The Consumer Viewpoint: Will They Use IT?

National Medicare Readmissions Summit
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AN ADMISSION AVERTED STORY

"During Mrs. J's second week home from her most recent hospitalization, her nurse noted a 6.6 lb. weight gain, with increased shortness of breath reported. Upon calling Mrs. J, the nurse found her confused…"

THE STORY OF MRS. J
CONGESTIVE HEART FAILURE PATIENT

Overview

- **It's no secret that care delivery in our health care system is already highly fragmented, with many patients receiving care from multiple providers. Study after study has found that we can contain health care costs through better management of chronic disease.**

- **More than 80% of current Medicare beneficiaries have at least one chronic medical illness and one in four have five or more chronic conditions – this latter group accounts to two-thirds of all Medicare spending.**

- **Patients with chronic illnesses routinely see multiple physicians who prescribe different and sometimes incompatible treatments and the current fee for services Medicare system does not encourage or support effective coordination of services across different providers or settings of care.**

- **Health insurance products for the aging population must address not only the growing number of chronic illnesses faced by older adults but also the tremendous challenges of coordinating the fragmented care across different providers and settings of care.**

Program Details

- **The Heart Failure Health Management and Diabetes Health Management programs provide eligible members with resources and tools to reduce the risks of coronary artery disease, congestive heart failure, and diabetes progression.**

- **Included in the Heart Failure Health Management program is home monitoring technology, patient-empowering education and the nurse-patient relationship to improve treatment plan compliance, increase patient awareness of their illness and reduce avoidable hospitalizations. Furthermore, eligible members with multiple conditions also have access to a High Risk Case Management program that provides individualized care plans and professional case workers to coordinate their treatment.**

- **All the pilot programs integrate behavioral and mental health services through depression management and will include medication compliance monitoring at the end of June. Depression screenings are be performed by trained professionals and prescription drug compliance is be monitored and managed. To ensure a holistic approach, important social services are available to members. Credentialed social workers assist members with services such as facilitating in home assessments, coordinating meals and social activities, and identifying transportation options.**

Health Care Management Pilot Programs

> **Recognizing that an individualized, holistic approach to health care delivery is essential to health care transformation, UnitedHealth Group - in collaboration with ASI - launched a series of care management pilot programs on December 1, 2008 for AARP members insured in the *AARP Medicare Supplement Plan* in Central North Carolina, Cleveland, Los Angeles, New York City, and Tampa. This program is provided at no additional cost to AARP members.**

Health Care Management Pilot Programs

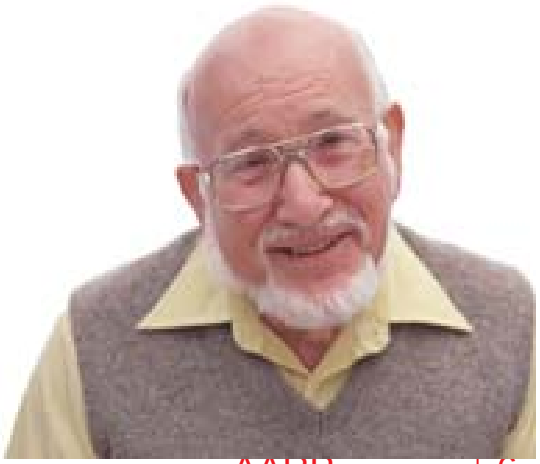
- **Heart Disease**
- **Diabetes**
- **High Risk Cases**

AARP Heath Care Management Pilot Program Update

Member Testimonials

"I will sleep better tonight after having spoken to you."

"This is great that AARP is doing a program like this for us."



The average age of participants in the Health Care Management pilot Programs is 79.29

Enrollment Numbers (5.20.09)

- **Coronary Artery Disease: 625 enrollees**
- **Diabetes Program: 607 enrollees**
- **High Risk Case Management Program: 1,275 enrollees**
- **Congestive Heart Failure: 582 enrollees**
- **Depression Only: 7 enrollees**

Total Enrollment: 3,096

By Market (5.20.09)

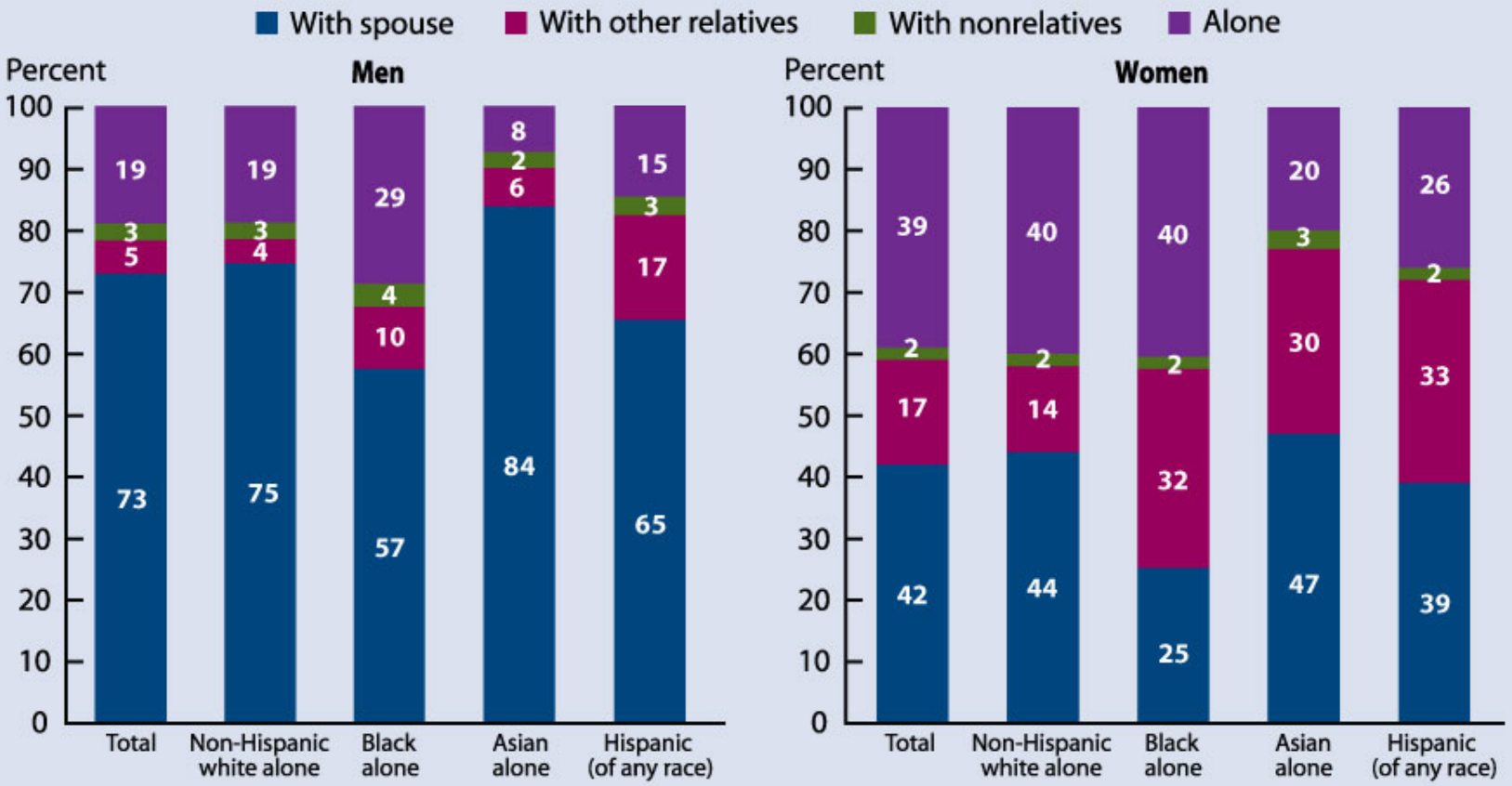
- **New York City: 940 enrollees**
- **Cleveland: 546 enrollees**
- **North Carolina: 772 enrollees**
- **Los Angeles: 401 enrollees**
- **Tampa: 437 enrollees**

EARLY OBSERVATIONS

From AARP/UHG Pilot Programs

- Average age of eligibility: 80
- Average age of enrollment – telephonic monitoring: 78
- Average age of enrollment – home assessment monitoring: 83
- Multiple needs: behavioral, social services, etc.
- Physical limitations

Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2007

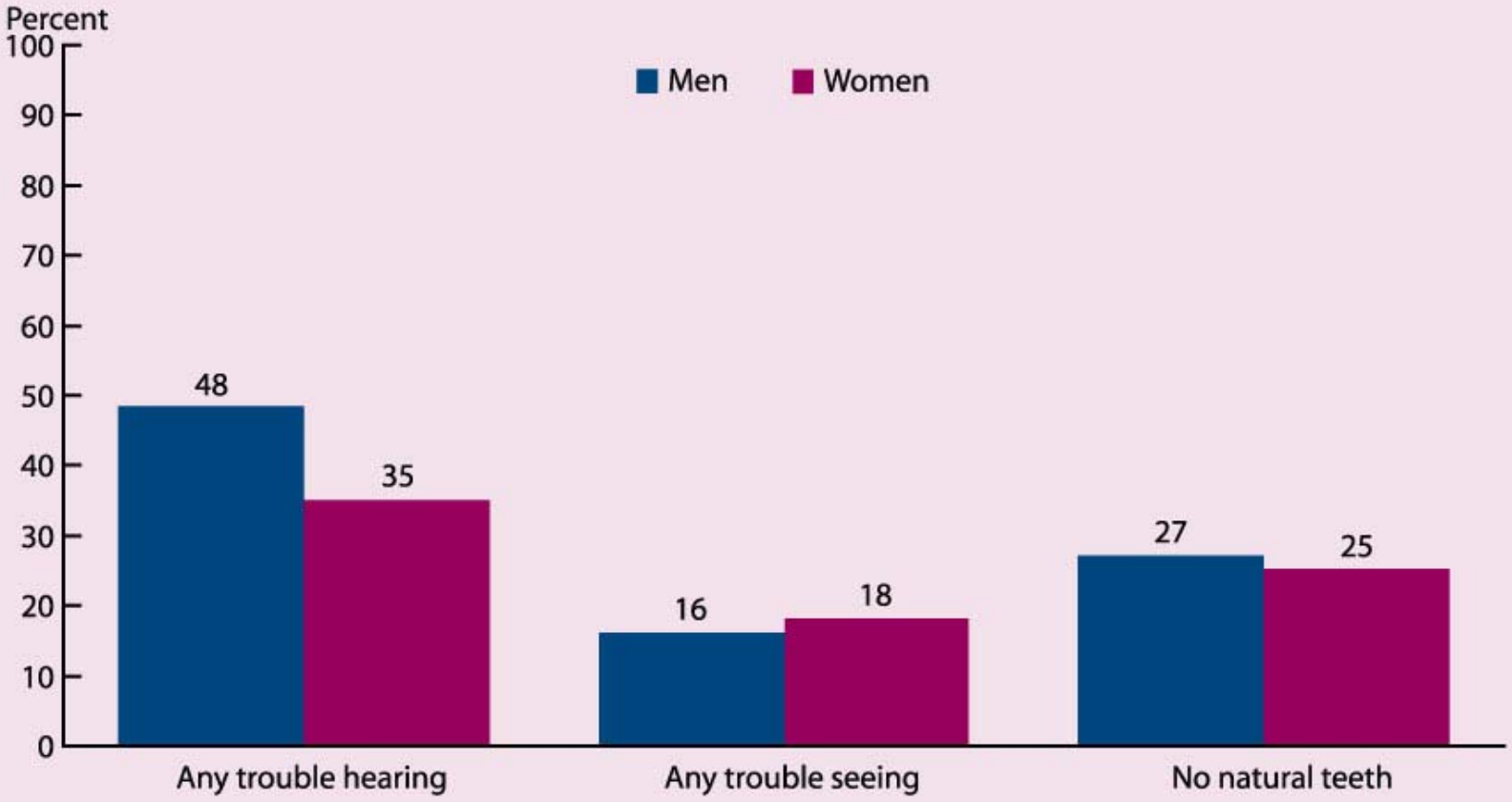


Note: Living with other relatives indicates no spouse present. Living with nonrelatives indicates no spouse or other relatives present. The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Percentage of people age 65 and over who reported having any trouble hearing, any trouble seeing, or no natural teeth, by sex, 2006



Note: Respondents were asked "Which statement best describes your hearing without a hearing aid: good, a little trouble, a lot of trouble, deaf?" For the purposes of this indicator the category "Any trouble hearing" includes "a little trouble, a lot of trouble, and deaf." Regarding their vision, respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" The category "Any trouble seeing" also includes those who in a subsequent question report themselves as blind. Lastly, respondents were asked, in one question, "Have you lost all of your upper and lower natural (permanent) teeth?"

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

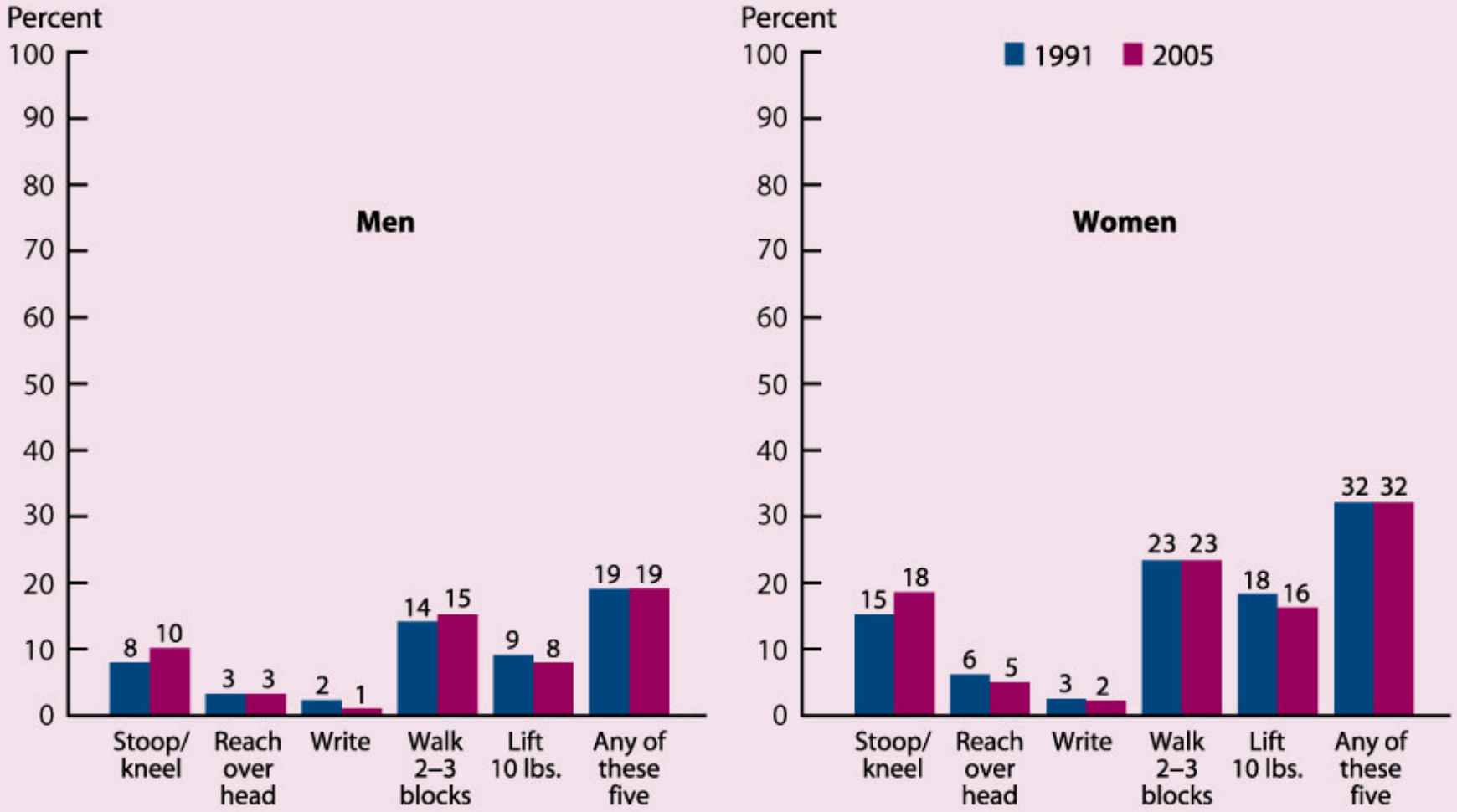
Percentage of Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a facility, selected years 1992–2005

Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of functional limitations (previously called disability) has changed from previous editions of *Older Americans*. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. IADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Rates are age adjusted using the 2000 standard population. Data for 1992 and 2001 do not sum to the totals because of rounding.

Reference: These data refer to Medicare enrollees.

Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2005



Note: Rates for 1991 are age adjusted to the 2005 population.
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

WHO IS THE READMISSIONS POPULATION?

An Emerging Profile?

- 80+, frail and multiple needs
- 80+: an exploding population – 19.5 million by 2030
- Centenarians: 834,000 by 2050
- “Over the hill?”

HEALTH CARE 2.0

Program design with the consumer as partner

- Medicare reform through program design
- Improving communication through health IT

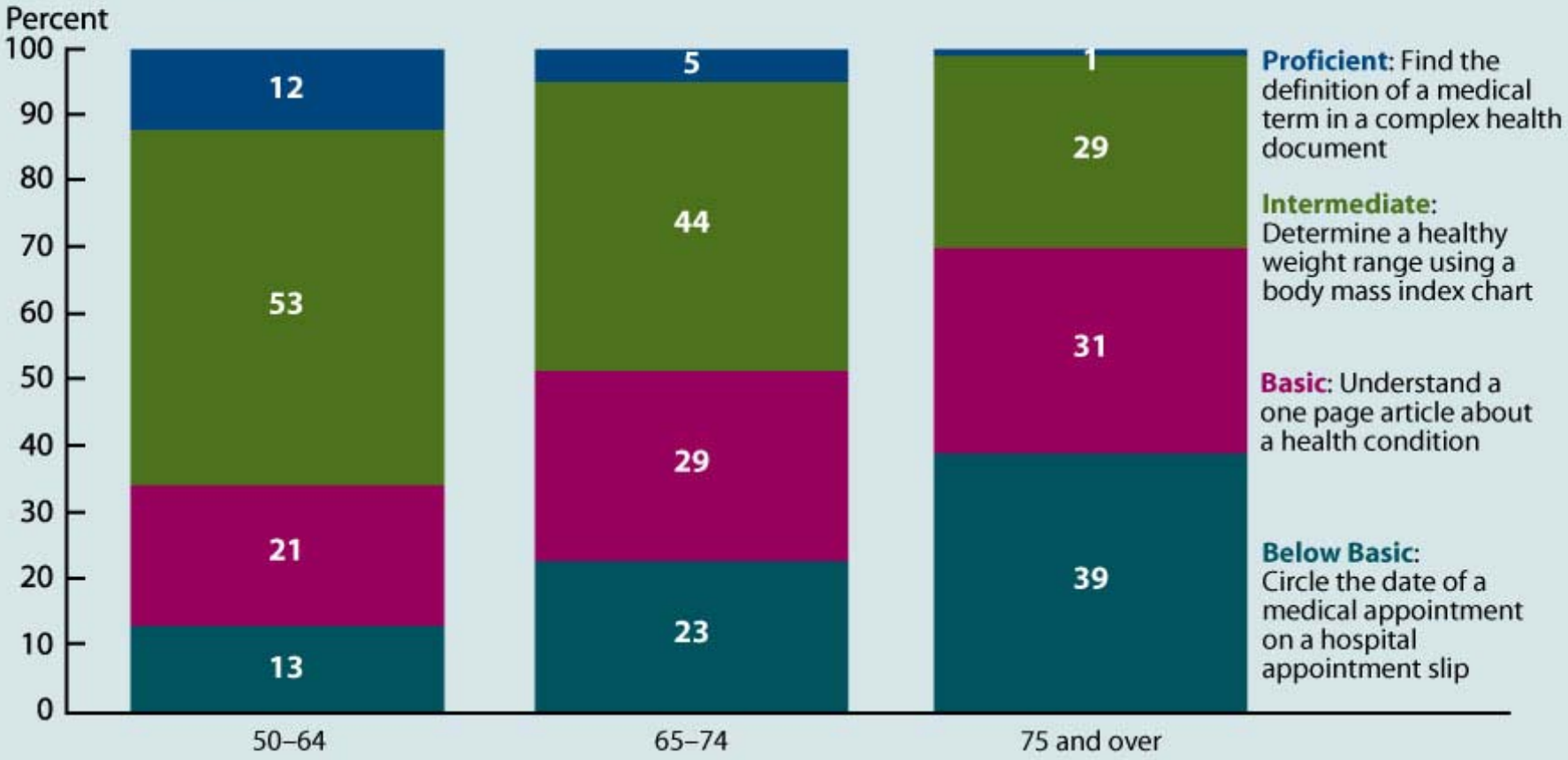
  - 74% of 50+ AARP members use technology to stay connected with family

  - 72% are comfortable using new technology devices

  - 54% like constant connection to others through cell phones, e-mail, etc

  - But 46% not likely to enroll in PHR

Percentage of people age 50 and over in each health literacy performance level, by age group, 2003



Note: Health literacy is the ability to locate and understand health-related information and services and requires skills represented in the three general components defined on the previous page—prose, document, and quantitative literacy. Tasks used to measure health literacy were organized around three domains of health and health care information and services—clinical, prevention, and navigation of the health care system—and mapped to the performance levels (proficient, intermediate, basic, and below basic) based on their level of difficulty.

Reference population: These data refer to people residing in households or prisons.

Source: U.S. Department of Education, National Center for Education Statistics, National Assessment of Adult Literacy.

COMMUNICATIONS

The role of IT

- Communication is vital element in transitional care
- 20% older adults' health suffered due to poor communication
- 60% of caregivers report being able to fill out medical forms by themselves
- 68% of caregivers understand and follow doctors instructions

RISING IT APTITUDE

An openness to new technology offers hope

- More 50+ women on Facebook
- More 50+ people with broadband access
- More 65+ users of health IT
- An interest in electronic health records
- Cautionary note: complexity of information to be tracked

GETTING CARE AT 65+

Differentiating how to involve people in care

- Over half of Medicare admissions through ED
- Chronic conditions via ED v. procedural cases not via ED
- Among 65+, one size does not fit all
    - 26% of 65+ “Lead the Way”
    - 27% of 65+ “I Need a Plan”

ONE MORE STORY

" Mr. A had 4 hospitalizations in the past year, developed a 'chest cold' but refused to see a doctor……"

THE STORY OF MR. A
EMPHYSEMA PATIENT

SUMMARY

- Successful programs: the consumer, behavioral incentives, support
- Know patient's limitations and technological competency
- Know patient's personality and behavior drivers
- Know patient's resources
- Design products and programs with consumer and family in mind