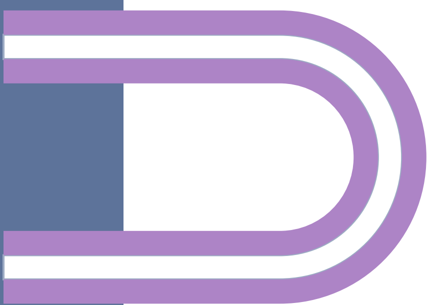

Addressing Loneliness and Isolation by Advancing Positive Social Connection

Quality Improvement Project

Quality of Care Program, AIDS Institute, New York State Department of Health

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Social Connection Quality Improvement Project: At a Glance

Aim: Improve positive social connection by 10% by December 31, 2025

Action Plan:

- Participating sites will submit their Quality Improvement Team Form.
- Participating sites will use the University of California, Los Angeles (UCLA) Loneliness Scale with individual clients.
- After using the scale for 30 days, participating sites will use the Data Collection Instrument, an Excel spreadsheet that we have developed to understand if there are subgroups of clients who are more impacted by loneliness than others.
- Participating sites will use the Data Aggregation and Reporting Tool to report outcomes to the Quality of Care Program at qocreviews@health.ny.gov.
    - Please remember not to submit any client identifying information, just aggregated data.
- Sites will identify a group they would like to focus upon for reducing loneliness and advancing connection.
- Sites may use the Action Planning Template to assist with planning this activity.
- Sites will test out the change using Plan Do Study Act (PDSA) small-scale short-term cycles, revising and improving the activity based on what they learn from each Plan Do Study Act cycle.
- Sites will re-administer the UCLA Loneliness Scale with clients in the group of focus to check-in at least quarterly. This will help the site understand if improvements are occurring.
- Sites will aggregate results using the UCLA Loneliness Scale on a quarterly basis.
- At the end of a year, sites will report on loneliness outcomes for the group of focus as well as for all clients of the program.
- Some sites may choose to implement a Quality Improvement Project to Advance Social Connection for their staff. In this case, all the data collected for staff will need to be kept separate from client data.
- Success can be assessed by measures such as a reduction in the average loneliness score or a reduction in the number of very elevated loneliness scores for the whole group of focus.
- Sites can choose to participate for any 10-month period between now and the end date of December 31, 2025.

Introduction

Since the Covid-19 pandemic, social isolation and loneliness amongst people with HIV and their care providers has substantially increased. Evidence suggests that public health and healthcare policies and practices can improve social connection, reducing the negative impact on health caused by social isolation and loneliness.

This project is a collaboration between care providers, supportive services providers, people with lived experience, and the New York State Department of Health AIDS Institute Quality of Care Program. The AIDS Institute has a long history of using quality improvement methodology to collaboratively improve health outcomes for people with HIV. Surveys that measure social isolation and loneliness, such as the UCLA Loneliness Scale, can be used to measure the effectiveness of quality improvement efforts. With these measurement tools, as well as proven social connection improvement activities, this project has all the elements necessary to advance positive social connection.

If you are interested in participating in the quality improvement project, please complete the Quality Improvement Team Form. We have included an AIM statement and Action Planning Template for you to complete with your team.

Social Connection Background

Definitions
There are three components to social connection. The first is structure, which is the number and variety of relationships a person has, and the frequency of their interactions with others. The second is function which is defined as the degree to which others can be relied upon for various needs. The last component is quality, or the degree to which relationships and interactions with others are positive, helpful, or satisfying. The surgeon general's advisory defines social isolation as a state of having few social relationships, social roles, and group memberships, as well as infrequent social interaction. Loneliness is defined as the distressing experience that results from perceived isolation or unmet need between an individual's preferred and actual experience.

Link to Health Outcomes
Many studies have demonstrated the negative impacts of loneliness and social isolation on various aspects of health, as well as the positive impacts of social connection. Loneliness may increase the risk for premature death by 26% and social isolation can increase this risk by 29%. Lacking social connection can increase the risk of premature death as much as smoking up to 15 cigarettes a day. Social isolation and loneliness are common, yet under recognized, determinants of cardiovascular and brain health. Lacking social connection can lead to increased cardiovascular risk factors. Poor social relationships have been associated with a 29% increase in the risk of heart disease and 32% increase in the risk of stroke. Childhood social isolation is associated with increased cardiovascular risk factors in adulthood. Greater social support has been associated with a 36% lower risk of high BP in Black Americans, who are at higher risk for the condition. Social disconnection has also been linked to increased risk of developing type 2 diabetes.

Studies have linked social isolation and loneliness with an approximately 50% increase in the risk of developing dementia (including Alzheimer's) and a 20% faster decline in cognitive abilities for older adults. Multiple studies have found that social isolation and loneliness also predict increased risk for developing depression and anxiety in adults and children and can worsen these conditions over time. The odds of developing depression in adults is more than double among those who report feeling lonely often, compared to those who rarely or never feel lonely.

Social isolation is arguably the strongest and most reliable predictor of suicidal ideation and behaviors among samples varying in age, nationality, and clinical severity, making the case that both loneliness and social isolation be included in the risk assessment of suicide. This also means that social connection may be one of the strongest protective factors against self-harm and suicide.

People who are less socially connected may have increased susceptibility and weaker immune responses when exposed to infectious diseases. For example, when exposed to the common cold virus, people with social ties to six or more diverse social roles had a four times lower risk of developing a cold compared to people who had ties to fewer diverse social roles.

Further research reveals a relationship between social connection and HIV health and well-being. Studies show that enhanced personal contact with a clinic staff member improved the number of primary care visits in HIV clinics. Improved quality of the relationship between patient and health care provider has been found to be highly predictive of HIV medication adherence. Social support has also been found to be a major buffer in coping with HIV/AIDS related stressors and stigma and is also associated with lower depression symptoms and slower illness progression from HIV to AIDS. These

findings have many implications for the potential positive health impact of increasing connections between providers and patients.

Prevalence

Over the past few decades, there have been concerning trends in the state of social connection in the United States. The percentage of trust in others has decreased by about 20% since 1972, and the percentage of people with social membership associations has decreased by almost 25% since 1999. The percentage of people with less than or equal to 3 close friends has increased since 1990 and so has the percentage of single-person households since 1960. In 2022, only 39% of US adults said that they felt very connected to others and recent surveys have found that around half of US adults report experiencing loneliness, with some of the highest rates among young adults. Despite this high prevalence, less than 20% of people who often or always feel lonely or isolated recognize it as a major problem. Considering this data, it is clear that this represents an urgent public health concern. Every level of increase in social connection corresponds with a risk reduction across many health conditions, which is why it is critical for us all to find ways to contribute to advancing positive social connection to ultimately improve health outcomes.

Solutions

The surgeon general's advisory offers a 6-pillar framework for we can advance positive social connection with specific activity recommendations. Some of these activities include establishing and scaling community connection programs, training healthcare providers, assessing and supporting patients, and increasing public awareness and building a culture of connection. This can take the form of expanding

conversation on social connection to workplaces, schools, clinics, and communities. It can also include targeted interventions to increase social connection at the clinic level, thereby improving patient health outcomes.

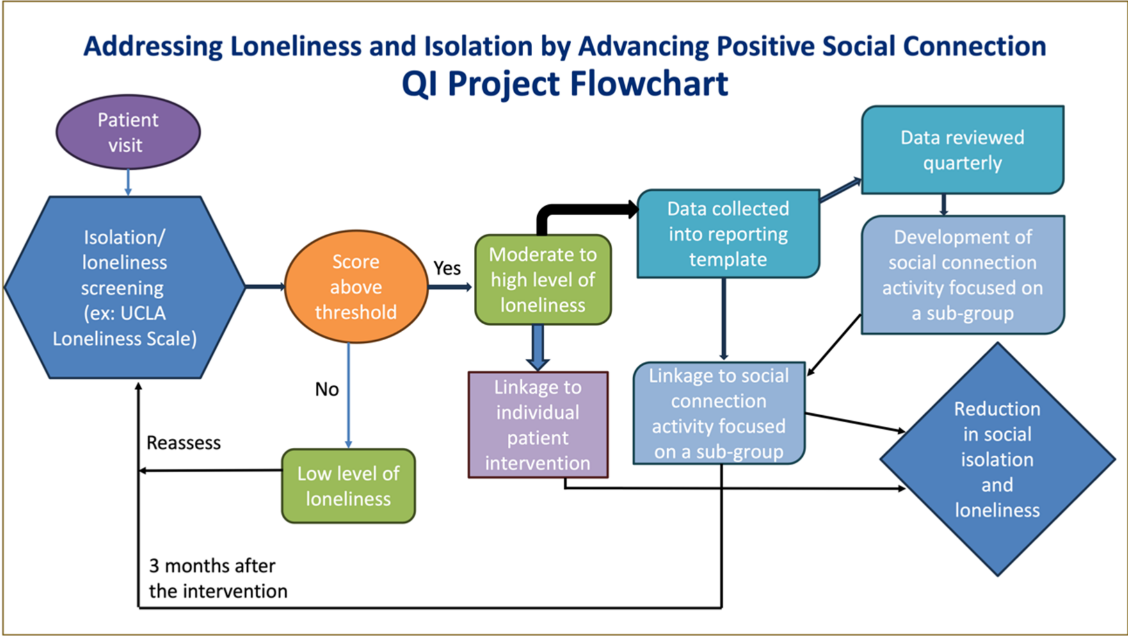
Quality Improvement Project Plan

Each participating organization or agency will use the UCLA scale and measures of client characteristics with each client to measure for loneliness. The results can be used to link clients to a social connection activity. The results from each individual UCLA Loneliness Scale individual client interview can be entered into the Data Collection Instrument. The Data Collection Instrument is an Excel sheet that is for agency use only and should not be returned to the Quality of Care Program. At the end of the reporting period (such as 30 days), the organization will aggregate the data from all client interviews using the Data Aggregation and Reporting Tool. This will assist with understanding intersectionality to identify subgroups of clients who have a higher level of loneliness based on the UCLA Loneliness Scale. The completed Data Aggregation and Reporting Tool will be returned to the Quality of Care Program after the reporting period.

This process will help your team identify which subgroup to focus on as you develop a quality improvement activity to reduce loneliness and isolation by advancing positive social connection. These activities can include support groups, cultural celebrations, recipe swaps, health education sessions. A list of possible activities with explanatory notes is included in this packet. To examine the potential impact of the project, the measure of loneliness and isolation should be administered to clients before and after the social connection activities are implemented.

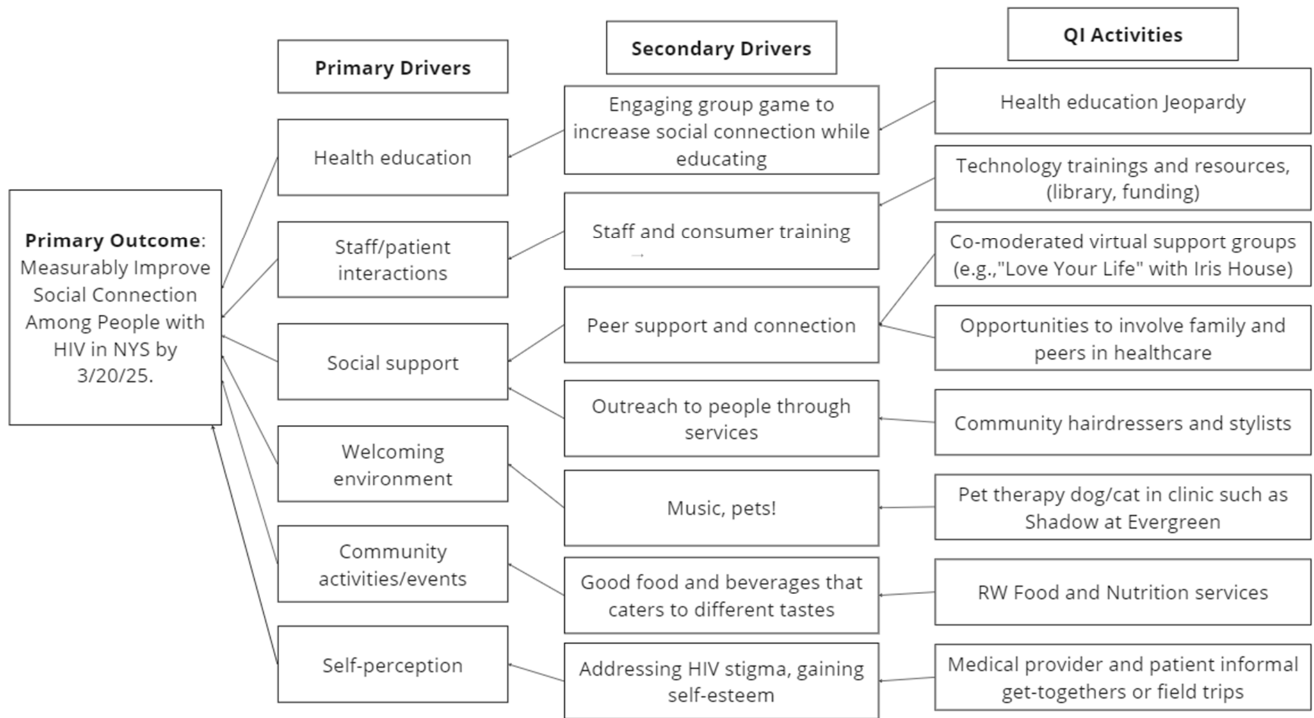
This measurement method can be used both with staff and clients, but we ask that you collect the data separately for analyzation purposes. The purpose for this project is to reduce loneliness and isolation by advancing positive social connection in the HIV care community. We hope this data will add to overall understanding of what works to improve social connection; however, our main goal is to improve the lives of our clients and colleagues.

Coaching is available to assist with project planning and implementation. To schedule an appointment, or for any questions or inquiries regarding this quality improvement project, please contact Quality of Care Program Director Daniel Belanger at 212-417-5131 or Daniel.belanger@health.ny.gov.


Addressing Loneliness and Isolation by Advancing Positive Social Connection
QI Project Flowchart
Patient visit
Isolation/ loneliness screening (ex: UCLA Loneliness Scale)
Score above threshold
Yes
No
Moderate to high level of loneliness
Low level of loneliness
Reassess
Data collected into reporting template
Data reviewed quarterly
Development of social connection activity focused on a sub-group
Linkage to individual patient intervention
Linkage to social connection activity focused on a sub-group
Reduction in social isolation and loneliness
3 months after the intervention

Driver Diagram: Advancing Positive Social Connection

This driver diagram was completed during the Addressing Loneliness and Isolation by Advancing Positive Social Connection Campaign Kickoff Meeting on March 21, 2024. Input was given by HIV care providers, supportive services providers, people with lived experience, and supportive staff from the AIDS Institute.



Social Connection

Quality Improvement Team Form

Please indicate the team members of your quality improvement project. (Note: We highly encourage you to involve cross- functional members of your care team in addition to people with lived experience/ consumers of your services)

Name: ____

Title/Role: ____

Email: ____

Name: ____

Title/Role: ____

Email: ____

Name: ____

Title/Role: ____

Email: ____

Name: ____

Title/Role: ____

Email: ____

Name: ____

Title/Role: ____

Email: ____

The UCLA Loneliness Scale and Client Characteristics

The UCLA Loneliness Scale (4-item version) can be used to assess each client's degree of loneliness before and after the Quality Improvement Project's social connection activity.

Instructions for administering

It is important that the wording of the instructions, questions and response options is not changed, and nothing is omitted, so that a standardized approach to measurement is maintained.

Due to the subjective nature of loneliness and the potential effects of stigma (which can make it harder to admit to feeling lonely), it is advised that participants answer these measures without help. When this is not possible, it is preferable to use the same method of presenting the questions and collecting answers each time the measure is used. Interpreters/translators assisting participants with literacy or language difficulties should try to keep closely to the instructions, questions and scoring options, without adding anything new.

Before administering the survey, please thank the client for participating and introduce the scale. Example language includes: "Thank you for agreeing to answer the loneliness scale survey. Because loneliness and isolation has increased, we are offering the scale to all our clients to understand how we can better serve you and support your health and well-being."

It is also important to make sure the client understands what each score means. When reading the instructions on the UCLA Loneliness Scale document, make sure to add that a score of 1 means never, 2 means rarely, 3 means sometimes, and 4 means always.

Since the UCLA Loneliness Scale is a validated tool, it is recommended that the language not be changed when administering the scale. The scale purposely uses open-ended questions, allowing for a wide range of responses.

If an interviewee asks for clarification, please explain that the questions are meant to be open to interpretation or, said another way, are meant to mean whatever the individual thinks they mean and can be responded to with this in mind. We recommend that you do not attempt to explain meaning or interpret the questions but remind the individual that the questions are purposely open-ended and offer formal definitions.

If an interviewee asks for clarification, you can offer the following definitions from the Cambridge Dictionary, and then re-ask the question.

- "Being in tune with someone/something" is defined as "having a good understanding of someone or something."
- "Really" is defined as "not imaginary" but "in fact."
- "Companionship" is defined as "the enjoyment of spending time with other people."
- "Around" is defined as "in a position or direction surrounding."
- "With" is defined as "in the same place as."

Instructions adapted from "Ending Loneliness Together (2021). A Guide to Measuring Loneliness for Community Organisations."

SECTION 1: The UCLA Loneliness Scale (4-item version)

Instructions

The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described.

For example: If you were asked the question “How often do you feel happy?”, if you never felt happy, you would circle “1”, while if you always felt happy, you would circle “4”.

	Please circle one response for each question			
	Never	**Rarely**	**Sometimes**	**Always**
1. *How often do you feel that you are “in tune” with the people around you?	4	3	2	1
2. How often do you feel that no one really knows you well?	1	2	3	4
3. *How often do you feel that you can find companionship when you want it?	4	3	2	1
4. How often do you feel that people are around you but not with you?	1	2	3	4

How to score and interpret this measure

Items with an asterisk are reverse scored (i.e., 1=4, 2=3, 3=2, 4=1) and the scores for each item are then summed. The minimum possible score is 4 and the maximum possible score is 16. Higher scores indicate greater degrees of loneliness.

SECTION 2: Demographic Questionnaire

1. What is your current age in years? _______ years

2. Are you Hispanic/Latino(a)?

☐ Yes ☐ No ☐ Prefer not to say

3. What is your race (*check all that apply*)?

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Prefer not to say

4. What is your sex assigned at birth?

☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say

5. What is your current gender identity?

☐ Female ☐ Male ☐ Transgender Man ☐ Transgender Woman

☐ Different gender identity ☐ Prefer not to say

6. What is your sexual orientation?

☐ Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual

☐ Different orientation ☐ Prefer not to say

7. What is your disability status?

☐ Identified disability ☐ Not disabled ☐ Prefer not to say

8. Do you have a current or recent diagnosis of a mental health need (i.e., anxiety, cognitive function, depression, PTSD)?

☐ Yes ☐ No ☐ Prefer not to say

9. What is your current employment status?

☐ Full-time employment ☐ Part-time employment ☐ Unemployed ☐ Prefer not to say

10. Do you currently have a stable place of residence?

☐ Yes ☐ No ☐ I have a temporary place of residence ☐ Prefer not to say

11. How many people currently live in your household (including you)? _______ people

12. What is your primary spoken language?

☐ Arabic ☐ Bengali ☐ Chinese ☐ Creole ☐ English ☐ French ☐ Italian ☐ Korean

☐ Polish ☐ Russian ☐ Spanish ☐ Urdu ☐ Yiddish ☐ Different language

☐ Prefer not to say

13. What is your level of education?

☐ Less than high school ☐ High school graduate or GED ☐ Some college ☐ College graduate

☐ Prefer not to say

SECCIÓN 1: La Escala de Soledad de UCLA (versión con 4 preguntas)

Instrucciones

Las siguientes preguntas describen cómo se sienten en ocasiones las personas. En cada pregunta, indique con cuánta frecuencia se siente de la manera descrita.

Por ejemplo: si se le preguntara: "¿con cuánta frecuencia se siente feliz?", si nunca se sintiera feliz, debería encerrar el "1", mientras que si siempre se sintiera feliz, debería encerrar el "4".

	Encierre una respuesta para cada pregunta			
	Nunca	**Rara vez**	**A veces**	**Siempre**
1. *¿Con cuánta frecuencia siente que está "en sintonía" con las personas que lo rodean?	4	3	2	1
2. ¿Con cuánta frecuencia siente que en realidad nadie lo conoce bien?	1	2	3	4
3. *¿Con cuánta frecuencia siente que pueden encontrar compañía cuando la desee?	4	3	2	1
4. ¿Con cuánta frecuencia siente que las personas lo rodean, pero no están con usted?	1	2	3	4

SECCIÓN 2: Cuestionario demográfico

1. ¿Cuál es su edad actual en años? ________ años

2. ¿Es de origen hispano o latino?

☐ Sí ☐ No

3. ¿Cuál es su raza? *(Marque todas las opciones que correspondan)*

☐ Indígena americano o nativo de Alaska ☐ Asiático ☐ Negro o afroamericano

☐ Nativo de Hawaii o isleño del Pacífico ☐ Blanco

4. ¿Cuál es su sexo asignado al nacer?

☐ Femenino ☐ Masculino ☐ Intersexual

5. ¿Cuál es su identidad de género actual?

☐ Femenino ☐ Masculino ☐ Hombre transgénero ☐ Mujer transgénero

☐ Una identidad de género diferente

6. ¿Cuál es su orientación sexual?

☐ Lesbiana ☐ Gay ☐ Bisexual ☐ Heterosexual

☐ Una orientación diferente

7. ¿Cuál es su estatus de discapacidad?

☐ Discapacidad identificada ☐ Sin discapacidad ☐ Prefiero no contestar

8. ¿Tiene un diagnóstico vigente o reciente de una necesidad de salud mental? (Por ejemplo, ansiedad, funcionamiento cognitivo, depresión, TEPT).

☐ Sí ☐ No ☐ Prefiero no contestar

9. ¿Cuál es su situación laboral actual?

☐ Empleado a tiempo completo ☐ Empleado a tiempo parcial ☐ Desempleado

10. ¿Actualmente tiene una residencia estable?

☐ Sí ☐ No ☐ Tengo una residencia temporal

11. ¿Cuántas personas viven actualmente en su domicilio (incluido usted)? _______ personas

12. ¿Cuál es su idioma principal?

☐ Árabe ☐ Bengalí ☐ Chino ☐ Criollo ☐ Inglés ☐ Francés ☐ Italiano ☐ Coreano

☐ Polaco ☐ Ruso ☐ Español ☐ Urdu ☐ Yidis

13. ¿Cuál es su nivel de escolaridad?

☐ Secundaria inconclusa ☐ Graduado de secundaria o GED ☐ Algo de universidad

☐ Graduado de la universidad

SECTION 3: The UCLA Loneliness Scale (3-item version)

Instructions

The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described.

This scale comprises 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness, and self-perceived isolation.

The questions are:

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

The scale generally uses three response categories:

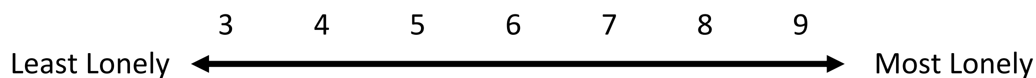
Hardly ever / Some of the time / Often

To score somebody's answers, their responses should be coded as follows:

Response	Score
Hardly Ever	1
Some of the Time	2
Often	3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.

Researchers in the past have grouped people who score 3-5 as "not lonely" and people with the score 6-9 as "lonely".



Source: Campaign to End Loneliness (UCLA Loneliness Scale, 2004)

SECTION 2: Demographic Questionnaire

1. What is your current age in years? ________ years

2. Are you Hispanic/Latino(a)?

☐ Yes ☐ No ☐ Prefer not to say

3. What is your race (*check all that apply*)?

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Prefer not to say

4. What is your sex assigned at birth?

☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say

5. What is your current gender identity?

☐ Female ☐ Male ☐ Transgender Man ☐ Transgender Woman

☐ Different gender identity ☐ Prefer not to say

6. What is your sexual orientation?

☐ Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual

☐ Different orientation ☐ Prefer not to say

7. What is your disability status?

☐ Identified disability ☐ Not disabled ☐ Prefer not to say

8. Do you have a current or recent diagnosis of a mental health need (i.e., anxiety, cognitive function, depression, PTSD)?

☐ Yes ☐ No ☐ Prefer not to say

9. What is your current employment status?

☐ Full-time employment ☐ Part-time employment ☐ Unemployed ☐ Prefer not to say

10. Do you currently have a stable place of residence?

☐ Yes ☐ No ☐ I have a temporary place of residence ☐ Prefer not to say

11. How many people currently live in your household (including you)? ________ people

12. What is your primary spoken language?

☐ Arabic ☐ Bengali ☐ Chinese ☐ Creole ☐ English ☐ French ☐ Italian ☐ Korean

☐ Polish ☐ Russian ☐ Spanish ☐ Urdu ☐ Yiddish ☐ Different language

☐ Prefer not to say

13. What is your level of education?

☐ Less than high school ☐ High school graduate or GED ☐ Some college ☐ College graduate

☐ Prefer not to say

Data Collection Instrument

The Data Collection Instrument Excel sheet is intended for collecting data for each survey administered. It will be sent out along with this packet. The Excel sheet is for clinic use only to aid in tracking the surveys administered. This client-level data should not be sent to the Quality of Care Program.

Instructions to fill out the instrument:

- First, include the date and client ID manually.
- For the 4-item UCLA Loneliness Scale questions, choose either “Never,” “Rarely,” “Sometimes,” or “Always” from the drop-down list or enter manually.
- After inputting the responses for the questions, the aggregated score will be calculated automatically.
- Enter the age of the respondent manually.
- Choose the ethnicity of the respondent from the drop-down list.
- For the race category, choose options from the list on the Race (1) box.
- Make additional selections for Race (2) and Race (3) box if the survey respondent identifies with 2 or more races. If not, choose not applicable.
- Input the survey respondent’s remaining information such as sex at birth, current gender, sexual orientation, disability status, current or recent diagnosis of a mental health need, employment and housing status, current household size, primary spoken language, and education level from the drop-down lists.

	A	B	C	D	E	F	G	H	I	J
1	Date and Patient ID		Survey Responses and Aggregate Score							
2	Date of Survey	Medical Record Number	1. How often do you feel that you are “in tune” with the people around you?	2. How often do you feel that no one really knows you well?	3. How often do you feel that you can find companionship when you want it?	4. How often do you feel that people are around you but not with you?	Aggregate Score [Calculated]	Age (at time of survey)	Ethnicity	Race (1)
12							[PENDING]			
13							[PENDING]			
14							[PENDING]			
15							[PENDING]			
16							[PENDING]			
17							[PENDING]			
18							[PENDING]			
19							[PENDING]			
20							[PENDING]			
21							[PENDING]			
22							[PENDING]			
23							[PENDING]			
24							[PENDING]			
25							[PENDING]			
26							[PENDING]			
27							[PENDING]			
28							[PENDING]			
29							[PENDING]			
30							[PENDING]			
31							[PENDING]			

Survey Data | Pick Lists

Data Aggregation and Reporting Tool

This document is for aggregating and reporting the data of the surveys collected within the 30-day reporting period. This can help sites find out which client subgroups have higher degrees of loneliness and allow the social connection activities to be targeted to these groups. After collecting and inputting the data on the survey instrument, please report the aggregated data on the Data Aggregation and Reporting Tool below.

This tool is for reporting the data to the Quality of Care Program. When completed, the document should be sent to qocreviews@health.ny.gov with "Social Connection Data" in the subject line.

Please be sure to not send client-level data when reporting.

Instructions to fill out the Data Aggregation and Reporting Tool:

- First, fill out the name of the participating organization, sites included, and the contact information for the program contact or person completing this aggregation form.
- Select the appropriate check box for the screening tool and screening eligibility.
- For the survey frequency, select [please choose an option] to view and select from the drop-down list.
- Next, fill out the aggregated data information in the boxes given.
- For the rest of the form, answer the questions in the boxes given, select appropriate checkboxes and options from the drop-down list. (To view the drop-down list, select [please choose an option].)

Data Aggregation and Reporting Tool

Organization Name

List the sites included in this review:

Contact Person (program contact or person completing this form):

Name:

Email:

Phone:

Nature and Scope of Review

1) Screening Tool Selection (please check box and elaborate below when needed)

☐ UCLA 4-item Loneliness Scale
☐ UCLA 3-item Loneliness Scale
☐ Other Screening Tool (please specify below)

2) Screening Eligibility (please check box and elaborate below when needed)

☐ HIV+ individuals who receive HIV care at the clinic.

☐ Individuals receiving other forms of healthcare/ support services (please specify below)

3) Survey frequency: How often do you plan to use the loneliness scale for client visits?
[Please choose an option]

Aggregated data

1) How many clients were eligible for screening?

2) How many of the eligible clients were screened?

3) How many of those screened had a score at or above the threshold (6 for the 3-item version or 9 for the 4-item version)?

Do the aggregated data suggest a specific group with a higher level of loneliness? Do you plan to focus on this group for your improvement activity?

What is your goal for this quality improvement project?

Please describe the activity you plan to test to improve positive social connection. Please update this section each time you submit this tool to let us know if you have made any changes to the original plan.

In developing this quality improvement project, are you using any of these particular intervention strategies?

[Please choose an option]

If yes, what interventions are being implemented? Check all that apply.

☐ Cultural celebrations/festivities

☐ Nutritionist led visit to local farmer's market.

☐ Connector services (includes outreach services, guided conversations motivational interviews)

☐ Cognitive behavioral therapy

☐ Friendly Peer-visiting, phone calls, support

☐ Online/virtual support or education groups

☐ Lunch clubs/recipe swaps

☐ Poetry writing club, therapeutic writing, and group therapy.

☐ Art classes and inspiring activities

☐ Group exercise and discussion

☐ Community singing group initiative.

☐ Group lessons in self-esteem, relational competence, phases in friendship formation and social skills.

☐ Other (please describe below):

Do you plan to measure any other outcome indicators such as viral load suppression or retention in care? If so, please specify below.

Action Planning Template

Action Period:

Purpose: This Action Plan is to help your Quality Improvement Project Team identify key action steps to support your involvement in the Addressing Social Isolation and Loneliness by Advancing Positive Social Connection Campaign.

Instructions: First, enter your site's name and complete the sections for AIM statement and chosen activity. For the hypothesis section, indicate what you think the outcome of your activity will be. Then, using action-oriented language, identify critical next steps for your Quality Improvement Project to Advance Positive Social Connection. For each action step, identify the team member(s) responsible and include a target date for completion.

Project AIM Statement: By May 2025, members of the Advancing Social Connection Quality Improvement Project Initiative will measurably (using the UCLA Loneliness scale) improve positive social connection amongst people with HIV by carrying out social connection activities targeted to specific client subgroups.

Site Name: ____

Aim statement: ____

____

____

____

Activity: ____

What is your hypothesis for the outcome of implementing this activity?

____

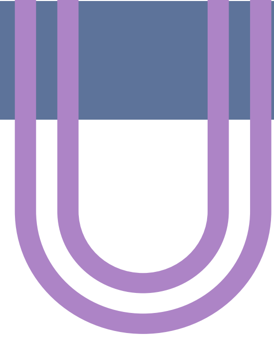
____

____

____

____

Key Action Steps	Team Member(s) Responsible	Target Date



Social Connection Activity Examples

These activities have been adapted from a literature review as well as conversations with HIV care and supportive service providers. This is a living list which will be updated with additional activities as they are discovered.

ONE-TO-ONE INTERVENTIONS

Befriending services can be used to build connections for clients. These services offer supportive relationships either in person or over the phone, usually by volunteers. Telephone befriending support projects can be a space where volunteers provide emotional support for older people. (DHA, 2021).

Peer/consumer support and involving people with lived experience can also be an extremely effective social connection activity. Peer/consumers/people with lived experience delivered services and support groups can provide affordable options to build connection within the clinic setting. There are also support groups and programs designed to connect people who experience loneliness like Circle of Friends and peer-mentoring programs like Java Mentorship. (CDC, 2023)

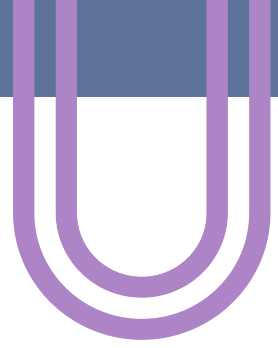
GROUP BASED INTERVENTIONS

Examples of effective social connection activities include delivery of socially stimulating group activities. This can include art and inspiring activities, group exercise and discussion and therapeutic writing. Can also include lunch clubs, recipe swaps, art sessions. Tapping into staff passions and talent to lead these groups may make these activities more feasible. (European Observatory on Health Systems and Policies, 2019)

Community-based exercise and physical activity: Exercise or leisure activities combined with exercise that are conducted by programs in communities. Providers can connect clients to these programs or host an event centered on physical activity. Exercise programs can be designed for seniors or specific groups. Examples of these programs include: Tai Chi for Arthritis Walk with Ease – Group Program and other formats (CDC) Arthritis Foundation Exercise Program EnhanceFitness Bingocize SilverSneakers (CDC, 2023)

Training to increase social skill capacity can be utilized as a social connection activity. One study found that 12 weekly group lessons in self-esteem, relational competence, phases in friendship formation and social skills resulted in a significant reduction in loneliness within a year after the programs, with a combination of developing new friendships and improving existing friendships reducing loneliness. (European Observatory on Health Systems and Policies, 2019)

Health education sessions can be delivered in group settings to build connections and learn about relevant health topics. Interactive aspects such as games and group discussions can be included. For example, session 1 can be a Jeopardy game on health information and session 2 can be a group reflection and discussion on the topic. This activity has been done at Evergreen Health, where it provided an opportunity for connection and helped enhance learning experiences.



TECHNOLOGY BASED INTERVENTIONS

Training in use of the internet and computers can also be an effective social connection activity. This can include support for setting up and learning how to use video communication, as well as computer sessions teaching basic information technology (IT) skills and training on Skype and internet use. (European Observatory on Health Systems and Policies, 2019)

The Positive Links smartphone app is a multicomponent intervention that allows users to interact in a clinic-affiliated anonymous online support group. Participants perceived connection and support as key benefits of the app. Mobile technology offers a useful tool to reach populations with barriers to in-person support and may improve care for people with HIV. (Flickinger et al, 2021)

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