Mini Kahlon, PhD, on making empathetic connections with older adults

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In today’s COVID-19 Update, Mini Kahlon, PhD, vice dean of the Health Ecosystem at Dell Medical School at UT Austin, discusses her research on the effects of empathetic connection with older adults during the pandemic and its surprisingly powerful impact on mental health.

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Speakers

- Mini Kahlon, PhD, vice dean, Health Ecosystem, Dell Medical School, UT Austin

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update. Today, we're talking with Dr. Mini Kahlon, a PhD and vice dean of the Health Ecosystem at Dell Medical School at UT Austin. In honor of May being Older Americans Month, we'll talk with Dr. Kahlon about a study that she led that looked at the effects of empathetic connection in older adults during the pandemic.

She's calling in from Austin, Texas. I'm Todd Unger, AMA's chief experience officer from Chicago. Dr. Kahlon, thanks so much for joining us today. Before we get into the details and results of your study, can you tell us a little bit about what inspired you to look at the impact of empathetic connection in older adults?

Dr. Kahlon: Thank you. And it's great to be here. So when we began really looking at empathetic connection, we were before COVID. We didn't know just how important it would be. We were really
looking at integrating empathetic connection with other elements of nonclinical interventions that might, for example, help to impact diabetes, et cetera.

In fact, we were going to start a program and a trial with our local Meals on Wheels, Meals on Wheels of Central Texas. We were going to start a trial that looked at diabetes. We're going to introduce medically tailored meals and social connection, and some of the empathetic components.

Just about started, and what do you know, COVID hits. We paused. Meals on Wheels had to rethink how they were supporting this community. But because we'd developed this really strong partnership with them, and had really gotten to to understand the folks that they were serving, we realized that, in fact, new and complicated issues were arising because now these folks were not even being seen on a daily basis as they might have been before.

As a result, we sat down together and said, "Well, what can we do to really address the condition of the time?" And the condition of the time was isolation.

**Unger:** Yes. That issue of isolation definitely exacerbated by the pandemic, in addition to complicating what you were going in to study. I mean your idea, from what I understand, grew out of a platform that you're involved with called Factor Health. Can you talk more about that initiative?

**Dr. Kahlon:** Sure. So Factor Health is part of the suite of new kinds of approaches we're all looking at that address the social determinants and the social drivers of health. And our particular part of the puzzle is looking at shorter term interventions, interventions where we are still really addressing individual risk factors. That is not the only problem to be solved, but that's a particular part of the puzzle we look at.

So we're imagining a world where instead of having to go to the doctor to better manage your diabetes, programs come to you in the cadence of your life, which is why we were really interested in, in this case, meals and social connection. But other kinds of programs include education and support for kids off to school, or really changing the curve of chronic kidney disease before it becomes renal failure, before you need dialysis.

And so we have several different programs that we work with, in conjunction with health care payers, in conjunction with community-based providers who have the assets that they can use to actually deliver programs. We identify opportunities, we build programs and then we test them out as rigorously as we can.

**Unger:** Yeah. That model of kind of distributed and digital health care is a definitely a trend and something we've been talking a lot about on the COVID-19 Update. Talk about your study a little bit. Without going into too much detail, can you give kind of the top line of what was involved in the study?
Dr. Kahlon: Sure. So the program itself was very simple and, in some ways, it has to be really simple because COVID-19 forced us to make it simple. Necessity is truly the mother of invention. And I'm really glad in retrospect that we had those pressures because we really have to go down to what are the basic and the simplest things we would need to do to make people feel better.

And so our program was designed to address loneliness, but we also then tested for depression and anxiety. And as we will share in a moment on the results side, we got some of the expected results in loneliness, but in fact, some of the results in depression and anxiety were beyond what we had expected.

So the program was one where we use the telephone, not even video conferencing, right? Because to video conference you'd have to go in and help people set up. So it was the telephone, the most simple technology possible. And then the other, the simplest and most important technology in health is human heart, empathy, connection and really being interested in the person at the other end.

So we found people that were truly interested in connecting with those we were trying to serve and we used really basic technology. We put it together with some thought which we could talk about it in a moment, and we deployed it over four weeks. Before and after we tested for loneliness, depression, anxiety and mental health. And we also use a randomized control trial structure, so we were actually able to compare against control.

Unger: And you had just shy about 250 older adults participating in this?

Dr. Kahlon: That's right. We had about 240 adults. Actually a third of them were below 65. Two-thirds above 65. And we actually didn't find any differences in our results on age, at least in the way we set it up right now.

Unger: Yeah. And then in terms of how often they were called, how did you determine that?

Dr. Kahlon: Great question. So the standard approach to these kinds of programs is you decide frequency. You decide all the elements that go into a program that you deliver to people. But of course, when we think about health outside the clinic, we realized that one of the most important pieces is agency, right? People feeling like they are in control of their own lives. And so we used that principle as we designed the program that we were delivering.

So in this case, we asked people what time they wanted to be called, and as much as possible we really tried to stick with their preference on time. When we began, we began the first week with five calls, so a daily call on every weekday. But at the end of that, we asked people, we said, "Well, you've now experienced a call every day. Do you want to continue with that pace or would you like fewer calls? Is that one too many?"
And we found that about half actually chose fewer calls, half chose the number of calls they'd received. But we thought that the most important part was that they got to choose. And even if they were saying, "Yes, I want to stick with five calls a week," they were choosing. They were deciding that.

**Unger:** I love that. Obviously different people need different levels of human contact. But what you point out there, the main ingredient is the heart and listening. Will you talk about ... you're using the simplest possible kind of communication outreach, which is the phone. What are the kind of specific guidelines that encompassed the conversations that you were having with folks?

**Dr. Kahlon:** So, we made sure that we had the first five days, there were calls. We had quality control in terms of making sure people were able to place the calls and did so at the frequency that that people requested.

And we had a little bit of training upfront. So the training we provided was net about two hours. It was one hour of a session the callers had with us. The callers were between 17- and 23-years-old. And then there was about, we estimate, maximum an extra hour, just to learn the logistics of using ... we had a Redcap system we were using when people were calling, et cetera. So not more than that.

But the main, training is probably not the right word. What I'd call it is more orientation. And the biggest orientation we gave folks who were calling was that the most important part of this whole program was to prioritize the person at the other end of the call. That was it. That was the most important thing, is that person that you are calling is the most important person in the world. And as part of that, the way they would know that they were successful is if by the end of the four weeks, they, the caller, had learned about the other person. If they understood who is this person, what are their likes and dislikes? What do they like to talking about? What's important to them?

And that orientation we've learned from focus groups, subsequent focus groups with our callers. That was really important because they realized that the key really was listening to the person at the other end. It wasn't anything fancy about how they spoke. And that ended up really being important, we believe, in the quality of the calls.

Now, then we did help them with some tips and tricks around how you draw someone out. That's not easy. The first time you call someone may want to talk to you, but they might not immediately have the words. And so there we use an approach where my colleague Steven Tomlinson suggested an approach where really you listen for clues. And so we did a little bit of a skit, a little bit of a role play, to show what it means to listen to the clues that someone else is providing in their conversation and then to pull on those clues and in that way draw them out into conversation.

**Unger:** I imagine that kind of orientation might be a good, powerful orientation for a lot of us out there, not just related to your study. But what I'm really interested to find out is then, after you've had these conversations, what did you find with this study?
Dr. Kahlon: Yeah. So as I said, we looked at loneliness. We used some standard scales and we definitely found a large and significant impact on loneliness, pre and post, in four weeks. But we also studied depression and anxiety. So we used the PHQ, a standard tool, to measure the symptoms of depression and GAD to measure the symptoms of anxiety. These are tools that are understood by practitioners, by health care payers, et cetera.

And to our surprise, we found a significant and meaningful impact on depression and anxiety. Now that's all the more remarkable because if you look at loneliness and you looked at sort of where our folks was starting. Take the UCLA scale that we use. That scale goes from three to nine. And anyone who has a score of six or above is considered lonely. On average, our population that we were serving were lonely, right? On average, they were a little bit above six.

On the other hand, when you look at depression and anxiety, we didn't select for depression and anxiety. So you had depression for example, ranging. The PHQ goes from zero all the way to the high twenties. High twenties are, of course, when you got serious depression. But anything 10 and above is considered moderate depression, and then you get to some more serious depression. But we had a lot of people below 10. Five to 10 is mild. We had people that had mild depression, but we had a lot of people below five that would not be considered depressed at all.

So, when you got such a large range and yet you see a meaningful and significant decrease in depression scores, that means that there was something really important happening. And in fact, we didn't publish this because we hadn't designed our study to really look at people only with higher depression scores. But when we did some extra analysis and we looked at people that had depression scores 10 and above, we found the decreases in depression scores were even greater for those. So that's very promising for future work.

Unger: You know, this is like a dream come true for the people that invented those words, "Reach out and touch someone," because it's amazing the impact of what that kind of human connection can be. And just how scalable something like this could be to improve people's lives on the other end. Do you want to talk about what the other big takeaways are for the medical community?

Dr. Kahlon: Sure, sure. I mean, I think there are several places that this can go and we're looking at it ourselves. We also invite anyone interested in collaborating to reach out to us. Our website is sunshinecalls.org. That should be easy to remember. We also have tips and tools by the way, the tool kit that explains what we think, what are the reasons why the program works. So, tips on training. As soon as folks contact us, we can share that with them.

So I think the implications are several. So firstly, there are a lot of amazing programs across the world globally, where people are placing phone calls for connection. In countries like the U.K., interventions for loneliness have been really prominent. They have a Ministry of Loneliness. In fact, Japan started one recently as well. And so in those communities, this work is already happening.
And at the very least, I really hope these results show that you’re making an impact. Now I can’t guarantee it’s exactly the impact that we got, but it should be helpful. I think on a personal level, it's impacted me and I hope it encourages every person who’s talked twice about calling their parents or their older family members. Go ahead and do it, because you’re really making a difference on very specific scales that your doctor would say, "Wow, you did better than me even." So go ahead and do it.

On the health care side though, there is huge potential. There are two ways we look at this. One is really to deploy and further test these programs, but now for people with clinical depression, with anxiety, and perhaps really focusing on older adults who are most vulnerable and at risk. We believe that that really has huge potential to become integrated into and become part of health programs that are eventually paid for by health care. Health care payers will benefit from these. As depression and anxiety improves, a lot of things improve. So down the road, once proven we hope health care payers would pay for that.

And then the other places where it’s really helpful is in integration with other chronic disease initiatives. So as you recall, we’d begun by thinking about how do you tie sort of empathetic listening together with, say, diabetes self-management. And now that we have these results and we know that empathetic listening can actually really better manage depression, we’re now moving on to starting to test whether such programs using these empathetic phone calls can actually help with people that have both depression and diabetes, for example, or depression and hypertension. And so we believe there’s a lot of potential there because then the value we generate could even greater, and thus make it even more attractive for, in the end, the health care system to pay for and support such programs.

**Unger:** Yeah, it really is amazing to think about something that is so simple and relatively low tech, and so scalable could make such a huge difference. You kind of took the words right out of my mouth. I'm going to finish up our discussion and get on the phone and call my mom and some of my friends, because that kind of connection appears to be great medicine. So thank you so much for being here today and sharing this important information.

**Dr. Kahlon:** Thank you so much, Todd.

**Unger:** I really look forward to seeing results of your further studies on this topic. That's it for today's COVID-19 Update. We'll be back with another segment tomorrow. For more resources on COVID-19, visit ama-assn.org/COVID-19. Thanks for joining us. Please take care.

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