As our population ages, there is an increasing need to develop effective, scalable interventions to support health and well-being among older adults. Scalable health care interventions are those that can be feasibly delivered to large numbers of people affected by adversity, including, for instance, communities with limited economic resources, people who are unable to access needed supports because of inadequate insurance or other barriers, or people confronted with natural or human-made disasters. Strategies to improve intervention scalability might include nonspecialist-delivered or self-help versions of evidence-based interventions, group-based interventions, and peer-support or peer-navigator interventions.1 Efforts to develop scalable interventions have been most prominent in mental health,1 but, among older adults, interventions have also been developed in other areas, such as to increase physical activity.2

There are few well-conducted randomized clinical trials (RCTs) on social support and other scalable interventions among older adults, which limits our ability to draw conclusions about intervention effects or relative advantages and disadvantages of different types of interventions.2,3 An overview of systematic reviews,3 however, found that processes and mechanisms that may facilitate successful implementation include bringing together people with similar experiences or characteristics and enabling participants to interact freely and develop meaningful relationships.

COVID-19 has pushed governments and other institutions that provide health care to seek scalable interventions to address multiple population-based needs, including mental health, and a living systematic review identified trials of 2 such interventions.4 One, a lay-delivered supportive telephone calling intervention, emphasized training of volunteers in empathetic listening and was effective in reducing symptoms of anxiety and depression among homebound older adults enrolled in a Meals on Wheels program in the US. The other, a peer-moderated group-based videoconference intervention, had similar effects among people from 12 countries with the rare autoimmune disease systemic sclerosis. These examples suggest that peer-to-peer interventions may be an effective solution when professional resources are overstretched, as has been the case during the pandemic, but more research is needed.

Schwei and colleagues5 report secondary results from a study they conducted between 2015 and 2017 that assessed peer-to-peer support provided to medically or socioeconomically vulnerable community-based adults aged 65 years and older receiving services from 3 social welfare organizations. Peer-to-peer support involved matching a trained older adult volunteer with a less able peer to provide a range of assistance, including home visits, transportation for shopping or medical appointments, and regular social connection. This was an observational study, and the amount and specific nature of peer-to-peer interactions were not prescribed but were tailored on an individual basis depending on the perceived needs of participants. A total of 456 participants were enrolled in the study, including 222 adults who were receiving peer-to-peer support and 234 adults who received standard community support only. Adults receiving services at study centers were eligible for peer-to-peer support if they were living in the community, were living at or below poverty level or on a fixed income and unable to meet living expenses, were socially isolated, had at least 1 chronic illness, or were frequent users of community organization services. Schwei et al5 enrolled participants receiving peer-to-peer support and participants receiving only standard services; services were not assigned as part of the study. Older adults in 2 centers were ongoing users of peer-to-peer support programming at the time of study initiation, whereas older adults in 1 center were new users at the time of study enrollment. For the study, participants receiving and not receiving
peer-to-peer support were matched at each study site according to age, sex, and race/ethnicity, and analyses were done using propensity scores to attempt to control for confounding.

In their report of primary results from the study,6 the authors found that there was a statistically significantly higher rate of hospitalizations in the peer-to-peer support group (0.68 vs 0.44 hospitalizations per year; risk ratio, 1.54; 95% CI, 1.14-2.07) and no differences in emergency department or usual care visits. In their report of secondary outcomes,5 they found that participants receiving peer-to-peer support had statistically significantly worse anxiety symptoms and that there were no differences between groups in depressive symptoms or mental and physical components of quality of life.

From these results, one might conclude that peer-to-peer programs, including that studied by Schwei and colleagues5 and Jacobs et al,6 should be reconsidered; participants in the program did not appear to have benefited and, in fact, may have had worse outcomes. Such a conclusion, however, could risk abandoning potentially helpful, inexpensive programming without high-quality trial evidence on likely benefit or harms. We typically think about bias in our studies as leading to spuriously positive results and portraying health care interventions in a better light than is merited. Bias, however, is not unidirectional, and it can also lead us to draw unwarranted conclusions about lack of effectiveness.

There are 2 major reasons why we should not be too quick to dismiss peer-to-peer support programs on the basis of the findings reported by Schwei and colleagues.5 First, this was not a randomized trial. Study participants were identified and invited to enroll in peer-to-peer support programs on the basis of characteristics, such as income and social isolation, that would be expected to be associated with the outcomes studied. Because participants were initially enrolled in peer-to-peer support programs outside the study, other perceived risk factors could have also influenced to whom health care practitioners offered peer-to-peer support. Statistical controls were implemented in the study, but such controls cannot always account for imbalances, particularly in difficult or impossible to measure attributes that may be perceived and acted on by health care practitioners. It is possible that naturally, without intervention, people in the peer-to-peer group might have fared worse than those in the standard care group, although it is impossible to know whether this was the case and, if so, how much worse. Second, of participants in the peer-to-peer condition, only 16% were enrolled at the single site that was newly initiating a peer-to-peer program at the time of study enrollment. Most participants were already receiving peer-to-peer support before initiation of the observational study; if there was an initial benefit from peer-to-peer support that was then sustained, this would have been measured as no gain over the course of the study period.

Given the overall evidence base2,3 and recent successful use of lay-led or peer-led interventions during COVID-19,4 there is hope, albeit a great deal of uncertainty, that peer-to-peer interventions may be scalable, effective options to improve quality of life for older adults. Well-conducted RCTs are needed, however. Ideally, primary outcomes in such trials will be patient-important outcomes, related to quality of life. Outcomes that reflect health care service usage, such as hospitalizations or medical visits, are less important to patients. In addition, they are difficult to influence, even for highly targeted, professionally delivered programs. For instance, professional interventions to prevent falls in older adults reduce falls successfully but not hospitalizations, emergency department visits, or outpatient visits.7 Given that peer-to-peer interventions are designed for scalability and to meet unmet needs feasibly, we should not expect this from them either. Consistent evidence from well-conducted RCTs of even small benefits in quality of life would be enough, but trials are needed to establish whether peer-to-peer programs can deliver this.
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