Putting it all Together

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March 24, 2026

What we have learned:

- Summary from TUESDAY:
    - Dr. Holt-Lunstad Julianne presented the comprehensive and conceptual models of how we define social connection
    - Dr. Ashwin Kotwal reviewed the challenges of large surveys and asked us to reflect on if these data sources capture the patients we see at the bedside
    - Dr. Matt Pantell: shared perspectives on the challenges of health systems dichotomizing complex topics and missing nuances
    - Matthew Smith: Provided a scientific and pragmatic how measurements tools are used and created in real world settings, which includes making sure that we match the question to the problem

Aligning on person-centered social connection measures:

- Daniel Hill and Ms. Matthews grounded us and reminded us that at the core of all this are REAL PEOPLE

- Our small group breakouts further brought out the complexities of measurement in diverse communities, in people living with serious illness and further understanding how technology affects social connection as an experience and as an outcome

Imagine you are:

- 93
- Monolingual Spanish speaker
- Living alone
- Flight of stairs
- Estranged extended family
- Cellphone --“Obama Phone”
- Caregivers 4-6 hours per day

Risks:

- Lonely almost every day
- Social Isolated
- Higher risk of death, functional decline, hospitalization and cognitive impairments

Questions:

-Do we have the right measurement tools to characterize his risks?

-Do we have a way to measure how socially connected he is?

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Priority questions to help us better understand social connection

- What is the language that PEOPLE (patients) want to use to discuss their social connection
- How do we not jump to premature closure on solutions?
- What is the dose that puts us at risk, and what is the dose that keeps us well?

- **Is it about WHAT we are measuring or HOW we are asking about it?**

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Key measurement challenges and opportunities

- WHAT are the questions we are asking
- HOW are we asking the questions
- Different questions to different people and environment (or different methods)
- Lets not let the perfect get in the way of progress and consensus
- If we have to dichotomize and ask 1 question what do we lose and what do we gain?
- Is there a way to move from risk based to asset based?
- And is there room in ICD-10 and medical coding to make room for this?

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Imagine you are Now:

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New View:
-He loves music
-He loves talking
-He loves listening to the morning radio
-He trusts his physician

“We” ask him if he feels loneliness or isolated and if he wants to talk about it.

He tells us about his experience

He declines “standard interventions”

Tells us that what he wants is a working phone so he can listen to the radio and music

MY PSA

move away from war terminology:

“combat”

>

address, impact

Foundation for Social Connection

Consensus

- It takes courage to share and be vulnerable AND it takes skill to listen
  - Do something with the data, don't just ask the questions and leave people hanging
- Encourage more collaboration
  - Lets move to *bridge* the ivory towers and lab benches and our communities
- We need to be nuanced when working cross-culturally
  - Invite others to the table
- STOP building walls.
  - Be more inclusive in the field, be broad in our understanding of "expertise"
- Even if we don't have ONE tool:
  - We can build consensus on a few tools and cut off points

Even More Consensus

- Continue to de-stigmatize the language around social isolation and loneliness
- Convenings have been really helpful to find cohesion amongst different sectors working in social connection
- **Our collective voices have knowledge, data, and experience to move the field forward**
- We will translate our knowledge, data and experience into “pieces of information” that the general public can understand

What Comes Next:

- Hope
- Convenings and working groups

“Final product(s)”