Loneliness and the Home Care Guarantee

Response to the U.S. Senate Committee on Finance Minority Staff request for information, *Delivering an Affordable Home Care Guarantee for American Families*, October 16, 2026

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Responding to Section I (pp. 15 and 27) and Section III (pp. 64, 72-74, and 79-81)

Summary

I ask the Committee to urge the Centers for Medicare & Medicaid Services (CMS) to publish a baseline on loneliness among people receiving care at home. Since 2023, Medicare-certified home health agencies have asked patients how often they feel lonely or isolated. CMS shares confidential state and national results from that question with agencies. I ask the Committee to request those figures and urge CMS to publish them, after any disclosure review they need. For Medicaid home care, CMS should use the first 2028 quality reporting cycle and start with willing states that already ask about loneliness (Recommendation 1). In Washington's 2024-25 survey, 29% of 993 in-home respondents said they often felt lonely (Human Services Research Institute & ADvancing States, n.d., Table 114, p. 149). Neither step requires a new survey.

I also ask the Committee to urge CMS to work with willing states and home care providers to test how aides can respond to loneliness (Recommendations 2 to 4). Give aides training and paid time and have a care coordinator follow up. Compare that package with usual care and measure loneliness and cost. If the package reduces loneliness compared with usual care, federal training standards should include the skills, and wider adoption should keep the paid time and follow-up that made it work.

I went to a man's home to change a light bulb he could no longer reach. His meals had arrived, he hadn't missed a dose, and his home was safe. The radio was giving the weather forecast. He was crying. I changed the bulb and stayed a little longer. The checklist had no line for what I saw (Prestridge, 2026a).

National survey data point to unmet need. In my unadjusted, survey-weighted estimates, 40% of older adults with paid help and no unpaid family help said they felt lonely at least two days a week, compared with 18% of those with unpaid family help and no paid help. After adjustment for health, care needs, living arrangements, and other factors, the difference on the full loneliness scale was smaller and uncertain. These findings identify a group with substantial reported loneliness. They do not show that expanding paid care would be ineffective or that unpaid family care could meet the same needs. Loneliness has been associated with higher odds of death and depression and with earlier entry into a care home (Holt-Lunstad et al., 2015; Office of the Surgeon General, 2023; Rickman et al., 2025). A guarantee would pay for more hours of help. It should also ask whether people feel less alone.

The request for information asks about social integration through community volunteer networks (p. 81). It does not name loneliness as an outcome. Medicare's home health rules require agencies to ask about loneliness. Federal aide training standards address communication and emotional needs, but do not explicitly specify attentive listening or recognition of loneliness as competencies.

I am submitting these comments as an individual. I am a psychology undergraduate, a licensed home care aide and nursing assistant, and a research assistant in a University of Washington lab that studies depression in older adults. I led training for more than 1,500 people at a large tech company. At the home care company I founded, I hired and trained 17 caregivers who served 42 families. I have since transferred ownership and have no financial stake in that company. I remain an unpaid advisor. I also have Parkinson's disease, and I expect to depend on this workforce myself. These views are my own.

What the Home Care Data Show

I looked at the National Health and Aging Trends Study (NHATS), a nationally representative survey of Medicare beneficiaries age 65 and older. This is my own unpublished, exploratory analysis. The appendix gives the methods and results.

Loneliness is how a person feels about the connection they have. Social isolation describes how much contact they have. I measured loneliness. Paid help in NHATS includes anyone paid to help with daily activities, including aides, housekeepers, and relatives who are paid. The federal training rule I discuss below covers a narrower group.

I included only people who answered the loneliness question themselves. The findings may not represent people with greater cognitive or communication difficulties, whose interviews were completed by a proxy.

In 2024, I looked at 5,225 older adults living in the community who received help with daily activities. An estimated 40% of those with paid help and no unpaid family help (261 people) said they felt lonely at least two days a week, compared with 18% of those with unpaid family help and no paid help (3,967 people). These are unadjusted, survey-weighted shares above a threshold. Some people in both groups also had unpaid help from friends or neighbors.

My adjusted analysis measured something different: the average score on a five-point loneliness scale. After I took differences in health, care needs, living arrangements, and other factors into account, the difference in average score was much smaller and uncertain. Among people with paid help and known hours, I found no clear link between more paid hours and less loneliness. The 2023 results were similar.

I also looked at consecutive interviews from 2021 to 2024. People who started receiving paid help were lonelier to begin with. After I took earlier loneliness and other differences into account, I found no clear link between starting paid help and feeling less lonely at the next interview.

I am not saying paid help makes people lonely. This analysis does not estimate the effect of expanding home care, and it does not measure the other benefits of paid help. Much of the gap goes with differences in health, care needs, and living arrangements. These survey comparisons also leave open whether paid help changes loneliness or helps keep it from getting worse. What they show is that frequent loneliness is common among people who rely on paid help, and that more paid hours did not clearly go with less of it. That gives Congress a reason to ask about loneliness directly. The survey records who helps and how much help someone gets. What happens during the visit is the part I could not see. That is what should be tested.

Why It Matters: Health, Cost, and Time at Home

Loneliness matters to a person's health. Across studies it has been associated with 26% higher odds of death (Holt-Lunstad et al., 2015). The Surgeon General's advisory reports that poor social relationships were associated with a 29% higher risk of heart disease and a 32% higher risk of stroke. It also links chronic loneliness and social isolation to about a 50% higher risk of dementia in older adults, and it reports that adults who often feel lonely have more than twice the odds of developing depression (Office of the Surgeon General, 2023). Medicare's home health assessment screens for depression and asks about loneliness on the same form.

There is a cost question here. A 2017 AARP report estimated that older adults who were socially isolated had $1,608 more in Medicare spending per person per year, or about $6.7 billion across traditional Medicare (Flowers et al., 2017). The companion journal article found that the extra spending associated with isolation was concentrated in hospital and skilled nursing facility care. In that analysis, loneliness was associated with lower Medicare spending. The authors suggested that loneliness may make it harder for people to get care (Shaw et al., 2017).

The question for long-term care is whether people can stay at home longer. In a study of 1,101 older adults receiving community care in one London borough, the estimated median time to care-home entry was about nine months shorter for lonely people among those at highest risk of entry (Rickman et al., 2025). In 2024, the national median annual price of a semi-private nursing home room was about $111,000 (Genworth & CareScout, 2025). Medicaid was the primary payer for more than six in ten nursing facility residents in July 2024 (KFF, 2025).

These studies show associations. They do not show that reducing loneliness would change health, spending, or time at home. That is why the test in Recommendation 2 should measure the cost of delivering the support and see whether it changes time at home and spending for Medicare and Medicaid.

Why this will matter to more people. The number of Americans age 65 and older is projected to rise from 58 million in 2022 to 82 million in 2050 (Population Reference Bureau, 2024). The number age 85 and older is projected to more than double, from 6.5 million in 2022 to 13.7 million in 2040 (Administration for Community Living, 2024). A 2025 AARP survey, using a different measure from NHATS, classified 40% of U.S. adults age 45 and older as lonely, up from 35% in 2018, and 46% of adults ages 45 to 59 (Choi-Allum & Rainville, 2025). An AARP projection estimated that the number of adults ages 45 to 64 for every adult age 80 or older would fall from more than seven in 2010 to about four in 2030 and fewer than three in 2050 (Redfoot et al., 2013). That ratio gives a sense of the pressure on families.

The Rules Ask About Loneliness but Do Not Name Listening

The request for information asks how federal training requirements can “deliver a high standard of care” (p. 72). It also asks whether community volunteer networks are effective at “facilitating social integration” (p. 81). That question also applies to the paid worker who is already in the home.

The request for information cites 42 C.F.R. § 483.152, the federal training rule for nurse aides in nursing homes. It does not mention 42 C.F.R. § 484.80, the rule for home health aides. Under that rule, the training program for home health aides at Medicare-certified agencies must run at least 75 hours. The communication provision names the ability to read, write, and verbally report clinical information. A separate provision covers people’s physical, emotional, and developmental needs. Federal standards address communication and emotional needs, but do not explicitly specify attentive listening or recognition of loneliness as competencies. Communication is already among the subjects evaluated by observing the aide’s performance (42 C.F.R. § 484.80(b)(3)(i), (viii), and (c)(1)).

The same regulations already require someone to ask about loneliness. A Medicare-certified home health agency must give patients covered by the reporting requirement a comprehensive assessment that includes a standard set of federal questions, completed by a nurse or therapist (42 C.F.R. § 484.55). That assessment includes a depression screen. Since 2023 it has also asked, “How often do you feel lonely or isolated from those around you?” (Centers for Medicare & Medicaid Services, n.d.-a). The agency has to ask. The aide training rule does not make responding to what the person says an explicit skill.

Washington, where I am licensed, generally requires 75 hours of entry-level training for long-term care workers subject to its training requirements. The basic training standards tell aides to “listen attentively” and to recognize and acknowledge what clients communicate, including signs of pain or confusion. Washington shows that listening can be written into a training standard for personal care aides (RCW 74.39A.074 and WAC 388-71-0911(1)).

Older adults do signal distress during home care visits. In a Norwegian study of 196 visits, they expressed emotional distress 635 times. About nine times out of ten it came as a cue, and staff made room to talk about the emotion in about half of their responses (Hafskjold et al., 2017). It is easy to miss what someone is trying to tell you when you are also watching the clock and working through a list of tasks.

Two early projects speak to whether people who are not clinicians can learn structured ways to help. In a pilot randomized study with 56 older adults with depression, trained volunteers and social workers each delivered a brief program called behavioral activation. Participants improved in both groups. The study shows the feasibility and promise of trained volunteers delivering a structured depression program in senior centers (Raue et al., 2022). I now work in Dr. Raue’s lab. I had no role in that study.

In a 2026 project at a small home care agency, aides took a 30-minute online module on empathy-focused communication and behavioral activation. Over four weeks they reported using the strategies on 87 of 111 care days. The project measured feasibility. It had no comparison group and did not test whether clients became less lonely (Robinson, 2026).

In 2020 the National Academies recommended that direct care worker training cover social isolation and loneliness (Recommendation 8-3). The next step is a test with a comparison group. It could show whether this approach helps people receiving care feel less alone.

Recommendations

1. Publish a baseline and make sure someone follows up (pp. 15 and 27)

Loneliness answers can serve four purposes: a screening response that prompts follow-up for one person, a prevalence estimate for a program or state, a measure of change over time, and an indicator of provider quality. This recommendation asks for prevalence first. Provider quality measures should wait for evidence about what providers can change.

Medicare, starting with data CMS holds. Medicare home health agencies ask their patients, “How often do you feel lonely or isolated from those around you?” Since fall 2024, CMS has given each agency a confidential quarterly report on how many of its patients screen positive for social isolation on that question, with state and national rates for comparison (Centers for Medicare & Medicaid Services, n.d.-a, n.d.-b). I ask the Committee to request the national and state figures from CMS and to urge CMS to publish them, subject to any administrative or disclosure review they need. Medicare home health patients are a different group from people receiving long-term Medicaid home care, and the question combines loneliness and isolation. It is still federal data on people receiving care at home. The request for information seeks feedback on establishing a Medicare home care benefit (p. 15). These figures would give that work a starting point.

Medicaid, from 2028. A survey already asks. The National Core Indicators-Aging and Disabilities (NCI-AD) Adult Consumer Survey covers older adults and adults with physical disabilities who receive publicly funded services, and it asks about loneliness. Washington publishes the answers by program. In 2024-25, 29% of its 993 in-home respondents said they often felt lonely. The survey asks a different question from NHATS and the Medicare assessment and covers a different population, so these percentages should not be compared directly
(Human Services Research Institute & ADvancing States, n.d., Table 114, p. 149).

CMS already treats loneliness as a quality measure for one group. Its 2024 quality set included a loneliness measure from the survey of people with intellectual and developmental disabilities (NCI-IDD). For 2028, CMS proposed requiring that measure for states using that survey. None of the five proposed mandatory measures from NCI-AD asks about loneliness, and the notice gives no reason specific to that item. Under the proposal, a state that uses both surveys would have to report loneliness for people with intellectual and developmental disabilities and not for older adults and adults with physical disabilities. The notice proposed voluntary reporting of other survey measures, asked about publishing the results, and considered letting states report by program (Centers for Medicare & Medicaid Services, 2024, 2026).

I ask the Committee to urge CMS to confirm how willing states can voluntarily report the existing loneliness question by program. From the first 2028 reporting cycle, CMS should publish how many people answered and what share said they often feel lonely in each participating in-home program. Include the survey year. The baseline would describe the people who answered. If the federal reporting system cannot accept that level of detail in the first cycle, CMS could start by compiling figures from participating states' published reports.

Initial publication should support understanding and improvement, with clear denominators, response rates, reporting periods, and small-cell protections, rather than provider ranking or payment penalties. Providers who serve people with more complex needs could otherwise look worse for reasons outside their control.

CMS must identify the 2028 quality measures by December 31, 2026. State reporting requirements take effect July 9, 2028 (42 C.F.R. §§ 441.311(c), 441.312(c)(1)). The Committee should raise this with CMS as the agency sets the 2028 measures or works out how states will report them. If CMS has already set the 2028 measures, the Committee can still ask how states could report the question voluntarily. The Committee can also raise this gap in the 2030 review. The workgroup is scheduled to meet and take public comment on March 10 and 11, 2027 (Mathematica, n.d.).

In law. Section 107 of the HCBS Access Act (S. 5321) offers a place to put this in law for the longer term. It calls for quality measures and beneficiary surveys. I ask Congress to name participant-reported loneliness among people receiving care at home as an outcome and to have states report it by program where the data support it. Congress will be able to count hours and workers. It will need this measure to know whether the people receiving care feel less alone.

Using the results. At the program level, use the results to see where people may need more help staying connected. At the individual level, ask whether the person wants help, record the support they choose, and name who will check back. Some people will decline help, and that choice should be recorded and respected. The Medicaid HCBS waiver planning rule already calls for a plan that reflects the person's goals and identifies who monitors it (42 C.F.R. § 441.301(c)(2)). The question a care team can answer is simple. If the person asked for help staying connected, did they get the help they chose?

2. Test training with paid time and coordinated follow-up (pp. 72 and 80)

CMS should work with willing states and home care providers to test an approach with three parts: training for aides, paid time to use it, and follow-up by a care coordinator. The request for information lists a similar step for family caregivers: directing the Center for Medicare and Medicaid Innovation (CMMI) to test participant-direction pathways that train and compensate them (p. 80). CMMI could test this approach for paid aides.

Teach aides to notice when a person signals loneliness, ask what kind of connection the person wants, and, with permission, bring it to the care coordinator. Someone might want to call an old friend, get back to a weekly church service, or spend more time with a partner or chosen family. Living alone does not mean a person feels lonely, and some people will not want help. This does not make the aide a counselor. The aide notices, asks, and passes it on. Aides should have paid time for this work.

What happens next. The aide passes the concern to the care coordinator named in the person's plan. The coordinator works with the person to arrange the help they chose, records it in the plan, and checks back to find out whether they received it. Aides should have a supervisor they can go to with questions. Urgent concerns, such as a risk of harm or a sudden change in condition, should go through the agency's existing reporting procedures and not wait for routine follow-up.

Listening will turn up problems an aide cannot fix: no transportation, inaccessible places, hearing loss, poverty, bereavement, discrimination, or a lack of local services. Loneliness is not only a communication problem. When the support a person wants does not exist nearby, the coordinator should record the unmet need. Those records would show where coordination and community investment are needed.

Costs the test should cover. CMMI could fund the test as a model and pay participating providers for the costs it adds: training hours, replacement coverage while aides train, the added visit time, supervision, and coordinator follow-up. Paying for those costs is part of what is being tested. A later program that drops them may not get the same results.

CMS should compare the full approach with usual care and ask people in both groups how often they feel lonely before and after the test. Plan for accessible communication and supported self-report so people with hearing, speech, or cognitive difficulties can answer. Medicare home health agencies already record a loneliness question at the start of care and at discharge, so a test there could build on answers they collect now. Check that aides received training and paid time and used what they learned. Check that aides raised concerns with the person's permission and that coordinators followed up. Count what it costs to deliver, including training, supervision, and paid visit and follow-up time. With enough follow-up, track hospital stays, nursing facility use, and time at home.

3. Add the skill to the federal training rule if the test supports it (p. 72)

Section 1891(a)(3)(D) of the Social Security Act directs the Secretary to set standards for home health aide training and competency evaluation, including curriculum content and minimum hours. If the test finds that the full approach reduces loneliness compared with usual care and shows that aides can learn and use the skills with paid time and follow-up, CMS should amend 42 C.F.R. § 484.80(b)(3)(i) to cover the skills below. The first sentence is the current text. The second sentence is new.

> *Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff. Training must also address the ability to listen attentively, recognize and acknowledge the emotional and social concerns patients express, including signs of loneliness, and recognize when a concern should be reported.*

A positive test would support the full package, not a change in curriculum wording alone. Any wider rollout should keep the paid time and coordinator follow-up the test included. The existing competency evaluation would let an instructor or evaluator observe this skill. Use the test to find out how much training time it takes and how to make room for it while protecting safety content.

4. Reach personal care aides through the wider training framework (pp. 64 and 73)

Recommendation 3 would reach only home health aides at Medicare-certified agencies. The request for information says certified nursing assistants, home health aides, and personal care aides provide the bulk of care in home care settings (p. 64). There is no federal minimum training standard for personal care aides (King, 2025). If the test supports the skill, make it a core competency in the universal training framework the request for information describes for direct care workers, so it reaches personal care aides as well, with the same paid time and follow-up. Washington's rule is a starting point for the wording.

5. Include loneliness and social isolation in the periodic training review (p. 74)

The request for information proposes reviewing training every two to four years and asks how to account for changes in acuity and dementia. In my 2024 analysis, people with dementia and people who lived alone reported more loneliness after adjustment for the other measured factors. The review should explicitly consider whether workers are prepared to recognize and respond to loneliness and social isolation.

6. Ask who helps and how often the person feels lonely (p. 79)

The request for information asks for better data on informal and unpaid caregiving, including outcomes. Ask the person receiving care how often they feel lonely and who helps them. Record whether each helper is a relative, a partner, a friend, or chosen family, and whether that helper is paid. Asking who provides help and how often the person feels lonely would let Congress see how people are doing when they receive unpaid help, paid help, or both. NHATS let me ask these questions together for people 65 and older. Surveys that cover younger adults can help Congress see what is happening across the people the proposed benefit would serve.

I made a related recommendation in my comment on the proposed 2028 redesign of the National Health Interview Survey. The survey asked about loneliness in 2024. I asked the National Center for Health Statistics to retain a direct loneliness question and include a way to identify people who receive help at home and where that help comes from (Prestridge, 2026b).

What Congress Can Ask From the Start

Paid care puts a person in the home. That alone may not make anyone less alone. What happens during those hours is worth testing.

A home care guarantee gives Congress a chance to ask two questions from the start. Do people feel less alone? Do they get more time at home? Washington already has a way to ask the first one. So does Medicare.

Thank you for considering these recommendations. I would welcome the chance to discuss them with Committee staff or to testify. I can provide my analysis tables and code.



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Appendix

NHATS results

Table 1. Loneliness by source of help, 2024 (Round 14), n = 5,225

Source of help	Share of sample	Lonely at least 2 days a week (unadjusted, weighted)	Adjusted difference in loneliness score (95% CI)
Unpaid family help, no paid help	76%	18%	Reference group
Paid help and unpaid family help	15%	24%	0.12 (0.03 to 0.22)
Paid help, no unpaid family help	5%	40%	0.14 (-0.07 to 0.35)
Unpaid nonfamily help only	4%	32%	0.00 (-0.18 to 0.18)

Notes. Paid help includes relatives who are paid. Family help here means unpaid relatives. People in the first three groups may also have had unpaid help from friends or neighbors. The counts were 489 of 3,967, 129 of 765, and 71 of 261, respectively. Loneliness is scored from 1 (never) to 5 (every day). The shares lonely at least two days a week are unadjusted and survey-weighted. The adjusted differences compare average scores on the five-point scale. These are different estimates. The weighted mean scores before adjustment were 1.70, 1.91, 2.29, and 2.06 in the order shown. The unadjusted difference between the third group and the reference group was 0.59 points. The average numbers of self-care activities with help, out of six, were 0.22, 0.61, 0.39, and 0.10. Estimates use NHATS weights, strata, and clusters. The model adjusts for age, sex, living alone, self-rated health, dementia, social isolation, and the number of activities with help.

The sample excludes interviews completed by a proxy, so the results may not represent people with greater cognitive or communication difficulties. Social isolation is included in the model. It may act as a confounder, or as a pathway through which help affects loneliness. If it is a pathway, adjusting for it could understate an association. Results without that adjustment are not shown here.

For the second group, the Holm-adjusted p-value was .09 across seven comparisons in the broader analysis. Round 13 (2023, n = 5,998) gave similar results for paid help without unpaid family help (0.08, 95% CI -0.13 to 0.29) and for both paid and unpaid family help (0.09, 95% CI 0.00 to 0.18). Among people with paid help and known hours, the estimated association with monthly paid hours (log scale) was -0.04 in 2024 (95% CI -0.14 to 0.05) and 0.06 in 2023 (95% CI -0.02 to 0.15).

Table 2. Loneliness before and after starting paid help, 2021 to 2024 (Rounds 11 to 14)

Group	Interview pairs	First interview	Second interview	Change (95% CI)
Did not start paid help	7,859	1.74	1.74	0.00 (-0.02 to 0.02)
Started paid help	846	1.96	1.94	-0.02 (-0.09 to 0.04)

Notes. 8,705 interview pairs from 5,062 people who lived in the community, answered for themselves at both interviews, and had unpaid family help and no paid help at the first interview. Means in the table are unweighted. The adjusted difference in later loneliness for those who started paid help was 0.02 (95% CI -0.05 to 0.10) with survey weights, strata, and clusters, and 0.05 (95% CI -0.01 to 0.11) unweighted. Models adjust for loneliness, age, sex, living alone, self-rated health, dementia, social isolation, and number of activities with help at the first interview, and for interview year. The analysis is exploratory and was not preregistered.

Data source. National Health and Aging Trends Study. Produced and distributed by https://www.nhats.org with funding from the National Institute on Aging and Office of Behavioral and Social Sciences Research (OBSSR) (grant number U01AG032947).

References

Administration for Community Living. (2024). *2023 profile of older Americans*. U.S. Department of Health and Human Services. https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans

Centers for Medicare & Medicaid Services. (n.d.-a). *OASIS data sets* (home health assessment instruments; OASIS-E took effect January 1, 2023; item D0700, Social Isolation). https://www.cms.gov/medicare/quality/home-health/oasis-data-sets

Centers for Medicare & Medicaid Services. (n.d.-b). *Screen positive for HRSN indicator: Confidential feedback report*. https://www.cms.gov/files/document/screen-positive-hsrn-fact-sheet.pdf

Centers for Medicare & Medicaid Services. (2024, April 11). *2024 home and community-based services quality measure set*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib041124.pdf

Centers for Medicare & Medicaid Services. (2026, April 28). Medicaid program: 2028 Medicaid home and community-based services quality measure set. *Federal Register*, *91*, 22823. https://www.govinfo.gov/content/pkg/FR-2026-04-28/pdf/2026-08190.pdf

Choi-Allum, L., & Rainville, C. (2025). *Disconnected: The escalating challenge of loneliness among adults 45-plus*. AARP Research. https://doi.org/10.26419/res.00983.001

Flowers, L., Houser, A., Noel-Miller, C., Shaw, J., Bhattacharya, J., Schoemaker, L., & Farid, M. (2017). *Medicare spends more on socially isolated older adults*. AARP Public Policy Institute. https://www.aarp.org/pri/topics/health/coverage-access/medicare-spends-more-on-socially-isolated-older-adults/

Genworth & CareScout. (2025, March 4). *Genworth and CareScout release cost of care survey results for 2024*. https://investor.genworth.com/news-events/press-releases/detail/982/

Hafskjold, L., Sundling, V., van Dulmen, S., & Eide, H. (2017). The use of supportive communication when responding to older people's emotional distress in home care: An observational study. *BMC Nursing*, *16*, Article 24. https://doi.org/10.1186/s12912-017-0220-8

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, *10*(2), 227-237. https://doi.org/10.1177/1745691614568352

Human Services Research Institute & ADvancing States. (n.d.). *National Core Indicators-Aging and Disabilities Adult Consumer Survey state results: Washington, 2024-25* (Table 114, p. 149). https://web.archive.org/web/20260808154558id_/https://nci-ad.org/upload/state-reports/NCI-AD_24-25_WA_State_Report.pdf#page=149

KFF. (2025, May 28). *5 key facts about nursing facilities and Medicaid*. https://www.kff.org/medicaid/5-key-facts-about-nursing-facilities-and-medicaid/

King, J. (2025, August 12). *Personal care aide training standards across the United States: 2025 update*. PHI. https://www.phinational.org/personal-care-aide-training-standards-across-the-united-states-2025-update/

Mathematica. (n.d.). *Home and Community-Based Services Quality Measure Set Review Workgroup* (2030 review schedule). https://www.mathematica.org/features/hcbsqmsreview

National Academies of Sciences, Engineering, and Medicine. (2020). *Social isolation and loneliness in older adults: Opportunities for the health care system* (Recommendation 8-3). The National Academies Press. https://doi.org/10.17226/25663

Office of the Surgeon General. (2023). *Our epidemic of loneliness and isolation: The U.S. Surgeon General's advisory on the healing effects of social connection and community*. U.S. Department of Health and Human Services. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

Population Reference Bureau. (2024, January 9). *Fact sheet: Aging in the United States*. https://www.prb.org/resource/fact-sheet-aging-in-the-united-states/

Prestridge, D. (2026a, August 17). *Loneliness is a care need: Why human connection should be part of home care*. National Council on Aging. https://www.ncoa.org/article/why-human-connection-should-be-part-of-home-care/

Prestridge, D. (2026b). *Comment on the proposed 2028 redesign of the National Health Interview Survey* (CDC-2026-1387-0019). https://www.regulations.gov/comment/CDC-2026-1387-0019

Raue, P. J., Hawrilenko, M., Corey, M., Lin, J., Chen, S., & Mosser, B. A. (2022). "Do More, Feel Better": Pilot RCT of lay-delivered behavioral activation for depressed senior center clients. *Behavior Therapy, 53*(3), 458-468. https://doi.org/10.1016/j.beth.2021.11.005

Redfoot, D., Feinberg, L., & Houser, A. (2013). *The aging of the baby boom and the growing care gap: A look at future declines in the availability of family caregivers*. AARP Public Policy Institute. https://caregiver-production-fca-cloudfront-origin.s3.amazonaws.com/media/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf

Rickman, S., Fernández, J.-L., & Malley, J. (2025). Loneliness as a risk factor for time to care home entry for older adults receiving community care. *Innovation in Aging*, *9*(6), Article igaf010. https://doi.org/10.1093/geroni/igaf010

Robinson, T. L. (2026). *Feasibility and acceptability of a home-health aide-delivered loneliness reduction program in a small home care agency: The Caring Connections quality improvement project*. Duquesne University. https://dsc.duq.edu/dnp/70/

Shaw, J. G., Farid, M., Noel-Miller, C., Joseph, N., Houser, A., Asch, S. M., Bhattacharya, J., & Flowers, L. (2017). Social isolation and Medicare spending: Among older adults, objective isolation increases expenditures while loneliness does not. *Journal of Aging and Health*, *29*(7), 1119-1143. https://doi.org/10.1177/0898264317703559

U.S. Senate Committee on Finance, Minority Staff. (2026, October 16). *Delivering an affordable home care guarantee for American families*. https://www.finance.senate.gov/wp-content/uploads/media/doc/101626_sfc_long-term_care_rfi.pdf

Statutes and regulations

HCBS Access Act, S. 5321, 119th Congress, § 107 (introduced 2026). https://www.govinfo.gov/content/pkg/BILLS-119s5321is/html/BILLS-119s5321is.htm

Social Security Act § 1891(a)(3)(D), 42 U.S.C. § 1395bbb(a)(3)(D). https://www.ssa.gov/OP_Home/ssact/title18/1891.htm

42 C.F.R. § 441.301. https://www.ecfr.gov/current/title-42/section-441.301

42 C.F.R. § 441.311. https://www.ecfr.gov/current/title-42/section-441.311

42 C.F.R. § 441.312. https://www.ecfr.gov/current/title-42/section-441.312

42 C.F.R. § 483.152. https://www.ecfr.gov/current/title-42/section-483.152

42 C.F.R. § 484.55. https://www.ecfr.gov/current/title-42/section-484.55

42 C.F.R. § 484.80. https://www.ecfr.gov/current/title-42/section-484.80

Washington RCW 74.39A.074. https://app.leg.wa.gov/RCW/default.aspx?cite=74.39A.074

Washington WAC 388-71-0911. https://app.leg.wa.gov/WAC/default.aspx?cite=388-71-0911