

USING QUALITATIVE DATA TO DEVELOP QUANTITATIVE STUDY DESIGNED TO INFLUENCE AGING POLICY

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**LYNDA FLOWERS
SENIOR STRATEGIC POLICY ADVISOR
AARP PUBLIC POLICY INSTITUTE**



Real Possibilities

ABOUT AARP

AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP PUBLIC POLICY INSTITUTE

- The Public Policy Institute (PPI) is the focal point of public policy research, analysis and development at AARP.
- PPI staff works to design policies that have a significant impact on improving economic security, health care and quality of life.
- Founded in 1985, PPI publishes staff research and analysis regularly throughout the year.
- PPI also frequently convenes leading policy experts for discussion of key national and state policy issues. In addition, staff members provide critical research and analytical support for AARP advocacy efforts and campaigns at the state and federal level.

ROADMAP TO DISCUSSION

- Description of Qualitative Study
- Study Limitations
- How Results Drove Development of Quantitative
- Description of Quantitative Study
- Study Limitations
- Public Policy Goals
- Discussion Questions

FOCUS GROUP STUDY

- **Qualitative Study:** 10 focus groups with older adults in five states with five different healthcare delivery models to determine levels of satisfaction.
- **Relevant Finding:** Even though only one of the models of care provided social opportunities, social opportunities were important to older adults across most of the other care models.

Study Subjects and Limitations

Subjects

- Age 65 or older.
- Enrolled in both Medicare and Medicaid.
- Receiving care through one of the specified delivery models.
- No cognitive impairments.
- Able to travel to an interview site.
- Currently managing multiple chronic conditions.
- Roughly one-half of participants had a recent interaction with a hospital (inpatient or emergency room encounter).

Limitations

- Bias in the selections process (people selected by plans; had to be able to travel)
- Group think
- Findings may not be generalized because of the methodology

MEDICARE

Medicare: A national social insurance program, administered by the U.S. federal government since 1966 that provides health insurance coverage to more than 55 million people: 46.3 million provides ages 65 and older and 9 million people with permanent disabilities under age 65.

Medicare: The program provides health insurance for Americans aged 65 and older who have worked and paid into the system (Part A (hospital insurance) = payroll taxes; Part B (supplemental medical insurance) = premiums and general federal funds).

MEDICARE, cont'd.

Medicare: The program also covers certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare: Does not cover long-term care.

MEDICAID

- **Medicaid:** The largest health insurance program in the U.S., covering over 62 million low-income Americans. Jointly financed by states and the federal government.
- **Medicaid:** The dominant source of the country's long-term care financing.
- **Medicaid:** The Affordable Care Act (ACA) expands Medicaid significantly.

CHALLENGES OF CONDUCTING FOCUS GROUPS

- Uncertainty about the type of program individuals were enrolled in.
- Difficulty including people with limited English proficiency
- Difficulties recruiting multi-ethnic participants
- Selection bias
- Challenges related to *group think*.
- Findings not generalizable.

FOCUS GROUP RESULTS LED TO QUANTITATIVE STUDY

- **Quantitative Study:** Despite challenges, we took focus group results around social connectedness to construct a quantitative study.
- **Research Question:** Do lack of social opportunities increase Medicare (health insurance program for older adults age 65 and older) costs.
- **Our Hypothesis:** Absence of social contacts (objective social isolation) increases Medicare costs.

BACKGROUND ON QUANTITATIVE SOCIAL ISOLATION STUDY

- The literature demonstrates that subjective loneliness and objective social isolation are risk factors for mortality and poor health outcomes.
- For purposes of this discussion, the focus will be on objective isolation, defined by insufficient numbers of social contacts vs. subjective isolation (feeling lonely).

BACKGROUND ON QUANTITATIVE SOCIAL ISOLATION STUDY, cont'd.

Objective Social Isolation encompasses such factors as the size and structure of social networks, the frequency and duration of social interactions, and the type and degree of social supports received (AARP Foundation 2012).

Unique Question: This is the first study we can identify that links both types of social isolation to U.S. health spending.

STUDY METHODS

- We partnered with researchers at Stanford University (certified restricted data user plus quantitative skills) to use three years (2006, 2008, 2010) of linked data.
- We used linked Health and Retirement Study (HRS)—a nationally representative, longitudinal survey—data to Medicare claims data.

STUDY METHODS, cont'd.

- **Medicare Claims Data:** Information on beneficiary service use (institutional and non-institutional).
- **Medicare Claims Data:** Includes birth dates, date of service, and, provider and beneficiary identifiers. Can access beneficiary information down to zip code level.
- **Medicare Claims Data:** Claims for about 75 percent of Medicare fee-for-service beneficiaries

STUDY METHODS, cont'd.

- **HRS:** The HRS is a longitudinal panel study of health, retirement, and aging that surveys a representative sample of approximately 20,000 Americans over the age of 50 every two years. It added psychosocial interview questions in 2006.
- **HRS:** Supported by the National Institute on Aging and the Social Security Administration, the HRS explores the changes in labor force participation and the health transitions that individuals undergo toward the end of their work lives and in the years that follow.
- **HRS:** Since its launch in 1992, the study has collected information about income, work, assets, pension plans, health insurance, disability, physical health and functioning, cognitive functioning, and health care expenditures. Through its unique and in-depth interviews, the HRS provides an invaluable and growing body of multidisciplinary data that researchers can use to address important questions about the challenges and opportunities of aging.

THE HRS

- The University of Michigan Health and Retirement Study (HRS) is a national panel study of more than 22,000 Americans over the age of 50. Sponsored by the National Institute on Aging, the study is conducted every two years (1992-2006) and includes core interviews with the sampled respondents and proxy interviews when the sampled respondents have died. The study collects data on physical and mental health, insurance coverage, financial status, family support systems, labor market status, and retirement planning.
- The HRS asks all respondents who are eligible for Medicare to provide their identification numbers; over 80% of them consent to do so.

GOALS OF THE HRS

- Understand the relationship between medical history and financial status
- Understand how use of health care changes as people age
- The HRS obtains information about health care costs and diagnoses from Medicare records maintained by the Centers for Medicare and Medicaid Services

STUDY METHODS, cont'd.

- **Population:** More than 5,000 community dwelling individuals who were ages 65 and older; also enrolled in Medicare; who also participated in three-years of the psychosocial interview.
- **Exclusions:** Living in a nursing home at time of initial interview; not continuously enrolled in FFS Medicare, died within 12 months of an interview.

PRELIMINARY FINDING

People who are *very* socially isolated, have about \$130 per month more in Medicare spending than their non- or less-isolated counterparts.

***Very* = one standard deviation above the mean.**

STUDY LIMITATIONS

- We constructed a scale to measure objective isolation based on the literature and previously validated methodology.
- Measure of objective isolation has not been extensively validated.
- We conducted sensitivity analysis on the scale and found that our results hold only for the most socially isolated.
- This is always the case when generating new concepts.
- Need continued work for robust validation of the scale.

POTENTIAL FEDERAL POLICY ACTION

Policy Goal: If social isolation leads to increased federal Medicare spending, Medicare may have an incentive to screen people and develop and fund evidence-based social interventions (not current policy).

NEXT STEPS

- Publish papers in the fall (AARP and Stanford)
- Hold forum on Capitol Hill to bring issue to attention of federal policymakers
- Try to generate interest in refining assessment tool and identifying effective interventions
- Ultimately have every Medicare beneficiary screened for isolation

THOUGHTS IN RELATIONSHIP TO SUSTAINABLE DEVELOPMENT DATA GOALS

- Qualitative studies with older adults very expensive compared to quantitative
- Still, they are worth doing to develop quantitative research questions most relevant to the public
- Mixed methods approach is useful for developing public policy solutions that resonate with the public

THOUGHTS IN RELATIONSHIP TO SUSTAINABLE DEVELOPMENT DATA GOALS, cont'd

- AARP has a strong interest in more “mixed methods” research to get at the needs, concerns, habits, and practices of racial and ethnic minorities (domains: health security, economic security, long-term services and supports, independent living, transportation, caregiving, and social determinants).
- However, we recognize the importance and utility of government-sponsored public and restricted use data. We also know they are imperfect and need some improvements as well (e.g., adding psychosocial component; incorporating the Aging, Demographics, and Memory Study—ADAMS—as a supplement to the HRS).

WISH LIST

Under Goal 3, Indicators 3.81 and 3c of SDG's, change language to say: Increase financing and the recruitment, development, and training of the health and the well-being labor force.

QUESTIONS AND DISCUSSION



DISCUSSION QUESTIONS

- What are some of the challenges to collecting data on older adults through novel channels?
- Is funding available to conduct this type of research?
- Are there ways to bring down the cost of doing qualitative research?
- Are funders willing to put money into collecting data in ways that may not be validated?
- How can researchers work together to create an evidence base for the effectiveness of such methods?

DISCUSSION QUESTIONS, cont'd.

- Are there ways to evaluate the effectiveness of these novel ways of collecting data?
- What can new technologies contribute to such data collection efforts (e.g. crossing language and cultural barriers).
- What about data acquired by new technologies (fit bits, smart phones , etc. What are some of the disclosure and privacy issues?

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