Social Bridging Project Brief
February 2023

Intergenerational Social Connectedness: A Multi-Pronged Strategy to Address Social Isolation and Loneliness, Reduce Ageism and Increase the Older Adult Workforce

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BACKGROUND

Social Isolation and Loneliness

Social isolation refers to the absence of social contact or a lack of social connections and is typically measured objectively through a count of contacts or social encounters during a given period of time. Loneliness is more subjective, refers to a disquieting feeling and is used to connote the discrepancy between actual and desired amounts of social contact. Prior to the COVID-19 pandemic, social isolation and loneliness already pervaded much of our populace. An abundance of literature has documented staggeringly high rates of social isolation and loneliness in the U.S. throughout our adult population, and rates among the young adult population (aged 18 to 24) are thought to be the worst in the country. A December 2021 survey included startling findings that 79% of young adults aged 18-24 in the U.S. report feeling lonely and 42% of those aged 18-34 report always feeling left out.[1] High levels of loneliness were reported by 61% of respondents aged 18 to 25 in a 2021 study conducted by Harvard University.[2] Key findings from a 2019 study (Child & Lawton) found that young adults (aged 21-30) reported slightly more than twice as many lonely days as late middle-aged adults (50 - 70 years) and nearly twice as many days isolated as

their older counterparts.[3] Data from a pre-pandemic 2020 WebMD Health Services report on employee well-being showed that more than half (56%) of all working women and nearly half (44%) of all working men feel lonely and isolated sometimes or always. Levels were even higher for women caring for children (62%).[4] Many studies also show a disproportionate impact on BIPOC and lower income populations with rates of loneliness 10% higher in Hispanic and African American adults compared with White adults and in those earning less than $50,000 per year compared to those earning higher amounts.[1,5,6]

A considerable body of evidence has also demonstrated the increased risk of poor health outcomes associated with isolation and loneliness. Social isolation presents a substantial risk for increased morbidity and premature mortality comparable to the risk associated with obesity, hypertension or daily tobacco use.[7,8,9] A 2020 report from the National Academies of Sciences, Engineering, and Medicine noted that social isolation is associated with a 50% increased risk of dementia, 29% increased risk of heart disease and 32% increased risk of stroke.[10] Loneliness is associated with higher rates of depression, anxiety and suicide and, among heart failure patients, is associated with a nearly four times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits.[10]

Public health measures adopted to slow the spread of the COVID-19 virus further exacerbated social isolation and loneliness in the U.S.[11,12,13,14] Although many Americans were able to stay

virtually connected with friends and family through the use of digital platforms like Zoom, some adults over the age of 65 were unable to similarly adapt to these changes.[13,15,16] Those living in rural areas were also disproportionately impacted. A Pew Research Center report demonstrated consistently lower rates of access to broadband internet in rural adults (66%) vs. urban adults (75%)[17] making participation in synchronous activities such as videoconferencing more challenging due to slower speeds and poor connectivity caused by low bandwidth access.[18]

Ageism

Ageism refers to the stereotypes, attitudes and discriminatory acts or policies against people on the basis of their age. Ageism may be implicit or explicit, can include cognitive, emotional and behavioral dimensions[19] and is considered a structural, institutionalized prejudice.[20,21,22] The term is most commonly associated with stereotypes or biases about older adults but also occurs against younger populations. Although there are positive forms, this brief will focus on ageism's negative manifestations.

Multiple studies have demonstrated the persistent presence of ageism across multiple domains of our society, including health care, employment, lending and advertising, particularly in social

media.[20,21,22,23] In 2019, the World Health Organization sponsored an analysis which found ageism in 96% of the 422 studies analyzed.[22] In 85% of the 149 studies included in a review by Levy (2022), older patients were denied access to procedures and treatments that were given to their younger counterparts despite the likelihood of a similar outcome.[20] Multiple studies have also reported findings that demonstrate the negative impact of ageism on physical and cognitive health and on longevity.[20,24,25,26] Health care costs associated with structural ageism are estimated to be $63 billion in the U.S. alone.[27]

Older Adult Healthcare Work Force

Like much of the country, North Carolina is experiencing a growing population of older adults amidst rising healthcare costs and simultaneous challenges with healthcare workforce shortages and declines in the number of potential family caregivers.

North Carolina currently ranks 8th nationwide in the number of residents 65 and older.[28] Similarly to trends seen nationwide, North Carolina adults aged 60+ outnumber children under the age of 18 due to increases in life expectancy and concomitant declines in birth rates.[28,29,30] In ten years, it is estimated that the state will have a shortage of more than 12,000 registered nurses and the greatest portion of the shortfall (31%) is predicted to be in the state's nursing homes and assisted living facilities.[31]

There are currently 158 doctors specializing in the care of older adults (geriatricians) in North Carolina. The Alzheimer's Association estimates that the number of geriatricians in the state needs to increase 238% by 2050 in order to meet the future care needs of NC's older adults (65+).[32] A shortage in the number of family caregivers is also predicted. The American Association of Retired Persons (AARP) reports that, in 2010, there were seven potential family caregivers for every person aged 80+. It estimates that, by 2030, the number of potential family caregivers could be as few as four per person.[33]

PROGRAM OVERVIEW

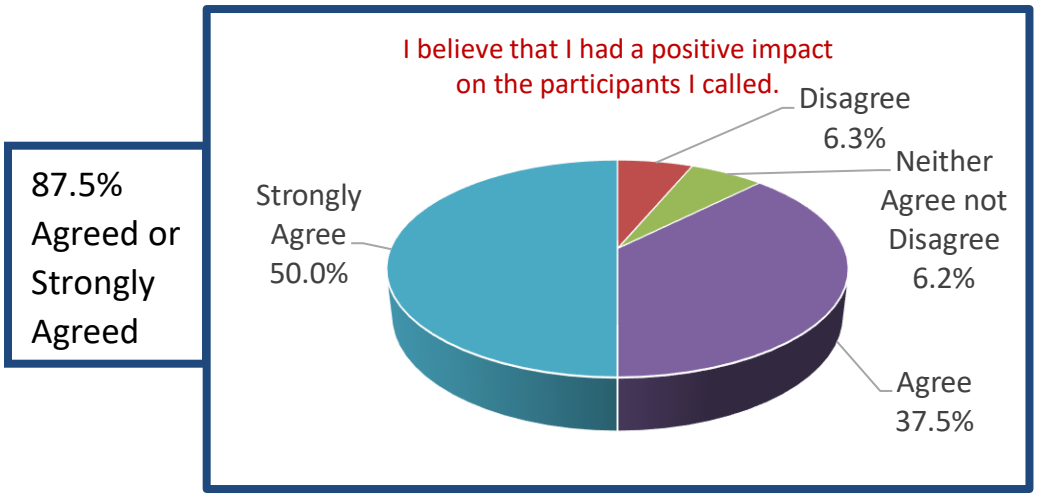
In May 2020, the North Carolina Center for Health and Wellness (NCCHW) and the Mountain Area Health Education Center (MAHEC) partnered together to form the Social Bridging Project as a response to concerns about the potential impact of social isolation on older adults as a result of the pandemic. Our aim was to provide them with a source of social connection, technology support and referrals to needed resources. Higher education students from multiple disciplines who were attending colleges and universities in the western North Carolina region were recruited as "wellness callers." A phone-based survey was conducted in June and July of 2021 to understand the project's impact on the older adult participants and was the first evaluation component of the project. A Qualtrics web-based survey was also implemented which wellness callers completed after each call. This provided an additional evaluation component. Although the health and well-being of older adults were our primary focus, feedback received from wellness callers during weekly debriefing sessions indicated that student and staff callers were also benefitting from their conversations with project participants. A subsequent review of the literature describing intergenerational interventions confirmed this symbiotic pattern and an evaluation of the callers themselves (through a Google Form survey) was conducted in July and August of 2021 to better understand callers' perceptions of the impact they generated in the lives of the participants with whom they spoke. This brief reports on the findings of the Google Form survey of callers and complements the results of other evaluation methods.[34]

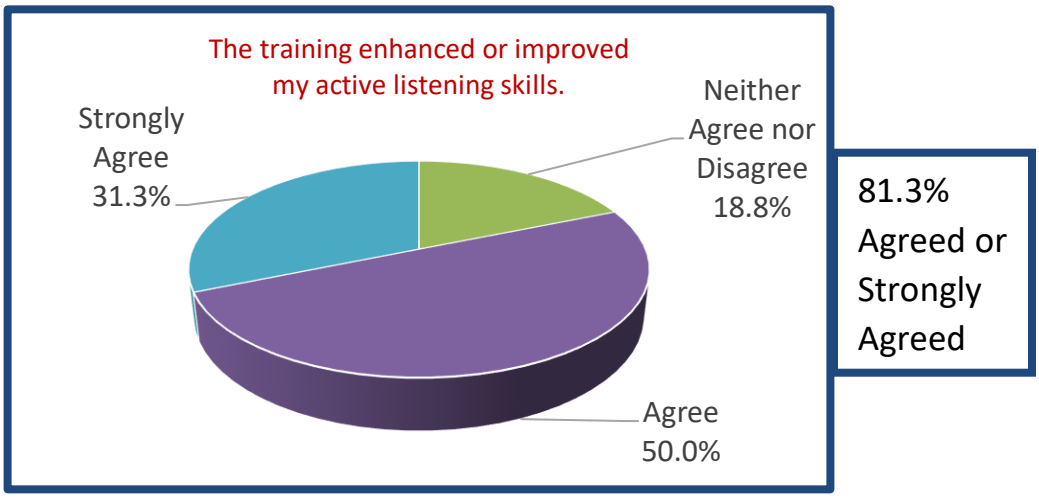
KEY FINDINGS

From August 2020 to July 2021, 76 staff members and students made 905 calls to 77 older adult participants in a five-county catchment area in western North Carolina (though many of the students volunteered for two weeks or less). From August 2020 to July 2021, staff and student callers A total of 76 paid and volunteer callers conversed with project participants and provided tech support or referrals to resources, as needed.

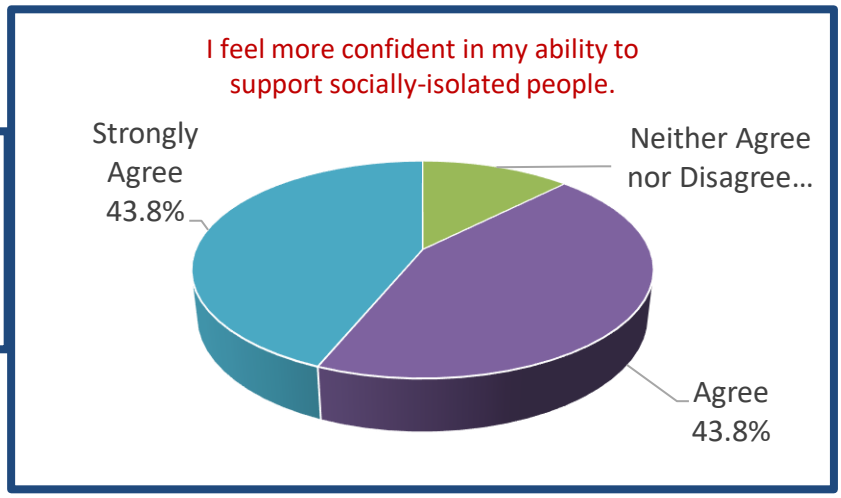
Period of time callers were active with the program (N = 76)		
≤2 weeks	>2 weeks and up to 1 semester	>1 semester
29 (38%)	39 (51%)	8 (11%)

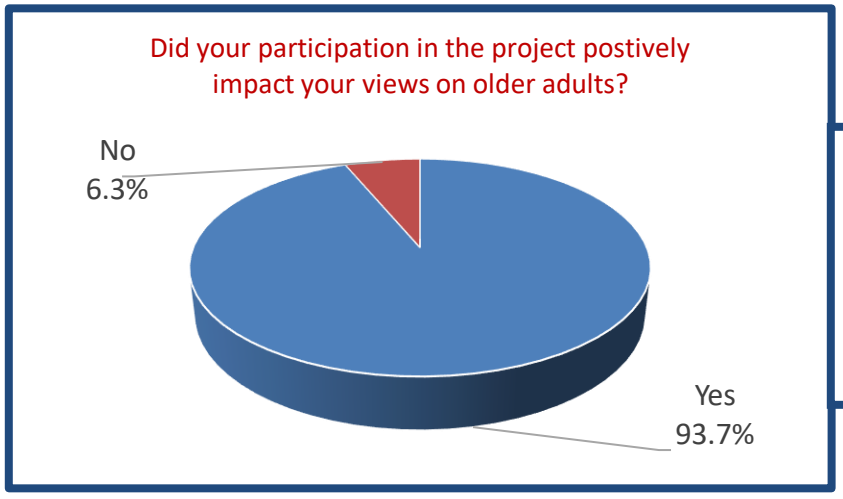
The Google Form survey instrument was disseminated by email to 56 paid and volunteer callers in late July and August 2021 to better understand their perceptions of the program's impact on their skills, knowledge and views on older adults and of their impact on the lives of program participants. The response rate was 29% (16 of 56) and its key findings follow.





87.6% Agreed or Strongly Agreed





93.7% believed their views on older adults were positively impacted

QUALITATIVE FEEDBACK

Open-ended questions provided rich qualitative data on what "worked best for the participants," what they learned "that will be useful" to them in their professional pursuits and what was "most helpful" to them personally or professionally.

What aspects do you think worked best for the participants?

"Just having someone to talk to. The people I had weren't that interested in our resources but just wanted a friend."

"Being able to communicate when and how long conversations would be was something I think my participants enjoyed having agency over. It didn't feel like I was checking in on them, they had the agency to make our phone calls into enjoyable social moments."

Is there anything you learned from the project that will be useful in your current job or in the future career path you have chosen?

"Patience, patient-friendly language, motivational interviewing and directing conversations in a positive light."

"Displaying empathy, active listening and being more attuned to the roadblocks faced by our aging communities."

"Learning how to be a better active listener through the Social Bridging Project training has been applicable in many different parts of my life."

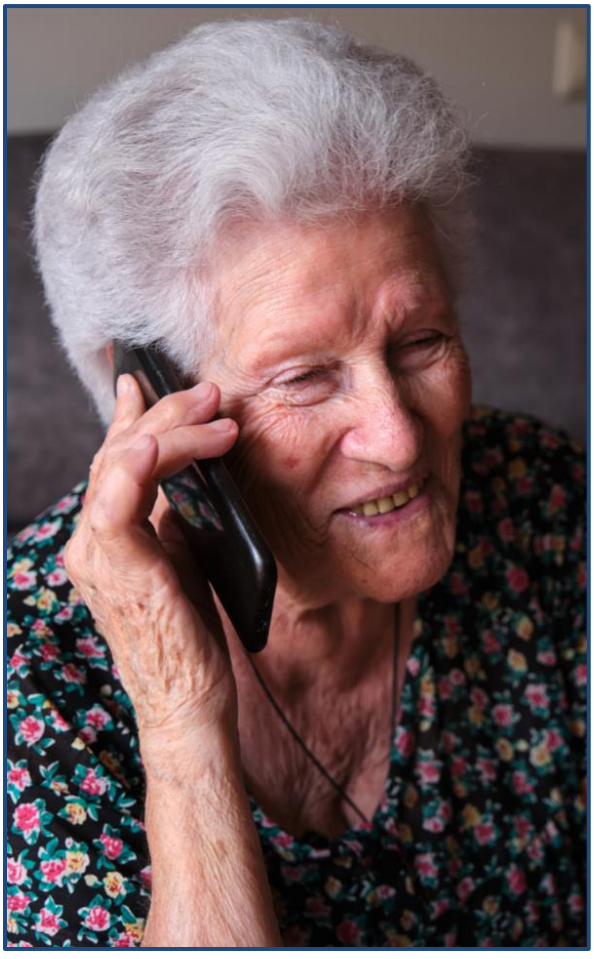
"Comfort in talking with a population of people I normally wouldn't speak to."

What did you learn that was most helpful to you either personally or professionally?

"I learned that it's important to be consistent with our calls and that with older individuals, sometimes listening to them is the most important thing we can do."

"Being a comforting presence even if you can't solve someone's problems."

"How to connect with someone that may be socially isolated in a personal way that was meaningful."



"Learning more about the barriers to healthcare and how social isolation can impact an individual."

DISCUSSION

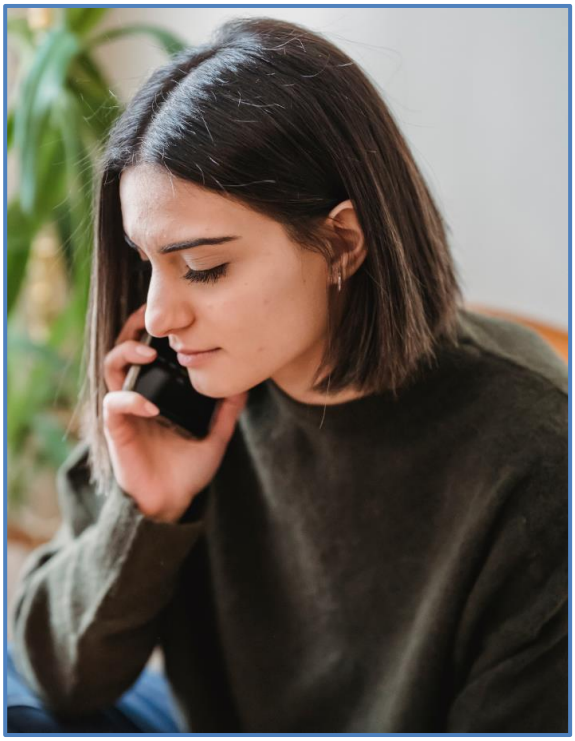
Staggeringly high rates of social isolation and loneliness were documented in both young adult (aged 18 to 30) and older adult (aged 60+) populations in the U.S. even prior to the COVID-19 pandemic. Two surveys conducted in August 2019 and December 2021 consistently found that more than half of American adults (61% and 58%, respectively)[1,35] are classified as lonely based on data using the Cigna Loneliness Index. This indicates that an "epidemic of loneliness"[1] engulfs more than 120 million Americans 18 and older who also carry an increased risk for the poor health outcomes associated with it. A 2021 study found that American adults now report having fewer close friendships than ever and more than half feel as though no one in their life knows them well.[36] Qualtrics survey responses from our evaluation indicated that loneliness (30%) or social isolation (26%) were the primary challenge for many of our project participants.

Numerous studies suggest that high quality, in-person contact is more strongly associated with depressive symptoms and loneliness. Although data on their effectiveness are mixed, several studies have demonstrated that interventions using phone and internet-based communication may also be effective in mitigating social isolation and loneliness.[29,37,38,39,40,41,42] A majority of project callers who completed the Google Form survey believed they had a "positive impact on the participants" they called (87.6%) and many also felt more confident in their "ability to support socially isolated people" (87.6%). Several qualitative responses indicated that some of the callers may have felt an increased connection with older adults or experienced changes in their understanding of and empathy for older adults.

- "It made me realize how much they like talking to others and how lonely they can get. They may be older, but they are just like me."
- "It brought me closer to individuals that I would have otherwise had no contact with. The project allowed me to gain firsthand experience with demographics that otherwise go unrecognized in my day to day life."
- "I learned much more about the impact of loneliness on the health and well-being of older adults."
- "I realized that loneliness in the older adults can cause many other issues with mental health and also physical health if they have no one to help them."

- "I have always had empathy towards older adults, but I think working with them through calling them regularly has increased my sympathy for them."
- "I empathize with them much more now."

Intergenerational programming, used for decades as a means of improving perceptions and reducing ageism through the increased connection, interaction and exchange between young and older adults, was primarily conducted in person until the COVID-19 pandemic necessitated a shift to phone and internet-based communication. There is little data on the effectiveness of intergenerational interventions in exclusively virtual settings as a means of reducing ageism. (Searches using several combinations of related terms yielded only two studies in the United States.) However, Ramamonjiarivelo et al. (2022) reported that, compared with a control group, posttest Aging Semantic Differential* (ASD) scores were significantly lower for students in a service learning project in which they were paired with older adults for virtual interaction (six week period with a minimum 30 minute per week dose).[43] Reductions in ageist beliefs and attitudes not only benefit those who are common targets of the prejudice but also those who hold the beliefs themselves. Young adults who accept and internalize ageist views may later be impacted as they themselves age.[24,25,44] Indeed, one 2022 study (Allen et al.) found that "internalized ageism was the category associated with the greatest increase in risk of poor outcomes for all health measures."[25]



In addition to increased risk of being denied medical treatment, those who have experienced age-related prejudice and discrimination, whether from internal or external sources, have poorer mental and physical health outcomes, are less likely to engage in preventive health behaviors and have reduced life expectancy.[22,24,26,41,45] Levy et al. (2002) found that older adults with more positive perceptions

*The Aging Semantic Differential is a 32-item scale used to measure attitudes and quantify bias and negative stereotypes toward older people.

of aging lived 7.5 years longer than those with less positive perceptions.[46] Although we did not administer an instrument that assessed levels of ageism, when callers were asked whether their participation in the project "positively impacted their views on older adults," 93.7% responded yes. "If so, in what ways?" prompted the following qualitative responses:

- "Many are just lonely and seeking social interaction; they all have such unique stories and lessons to share."
- "I already enjoyed working with older adults but being able to take time to listen to their stories and hear about their experiences really does make you appreciate all they have seen in their lifetimes."

Few studies have examined the impact of intergenerational interventions, in the context of in-person or virtual programming, on young adults' interest in pursuing careers that primarily serve older adults. Multiple studies have found ageism scores to be predictive of young adult intention to work with older adults[47,48,49] suggesting that interventions aimed at increasing positive images of, and contact with, older adults might also positively impact young adult interest in pursuing an aging-related career. A 2019 review of 63 studies (1976-2018) by Burnes et al. examined interventions designed to reduce ageism, six of which also analyzed a secondary outcome related to the intervention's impact on young adult interest in working in geriatrics. Their review found that the interventions had no significant effect on young adults' career interests,[45] but one more recent study had positive findings. Both quantitative and qualitative data from a 2020 study conducted by Leedahl et al. demonstrated an increased openness in working with older adults after participation in an intergenerational digital-learning program.[21]

Phone-based interventions of this type may also be an effective means of improving students' communication skills, particularly active listening. Several callers alluded to these skills in their responses to two open-ended questions "What did you learn that was most helpful to you either personally or professionally?"

- "I learned how to have better communication on the phone. I also learned a lot of active listening skills."
- "Learning how to be a better active listener through the SBP training has been applicable in many different parts of my life."

- “Personally, I was able to communicate with isolated people that needed assistance.”
- “How to connect with someone that may be socially isolated in a personal way that was meaningful.”

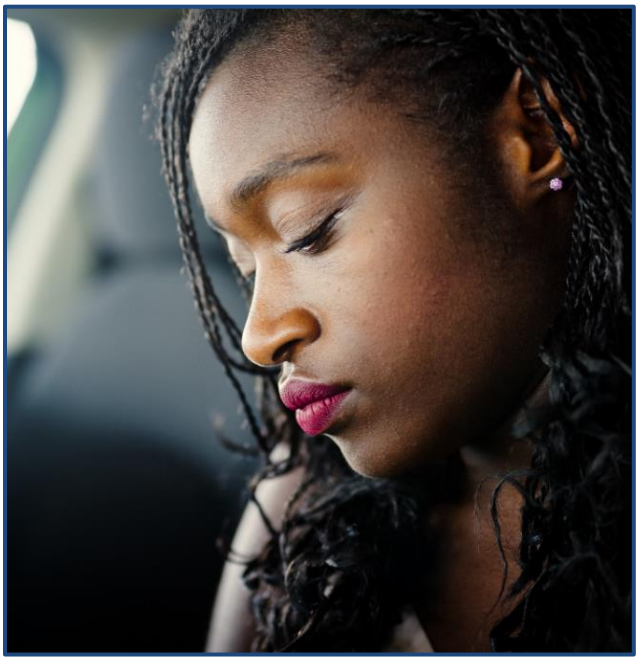
In addition to some other skills, improved communication skills were also a common theme in caller responses to “Is there anything you learned from the project that will be useful in your current job or in the future career path you have chosen?”

- “I have learned active listening skills and how to communicate with older adults better.”
- “I learned how to communicate better and also work with others.”
- “Displaying empathy, active listening, and being more attuned to the roadblocks faced by our aging communities.”
- “I will be able to communicate with people and make them feel comfortable if it’s in person or on the phone.”
- “I think the listening skills and also skills to help individuals find resources in the community will greatly help me.”
- “Being able to identify resources for somebody's specific needs and requests is definitely a valuable skill I appreciate utilizing here.”
- “Patience, patient-friendly language, motivational interviewing, directing conversations in a positive light.”
- “Comfortability of talking with a population of people I normally wouldn’t speak to.”

More research is needed into the efficacy of phone and internet-based intergenerational interventions (vs. those conducted in person) in reducing levels of social isolation, loneliness and ageism and on secondary and higher education students’ interest in pursuing careers devoted to the older adult population. Although our project model was necessarily phone-based due to the pandemic, the simplicity and feasibility of phone-based interventions could increase the likelihood of implementation if further study should confirm their efficacy.

The project had some notable strengths. We were able to recruit students from multiple colleges and universities in the region to serve as wellness callers which provided a diverse group of students with a wide range of academic interests and pursuits. The partnership between NCCHW and MAHEC also facilitated recruitment of older adult participants who may traditionally be excluded from studies. The callers’ commitment to providing phone support with few restrictions on the number of calls or on call duration was likely a strength.

The project also had limitations. Although wellness callers were instructed to complete the Qualtrics survey instrument immediately after each call, recall bias may have affected their responses. Callers' responses to the Qualtrics survey question about participants' primary challenge may have been affected by callers' confirmation bias and subjectivity.



Feedback on program improvement came during weekly huddles and from the caller evaluation survey. Callers frequently expressed frustration during huddles over the number of incomplete/unsuccessful calls and this feedback was also reflected in responses to the caller survey question "What changes would you make to the project?" Other responses related to program improvement focused on project expansion and process-related improvements:

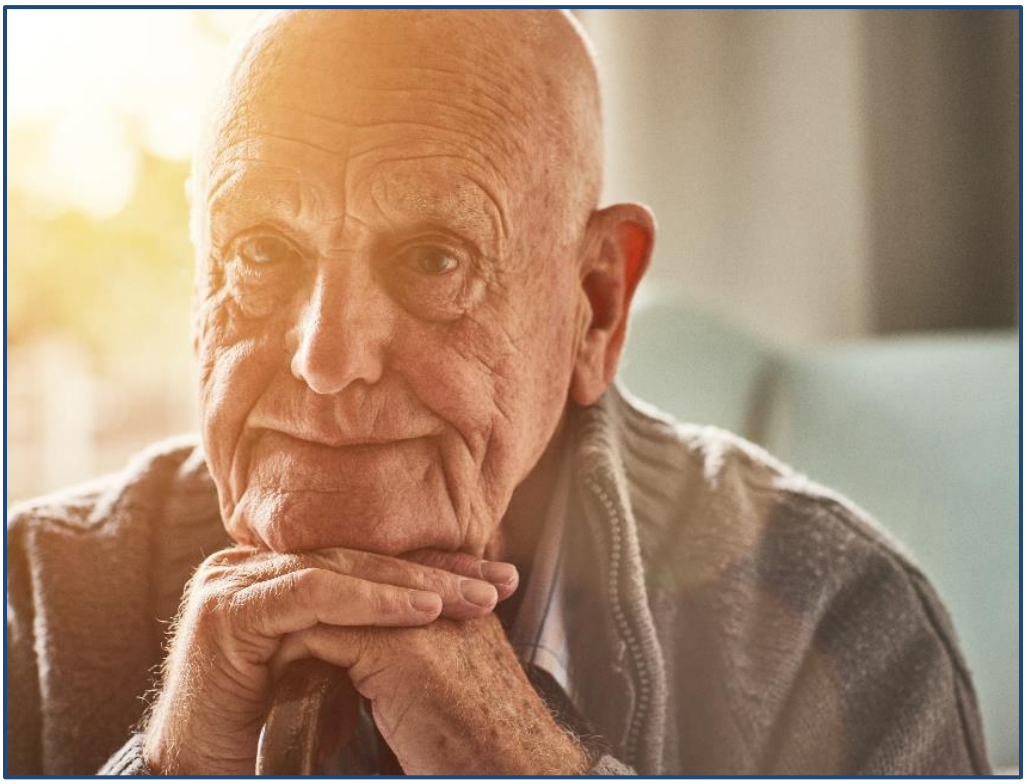
- "Continue building relationships with different organizations in the area to increase the range of what we can provide to participants."
- "Expand phone calls to a larger community rather than sticking with a small number of people."
- "Better communication on passing off individuals [transitioning to a new student caller] and the flow between the different starting caller groups"
- "Better follow-up with participants to ensure a good fit between caller and participant"

We have made some programmatic changes based on callers' feedback. Older adult volunteer callers are being recruited as an option for peer to peer support and we have contracted a licensed clinician to address untreated mental health needs and to support callers and participants as needed. Non-denominational, faith-based volunteers may also be recruited to serve as callers when appropriate and, most importantly, the program has expanded to include adults of any age.

CONCLUSION

Our findings suggest that a phone-based intervention such as the one described may positively impact young adults' views on older adult community members and may increase their interest in pursuing careers focused on work with older adult populations. It may also serve to strengthen young adults' communication skills, particularly their active listening skills.

The reciprocal aspects and symbiotic nature of an intervention of this type may benefit participants and callers alike and programs such as this may also be effective in increasing participants' feelings of connectedness and decreasing their feelings of loneliness. Further research is needed to ascertain the efficacy of similar interventions with young and middle-aged adults who are experiencing social isolation and loneliness. Analyses of peer-to-peer vs. intergenerational programming models in distinct age groups would also be useful in determining which is most appropriate and efficacious for young, middle-aged, older and oldest adult populations. Future studies might also investigate the impact of programs of this type on the wellness caller's knowledge and skills, potential benefits from the reciprocal aspects of the intervention and the potential impact on young adult caller interest in working with older adults.



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