adult was willing to be contacted by a researcher.	We clarified that one person at each AAA should be designated as a recruitment coordinator, provided an overview of the recruitment procedure in a meeting with the five AAAs after they had begun recruiting, and tailored the recruitment form to each AAA by listing the programs funded under the social isolation initiative that were identified in their area plans. We periodically emailed the updated recruitment forms to all recruitment coordinators. We suggested target numbers by program types and demographic characteristics, to ensure a diverse sample. The interviewer instituted a screening process to verify participation in programs to reduce social isolation and age before beginning to verbal informed consent process with each participant.	Our initial plan was to designate one person at each AAA as a recruitment coordinator, providing those coordinators with orientation along with detailed written instructions on a form that they would then share with Program Partners who were in direct contact with older adults and caregivers. An introductory/orientation meeting to provide an overview of the overall project, components, and timeline (see Communications with AAAs and their Program Partners) should include explanation of recruitment procedures. Regardless, anyone involved in recruitment throughout the data collection period is likely to need repeated clarification of recruitment procedures. Future projects should budget extra time for communication with and support for AAAs/Program Partners.
Recruitment for Interviews	On a few occasions staff offered to ask the interview questions or translate interviews.	When such offers arose, we explained the research process and why it was important that staff were not involved in interviews, including the potential for biased responses.	A basic orientation to the rationale for data collection by researchers (as opposed to staff) and the concept of bias could be included an introductory/orientation meeting (see Communications with AAAs and their Program Partners).

Appendix II. Online Pre/Post Survey

Thank you for completing this survey for the Health and Aging Study!

Technology Use, Physical Health

1. How would you rate your confidence in your ability to use the Internet?
    a. Very confident
    b. Moderately confident
    c. A little bit confident
    d. Not at all confident

2. In what ways do you use the Internet? Select all that apply.
    a. Browsing the web, seeking information, or reading the news
    b. Shopping
    c. Getting prescriptions, contacting my medical provider(s), or handling Medicare or other insurance matters
    d. Social media or social networking (such as on Facebook, Instagram, Twitter, or LinkedIn)
    e. Video calls (such as on Zoom and Facetime)
    f. Attending events (such as workshops, meetings, or religious/spiritual services)
    g. None of the above

3. In the next 4 months, how much would you like to socialize with others in-person, compared to other ways of socializing (such as by phone, video calls, text messages, or online)?
    a. Only in-person
    b. Mostly in-person
    c. An equal amount in-person and other ways (not in-person)
    d. Only a little bit in-person
    e. Not at all in-person

4. Currently, would you say that your physical health is excellent, very good, good, fair, or poor?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

Social Isolation/Social Engagement/Relationship Quality

People differ in how often and how easy it is for them to socialize. Thinking of all the ways you interact with others—whether in-person or by phone, video calls, text messages, or social media—*how often in the past 4 weeks have the following statements been true for you*?

5. I attended social clubs, residents' groups, or committees
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

6. I attended religious groups
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

7. I was satisfied with the relationships I have with my friends and family
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often
    e. Not applicable

8. I wanted to socialize with others, but was unable to
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

9. My hearing made it hard to understand conversations
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

10. I was unable to leave my place of residence because of disability or illness
    a. Never

b. Hardly ever
c. Some of the time
a. Often

11. I was unable to leave my place of residence because I was concerned about catching or spreading COVID-19
    a. Never
    b. Hardly ever
    c. Some of the time
    a. Often

12. I had control over who I spent my time with
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

13. There were people I could talk to
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

UCLA Loneliness Scale

14. How often in the past 4 weeks have you felt that you lack companionship?
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

15. How often in the past 4 weeks have you felt that you are isolated from others?
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

16. How often in the past 4 weeks have you felt that you are left out?
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

Social Support

17. When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, house cleaning, cooking, telephoning, or giving you a ride? Please include any paid helpers.
    a. Yes
    b. No
    c. I don't need help
    d. Don't know

18. Can you count on anyone to provide you with emotional support? (Talking over problems or helping you make a difficult decision).
    a. Yes
    b. No
    c. I don't need help
    d. Don't know

Other Social Activity Questions

19. How often have you had opportunities to socialize with others in the past 4 weeks?
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often

20. How often have you been able to see your children or grandchildren in the past 4 weeks?
    a. Never
    b. Hardly ever
    c. Some of the time
    d. Often
    e. Not applicable – I do not have children or grandchildren

21. If your community were to offer the activities/events below, which ones would you be interested in participating in? Please select all that apply.
    a. Educational
    b. Sports or exercise
    c. Luncheons or dinners
    d. Music and the arts
    e. Spiritual and/or religious

f. Volunteering
g. Outdoor activities
h. Political
i. Unstructured time spent with others
j. Events I can attend by phone or online
k. Other

22. Is there anything else you would like to tell us? [Free response]

Demographics

23. Are you currently married, living with a partner, have a partner who you do not live with, separated, divorced, widowed, or have you never been married?
    a. Married
    b. Living with a partner
    c. Have a partner, and am not living with them
    d. Separated
    e. Divorced
    f. Widowed
    g. Never married

24. What is your date of birth?
    a. Fill in: XX/XX/XXXX

25. How would you describe your gender?
    a. Male
    b. Female
    c. Non-binary or gender-fluid

26. Are you of Hispanic, Latino, or Spanish origin?
    a. Yes
    b. No

27. How would you describe your race? Please select all that apply.
    a. Asian
    b. American Indian or Alaska Native
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Other race
        i. [If Selected] Please specify _____

28. What is your name?

a. First _____
b. Last _____

29. What is your phone number?
    a. _____

30. What is your email address? This is the email address that we will use to invite you to complete the follow-up survey in 3-4 months.
    a. _____

31. What is your zip code?
    a. _____

Thank you very much for completing this survey!

Appendix III. Online and Text-Based Survey Recruitment Script

Hello!

We at [insert name of particular Area Agency on Aging or Servicer Provider] are currently recruiting participants for the Health and Aging Study—a research study that aims to understand the health and well-being of older adults in Illinois. We also want to learn what older adults think about the aging services that we provide, so that we can make informed improvements to our programs. At this time, the study surveys are only offered in English.

If you participate in this study, you may be asked to respond to a brief 3-minute survey via text message once per month for 4 months.

You may also be asked to complete a 10 to 15-minute online survey two times: at the beginning of the study and 3-4 months later.

Please follow the link below for more information and to let us know if you are interested in participating. Participation in the study is completely voluntary and any information you provide will be kept strictly confidential.

Thank you,
[insert name of particular Area Agency on Aging or Service Provider]

Appendix IV. Online and Text-Based Survey Informed Consent

NORC at the University of Chicago

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Health and Aging Study

Illinois Aging Services and Co-Investigator Louise Hawkley, Ph.D. at the Academic Research Centers at NORC at the University of Chicago are conducting a research study. This study is funded by the Retirement Research Foundation.

You were selected as a possible participant in the study because you use a program or service that may provide you with opportunities to socialize or connect with other people. You live in one of the five regions included in this study. Your participation in this research study is voluntary.

Why is the study being done?

Illinois Aging Services and NORC at the University of Chicago are conducting this study to understand the social activity and well-being of older adults in Illinois. We also want to learn what older adults think about the programs and services provided by Illinois Aging Services. The study includes older people living in five regions of Illinois.

What will happen if I take part in the research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

- Complete a brief 3-minute survey via text message once per month for 4 months. This survey will ask about your mood, whether you have recently used services or programs for older adults, and your satisfaction with any of these services. Note that standard text messing rates may apply, following your own particular cell phone plan.
- Complete a 10-15 minute online survey two times: at the beginning of the study and 3-4 months later. This survey will ask about your Internet use, well-being, social activities and relationships, and demographics.

How long will I be in the research study?

Participation will take place across a 4-month time period. Across this study period, participation in the text messaging surveys will amount to about 30-35 minutes in total and participation in the online survey will amount to 30-40 minutes in total.

Are there any potential risks or discomforts that I can expect from the study?

- There are no risks in participating in this research beyond those experienced in everyday life. You may feel uncomfortable answering questions about your thoughts or feelings. You have the right to skip any question that makes you uncomfortable. You may end your participation at any time.

Are there any potential benefits if I participate?

Your participation does not carry any direct benefits. However, we hope that this research will provide a better understanding of health and well-being among older adults, as well as your satisfaction with the aging-related programming you may receive.

Will I be paid for participating?

You will not be paid for participation in this study.

Will information about me and my participation be kept confidential?

Any information that is obtained in connection with the study and that can identify you will remain confidential and protected to the best of our ability. However, complete confidentiality cannot be promised for any information shared over the Internet. Any of your identifying information will only be disclosed by the researchers with your permission or as required by law. If provided, the researchers will have access to your name and current phone number. However, you will be assigned a random participation code to complete the surveys, and your survey responses will be stored with this code, rather than with any information that could identify you. All data collected will be stored in a secure, password-protected server.

What are my rights if I take part in the study?

- You can choose whether or not you want to be in the study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.

- You may refuse to answer any questions that you do not want to answer and still remain in the study.

Who can I contact if I have questions about the study?

- **The research team:**
  If you have any questions, comments or concerns about the research, you can talk to the one of Co-Investigators. Please contact:

  Louise Hawkley
  NORC at the University of Chicago
  1155 East 60th Street
  Chicago, IL 60637
  hawkley-louise@norc.org

NORC at the University of Chicago Institutional Review Board:

- If you have questions about your rights as a research subject, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the NORC at the University of Chicago Institutional Review Board by toll-free phone number at (866) 309-0542.

Completion or return of this survey implies that you have read the information in this form and consent to take part in this research study.

Please keep this form for your records or future reference.

Appendix V. Text-Based Survey

Hello! This is a text message survey for the Health and Aging research study that you signed up for.

This set of questions asks about how you are feeling right now.

1. Do you feel tired?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

2. Do you feel happy?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

3. Do you feel stressed?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

4. Do you feel like there are people you can talk to?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

5. Do you feel lonely?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

6. Do you feel calm?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

7. Do you feel left out?
    1. Very
    2. Moderately
    3. Slightly
    4. Not at all

8. Have you used any services or programs for older adults during the last month?
    1. Yes [go to #9 below]
    2. No [go to #11 below]

9. Which type of service(s) did you receive? Select all that apply.
    1. Friendly visit or telephone call
    2. Education
    3. Nutrition/meals
    4. Music and the arts
    5. Memory cafe
    6. Other

10. [If respondent endorsed any response options from #X above, loop through each one to ask about satisfaction for each]:

    On a scale from 1 (not at all satisfied) to 5 (very satisfied), how satisfied were you with the [INSERT ENDORSED SERVICE] service(s) you received?

        [Respondent types in a # from 1-5)

11. Not including any older adult services or programs you may have used, how often in the past month have you socialized with others, either in groups or one-on-one?
    1. Never
    2. Hardly ever
    3. Some of the time
    4. Often

Thank you for completing this survey!

Appendix VI. Recruitment Script and Referral Form for Older Adult Interviews

Reducing Social Isolation: A Process Evaluation Study for Illinois Aging Services
Older Adult Assent to be Contacted by a Researcher

INSTRUCTIONS: Use the script below. Do not attempt to explain the study. If the person asks for more information, simply say that the researcher will explain the study when they call and will be able to answer any questions.

Who can you recruit?

- *Age 60 and older*
- *Able to participate in a 45-minute conversational interview in English*
- *Uses one or more programs offered through AgeOptions as part of the Illinois Social Isolation initiative such as:*
    - *Mather Telephone Topics*
    - *Friendly Phone Visits*
    - *Dementia Friendly Communities/Memory Café*
    - *Thrive with Pride Cafes*
    - *Ethnic Partners in Nutrition*
    - *UNIPER System programs*
    - *Promoting Intergenerational Connections - Senior Skip Day*
    - *Caring Better Living Better Program*

SCRIPT:

My name is _____ from _____. I am calling about the [insert the name of the social isolation service or program] that you use. Illinois Aging Services is doing an evaluation study of programs that provide social opportunities for older people in our region. They are working with researchers from CJE SeniorLife and the National Opinion Research Center in Chicago. A researcher from CJE SeniorLife would like to call you to explain this opportunity to volunteer to be part of the study. After you complete the interview, Illinois Aging Services will send you a $25 gift card as a thank you. Would it be ok if I share your name and contact information with the researcher? Her name is Aura Espinoza and she will be calling from Chicago (312) 539-0519.

If the person assents to be contacted (says yes), please provide the information below

Potential Participant Name: _____

How do you prefer to be contacted by the researcher?

_____By phone, Cell phone: _____ Landline: _____

_____By email, Email address: _____

What days or times would it be better for a researcher to call you?

Name of staff person calling the older adult: _____
Phone: _____ **Email**: _____
Name of Area Agency on Aging: _____

PLEASE PROVIDE INFORMATION ABOUT THE PROGRAMS/SERVICES THIS PERSON USES ON THE BACK OF THIS SHEET

Complete this information for any programs or services that are intended to reduce social isolation that this older adult is currently using.

Program Name: _____
Estimated frequency of program/service offered (weekly, daily, monthly): _____
Delivery: ____in person ____voice phone _____video phone ____online (e.g. zoom)
Social setting: _____one on one _____group
Did they start using this program/service at least 3 months? ____Yes ____No
Have they used this program more than 9 months? _____Yes ____No

Program Name: _____
Estimated frequency of program/service offered (weekly, daily, monthly): _____
Delivery: ____in person ____voice phone _____video phone ____online (e.g. Zoom)
Social setting: _____one on one _____group
Did they start using this program/service at least 3 months? ____Yes ____No
Have they used this program more than 9 months? _____Yes ____No

Program Name: _____
Estimated frequency of program/service offered (weekly, daily, monthly): _____
Delivery: ____in person ____voice phone _____video phone ____online (e.g. Zoom)
Social setting: _____one on one _____group
Did they start using this program/service at least 3 months? ____Yes ____No
Have they used this program more than 9 months? _____Yes ____No

Does this client receive services from the Community Care Program?
____Yes ____ No ____Don't know/unsure

Appendix VII. Statement of Informed Consent for Older Adult Interviews

STATEMENT OF INFORMED CONSENT FOR OLDER ADULT

(Permission to Take Part in a Human Research Study)

Reducing Social Isolation: A Process Evaluation Study by Illinois Aging Services

Key information about this evaluation study:

Illinois Aging Services is conducting this study is to collect information about older peoples' experiences with programs or services that provide opportunities for socializing and their preferences for socializing. The researchers want to learn how programs or services are provided, how they are used, the possible benefits for older people, and what could be improved. The study includes older people living in five regions of Illinois.

You will be asked to participate in one interview, lasting about 45 minutes. The research study lasts for approximately one and a half years, but you will be interviewed only once.

Why are you being asked to take part in this research study?

We are asking you to take part in this research study because you use a program or service that may provide you with opportunities to socialize or connect with other people. You live in one of the five regions included in this study.

How many people will be studied?

We expect up to interview up to 60 older people.

What should you know about being in a research study?

- ❑ Someone must explain the research study to you.
- ❑ Whether or not you take part is up to you.
- ❑ You can choose not to take part.
- ❑ You can agree to take part and later change your mind.
- ❑ Your decision will not be held against you.
- ❑ Your decision will not affect any programs or services you use.
- ❑ You can ask all the questions you want before you decide.

What happens if you say, "Yes, I want to be in this research?"

You will be interviewed by phone. This one-time interview will take up to 45 minutes. Your responses will be recorded with detailed notes. You will be asked questions about how you found out about the program/service, your experience with the program/service, what could be improved or changed, and your preferences for socializing.

Will you be compensated for your time and effort?

After you complete the interview Illinois Aging Services will mail you a $25 gift card.

Will being in this study help you in any way?

We cannot promise any benefits to you or others from your taking part in this research study. You may feel positive about sharing information that could help agencies, service providers, or policy makers improve programs or services that could benefit older people.

Is there any way being in this study could be bad for you?

There is minimal risk to you in taking part in this study. However, if you find some questions to be irrelevant to your experience or uncomfortable to answer or you experience discomfort, you can choose not to answer a certain question or stop the interview completely.

What happens if you do not want to be in this research?

Participation in research is voluntary. You can decide to participate or not to participate.

What happens if you say, "Yes", but change your mind later?

You can stop the interview or leave the research study at any time. Your information will not be saved.

What happens to the information collected for the research?

We will do everything we can to limit the use and disclosure of your personal information to people who need to review this information for the purpose of the study. The interviewer and other researchers involved in this project cannot promise complete secrecy. Researchers working on this project will have access to the information from your interview. Representatives in charge of oversight of this study may need to see your information.

We will not ask you about child or elder abuse, but if you tell us about child or elder abuse or neglect, we may be required or permitted by law or policy to report to authorities.

The researchers conducting these interviews are from CJE SeniorLife in Chicago. All information collected, including notes of interviews, will be stored in a secure, password protected and/or in locked file cabinets at CJE SeniorLife in Chicago. All data will be destroyed at the end of the project.

Who else can you talk to about this study?

If you have questions, concerns, or complaints, or think the research has hurt you, talk to one of the primary researchers (Co-Investigator), Rebecca Berman, at (773) 508-1158 or contact her at rebecca.berman@cje.net .

This research has been reviewed and approved by the Institutional Review Board (IRB) of the National Opinion Research Center at University of Chicago. You may talk to them by toll-free phone number at (866) 309-0542 if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

Appendix VIII. Interview Guide for Older Adults

Interviewer instructions: Record Participant ID in interview notes.

1. **How did you hear about [insert the name or description of the program or service]?**
   Note: may not know the name of the program so be prepared to describe

2. **Why did you decide to use this program/service?**

3. **Please share a story or an example about your experience with this program/service.**

   What has been the most significant change in the quality of your day-to-day life as a result of using INSERT PROGRAM NAME?

   *Alternate: What has been the **biggest change in your day-to-day life** as a result of INSERT PROGRAM NAME?*

   Prompt for more detail as needed.
   - Who, what, where, when, how, why
   - Listen for issues that are important to him/her and prompt for more detail (.e.,g "tell me more about that" or "can you give me an example")
   - Has the program changed your social life or how you connect with others? If so how? If not, please explain.
   - What did you find to be most satisfying?... most socially satisfying?
   - What did you find to be useful?
   - What did you learn about ways to connect with the "world"? (new skills, technology, other programs for socializing, anything else)

   When done taking notes, read the paraphrased story back and confirm its accuracy

4. **Was there anything you did NOT like about INSERT PROGRAM NAME?**
   - Was there anything that did NOT meet your expectations? Tell me more about that.

5. **Has your experience with INSERT PROGRAM NAME changed since you started using it?**
   Prompt for more detail as needed
   The people
   - Frequency
   - Way the program works (aim for delivery mode, changed due to pandemic)
   - Have you used it more or less often? For what reasons?
   - If he/she stopped using the program, explore reasons why.

6. **Do you plan to continue using this program? Why or why not?**

7. **What might have improved your experience with INSERT PROGRAM NAME?**
   Prompt for more detail as needed
   - What would have made it easier to find out about it?
   - What would have made it easier to use it?
   - Do you have any other suggestions to make INSERT PROGRAM NAME better?

8. **How do you connect with the world around you?**
   Keep it open...possible answers might include nature, television, people watching...then prompt for more detail
   - How do you socialize or connect with other people?
   - How has that changed due to the pandemic?
   - How have you adjusted to [any changes]?

9. **What other types of social opportunities or programs are you interested in?**
   Prompt for more detail as needed
   - What would be most helpful for you?
   - What might be helpful for other people in your situation?

10. **Is there anything you would like to share about your experience?**

Before we end the interview, I have a few questions about you. By answering these questions, we can learn more about the variety of people that were interviewed for this study.

Interviewer instructions: Enter this information into a participant face sheet; include participant ID on face sheet. As a reminder you do not have to answer a question if you prefer.

Ask all questions below as open-ended and create categories based on response

What type of community do you live in?
- Rural/Small town
- Suburban/Urban

What type of housing do you live in?
- Senior housing
- Rental apt
- Own home
- Add other types

Including yourself, how many people live in your household?

How old are you? *ONLY provide the following categories if refused to share age*
- *60-74*
- *75-84*
- *85+*

How would you describe your race and ethnicity?

- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Other Pacific Islander
- White or Caucasian
- Hispanic/Latinx
- Arab
- Add any mentioned
- Prefer not to answer

Thinking about your gender and preferences, how would you describe yourself?

- Female
- Male
- Transgender Male or Female
- Add any other identities mentioned
- Prefer not to answer

Interviewer instructions: Inform the participant that they will receive a $25 gift card for their effort, along with a copy of the Statement of Informed Consent that you read to them. Enter their mailing address in the password-protected file that contains participant names

Appendix IX. Statement of Informed Consent for Staff Focus Group

STATEMENT OF INFORMED CONSENT

Reducing Social Isolation: A Process Evaluation Study by Illinois Aging Services

Key information about this evaluation study:

The purpose of this study is to collect information about how programs and services intended to reduce social isolation are provided to and used by older adults. The study focuses on programs provided through five Area Agencies on Aging in Illinois: AgeGuide (Area 2), East Central Illinois Area Agency on Aging (Area 5), Lincolnland Area Agency on Aging (Area 7), AgeSmart (Area 8) and AgeOptions (Area 13)***.*** The researchers want to learn about how programs or services are provided, how they are used by older people, the possible benefits for older people, and what could be improved. The researchers also ***hope to use study results to determine the best ways to evaluate the effectiveness of programs/services in the future. The research study lasts one and a half years. You will be asked to voluntarily participate in one focus group discussion, lasting about one and a half hours.***

Why are you being asked to take part in this research study?

We are asking you to take part in this research study because you are involved with delivering programs to older adults that provide them with social opportunities. Your agency delivers services through one of the five Area Agencies on Aging (AAAs) that are included in this study.

How many people will be studied?

The study will conduct three focus groups with up to 45 staff members representing services providers from the five AAA's. (In another part of the study we will also interview up to 60 older people who use programs or services.)

What should you know about a research study?

- ❑ Someone will explain the research study to you.
- ❑ Whether or not you take part is up to you.
- ❑ You can choose not to take part.
- ❑ You can agree to take part and later change your mind.
- ❑ Your decision will not be held against you.
- ❑ You can ask all the questions you want before you decide.

What happens if you say, "Yes, I want to be in this research?"

A researcher will facilitate an online focus group discussion with you and other staff members from the five AAA's. The focus group discussion will be recorded and transcribed. The focus group will discuss successes and challenges related to reaching older adults at risk of social isolation or loneliness, delivering social isolation programs/services, and the potential impact of programs/services on older adults. You will also be asked to voluntarily share a brief paragraph story or example of a significant change that an older adult may have experienced in their day-to-day quality of life due to participating in a program or service to reduce their social isolation. Your story will not be identified by your name and we ask that you do not include any names in your story. The stories will be included as data and analyzed for themes. Some of the stories may be reviewed by the project steering committee and/or advisory groups made up of older adults, agency staff or community members.

Will you be compensated for your time and effort?

You will not be compensated.

Will being in this study help you in any way?

We cannot promise any benefits to you or others from your taking part in this research study. You may feel positive about sharing information that may help agencies, service providers or policy makers improve the design, delivery, and evaluation social isolation programs for older people.

Is there any way being in this study could be bad for you?

There is minimal risk to you in taking part in this study. However, if you find some questions to be irrelevant to your experience or uncomfortable to answer, you can choose not to answer a certain question or stop the interview completely.

What happens if you do not want to be in this research?

Participation in research is voluntary. You can decide to participate or not to participate.

What happens if I say "Yes", but I change my mind later?

You can stop the interview or leave the research study at any time and it will not be held against you. Your information will not be saved.

What happens to the information collected for the research?
We will do everything we can to limit the use and disclosure of your personal information to people need to review this information for the purpose of the study. The interviewer and other researchers involved in this project cannot promise complete secrecy. The other members of the focus group will hear the information you share during the discussion. The project's research team will have access to your information. The Institutional Review Board at National Opinion Research Center at University of Chicago who are in charge of oversight of research studies may inspect and copy your information.

We will not ask you about child or elder abuse, but if you tell us about child or elder abuse or neglect, we may be required or permitted by law or policy to report to authorities.

All information collected, including recordings and hard copies of transcripts, will be stored in a secure, password protected digital storage format and/or in locked file cabinet at CJE SeniorLife in Chicago. All data will be destroyed at the end of the project.

Who can I talk to?

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research investigator Rebecca Berman at (773) 508-158 or contact her at rebecca.berman@cje.net .

This research has been reviewed and approved by the Institutional Review Board (IRB) of the National Opinion Research Center at University of Chicago. You may talk to them by toll-free phone number at (866) 309-0542 if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

Appendix X. Staff Focus Group Registration Form

Instructions: You can fill this form our for yourself or use the script below to recruit staff. The researcher will also explain the study right before starting the focus group and will answer any questions at that time.

Illinois Aging Services is conducting a process evaluation study of programs and services to address social isolation among older people in our region. They are working with researchers from CJE SeniorLife and the National Opinion Research Center in Chicago. The researchers are asking for volunteers to participate in a single focus group on social isolation programs or services. The focus group will be held online at three different dates and times, but you only need to attend one. The researchers will send you a description of the study and also explain the study before the focus group. The first focus group will be held on Tuesday, Aug 3rd from noon-1:30pm.

You can participate if you:

- Provide services in one of the AAA's that are included in this study: AgeOptions, AgeLinc, ECIAAA, AgeSmart or AgeGuide
- Have **at least 3 months experience** with any or all of the following
    - Designing programs/services for socially isolated older adults
    - Delivering those programs/services
    - Identifying/referring socially isolated older adults to such programs/services
    - Assessing older adults for isolation/loneliness
    - Reaching socially isolated older adults in diverse or underserved communities and settings
- Speak English

Do you wish to participate in one of the focus groups? _____Yes ____No

Please share your name, email address and phone number(s) so that the researchers can send you an invitation to an online focus group. If you have any questions before the focus group, please contact Rebecca Berman at 773-508-1158, the project Co-Investigator and Research Scientist at Leonard Schanfield Research Institute at CJE SeniorLIfe. **Sharing your contact information serves as your consent to participate in the focus group.**

Name: _____

Agency/Organization: _____Position: _____

Phone number(s): Work _____ Cell: _____

Email address: _____

Which Area Agency on Aging are you part of? _____

Appendix XI. Staff Focus Group Question Guide

Warm Up

1. Let's go around the room and state your name, position, and where you work. 10 sec each

Transition Questions

2. What is the first word or phrase that comes to mind when you think of "social isolation"- 15 seconds each? (round robin/build list)

Key Questions

3. What are social concerns or needs of older adults in your communities? (open discussion)

   Prompt for...
   - Changes during the pandemic

4. How do you reach older adults at risk of social isolation or loneliness? (open discussion)

   Prompt for...
   - How identify and refer
   - Target populations/subgroups that are hard to reach/reasons why
   - Changes or challenges due the pandemic
   - Other challenges/barriers

5. How do you determine if older adults are at risk of social isolation or loneliness before referring them to a program or service? (open discussion)

   Prompt for...
   - Assessment strategies or tools...include prompt for how UCLA Lonliness scale is used
   - Characteristics of those who are referred or enrolled in a program/service
   - Changes or challenges due to pandemic
   - Challenges or barriers

6. Based on our review of AAA plans, we compiled a list of different types of programs or services that might reduce social isolation or loneliness among older adults. (Present summary of types of programs). Thinking about all the different types of programs, what **strategies** have the most impact on older adults? What really works? (open discussion)

Prompt for...

- Most effective strategies or practices
- Most effective elements of a program/service
- Program/services most used by older adults
- Older adult satisfaction with program/services

7. How has delivering these program/services changed during the pandemic? (open discussion)

   Prompt for...

   - Types of older adults needing or requesting programs/services
   - Increases/decreases in program use
   - Balance/diversity of program offerings
   - Delivery/mode
   - New programs/ innovations
   - Other changes

8. What have been the biggest challenges to delivering programs/services? (open discussion)

   Prompt for...

   - For older adults...complaints, concerns, accessing programs
   - For staff

9. Now think about what worked, each of you to identify ONE highly successful strategy or practice you used when providing programs/services...something that went really well. (round robin)

10. What suggestions do you have for <u>improving</u> programs/services to reduce social isolation or loneliness in the future? (open discussion)

    Prompt for...

    - Outreach
    - Target populations/subgroups
    - Design...include prompt for how data could be collected and used
    - Delivery
    - How data could be collected/used

<u>Wrap Up</u>

11. What other advice would you give other service providers about how to address social isolation or loneliness among older adults?

Appendix XII. 27 Most Significant Change Stories

To protect individual's privacy, stories do not identify the interviewee's gender, age or race/ethnicity, nor do they refer to any names of people, programs, organizations or communities. Interviewees have been assigned false initials. A spouse or significant other is referred to as 'partner.' Each story includes:

- A description of living situation, type of program(s) in bold font, and reasons for using programs
- A summary of their response to the question "What has been the most significant change in your day-to-day quality of life as a result of using the program?"
- Other issues the interviewee brought up when prompted for more details, including comments about the pandemic.

Stories are written in third person but include excerpts from interview notes that captured the words of the participant, in quotation marks.

Story 1
Meeting People in Similar Situations
(caregiver)

Selected by 4 steering committee members and older adult advisory group

JA cares for his/her/their partner and lives in a home in a suburban community. JA participates in a **caregiver group** that has shifted to Zoom as a result of the pandemic and has also taken advantage of **one on phone calls for caregivers**. JA has also used training for caregivers and participated in other caregiver groups and feels that the organization that provides the caregiver program has "real great caregiver groups" that are "well run" and provide "excellent help." JA mentioned that meeting virtually works great because they live in another state part of the year and can now participate from wherever they are.

The most significant change for JA, besides learning "what to do and what's going on" is "meeting other people that are in similar situations and being able to talk to them and relate to their experiences. You're not alone, and you can learn so much more from other people who have more experience with this and who have been dealing with similar situations for longer." JA also values "hearing the guidance that [the program] is providing to other people." JA added that the one-on-one sessions are "more for when you have something that's really bothering you" were helpful for getting "advice and suggestions" on how to deal with a particular problem or issue.

Since the pandemic JA has not done much socially. He/she/they stays connected to the world by reading news and articles on the internet and emailing people. JA misses the "hanging out and talking to people" in person and explained that "the social aspect is really hurting for me. It's better for my [partner] [because he/she/they has access to a program], but "I just have the caregiver. Before the pandemic he/she/they participated in clubs and activities, went to a fitness club regularly, hiked trails and enjoyed meals and activities at center with his/her/their partner. They were just starting to return to in person activities at the center.

Story 2
More People to Be in Contact With

Selected by older adult, community and staff advisory groups

LB lives alone in an apartment in a suburban community. He/she/they participates in an **educational discussion group** that was in person prior to the pandemic that had since shifted to zoom. LB described the program as an "awesome resource" that "brings people together and gets the information shared." One reason LB participates is because "It's great to hear what other people are experiencing and they have different resources that they point out that you might not be aware of. It's just a good community town square kind of thing, where people can come together." LB also **volunteers** at a food pantry and is a **friendly visitor**. LB misses weekly **lunches for seniors** that were discontinued due to the pandemic as well as socializing in person and travelling with friends.

LB felt that the most significant changes due using this program were "It just gives me more people to be in contact with, puts me in touch with a larger range of different people. It just gives me a better positive outlook that things can get better, just hearing what other people are experiencing and going through, and also being able to put my own experiences and perspectives out there. It's really good, knowing that I'm not the only one dealing with this stuff. I'm not the only one experiencing certain issues. It's just always helpful." LB gave an example of how discussing end of life planning resources with the group was especially helpful when thinking of "people who have passed away during the pandemic."

LB felt the pandemic forced the group to adjust in a positive way. "At first I thought it was going to be very dispiriting. It's frustrating but at the same time, the Zoom gatherings and the outreach has been terrific. It's kept people socializing and continuing the friendships that we had built through different social chains. But at the same time, there are those that I'm friends with from [another group] who aren't tech-savvy. They don't have computers or don't have internet, and at least by me being connected to the Zoom meetings I can relate to them what's going on. The Zoom stuff was hard to figure out at the beginning, but it's getting better." LB stays socially connected through phone calls, emails, and Facebook.

Story 3
Getting Out and Doing Something Together

Selected by community advisory group

AM lives with his/her/their partner in their home in an urban setting. AM uses a **variety of programs at a center**, primarily to "see more people" and "get out of the house" so he/she/they is "not just sitting in these four walls looking at the TV." The center also gave AM a hotspot and a **tablet** and "walked me through" how to use it.

AM feels the most significant change due to participating the programs is meeting and talking to people. "I get to see other folks that share the same interests as me, get to see some new faces." AM reiterated the importance of having "the chance to get out and do something together," but is also happy to see his/her/their partner do something he/she/they enjoys. AM uses the tablet to stay in touch with family. "I can see them! And that's very good. Of course, I got bad news from them both too but no, I also got good news. And I, you know, I got to keep in touch with my family again, so I really like that."

Since the pandemic, AM uses the internet more but still gets out with the same frequency, going shopping and participating in programs. "I'm not afraid of COVID. I figure, I'm going to die anyhow, it's going to happen….might be because of covid, might be because of something else. I don't know if I'll be one hundred, but no I'm not afraid of it. And I got my two shots. But, no,

nothing really changed for me [during the pandemic].” AM uses the tablet to stay in contact with family another state and reads articles on the internet.

Story 4
Staying Socially Active

Selected by 5 steering committee members
Selected by older adult, community and staff advisory groups

BL lives alone in his/her/their condominium in an urban neighborhood and attends **a group that provides activities and discussions**, which met at a building before the pandemic. BL started participating because of an interest in a class, the convenience of the location, and the variety of other interesting activities available at that site. BL described his/her/their self as “very active.” BL has regular daily exercise routines, takes walks, talks to neighbors in public spaces in his/her/their building, attends board meetings in the building, frequently visits with a wide variety of family members, and tutors a grandchild.

For BL, the most significant change in his/her/their day-to-day quality of life due was socializing. Before the pandemic, BL enjoyed participating in the variety of classes and activities and celebrating occasions with food and music, while also making “so many friends and socializing.” BL likes “anything that keeps my brain active… anything that has to do with the brain and the mind.” Since the pandemic, BL has been joining all classes and activities on Zoom, which he/she/they had not used before. BL prefers Zoom over joining by phone because then he/she/they can see the instructor and other participants. BL feels there are still some social benefits to participating online. "I get to hear a lot of other people who join in on our conversations, or during meditation, or this or that, so it’s kind of a social thing. And there’s a lot of people from...other cities.... we all join for a great cause.” BL especially enjoys a meditation class, which “taught me to not worry… not having any negative thoughts.” BL also feels that he/she/they ‘sees a lot of improvement with myself” as a result of attending exercise classes. BL feels that using such programs helped him/her/they stay physically and socially “busy” and adjust to the limitations of the pandemic.

When the program shifted to online, BL decided to learn new things. “I said, ‘Well I’m locked up, but I’m going to do all these things,’ … it’s not the same, but it’s still the same. But it’s still kind of socializing a little, because talking to the instructor and this and that and whatever. Through them, I learned a lot too! Even though I’m locked up, I have Zoom.” BL still keeps in touch with nearby friends that also participate in the program, socializing outdoors on their terraces. BL has told others about the online activities. BL misses events and activities that cannot be easily replicated on zoom such as special occasion gatherings, chess, dancing and movies. He/she/they is eager to get back to in person activities, but for now, “I’m not stressed, I’m happy … even though it’s not the same, but it’s quite a bit better than nothing.” BL repeatedly mentioned the importance of making friends and “who knows, maybe fall in love! Again!” However, BL is worried about finding a new program to go when the pandemic is over because he/she/they believes that the physical location is permanently closed and stated that when it closed, “I was crying because it wasn’t there anymore and I was missing learning ...and all the socializing we did.”

Story 5
The Library is Part of My Life

Selected by older adult and community advisory groups

WG lives alone in his/her/their own home in a suburban community and uses **senior programs at a local library**. WG explained that libraries have always been “part of my life” and “useful for everything.”

When asked about how library programs change his/her/their day-to-day quality of life, WG responded, "You know the library is there. I don't have to have a computer and internet or nothing. I don't know something, they help me. I love the people. I know all of them. I know [librarian] who is in charge of [programs for older adults]." WG enjoys going to senior socials at the library because "I can meet other friends. They're good people, people from the community. Sometimes you want to meet other people that are like you. We have things in common." Librarians also answer "computer questions" for W. For instance, the librarian showed WG how to use Zoom and is now able to do "Zoom calls." WG is grateful that "I don't have to figure it out on my own."

Prior to the pandemic "I was always coming and going. I had a lovely life." After the pandemic started, WG missed inviting friends over and cooking for each other, going out to eat and going to the gym, and going on "field trips." WG spends more time on the phone than before the pandemic. WG also connects to the world through reading.

Story 6
Looking for Someone in a Similar Position

Selected by staff advisory group

RI lives alone in a rental apartment in a suburban community. RI participates in **an educational discussion group** that is currently online. RI was interested in the program because he/she/they was "looking for somebody to talk to that was my age, and in a similar position. And I didn't really find that through this program, but I still thought it was worthwhile, so I continued.

The most significant change RI experienced as a result of the group program what discovering "other resources that I didn't know about." RI also enjoyed a virtual dinner with people of different ages, which "was a nice experience, especially during Covid."

RI also had to learn new technology. "With Zoom, I'm thinking I still needed to learn how to do the chat. And I couldn't catch onto that - I kept thinking that I needed to ask and find out, and I never did. That would have been a good thing to learn. I had bought an iPad just for Zoom before [joining the group program], and I had to teach myself how to do that. I think there was a class and also some Church services on Zoom." RI has also met friends through book discussions at a library, goes to an open art studio, and takes an art class with a friend. RI provides art therapy to one person for free. RI interacts with friends and family online and by phone. RI also connects with the world through meditation, nature, art, and reading.

Story 7
Becoming More Enlightened

Selected by older adult and community advisory groups

PK lives in his/her/their own home with a disabled partner. PK uses an online **group that provides activities and discussions**. After learning about the program from a friend PK "looked it up online" and found "the variety of programs" to be very interesting. Before the pandemic, PK attended in person programs offered by the same organization. PK uses public transportation or gets rides from friends and relatives.

The most significant change for PK due to using this program was that he/she/they has "become more enlightened with information" and gained "knowledge." PK gave several examples of the variety of "high quality programs." PK liked being able to participate in some of the activities by using various features of the online platform to make comments, click on reactions, ask

questions, or talk with other participants. PK especially valued the variety of offerings, being able to have choices, and being able to access information from a program afterwards. PK also liked to be able to participate from anywhere, whether on zoom or just listening in on a cell phone. PK tells others about the program when they overhear him/her/they listening to a group on the phone.

PK first used Zoom during the pandemic to attend a funeral. PK also attends church services online but is looking forward to attending in person when his/her/their partner is able to. PK had no difficulty using Zoom and likes the convenience and the ability to connect with others during the pandemic, including college friends. As a result, PK did not experience much "cabin fever" during the pandemic. PK also substitute teaches and maintains connections with a college group that has a reading group.

Story 8
Dealing with Loss and Loneliness

Selected by 4 steering committee members
Selected by community advisory group

EE lives alone in his/her/their own home in a suburban community. EE participates in a variety of activities that are available through an **online program platform**, and a **phone-based discussion group**. EE found Zoom "difficult" but people from the program came to install some equipment and explain how to access programs. EE **used to go to the center** that was closed down during the pandemic and became "lonesome but this helped a lot. I'm not lonely anymore."

One of the most significant changes EE experienced was being able to "mentally relax" because "I've had a lot of deaths in the family, so this helped me during the grief and relaxed me." The bible classes and opportunities to "laugh" also helped EE cope with stress. EE prefers listening to these online programs "instead of listening to the news, when everything was so bad all the time you get down and you lose hope." EE also enjoys seeing faces of other participants and discussing things with people from all over the country. EE finds the online yoga class especially valuable "because going through all this death, not being able to move around, I'd be stiff and tired all the time, and have no energy. And this gave me energy…and, because of the mindfulness, I can improve my thinking a little better now, instead of thinking of all the death I've had and feeling sorry for myself." EE also noted that the online programs focus on positive things. "You don't want to fill yourself up with things that are going to put you down. This brings you up! This brings your spirits up. This is constructive. It gives seniors hope." EE observed that sometimes family members do not have time, but seniors can support each other. "We can get here with each other, we can identify each other's aches and things and when you're talking, you become like friends and identify needs and shared experiences." Once He/she/they also values "being able to talk and see other people, see their faces, their expressions, their smiles, their personality and compassion. It's like family, like a new family." EE describes the program leaders as caring people who listen and "have patience with seniors," which "helps them grow more, see other people going through, trials and tribulations too. You're not alone. Other people are facing it too and just taking their minds off of it for a bit." For her, participating online was like participating in the community from the TV. EE also started doing more exercises and noticed both mental and physical improvements.

During the winter weather and the pandemic, EE felt the online programs were "very handy for talking to people," and learning. "So this was like learning it all over again, you know as you get older, if you don't use things, they go away, so this was bringing them back. And I needed that." Using online programs inspired EE to learn more about technology. "I want to learn, because this is the new way." In the past, EE socialized with a group of friends, going to each other's home to

dance, sing, cook, or pray or going to a restaurant or movie. These friends still got together from time to time prior to the pandemic. EE also participates in groups at his/her/their church.

Story 9
Leading a Class

Selected by older adult, community and staff advisory groups

PF lives alone in an apartment in senior housing. He/she/they experienced the loss of more than one family member over the year. PF participates in a variety of activities through an **online program platform** and "enjoyed what I was watching." When asked to lead an online class related to a hobby or something he/she/they did, PF cautiously agreed to try facilitating a group. The class become an important role and PF then started participating in more of the online activities. "I like the nutrition programs, and the exercise programs. I started out with those and I thought, if I'm going to be in the house, I need to do this! That was what I was doing mainly before the [class] started and I still do them, except now I'm doing more.

When asked how the program changed day-to-day quality of life, PF explained, "I just don't know where I would be right now. There was just so much going on at the time. I didn't want to get depressed. I was scared to death, I didn't know what I was doing…leading the classes. I hadn't done that before. But it turned out to be the best thing." PF then described how "the more I did the class, the more excited I got. I would think about it all week, I would be so, I don't know if happy is the right word, motivated? And I simply thought it was a godsend. I thought it was just for me at that particular time, I needed that so much." PF also valued the exercise classes because "there just aren't that many places that I want to go out to and walk with the area, and the way things are. It's not always safe and then the winter was bad too. And then [the online programs] came and they had these exercises, and the programs. I even stopped watching TV during the day! And I think that was a good thing. [The program] saved my life."

PF compared had taught a class before but noted that this was different because "I plan for it the whole week, and I like the people." PF talked about how the large the group had become and how they all "get excited." Before the pandemic, PF also **volunteered** as a senior companion, drives people to various places and is active at church. PF currently attends church services online. PF mentioned an upcoming visit from a son and supportive friends. "I have a big friend base and they were so kind to me when I was grieving."

Story 10
Getting to Know the Drivers

Selected by 3 steering committee members
Selected by older adult, community and staff advisory groups

DL lives alone in his/her/their own home in a small community in a rural area. DL uses a **transportation** program for medical appointments and grocery shopping. Someone from the program reached out to offer the service. The primary reason he/she/they uses the program is because nearby family do not always have the time to drive for DL and he/she/they has difficulty walking.

When asked about how the program has change in his/her/their day-to-day quality of life, DL responded that it "just made everything better." It makes it "easier" for family and DL no longer has to rush while grocery shopping. "I can take my time" and "it's really the most people I see, honestly." DL has met all the drivers, who "know me very well" and "we talk about everything" on the ride. DL has met and talked with other riders. "I don't know if we're friends, but we're with each other and it's nice, we can talk and see one another.

DL is especially grateful for the convenience and "knowing that I can set out and have somebody responsible waiting for me, somebody I can depend on." "They're always right there for me, and they go beyond…Yes, they really care!" DL noted that he/she/they has not made any friends since moving to the community and would like to be able to attend church more frequently.

Story 11
Having Someone Check on Me

Selected by community advisory group

KS lives alone in his/her/their own home in a small town. KS uses **home delivered meals**, noting that he/she/they can no longer drive due to vision problems. "Occasionally I'll use it, because I can have it delivered. Or my friends will ask me, 'Do you want to go to the center to eat?' And I'll go there to heat it up." Family members told KS about the organization that provides meals. KS noted that in the past, "I got a job there" because he/she/they felt it was a great idea to have a place for older people to socialize. Currently, KS no longer cooks as much. While KS doesn't really need meals, it is an opportunity to go out.

When asked about the most significant change in the quality of his/her/their day-to-day life as a result of the program, KS responded, "I'm eating better! Like lots of seniors, I have some problems...so I know I've got at least one good meal where I'm getting everything I'm supposed to…" KS likes meeting the people delivering the meals and "having somebody checking in on me." KS noted that in a small town, older adults do not always have relatives nearby to check on them and talk at some length about how other older people benefit from this as well. KS explained that the volunteers are trained to notice changes and say something to the office staff. KS also commented, "I'm realistic, I know I'm going to be using it all the time now. But I still like a little bit of independence." KS also feels "it's peace of mind for my family."

To stay connected, KS watches a lot of news and, when he/she/they is feeling physically up to it KS will ask someone to "take me places," including going to volunteer at the meal site where "I get to see different people." Family and friends will stop by "to see how I'm doing" and bring groceries. These visits also give KS opportunities "to get the local news." During the pandemic the restaurant that he/she/they used to go to closed so KS appreciates getting meals. KS also noted that he/she/they still has family in the area. KS said, "It wasn't hard for me, as it was for some people that were always on the go." KS reflected, "Sometimes, when you're by yourself in the house, you adapt to it. But you know [family] is always a phone call away." KS also noted he/she/they is comfortable being on his/her/their own "because I live by myself, I've learned to entertain myself," but reading and hobbies have become more difficult as his/her/their vision declines.

Story 12
Looking Forward to Friendly Calls

Selected by 3 steering committee members
Selected by older adult, community and staff advisory groups

NS lives alone in his/her/their own home in a small town. NS receives **friendly calls** and heard about the program from a staff person at a senior service organization. NS says he/she/they decided to accept calls "because I was pretty much isolated at that time" due to the pandemic. NS noted that a nearby family member would not come visit because of NW's health conditions and the doctor had told NS to stay home. NS noted, "It was very hard to be here by myself all the time. So the calls, it came at the right time."

When asked about significant changes in his/her/their day-to-day quality of life due to the calls, NS responded, “I look forward to the calls. I actually think I look forward to the future more than I did, because I know [the caller] is going to be calling and we have a lot in common! And we always enjoy visiting with each other, so … it really helps to take your mind off of what’s going on.” NS said that they tried to arrange an in person visit but haven’t yet succeeded in finding a time that is convenient. NS went on to describe the experiences and hobbies he/she/they and the caller have in common and what they talk about. The calls also gave NS something to do when he/she/they had to stay off his/her/their feet due to health issues “and it *still* gives me something to do. When [caller] calls, it’s like visiting with a good friend." NS later noted that the friendly calls may have helped him/her/they deal with the death of a family member and the passing of several neighbors, noting that “This has been a year of goodbyes.” “And I’ve always been somebody who knows everybody, so to see the group getting smaller like this … it’s been hard.”

NS is familiar with computers from his/her/their past career. NS connects with neighbors and family both in person and on the phone. One neighbor has been particularly helpful when NS has emergencies. He/she/they also uses Facebook to stay in touch with friends and former students, is not Facebook friends with the person who calls. During the pandemic, NS adjusted to not seeing people in person, explaining, “I missed that one on one contact an awful lot, but I still was able to do some things. Our church started having their services online, so I could watch it online until they decided we would have it in the parking lot...We did find ways to do the things we do in-person. It was just different!” NS has also participated in craft programs through a library and received an Ipad and internet connection device from them “that was handy when I was so cut off.” He/she/they learned how to do more shopping on the internet. NS describes him/her/their self as an “outgoing person.” NS also does a “card ministry” for his/her/their church and sits and visits with neighbors.

Story 13
Learning Together and Getting to Know People

Selected by older adult, community and staff advisory groups

WR lives alone in his/her/their own home in an urban neighborhood. WR was approached by someone from a center to become a **volunteer visitor** for “shut-in” people. WR also uses a variety of other **activities and programs at the center**. WR was looking for something to do other than watching TV all day. “I needed something that would keep me going. Because I was doing nothing.”

When asked about the most significant change in his/her/their day-to-day quality of life due to participating programs at the center, WR responded, “Getting out and meeting new people. And, you know, just enjoying myself and trying to be more outgoing, and doing more things and trying things out that I maybe wouldn’t have tried before.” WR went on to give examples of the variety of activities. WR recently enjoyed a class that taught “different strategies of dealing with things, with daily life, with frustrations, with medications.” WR valued the opportunity to share with others in the class, noting, “So we’re learning, but we’re doing it together, and maybe some of us have questions or suggestions, and we learn from each other.” WR also enjoys going to the center’s café, which had recently opened back up since the pandemic and “just sitting there and getting to know people and meet new people.” WR reiterated the value of being in the volunteer program because it “gets you to see people you might not have seen, because they might not have been about to get out...and it’s more people your age... As you get older it’s nice to socialize with people that know what you’re going through and can relate to you and bounce ideas off each other to help you because we’re all different, and we all do have the same type of illnesses maybe, but it might not affect one person the same way it does others. We’re all unique.” WR also feels it is important to do things because “I’m trying to …not be in here with just my thoughts, I don’t want to be depressed and I’m trying to get out of that” WR continues to

explore other activities the organization has to offer. He/she/they will continue to participate "because it helps me learn, and do, and be active, and it keeps me young." WR also observed, "I know that I'm depressed, I know why, I know my reasons. And I'll think, I'm going to go ... and just sit in the cafe and have a good time with other people, and that gets me out of the house...What I need sometimes is to get out and be with others, and that changes things and helps manage things. It's what I need."

During the pandemic, the friendly visiting program he/she/they volunteers for shifted to phone calls, due to COVID and many activities and classes shifted to Zoom. WR was able to learn how to use Zoom to attend church and group activities. WR reflected on the Zoom experience saying, "I like it and I don't like it ...It's okay to be on Zoom, but in-person you can see what they're not telling you and ask them about it and it'll come out later....It's just better for me, in-person....It makes it easier in-person. But I'm also grateful, because the Zoom helped us keep some things going when everything was shutting down. So it's both." During the pandemic, WR stayed in touch with friends he describes as "like family" by phone. WR calls or texts friends but no longer travels as often to see family. His/her/their friends are considering starting up their get-togethers in person again, and WR recently had dinner out with family. For now, WR is cautious and prefers to continue to do friendly visits by phone, rather than in person.

Story 14
Having Something Different to Do

Selected by 3 steering committee members
Selected by staff advisory group

PG lives alone in a condominium apartment in a small town. He/she/they had never used a computer before and, prior to the pandemic, was provided with a **tablet** and online group training on how to use the tablet. PG had no prior interest in computers and had no experience with email or the internet but thought "sure, why not, no reason not to."

The most significant change in PG's quality of life due to using a tablet was "just having something a little different to do besides talking on the phone or reading or doing puzzles." PG does not know how to do very many things on the tablet "but for what I've used it, it's just made me happier, it's fulfilled my life." He/she/they would not have been able to attend Zoom meetings for his/her/their condo association without a tablet. Since the senior center was closed due to the pandemic, it was also good to be able to attend lectures, classes or other meetings virtually. For instance, PG found it fun and interesting to attend a cooking class and "just stand in my kitchen" while cooking with others. PG explained, "It's hard to explain, but that made my days much happier," and noted, "I don't know how I would have done it during COVID if it weren't for the tablet." "So now it's …. A whole new life. It's fun! It's great fun!" He/she/they noted that the person who provided the training that came with the tablets was excellent and "very patient." PG felt that there was too much to learn in only three sessions and there should have been more follow-up instruction.

During the pandemic, PG met up with neighbors who wore masks and went to a nearby grocery store. PG gets together with a group of neighbors in the building every day and attends a senior center in person. PG explained that he/she/they is "not short on socialization at all." PG does not know how to use email, cannot easily type, and does not use text messaging, but was interested in learning how to order food online on his/her/their Ipad. PG mentioned that he/she/they would eventually have to buy it and pay for internet.

Story 15
They Really Care

Selected by 4 steering committee members
Selected by older adult and community advisory groups

WL described his/her/their self as "disabled" and lives alone in an apartment in an urban setting. WT decided to use a program that he/she/they describes as providing **information and resources**, which also provided him/her/they with a **smart speaker**.

He/she/they only briefly mentioned the smart speaker device and did not explain if or how he/she/they uses it. WL felt that the having access to resources through this organizatioin "was like a miracle for me. It opened doors for me, it was really helpful." He/she/they feels the people are helpful, nice and responsive, and felt that "my needs were being met". When asked how it impacted his/her/their day-to-day life, WL gave several examples of receiving resources and benefits that met specific, tangible needs. WL also noted, "They answer the phone! And they listen to what's going on, and they get back to me with information. If they don't have the answer, they will search it and will mail me the information and I appreciate that. It feels like they really care." WL also appreciated their calls him/her/they to keep in touch. He/she/they will continue to use the program "because I get results, I get answers, and it gets resolved."

WL does not typically go out socially, and other than attending church, mostly stays at home. WL feels that finding help or transportation makes it a "hassle" to go places, in part due to his/her/their disability but also because he/she/they feels it is dangerous to go out because of potential violence in the area. He/she/they always kept to him/her/their self, even before the pandemic, but stopped attending church when many of the church members contracted the virus. WL stays in touch with family, who also help him/her/they with picking up groceries and medications. WL likes having a cell phone so he/she/they can call family from anywhere. WL has a computer and would like to learn more about using the internet safely. He/she/they has a Facebook account but does not use it.

Story 16
It Frames the Day
(caregiver)

Selected by older adult and community advisory groups

BS and his/her/their partner who lives with dementia live in their own home in suburban setting. They both started participating in a **choir** on Zoom after the pandemic started. Before the "lockdown" they were not able to easily attend the other choir due to the location and time. BS and his/her/their partner had sung in other choirs previously.

The most significant change in their day-to-day quality of life was having an activity that BS and his/her/their partner can do together. It is also a way to have "something on the calendar… it frames the day". BS described it as "a nice social opportunity, a chance to talk to other people." They stay for a "coffee hour" after rehearsals to chat with choir members. They have never met any of the choir members in person. BS commented, "It's been a nice experience…so you feel less isolated." BS was looking forward to singing in person again, in part because looking at a screen is "less concrete" and not very "free flowing" for his/her/their partner with dementia. Yet BS observed that a positive part of socializing on Zoom it that it requires everyone to learn how to take turns. BS and his/her/their partner watch recordings of the choir when they aren't able to attend rehearsals. BW feels that it provides his/her/their partner with social interaction, a sense of purpose, something to do other than "just sit," and something for both of them to look forward to.

BS's children taught him/her/they how to use Zoom which he/she/they uses to participate in Tai Chi, a caregiver support group and another program for caregivers. BS connects with the world by reading, emailing or talking with friends, meeting up or walking outdoors with friends or family, watching "foreign DVDs" and spending some time on Facebook. They would be going out for concerts, plays and dinners, as well as travelling, if not for the pandemic. BS describes him/her/their self as a "survivor" who can adjust and "move on" in situations like the pandemic.

Story 17
Becoming a Resource for Each Other
(caregiver)

Selected by older adult and staff advisory groups

He/she/they lives in a duplex in a continuing care retirement community in an urban setting. SW previously cared for his/her/their partner with dementia. SW started attending an **educational group for caregivers** to learn about dementia quite some time ago and continues attending.

The most significant change in SW's quality of life since using the program has been finding and getting "all kinds of services" including programs for stress relief, help with insurance coverage for a program for his/her/their partner, finding a place to care for his/her/their partner, and finding support groups. SW also found that meeting other caregivers and hearing about other issues was helpful, noting "You become a resource for each other." Socially, SW liked "networking" with other people in the program. He/she/they gave an example of how another caregiver provided SW with encouragement and how they connected each other with activities and resources. They still keep in touch as friends. SW continued participating in the program throughout the pandemic but felt that it became "highly handicapped" when they had to shift online because some people did not know how to join the online meetings and the hosts had trouble finding presenters. In addition, SW observed that there are "many of us that are older don't want our living rooms opened up to the public!" Some of SW's friends stopped attending the program.

SW was able to learn Zoom and also joined his/her/their church services via livestreaming on Facebook. SW will continue to use the program for now but has been thinking about doing more to provide support to other caregivers in the future and volunteers for an organization. SW stays connected to family by phone and computer, noting that he/she/they has "always been able to adjust" to change and not feel sorry for yourself. SW is also involved in exercise programs and has a leadership role in his/her/their church.

Story 18
A Group That Likes to Laugh
(caregiver)

Selected by older adult and staff advisory groups

CW lives with his/her/their partner, who lives with dementia. They live in a retirement community in a suburban setting. CW learned about a **group activities and discussion for caregivers and people with dementia** from a center from being in a **support group**. They participate by Zoom.

CW described the people as a group "that really likes to laugh" and has a sense of "comradery." CW says it is a good "release" for him/her/they. The most significant change for CW's quality of life is that the program is "something we can do together and so it strengthens our...sense of coupleness and…cooperation." CW added that there are not many things that he/she/they and his/her/their partner can do together. It is helpful for CW to see him/her/they smiling, agreeable and responding rather than crabby or bored. CW believes his/her/their partner feels respected,

honored, is appreciated by the group, and is able to be "with it"…and have "now time." He/she/they also enjoys the discussion topics and "lessons" learned along the way. CW observed that the group leader "has a way of including people without putting them on guard or in a spot" without judgement. CW summed up the experience by saying, "It lightens your mood…brings some sunshine in your life that you may to be able to accomplish the rest of day or week…some moments where everybody is happy…that's what socializing can do for you!"

When CW first tried Zoom for a family event, he/she/they struggled with the sound and other features and his/her/their partner did not recognize family faces. However, it got "easier" as they had to use zoom for the program. Now CW prefers meeting online, noting, "I've thought sometimes it would be nice to get together (in person) but then have a second thought that says but that's the beauty of it…the simplicity of it…you don't have to get in car…if weather is bad it doesn't matter, you are at home…the simplicity is one of the pluses." CW does not have the opportunity to pursue some of the intellectual activities and accomplishment he/she/they used to love to do. CW could participate in social activities in his/her/their place of residence but feels too busy with his/her/their partner's need for attention and household responsibilities to do much else. CW enjoys "alone time" but also notes that not socializing is "not healthy for me."

Story 19
Having the Company

Selected by older adult, community and staff advisory groups

NK lives alone in a home in a retirement community that is located in a suburban setting. He/she/they learned about the **visiting program** from a flyer or ad in the newspaper when looking for home care. NK receives visits from more than one program. NK describe him/her/their self as handicapped and also has **in home services**.

The most significant change in the quality of NK's day to day life is "just having the company." Friendly visits were in person throughout the pandemic. NK, who has lived alone most of his/her/their life, explained that "living alone and being a senior and being incapacitated…was scary…and you were lonesome, and you get depressed." When his/her/their visitors come "my whole day is different…I feel better when they're here, I feel better when they leave, I miss them when I leave." NK feels some of the people who visit really "extend themselves" because they frequently call "to make sure that I am ok…. That little friendly call just makes my day." Another visitor plays cards with NK while they "rehash what's going on in our lives…one of the best part of my week." Sometimes these visitors bring food, give rides and help him/her/they get access to resources that have improved NK's quality of life and mobility. NK says, "I feel safe because of the way they take care of me." NK noted that it is hard to accept all this help "because I have always been so independent" but the visitors made him/her/they feel comfortable.

NK reflected how his/her/their life had changed from being very active to no longer be able to do what he/she/they used to. NK's family members rarely visit because "have their own lives." NK stays in touch with them by email, letters, and phone. He/she/they plays solitary games on the computer when he/she/they feel "depressed or needs some company." NK does not use zoom or social media and rarely uses his/her/their smart phone. NK continues to volunteer by coordinating drives for donated items for an organization over the phone, explaining, "I'm still trying...can't physically do what I did but I can use the phone or I can direct." NK's caregiver also takes him/her/they out to different places and the neighbors check on her.

Story 20
A Good Match

Selected by community and staff advisory groups

HT lives in his/her/their townhome in a suburban setting. HT decided to get a **friendly visitor** because he/she/they had been a friendly visitor volunteer in the past and believes that the experience benefits both the visitor and the visitee, when they are able to form a bond and be themselves. HT described him/her/their self as homebound due to health conditions and disability. After experiencing multiple losses in his/her/their family, HT felt that being visited would keep him/her/they busy so as to avoid dwelling on those issues.

HT felt the most significant change in his/her/their day-to-day quality of life has been having "something to look forward to." The visiting volunteer is a "good match" because they enjoy the same sense of humor and have many have things in common. HT said, "We end up laughing so hard that we are both in tears." Their relationship has developed into a friendship and expanded to include relationships with the visitor's family members. HT noted that with the pandemic, his/her/their anxiety had returned and the visits are a great distraction. He/she/they added, "It makes a difference in life as far as your mental standing because we are really social animals so being alone for extended periods of time is just not a good thing….not being able to get out to interact with some people even if just shopping whatever..." HT also noted, "Just the fact that somebody is coming to see you" is also helpful. HT also gave an example of how the visitor noticed a risky situation in his/her/their home that was resolved.

HT is aware of online programs that are available through a nearby center, but those programs don't fit his/her/their schedule. HT plays a variety of solitary games on the computer, which he/she/they views as "a bit of a workout I can give my brain cells." He/she/they also shops online for items related to a hobby. HT does not use social media due to concerns about privacy and does not like what people post on Facebook. HT has a smart phone but was more comfortable with his/her/their old mobile phone. HT exchanges phone calls with one family member who lives nearby. Most of HT's remaining family members have fallen out of touch with him/her/they.

Story 21
A Place to Grow

Selected by 3 steering committee members
Selected by community and staff advisory groups

RB lives alone in an apartment in a small city. He/she/they uses a a variety of **group programs at a center** and also goes there to socialize. RB recently recognized that he/she/they was an "isolator and had some personal issues" and needed to interact more with other people. After retiring RB didn't know what to do. Making a commitment to **volunteer at the center** "made me get out," be "accountable" to others, and be "involved." During the pandemic, RB also appreciated getting **wellness calls** from the center because it "reminded you that you were a part of the center, that you were a part of something."

The most significant change in the quality of RB's day to day life was having "something to do" on a regular schedule. RB also said, **"**It forced me to mingle with people, it gave me contact." By volunteering at the center, RB met interesting people and enjoyed helping them. He/she/they explained, "but mostly what they wanted and what I wanted was companionship." The most socially satisfying part of RB's experience was the commonality among people. RB said, "As different as we were, we all had the same question—what do I do now?" and that "when you sit at a table and people just get together over a cup of coffee or something, people will start talking, and at first it's small stuff, but then the conversation changes and you get stories" and "once I

started listening to people there came a point where they wanted to hear my stories." He/she/they explained, "It helped me discover the value of fellowship and of accountability. People expected me to be there, so I was, and eventually…I started seeking it…but it wouldn't have happened without first having gone to the center." RB added, "The skills that I learned at the center helped me survive COVID and I found that once COVID was up and the center shut down, I started doing that but over the computer." RB has resumed attending the center. He/she/they will continue to use the center because "It's a place to be and to grow." While socializing is "natural for a lot of people, but it wasn't to me…I'm still figuring it out."

RB describes him/her/their self a "techie." Once he/she/they figured out how to use Zoom, RB started connecting with past friends virtually even though he/she/they prefers seeing people in person. RB also visits Facebook pages of family and friends. RB has other volunteer roles in his/her/their building, at church and in a medical setting.

Story 22
Having Human Contact

Selected by staff advisory group

CR lives alone in his/her/their own home in a rural area. He/she/they had been using another **dining site** but switched to a different site because they offered meals five days a week, instead of only twice a week. CR felt this gave him/her/they "more choice" and also had to deal with less traffic to get there.

The most significant change in his/her/their quality of day-to-day life was "having human contact and getting to be with other people." CR went on to explain, "You can sit at the table and talk, and … kind of … judge how the other people are doing at my age, health wise and mentally and everything. See how they're doing, how am I doing ….you just sit down and kind of ramble." CR noted that getting to know people he/she/they didn't know was "good for me because I live by myself." CR also mentioned making a friend there and joins "things you can do with other people" at the meals, such as games and puzzles. CR explain it helped because "…I was getting very depressed at home." The program is also useful to CR because he/she/they eats more variety of foods than if he/she/they cooked at home.

During the pandemic the dining site was closed but has since opened. CR feels there is enough space to socially distance and that staff are being very careful with masking for everyone. When family couldn't come over during the pandemic, he/she/they felt safe but lonely. CR explained, "the phone was a must for me at that time." Other than going to the center, CR connects with the world by reading and doing puzzles or other things while watching TV to keep his/he mind "sharp." CR has not resumed attending church due to discomfort with their COVID protocols. When he/she/they "lost contact with the outside world," CR stayed in touch with people by phone or by visiting at the door with family. About midway through the pandemic CR's depression "got pretty bad." CR is not comfortable with social media but is able to text on an older phone. However, he/she/they misses the art of writing letters.

Story 23
Being Accepted

Selected by older adult advisory group

SH lives alone in an apartment in a small town. He/she/they uses a **dining program at a center**. SH learned about the center from a family member after recently moving back to the town used to live in. SH started going because someone else encouraged him/her/they to come with them, even though SH was initially reluctant to go somewhere where he/she/they didn't know anyone.

Later in the interview SH observed that if that individual "hadn't actually took me down there I probably wouldn't be going there." SH explained, "I've never been a person who just goes out and socialize" without someone else coming along. He/she/they also likes that people from the center **call to check on you**.

SH ended up meeting people that he/she/they had known through work or the community and has made new friends. When asked what the most significant change in his/her/their day-to-day quality of life has been, SH responded, "I'm keeping myself from being depressed…I live by myself…and the bills are over my head…I can go down there and….get a good meal…and get to see people." SH noted that he/she/they often spends the whole afternoon chatting after the meal. The most socially satisfying part of the experience is "just being accepted and people talking to me instead of ignoring me like didn't belong… it's like another home…they are all friends…." SH went on to explain that he/she/they has also made some friend who share their concerns with each other and he/she/they "can talk to them about anything." SH frequently often tells his/her/their family members what went on at the center.

The center has been open with social distancing since SH started going, but they are just getting back to activities that they used to have such as bingo and other games. He/she/they also learned about a food pantry through the center and started using it since his/her/their budget is tight. Some of the friends SH has made have invited him/her/they to their church. SH also connects with the world by doing things with family members and texting friends and family. SH does not use social media or a computer, describing him/her/their self as "a simple person" when it comes to technology.

Story 24
We Have Fun

Selected by staff advisory group

DT lives alone in an assisted living residence in a small town. He/she/they has been using a **transportation** service for years and continues to use it because the bus provided by his/her/their building is only available one day a week to go to medical appointments.

DT likes the transportation service because he/she/they can plan to do different things, like shopping and going out to lunch, before the pandemic. DT feels the drivers do their best to accommodate his/her/their needs. The most significant impact on DT's quality of life is that the drivers take him/her/they to a **center where they have meals**, play games, have crafts and said, "we have fun, we talk, we sit and see others … it's really nice, we look forward to that." DT went on to explain, "If it weren't for the center, we would be stuck here, and couldn't get out at all."

During the pandemic, the residents of DT's building were "stuck in their rooms" but would open windows and yell to family members who visited from outside. DT added, "I never hated a room more in my life than that year." When DT's church was closed during the pandemic, he/she/they watched services on TV. DT commented, "…it was like, every day, you didn't get dressed … some days, I wouldn't bother doing making the bed … nobody's coming to see you, so what's the point…I didn't have a routine anymore, because my routine involved going outside, seeing other people." During the pandemic, DT stayed in touch with family and friends by phone. DT also spends his/her/their days "keeping my body going" with physical therapy and group exercises at the center.

Story 25
Drivers Help Me Shop

Selected by staff advisory group

JW lives alone in a rental home in a small town. He/she/they hasn't been able to drive for some time. In the past friends or family members would give rides to or go places with JW. Now JW relies mostly on **transportation** services for getting to medical appoints, local shopping, haircuts, and other destinations. JW has several conditions that do not allow him/her/they to walk around alone.

JW often rides with others who he/she/they knows and will talk with them. He/she/they described the service as very accommodating and the drivers as "very helpful." JW explained that it is difficult for him/her/they to maneuver around stores and that some drivers "go in help me shop." The most significant change in JW's quality of life was that "I …have got back a lot my independence that I had lost when I quit driving." JW added, "I was just so grateful and thankful that they have these services that I am able to go some place…I'm not limited as to where I can go and what I can do."

During the pandemic, the service would only take one person at a time. However, JW's life didn't change much during the pandemic because he/she/they doesn't socialize that much and was still able to go where he/she/they needed. JW explained, "I don't really think there is anything that I would want to do. [a family member] asked JW, 'don't you ever get lonely…and I said no, as a matter of fact I don't.' I just don't want people running in and out of the house and visiting, coffee in the morning. I'm just not that kind of person. I don't get lonely." JW is in touch with family by phone or text on a daily basis and uses a computer, email, some Facebook and a website related to pets. He/she/they can sometimes rely on neighbors for help in emergencies. JW misses being able to take walks by him/her/their self but can't find anyone to walk with.

Story 26
Chance to Get Out

Selected by older adult and community advisory group

WB lives alone in senior housing in a small town. WB started using **transportation** services because he/she/they has not been able to drive for some time due to a disability and he/she/they felt that family and friends were too busy to rely on for rides.

The most significant change in WB's day to day life has been being able to go most places he/she/they needs to go to stores, medical appointments, to vote, and to do taxes. WB stated, "It gives me more independence and gives me a chance to get out." WB added that if a friend were to pass away he/she/they would be able to use the transportation service to go to the funeral home because "they take you to as long as you are within their area." Sometimes there are other people in the van and WB "figures out who doesn't want to talk and who does" noting that "it's company for me either way." WB also "gets some exercise" walking to and from the van. Even though WB would be able to use deliveries or curbside shopping, he/she/they prefers the opportunity to get out.

During the pandemic, the transportation service did not change, other than requiring masks and having somewhat more limited hours. He/she/they felt safe using the service. The pandemic did not affect WB's daily life much because "I'm homebound anyway." WB can also use a church's transportation service to occasionally attend a service. WB connects with the world by staying in touch with family by phone and emailing, texting or calling friends, but he/she/they prefers voice over text. WB used to go to the library to use their computers but now has a computer which he/she/they uses to shop and go online to complete continuing education credits for a

professional license because “I don’t want to let my education go to waste.” WB is interested in finding a place to exercise but would need someone to accompany him/her/they.

Story 27
Mix With and Help Others

Selected by older adult, community and staff advisory groups

HS lives alone in his/her/their own home in a small city. When HS stopped driving, he/she/they read about **transportation** services in the local paper and called them. The same organization also **calls to check on** his/her/their needs. HS uses the transportation for medical appointments, getting to a volunteer job, and shopping.

When asked what the most significant change in his/her/their day-to-day quality of life was due to getting transportation, HS responded, “Socialization! …I live alone and to mix with….and help individuals…and give back to the community…” at his/her/their volunteer job. HS commented that driver always asks if he/she/they needs to stop at a store. HS also appreciates the regular calls to see if he/she/they needs anything explaining, “checking means a lot…that you’re ok and that someone is concerned…through an organization that you didn’t even know about until then!’

When the transportation was mostly limited to medical appointments during the pandemic HS commented, “I was really, really hurting.” HS was grateful when they could at least take him/her/they one day a week and that services are finally back to the normal schedule. HS has friends among the staff and other people at his/her/their volunteer job, one of whom invited him/her/they to a short term group program for seniors where they chatted, did crafts and learn about Ipads. HS already has an Ipad and was able to help some of the other people in the group learn what they can do with it. HS has stayed in contact with the people he/she/they met at that program noting, “We really developed a friendship….we even text and phone each other.” HS stays in touch with family on his/her/their phone or IPad by using Facetime and calls friend. During the pandemic HS attended church services by teleconferencing as well as Zoom meetings of a local advisory group he/she/they is involved with. HS did not feel alone during pandemic because he/she/they was able to continue volunteer work at home by phone and made weekly plans for organizing and cleaning the house to keep busy. HS is looking forward to being able to travel again.

Appendix XIII. Examples of Selected Themes in Older Adult Interviews

Interview notes captured interviewees' wording but are not verbatim quotes. Ellipses indicate that a section of notes that did not directly pertain to this theme or that repeated information was not included or that portions of an interviewees' response were not captured in those notes. Some excerpts illustrate more than one theme. Items in brackets clarify the context or what the interviewee was referring to without referencing names or other identifying characteristics. The individual has been assigned fake initials and the story number is included when an excerpt is from an interview that was included in the 27 stories (Appendix XII).

THEMES	EXCERPTS FROM INTERVIEW NOTES
	Experiencing the Pandemic
Changes in routines & Adjusting to changes	[family members] would come by and you had to distance yourself from them, and that took a toll on me. And I missed church.....…… And I love to hug, and now I'm afraid, and it's like … Covid changed me. It took that from me. Emotionally, physically, it just … it took away the spiritual part of going to church, and just being in church, and not sitting there watching it on TV just like it was another movie or another show or something ……. especially as you get older…….. I've lived my days already, and now the days that are left … it feels like Covid … it felt like it was never going to be over……..and then it started to feel better, and now it's starting to flare up again…. [later in interview] I had so much anxiety. I even got depressed, I ate, I gained weight, and ……. I'm seeing the world differently now. Healing and understanding and just … loving people. It's a spiritual thing now for me……(MZ participated in multiple activities at a center) Prior to the pandemic, my life was heaven. Retirement life was like heaven but you're alive. I was going to the gym three times a week, I was doing yoga, track, all the other exercises ……And I had friends come over once a week for breakfast or we'd go out to eat. Life was totally different. I was always coming and going. I had a lovely life. (WG participates in activities through a library, Story 5) [During the pandemic] It's been a little stressful, but … when you're used to being alone … it wasn't a big change, for me…..I knew that [caregiver] was alright, and I knew that [adult child] was alright, and that…. lessened my anxiety because I knew they'd be okay. And I was so grateful that [meals] didn't discontinue anything …. And I knew in my mind, that if everybody else is going through this then so do I, I have to go through this too and learn to calm myself down. And at first I was worried that my depression and anxiety, I thought it would get worse but it didn't! I'm not letting it get to me! Because I thought, everybody else is going through it. So I think I adjusted well. (BN receives home delivered meals, uses an activity packet, receives reassurance calls, and has homecare) I've worked all my life. I've lived by myself … I'm not used to having a lot of people around me…… It wasn't hard for me, as it was for some people that were always on the go …….. But sometimes, when you're by yourself in the house, you adapt to it……. (KS receives home delivered meals, Story 11) Yes, I was used to going out so much more. But …. overall, I adjusted pretty well. My [adult children] they come visit me… we managed. I didn't really suffer. Going and coming wasn't as much as normal, but there was always the phone, so that helped….We have our little outings even during

Covid……..a friend of mine, we'd see each other once a week. We'd go to the park, and we'd park our cars with a parking space in between us, and we sat there, and we laughed and talked and had a good time. (KH uses online application for multiple activities)

	Program Benefits & Impact (Most Significant Changes)
Social contact	Other than my [in home] helpers … it's somebody to talk to. (AW uses friendly visits and receives reassurance calls) It just gives me more people to be in contact with, puts me in touch with a larger range of different people. It just gives me a better positive outlook that things can get better. (LB uses an online educational and social group program, Story 2) It forced me to mingle with people…it gave me contact. (RB uses participates in multiple activities through a center, Story 21) And I think that was part of [online programs] getting to me being able to watch other people I was still thinking about it, I was thinking about it all the time but it just, it improves my whole attitude and ability to do things. It filled me. (PF uses an online application for multiple activities, Story 9)
Meet people	Sometimes you want to meet other people that are like you… we have things in common, we can relate… (WG participates in activities through a library, Story 5) ….they have a little cafe which has just opened back up …and just sitting there and getting to know people and meet new people (WR uses multiple activities through a center, Story 13) …. got to know a lot of people I didn't know down there… I got to have a wider contact of people to talk to. That's good, because I live by myself. So I needed that (CR uses a dining site, Story 22) And so I have a few friends, not many left - but a few friends. I … somehow or another, the one good friend I had here died … she was it, right at the beginning of COVID, and it was like Oh God …. But no, I have a hard time meeting new people. (VR uses an educational group program)
Social interaction	… having someone to talk to. To have a conversation with, to speak with, and share with… (HJ uses friendly visits) …picking up a meal and chitchatting with people there… (FT uses home delivered meals) When I get on the bus there are people like to talk….if you say hi…they may or may not answer depending on what their condition is… …some people just look at you…so you figure out who doesn't want to talk and who does…and there's other people who…..talk and talk…but it's company for me either way (WB uses a transportation program, Story 26) Just being with others, getting to visit, getting to speak to anyone there and interact with them it's just a nice day, a nice hour and half….(BC uses a group program for caregivers and persons with dementia)
Sense of community	The quality of my life was more about being engaged in the … the concerns of the community and the individuals that were eating there. (FT uses home delivered meals) The bottom line is that my time at the [center] helped me discover the value of fellowship, and of accountability. People expected me to be there, so I was, and eventually, I started looking forward to it.... (RB uses multiple activities through a center, Story 21) I guess just being accepted and people talking to me instead of ignoring me like didn't belong… it's like another home…say hi and stop to talk to you…they are all friends…. (SH uses a dining site, Story 23)

	Just the camaraderie in the group sessions - there's just something about it…. (MD uses a caregiver group) Like you're in the community, except from the TV. I used to be part of a community center, but because of Covid they closed it down and it was lonesome. But this helped a lot, I'm not lonely anymore. And you learn so much! …. It really relaxes you! (EE uses multiple activities through an online application, Story 8)
Happenings	… just being informed on what's going on, within my church (HJ uses friendly visits) …while we're waiting and we sit around …we reminisce or discuss what's going to happen… in town or wherever… (MC uses a dining site)
Sense of history	… you have sixty years of experience and living behind you, so there's something in there that you'll want to share. And when you sit at a table and people just get together, over a cup of coffee or something, people will start talking, and at first it's small stuff but then the conversation changes and you get stories…. (RB uses participates in multiple activities through a center, Story 21) … it's just like going home, going back there. And some of the seniors when I was working there… they're still seniors now and I'm seniors with them … and there's a history there. (GW uses a dining site)
Eating together	You can sit at the table [for a meal] and talk, and … judge how the other people are doing at my age, health wise and mentally and everything…., you just sit down and kind of ramble, and start talking… (CR uses a dining site, Story 22) …a get-together…because of Covid having taken over our lives, we were just going to go there to have a little snack…they always have a little something for us, maybe cookies or coffee or sometimes we'll have a little activity to do. And we'll talk to each other, say what we're interested in doing. (WG participates in activities through a library, Story 5) …[program] has a virtual… dinner and I did really enjoy that. I mostly just talked to one other person and it was nice to talk to her even though were weren't exactly the same or anything…but it was a nice experience, especially during Covid. (RI participates in an educational and social group)
Develop relationships	I just thought, I'm gonna try it! … I have a lot of wonderful friends out here … it wasn't like I was super lonely before…but I got to make a new friend! (RU uses friendly visits and receives reassurance calls) I feel comfortable, speaking with the person who calls me. She's almost like my new best friend, sort of, and we get a chance to really talk about things that are bothering me. It's always a positive experience. (MB uses friendly visits) …[another participant] and I talked to one another often. [Interviewer: what was the most socially satisfying aspect of the program?]… Just the networking with other people who are there. And we are still very good friends….We both lost our [partners], and we talk about that a lot…. (SW uses a caregiver education group) And who knows, maybe fall in love! Again! (BL uses a discussion group and other activities through a center 112, Story 4)

Share personal experiences & You are not alone	I don't know how to describe it - I'm very empathetic, and we can share our stresses……. If I hadn't gone to this group, I would have felt alone, like an island, like I'm on my own and I need interaction. I need that…. getting with people. (MD uses a caregiver group) …meeting other people that are in similar situations, and being able to talk to them and relate to their experiences….because you're not alone, and you can learn so much more from other people who have more experience with this and who have been dealing with similar situations for longer…. (JA uses multiple programs for caregivers, Story 1) …It's just a good 'community town square' kind of thing, where people can come together…… just hearing what other people are experiencing and going through, and also being able to put my own experiences and perspectives out there. It's really good, knowing that I'm not the only one dealing with this stuff. (LB uses an online educational and social group program, Story 2) …it helps them [seniors] grow more…see other people going through, trials and tribulations too… you're not alone, other people are facing it [pandemic] too…and just, taking their minds off of it for a bit. Just like family! Like a big extended family. (EE uses multiple activities through an online application, Story 8)
Someone cares & Being checked on	if I have an issue…lets say I am feeling lonely…they check to see through the conversations…how are you doing how are you feeling…if they perceive that you are …going through anxiety or sadness…they get involved…they will call more often…[the visitor] had even spoken with my daughter…. when you are alone it is nice to know… that somebody out there…. truly cares and will engage you in conversation and will truly want to know. (JM uses friendly visits) ….I'm going through a crisis now to find out what's wrong and they're always right there for me, and they go beyond. Like, sometimes they walk me to the door if I need it, make sure that I'm okay….Yes, they really care! (DL uses transportation, Story 10) They try to call you every month to see how you're doing, if you've had any falls, checking on the alarm and the unit to see if it's working…you can tell that they care. (BN receives home delivered meals, uses an activity packet, receives reassurance calls, and has homecare) They call just to see if need anything, if everything is going ok…checking means a lot…that you're ok and that someone is concerned…through an organization that you didn't even know about until then. (HS uses transportation, gets reassurance calls, and used a short-term group program, Story 27) …when the facility was closed, where they would prepare little care packages [with the meal delivery]…….even if we didn't go up there or were doing the homebound they still stayed in communication with us and I thought that was a wonderful part of the program….. [the meal delivery person] found out what I liked to read, and so now she furnishes me with books so the entire quarantine time I'd have a couple of books waiting to keep me company…..She was always doing little extra things for us that were wonderful. (FN uses a dining site)

Advocates for or connects to resources	They answer the phone! And they listen to what's going on, and they get back to me with information. If they don't have the answer, they will search it and will mail me the information - and I appreciate that, it feels like they really care. (WL gets telephone reassurance calls) ….they said we wanted to touch somebodies' life and they touched mine" and every time I think about them, it is hard to accept [described types of help] because I have always been so independent but they didn't make me feel that way. If I need something, I feel could ask them… (NK uses friendly visiting and has homecare) [Interviewee lost access to wifi]…So I couldn't access anything! So [visitor] went out of her way and called Meals on Wheels and asked if there's anything out there that can help her…So they provide an iPad, and free connection for a year…So now I'm back to my Zoom classes, and the whole world opened up again. And I never would have known about it without her seeking it out and having her as an advocate to see what's out there. (NV uses friendly visits, receives reassurance calls, received a tablet with training and previously used meals on wheels)
Reduced isolation or loneliness	Outreach programs are nice for older citizens like me. A phone call maybe, or send a card to say hello, I'd like something like that. Especially when you live alone, because you get lonely sometimes. I know I do. (NW uses a program that provides calls and resources) after I get off of the phone… better in the sense that I feel more … confident … with that friend. Like I'm not alone, like I have someone to talk to. (MT uses friendly calls and also takes lifelong learning classes) If I hadn't gone to this group, I would have felt alone, like an island, like I'm on my own, and I need interaction. I need that, um, getting with people. (MD uses a caregiver group) I used to be part of a [center] but because of Covid they closed it down and it was lonesome but this helped a lot, I'm not lonely anymore. And you learn so much! ….. it really relaxes you! I'm so mentally relaxed… (EE uses multiple activities through an online application, Story 8) it's mostly just being able to get out and not feel so isolated. ….. they had to close. I was sitting at home and I'd feel like ….. all alone. I was tired. And now, I get dressed and I go over to the [center], and there's always something to do… I can exercise… … there are always somebody there to talk to ….just to get out, and be around people… (MZ participated in multiple activities at a center)
Improved Outlook	[using the program] is helping a lot. And making a new light on life, instead of looking at life all negative … and accepting life as it is and trying to give to life instead of just being negative. 'Cause life has some ups and downs, and we're gonna have some obstacles in life, we're gonna have some problems, and we have to go through it and we get stronger, once we go through it and accept it. (EE uses multiple activities through an online application, Story 8) It just gives me more people to be in contact with, puts me in touch with a larger range of different people. It just gives me a better positive outlook that things can get better. (LB uses an online educational and social group program, Story 2) But it is such a release for us to be able to laugh and not judge and enjoy seeing and responding …..……it lightens your mood…brings some sunshine in your life that you may to be able to accomplish the…not have the rest of day or week…moments where everybody is happy…that's what socializing can do for you….(CW uses a group for caregivers and persons with dementia, Story 18)

Social skills	It has really convinced me to be out in the public now that can get out and go and do things…before I started going down there I didn't want to go by myself….now I figured what the heck…….. go enjoy yourself so that's what I do… [before] I didn't like going out in public…by myself. …… …if I didn't know who was going to be there, I didn't want to go…… (MC uses a dining site) I'm usually the type of person that needs to get to know you first, like I need to talk to you, and you talk to me, and then over time, as I get to know you … but I'm trying to be a more open person to doing stuff like that. I guess I need to, and I'm trying! But I need to improve on my, openness? To new people and trying new things. But it's a work in progress. (WR uses multiple activities through a center, Story 13) …they told me I was in too much isolation, and so they told me, go to the [center], talk to people. Get out. And so I did, and I started talking to people but I wasn't like that before and it was very different for me. The skills that I learned at the [center] helped me survive Covid (RB uses participates in multiple activities through a center, Story 21)
Cope or manage feelings & Selfcare	I know always enjoy visiting with each other, so uh … it really helps to take your mind off of what's going on. [Later in interview, mentioned death of a family member]…… I think the friendly calls have helped with that. … [caller] has had some of the same things … Unfortunately, a lot of people have. This has been a year of goodbyes. ……. And I've always been somebody who knows everybody, so to see the group getting smaller like this … it's been hard. (NS uses friendly calls, Story 12) I always feel so much better after I speak to my caller … especially if it's about something that's been on mind, and especially if it's not something I might talk to about to other people. (MB uses friendly visits) And this year, I've had a lot of deaths in the family, so this helped me during the grief. And this, this relaxed me. They have bible classes. Every month they will laugh, and it helps me with the stress….. I prefer to listen to [online programs] instead of the news ….when everything was so bad all the time, you get down and … you lose hope ….. So I started watching this [online programs]. …..……[using online activities] it helps your mental state as well as your physical state. …. (EE uses multiple activities through an online application, Story 8) I'm trying to like, not be in here with just my thoughts, I don't want to be depressed - and I'm trying to get out of that because I don't want to turn into somebody, who, you know. I want to do something….(WR uses multiple activities through a center, Story 13) I'm keeping myself from being depressed…I live by myself…and the bills are over my head…I can go down there and it's $4 and I get a good meal…and get to see people…and they seem to like me (chuckles)…even though meal is at 11 or so, after we eat a lot of us are still sitting there and still talking …sometimes up to 2 o'clock (SH uses a dining site, Story 23)
Spirituality or mindfulness	And I feel that, you know, uh … my conversation is confidential … it's … it's enlightening, spiritual … it's a combination of a lot of good things. (MB uses friendly visits) … with [the group program] , I love the [various mind/body activities] … I'm not stressed, I'm happy … even though it's not the same [as being in person] [later in the interview] …since I do my meditation, it's taught me to … um … to not worry. Being depressed … not having any negative thoughts … happy! (BL uses a discussion group and other activities through a center, Story 4)

[using online activities] stimulates the brain to stay focused, and gives you energy, it energizes you because you have something to look forward to and think about instead of the sadness and, you know, on tv, all the sadness and the killing… (EE uses multiple activities through an online application, Story 8)

	Using Programs and Technology During the Pandemic
Feeling safe during the pandemic	I think they're trying so hard, with this Covid, to keep everybody safe. They do more calls, distanced calls…. And they're still trying to keep up with the people at home, trying to cheer us on, trying to keep us going and, you know, call us….. They're caring for us. (BN receives home delivered meals, uses an activity packet, receives reassurance calls, and has homecare) because with seniors when you get older you get more frightened…everything was done so…..professionally…there wasn't one time that they walked in not wearing a mask or is it ok for us to come in….(JM uses friendly visits) We, right now, sit down and have our meals with our mask on, and we can be sitting down with other people, but they had to be vaccinated … … if we got up to walk around or go to the bathroom, we had to put on our …. … she's been really careful with us. I hope everything she's done with us is working….(CR uses a dining site, Story 22)
Changes in program experiences during the pandemic	<u>One on one programs</u> They had, um, little projects …. …. and I'm still working on mine, I've got it here on the table with all these other things, and it's been a couple of months and I'm still going at it …but I thought that was really interesting. And then when COVID got real bad, we did it over the phone (RY uses transportation, gets reassurance calls and uses an activity packet) I live alone and to mix with….and help individuals…and give back to the community I just enjoy going….During pandemic with only emergency [transportation] like medical appts….I was really, really hurting… (HS uses transportation, gets reassurance calls, and used a short term group program, Story 27) It used to be a couple of days ahead of time, but now it's a week ahead of time so I don't use it now anymore for groceries. (RY uses transportation, gets reassurance calls and uses an activity packet) <u>Group programs</u> …. I did notice that the attendance in Zoom was down. Maybe not everybody had access, maybe others got so frustrated they simply decided to wait until they were in-person. And you know, when we returned, many of us had gotten older. …. And who knows, maybe they might've gotten sick during that time…..(WO uses a caregiver group) Umm, well, if anything I'd say it brought in more people. I don't know if it's just because they're now, you know, sitting at home because they're not working, because of Covid, or if it was the convenience. …. …. and it's grown to include different people from all over the Chicago Area…. (LB uses an educational and social group, Story 2) …for a brief month or two offered hybrid with zoom…now have gone back to all zoom and they are hoping to go back to hybrid again…but I will probably continue on zoom unless I have reason to [drive to the in person group]. (OP uses educational and social groups) …. Like I said, once things opened up, I've been doing other things. [later in interview] maybe this winter when I'm cooped again and without a car and then see what's available. But right now, I want to take advantage of getting out as much as possible. (RI uses an educational and social group) <u>Centers and dining sites</u>

	[the dining site] reopened not too long ago. Of course, it's not all back to normal, a lot of people are still taking their meals at home, …… I'm getting older, and my mobility isn't as good as it once was and so … I still get quite a few meals at home. I still go to the center as well, but not as often as I used to, before the whole COVID came. (FN uses a dining site) the [center] opened up again …… some were scared, others were gone, a lot of them didn't like the restrictions so they'd stop coming and what happened, a lot of the things I was used to doing weren't available anymore….. [later in the interview] … believe it or not, the staff kept in touch with people. Like wellness calls ….Everybody would call, they'd take turns …….. the calls reminded you that you were a part of the [center], that you were a part of something. [later in interview]…. the [center] created an identity for a lot of people. They were members of something, they were either there as patrons or as part of staff. It was a breath of fresh air for a lot of us, we had something to look forward to and to have that taken away during Covid…….. to just be denied that sense of identity out of the blue … (RB uses participates in multiple activities through a center, Story 21)
Missed being in person	during the pandemic when we were quarantined…we did a lot of over phone conversations…….it was something I could look forward to …but wasn't quite the same as the in person visits…[interviewer asked what makes in person better?] it's a little easier to interact… and …..stay alert… (AR uses friendly visits) it's just not the same on the computer as it is in-person. It's nice for me, because I can still attend from [out of state] but still, it's different. [Later in interview]…. I really miss the social aspect of things, getting to hang out with people and talk to people. (JA uses multiple programs for caregivers, Story 1) when I began to get most of my meals delivered instead of going to the center. It was a matter of … missing that companionship, and missing other people….Not getting out as much, not seeing my friends in the center … … But I can't deny it was a lonely time….(FN uses a dining site) I need that, um, getting with people. And with this pandemic [when group shifted to online], I do miss the group get-togethers. There are some things that just fall apart in Zoom. (MD uses a caregiver group) … can't see my friends at the library … because I don't have internet, so, those kinds of things are gone except what I can do on my phone……So you would call, or you could sit outside and they'd bring out what you wanted. (WG participates in activities through a library, Story 5) It's okay to be on Zoom, but in-person you can see what they're not telling you and ask them about it and it'll come out later... (WR uses multiple activities through a center, Story 13)
Benefits of online programs	Yes. I said, "Well I'm locked up, but I'm going to do all these things," … so that … it's not the same, but it's still the same but it's still kind of socializing a little, because talking to the instructor and this and that and whatever … through them, I learned a lot too! [later in interview explained how instructor make it easy to see images or demonstrate exercises online] I need the Zoom … so the telephone doesn't help much - it's much better on Zoom. (BL uses a discussion group and other activities through a center 112, Story 4) … because we haven't been in a group for a while, because of Covid. It's really, it's really nice to see their face. [Later in interview] I can connect with my grandson in-person, through the [online application], and we can talk to each other, and all we had to do is call each other …….. but it was nice to see him face to face. (KH uses online application for multiple activities)

	You know, you don't have to go anywhere now, you just press a button and you're there. (LB uses an online educational and social group program, Story 2) But then, who knows, maybe we wouldn't have had as many speakers because with Zoom they could just, on their computers, but in-person they would have had to travel (VP uses an educational and social group program) ….you don't have to worry about dressing and running somewhere. You can just sit there! That's an advantage too! ……. because I have a disabled [partner], going back and forth between doctors or meetings and things …..that I can still participate, and still be here for him. [Zoom] been such a great advantage, to be able to connect with the world. (PK uses an educational and social group, Story 7)
Limitations of online programs	I mean, even if you have a tablet and you do Zoom, or … or Zoom meetings, that kind of thing … it's still not the same as being in somebody's presence. I read somewhere too about, somebody talking about social media that a lot of people are just putting their best foot forward, and you don't see what's really going on in their lives. They might be struggling so much more, and you just don't know! And the connection is just not there. (NV uses friendly visits, receives reassurance calls, received a tablet with training and previously used meals on wheels) I was disappointed. Because I expected it to be interactive….. The only interaction was before and after…. And that was basically the reason I dropped out, partly at least. …… If it hadn't been for the pandemic, we could have arranged to go out for lunch before (VR uses an educational group program) …..there's sometimes some people who will go on and on on a topic …… Sometimes I wish the person leading the group would maybe .. nudge things along you know, out of consideration of how many people there are, and how much time there's left. (LB uses an educational and social group program, Story 2) Oh well, I've tried, a few times, to do the Zoom thing and I can do it! But it's just not the same as in-person, and [my partner with dementia] just will not do anything on the computer… flat out refuses. [later in the interview] …..But again, I'm not a big computer person either. For us it isn't a good fit. (BC uses a group program for caregivers and persons with dementia, but dropped out when it went online) …it's hard to tell who's talking when all the little squares are so small ….. if there's a lot of people on it gets a little messy. …. if i knew more about the Zoom, I might be able to figure it out …(EG uses a program for caregivers and persons with dementia 507)
Adjusting to new technology	I got pretty good at it because we started having church via livestreaming on Facebook … From there, I was able to learn how to do church meetings, and learn to do more things like [the caregiver group] (SW uses a caregiver education group) Uh, yes. I was a newbie pretty much, I had had one or two Zoom experiences, which were not easy for me at all. I'm not a techie. My consultants are my children and my grandchildren, and it was intimidating at first, but it became a normal thing through this, especially after a social thing with a different group for people who weren't able to meet in person (VP uses an educational and social group program) So far I've had two Zoom calls , which I'd never done before, and I went to the library, and they showed me how to do it, and they showed me how to set it all up….I don't have to figure it out on my

	own…. and somehow, no matter how busy they get, they always have time to show me. (WG participates in activities through a library, Story 5) It's hard to keep up with technology, it feels like it's always changing…. But this was, once I started [using the smart speaker]… It's been a blessing. I still don't know .. everything that it does, but for what I've used it for, it's been great. [Later in the interview]… . I never thought I would have liked to have something like Her [smart speaker] in the house because I didn't want Her in my business, I didn't want Her listening to me or talking to me [laughing] but I enjoy it! Yeah. ….. I will continue to explore with her and see what else, what more I can come up with, so she can be more useful (GT received a smart speaker and gets calls from the service provider) … managed to get ahold of a hotspot and a tablet for me through them. So, they walked me through it and I can talk with [family members] now! And I can see them! And that's very good. I've gotten a lot of good news from them, with the tablet. Of course, I got bad news from them both too … I got to keep in touch with my family again, so I really like that. (AM uses multiple programs at a center and received a tablet, Story) I do more on my iPad than I do on my phone. ….The old screen on my old phone was so small … I can't see why I'd want to use it. … (FN uses a dining site) more recently my granddaughter got me into the face to face programs, a lot of facetime and duo, (GW uses a dining site)
Open to using technology	…. You only have three classes [on using a tablet] to learn an awful lot. I think I was the only one that was basically not familiar at all with tablets computers, and emails and internet … …. when it came out, the questionnaire, I thought, "Gosh, I don't have anything else to do - it'll be fun!" …. So now it's …. A whole new life. It's fun! It's great fun! (PG received a tablet and participated in training to learn how to use it, Story 14) well, it exposed me to…. I want to take a class and go more into Zoom, and learn more about technology. I want to learn, because this is the new way. I'd think to myself "I can't do it," being all negative about it - but this, it helps you a lot. (EE uses multiple activities through an online application, Story 8) with Zoom, I'm thinking I still needed to learn how to do the chat. And I couldn't catch onto that - I kept thinking that I needed to ask and find out, and I never did. That would have been a good thing to learn. I had bought an iPad just for Zoom before, and I had to teach myself how to do that. … I also decided to use it before that for some … …. a class … and also some … …. Church services. (RI participates in an educational and social group) … I've always been a techie, I've always been a bit of a computer guy so I played around and figured it out, and I'd call people on the computer so I could see their faces, and at first they were like, "Who is this?" but then we'd start talking, and they liked that, and then next I saw other people reaching out and telling me about it. ….. (RB uses participates in multiple activities through a center, Story 21)
Reluctance to use technologies	The idea of someone I don't know having my email address. I wouldn't probably do that. During pandemic some senior centers offered programs online..... and If I am on the computer rather do …… things that require me to think to see if it helps my brain cells. (HT uses friendly visits and gets reassurance calls, Story 20) [At work] it was going more to texting and emailing, and I was never a fan of that. For something

quick, maybe, yes, but to really talk about something you like to hear somebody's voice. You can pick up on things, hear their voice, hear what isn't being said, their tone. Email and text, it can be very cold and it can sometimes be misunderstood! (NV uses friendly visits, receives reassurance calls, received a tablet with training and previously used meals on wheels)

I don't use that [mobile] phone too often, I can't hear well from it. I like my landline. ….I have it wired up so that it sounds better, so I can hear better. (AW uses friendly visits and receives reassurance calls)

We didn't grow up with this, technology left us behind….. I have no idea where to go or what to do, and I'll start doing it, and then I'll freeze because I don't know where to go and they, over the phone, they make you feel stupid, like you don't know anything, because to them it's so easy, they think it's obvious. (WL gets telephone reassurance calls, Story 15)

> … it went to something like Zoom … although some of them called it Webex? It went to those … I do not think they were very successful, because lots of people didn't know how to get on with Zoom or didn't have the facilities. Because many of us that are older don't want our living rooms opened up to the public! It didn't bother me, because the facility that I'm in, but many of my friends stopped going. (SW uses a caregiver education group, Story 17)

….I can touch-type, so typing on the computer is real easy, but with the cell phone I can't tell where the letters are so it's just not as easy. … I'm just not a texter. I can call! (JA uses multiple programs for caregivers, Story 1)

My laptop is tied to my chair. Because I don't want hackers to break in so it's kind of isolated. The tablet is more for general information and social stuff….not personal data (RZ uses a tablet and training that was received from a service provider)