SUPPORTING FRONTLINE HEALTHCARE AND SOCIAL SERVICE PROFESSIONALS TO ADDRESS SOCIAL ISOLATION AND LONELINESS IN THEIR WORK WITH OLDER ADULTS

Prepared for:
Canadian Coalition of Seniors Mental Health (CCSMH)

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INTRODUCTION

In Canada, social isolation and loneliness (SI&L) among older adults (65+) is a serious public health issue. Studies show that SI&L can lead to poor health outcomes, such as heart disease, cognitive decline, depression, anxiety, and even early death. These effects not only reduce quality of life for older adults but also increase pressure on the healthcare system. As SI&L becomes more common, it's expected to place even more strain on already limited healthcare resources.

Healthcare and social service professionals (HSSPs) are in a strong position to help prevent and reduce SI&L using proven, evidence-based approaches. However, these interventions are not consistently used across the healthcare system. One major reason is the gap between policy and practice. There is often a lack of clear, practical tools to help HSSPs apply policies effectively. To improve care, it's essential to turn research into clear policy priorities and provide simple, usable resources for HSSPs.

In 2024, CCSMH published the Canadian Clinical Guidelines on Social Isolation and Loneliness in Older Adults. The purpose of these guidelines is "to empower and support clinicians in their work with older adults who may be at risk of or already experiencing the health impacts of social isolation and loneliness." Building on this work, CCSMH sought to identify opportunities for action in the policy realm that could serve to further support clinicians in their work in this area. As this policy work progressed, the areas of interest identified by the CCSMH ranged from broad examination of national/provincial/territorial policies to specific issues on the day-to-day level encountered by clinicians.

This report identifies Canadian policies that support or encourage SI&L interventions by HSSPs. It examines policies across the country (nationally, provincially/territorially, and regionally) to give a detailed picture of the current landscape. It also explores policies internationally, in a select number of countries. Additionally, the report explores selected micro-level areas for potential policy impact.

The results this scan have been divided into three pillars (Table 1). Pillar I focuses on the 'macro' level and the broader policy landscape. Pillar II focuses on the 'meso' level and translating the vision from the macro level to consistent, on-the-ground change. Pillar III focuses on the 'micro' level and the policies that address on-the-ground operational work.

Level	Core question	Scope	Example
Macro	"Where are we heading, and why?"	Legislation; national strategies; white papers; multi-year fiscal frameworks	Canada's forthcoming (government backed) National Seniors Strategy
Meso	"How will the whole system move in that direction?"	Large-scale programs, grant funds, workforce schemes, branded campaigns	Provincial/Territorial or National-scale public awareness and practice-change campaign, workforce training and education program, community-of-practice network, 'what works' evidence hub, public dash-board
Micro	"What do health care and social care professionals do in day-to-day practice?"	Clinical guidelines, billing codes, EMR templates	Professional-level operational infrastructure elements: A 15-minute SI&L assessment code in a provincial fee schedule

Pillar I: Broader Policy Landscape (Macro-level Policy Directions)

Macro-level policy establishes the overarching vision and sets the rules and frameworks that shape the broader (national/ provincial-level) response to SI&L.

Scope: Pillar I focuses on system-level positions advanced by government and other high-level authorities that articulate national and provincial strategic directions. These directions guide communities and health systems on what actions should be taken (and why) to reduce SI&L among older adults.

Types of Documents: This search included extraction and analysis of documents* such as government or ministry strategies, budgetary priorities, and regulatory frameworks. *(*In these documents, SI&L could have been the primary focus or addressed within the broader context of social connection and overall well-being.)*

Analysis: To assess the extent to which SI&L is recognized as a priority by governments and other high-level authorities in Canada and select international jurisdictions. Where emerging policy directions on SI&L are identified, what do they entail? What supports are in place (or recommended) to move in that direction, and where are the gaps? In what areas is SI&L absent from the policy conversation?

Relevance for CCSMH: Information from Pillar 1 can be used to map the broader policy landscape in Canada, highlight existing macro-level directions, incentives, and points of alignment within and across provinces. This also includes understanding how Canada compares to other countries recognized for leadership in addressing SI&L and identifying promising macro-level policy approaches from those jurisdictions that could inform and be adapted to a pan-Canadian context.

Pillar II**:** Translating the Vision (Meso-level Policy Directions)

Meso-level policies are action initiatives with system-wide reach (e.g., national-level implementation programs, campaigns, delivery systems) that turn macro-level policy into consistent, on-the-ground change.

Scope: Pillar II focuses on provincial and pan-Canadian strategic programs and initiatives that translate forward-looking macro-level policy directives into practical action on the ground. Some programs and initiatives are designed around SI&L directly, in other instances SI&L is subsumed under the broader context of social connections and well-being.

Types of Documents: The types of documents included in this section consist of provincial- and national-level public awareness and practice-change campaigns, training and education programs, and strategic service-delivery models.

Analysis: The analysis identifies promising large-scale programs and initiatives in Canadian provinces, territories, and abroad that drive meso-level policy action to reduce SI&L among older adults. The findings highlight opportunities to leverage or scale successful efforts within

and across jurisdictions and distills lessons from leading international examples to inform possible initiatives that could be translated to the Canadian context.

Relevance to CCSMH: Mapping Canadian and international meso-level efforts can provide ideas for how CCSMH can operate as the go-to source about "What Works" when it comes to SI&L in older adults and serve as a system integrator revealing partnership opportunities and informing broad-scale initiatives that translate guidelines into practice.

Pillar III: Shaping what Health and Social Care Professionals Do on the Ground (Micro-level Policy Directions)

Micro-level policy provides the operational infrastructure—coding fields, EMR templates, screening check-boxes, billing codes, and standardized data definitions—that makes the work possible.

Scope: Pillar III addresses the operational work needed to integrate SI&L screening and surveillance into routine practice and to establish standardized billing mechanisms across professions and provinces.

Types of Documents: This search included extraction and analysis of documents* such as schedules for operational schedules, professional association materials, legislative instruments. *(*In these documents, SI&L could have been the primary focus or addressed within the broader context of social connection and overall well-being.)*

Analysis: To examine the operational steps necessary to embed SI&L screening, surveillance, and billing across Canada, highlighting the key barriers and facilitators that could shape their implementation.

Relevance to CCSMH: Mapping the concrete steps, obstacles, and enablers for SI&L screening, surveillance, and billing across Canada equips CCSMH to advance everyday practice. A granular view of operational procedures reveals how an organization like the CCSMH could go about making broad-scale operational changes to micro-level workflows. Additionally, by capturing operational enablers, the CCSMH can offer actionable guidance to its members on embedding SI&L screening and counselling into routine practice—and on billing for these services appropriately—so compensation gaps do not become a barrier.

METHODS

To be responsive to the need for emergence in determining next steps for the CCSMH, the current review gathered information and evidence that spans macro (Pillar I), meso (Pillar II) and micro (Pillar III) policy levels.

Pillars I & II Search & Analysis

The methodology for the Pillars I & II scan consisted of a grey literature as well as academic search. The scan aimed to summarize peer-reviewed and grey literature, and organizational websites from Canadian sources (national, provincial/territorial, regional) as well as selected international settings, asking:

- What current policies support HCSSPs in mitigating SI&L?
- What insights can be drawn from internationally?
- What actionable strategies could be adopted by CCSMH and similar organizations?

The peer-reviewed literature was limited to 2020-2025, while the grey literature was limited to 2015-2025. Sources included databases (e.g., PubMed, CINAHL, Scopus), grey literature portals, and organizational websites. Retrieved documents were screened for inclusion. Data from included documents were charted using a standardized template. Analysis included descriptive, thematic, and comparative methodologies. A detailed methodology for Pillars I and II was previously submitted to CCSMH.

Pillar III Search & Analysis

Following review of preliminary analyses of the results of Pillars I & II and iterative discussions with the CCSMH, further search and analysis was conducted at the micro level. Two specific topics areas were requested as the areas of focus. These two areas were:

- Policies and activities related to the integration of screening for SI&L (e.g. within medical records, health surveillance efforts)
- Policies related to billable codes for SI&L (or in their absence information on process for establishing new codes or modifying/leveraging existing codes)

This included understanding existing mechanisms, standards, and regulations, as well as barriers/facilitators to pursuing action in these areas. In each instance there was also interest in understanding the policy levers (e.g. if the integration of SI&L into EMRs is limited, what are the mechanisms to support change? Who are the decision makers? What is the process/mechanism for adaptation?)

The methodology for Pillar III necessitated targeted searches of the grey literature to answer these specific questions. Analysis included descriptive reporting of findings as well as identification of barriers/facilitators and preparation of a ‘menu of options’, should CCSMH wish to proceed further in any of these areas.

RESULTS

The following pages offer a concise overview of the policy landscape at each level. CCSMH members can use this synthesis to pinpoint the policy tiers and action initiatives that best match the organization's mandate and sphere of influence. After selecting a preferred path, the supplementary files provide detailed, illustrative examples of relevant policies and initiatives—including evidence of effectiveness where available—to serve as practical reference points. A consolidated table summarizing options across all three pillars appears on page 19.

Pillar 1

What we learned:

Canadian Context: We conducted an investigation and analysis of macro-level policy directions relevant to SI&L across all 13 provinces and territories. The goal was to identify similarities and differences in how each jurisdiction's strategic priorities reflect progress on SI&L, the policy levers being used to advance this work, and any notable gaps.

Findings: Across Canada, all provinces and territories now reference social isolation and loneliness (SI&L) in their high-level policy visions for aging. Highlighted below are key points of alignment, alongside important differences that shape how each jurisdiction addresses the issue.

Common Policy Features Across Provinces/Territories	Variation in Policy Response Across Provinces/Territories
Problem framing SI&L is universally treated as a determinant of healthy ageing, rather than as a niche social issue. E.g., 'staying socially connected'; 'essential to dignity and mental health in later life'.	**Explicitness of the priority** Ontario, Nova Scotia, New Brunswick and the territories have SI&L as a stand-alone strategic objective. Alberta, Saskatchewan and Manitoba reference SI&L only inside broader "social participation" or mental-health sections. Quebec and British Columbia embed it under "living together" or "community connections" without separate actions.
Policy governance Most jurisdictions embed SI&L inside multi-ministerial seniors or healthy-ageing strategies that report to a Seniors, Health or Community Services ministry.	**Depth of action** Atlantic provinces and Québec outline multi-year action plans. Western provinces lean more on community-grant programs and resource toolkits) with fewer provincial-level levers.
Age-friendly and "aging-in-place" context Most jurisdictions explicitly adopt the WHO Age-Friendly Communities framework or an "aging-in-place" lens, positioning social connectedness as an environmental and community-design challenge as much as a health-care one.	**Funding** Nova Scotia and Ontario earmark provincial dollars for age-friendly community work and social-prescribing pilots. Most other jurisdictions depend on cost-shared or time-limited funding streams; Yukon and NWT bundle SI&L work inside housing or ageing-in-place capital commitments.
Delivery Provinces/territories emphasize grants and partnership programs over direct legislation. Most tap the federal *New Horizons for Seniors* fund or parallel provincial funding to seed projects, then fold into wider seniors' action plans.	**Data and measurement** Only Ontario and Nova Scotia commit to building SI&L indicators into regular population-health reporting. Territories prioritize community "storytelling" and Elder consultations over quantitative metrics. Prairie provinces indicate interest but have not yet set out a measurement plan.

Shared gaps	Population focus
Few macro-level documents set measurable SI&L targets or attach line-item funding for evaluation. Surveillance commitments are typically limited to "exploring indicators," and only Ontario, Nova Scotia and the Yukon promise to develop province-wide SI&L metrics.	Manitoba singles out 2SLGBTQ+ older adults; Nunavut and Yukon stress cultural safety for Indigenous Elders; Newfoundland and Labrador channel isolation work through rural health-services. Most provinces adopt a universal seniors framing, that do not prioritize sub-groups.

Key Take Aways – Canadian Context
▪ The policy directions for all jurisdictions emphasize that SI&L threatens healthy ageing and should be tackled through age-friendly, community-based action and not solely through clinical services. ▪ Provinces and territories diverge on how explicit, well-resourced and measurable their commitments are. ▪ The strongest through-line is reliance on partnership grants and age-friendly frameworks; the weakest is the absence of clear, comparable indicators and sustained funding streams to evaluate progress.

International Context: We also conducted an investigation and analysis of macro-level policy directions in seven countries recognized for significant advancements in addressing social isolation and loneliness (SI&L): the United States, United Kingdom, Australia, Denmark, the Netherlands, Sweden, and Japan. Our aim was to identify key similarities and differences in how these countries approach SI&L, the strategic directions they have adopted, the policy levers they employ, and the gaps that remain.

Findings: Internationally, many countries now recognize social isolation and loneliness (SI&L) as public health priorities, with several—such as the UK, Japan, and Australia—implementing national strategies or frameworks to address the issue. Common approaches emphasize community-based interventions, cross-sector collaboration, and targeted funding, though standardized measurement and implementation supports remain limited.

Common Policy Features Across Lead Countries	Variation in Policy Response Across Lead Countries
Problem framing *All* jurisdictions explicitly link SI&L to morbidity, mortality and health-system cost. Examples: England frames loneliness alongside obesity and mental health. Japan frames SI&L as a determinant of premature death. The U.S. positions it with tobacco and obesity risk. Sweden emphasizes social connection as a "pre-condition for equitable health".	**Regulatory and strategic weight** Spectrum from binding law to soft guidance. Japan's and Denmark's national strategy give ministries statutory duties, while the UK and Sweden operate through cabinet-endorsed (but not legally binding) strategies. The U.S. Surgeon-General's advisory and Australia's civil-society "shadow plan" are 'persuasive', leaving implementation voluntary.
Cross-government responsibility Each country has places responsibility for SI&L across multiple ministries. England hosts a loneliness team inside the Department for Culture, Media & Sport; Japan has a Cabinet-level headquarters; Sweden's strategy is led by the Ministry of Health & Social Affairs; Denmark's positions responsibility for SI&L under both the Social and Health portfolios.	**Dedicated funding** Dedicated (country-wide) budgets; legal mandates exist. Japan commits ¥30 billion over five years; the UK earmarks £80 million; Denmark and Sweden provide smaller but recurrent municipal grants. The U.S. and Australia embed into existing ageing or health funding envelopes, and the Netherlands has a national prevention fund with private-sector co-financing.

“Community-first” delivery Lead countries stress municipal action, age-friendly design and voluntary sector partnerships as opposed to single channel clinical care-based responses.	**Targets and measurement commitments** Numeric goals are rare. Japan plans a 20 % reduction in chronic loneliness among single-household seniors by 2028. Denmark aims to halve prevalence by 2040; Sweden on a 15 % cut by 2032. The UK, U.S., Australia and the Netherlands have process indicators (e.g., social-prescribing uptake) but avoid prevalence targets.
Commitment to evidence & metrics. Lead countries embed SI&L as an item(s) in national surveys. Japan, the UK, the U.S. and the Netherlands publish baseline prevalence; Sweden’s new strategy promises an indicator set in 2026, and Denmark pledges to monitor progress in their National Health Profile.	**Depth of health-system integration** The use of healthcare channels varies widely. Japan embeds loneliness screening in annual check-ups for everyone 75 +; the Netherlands pays GPs to refer patients to community connectors. The UK relies on NHS link workers without a dedicated fee code. Sweden and Denmark integrate “social-connection conversations” into district-nurse or home-care visits. In the U.S. and Australia, integration remains pilot-based and uneven.
	Centrality of older adults Although all lead countries mention seniors, only Japan, Denmark and the Netherlands position seniors as a principal focus. The UK and Sweden adopt a life-course lens that spreads attention across age groups. Both Australia and the U.S. frame loneliness as an inter-generational challenge, with older adults as one priority group, among several.

Key Take Aways – International Context
▪ Lead countries position social isolation and loneliness (SI&L) as national priority. ▪ SI&L is embedded them within broader national-level aging, mental health, or public health strategies. ▪ SI&L is positioned as a modifiable risk factor with social and system-cost implications. ▪ Common policy responses emphasize community-based interventions, cross-sector collaboration, and targeted funding, ▪ Consistent measurement and implementation infrastructure remain underdeveloped.

Menu of Options:

Our investigation of macro-level policy pathways in Canada and internationally uncovered numerous examples of directives, legislation, and regulations that have successfully elevated SI&L as a priority and encouraged healthcare and social service professionals to screen for, address, and monitor SI&L among older adults. These exemplars provide a menu of actionable options that the CCSMH could consider to strengthen the macro-level policy landscape surrounding SI&L in Canada. The Supplementary File for Pillar I provides additional details on provincial, territorial, and international policies that can be explored further as illustrative examples.

The following are actions that the CCSMH could pursue to foster change with respect to macro-level policy directions in Canada:

Action Item	Additional Details
Advocate for changes in the conceptualization, legislation and regulation of SI&L within macro-level policies	Prepare an Advocacy Statement and aligned Strategic Direction Position Paper that advocates for changes in the conceptualization, legislation and regulation of SI&L to help strengthen attention to SI&L in practice. Some examples of items that the CCSMH could advocate for: o Re-frame SI&L as an explicit public-health risk o Identify a central government entity responsible for SI&L and attach dedicated funding o Mandate and fund training initiatives for **front-line HCSSPs** to identify and support SI&L in older adults. o Embed training initiatives on SI&L in older adults in accreditation standards. o Embed link workers in Primary Care Networks o Position primary care, home and community care practitioners as brokers who connect medical risk (e.g., frailty, falls) with social risk (loneliness, low digital literacy). o GPs and practice nurses gain a formal mandate to redirect patients from medical pathways toward community or municipal supports when isolation is the root issue. o Mandate and/or incentivize SI&L screening & assessment into routine care in PC, AC, LTC, MH, H&CC o Prioritize **early detection** of SI&L by requiring consistent monitoring o Use routine contacts (home-care visits, GP appointments, pharmacy encounters) to screen for loneliness and refer to partner initiatives. o Monitor SI&L with uniform indicators and publish annual dashboards o Share data on SI&L with municipal monitors. o Embed social isolation and loneliness metrics in regional health-outcome contracts / benchmarking o Mandate and/or incentivize social prescriptions into care plans for at-risk older adults in PC, MH, AC, H&CC, LTC o Make social prescribing for SI&L directly billable (in PC, MH, AC, H&CC, LTC) o Fund the development of **innovative technologies** to reduce loneliness and isolation o Track use of pharmacotherapy for issues of SI&L – apply disincentives to decrease inappropriate prescribing.

<table>
<tr><td>Use the federal New Horizons for Seniors Program (NHSP) as a policy lever</td><td>Ottawa recently opened a new NHSP intake that will fund up to 20 pan-Canadian projects focused on “social inclusion of seniors.” CCSMH can:
Lead a multi-province demonstration project that implements the guidelines in primary care and measures cost offsets (e.g., reduced ED visits).
Make the case that NHSP should carve out a dedicated SI&L funding stream in its next five-year plan, embedding the issue in federal spending architecture.</td></tr>
<tr><td>Embed measurable SI&L indicators in national surveillance systems</td><td>PHAC’s Aging, Seniors and Dementia Division must now align its work with the UN Decade of Healthy Ageing and is evaluating new indicator sets. CCSMH can:
Propose a short SI&L indicator module (e.g., three-item UCLA Loneliness Scale) for the Canadian Community Health Survey.
Advocate for a “social connection” quality indicator in CIHI’s Home and Community Care Reporting System so that provinces must track it to receive federal transfers.</td></tr>
<tr><td>Align with provincial Age-Friendly and Seniors Community Grant programs</td><td>Ontario, Nova Scotia and the three territories already earmark seniors-community-grant envelopes for projects that “increase social participation.” By partnering with local NGOs, CCSMH can:
Seed guideline-based pilots in multiple provinces simultaneously, creating bottom-up pressure for macro adoption.
Collect province-specific ROI data to persuade finance ministries that permanent funding streams are warranted.</td></tr>
<tr><td>Leverage the new National Long-Term Care Services Standard</td><td>The 2023 HSO/CSA standard makes “meaningful resident quality of life” (including social connection) a compliance item for accreditation. CCSMH can:
Offer a standardized SI&L assessment package to LTC homes seeking to meet the new standard.
Use early adopter facilities as proof-of-concept sites in subsequent advocacy for federal LTC legislation that mandates social-connection indicators nationally.</td></tr>
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Pillar 2

What we learned:

Canadian Context: We undertook an investigation and analysis of meso-level initiatives with relevance to SI&L in each of the 13 provinces/territories. We sought to identify similarities and differences across provinces/territories in the programs and initiatives rolled out to help operationalize macro-level policy directives that relate to SI&L.

Findings: Across Canada, every province and territory now backs at least one meso-level initiative to curb social isolation and loneliness among older adults—ranging from volunteer-driven supports like Better at Home, to social-prescribing pilots in primary care, to hubs such as Seniors Active Living Centres.

Common Policy Features Across Provinces/Territories	Variation in Policy Response Across Provinces/Territories
Age-friendly grants Most provinces/territories funnel small, competitive grants to local groups so they can launch coffee-and-conversation clubs, walking groups, or virtual "seniors' centres."	**Depth of health-system integration** Ontario and Alberta embed pilots directly in primary-care teams, collecting EMR-based outcome data and lobbying for eventual billing codes. In most other provinces the health system still plays a background role; community non-profits hold the referral lists, and clinical participation is voluntary.
Volunteer networks Most provinces promote some form of screened-volunteer befriending initiative.	**Scale and permanence of funding** Some provinces have multi-year funding and mandatory evaluations (for social prescribing pilots)
Social-prescribing pilots inside primary care Ontario's *Rx:Community* and *Links2Wellbeing* projects issue social prescriptions through older-adult centres. Alberta, Saskatchewan and New Brunswick are testing clinical-to-community referral pathways.	**Population focus** Some provinces/territories apply a universal 'seniors' specific lens, while other provinces recognize priority cultural groups.
Low-cost practitioner toolkits for rapid up-skilling Manuals from many different provinces and territories package risk flags, conversation scripts and local directory templates so frontline workers can start screening without a formal code change.	**Presence of province-wide public campaigns** Nova Scotia's *SHIFT* sponsors an annual "We're Better Together" Loneliness Week; B.C. brands its *Better at Home* media spots; Saskatchewan, Manitoba and the territories have no equivalent campaign.
Framing SI&L inside broader "age-friendly" or "aging-in-place" branding SI&L is rarely tackled in isolation; instead it is commonly bundled with transport, housing or digital-inclusion actions.	**Data and evaluation** New Brunswick's Healthy Seniors Pilot Project allocates up to 15 % of each award for rigorous mixed-methods evaluation, while Saskatchewan's toolkit and many Atlantic grants track outputs (number of visits) but not loneliness scores. Ontario uses shortened UCLA or De Jong scales.

Key Take Aways – Canadian Context
▪ In Canada, SI&L is being addressed at a meso-level mainly through (provincial-level) pilot social-prescribing programs in primary care and age-friendly community initiatives. ▪ There are also pilots that embed loneliness screening questions into standardized geriatric assessments in hospitals and community health centres. ▪ Funding streams are short-term, screening tools and referral pathways vary by province, and providers often lack billing codes or workload protection to sustain the work. ▪ Promising evidence-based clinical models are emerging, but they are subject to inconsistent funding, evaluation metrics, and supports for scaling.

International Context: We also conducted an investigation and analysis of meso-level policy directions in seven countries recognized for significant advancements in addressing social isolation and loneliness (SI&L): the United States, United Kingdom, Australia, Denmark, the Netherlands, Sweden, and Japan. Our aim was to identify key similarities and differences in how these countries approach SI&L, the strategic directions they have adopted, the policy levers they employ, and the gaps that remain.

Findings: Many lead countries have scaled meso-level programs that connect older adults to community supports. Like the national network of Social Prescribing Link Workers in the UK, social-prescribing pilots in Australia, and Denmark's multi-stakeholder National Partnership Against Loneliness. Many countries have adopted national-level loneliness campaigns that coordinate nationwide messaging, toolkits, and an annual Loneliness Awareness Week to raise public awareness and spur local action

Common Policy Features Across Lead Countries	Variation in Policy Response Across Lead Countries
Big scale public campaigns Each country runs a campaign so people hear about SI&L on TV, radio and social media. England's *Let's Talk Loneliness*, the Netherlands' orange-branded *One Against Loneliness* week, or Australia's *Ending Loneliness Together* blitz.	**Regulation & Funding** Japan and Denmark have laws or formal agreements that come with fixed budgets and clear targets. The UK and Sweden rely on government strategies that can change with politics. Australia and the USA mostly use philanthropic dollars and advisory reports.
Workforce training In England there are paid "link workers" in doctors' offices; in Japan and the USA there are volunteers who get a short course; Australia offers a micro-credential you can finish online.	**Connection to health care** England and the Netherlands require family doctors to use a specific referral pathway. Japan and Denmark offer annual health or nurse visits. In Australia and the USA it still depends on whether a clinic feels like joining in.
Grant money National-scale small grants are given to hundreds of neighbourhood projects at once—coffee clubs, walking groups, digital-skills classes— to generate movement.	**Depth of training** Australia's online course gives a formal badge to healthcare workers. England has short e-learning modules. In Netherlands volunteers often get a handbook and a short briefing.
Hand-off from health care to community Most lead countries embed a short loneliness question into routine check-ups. If someone screens positive, the doctor or nurse can write a "social prescription" that sends the person straight to one of those community projects – by passing red-tape referrals.	**Surveillance** The Netherlands and Denmark publish live dashboards showing how many people are reached. The UK puts out fund reports once in a while. Japan, Sweden, Australia and the USA share headline stats but no real-time data.
	Population Sweden and the UK talk about loneliness across the whole lifespan, so older adults share the spotlight with teens and working-age adults. Japan, Denmark and the Netherlands keep seniors as the main focus. Australia and the USA position older people as one of several priority groups.

Key Take Aways – International Context
▪ Internationally, the most effective meso-level responses to SI&L center on social-prescribing link workers, volunteer platforms, and community hubs that channel older adults toward social and clinical supports. ▪ Programs thrive where governments commit multi-year funding, invest in dedicated workforces, and build cross-sector coalitions that embed campaigns and data infrastructure into routine practice; ▪ Sustained resources, clear accountability structures, and shared metrics are essential to convert promising pilots into system-wide impact.

Menu of Options:

Our investigation of meso-level policy pathways in Canada and internationally uncovered numerous examples of national-level public awareness and practice-change campaigns, training and education programs, and strategic service-delivery models. These exemplars provide a menu of actionable options that the CCSMH could consider to strengthen the meso-level policy landscape surrounding SI&L in Canada. The Supplementary File for Pillar II provides additional details on provincial, territorial, and international policies that can be explored further as illustrative examples.

The following are actions that the CCSMH could pursue to foster change in meso-level policy directions in Canada:

Action Item	Additional Details
National Advocacy / Public Awareness Campaign	Under the banner of a national campaign, CCSMH could provide some or all of the following: media kits and social-media assets, promote a recommended screening tool (e.g., the three-item UCLA screener); offer micro-credential training for health care and social care professionals – attached to an e-learning module; ○ Local programs (Ontario's Links2Wellbeing, B.C.'s Better at Home, Nova Scotia's SHIFT week, northern aging-in-place projects) could co-brand with the national campaign and adopt common data templates and referral tools. ○ Sites that adopt the campaign tools (screening tools, e-learning modules) can feed their data (screen-positive rates, referral uptake, patient-reported loneliness scores) into a national dashboard (manned by the CCSMH) contributing to a national 'score card'.
Coast-to-coast awareness week for SI&L in older adults	A nationally branded Awareness Week spearheaded by the CCSMH would amplify local events and normalize help-seeking. ○ Only Nova Scotia and B.C. run named awareness weeks – that could feed into a national initiative
Pan-Canadian SI&L Training & Education Initiative	CCSMH could host a **modular e-learning and mentoring program.** one **national learning spine** that gives practitioners a common language, a recognized micro-credential, and a live referral network. ○ Consisting of four 90-minute online modules (screening & assessment, brief interventions, social prescribing workflows, and monitoring & evaluation) plus optional cultural-safety add-ons.

	○ Completion could earn a **micro-credential** accredited for continuing-education hours by nursing, social-work and medical colleges.
Practice Resource Hub	CCSMH could create a clearing house of existing templates and tools. ○ Including: *Links2Wellbeing* social-prescribing webinars and screening tools; volunteer-orientation materials from the United Way's *Better at Home* network; Healthy Seniors Pilot Project's evaluation template and outcomes framework; *Alone or Lonely* rural toolkit; cultural appropriateness modules.
Public Dash-Board	CCSMH could host a public, interactive dashboard that lets policymakers, practitioners, journalists, and older adults see how social-connection efforts are performing across the country. ○ This could be achieved by accessing and reporting on the prevalence (%) of older adults screening positive on the UCLA-3 (from the Canadian Community Health Survey and provincial* surveys). ***Ontario & New Brunswick** already collect UCLA scores and referral counts in their social-prescribing pilots.

Pillar 3

What we learned:

EMR/Screening: We conducted an investigation and analysis of micro-level policy directions relevant to the incorporation of SI&L into EMRs/surveillance and screening across all 13 provinces and territories and the various professions/sectors.

Findings: SI&L are significant public health concerns, yet there are no national mandates or standardized reporting requirements for health professionals to assess or document these issues. While tools like the interRAI assessment system are used in home and long-term care settings across many provinces, screening in primary care and community settings is inconsistent and largely optional. EMRs generally do not include standardized fields for capturing social isolation or loneliness, though some community health centres and pilot programs (e.g., social prescribing) are starting to integrate such measures.

Barriers	Facilitators
Lack of National Mandates or Standards ▪ No federal requirement or **consensus** on screening for social isolation/loneliness. ▪ Provinces, EMR vendors, and health authorities are unlikely to act without **aligned direction or incentives**.	**Existing Use of interRAI Tools in Many Provinces** ▪ interRAI already includes standardized items on loneliness and social support. ▪ Use interRAI as a model or bridge to expand screening into primary care and CHCs.
Fragmentation of EMR Systems ▪ Canada has a patchwork of EMR vendors (e.g., Telus PS Suite, OSCAR, Med Access) and **no national EMR standard for social needs documentation**. ▪ Custom integration is costly and inconsistent across jurisdictions.	**Momentum Around Social Prescribing in Canada** ▪ Pilots in Ontario and BC show that **screening for loneliness is feasible and acceptable** in primary care. ▪ Partner with organizations like the **Alliance for Healthier Communities** or **Better at Home** to scale up from pilots.
Time Constraints in Primary Care ▪ Clinicians already report overloaded appointment times; adding screenings can be perceived as "non-essential" without clear compensation. ▪ Low uptake unless screening is brief, easy to use, and tied to actionable interventions.	**Increased Awareness Post-COVID** ▪ Public and professional awareness of SI&L has grown. ▪ Use pandemic-era data and stories to justify the need for systematic screening.
Perceived Irrelevance to "Medical" Practice ▪ Social isolation may be seen as outside the medical scope, particularly by physicians or specialists focused on biomedical care. ▪ Risk of low engagement without demonstrating clinical relevance (e.g., to depression, frailty, dementia).	**Support from Professional Organizations** ▪ Groups like CFPC, CNA, and CGNA are prioritizing social determinants of health. ▪ Collaborate with these bodies to incorporate loneliness into **CPD requirements**.
Limited Community Referral Infrastructure ▪ Even when loneliness is identified, providers often lack community resources (e.g., social prescribing hubs, peer programs) to refer patients to. ▪ Screening without solutions risks frustration and "screening fatigue."	**Alignment with Federal Priorities on Healthy Aging** ▪ Federal strategies (e.g., PHAC Age-Friendly Communities, National Dementia Strategy) already mention **social inclusion**. ▪ Position CCSMH's work as **filling a data and practice gap** aligned with existing national goals.

Billing: We conducted an investigation and analysis of micro-level policy directions relevant to Billing codes across all 13 provinces and territories and the various professions/sectors in which billing for SI&L could occur.

Findings: Implementing a billing code for SI&L in Canada requires coordinated advocacy with each province's fee-schedule committees, backed by data showing clinical value and cost neutrality. The literature suggests that it is most feasible to create modifiers or bundled preventive-care codes that slot into existing mental-health or geriatric billing structures while aligning EMR templates and screening fields to standard definitions.

Barriers	Facilitators
No dedicated fee codes No Canadian province or territory offers a billing code specifically for screening, assessing, or treating social isolation and loneliness (SI & L) in older adults (or the general population).	**Stakeholder mapping** ▪ Name a **Lead Negotiator** and a small "SI & L Billing Task-Force." ▪ Build a master contact list for (tariff chairs, ministry analysts, EMR spec leads..) Draft a one-page **"elevator brief"** : *problem, clinical tool (UCLA-3), proposed fee logic, expected cost, offset idea*.
Physician workarounds Fee-for-service physicians bill SI & L activities under broader mental-health, preventive-care, or case-management codes, documenting the service in their clinical notes and selecting the nearest psychiatry / counselling line item.	**Evidence package & coalition sign-on** ▪ Publish (or commission) a concise **evidence brief**—prevalence, cost of untreated loneliness, ROI from pilot studies. Collect **letters of intent** from the Canadian Psychiatric Association, OMA Section of Geriatrics, CAOT, CASW, provincial LTC associations.
Allied-health funding models Allied-health and social-service providers are paid by salary, block contract, or per-diem; they do not submit line-item claims for SI & L work.	**Data-standards** ▪ Book a **pre-submission call** with Infoway's SDOH Working Group lead; confirm template for a CACDI change request. Draft the official **CIHI/Infoway change-request form** for "Loneliness screen score" & "Follow-up plan," circulate for coalition sign-off.
No inpatient code Loneliness is not recognized as a stand-alone inpatient diagnosis-related code.	**Claims-IT & EMR alignment** ▪ Set up a **joint call** with RAMQ, Medavie MSI, Health PEI Billing, Nunavut Insured Services + the lead EMR cert body (OntarioMD / DSQ / OPOR team). Ask for **an agenda of technical artifacts** they need (field name, code value, adjudication rule) and their typical lead time.
Fragmented fee structure Codes repurposed for SI & L vary by province, profession, and visit length (e.g., 15- vs 30-minute consultations). Psychiatrists and family physicians often use different codes—and receive different remuneration—for comparable services.	**Quality-indicator hook** Meet with orgs like **Ontario Health QIP unit, Accreditation Canada,** to propose a draft indicator: *"% seniors screened for loneliness with score recorded."*
Weak financial and data incentives Because there is no dedicated code, clinicians gain no extra remuneration for addressing SI & L, and health systems capture little standardized data on its prevalence or impact.	**Pilot site commitments** Secure 2 – 3 clinics / LTC homes in each province willing to pilot the code on day 1 and share utilization data.

Key Take Aways – Billing
▪ Success would hinge on a phased approach—pilot demonstrations linked to outcome metrics, harmonized documentation standards, and cross-professional reimbursement models—to prove impact, minimize administrative burden, and build the fiscal case needed for nationwide adoption.

Key Take Aways – EMR/Screening
▪ Canada lacks standardized, system-wide policies requiring the screening, documentation, or reporting of social isolation and loneliness among older adults, despite widespread recognition of their health impacts. To address this, a multi-tiered effort to integrate loneliness screening into EMRs, professional standards, and policy frameworks through collaboration with health regulators, policymakers, and community partners is needed.

Menu of Options

Our investigation of micro-level policy pathways that shape screening, surveillance and billing for SI&L in Canada uncovered granular view of operational procedures that reveals how an organization like the CCSMH can go about making broad-scale operational changes to micro-level workflows. The information we uncovered points to a menu of actionable options that the CCSMH could consider to strengthen the micro-level policy landscape surrounding SI&L in Canada. The Appendix for Pillar III provides additional details on how to action / influence changes in SI&L screening, surveillance, and billing across Canada.

The following are actions that the CCSMH could pursue to foster change in micro-level policy directions in Canada:

Billing	EMR/Screening
Implement a multi-year strategy to establish a national-level coding/billing system for SI&L (screening, assessment and /or treatment) in older adults.	Identify aligned frameworks. Map to existing strategies (e.g., PHAC Age-Friendly, National Dementia Strategy, interRAI, CFPC guidelines)
Implement bite size actions. The following are low-cost, achievable by a small team, and can generate tangible outputs, should a multi-year strategy be infeasible.	Prepare advocacy materials. Create briefing notes, slide decks, and 1-pagers tailored to each audience (regulators, funders, providers).
Establish a national data placeholder, not a fee File a single change-request to CIHI/Infoway for one new CACDI/SNOMED-CT code— *“Loneliness screening score (validated tool).”* It costs nothing, requires no provincial negotiation, and creates the technical hook that every province and EMR vendor will eventually need.	Prioritize "early adopter" provinces or networks. Focus on Ontario, BC, Alberta, and pan-Canadian actors like Infoway, CIHI, PHAC. For each partner, outline mandate, priorities, known champions, potential resistance
Pilot a “shadow code” in one primary-care clinic Ask an Ontario Family Health Team to record the loneliness score in a spare billing slot (e.g., a dummy	Engage clinical, regulatory, and lived experience reps to advise and co-sponsor the initiative

internal code). *Goal:* real utilisation data (minutes, frequency, staff mix) that can populate future tariff submissions.	
Attach SI&L to an existing QI template Work with Ontario Health's QIP team (or another province's quality office) to add a voluntary indicator: *"% of patients ≥ 65 with documented loneliness score this fiscal year."* Once the indicator exists—even as "optional"—EMR vendors must surface the field, and clinics begin routine data capture.	Initiative high-level conversations. Begin with "exploratory" meetings, not policy demands – focus on shared goals (e.g., healthy aging, system efficiency)
Publish a clinical micro-guide Release a two-page "Best Practice Quick Guide" for busy family doctors and NPs: when to screen, which tool (UCLA-3), 5-minute counselling script, community referral link, how to bill for SI&L within the current system (adapted to professions/provinces) This costs little, builds demand, and demonstrates that the service fits into ordinary appointment slots.	Map existing pilot leaders and advisory contacts (e.g., from social prescribing, interRAI).
Lobby for a single-province physician screen premium Choose the province with the fastest tariff cycle (e.g., British Columbia MSC) and request a once-per-year $8 add-on for completing the loneliness screen. If accepted, other provinces can copy-paste the wording, but a national rollout is not required up-front.	Develop a contact database of provincial health ministry reps, EMR leads, and college policy directors.
Draft a generic contract clause for home-care agencies Produce model language for a "Social-Connection Follow-Up Hour" that regional health authorities can drop into upcoming home-care RFPs.	Host a virtual roundtable with early adopters and regulators to co-surface challenges and solutions.
Offer an open-source EMR "smart form" Fund a vendor-agnostic FHIR form (PS Suite / Accuro / OSCAR) that: - captures the UCLA-3 score, - timestamps start/stop, - auto-suggests the local shadow or official billing code.* - Clinics can download and use immediately; once a formal fee exists, only the code value needs swapping.	Create a champion network across professions and provinces to support influence from inside the system.
Produce a two-minute explainer video for ministers A concise visual clip —*"Loneliness screening saves $X in ED visits; here's how one clinic bills it"* can help political champions grasp the ask quickly, smoothing future funding talks.	Work with professional colleges to draft clinical screening guidance, documentation templates, and EMR field recommendations.
Seek a small targeted research grant Apply to CIHR or a provincial foundation for a $50-100 k evaluative study of the pilot site. The resulting peer-reviewed data satisfy tariff committees' evidence requirement later.	Offer to co-lead a screening and EMR integration pilot in a CHC, LTC network, or primary care site.

CONCLUSIONS

This scan highlights a clear and pressing opportunity to strengthen Canada's response to SI&L in older adults. While encouraging efforts exist at the macro, meso, and micro levels, they remain uneven, under-resourced, and lacking the cohesion needed for system-wide impact. Canada can learn from international leaders who have embedded SI&L into national frameworks, funded large-scale delivery models, and developed integrated data and reporting systems. For CCSMH, this landscape offers multiple, actionable levers—from advocating for screening indicators in EMRs, to launching national awareness campaigns, to piloting billing codes and scalable interventions. With coordinated leadership, practical tools, and strategic partnerships, CCSMH is well-positioned to drive change across any of the three pillars. A consolidated menu of options across the three pillars is presented at the end of this report. Supplementary files consisting of raw data identified and analyzed in support of this report's findings are included. (Supplementary Files 1-3).

Consolidated Menu of Options Across Pillar I,II, III

Macro	Meso	Micro	
"Where are we heading, and why?"	*"How will the whole system move in that direction?"*	*"What do health care and social care professionals do in day-to-day practice?"*	
Advocate for changes in the conceptualization, legislation and regulation of SI&L within macro-level policies	Spearhead a National Advocacy / Public Awareness campaign	Implement a multi-year strategy to establish a national-level coding/billing system for SI&L in older adults.	Identify aligned frameworks
Use the federal *New Horizons for Seniors Program* (NHSP) as a policy lever	Lead a coast-to-coast Awareness Week for SI&L in older adults	Establish a national data placeholder, not a fee	Prioritize early adopters
Embed *measurable SI&L indicators* in national surveillance systems	Promote a Pan-Canadian SI&L Training & Education initiative	Pilot a "shadow code" in one primary-care clinic	Host a virtual roundtable with early adopters and regulators to co-surface challenges and solutions
Align with provincial Age-Friendly and Seniors Community Grant programs	Create a Practice Resource Hub	Publish a clinical micro-guide	Work with professional colleges to draft screening guidance and EMR field recommendations.
Leverage the new National Long-Term Care Services Standard	Host a Public Dash-Board	Offer an open-source EMR "smart form"	Offer to co-lead a screening and EMR integration pilot