Technologies to Help Older Adults Maintain Independence:
Advancing Technology Adoption

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Briefing Paper
# Technologies to Help Older Adults Maintain Independence: Advancing Technology Adoption

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Introduction

Americans are living longer. And despite the health challenges of longevity, a majority of older adults hope to remain in their homes as long as possible. Fortunately, many technologies have the potential to help older adults maintain their independence and health. Technology is an enabler in creating systems of health and long-term care that are more integrated and reliable, and that address the needs of older adults in a more efficient and effective way. If these technologies could also mitigate the workforce shortages and financial burdens that are inherent to long-term care today, both older adults and society at large will benefit.

Supported by a grant from The SCAN Foundation, the Center for Technology and Aging was established to advance the diffusion of technologies that help older adults lead healthier lives and maintain independence. The Center will identify promising technologies and adoption strategies, and provide grant funding to test these strategies. In collaboration with grantees and key stakeholders, the Center will identify and disseminate best practices and lessons learned from grantmaking initiatives. The Center will promote further adoption of successful technologies and serve as a state and national resource for those involved in this arena.

The SCAN Foundation is dedicated to finding innovative solutions to the health and long-term care needs of older adults in California and throughout the nation. The Foundation’s vision is a society where older adults receive medical treatment and human services that are integrated in the setting most appropriate to their needs and have the greatest likelihood of creating a healthy, independent life. Technology is an enabler in creating systems of health and long-term care that are more integrated and reliable, and that address the needs of older adults in a more efficient and effective way.

This paper is intended to inform potential grant applicants and other key stakeholders, including older adults, health and social service practitioners, technology vendors, payers, policy makers/regulators, and The SCAN Foundation about technologies that are ready to be quickly taken to scale. Drawing from the array of existing telemonitoring, telehealth, assistive, and communication technologies that are used in the management of chronic disease, we identify specific technology domains that have proven benefits and have significant potential for diffusion. We further identify those technologies that offer the greatest opportunity to accelerate the pace of diffusion; have the support of a long-term, sustainable business model; and have the greatest likelihood of alignment with public and private policies designed to improve outcomes and reduce spending. As the Administration starts on the path toward health reform, the need to improve the delivery of care for older adults in home and community settings will be unavoidable. The broad diffusion of transformative technologies offers a significant means to advance the effort of improving quality and reducing cost of care.
Executive Summary

Technologies that extend the ability to provide care for persons with chronic illness have been increasingly successful in improving the well-being and independence of older adults, the segment of our population that has the greatest demand for health and long-term care services. These technologies offer a means of reducing the burden of chronic care for patients, families, and the health care system as a whole, while improving older adults’ safety, health/well-being, and social interaction. However, for these technologies to realize their potential to improve the efficiency of health care delivery, reduce the costs of health care, improve health care outcomes, and most importantly, maximize the independence and quality of life of older adults, these technologies must be rapidly expanded to scale in home and community-based care settings.

The mission of the Center for Technology and Aging is to identify and promote successful strategies that accelerate the adoption and diffusion of technologies that improve the ability of older adults to remain in the community. This paper discusses technologies that have the greatest likelihood of successful diffusion and will offer a significant opportunity to reduce the burden of chronic care for older adults, their families, and the health care system. It further identifies the Center’s current list of candidate technologies that will be targeted for near-term diffusion grants that promote broader adoption of technology. It addresses the current state of these technologies as well as the opportunities for and barriers to widespread adoption.

Technology Focus Areas

Technologies that assist in the care of chronic conditions and improve the independence of older adults can cover a very wide spectrum, including communication, assistive, telemonitoring, telehealth and other technology-enabled services. Based on an extensive literature review, expert interviews and data drawn from expert panels, seven technology domains were identified as high priority candidates for rapid diffusion. This process included an assessment of the experience of early adopters and the viability of each technology. After review of the seven areas of technology, two priority areas for the Center for Technology and Aging grantmaking have been identified: medication optimization and remote patient monitoring.

These two technology areas are well balanced in terms of offering high value to stakeholders and surmountable barriers to adoption and diffusion. In addition to alignment with the mission of the Center, each of these two technology areas offers evidence that there are clear benefits to as well as a high degree of acceptability for older adults. Both technologies offer immediate relevancy given the health reform debate and specific opportunities to inform national and/or state policymakers. These technologies also complement the interests and capabilities of potential grantees and should be able to support sustainable diffusion strategies. Finally, and of highest priority, each of these technology areas can lead to significant cost savings for the health and long-term care system.
Executive Summary

These two technology domains are defined as follows:

1) **Medication Optimization** refers to a wide variety of technologies designed to help manage medication information, dispensing, adherence, and tracking. Technologies range from the more complex, fully integrated devices that use information and communication technologies to inform and remind stakeholders at multiple decision and action points throughout the patient care process to the simpler, standalone devices with more limited functionality.

2) **Remote Patient Monitoring (RPM)** includes a wide variety of technologies designed to manage and monitor a range of health conditions. Point-of-care (e.g., home) monitoring devices, such as weight scales, glucometers, and blood pressure monitors, may stand alone to collect and report health data, or they may become part of a fully integrated health data collection, analysis, and reporting system that communicates to multiple nodes of the health system and provides alerts when health conditions decline.

The next three technology domains will continue to be reviewed closely for opportunities to test models of diffusion, but are not ready for immediate grantmaking.

3) **Assistive Technologies** include a wide range of devices and equipment that help individuals perform a task or prevent injury. Assistive technologies promote independence as they compensate for sensory, physical, and cognitive impairments, and promote safety for vulnerable individuals as they detect and report health hazards. Non-computer-based assistive technologies include items such as wheelchairs, grab bars, Braille, and a more accessible home environment. Examples of computer-based technologies include voice recognition software, and monitoring and alert systems that detect and report environmental hazards or personal crises.

4) **Remote Training and Supervision (RTS)** technologies can be used to train and supervise health and long-term care workers, and offer the potential for continuing education and quality assurance. Remote training means the student does not have to be physically located where the teaching is taking place – teaching and learning can be asynchronous or synchronous in time. Access to training is gained through technologies such as the Internet, interactive videoconferencing, and satellite. Examples of remote training include a distance learning course, a simulation exercise, and a video-guided practicum. RTS technologies are also useful in the ongoing supervision of workers, particularly low-skill workers, and for on-demand consultation with more experienced supervisors or instructors. In many cases, these or similar approaches may also be used to train and support informal caregivers, i.e., family members.

5) **Disease Management (DM)** is a patient-centric, coordinated care process for patients with specific health conditions, particularly chronic conditions and conditions that have a significant self-care component. DM programs include data mining processes to identify high risk patients within a population, use of evidence-based medical practice guidelines to support and treat individual patients, and a coordinated, data-informed system of patient outreach, feedback, and response.
The final two areas, as newly emerging technologies, offer limited opportunity for rapid diffusion, but will continue to be tracked over time.

6) **Cognitive Fitness and Assessment**

Technologies include thinking games and cognitive challenge regimens. Like physical fitness, the premise of cognitive fitness is that cognitive health can be maintained or improved if individuals exercise their brain. The emphasis with older adults is to prevent or delay Alzheimer’s and related dementias. Many cognitive fitness technologies are computer or Internet based, and include an assessment and tracking component.

7) **Social Networking**

Technologies enable the creation of social networks and focus on building communities of interest that help older adults communicate, organize, and share with other older adults and with their care providers. These are already gaining traction among older adults, and could be important both for the functions just described and for peer counseling and education that would complement the Remote Training and Supervision technologies described previously.

**Next Steps**

Prior to the initial round of grantmaking the priority technology areas will undergo further review with stakeholders who are engaged in the provision of aging technology services as well as with individuals with expertise in program diffusion. Technical experts in each respective technology area, including policymakers, regulators and funders, will be consulted to identify opportunities and barriers to diffusion. Finally, a field review will be conducted with health and social service organizations who are currently using the targeted technologies and who are potential large-scale adopters.

As health care delivery and long-term care evolve, evidence will continue to emerge regarding the viability of new technologies and their contribution to the health and well-being of older adults. This paper forms the framework for reviewing existing technologies as well as assessing emerging technologies in terms of their likely potential for rapid diffusion. Not only do beneficial technologies offer significant potential for assisting older adults in maintaining their independence, they provide a very promising method for helping address some of the challenges currently facing the US health care system. For if the rate and scale of technology adoption can be increased, even modestly, it offers considerable potential for reducing the ever escalating personal and societal costs of chronic illness among older adults.
Background

The United States has experienced considerable gains in life expectancy in the past century thanks to a combination of medical and social innovations. However, our ever-growing, chronically ill, and aging population increases the public health challenges of curbing health and long-term care costs and minimizing the burden of disease and disability. Some of the demographic, epidemiological, workforce, and economic factors that underlie this challenge will now be described.

Demographics

In 2005, the average human life expectancy in the United States was 77.8 years, with life expectancy for women five years longer than for men. The US Census Bureau estimates that life expectancy will increase by approximately six years by 2050. The population of Americans aged 65 and older will double during the next 25 years and account for roughly 20% of the total population. America’s older adult population is also becoming more racially and ethnically diverse.

Epidemiology

The US Centers for Disease Control and Prevention estimates that approximately 80% of older Americans have at least one chronic condition and 50% have at least two. A relatively few risk factors — smoking, poor diet, and physical inactivity — underlie the development of the majority of the nation’s chronic disease burden (heart disease, cancer, stroke, and diabetes). The growing burden of chronic health issues among older adults correlates strongly with the likelihood of functional decline as the population ages. This burden is not shared evenly among the nation’s population segments, as there is significant variation among racial, ethnic, and geographic subpopulations.

Prevalence Of Chronic Conditions Among Adults Aged 65 Years Or Older Varied By Race/Ethnicity In 2002-2003


Economics

US health care spending as a percentage of gross domestic product (GDP) is almost twice the average of spending in other developed countries. The US Congressional Budget Office (CBO) estimates that the US share of GDP on health care spending is likely to rise from 16% of GDP in 2007 to 25% in 2025. According to the CBO, the rise in cost will result from rising costs per beneficiary (which will continue to grow more quickly than per capita GDP) rather than rising numbers of beneficiaries.

The US Centers for Disease Control and Prevention reports that the cost of providing health care for an older American is three to five times greater than the cost for someone younger than 65.

Two-thirds of US health care spending is attributable to chronic illness treatment. This compares to 95% of health care expenditures among older Americans. Per person personal health care spending for the 65 and older population was $14,797 in 2004, 5.6 times higher than spending per child ($2,650) and 3.3 times spending per working-age person ($4,511).

By 2030, the nation’s health care spending is projected to increase by 25% due to epidemiologic and demographic shifts. The health system is in urgent need of new tools that bring about systemic change and help slow down the rate of cost increases and the rate of spending growth.
Background

Workforce

In the next decade, home- and community-based long-term care providers will face a shortage of direct care workers (nurse aides, home health aides, home care aides, personal aides, and paraprofessional caregivers). The number of women aged 25 to 54 (the traditional source for direct care workers) will increase by only 1%, while overall demand for direct-care workers is projected to increase by 34%.6

Compounding the problem of workforce shortages, high-stress, low pay, and poor benefits make it difficult to attract and retain large numbers of these workers once employed.

Conclusion

Many technologies have the potential to simultaneously help older adults remain in their homes as long as possible and mitigate the workforce shortages and financial burdens that are inherent to long-term care. The drivers identified above are all compelling reasons to consider technology solutions that will improve the health and long-term care system for older adults.

Source: Retooling for an Aging America: Building the Health Care Workforce, IOM

Source: http://www.directcareclearinghouse.org/download/BLSfactSheet4-10-08.pdf
Seven technology focus areas will be described in the following pages. As can be seen, these offer numerous opportunities for the Center’s grantmaking program. However, the initial round of diffusion grants will be focused in two areas: medication optimization (MedOp) technologies, and remote patient monitoring (RPM) technologies. While the Center will continue to build its knowledge and experience base in all focus areas, a focus on two initial priority areas will support a more cohesive evaluation of results, and a more effective means to share the lessons learned.

The Center’s initial prioritization of MedOp and RPM technologies was based on a comparative assessment using the following criteria.7

1) Population Applicability: The degree to which the technology is beneficial to a significant population of older adults who are at-risk for moving to a higher level of care, or the technology is instrumental in enabling people with high-burden disabilities and chronic illnesses to better self-manage their health conditions and prevent injuries and complications.

2) Health Outcomes: The degree to which credible outcome studies demonstrate that use of the technology significantly improves or maintains patient health.

3) Economic Outcomes: The degree to which credible health economic studies demonstrate that technology use reduces or has the potential to reduce the overall costs of care.

4) Workforce Relief: The degree to which use of the technology mitigates home care and health care workforce shortages.

5) Technology Viability: The degree to which the technology is ready for adoption and diffusion—either in theory or practice. In practice, a credible organization (e.g., the VA) may demonstrate and endorse the technology’s viability. In theory, technologies will diffuse more rapidly within a social system if they have certain characteristics.8 Viable technologies are often designed so they are:

- Compatible with legacy knowledge, attitudes and practices (KAP). This assumes that the technology design or user interface requires or elicits a reaction from stakeholders. A compatible technology will resonate with legacy KAP and be adopted and diffused more quickly. Adoption and diffusion of an incompatible technology will stall because it is at odds with entrenched KAPs, e.g., adoption of the technology requires a change in an organization’s business model or a change in stakeholder roles and self-perceptions.

- Trialable, meaning the technology can be used on a limited basis. In other words, the technology is amenable to “test driving.” A technology that is not trialable will require a commitment from stakeholders before they may be comfortable with that commitment.

- Observable/Communicable, meaning the benefits of using the technology can be easily seen, understood, and communicated. Benefits are difficult to see if technologies are bundled along with other complex technologies, or when the benefits have to be taken on “faith.” Note that high-visibility role models, such as the VA, are important in demonstrating technology benefits.

- Usable, meaning the technology can be easily installed, used, and maintained by stakeholders and end-users.
6) **Stakeholder Readiness:** The degree to which the people and systems are ready to adopt and diffuse the technology in a reasonable time frame (i.e., introduction and expanded use of technology within one year). Note that technologies can be designed to meet the needs of stakeholders (“technology viability”) or stakeholders can change or transform to accommodate the technology.

7) **Policy Relevance:** The degree to which use of the technology aligns with current/emerging policies, or further diffusion of the technology could inspire positive change to health and long-term care system policies.

**Focus Technologies in Context**

The Institute of Medicine has called for fundamental reform in the way that care is delivered to older adults. Current models of care often fail to deliver adequate and efficient care to older adults. A transformation in care processes is needed, according to the IOM, in order to better address the needs of the growing population of older adults in a workforce- and cost-constrained health and long-term care environment. The IOM believes that innovative models of care, and the use of transformative technologies to implement such care models, are urgently needed.

Developed by Edward Wagner in collaboration with the Robert Wood Johnson Foundation, the Chronic Care Model (CCM) is particularly useful as a guide to the care of older adults with multiple chronic illnesses. The CCM conceptualizes an integrated, coordinated, and productive system of care at the community, organization, practice, and patient level. This care involves self-management, delivery system redesign, and clinical information systems.

Technology is widely recognized as an enabler of the CCM model. As depicted above, each of the Center’s technology focus areas supports one or more care processes within the CCM.

Technologies described in the following pages better enable self-management support, delivery system redesign, and decision support. Clinical information systems collect data and track numerous steps in the process.
Overview

Medication optimization refers to a wide variety of technologies designed to help manage medication information, dispensing, adherence and tracking. Medication optimization technologies are particularly applicable for the elderly, caregivers, and people with chronic illness or complicated medication regimens.¹⁰

Technologies described in this section tend to help individual patients take their medications according to clinician instruction. Although not mentioned here, medication optimization technologies could also include technologies that help physicians, pharmacists, and other professionals better carry out their responsibility to provide the right medications, in the right dose, to the right patient.

<table>
<thead>
<tr>
<th>Technology</th>
<th>Medication Optimization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>Chronic disease and medication management</td>
</tr>
<tr>
<td>Comparison Technology</td>
<td>Patient and caregiver reminders</td>
</tr>
<tr>
<td>Vendors</td>
<td>Many; some examples include Pillbox Pager, EMMA™, Med-e-Monitor™, Health Hero® Network</td>
</tr>
<tr>
<td>Drivers</td>
<td>Better medication adherence has been shown to reduce hospitalizations and improve health outcomes</td>
</tr>
<tr>
<td>Barriers</td>
<td>Cost and/or complexity for some technologies</td>
</tr>
<tr>
<td>Cost</td>
<td>Varies widely; $4-$1000+</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Mostly consumer-driven</td>
</tr>
</tbody>
</table>
Applications

Medication optimization technologies range from very simple to highly sophisticated. A technology can potentially provide one or more functions to an individual patient under a “medication administration continuum,” including: 11

1) **Fill**: provides patient with information and/or instructions about the drug

2) **Remind**: reminds patients to take medications—audibly, visually, or both

3) **Dispense**: automatically dispenses medications (e.g., in the home), usually at certain times/intervals

4) **Ingest**: detects whether or not a patient has ingested his/her medications

5) **Metabolize**: detects whether or not a patient has metabolized his/her medication

6) **Report**: logs date and time when medication is taken and reports to clinician/caregiver

7) **Adjust**: adjusts medication automatically if needed

Ingest, Metabolize, and Adjust can be considered “advanced functions” because these capabilities are still largely in development.

Note: Technologies in **BLUE** are already available. Technologies in **GREY** are in development. Technology continuum focused mainly on patient errors.
Medication optimization technologies have been expanding in both variety and sophistication. Medication error data highlight the growing importance of these technologies. Deaths from medication errors at home increased sevenfold (adjusted for population) from 1983 to 2004, while 50% of the 1.8 billion prescription medications dispensed annually in the U.S. are taken incorrectly. In addition, medication errors can have significant financial implications. Medication non-adherence results in approximately $177 billion annually in direct and indirect costs to the U.S. economy, while $47 billion each year is spent for drug-related hospitalizations.

Given these issues facing medication administration, a wide variety of technologies have emerged to help improve medication adherence. **Standalone technologies** tend to be less complicated and include some single-function technologies as well as some multi-function technologies. These technologies are the simplest and easiest to use; however, they lack the functionality for more comprehensive health management. Examples of a standalone technology include a medication reminder, a medication dispenser, or a device that combines filling, reminding, and dispensing. Many standalone technologies are currently available on the market, with a wide price range depending on the level of sophistication. Additional standalone technologies are currently being developed, including those with advanced functions.

On the other hand, **integrated technologies** are a more recent development. These technologies are more complex and integrate medication management with other health management capabilities such as general health monitoring, sensors, or health information storage. While these integrated technologies allow for more comprehensive health management, they can be more expensive and complicated than their standalone counterparts, making them inappropriate for simpler situations. These integrated technologies often use a service-based pricing model (compared to a one-time fee for standalone technologies). Some integrated solutions are currently available on the market, while others are currently in development.
The Future

Many medication optimization products are available and continue to be developed. Both standalone and integrated technologies will continue in their adoption and development. It will be up to consumers and providers to select the solution(s) that are most appropriate.

Currently, advanced function technologies are mostly in development and not yet available on the market. These correspond to technologies that perform the Ingest, Metabolize, or Adjust functions on the continuum. A few examples include MagneTrace (pictured) and Xhale’s SMARTTM. Being able to fully develop these advanced technologies and incorporate them with existing technologies would result in getting closer to the “ideal medication administration technology,” which would allow for closed-loop optimal dosing and automatic adjustment of medication. This ideal technology, though still many years off, would continue to improve the patient’s medication behavior, as well as automatically adjust medication doses.

Integrated service-oriented technologies will also continue in their development and adoption, allowing consumers more choices in managing their health. Currently, several of these technologies are widely used, including the Health Hero® Network’s Health Buddy® (pictured) by the Veterans Health Administration. Funding decisions may also impact the adoption of these technologies, as these technologies tend to be more expensive. These integrated technologies especially hold promise for patients with multiple health problems, elderly people living alone, and patients who are looking for more independent ways to manage their health.

Over the longer-term, as more people continue to use medication administration technologies appropriate for managing their conditions, the ultimate goal is an improvement in patient outcomes. This will translate into decreased hospitalizations, decreased costs, increased quality of life, and a more independent lifestyle for patients. These technologies also can help clinicians and caregivers by allowing for remote monitoring and better health management on the part of the patient. The extent of these gains will depend on the development, adoption, and usage for this class of technologies.
Remote Patient Monitoring (RPM) refers to a wide variety of technologies designed to manage and monitor a range of health conditions. Point-of-care (e.g., home) monitoring devices, such as weight scales, glucometers, and blood pressure monitors, may stand-alone to collect and report health data, or they may become part of a fully integrated health data collection, analysis, and reporting system that communicates to multiple nodes of the health system, and provides alerts when health conditions decline. These technologies are particularly useful for the elderly, chronically ill, and people who have trouble accessing traditional sites of care.

Several types of health care organizations are now fielding RPM-enabled programs for chronic disease management. Broadly deployed within the Veterans Health Administration and in many small trials elsewhere like Kaiser Permanente and Group Health of Puget Sound, RPM has been shown to support patient self-management, shift responsibilities to non-clinical providers, reduce the use of emergency department and hospital services, and improve patient and provider satisfaction.

Early adopters of RPM technologies identify six components of chronic care management that are facilitated by these technologies: (1) early intervention—to detect deterioration and intervene before unscheduled and preventable services are needed; (2) integration of care—exchange of data and communication across multiple co-morbidities, multiple providers, and complex disease states; (3) coaching—motivational interviewing and other techniques to encourage patient behavioral change and self-care; (4) increased trust—patients’ satisfaction and feelings of “connectedness” with providers; (5) workforce changes—shifts to lower-cost and more plentiful health care workers, including medical assistants, community health workers, and social workers; and (6) increased productivity—decreased home visit travel time and automated documentation.

<table>
<thead>
<tr>
<th>Technology Focus Area</th>
<th>Remote Patient Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>Chronic disease management</td>
</tr>
<tr>
<td>Comparison Technology</td>
<td>In-person visits</td>
</tr>
<tr>
<td>Vendors</td>
<td>Many; some examples include Bosch, Philips, Cisco, Intel and other companies</td>
</tr>
<tr>
<td>Drivers</td>
<td>Improved patient outcomes and efficiency, lower costs, better access to care, and others</td>
</tr>
<tr>
<td>Barriers</td>
<td>Reimbursement and funding inconsistent; technology requirements also a barrier in some cases, lack of interoperability between devices, data security concerns</td>
</tr>
<tr>
<td>Cost</td>
<td>$100 - $1000 technology cost</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Varies widely</td>
</tr>
</tbody>
</table>
RPM technologies provide essential support for the coordination of care, behavior change (of providers as well as patients), and evidence-based decision support for patients. There are features of remote patient monitoring that can be used by patients, providers, and caregivers. An ideal remote patient monitoring solution takes into account the needs of all three. The evidence base for RPM is building, and demonstrates decreases in emergency department (ED) visits and hospital admissions for pulmonary and cardiac disease. In four New England hospitals, in-home monitoring and coaching after hospitalization for congestive heart failure (CHF) reduced rehospitalizations for heart failure by 72 percent, and all cardiac-related hospitalizations by 63 percent.\textsuperscript{15}

### Technology Focus Areas

#### Remote Patient Monitoring

**Applications**

RPM technologies provide essential support for the coordination of care, behavior change (of providers as well as patients), and evidence-based decision support for patients. There are features of remote patient monitoring that can be used by patients, providers, and caregivers. An ideal remote patient monitoring solution takes into account the needs of all three. The evidence base for RPM is building, and demonstrates decreases in emergency department (ED) visits and hospital admissions for pulmonary and cardiac disease. In four New England hospitals, in-home monitoring and coaching after hospitalization for congestive heart failure (CHF) reduced rehospitalizations for heart failure by 72 percent, and all cardiac-related hospitalizations by 63 percent.\textsuperscript{15}

### Patients

- **Collect patient info**
  - Remote collection of patient information, whether physiological or emotional, using a device. May include video or phone interaction. May collect specific vital signs manually or automatically.

- **Send alerts**
  - Sends alerts to patients on changes in health status, medication reminders, upcoming appointments, or motivational statements.
  - Sends alerts to caregivers and providers on changes in health status and/or warning signs.

- **Educate**
  - Built-in patient education programs allow patients access to information on their specific condition(s), medications, symptoms, etc.

### Providers and Caregivers

- **Diagnose early**
  - Use remote information to diagnose patient early.

- **Intervene early**
  - Inform providers of changes in health status and intervene early to prevent hospitalizations.

- **Improve care coordination.**

### Patient interacts with telehealth device

- **Data collected includes:**
  - Vital signs (blood pressure, glucose meters, pulse oximeters, weight, etc.)
  - Physical and emotional well-being assessment

### Patient information is collected & transmitted

- **Data transmitted over:**
  - Video over low-bandwidth POTS
  - Video over IP
  - LAN/WAN

### Patient information is used in treatment

- **Results include:**
  - Enhanced communication between caregivers, providers, and patients leads to improvements in care coordination and caregiver support
  - Reduce unnecessary visits
  - Improve medication compliance

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Note: POTS is "plain old telephone service." IP is "internet protocol." LAN/WAN is "local area network/wide area network."
The Veterans Health Administration (VHA) has evaluated, piloted, reevaluated, and deployed RPM technologies in a continuing process of learning and improvement. Reports in the literature of VHA studies cite improvements in a wide range of metrics. In addition to the expected decreases in ED, hospital, and nursing home use, use of preventive services and medication adherence increased, as did patients’ understanding of their condition, confidence in self-management, communications with physicians and nurses, feeling of connectedness to the care team, sense of security, and health-related quality-of-life scores. Although most studies did not include direct cost measures, remote monitoring for end-of-life care decreased the total combined costs of hospital and ED use over six months for 100 veterans from $151,771 to $25,119.11.

The Future

Remote patient monitoring is currently growing rapidly, bringing convenience and simplifying care for patients and health care professionals. In the future, not only is remote patient monitoring expected to expand in terms of adoption, but also in terms of the variety of applications and offerings. An increase in the use of general broadband technology and the “wiredness” of homes, hospitals, and other care settings will facilitate the growth of RPM.

Home care agencies may well prove to be the most effective entities in the adoption of RPM. Unlike provider-based plans and home health agencies, the business model for hospital-based delivery systems has historically been poorly aligned with chronic care innovations and the RPM technologies that support them. After some early experimentation with RPM technologies, many health plans have relied upon disease management (DM) contractors to identify opportunities to use RPM in chronic care management.

RPM technologies represent an opportunity to grapple with the coverage issues that arise when a category of technology is continuously and rapidly evolving. Whether it is by DM companies, health plans or homecare providers and senior living communities, coverage and reimbursement policies remain a barrier to RPM deployment. We have a great deal to learn about the most effective means of compensating providers for their use.

The prevalence of this technology will increase and the skills of providers will be tested not only by the quality of the patient-provider interaction, but by technological proficiency and access. In turn, medical facilities will encounter new challenges in preparing and training adequate personnel. The cost structures of medical facilities will change as capital investments in medicine will have to increase to respond to growing demand. Given its enormous potential, remote patient monitoring will continue its rapid growth, playing a large role in the future of medicine and treatment.
Technology Focus Areas

Assistive Technologies

Overview

Assistive Technologies include a wide range of devices and equipment that are used to increase, maintain, or improve functional capabilities of individuals with disabilities.\(^{17}\) An AARP study showed that 34% of adults over 65 have an impairment that limits one or more basic physical activities.\(^{18}\) These impairments impact Activities of Daily Living (ADLs) as individuals age. Assistive technologies promote independence as they compensate for sensory, physical, and cognitive impairments, and promote safety for vulnerable individuals as they mitigate, detect and report health hazards.

Examples range from active technologies that directly interact with the user to support ADLs such as wheelchairs and large-button cellphones, to more passive systems such as computer controlled “smart homes” that provide support for persons with substantial cognitive impairment through the use of motion sensors and other passive data. Additionally, active and passive systems such as Personal Emergency Response Systems and acceleration sensors have been developed to assist individuals who would otherwise be unable to contact emergency services in the event of a fall or loss of mobility.

The market for assistive devices is large. More than 19,000 products are available and the market for wheelchairs alone was $1.33 billion in 2007.\(^{19}\) Despite the size of the market there is limited evidence that assistive devices improve outcomes, reduce workforce demands, and reduce overall health care expenditures.\(^{20,21}\)

<table>
<thead>
<tr>
<th>Technology</th>
<th>Assistive Technologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison Technology</td>
<td>N/A</td>
</tr>
<tr>
<td>Vendors</td>
<td>ADT, ScanSoft, IBM, Honda, AbleNet</td>
</tr>
<tr>
<td>Drivers</td>
<td>Demographics, Cost reduction, Drive for aging at home, Payer policy</td>
</tr>
<tr>
<td>Barriers</td>
<td>Limited outcomes data, Receptivity of aging population, Privacy</td>
</tr>
<tr>
<td>Cost</td>
<td>$10-$40,000 (e.g. smart wheelchair)</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Government and Private Payers</td>
</tr>
</tbody>
</table>

Applications

Assistive Technologies provide for independence and safety for aging adults in a variety of settings including: home, work, transportation, recreation, and health care environments. There are a number of systems of classifications for assistive technologies including standards developed by the WHO, and the International Standards Organization (ISO), and the National Institute on Disability and Rehabilitation Research (NIDRR).\(^{22}\) The example applications that follow are a subset of the system developed by rehabtool.com, a resource to assist consumers in selecting products.
As the population continues to age the number of people who will benefit from assistive technologies in a variety of settings (home, work, recreation, transportation) will continue to increase. More and more assistive technologies will integrate with other smart systems in the home to provide information remotely to both professional and family caregivers. These systems will take advantage of the wealth of data that can be obtained passively from technologies that a frail elder may interact with directly. For example, a grab-bar with a pressure sensor could communicate important information about the activity level of an elder. Additionally, breakthrough technologies for mobility such as Honda’s exoskeleton to assist with walking or smart wheelchair technologies that integrate GPS with route planning systems will support independence for aging individuals with increasing levels of disability. Although changing demographics will be a powerful driver for the development and adoption of assistive technologies, there are a number of barriers that may inhibit the diffusion rate including receptivity of seniors, and reimbursement by payers.

As assistive technologies integrate with other remote devices and home monitoring equipment they will present an opportunity to gather important information about the level of activity of a frail elder. It will be critical to design technologies that are unobtrusive and/or passive as studies show that elders are very receptive to technologies that will support independence in their home even those that will limit their privacy.23

Payer reimbursement will also be a challenge to the diffusion of technologies. Future, networked technologies will increase in complexity and cost. The market for assistive technologies is large, estimated at $15-20 billion with Medicare accounting for over $2 billion in 2002.24 These data indicate that a substantial portion of spending is out of pocket. Even though there will be considerable growth in the market driven by the elderly population, substantial reductions in health care costs are only likely to be achieved through changes in Medicare reimbursement policy.

<table>
<thead>
<tr>
<th>Activity/Application of Technology</th>
<th>Example technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Large button cellular phone</td>
</tr>
<tr>
<td>Computer Access</td>
<td>Voice recognitions software</td>
</tr>
<tr>
<td>Environmental</td>
<td>Smart HVAC systems</td>
</tr>
<tr>
<td>Sensory</td>
<td>Cochlear implants</td>
</tr>
<tr>
<td>Mobility and Transportation</td>
<td>Smart Wheelchair</td>
</tr>
<tr>
<td>Seating and Positioning</td>
<td>Posture optimization devices</td>
</tr>
<tr>
<td>Vision and Reading</td>
<td>Visible light audio information transfer systems</td>
</tr>
</tbody>
</table>
Overview

Remote Training and Supervision (RTS) technologies are systems that support the training and supervision of health care workers who are not physically collocated with their educator. The training can occur synchronously in real-time, or asynchronously in the manner of an online education course. Training is facilitated using web-based internet protocol (IP) technologies ranging from basic e-learning courses, to collaborative web conferencing platforms, to immersive virtual environments. Additionally, training can be accomplished using existing video-conferencing technologies that utilize analog communication systems. Particularly in the case of less skilled health workers, the use of remote systems for ongoing supervision of the workers, and for on-demand consultation with more experienced supervisors or instructors, offers the potential for continuing education and quality assurance. In many cases, these technologies can also be used to train and support family caregivers to augment the existing workforce. This is particularly important to support “aging at home” initiatives. The US health system will face a multitude of challenges over the coming years as it attempts to cope with a rapidly aging population. Workforce shortages will be one of the key obstacles to success in the coming decades. By 2025, it is estimated that there will be a shortage of 500,000 RN’s alone. RTS offers a possible solution to mitigating the effects of these shortages by increasing the training capacity of existing institutions and educators, and also by augmenting paraprofessional and family caregivers with access to professional consultation and support.

Applications

RTS technologies are being applied as training tools for paraprofessionals and family caregivers to support continuing education, address a shortage of educators, and provide a low cost alternative to on-site training initiatives. Also, RTS systems are augmenting paraprofessionals and family caregivers with consultation and support from more skilled or specialized professionals.

<table>
<thead>
<tr>
<th>Technology</th>
<th>Remote Training and Supervision technologies for caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>Training, support, and specialty consultation for professional and family caregivers</td>
</tr>
<tr>
<td>Comparison Technology</td>
<td>On-site training and consultation</td>
</tr>
<tr>
<td>Vendors</td>
<td>MedSmart, InTouch, aquire Training Solutions</td>
</tr>
<tr>
<td>Drivers</td>
<td>Workforce Shortages, Aging at home, Demographics</td>
</tr>
<tr>
<td>Barriers</td>
<td>Outcomes data, Funding for initiatives, Availability of trained educators, limitations of virtual interaction</td>
</tr>
<tr>
<td>Cost</td>
<td>$100-$2000</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Drivers

Workforce Shortages, Aging at home, Demographics

Barriers

Outcomes data, Funding for initiatives, Availability of trained educators, limitations of virtual interaction

Cost

$100-$2000

Reimbursement

N/A
The Future

As the population continues to age and workforce shortages become more acute, the need for innovations in remote training and supervision will grow. These needs will drive the development and deployment of RTS solutions, and it is likely that RTS solutions will begin not only to supplement education and support but in some cases to substitute for on-site education and consultation.

Technology developments in medical simulation will likely diffuse to remote training. For example, virtual environments being used to train professionals are often web-based and could easily be made accessible from a home or long-term care setting. Additionally, developments in Remote Patient Monitoring (RPM) technologies will increase the volume of clinical information that may be made available to consulting or supervising clinicians. Integrating the RTS and RPM systems can enhance the ability of less skilled caregivers to support frail elders who would otherwise need to be cared for in settings that provide a higher level of care.

Barriers to adoption and development include limited outcomes data, access to funding for initiatives, a shortage of trained educators and limitations inherent in remote education and support. Many of these challenges may be overcome in the future through the use of simulation and remote training for clinicians and health care professionals. Substantial work in medical simulation is being done in university, military, and health system settings. This work is generating positive outcomes data regarding remote and virtual training and is supporting the development of curriculums and expertise in the discipline.
Technologies to Help Older Adults Maintain Independence: Advancing Technology Adoption

Overview

Disease Management (DM) is a patient-centric, coordinated care process for patients with specific health conditions, particularly chronic conditions and conditions that have a significant self-care component. DM programs include data mining processes to identify high-risk patients within a population; use of evidence-based medical practice guidelines to support and treat individual patients; and a coordinated, data-informed system of patient outreach, feedback, and response.

Applications

DM is a proactive care coordination process that is commonly used to control or reverse the effects of chronic health conditions. In the past decade, the emphasis of DM has shifted from a strictly disease-centric approach, where separate DM programs were tailored to single chronic illnesses, to one that is more patient-centric i.e., programs are tailored more to individual patient needs and better accommodate patients with multiple health challenges. DM programs have also expanded beyond the “big five” chronic illnesses. For example, current DM programs are designed to improve patient management and decision making for “supply-sensitive” health conditions; and, they have expanded from an emphasis on secondary prevention to an emphasis on primary prevention.

Technology Focus Areas

<table>
<thead>
<tr>
<th>Technology</th>
<th>Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>Chronic illnesses, disabilities, supply-sensitive care</td>
</tr>
<tr>
<td>Comparison Technology</td>
<td>In-person visits</td>
</tr>
<tr>
<td>Vendors</td>
<td>Healthways, Health Dialog, LifeMasters, McKesson Health Solutions and many more</td>
</tr>
<tr>
<td>Drivers</td>
<td>Improved patient outcomes and efficiency; competitive advantage (for health plans)</td>
</tr>
<tr>
<td>Barriers</td>
<td>Demonstrating positive economic outcomes</td>
</tr>
<tr>
<td>Cost</td>
<td>$70 to $200 PMPM for Medicare eligible patients</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Health plan: absorbed into overhead costs; Large employer: paid for directly; Patient: usually no OOP fees</td>
</tr>
</tbody>
</table>

Note: PMPM is “per member, per month.” OOP is “out of pocket.”

Outcomes from a successful DM program include decreased utilization of ED and hospital services, health status improvements, decreases in health care costs, and increased utilization of evidence-based medical practices. Improvements in a patient’s self-management skills, satisfaction with care, and perceived quality of life are also benefits of DM.

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a The “big five” chronic illnesses include asthma, diabetes, chronic obstructive pulmonary disease, cardiovascular diseases, and congestive heart failure.

b “Supply sensitive” condition means the amount and type of treatment will be influenced by the type and location of the supplier, which is typically the physician. For example, surgery will be recommended for back pain if the patient seeks the opinion of a back surgeon. An internist, chiropractor, or acupuncturist will each have a different approach.
Nearly all managed care organizations (MCO) offer DM services to employer-based health plan members. DM is offered on a more limited basis to Medicaid recipients. States once considered DM as “the new tool for cost containment” for Medicaid recipients. But studies are showing that cost savings of DM (vs. usual care) have been limited to specific patient populations, e.g., patients with congestive heart failure (CHF). Medicare is concluding a large-scale study of DM that began in 2005. Although study results continue to be discussed and debated, results do not seem to support the expectation that DM would become the new, hoped-for cost containment tool.

Health care stakeholders can build DM services and programs organically, or they can subcontract to dedicated DM vendors. The DM industry is large and growing. According to the Disease Management Purchasing Consortium, industry revenues grew from $78 million in 1997 to an estimated $1.2 billion in 2005.

DM programs are typically high touch and high tech. One-on-one health coaching is an important component of most DM programs. Health coaches (typically nurses) often work from large call centers to reach out to patients via phone or email.

Technologies support many phases of the disease management process. An example of technology use can be seen in the first step below. Data must be collected and analyzed to identify patients that will benefit from a disease management program. Since electronic medical records are still largely absent in much of the health care system, DM vendors have become masters at patching together disparate data, such as health claims, pharmacy, laboratory, and hospitalization data. But often these data are too little, too late as, for example, health claims are submitted weeks after a health event. Electronic health records clearly enable identification of at-risk patients. In non-EHR health systems, self-completed, online health risk assessments can be a useful supplement.
Outcomes from disease management programs have recently been scrutinized through the use of large, randomized trials. Study results have been disappointing in many cases. However, niche applications of DM still seem promising, e.g., the use of DM in managing individuals with congestive heart failure. The Center will continue to track DM outcomes studies and determine the best applications of DM.

The case of DM outcomes studies offers many useful lessons learned that might be relevant to the Center’s other technology focus areas. The early, less-rigorous trials of DM seemed to demonstrate promising health and economic benefits—just as the extant, less rigorous studies of the Center’s other technology focus areas currently do. This raises the question: if other technologies were tested more rigorously would outcomes results be consistent with results derived from less rigorous trials? Moreover, some believe that DM is not yielding the expected cost and health outcomes improvements in randomized trials because of simple but important barriers, such as high study dropout rates. In the future, the Center will track approaches used to overcome these barriers—because such approaches may be relevant to adoption and diffusion of other remote management technologies.
Cognitive fitness and assessment technologies include thinking games and cognitive challenge regimens. Like physical fitness, the premise of cognitive fitness is that cognitive health can be maintained or improved if individuals exercise their brain. The emphasis with older adults is predominantly focused on the prevention or delay of Alzheimer’s disease and related dementias. Many cognitive fitness technologies are computer- or internet-based, multi-media platforms, and include assessment and tracking components.

Participation in cognitive stimulation can lessen decline in memory, mental speed and decision-making. One study found adults over 65 who frequently participated in cognitive stimulation activities had 35% less cognitive decline than those with infrequent cognitive activity. Use of computer-based cognitive fitness and assessment technologies have rapidly expanded over the last five years with advancements in computing and communication technologies.

Sales of cognitive fitness and assessment products in the US grew between 2005 to 2008 from an estimated $100 million to $265 million. Most of the growth came from consumers, followed by health care providers. Residential facilities are also experiencing a large uptake in computerized cognitive fitness and assessment technologies. Over 700 residential facilities, mostly independent assisted living facilities and continuing care retirement communities (CCRCs), have installed these technologies.

Applications

Cognitive fitness and assessment technologies give health professionals, caregivers and acute care hospitals a better understanding of whether the patient can be self-sufficient and self manage their care at home. Clinicians and acute care hospitals use assessment tools to understand where deficits are occurring in the patient and incorporate these results in the decision-making process and discharge planning. Health insurers and delivery systems are beginning to explore the potential of cognitive fitness and assessment technologies. OptumHealth made an $18 million agreement with Brain Resource to develop computerized assessments for clinicians to evaluate social cognitive functions in 40-minute tests. Older adults can also use these technologies for preservation of cognitive abilities. Many products offer cognitive fitness games for regular long-term use. Common areas of focus for games include long-term and short-term memory, language, executive function, computation, visuospatial orientation and critical thinking.
The Future

Despite the strong consumer interest in cognitive fitness and assessment technologies, the evidence base to validate and support the broad use of these technologies to deliver measurable health benefits is limited (but emerging). Lack of uniformity across cognitive assessment measures is another challenge. In 2006, the National Institutes of Health (NIH) launched a 5-year initiative called the NIH Toolbox, which seeks to assemble brief, comprehensive assessment tools with a particular emphasis on measuring outcomes in longitudinal epidemiologic studies. The high cost of clinical research testing represents a considerable barrier to market development. Development of better training tools to improve cognitive functions and to reduce cognitive decline will grow with validation studies.

The regular use of computerized cognitive assessments can establish a clear baseline of cognitive function. Subsequent assessments can track changes in cognition related to aging and onset of various clinical conditions. In May 2008, the military implemented the Automated Neuropsychological Assessment Metrics, a computer-based cognitive test examining reaction time, memory, attention, concentration and other cognitive functions. This test is given to troops before they are deployed providing a baseline cognitive assessment. When examining a post-deployment injury, clinicians can compare cognitive test results with the baseline test to provide greater accuracy in diagnosis and treatment.

Combination computer-based cognitive and physical fitness and assessment technologies have also been developed to help prevent physical and cognitive decline simultaneously. The use of gaming consoles like Wii and Xbox not only support strength training and balance games, but also can assist with physical rehabilitation for stroke and traumatic brain disorders.

<table>
<thead>
<tr>
<th>Cognitive Fitness and Assessment Technology Example</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>InSight (Posit Science)</td>
<td>Reduced effects of age-related mental decline through exercising areas of memory, language, concentration, executive function, and assessing visual attention performance with cognitive speed and skills. InSight software can be installed on a PC.</td>
</tr>
</tbody>
</table>
Web-based social networking allows communities of older adults to connect, share knowledge with, and provide support to other older adults and their care providers. These web-based social networks utilize a variety of means to facilitate communication among patients including discussion groups, chat, messaging, email, video, and file-sharing.

In 2007, 56 percent of American adults used the Internet to look for health information. Their activities ranged anywhere from seeking opinions on medications and treatments and getting emotional support, to researching conditions or treatments, learning self-management skills, and receiving education to manage a condition. The benefits of providing support and exchanging knowledge, especially for patients with chronic conditions, are well studied. Web-based online social networking emerged as a way to connect peers, independent of geography. Before web-based social networking services existed, in-person peer groups like the Chronic Disease Self-Management Program have recognized the effect of sharing experiences, exchanging knowledge, and providing support to improve health outcomes for patients with various chronic conditions. The combination of patient-centered knowledge exchange and caregiver support makes social networking a powerful platform in changing the way that health care is delivered.

### Applications

Social networking services connect older adults with other older adults as well as to clinicians, caregivers, researchers, health plans and suppliers. Older adults can use web-based social networking services to connect with friends and family as well as to exchange their knowledge and experiences of managing their conditions with other patients.

Caregivers and clinicians can use social networks to manage and coordinate care for an older adult. Clinicians are also able to educate and promote preventive health, to collectively understand their patients’ needs and to remotely assist the patient, caregiver and family members.

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<table>
<thead>
<tr>
<th>Technology</th>
<th>Web-based Social Networking Services for Patients and Family Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>Health education &amp; promotion, social support and information exchange, enable self-management</td>
</tr>
<tr>
<td>Comparison Technology</td>
<td>In-person patient education and support groups</td>
</tr>
<tr>
<td>Vendors</td>
<td>Patientslikeme, DiabetesMine, Jive Kinnexxus, Facebook, Tyze</td>
</tr>
<tr>
<td>Drivers</td>
<td>Increased connectivity between patients and clinicians, lower costs in the acute setting</td>
</tr>
<tr>
<td>Barriers</td>
<td>Conflicts of interest between stakeholders and users, patient privacy concerns, health care’s organizational culture</td>
</tr>
<tr>
<td>Cost</td>
<td>$0 - $100</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>N/A</td>
</tr>
</tbody>
</table>
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\(^{c}\) The Chronic Disease Self-Management Program was developed by Kate Lorig and colleagues.
### Use of Social Networking by Older Adults

<table>
<thead>
<tr>
<th>Application:</th>
<th>Example:</th>
<th>Description:</th>
</tr>
</thead>
</table>
| **Connect with Friends and Family** | **Facebook**  
www.facebook.com | Website where users can join networks organized by city, workplace, school, and region to connect and interact with other people. Users can add friends, send messages, update their personal profiles, and use an increasing number of applications. |
| **Connect with Friends and Family** | **Jive**  
http://jive.benarent.co.uk/ | Three bundled products designed to connect older adults to friends and family online in “plug and play” capacity. The 3 products include a router, mouse free communication device, and friend passes, which store friends and family contact information. |
| **Chronic Disease** | **PatientsLikeMe**  
www.patientslikeme.com/ | Website where members share treatment and symptom information in order to track and to learn from real-world outcomes. PatientsLikeMe currently has communities for amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Parkinson’s disease, fibromyalgia, HIV, and mood disorders, as well as the rare conditions progressive supranuclear palsy, multiple system atrophy, and Devic’s disease (neuromyelitis optica). |

### Use of Social Networking by Caregivers and Clinicians

<table>
<thead>
<tr>
<th>Application:</th>
<th>Example:</th>
<th>Description:</th>
</tr>
</thead>
</table>
| **Care Coordination** | **Tyze**  
www.tyze.com | A platform that hosts personal support networks for older adults, persons with disabilities and their caregivers. Tyze offers scheduling, task planning and messaging as well as storytelling around the person at the center of the network. |
| **Care Coordination** | **Kinnexxus**  
www.kinnexxus.com | Web-based platform provides a senior support network connecting older adults to each other, caregivers and professional care providers. Features include: scheduling, task planning and messaging as well as integrating with remote monitoring devices. |

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Technologies to Help Older Adults Maintain Independence:  *Advancing Technology Adoption*
The Future

Social networking is rapidly evolving, with new players still joining and transforming the field. Though the future remains uncertain due to recession-induced funding decreases, the potential for transforming health care outside of the traditional model remains.

Despite these drivers, there are three main barriers preventing rapid development and dissemination of social networking for health. The first barrier involves conflicts of interest between stakeholders and users. It is oftentimes unclear how a patient’s information will be used by health plans and suppliers. The second barrier involves patient privacy concerns. Social networking for health relies on the open sharing of patient information. Within a hospital, a patient’s privacy is protected by HIPAA. Outside of the hospital, privacy issues become a concern. It is uncertain how our judicial system will deal with violations of privacy as well as how they will provide for protection of this information. The third barrier relates to the organizational culture of traditional health care, where health care providers control the information and messages that are directed to patients. Since content on social networking is mostly patient-generated, traditional health care is concerned how this will affect their message.

Social networks are just beginning to incorporate applications such as search and personal health records (PHRs). Websites that integrate search with social networking allow older adults and caregivers to search for health information and see both their Web search results as well as a list of patients that may be suffering from similar conditions. Additionally, websites that integrate PHRs with social networking give the patients the ability to view their medical information data as well as to share it with whom they wish. Furthermore, the overlay of intelligent algorithms onto both applications gives patients the ability to see customized information about their health that they could then use to proactively manage their health in a personalized and tailored fashion. Not only can intelligent algorithms help patient’s improve their own health, the integration of intelligent algorithms has the potential to learn from the collective wisdom of patients by seeking patterns, understanding behaviors, and ultimately using that wisdom to improve care. As patients demand different ways to manage their health outside of the traditional health care model, these powerful new additions will play a large role in advancing online social networking services for health.

Traditional health care stands to benefit greatly from the addition of social networking services to their model. Over the long term, social networking can benefit health care providers in a number of ways including “integrating patient care and enabling community, enhancing patients’ compliance with therapies, building goodwill in communities, providing useful health information to people who opt-in to receive it, and averting costs that would be incurred in acute settings.” Social networking services have the potential to form a more collaborative model of health care delivering more effective and efficient care.
Next Steps

The Center will continue to review the seven technology areas with the help of experts and stakeholders in a number of areas. To identify potential opportunities, the Center will tap the experience and expertise of individuals involved in aging technologies, aging services, and program diffusion. Such individuals will include technical experts, policymakers, regulators and funders. The Center will also conduct field reviews with health and social service organizations, which are current and potential users of aging technologies.

As health care delivery evolves over the coming years, evidence will continue to emerge regarding the viability of new technologies and their contribution to the health and well-being of older adults. Not only do beneficial technologies offer significant potential for assisting older adults in maintaining their independence, they also provide a very promising method for helping address some of the challenges currently facing the U.S. health care system. For if the rate and scale of technology adoption can be increased, even modestly, it offers considerable potential for reducing the ever escalating personal and societal costs of chronic illness among older adults.
Introduction


Background


Technology Focus Areas


Medication Optimization


Remote Patient Monitoring


References

Assistive Technologies

Remote Training and Supervision

Disease Management

Cognitive Fitness and Assessment

Social Networking
About the Authors

This report was developed collaboratively between The Center for Technology and Aging and HealthTech. Authors included Jean Armas, Joyce Berger, Andrew Broderick, Molly Coye, Steve DeMello, Barbara Harvath, David Lindeman, Aaron Mintz, Neeraja Penumetcha, Lynn Redington, Valerie Steinmetz, Thomas Tinstman, and Ange Wang.

About the Center for Technology and Aging

The Center for Technology and Aging is devoted to helping California and the nation more rapidly adopt and diffuse technologies that improve home- and community-based care for older adults. The Center is addressing the challenge of adoption, diffusion and sustainability of creative technologies that support the health and independence of older adults. Through research, grants, public policy involvement, and development of practical implementation tools, the Center serves as a resource for all those seeking to improve the quality and cost-effectiveness of long-term care services. The Center for Technology and Aging at the Public Health Institute is funded by The SCAN Foundation.

About The SCAN Foundation

The SCAN Foundation is an independent charitable Foundation located in Long Beach, California. Uniquely positioned as the only Foundation with a mission focused exclusively on long-term care, The SCAN Foundation is dedicated to long-term services and support that keep seniors independent, at home and in the community. The SCAN Foundation is taking action as leaders of a social movement to develop programmatic and policy-oriented recommendations and solutions that will support the needs of seniors and influence public policy to improve the current system.

About the Public Health Institute

The Public Health Institute (PHI), an independent nonprofit organization based in Oakland, California, is dedicated to promoting health, well-being and quality of life for people throughout California, across the nation and around the world. PHI’s primary methods for achieving these goals include: sharing evidence developed through quality research and evaluation; providing training and technical assistance; and promoting successful prevention strategies to policymakers, communities, and individuals.

Request for Proposal

The initial RFP cycle for proposals addressing diffusion of a specific area of technology that helps maintain the independence of older adults is expected to take place in the fall of 2009.

If you would like to be added to the Center for Technology and Aging RFP notification email list, please submit an email request to: Valerie Steinmetz, Senior Program Manager at vsteinmetz@techandaging.org