

Health Care and Wellness

Marge had intended for years to get serious about losing weight. She could not believe it when her physician told her she was diabetic. She had just celebrated her 65th birthday, she felt great, and she was as active as she had ever been. Marge discussed her options for treatment with her doctor and decided to try diet and exercise because her sugar levels were only a little above normal. However, she knew her personality and lifestyle well enough to be aware that she could not do this on her own. Her doctor suggested that she contact the Lifetime Wellness Center through the local hospital. The center encouraged her to enroll in a “Slim for Life” class sponsored by the American Heart Association and attend a “Managing Diabetes” class sponsored by the hospital. After 8 weeks of classes, Marge believes she is on her way to getting control of her weight problem. She also knows the consequences of her actions and that if she needs more help, the Wellness Center is there to support her.

Although changes in physical health are inevitable as individuals age, it is possible to live a healthy life well into the ninth decade. Early detection of conditions such as Marge’s diabetes and the assistance of wellness programs will make it possible for her to manage her illness for many years. Indeed, older adults are living longer partly because of the advances in preventive and traditional medical care and improved access to health care services through Medicare. In this chapter, we provide a summary of the health status of older adults, the Affordable Care Act, and the Medicare and Medicaid programs. We conclude this chapter by describing health promotion and wellness programs available to older adults and looking at future challenges for health care policy and health promotion programs.

Health Status of Older Adults

Overall, the majority of older adults consider their health to be good, very good, or excellent (Mirel, Wheatcroft, Parker, & Makuc, 2012). Although self-assessment is certainly one way to measure health status, the presence or absence of chronic or acute disease and the degree of inability in level of functioning are other measures of health status (R. A. Kane & Kane, 1981). Although older adults suffer more frequently from chronic than acute conditions, the consequences of acute illness are more severe for older adults than for younger adults. For example, an equal number of older adults and younger adults get respiratory infections, but death rates are 30% higher for older adults who

get these infections (Hooyman & Kiyak, 2002; Hoyert, Heron, Murphy, & Kung, 2006). In contrast, older adults are more likely than younger adults to have chronic illnesses—those that are long term, often permanent, and result in a disability that requires management rather than a cure. Marge's diabetes is a good example of a chronic condition that will require health management for the rest of her life. According to the National Center for Health Statistics (2017b), 61.6% of adults over 65 have two or more of the top ten chronic conditions (hypertension, coronary heart disease, stroke, diabetes, cancer, arthritis, hepatitis, weak or failing kidneys, chronic obstructive pulmonary disease, and current asthma).

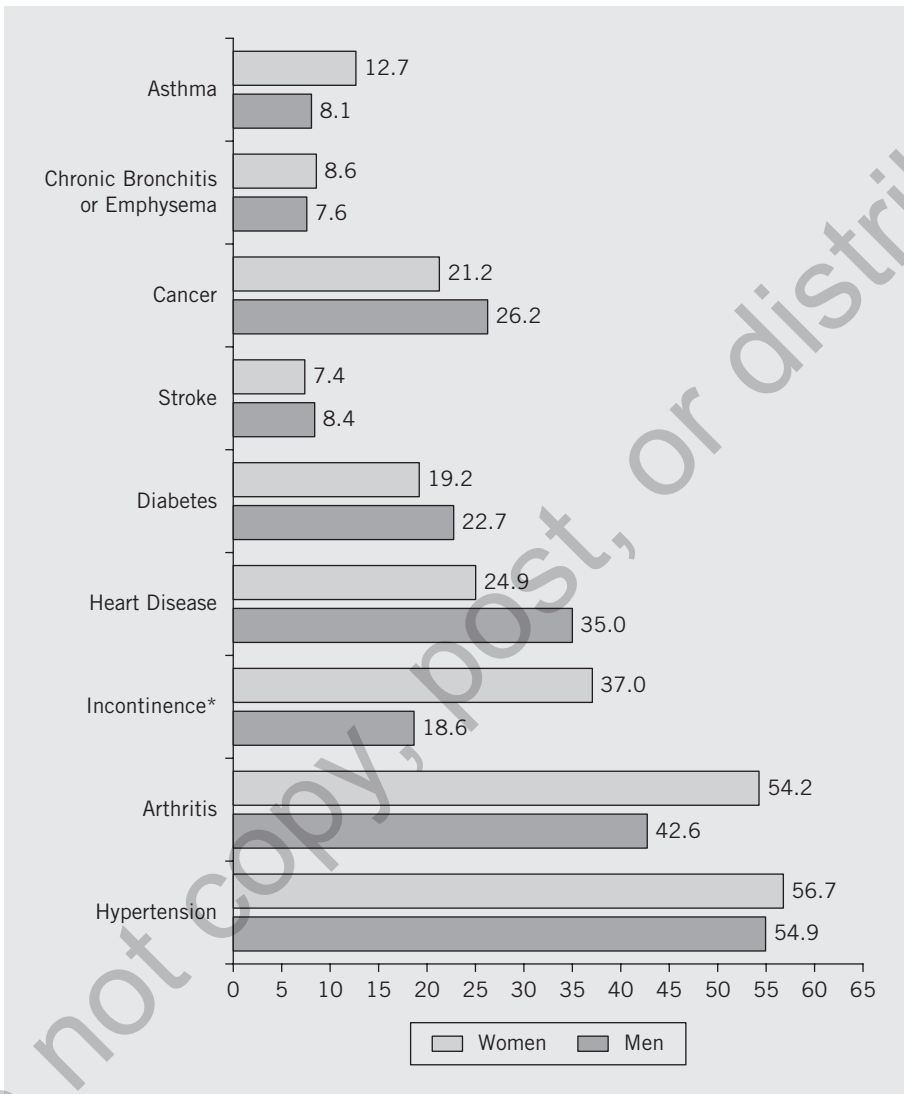
The presence of chronic conditions varies across subpopulations of older adults. For example, as shown in Exhibit 11.1, older women are more likely than older men to suffer from chronic conditions such as arthritis, hypertension, incontinence, and asthma, whereas men are more likely to suffer from heart disease and diabetes. Similarly, older adults of color suffer from chronic conditions at rates that are often significantly higher than those of White older adults. Exhibit 11.2 show the prevalence of chronic conditions experienced by Hispanic, Black, and White older persons. Black and Hispanic older adults are more likely to suffer from diabetes than White elders. Elderly Blacks are also more likely to suffer from hypertension, arthritis, and stroke than are Hispanic and White elders. Elderly Hispanics are less likely to suffer from heart disease and arthritis than their counterparts. In addition, 85% of older Hispanic adults suffer from at least one chronic condition; by the age of 45, many experience chronic health impairments, such as arthritis, heart disease, and diabetes, similar to those of a typical White 65-year-old (Cuellar, 1990). Older Native Americans have even greater rates of chronic conditions. Older Native Americans are more likely to have arthritis, congestive heart failure, stroke, asthma, prostate cancer, high blood pressure, and diabetes than the general population age 55 and older (Moulton et al., 2005).

A more recent health concern among the aging population is the increasing number of overweight and obese individuals. Currently, 73.2% of adults age 75 and older are considered overweight, and of those, 26.6% are considered obese (Centers for Disease Control and Prevention [CDC], 2012c)—percentages that have increased by 17% and 13%, respectively, since 1988 (see Exhibit 11.3). In addition, the prevalence of being overweight and obese in persons ages 65 to 74 is higher than those age 75 and over, as 77.0% of persons ages 65 to 74 are overweight, and 41.5% of those are considered obese, percentages that are also up significantly from 1988. Individuals who are overweight and obese have increased likelihood of being in poorer health, suffering from more chronic health conditions, and being limited in their ability to carry out activities of daily living (Strum, Ringel, & Andreyeva, 2004).

Older adults are also living with HIV and dying from AIDS. According to the National Center for Health Statistics, more people over age 65 died of AIDS than did children and adults under the age of 40 (CDC, 2017a). The number of persons age 65 and older who died from AIDS increased significantly over the past 20 years, from 1,631 in 1999 to 2,642 in 2015. As of 2015, there were an estimated 185,066 persons age 55 and older diagnosed with stage 3 AIDS (CDC, 2017a).

Persons living with chronic conditions, including HIV/AIDS, often experience functional limitations for which they need assistance. Functional limitation, one measure of an individual's health status, is the inability to perform personal care tasks and home-management activities. Personal care tasks, commonly referred to as *activities of*

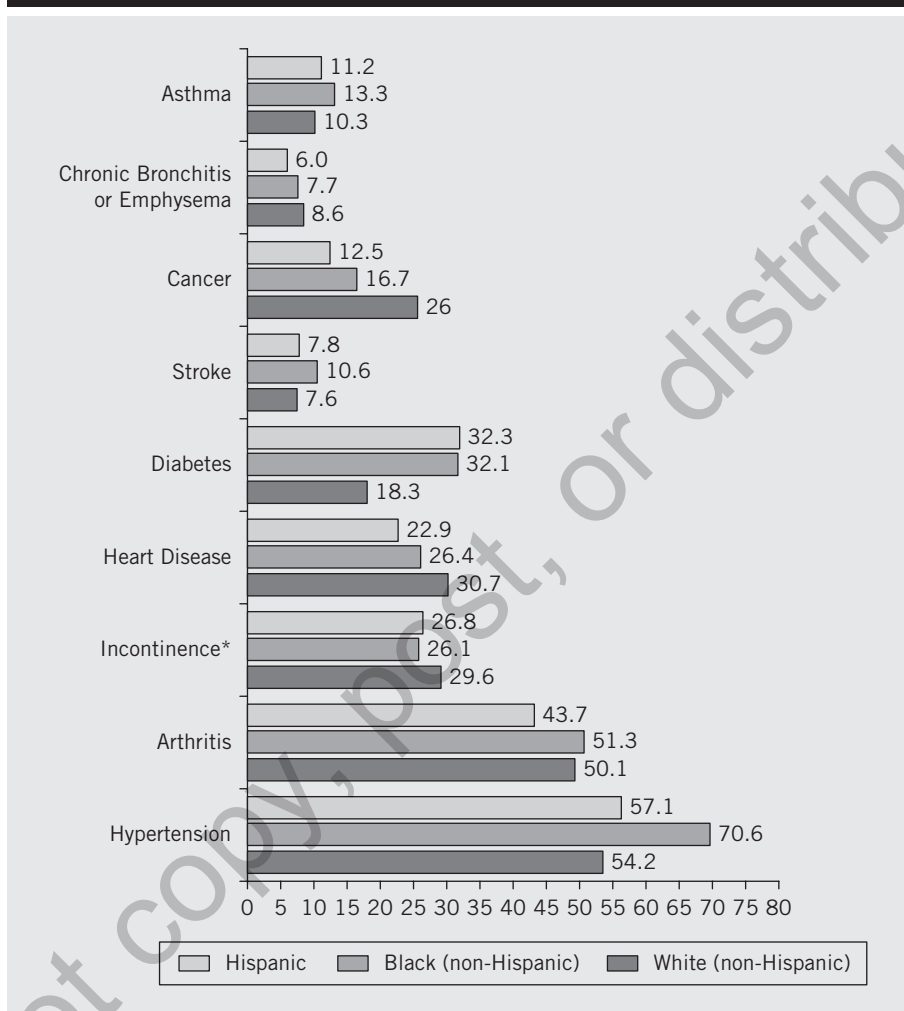
Exhibit 11.1 Prevalence of Selected Chronic Conditions of Persons Age 65 and Over by Gender, 2013–2014 (percentage)



Sources: Federal Interagency Forum on Aging-Related Statistics (2016); *Gorina, Schappert, Bercovitz, Elgaddal, & Kramarow (2014).

daily living (ADLs), include tasks such as bathing and grooming, toileting, dressing, and eating. Home-management activities, or *instrumental activities of daily living* (IADLs), include tasks such as shopping and preparing meals, doing housework, and handling

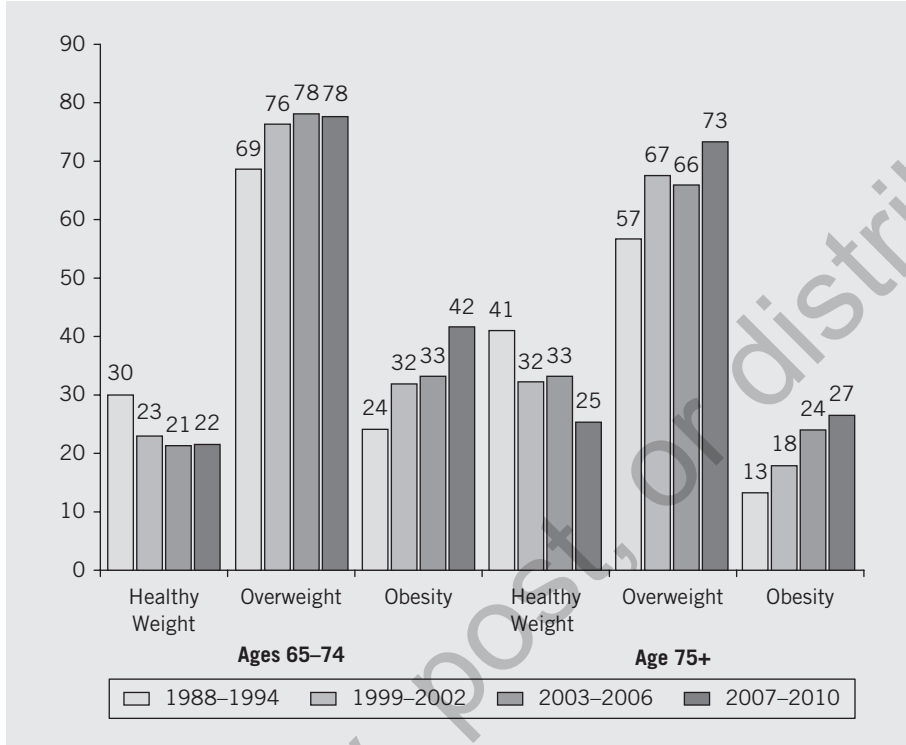
Exhibit 11.2 Prevalence of Selected Chronic Conditions of Persons Age 65 and Over by Race and Ethnicity, 2013–2014 (percentage)



Sources: Federal Interagency Forum on Aging-Related Statistics (2016); *Gorina et al. (2014).

personal finances. National data reveal that 40.3% of older adults living in the community have difficulty performing ADLs or IADLs, and more older women are likely to have a functional limitation than older men (44.7% vs. 34.7%; Federal Interagency Forum on Aging-Related Statistics, 2016). As shown in Exhibit 11.4, older women are more likely than older men to have trouble doing a number of activities, including walking, light and heavy housework, transferring (e.g., in/out of bed), shopping, and bathing. Just as

Exhibit 11.3 Trends in Weight Among Adults Ages 65 to 74 and 75 and Over, Selected Years 1988–2010 (percentage)



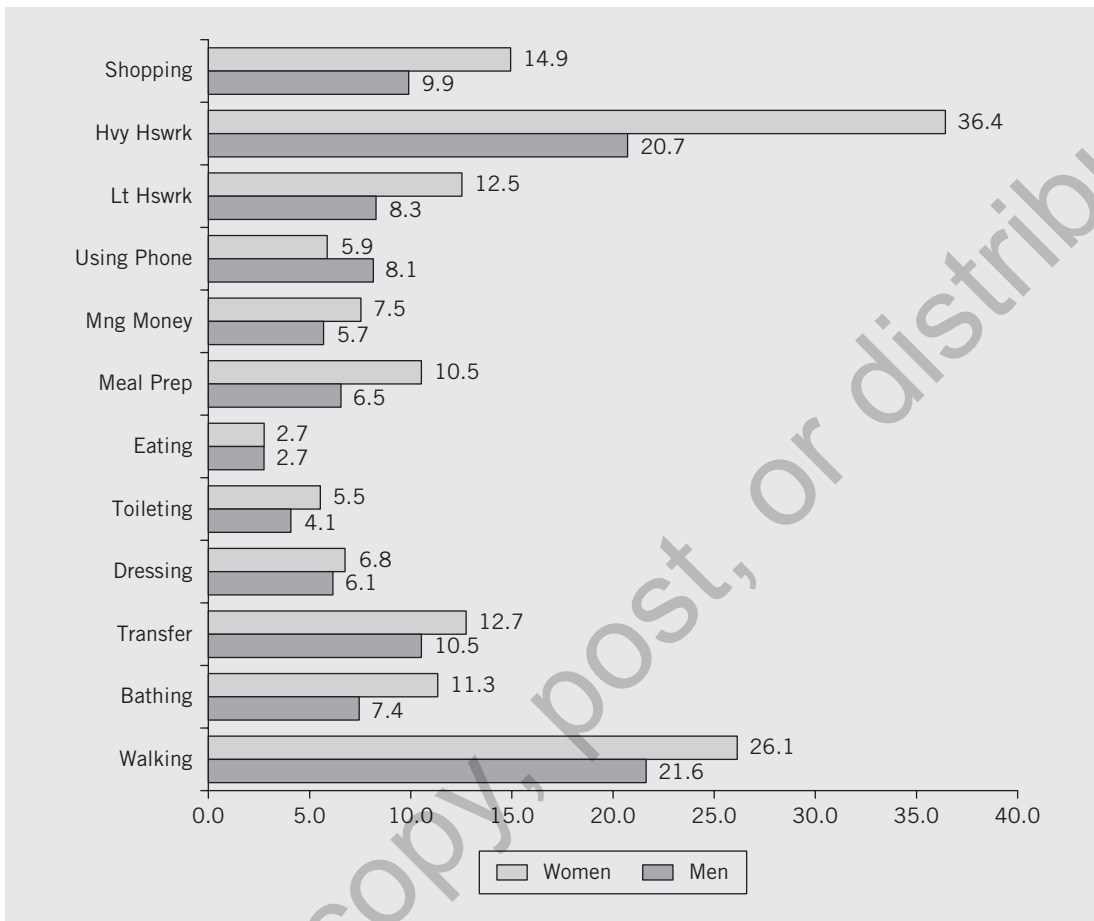
Source: CDC (2012c).

Normal weight: body mass index (BMI) between 18.5 and 25; *overweight:* BMI between 25 and 30; *obese:* BMI between 30 and 35.

Notes: Percentages do not sum to 100 because the percentage of persons with BMI less than healthy weight is not shown and the percentage of persons with obesity is a subset of the percentage who are overweight.

older women and older adults of different ethnic and racial groups suffer from multiple chronic impairments, they are also likely to have multiple limitations in their everyday activities. In a sample of community-dwelling older adults, 15.3% of women compared with 7.8% of men could not do IADLs without assistance (CDC, 2012a). A similar disparity existed between older Whites and other racial and ethnic groups in functional abilities. Forty-five percent of Blacks, 58% of Native Americans or Alaska Natives, and 46% of Hispanics had one or more functional limitations in IADLs and ADLs, compared with 38% of non-Hispanic Whites over 65 years of age (CDC, 2012a, 2012b; J. Waldrop & Stern, 2003).

Exhibit 11.4 Functional Limitations of Women and Men Age 65 and Over, 2012 (percentage)

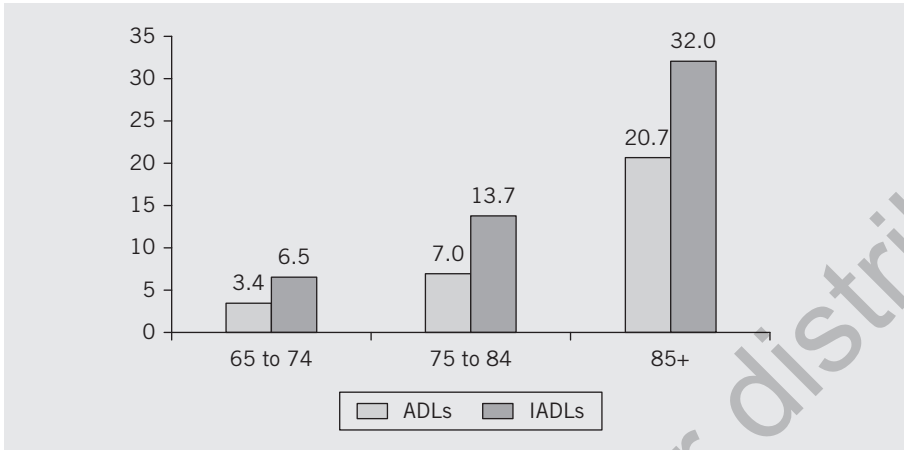


Source: CDC (2012a, 2012b).

A related indicator of functional limitation is the need for assistance in carrying out ADLs and IADLs. Not surprisingly, the need for assistance with daily activities increases with age. As shown in Exhibit 11.5, 7.0% and 13.7% of older adults ages 75 to 84 need assistance with ADLs and IADLs. The need for assistance with ADLs and IADLs increases to 20.7% and 32.0% for those over age 85.

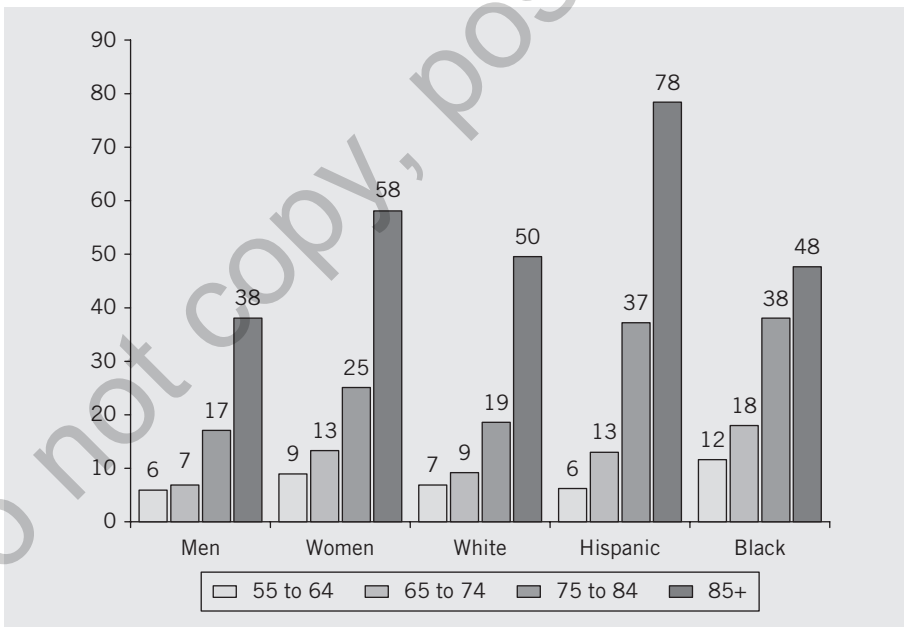
Older women are more likely than older men to need assistance with major ADL and IADL tasks, such as assistance with bathing, dressing, eating, transferring between bed and chair, toileting (ADLs) and preparing meals, doing housework, shopping (IADLs). Although the percentages of women and men ages 65 to 74 who need assistance with everyday activities are similar (13% and 7%, respectively), by age 85 and older, 58% of women need assistance with everyday activities compared with 38% of men (see Exhibit 11.6).

Exhibit 11.5 Persons Needing Assistance With ADL and IADL Needs by Age, 2010 and 2016 (percentage)



Sources: CDC (2012a, 2012b); Clark, Norris, & Schiller (2017).

Exhibit 11.6 Persons Needing Assistance With ADL and IADL Needs by Age, Gender, and Race, 2010 (percentage)



Source: CDC (2012a, 2012b).

Note: Data do not total 100% as data for IADL and ADL needs were summed.

For Your Files

AbleData

Assistive technology devices help people maintain independent living by helping them perform ADLs. Assistive technology devices have been used by persons with disabilities for years; with the growing number of older adults with chronic conditions, however, such devices can effectively assist more older adults with their functional limitations. AbleData is sponsored by the National Institute on Disability, Independent Living, and Rehabilitation Research, which is part of the U.S. Department of Health and Human Services' Administration for Community Living. The AbleData website is a national database of information on assistive technology and rehabilitation equipment

from domestic and international sources. AbleData contains information on more than 40,000 assistive technology products that consumers can search on the web or by phone. AbleData also offers fact sheets about devices and topics related to assistive technology, consumer guides to assist with product selection, and other publications for consumers of assistive technology devices. AbleData can refer people to resources that can help them make their companies accessible. For more information, contact AbleData, 103 W. Broad Street, Suite 400, Falls Church, VA 22046, 800-227-0216, www.abledata.com. Follow them on Facebook, Twitter, and Instagram.

Similar to older women, older adults of different ethnic and racial groups experience a higher number of chronic conditions and functional limitations than do older Whites and therefore are more likely to need assistance with everyday activities. As shown in Exhibit 11.6, a higher percentage of older Blacks and Hispanics report needing assistance in everyday activities than do older non-Hispanic Whites ages 65 to 74, and a higher percentage of Hispanics report needing assistance in everyday activities than do non-Hispanic Whites and Blacks at age 85 and older (CDC, 2012a, 2012b).

In summary, most older adults do enjoy relatively good health; however, as people grow older and move into later life, they acquire more chronic conditions and experience fewer acute conditions, although the latter can result in life-threatening illnesses for some. Furthermore, health status varies between older women and men, between Whites and older adults of different racial and ethnic backgrounds, and between persons of different ages. In general, women, racial and ethnic minority elders, and those over age 85 have more chronic illnesses and more functional limitations, and are more likely to need assistance with major activities.

These health characteristics have significant implications for the delivery of health care and health promotion programs. For example, in later life, adults need health care programs and services that address chronic, rather than acute, conditions. They also need access to and coverage of rehabilitation services, including help with assistive technology devices that are designed to maintain functional independence. Furthermore, health promotion and prevention programs can assist in preventing illness as well as in maintaining functioning. Later in this chapter, we discuss the health promotion and wellness programs designed to improve the health status of older adults. In this next section, we provide an overview of the federal health insurance programs: the Patient Protection and Affordable Care Act, Medicare, and Medicaid.

Federal Health Care Policy

Patient Protection and Affordable Care Act¹

The most significant change to health care policy to be enacted in the last 40 years was the passage of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-152, signed into law by President Obama on March 23, 2010.² The ACA expands health care coverage through a number of public and private approaches. When the ACA was enacted, 44.1 million non-elderly adults did not have health care coverage; as of 2016, the ACA had provided health care coverage to a significant number of persons and the number of uninsured had dropped to 27.6 million. Those covered have attained almost universal coverage through a combination of public programs and private insurance options, incentives for employers and small businesses to cover employees, expansion of Medicare and Medicaid, and changes to provisions allowable under private insurance policies (Kaiser Family Foundation [KFF], 2013b; Tolbert, 2015). In addition, the ACA has provisions designed to control health care costs and improve the health care delivery system. The provisions of the Act were phased in from 2010 to 2014. The ACA broadens access to health insurance by expanding Medicaid for individuals with low incomes and extending subsidies for the purchase of private insurance by individuals with moderate incomes. The Act requires most U.S. citizens and legal residents to have health insurance, and those low-income adults not covered under Medicaid or who have private insurance through their work and employers are able to purchase plans through an Insurance Marketplace.³ The Marketplace offers buyers a choice between four categories of coverage.

These are some of the key features of the ACA in effect as of 2017:

- Individual and group health plans are prohibited from placing lifetime limits on the dollar value of coverage, rescinding coverage except in cases of fraud, and denying children coverage based on preexisting medical conditions or from including preexisting condition exclusions for children.
- The law extends dependent coverage to young adults up to age 26.
- All individual and group health plans must provide coverage to any applicant, regardless of health status, gender, or any other factors.
- Rules prohibit insurers from adjusting premiums based on a person's health status. Insurers may only adjust premiums based on a limited number of factors. One adjustment permitted is that insurers may charge older adults more than younger adults; however, insurers can't charge older adults more than three times what they charge younger adults.

¹The Patient Protection and Affordable Care Act is the official legislation title; the lay press commonly uses "Obamacare" to refer to this Act. We refer to its official title of the Affordable Care Act, or ACA, in our discussion.

²Unless otherwise noted, the summary of the ACA is from Tolbert (2015) and Kaiser Family Foundation (2013b).

³On December 22, 2017, President Trump signed tax legislation that included eliminating the ACA individual mandate—the requirement that individuals purchase health coverage beginning in 2019. This ACA rule was in place to broaden the insurance risk pool so individuals with various health statuses would purchase insurance.

- All health plans must provide a uniform summary of benefits and coverage to applicants and enrollees.
- Plans generally must provide coverage for a range of preventive health services without requiring any patient cost-sharing (copayments, deductibles, or coinsurance).
- The law limits the amount of premium dollars insurers can spend on administration, marketing, and profits.
- The law sets uniform standards for covered benefits and cost-sharing in the individual and small-group markets, and all plans cover 10 categories of essential health benefits.
- There is a limit on the amount of cost-sharing consumers can be expected to pay for services covered by the plan. (Tolbert, 2015)

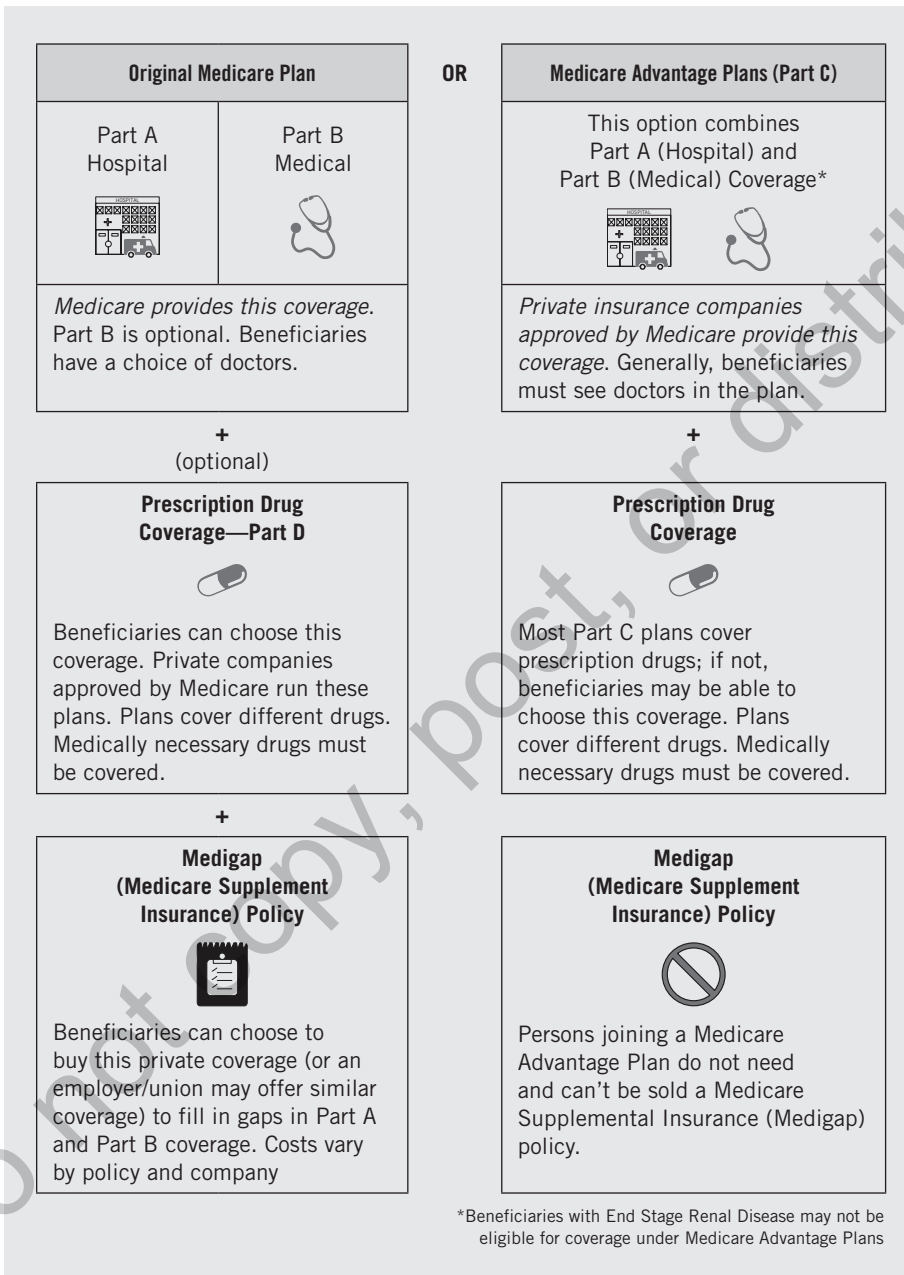
In addition, the ACA makes significant changes to the Medicare and Medicaid programs, which we discuss in the sections that follow.

Medicare

Medicare is a national health insurance program authorized in 1965 under Title XVII of the Social Security Act as a complement to those receiving Social Security benefits. Originally, Medicare covered adults age 65 and over, but since its passage, coverage has been extended to persons who are entitled to Social Security disability for 24 months or more, persons with end-stage kidney disease requiring dialysis or transplant, and noncovered persons who elect to buy into Medicare. Beginning in 2001, persons with Lou Gehrig's disease were allowed to waive the 24-month waiting period and could be covered under Medicare (Klees, Wolfe, & Curtis, 2011). The Centers for Medicare and Medicaid Services (CMS) administer the program under the direction of the U.S. Department of Health and Human Services (USDHHS).

There are two original parts to Medicare: *Part A, Hospital Insurance*, which covers costs associated with inpatient hospitalization and some posthospitalization care, and *Part B, Supplemental Medical Insurance*, which covers physician, outpatient care, and other medical services. A third part of Medicare, sometimes called *Part C*, was established in 1997 and later renamed the *Medicare Advantage Program* in 2003; it expanded beneficiaries' option for participation in private sector health care plans. The 2003 changes in Medicare introduced *Part D*, which established a new prescription drug program (Hoffman, Klees, & Curtis, 2006; see Exhibit 11.7). Part A is funded by taxes on earnings; employers and employees each pay 1.45% of payroll, and self-employed persons pay 2.9%. Starting in 2013, a payroll tax of 0.9% is collected on earned income over \$200,000 for single filers and \$250,000 for joint filers (Internal Revenue Service, 2016; Klees et al., 2011). Older households and Social Security beneficiaries with incomes above a certain amount also contribute to the Part A funding through payroll taxes. Part B is funded primarily through income-related premiums paid by beneficiaries and general federal revenues. Individuals exceeding a threshold income level (starting at \$85,000 for individuals and \$170,000 for couples) will pay slightly

Exhibit 11.7 Overview of Medicare Coverage



Source: CMS (2017e).

higher premiums that will cover 35%, 50%, 65%, or 80% of the average program cost for aged beneficiaries compared with the standard base premium that covers 25% (Cubanski & Neuman, 2017b). The ACA freezes these income threshold levels through 2019. Thus, premiums for Part B cover approximately 25% to 80% of program costs, and general federal revenues cover the remainder (Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, 2017). Reviewing and paying claims under both Part A and Part B are done by intermediaries called Medicare administrative contractors, organized by geographical area, creating a single point of contact for all claims. In 2017, 58 million people were enrolled in Part A and/or Part B, approximately 18.6 million have chosen to participate in Medicare Advantage, and Part D covered more than 42.5 million enrollees, 40% of whom are in Medicare Advantage (CMS, 2017a; KFF, 2017c).

Who Is Eligible for Medicare?

All persons who are eligible for Social Security or Railroad Retirement benefits are also eligible for Medicare benefits. In addition, individuals who are entitled to Social Security Disability or Railroad Retirement Disability benefits for at least 24 months and government employees with Medicare-only coverage who have been disabled for 29 or more months are also entitled to receive Part A benefits. Therefore, individuals qualify for Medicare if they or their spouses, including same-sex married spouses, worked for 10 years (or 40 quarters) in employment that paid into Social Security. Those who lack a sufficient number of quarters can purchase Part A benefits if they also buy Part B coverage. In 2018, individuals who wished to buy Part A coverage could do so for \$422 (CMS, n.d.-d). For individuals who have earned enough quarters, there is no premium cost associated with Part A; older adults choosing to participate in Part B, however, pay a monthly premium. Beginning in January 2018, the amount of the Part B monthly premium is based on the beneficiary's gross income. Individuals with incomes less than \$85,000 pay \$134.00, those with incomes between \$85,000 and \$107,000 pay \$187.50, those between \$107,000 and \$160,000 pay \$267.90, those between \$160,000 and \$214,000 pay \$348.30, and those above \$214,000 pay \$428.60. All beneficiaries must meet the \$183 per year deductible for physician services (Cubanski & Neuman, 2017b; CMS, n.d.-e).

Coverage

Exhibits 11.8, 11.9, 11.10, and 11.11 present detailed explanations of the coverage provided by Part A, Part B, expanded coverage under the ACA, and Part D. Medicare Part A provides coverage of inpatient hospital services up to 90 days per benefit period⁴ plus 60 days of lifetime reserve days, skilled nursing facilities for 100 days following a 3-day hospital stay, intermittent home health services if skilled care is needed, and hospice care (CMS, 2018b). Medicare Part B helps pay for the cost of physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies. As mentioned previously, the ACA expands coverage of preventive services to 19 different services, reduces or

⁴A benefit period begins on the first day a beneficiary receives inpatient hospital benefits and ends after being discharged from the hospital or skilled facility for 60 consecutive days.

eliminates deductibles and copayments, and covers annual wellness visits and a personalized prevention/wellness plan (CMS, 2017e). Payments made by Medicare under Part A for inpatient hospital costs are based on the patient's diagnosis, referred to as *diagnostic related group* (DRG). The patient's DRG dictates the payment the hospital will receive as well as the length of stay on which the payment is based. Under the DRG system, payments to the hospital for a given Medicare patient may be more or less than the hospital's cost—thus, the hospital either absorbs the loss or enjoys a profit. Payments for other services under Part A (home health, skilled nursing facility, and hospice) are paid on a “reasonable cost” basis billed by the provider. Under Part B, Medicare pays physicians on the basis of a “reasonable charge,” which is the lowest of either the submitted charges or a fee schedule based on a relative value scale (CMS, 2018b). If a provider agrees to accept the approved rate as full payment for services, the provider “accepts assignment.” If the provider does not accept assignment for the services provided, the beneficiary is responsible for the remaining balance of the cost of the service and what Medicare will pay. Other services covered under Part B, such as durable medical equipment and clinical laboratory services, are also paid on a fee schedule. Outpatient and home health coverage under Part B is paid on a reasonable cost basis.

Exhibit 11.8 Medicare Coverage, Part A

Services	Benefit ^a	Medicare Pays	Beneficiary Pays
Hospitalization (in-patient^b) Semi-private room, meals, regular nursing services, specialized care units, intensive care, operating and recovering room, drugs, laboratory tests, X-rays, and all other medically necessary supplies	First 60 days	All approved charges but \$1,340	\$1,340
	Days 61–90	All but \$335 per day coinsurance	\$335 per day for each benefit period
	Days 91–150	All but \$670 per day coinsurance	\$670 per day for each benefit period
	150+ days	Nothing	All
	Lifetime reserve days		“Lifetime reserve days” are 60 extra days of coverage that can be used during the lifetime of the beneficiary
Inpatient mental health care in a psychiatric hospital	Same as above	Same as above	Pay \$670 per day during the 60 days of coverage
		Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime	All after 190 lifetime days

(Continued)

Exhibit 11.8 (Continued)

Services	Benefit ^a	Medicare Pays	Beneficiary Pays
Skilled Nursing Facility Semi-private room and board, skilled nursing and rehabilitative services, and other services and supplies	Days 1–20	100% of covered services	Nothing
	Days 21–100	All but \$167.50 per day	\$167.50 per day
	100+ days	Nothing	All costs
Home Health Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, physical therapy, occupational therapy, and speech-language pathology	Unlimited as long as Medicare conditions are met	100% of the cost of covered home health care; 80% of approved amount for durable medical equipment	Nothing for services; 20% for durable medical equipment
Hospice Pain relief, symptom management, and support services for the terminally ill	For as long as doctor certifies and patient has 6 months or less to live	100% of charges; no deductible	A copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care
Blood When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited if medically necessary	All but first three pints per calendar year	For first three pints then 20% of the Medicare-approved amount for additional pints of blood

Source: CMS (2017e).

^aA benefit period begins on the first day a beneficiary receives inpatient hospital benefits and ends after being discharged from the hospital or skilled facility for 60 consecutive days.

^bInpatient is when the hospital formally admits someone; a Medicare Outpatient Observation Notice is a document that a patient must receive if receiving outpatient versus inpatient services.

According to Boards of Trustees (2017), in 2016, Part A provided benefits of \$285.4 billion to 47.5 million elderly enrollees and 9 million disabled enrollees with an average benefit per enrollee of \$4,968. Part B provided coverage to approximately 43.9 million elderly enrollees and 8.2 million disabled enrollees totaling \$293.4 billion with an average benefit of \$5,558.

Exhibit 11.9 Medicare Coverage, Part B

Services	Benefit ^a	Medicare Pays	Beneficiary Pays
Preventive Services See Exhibit 11.10			
Medical Expenses Doctors' and physician assistants' services, inpatient and outpatient preventive services, emergency services, medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services	Unlimited if medically necessary	80% of approved amount after \$183 deductible	\$183 deductible, plus 20% of approved amount and limited charges above the approved amount
Clinical Laboratory Services Blood tests, urinalyses, and more	Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services	Unlimited as long as Medicare conditions are met	100% of the cost of covered home health care; 80% of approved amount for durable medical equipment	Nothing for services; 20% for durable medical equipment
Outpatient Hospital Services Services for the diagnosis or treatment of illness or injury	Unlimited if medically necessary	Approved amount minus copay or coinsurance amount	Copay or coinsurance amount
Blood When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited if medically necessary	80% of approved amount after deductible and starting with the fourth pint	For first three pints unless replaced by an outside donation of blood to the hospital, plus 20% of approved amount for additional pints
Mental Health Services	Unlimited if medically necessary	80% of approved amount	20% of approved amount
Ambulance Services	Unlimited if medically necessary	80% of approved amount	20% of approved amount
Eyeglasses (limited)	One pair of eyeglasses or contact lenses after cataract surgery	80% of approved amount	20% of approved amount

Source: CMS (2017e).

^aA benefit period begins on the first day a beneficiary receives inpatient hospital benefits and ends after being discharged from the hospital or skilled facility for 60 consecutive days.

Medicare beneficiaries can select to receive benefits under the Part C or Medicare Advantage program. This program offers beneficiaries the option to enroll in plans offered by health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service plans (PFFS), and a few other types of plans. To enroll, beneficiaries must live in a locale in which these private sector plans are available. Under Medicare-managed care plans, Medicare pays a set amount of money every month to a private insurance company participating in the Medicare Advantage program, and beneficiaries must use doctors and hospitals that are members of the plan and must obtain a referral from their primary care provider to see a specialist. PFFS plans are offered by private insurance companies, and, as with the managed care plans, Medicare pays a set amount of money every month to the private insurance company. Beneficiaries must go to selected health care providers and hospitals, receive prior authorization for certain medical treatments, and pay Medicare's Part B premium and possibly an additional monthly premium. The insurance company decides how much it will pay and how much the beneficiaries pay for the health services provided.

Under the ACA, the Medicare program will gradually phase down payments to the providers of these plans (which is currently 9% to 13% higher on average than local fee-for-service costs) to be more closely aligned to the average cost of the traditional Medicare program (KFF, 2010a). In turn, providers will receive monetary incentives for offering high-quality plans and for increased cost-effectiveness. In addition, cost-sharing requirements must not be higher than traditional Medicare for chemotherapy, renal dialysis, and skilled nursing care, and enrollees will be able to receive improved prescription drug coverage (KFF, 2010a). Beneficiaries pay the monthly Part B premium, and most plans require a copayment (\$10 to \$20) for each doctor visit and possibly an additional monthly premium. Some plans offer additional benefits such as prescription drug coverage.

Exhibit 11.10 ACA Expansion of Covered Preventive Services Under Medicare

Service	Who Is Eligible	How Frequently	Beneficiary's Costs
Initial Preventive Physical Examination (IPPE), or "Welcome to Medicare Exam"	Enrollees in Part B within first 12 months of enrollment	Once-in-a-lifetime benefit per beneficiary	None
Annual Wellness Visit (AWV), new benefit in 2011	Enrollees in Part B after first 12 months of enrollment who have not received an IPPE or AWV within the past 12 months	Annually	None
Abdominal Aortic Aneurysm Ultrasound Screening	Part B enrollees with certain risk factors for abdominal aortic aneurysm	Once in a lifetime based on referral resulting from a "Welcome to Medicare Exam"	None

Service	Who Is Eligible	How Frequently	Beneficiary's Costs
Bone Mass Measurements	Female Part B enrollees who are estrogen deficient and at clinical risk for osteoporosis; all Part B enrollees with vertebral abnormalities receiving (or expecting to receive) glucocorticoid therapy for more than 3 months with primary hyperparathyroidism or being monitored to assess response to osteoporosis drug therapy	Every 24 months; more frequently if medically necessary	None
Breast Cancer Screening Mammography	Female Part B enrollees age 35 and older	Age 35 through 39: one baseline Age 40 and older: annually	None
Cardiovascular Disease Screenings	All Part B enrollees	Every 5 years	None
Colorectal Cancer Screening	Part B enrollees age 50 and older	Normal risk: Fecal Occult Blood Test (FOBT) every year, flexible sigmoidoscopy every 4 years (or at least 119 months after a screening colonoscopy), screening colonoscopy every 10 years (or at least 48 months after a screening flexible sigmoidoscopy), barium enema once every 48 months High risk: FOBT every year, flexible sigmoidoscopy once every 4 years, screening colonoscopy every 2 years (or at least 48 months after a screening flexible sigmoidoscopy), barium enema	None: Except: Deductible and copayment/coinsurance apply to barium enema, Copayment/coinsurance apply to screening colonoscopy where polyps or other abnormalities are found and treated
Diabetes Screening Tests	Part B enrollees with certain risk factors for diabetes or diagnosed with prediabetes	Two per year for beneficiaries diagnosed with prediabetes; one per year if previously tested, but not diagnosed with prediabetes, or if never tested	None

(Continued)

Exhibit 11.10 (Continued)

Service	Who Is Eligible	How Frequently	Beneficiary's Costs
Diabetes Self-Management Training	Part B enrollees diagnosed with diabetes	First year: up to 10 hours of initial training; subsequent years: up to 2 hours of follow-up training annually	Deductible and coinsurance/copayment
Glaucoma Screening	Part B enrollees: with diabetes mellitus, family history of glaucoma, African Americans age 50 and older, or Hispanic-Americans age 65 and older	Annually	Deductible and copayment/coinsurance
Hepatitis B (HBV) Vaccine	Certain Part B enrollees at intermediate or high risk who are not at the time of the vaccine positive for antibodies for hepatitis B	Scheduled dosages required	None
Human Immunodeficiency Virus (HIV) Screening	Beneficiaries who are at increased risk for HIV infection or pregnant	Annually for beneficiaries at increased risk; three times per pregnancy for beneficiaries who are pregnant	None
Lung Cancer Screening	All Medicare enrollees who meet all of these conditions: age 55–77; current smoker or have quit smoking within the last 15 years; have a tobacco smoking history of at least 30 “pack years”; get a written order from their physician	Once every 12 months	None
Medical Nutrition Therapy (MNT)	Certain Part B enrollees diagnosed with diabetes, renal disease, or who have had a kidney transplant within the last 3 years	First year: 3 hours of one-on-one counseling; subsequent years: 2 hours	None
Obesity Screening and Counseling	All people with Medicare; counseling is covered for anyone found to have a body mass index of 30 or more	Counseling is covered if it is in a primary care setting (like a doctor's office); 15-minute face-to-face individual behavioral therapy sessions and 30-minute face-to-face group behavioral counseling sessions	None

Service	Who Is Eligible	How Frequently	Beneficiary's Costs
Pneumococcal Vaccine	Part B enrollees	Once in a lifetime, but Medicare may provide additional vaccinations based on risk if at least 5 years have passed since receipt of a previous dose	None
Prostate Cancer Screening	Male Part B enrollees age 50 and older	Annually	Digital rectal examination: deductible and copayment/coinsurance; prostate-specific antigen (PSA) test: none
Screening Pap Test	Female Part B enrollees	Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years; every 24 months for all other women	None
Screening Pelvic Exam	Female Part B enrollees	Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years; every 24 months for all other women	None
Seasonal Influenza Virus Vaccine	Part B enrollees	Once per influenza season in the fall or winter, but Medicare may provide additional flu shots if medically necessary	None
Tobacco Cessation Counseling	All Part B enrollees who use tobacco when counseled by a Medicare-recognized counselor	Two cessation attempts of up to four intermediate or intensive sessions per year	None

Source: CMS (2015c).

In 2017, 19 million Medicare beneficiaries, or 33% of people on Medicare, chose to be in the Medicare Advantage program, an increase from 13% in 2004 (Jacobson, Damico, Neuman, & Gold, 2017). Of those enrolled in the Medicare Advantage program, 63% were in HMOs, 26% in local PPOs, 7% in regional PPOs, and 3% in PFFS or other plans (KFF, 2017c). Since the creation of Medicare Advantage, the number of organizations providing plans under Medicare Advantage contracts has fluctuated. In the early years of the program, the number of available plans declined from 346 in 1998 to 212 in 2005 (Gold, Hudson, & Davis, 2006; Health Care Financing Administration, 2001). The decline in the number of private companies offering Medicare Advantage plans to beneficiaries during this timeframe forced more than 1.7 million enrollees back to the original Medicare program or another Medicare Advantage provider. Since 2005, the number of Medicare Advantage plans available nationwide continues to fluctuate. There were 2,098

plans in 2007, 2,314 in 2010, 2,074 in 2013, 2,001 in 2016, and 2,317 in 2018; the average Medicare beneficiary has access to 21 plans (Jacobson et al., 2017; KFF, 2017b). In addition, benefits under many of the Medicare Advantage plans have become less generous in some respects and more generous in others. In 1998, 78% of enrollees were in Medicare Advantage plans that had no additional premium cost and that included coverage of outpatient prescription drug coverage. By 2017, the percentage of enrollees in plans that did not have additional premiums dropped to 50%; however, the average enrollee's monthly premium dropped from \$44 in 2010 to \$36 in 2017 (Jacobson et al., 2017).

Cain (1996) has identified a number of advantages that Medicare beneficiaries enjoy when they join HMOs. They usually do not have to pay deductibles or coinsurance payments required under Part A or Part B, and HMOs agree not to charge more than Medicare's approved amount. Therefore, for many older adults, HMOs are an alternative to buying supplemental Medigap policies. In addition, HMOs often provide a wider range of services, including preventive health care, outpatient mental health services, prescription drugs, and eyeglasses. Disadvantages include restrictions on choice of doctor and hospitals not associated with the HMO; there is also a fear that older adults will not get the health services they need (R. L. Kane et al., 1996). Other problems include misunderstandings among enrollees about the terms associated with HMO enrollment, restrictions, and denial of services, and simply a lack of awareness of the availability of plans (Mittler, Landon, Zaslavsky, & Cleary, 2011; Wilson, cited in National Association of Area Agencies on Aging, 1996). Gold et al. (2006) examined the characteristics of benefits and premiums offered by Medicare Advantage plans in 2006 and found that the structure of the benefits and premiums was complex, "presenting beneficiaries with even more Medicare Advantage plan types that vary in how they function and in how benefits and cost sharing are structured" (p. 17). They concluded that, because of the complexities of plans, beneficiaries will need a great deal of support and assistance as they try to choose between the original Medicare Part A and B, and Medicare Advantage.

As mentioned earlier, Medicare now offers prescription drug coverage. Drug coverage can be obtained either under Part D through the additional purchase of a private plan authorized under the Medicare program or as part of a Medicare Advantage plan. Medicare beneficiaries enrolling under Part D are encouraged to join when they are first eligible to do so, or they pay a penalty as long as they have Medicare. Individuals who have drug coverage from another source, such as a previous employer, can choose not to enroll in Part D. Beneficiaries may switch prescription drug plans during the enrollment period each year (November 15–December 31) and under other situations as approved by Medicare (e.g., moving out of the service area of the plan). As of 2017, 42.5 million older adults received prescription coverage under Part D traditional Medicare and Medicare Advantage drug plans; they have 23 Medicare Part D stand-alone prescription drug plans and 17 Medicare Advantage prescription drug plans in their area to choose from (CMS, 2017a; Cubanski, Damico, Hoadley, Orgera, & Neuman, 2017).

Each calendar year, those enrolled in Part D pay a base monthly premium—the average is expected to be \$43.48 (a 68% increase from 2006) but varies by plan from \$12.60 to \$243—and a yearly deductible (not greater than \$405 in 2018; Cubanski et al., 2017). Starting in 2012, enrollees paid an additional premium surcharge above the plan's base amount based on their Modified Adjusted Gross Income. The additional surcharge ranges on a sliding scale, depending on income level, from \$13.00 to \$74.80

for beneficiaries with incomes greater than \$85,000 (KFF, 2017c). No plan may have a deductible higher than the amount set each year. After the deductible has been reached, the plan covers 75% of the next \$3,750 of the prescription drug costs, and the beneficiary pays the remaining 25%.

After this initial coverage amount has been met, a coverage gap—often referred to as the *donut hole*—is in effect. The donut hole is the gap in coverage after the plan and the beneficiary reach a predetermined amount that has been spent on coverage (\$5,000 in 2018). Once this amount has been spent, under the basic benefit, the beneficiary gets a 50% discount on the cost of name-brand drugs, with plans paying an additional 15% of the cost and enrollees responsible for 35%; plans pay 56% of the cost for generic drugs in the gap phase, with enrollees paying 44% until they reach an out-of-pocket amount (\$5,000 in 2018), and then catastrophic coverage begins. During the catastrophic coverage, the plan covers up to 95% of prescription costs, or \$3.35 or \$8.35 for each generic or brand-name drug, until the end of the calendar year (KFF, 2017c; J. L. Matthews, 2017; see Exhibit 11.11). Under the ACA, changes designed to address the donut hole problem include providing a \$250 rebate to beneficiaries, introducing discounted payment rates of 50% and 86% on name-brand and generic drugs mentioned above (both now in effect), and gradually phasing out the donut hole in 2020 (Klees et al., 2011).

Finally, individuals with low incomes (less than 150% of poverty, or \$18,090 for individuals/\$24,360 for married couples in 2017) and modest assets (less than \$13,820 for individuals/\$27,600 for couples in 2017) qualify for the Part D Low-Income Subsidy (LIS) program. These individuals receive additional premium and cost-sharing assistance, and as of 2018, 216 plans would be available for enrollment of LIS beneficiaries for no premium, a 6% decrease in premium-free (“benchmark”) plans from the previous year (KFF, 2017c).

For older adults to benefit from Part D, they must be able to sort through a myriad of plans available in their area and identify which plan has better coverage for

Exhibit 11.11 Medicare Prescription Drug Coverage, Part D, 2018

Prescription Drug Spending	Medicare-Approved Plan Pays	Beneficiary Pays
Up to \$405 (annual deductible)	Nothing	Up to \$405 for the annual deductible amount
\$405 to \$3,750 (initial coverage)	75% of drug costs	Copay of 25% of drug costs
\$3,750 to \$5,000 (gap or donut hole)	10% of name-brand drug costs 49% of generic drug costs. 50% price break on cost from manufacturer	40% of name-brand drug costs 51% of generic drug costs Out-of-pocket costs totaling \$5,000
Over \$5,000 (catastrophic coverage)	Medicare pays 95% Plan pays 15%	The greater of 5% coinsurance or \$3.35 (generic) and \$8.35 (brand-name)

Sources: CMS (2017e); KFF (2017c).

the prescription drugs they use. The Medicare website has an interactive Medicare Plan Finder to help consumers sort through their options (www.medicare.gov/find-a-plan/questions/home.aspx). Prescription drug coverage in a select plan can also change; thus enrollees may have to reevaluate their plans on a regular basis. Enrollment patterns and benefits need to be studied in the future. One early study found that over half of respondents reported being confused about the changes and viewed the task of choosing a plan as stressful (Hibbard, Greene, & Tusler, 2006).

Medigap Policies

Many older adults purchase Medicare supplemental insurance policies, commonly referred to as *Medigap* policies, which are designed to assist with the costs of health care services not covered by Medicare. Medigap policies usually pay deductibles, copayments, and the remaining 20% of the approved charges for physician and hospital services. Limited coverage is sometimes provided for prescription drugs, home care, and preventive care. The Medicare consumer site has a link to help individuals explore different plan options in their area (www.medicare.gov/find-a-plan/questions/medigap-home.aspx).

Medicaid

In the same year in which Congress enacted Medicare (1965), Medicaid became law as Title XIX of the Social Security Act. Medicaid, unlike Medicare, operates as a joint federal–state program and is the nation’s single largest health care insurer. Subject to standards set by the federal government, states have flexibility to determine covered populations, covered services, health care delivery models, methods for paying physicians and hospitals, and many other aspects of their Medicaid programs. States may also apply to the Department of Health and Human Services for a Medicaid waiver that allows the testing of new benefits, financing or implementing a major restructuring of the Medicaid program. The passage of the ACA significantly expanded the Medicaid program, primarily for non-elderly adults and children by making changes to eligibility criteria and coverage. In order for you to have a general understanding of the Medicaid program, we provide an overview of the program that discusses changes that cover both non-elderly and elderly adults. Unless noted otherwise, the information that follows is from three of the Kaiser Family Foundation’s (2013a, 2015, 2017a) in-depth Medicaid analyses.

Who Is Eligible for Medicaid?

Because states are granted significant flexibility, Medicaid programs vary by state. Prior to the ACA, states based their Medicaid eligibility on having low income, having limited assets, and being a child, a parent or caretaker adult of an eligible child, a disabled adult or child, or an aged adult (Boards of Trustees, 2017). The federal government, however, requires states to include persons who receive federal income maintenance assistance, such as current and some former Supplemental Security Income (SSI) recipients, low-income Medicare beneficiaries, and individuals who were eligible for Aid to Families with Dependent Children (AFDC) as of 1996 ([Medicaid.gov](http://www.Medicaid.gov), n.d.-b). Because of this state-by-state variability in eligibility guidelines, not all low-income individuals are eligible for Medicaid, and a person deemed eligible for Medicaid in one state may

not qualify for Medicaid in a different state. However, all Americans who meet Medicaid eligibility requirements are guaranteed some level of coverage.

The ACA expanded Medicaid by establishing eligibility for adults under age 65 with income at or below 138% of the federal poverty line, and individuals no longer needed to meet the previous criteria. However, the ACA did not change Medicaid eligibility for elderly adults and people with disabilities. In 2012, the Supreme Court ruled that states did not have to adopt the new Medicaid eligibility requirements, making the expanded Medicaid health care coverage optional for states; however, the ACA provided strong incentives for states to participate as the federal government paid 100% of those newly eligible individuals from 2014 to 2016 and 90% after 2016 (KFF, 2013b). As of FY 2017, 31 states and the District of Columbia had expanded Medicaid by adopting the ACA expansion criteria.

Regardless of whether states have adopted the expanded Medicaid guidelines or kept their original state-based Medicaid, eligibility falls into two categories: categorically needy and medically needy. The *categorically needy* are those individuals who meet the eligibility guidelines in place, and states also have the option of covering other categories of individuals such as (a) certain aged, blind, or disabled adults who have income above those requiring mandatory coverage but below the federal poverty level; (b) institutionalized individuals with income and resources below specified limits; (c) persons who would be eligible if institutionalized but who are receiving care through home- and community-based services; and (d) recipients of state supplementary payments, such as old-age pensions (Klees et al., 2011). In addition, some states opt to include individuals who are considered *medically needy* but who have too much income to qualify as categorically eligible. Medically eligible individuals (e.g., aged, blind, or disabled persons) are allowed to spend down to Medicaid income eligibility guidelines by using their medical expenses to offset their excess income, thus reducing their income level to meet the Medicaid guidelines. Two groups recently added to the list of medically eligible individuals that states may cover are women who have breast or cervical cancer and persons with tuberculosis who are uninsured (Klees et al., 2011).

Coverage

Medicaid covers a broad range of health care services to address the various medical needs of the populations it serves and provides three types of medical assistance: (1) health insurance for acute care, (2) long-term care and home care, and (3) supplemental coverage for low-income Medicare beneficiaries (called dual-eligible) for services not covered by Medicare and Medicare premiums, deductibles, and cost-sharing.

States participating in Medicaid must cover basic medical services to all Medicaid beneficiaries but within broad federal guidelines and certain limitations; the amount and duration of services can be limited. The following medical services are provided to those who qualify:

- physicians' services
- inpatient and outpatient hospital services
- laboratory and X-ray services
- early and periodic screening, diagnostic, and treatment services for individuals under age 21

- federally qualified health center services
- family planning services and supplies
- rural health clinic services
- vaccines for children
- pediatric and family nurse practitioner services
- nurse midwife services
- nursing facility services for individuals 21 and older
- home health care for persons eligible for nursing facility services

States also may receive federal financial assistance if they choose to provide other optional approved medical services. Some optional medical services covered by Medicaid include the following:

- clinic and diagnostic services
- prescription drugs
- care furnished by other licensed practitioners
- dental services and dentures
- transportation services to medical care
- prosthetic devices, eyeglasses, and durable medical equipment
- rehabilitation and other therapies
- case management
- nursing facility services for individuals under age 21
- intermediate care facility services for individuals with intellectual disabilities
- home- and community-based services (including under waivers) and personal care services
- inpatient psychiatric services for individuals under age 21
- hospice services

States opting into the ACA Medicaid expansion must provide ACA's 10 "essential health benefits": (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

As mentioned above, Medicaid also provides benefits to persons who qualify for Medicare. For persons who are eligible for both Medicare and Medicaid (i.e., dual-eligible), Medicaid pays all the premiums, deductibles, and coinsurance costs associated with Part A

and Part B. Medicaid may also pay for services beyond what is covered under Medicare (e.g., hearing aids, skilled nursing after 100 days). The Medicare program must pay for services before any payments are made by Medicaid. Other Medicare beneficiaries who can receive assistance from Medicaid are those who have incomes at or below 100% of the federal poverty line (FPL) and whose resources are at or below 200% of the SSI guidelines (Medicaid.gov, n.d.-b). There are three categories of these beneficiaries, and all receive some assistance in paying the cost-sharing provisions in Medicare. Qualified Medicare beneficiaries whose income is at or below 100% of the FPL receive some assistance from Medicaid for payment of the cost-sharing provisions in Medicare in Parts A and B. Specified low-income Medicare beneficiaries who have incomes above 100% but below 120% of the FPL and qualified individuals whose incomes are above 120% but below 135% of the FPL also receive assistance from Medicaid in paying Part B premiums. Finally, dual-eligible persons receive assistance with the cost of copayments and premiums required under Part D prescription drug coverage. In 2017, Medicaid provided some level of assistance to 8.3 million dual-eligible persons (Klees et al., 2011; Medicaid.gov, n.d.-d).

Persons who are over the age of 65 represent 10% of persons enrolled in Medicaid (4.6 million) and account for 23% of Medicaid spending (Klees et al., 2011). Data indicate that much of the Medicaid spending for this group is for long-term care—an amount totaling almost \$123 billion, or 28% of total Medicaid spending, and paying an average of \$29,533 per nursing home beneficiary (KFF, 2012a; Klees et al., 2011). In an attempt to moderate the growth in health care costs for low-income and dual-eligible persons (which represents 38% of Medicaid costs; KFF, 2012a), managed care has emerged as a way to control health care costs. Another way legislators have acted to control Medicaid spending on long-term care costs has been the recent enactment of legislation allowing all states to enact legislation that links the purchase of long-term care insurance with Medicaid. In February 2006, Congress passed legislation that permits Medicaid to cover long-term care needs beyond the terms of the policy, with policy holders not required to “spend down” their assets to meet the Medicaid eligibility guidelines (Capretta, 2007).

New to Medicaid is an option to provide Health Homes for beneficiaries with at least two chronic conditions (or with one chronic condition and at risk for another), which will offer a more holistic approach designed to reduce fragmentation of care. The Health Home program will offer integrated care management and coordination, health promotion, transition care from inpatient to other settings, and referrals to social services (KFF, 2012b). Other long-term care services under the ACA include the following:

- It expanded the scope of services and increases eligibility to individuals with incomes up to 150% of the FPL, covered under the home- and community-based services program.
- It extended the Money Follows the Person demonstration program until 2016, which supports options for individuals with disabilities and older adults who live in an institution to transition back to the community (its future after 2016 is uncertain).
- It established the Community First Choice (CFC) option, which allows states to provide support to qualified individuals who need institutional care but wish to live in noninstitutional settings to receive personal care and assist

individuals with ADLs, IADLs, and health-related tasks. States may also leverage CFC funds to cover transition services to help people leave nursing facilities and return to their homes and communities. As of 2016, eight states offered this option in their respective Medicaid programs. (KFF, 2010b; Medicaid.gov, n.d.-a)

How Is Coverage Provided?

After obtaining permission from CMS, states can require beneficiaries to enroll in managed care plans and can offer home- and community-based services to those individuals with chronic impairments who are eligible for Medicaid. As of July 2016, all states except three—Alaska, Connecticut, and Wyoming—enrolled some percentage of Medicaid beneficiaries in a managed health care plan. Twenty-nine states have over 75% of their Medicaid recipients enrolled in Medicaid managed care plans (KFF, 2017a). In 48 states with some form of managed care, 39 have contracts with comprehensive risk-based managed care organizations to serve at-risk populations (e.g. persons with disabilities). States also can request a waiver called a Program of All-Inclusive Care for the Elderly (PACE), which allows them to offer a package of services to persons who, without community support services, might otherwise be institutionalized. Such services include case management, adult day program services, respite care, and homemaker/home health care.

Payment for services may be made directly to the provider on a fee-for-service basis or be paid to providers such as HMOs through prepayment agreements. The provider must accept the Medicaid payment as payment in full, and the amount must be enough to enlist providers so that the covered services are available. States may also require beneficiaries to pay nominal copayments or a deductible for certain services; persons in long-term care facilities must contribute most of their income as a copayment for long-term care coverage (Klees et al., 2011).

Medical Benefits for Retired Veterans

The federal government provides health care coverage for retired members of the uniformed services, as well as their spouses and children, through the TRICARE program. TRICARE provides coverage for civilian hospital services, doctors, and other health care services and supplies. With a few exceptions, retirees who become eligible for Medicare lose their previous TRICARE coverage, and they become dual-enrolled in Medicare and the TRICARE for Life (TFL) program. Under this program, beneficiaries must have Medicare Part A and Part B to have TFL, and Medicare becomes their primary payer. TFL is similar to other Medigap policies that act as a second payer to Medicare, paying for out-of-pocket costs for services provided under Medicare. In addition, TFL pays for some health care services not covered by Medicare, including pharmacy benefits, extended hospital and skilled nursing home care, and mental health counselors (Defense Health Agency, 2017).

Health Promotion and Wellness

The focus on health promotion and wellness has been driven, in part, by the desire to enjoy a high level of functioning in later life. Growing evidence shows that

individuals who engage in healthy lifestyle behaviors have positive health outcomes. For example, 7 of the 10 leading causes of death (e.g., heart disease, stroke) can be reduced by changes in lifestyle, including proper nutrition, exercise, reduced alcohol consumption, and not smoking (Belloc & Breslow, 1972; G. Low & Molzahn, 2007; Saxon et al., 2010). For older adults in particular, health promotion activities can prevent illness in those who are healthy, prevent those who are ill from becoming disabled, and help those who are disabled to preserve function and prevent further disability (Coberley, Rula, & Pope, 2011; Institute of Medicine, 1991; see Lima et al., 2017). Therefore, numerous health promotion programs targeting older adults have emerged. The Older Americans Act (OAA) has supported the funding of evidence-based health promotion programs, and the Administration on Aging (AoA) has been instrumental in supporting initiatives designed to enhance the well-being of older adults. These efforts are discussed below.

Policy Background

The 1992 amendment to the OAA authorized the creation of *Part F, Disease Prevention and Health Promotion Services*, under Title III. Under the 2000 amendments, the health promotion programs under Part F were moved to Part D and included funding of the following health promotion programs:

- health risk assessments
- routine health screenings
- nutrition counseling and education
- health promotion programs relating to chronic conditions
- alcohol and substance abuse, smoking cessation, weight loss, and stress management
- physical fitness programs, group exercise, music therapy, art therapy, and dance movement
- home injury control services
- mental health services
- education about the availability of preventive services covered under Medicare
- medication management
- information about age-related diseases
- gerontological counseling
- counseling regarding social services and follow-up health services

Funding for preventive health services under Part F for fiscal year 2012 was \$20.9 million; in FY 2017 it was \$19.8 million, which is the same amount requested for FY 2019 (USDHHS, 2012a, 2017a).

Health Promotion Programs Funded Under the OAA

During the past three decades, the AoA has been instrumental in sponsoring a number of nationwide initiatives designed to promote health and wellness of older adults. The National Health Promotion Initiative sponsored by the AoA and the U.S. Public Health Service in 1986 was designed to facilitate collaboration between state and local health departments, state and local Area Agencies on Aging (AAAs), and volunteer organizations in developing and implementing health promotion programs (FallCreek, Allen, & Halls, 1986). The initiative targeted four areas of health promotion: injury control, proper drug use, better nutrition, and improved physical fitness. The initiative was responsible for the development of resource materials, including *Health Promotion and Aging: A National Directory of Selected Programs* (FallCreek et al., 1986), *A Healthy Old Age: A Sourcebook for Health Promotion With Older Adults* (FallCreek & Mettler, 1982), and *Health Promotion and Aging: Strategies for Action* (FallCreek & Franks, 1984).

In 1989, the AoA launched the Historically Black Colleges and Universities Initiative to address the health promotion needs of older adults of color. Ten schools were awarded grants under this initiative to develop strategies and demonstration projects to promote better self-care habits among minority older persons. Health promotion strategies included church-based health promotion programs, programs for low-income Black older people living in inner cities and rural areas in Georgia using peer counselors, and the creation of videos and instructional guides targeted to older African American audiences through public access television (USDHHS, 1993).

In the 1990s, a major initiative sponsored by the AoA was the Action for Health: Older Women's Project, the goal of which was to demonstrate the feasibility of developing and implementing an innovative community-based, peer educator-facilitated health and wellness promotion program for older minority and low-income women (Herman & Wadsworth, 1992). In 1994, the AoA became a participant in the National Coalition on Disability and Aging to focus attention on the common concerns of older persons and persons with disabilities. The delivery of care under managed care was just one of the topics coalition members examined.

In the 2000s, the AoA collaborated with the Centers for Disease Control and Prevention's Healthy People 2010 initiative to focus on diabetes, cardiovascular disease, and rates of immunization in older ethnic minority groups. The AoA earmarked \$1 million to support the initiative called Racial and Ethnic Approaches to Community Health 2010 (REACH 2010; CDC, 2017c). Agencies in four communities were awarded demonstration grants designed to educate older ethnic minorities about diabetes, cardiovascular disease, and immunizations. The four agencies were the Boston Public Health Commission, which targeted its efforts to older African Americans; the Latino Education Project of Corpus Christi, Texas, which targeted older Latinos; the National Indian Council on Aging, which targeted Native American and Alaskan Native populations; and Special Services for Groups of Los Angeles, California, which targeted individuals of Southeast Asian descent. The new Healthy People 2020 also includes a focus on older adults and has the following objectives specifically related to health promotion for older adults:

- Increase the proportion of older adults who use the Welcome to Medicare benefit.
- Increase the proportion of older adults who are up to date on a core set of clinical preventive services.

- Increase the proportion of males age 65 and older who are up to date on a core set of clinical preventive services.
- Increase the proportion of females age 65 and older who are up to date on a core set of clinical preventive services.
- Increase the proportion of older adults with one or more chronic health conditions who report confidence in managing their conditions.
- Increase the proportion of older adults who receive Diabetes Self-Management Benefits.
- Reduce the proportion of older adults who have moderate to severe functional limitations.
- Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities. (Healthy People, 2018)

A relatively new effort to direct funding toward evidence-based health promotion and prevention programs began in 2003. Evidence-based prevention programs use interventions based on results from scientific studies published in peer-reviewed journals. In 2003, the AoA funded 12 grants totaling more than \$2 million per year for 3 years to implement evidence-based prevention programs in the community. The areas of focus were as follows:

- falls prevention
- physical activity
- sound nutrition
- medication management
- disease self-management
- depression (AoA, 2006)

Examples of programs funded in 2003 included the Chronic Disease Self-Management for African-American Urban Elders program in Philadelphia, Pennsylvania; the Neighborhood Centers, Activity Centers for Seniors, in Houston, Texas; and the A Matter of Balance fall-prevention program in Portland, Maine. In 2004, the AoA partnered with the President's Council on Physical Fitness and Sports, the National Institute on Aging, the Centers for Disease Control and Prevention, and other federal agencies to launch You Can! Steps to Healthier Aging, a social marketing campaign designed to increase the number of older adults who are active and healthy by using a partnership approach to mobilize communities. More than 2,700 community organizations joined the campaign (USDHHS, 2006). In 2006, the AoA continued to support health promotion and prevention activities in the six areas mentioned above and awarded \$13 million to 16 states to implement evidence-based programs in senior centers, nutrition programs, senior housing, and faith-based organizations (AoA, 2006). In the current

decade, the focus on health and wellness continues to be on providing evidence-based programs to elders living in medically underserved geographical areas that have the greatest economic need (Klees et al., 2011). Funding under OAA Preventive Health Services in 2012 included (a) health promotion information and outreach through a variety of entities including the Aging and Disability Resources Centers, AAAs, parks and recreation centers, faith-based organizations, and congregate meal sites; (b) health screenings and risk assessments for a variety of conditions, including diabetes, hypertension, high cholesterol, and hearing and vision loss; and (c) evidence-based health promotion intervention programs. Similar grants were available in 2017, including those for innovations in nutrition programs and services, and for chronic disease self-management education and falls prevention (Administration for Community Living [ACL], 2017a).

The AoA has worked over the years to refine the definition and criteria of evidence-based programs (EBPs) in order to increase the rigor and efficacy of health promotion programs that receive federal funding. In 2012, the AoA expanded the 2003 definition and criteria of EBPs under Title III, Part D. The definition stated that EBPs are programs that have been empirically demonstrated to be effective in helping to promote the adoption of healthy behaviors, improve health status, or reduce the use of medical services, and created three new tiers of EBP: (1) minimum—demonstrated through evaluation and ready for implementation; (2) intermediate—outcomes published in a peer-reviewed journal or effective with an older adult population and evidence that the outcomes are ready to be implemented; and (3) high—outcomes based on an experimental or quasi-experimental research design, full translation of findings in the community, and dissemination of products to the public (AoA, 2012). As of October 1, 2016, all programs using Title III, Part D funds have to meet these criteria, which are equivalent to the highest-level criteria of the former definition: (a) demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability, and/or injury among older adults; (b) proven effective with an older adult population, using experimental or quasi-experimental design; (c) research results published in a peer-reviewed journal; (d) fully translated in one or more community sites; and (e) includes developed dissemination products that are available to the public (ACL, n.d.-c). Exhibit 11.12 provides a partial listing of health, prevention, and wellness programs currently supported by the AoA.

Health Promotion for Older Adults

For many years, older adults were not targets of health promotion programs (McGinnis, 1988). As S. N. Walker (1989) pointed out, health promotion programs excluded older adults because it was thought that they could not benefit from activities in which the benefits would emerge in the future. In addition, many believed that health promotion programs would not be successful in changing the lifelong behaviors of older adults. Fortunately, both of these notions have been proven to be incorrect, and health promotion programs that target older adults have become more frequent in recent years and have been shown to have beneficial outcomes.

Health promotion programs for older adults have shifted from focusing solely on the management of specific disease conditions to including prevention of illness and injury and enhancement of health (S. N. Walker, 1989). Thus health promotion programs can address a multitude of concerns and be defined in a variety of ways.

Exhibit 1.1.12 Examples of Health, Prevention, and Wellness Programs Funded by the Administration on Aging

Area of Focus	Program Description	Example Projects
<p>Alzheimer's Disease Supportive Services Program</p> <p>Funded under Public Health Services Act and administered by the AoA</p> <p>www.acl.gov/node/458</p>	<p>Supports state efforts to expand the availability of community-level supportive services for persons with Alzheimer's disease and related disorders and their caregivers</p>	<p>Telehealth Early Stage Dementia</p> <p>In Nevada, the Telehealth Early Stage Dementia project reported that it improved the relationships between Native American populations and the existing Nevada Alzheimer's care infrastructure, resulting in increased opportunities to provide support to this population.</p> <p>https://nadr.acl.gov/sites/default/files/uploads/docs/Closed_grant_aggregate_report_2015%20508%20compliant%2009032015.docx</p> <p>Managing Difficult Behaviors: A Standardized Intervention to Help Family Caregivers (STAR-C)</p> <p>STAR-C is an evidence-based intervention for Alzheimer's and dementia care that helps caregivers manage difficult behaviors associated with Alzheimer's disease. In the Seattle program, four 1-hour in-home visits and two 15- to 30-minute phone calls are conducted over 6 weeks with four follow-up phone calls. The program lowers depression in caregivers and decreases problem behaviors in the person with dementia.</p> <p>www.agingkingcounty.org/wp-content/uploads/sites/185/2017/12/Area-Plan_2016-2019_MASTER-new.pdf</p>
<p>Behavioral Health</p> <p>Behavioral health is a state of mental and emotional well-being and/or choices and actions that affect wellness</p> <p>www.acl.gov/programs/health-wellness/behavioral-health</p>	<p>States are enhancing the ability of their systems to educate, identify, refer, and provide appropriate services/interventions for older adults, persons with disabilities, and caregivers with or at risk for behavioral health disorders.</p>	<p>ElderVention®</p> <p>Provides prevention education for older adults who are at risk for depression and suicide. Region I—Area Agency on Aging, Phoenix, AZ</p> <p>www.aaphx.org/program-services/eldervention-program/</p> <p>SAMHSA-HRSA Center for Integrated Health Solutions, Older Adults</p> <p>This partnership between the Substance Abuse and Mental Health Services Administration and the ACL provides states and communities with learning opportunities and support for behavioral health services for older adults. Webinars and issue briefs are available.</p> <p>www.integration.samhsa.gov/integrated-care-models/older-adults</p>

(Continued)

Exhibit 1.1.1.2 (Continued)

Area of Focus	Program Description	Example Projects
<p>Chronic Disease Self-Management Programs (CDSMP)</p> <p>Funded by the American Recovery and Reinvestment Act of 2009</p> <p>www.acl.gov/programs/health-wellness/chronic-disease-self-management-education-programs</p>	<p>The CDSMP program enables older Americans with chronic diseases to learn how to manage their conditions and take control of their health. In 2010, the AoA awarded grants to 45 states, Puerto Rico, and the District of Columbia to deliver evidence-based self-management programs to older adults with chronic diseases; since the inception of the program, funding has supported nearly 317,000 CDSMP participants.</p>	<p>Great Plains Tribal Chairmen's Health Board</p> <p>This organization engages American Indians/Alaska Natives in the CDSMP program and Active Living Every Day (ALED) workshops. Potential CDSMP and ALED participants are connected through public service announcements, community websites, social media, and local media outlets. Tribal community members are trained to become CDSMP lay leaders and master trainers and ALED facilitators.</p> <p>www.acl.gov/sites/default/files/programs/2017-11/2016CDSMEGranteeProfileGreatPlains.pdf</p>
<p>Disease Prevention and Health Promotion Services</p> <p>(OAA Title III, Part D)</p> <p>www.acl.gov/programs/health-wellness/disease-prevention</p> <p>Aging and Disability Evidence-Based Programs and Practices (ADEPP)</p>	<p>Programs under ADEPP provide education and implementation activities that support healthy lifestyles and promote healthy behaviors.</p>	<p>Tai Chi: Moving for Better Balance</p> <p>This program is designed to improve the strength, balance, and physical functioning of individuals with diminished physical abilities. The Tai Chi program is community based and implemented through instructor-led group sessions held two or three times per week for approximately 6 months, with the ultimate goals of improving participants' functional balance, increasing their mobility, and reducing the incidence of falls.</p> <p>www.acl.gov/sites/default/files/programs/2017-03/TaiChi_InterventionSummary.pdf</p> <p>Programa de Manejo Personal de la Diabetes (Spanish Diabetes Self-Management Program)</p> <p>This program is designed to help Spanish-speaking adults with type 2 diabetes self-manage and improve their blood glucose levels, understand how their health problems affect their lives, and improve their general health.</p> <p>www.acl.gov/sites/default/files/programs/2017-03/Programa_de_Manejo_Personal_de_la_Diabetes.pdf</p>

Area of Focus	Program Description	Example Projects
<p>www.acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs</p>		<p>Wellness Initiative for Senior Education (WISE)</p> <p>WISE is a curriculum-based health promotion program that aims to help older adults increase their knowledge and awareness of issues related to health and the aging process. Based on the health belief model of behavioral change, WISE provides older adults with the information and resources they need to maintain a healthy lifestyle and become empowered in regard to both their health and the health care they receive.</p> <p>www.acl.gov/sites/default/files/programs/2017-03/WISE_ACL_Summary.pdf</p>
<p>Older Adults and HIV/AIDS</p> <p>www.acl.gov/programs/health-wellness/hiv/aids</p>	<p>The Older Adults and HIV/AIDS website provides resources for aging professionals and others interested in designing programs for older adults about the prevention and treatment of HIV/AIDS.</p>	<p>Graying of HIV/AIDS: Community Resources for the Aging Services Network Webinar</p> <p>www.acl.gov/sites/default/files/programs/2016-11/Graying_HIV_Slides.pdf</p> <p>National Resource Center on LGBT Aging, HIV and Aging Resources</p> <p>www.lgbtagingcenter.org/resources/index.cfm?s=12</p>
<p>Older Adults and Oral Health</p> <p>www.acl.gov/programs/health-wellness/oral-health</p>	<p>Supports programs to help address the oral health needs of older adults.</p>	<p>Virtual Dental Home System of Care</p> <p>The Pacific Center for Special Care at the University of the Pacific, Arthur A. Dugoni School of Dentistry (Pacific), is demonstrating a new model of care by creating a “Virtual Dental Home” in sites throughout California. Pacific delivers oral health services in locations where people live, work, play, go to school, and receive social services. Populations served include children in Head Start centers and elementary schools, and older or disabled adults in residential care settings or nursing homes.</p> <p>www.dental.pacific.edu/departments-and-groups/pacific-center-for-special-care/publications</p>

For example, Teague (1987) defines *health promotion* as any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental changes that prevent, delay the occurrence of, or minimize the impact of disease or disability while promoting the independence and well-being of older adults (p. 23).

Health promotion programs can be illness specific, such as programs designed to reduce high blood pressure, or can be broad based and include physical fitness, stress management, nutrition, and environmental awareness. In addition, there are different levels of health program intervention strategies (O'Donnell & Ainsworth, cited in Teague, 1987). *Educational health promotion* programs provide participants with information designed to increase awareness, education, and behavioral change. Health education can be delivered through lectures, flyers and posters, health fairs, and resource libraries. *Evaluation screening* programs test for past, current, and potential health problems. Fitness assessments are perhaps the most popular evaluation screening programs. *Prescription* programs are used in conjunction with evaluation screening and give participants the information they need to correct or prevent a current health problem. Finally, *behavior change support* programs provide participants with evaluation screening, a prescription for change, and the support system needed for participants to be successful in changing health habits.

Across the Globe

Health Promotion Program—Well for Life, State Government of Victoria, Australia

The Well for Life program is designed to improve nutrition and physical activity for older people living at home in the community. The Well for Life Resource Kit is an initiative of the Department of Health, Public Health and Aged Care Branches in Australia. The Resource Kit has been developed for staff of primary health and community service organizations that provide care and services for older people living at home.

According to the program's website, the Resource Kit addresses nutritional, physical activity, and emotional well-being issues for older people and their caregivers, using primary health and community services. It includes the following:

Guide to Action: A Facilitator's Guide: case studies, a good practice checklist for physical activity and nutrition, and an action plan template to record agreed actions

Nineteen help sheets: information and tips to increase awareness and knowledge of physical activity and nutritional needs to inform discussion, strategies and action on physical activity, and nutrition

Education supplements: training modules and case studies on physical activity and nutrition to support quality improvement in organizational practice

Resources: information on resources and programs that may improve physical activity and nutrition for older people living at home

For more information go to www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/healthy-ageing/well-for-life.

Health promotion programs may be sponsored by hospitals, universities, churches, departments of public health, local AAAs or aging network members, insurance companies, or community organizations such as the Red Cross. Programs may be delivered in a variety of settings, including shopping malls, senior centers, hospitals, senior housing, and local schools.

Best Practice

Reach Program, Colorado Black Health Collaborative: The Barbershop and Salon Program

A major effort to help address these health disparities is the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) Program, which supports community-based coalitions in the design, implementation, and evaluation of innovative strategies to reduce or eliminate health disparities among racial and ethnic minorities. One example of a successful REACH Program is the Colorado Black Health Collaborative (CBHC), in Denver, Colorado. The CBHC targets health promotion outreach to African American/Black people who, compared with others of different racial and ethnic backgrounds, experience a disproportionate burden of cardiovascular disease, high blood pressure, first-ever strokes, obesity, diabetes, prostate cancer, and breast cancer. Moreover, African American/Black men are less likely to visit a doctor and less likely to access preventive care services even when they have health insurance. One outreach program of the CBHC is the Barbershop and Salon Program, which uses volunteers and students to provide health screening and education outreach at 12 shops. While the primary focus of the screening and education is for hypertension, diabetes, and HIV, other health education and screening programs include obesity assessment, physical assessments (e.g., height, weight, waist circumference, heart rate, blood pressure, grip strength, step test), cholesterol screening, health assessments, and prostate cancer screening. The Barbershop and Salon

Source: CDC (2016).

Program has a Toolkit that was developed by the CBHC and the Kaiser Permanente African American Center of Excellence. The Toolkit is designed to empower community health workers, clinicians, and volunteers to launch, sustain, and monitor the success of an effective barbershop and salon outreach program. The volunteers also distribute literature/pamphlets, pedometers, bags, cookbooks, and gift cards.

Mr. McGee is a wonderful example of the impact this program has on clients in the shops. A volunteer explained that regular walking was good for the brain, heart, and bones, even at his age of 81. Volunteers gave him a free pedometer and told him that 10,000 steps per day would keep the doctor away and that they would be back in about 6 weeks to check in on him. When the volunteers saw Mr. McGee again, he had recorded 7 weeks of step totals and walked more than 10,000 steps every week. One of the weeks he walked 21,614 steps, and his total number of steps for the 7-week period was 95,885. This is equivalent to about 48 miles total. Mr. McGee told the volunteers that he will be back every time they come, to make sure he is still doing well.

For more information about REACH, go to www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/index.htm. For more information about the Colorado Black Health Collaboration and the Barbershop and Salon program and to download the Toolkit, visit www.coloradoblackhealth.org/.

Although information about health promotion programs and activities is widely available, empirical published research that documents who participates in and the outcomes of formal health promotion programs is growing, but still limited. Admittedly, the generalizability of such research is somewhat problematic because of the wide variation in program content, format and length of program, and participant characteristics. Existing studies, however, are building a baseline understanding of participation rates and benefits.

Health Promotion Program Participants

Some evidence suggests that participants in health promotion programs have higher incomes and education, have higher levels of community involvement, and are more often women (Gallant, Tartaglia, Hardman, & Burke, 2017; Given & Given, 2001; Nigg & Long, 2012; Martinson, Crain, et al., 2010; Pirie et al., 1986; Lefebvre, Harden, Rakowski, Lasater, & Careton, 1987; Zgibor et al., 2017). For example, Buchner and Pearson (1989) examined the characteristics of participants in an HMO senior health promotion program. Demographic factors associated with participation included being older and female, having higher levels of income and education, and being a nonsmoker. Ratings of general health status were not related to participation, and participants were more likely to have lower mental and social health ratings than nonparticipants. E. H. Wagner, Grothaus, Hecht, and LaCroix (1991) evaluated a senior health program involving a sample of people who were 65 and older and who were enrolled in an HMO. The health promotion program consisted of a nurse educator visit to assess health risks, follow-up classes, written materials, and a review of prescription medications. Researchers interviewed the enrollees who chose not to participate. Nonparticipants had lower levels of education and family income, were less likely to be members of community organizations, were more likely to smoke, and had more negative self-evaluations of chronic conditions and health status than participants. Results of a national study on the effectiveness of the Chronic Disease Self-Management Program offered at 22 organizations in 17 states found that those who enrolled and completed the program were predominately female, were non-Hispanic White, had an average of 13 years of education, and were in their late 60s (Ory et al., 2013).

Because non-Hispanic Whites are more likely to participate in health promotion programs, scholars and practitioners have worked to better understand how to recruit older adults of color into health promotion programs. Liljas and colleagues (2017), in their review of 23 health promotion studies, identified a number of barriers to participation in health promotion programs among older adults of color. Barriers included lack of transportation, lack of support from family members, lack of motivation and self-confidence, and cultural and language differences. Other studies comparing participants and nonparticipants in health promotion programs generally conclude that participants are individuals who already have preventive attitudes toward health care and engage in a variety of preventive health behaviors (Carter, Elward, Malmgren, Martin, & Larson, 1991; van Heuvelen et al., 2005).

Finally, there is some concern that health promotion programs do not have lasting results (Hickey & Stilwell, 1991; Warshaw, 1988). Lalonde, Hooyman, and Blumhagen (1988) investigated the long-term effectiveness of the Wallingford Wellness Project, a 3-year community-based health promotion demonstration project that offered 21 weeks of education and behavior change training to persons 55 and older in physical fitness,

For Your Files

National Institute on Aging—Exercise and Physical Activity Resources

The National Institute on Aging (NIA) has a number of health and fitness resources that you might find useful when encouraging older adults to engage in fitness activities. The centerpiece of the site is Go4Life, NIA's national campaign to help older adults fit exercise and physical activity into their daily life. The site has tip sheets, infographics, exercise guides, resources in Spanish, posters and bookmarks, exercise audiobooks, exercise AgePages, and *Exercise and Physical Activity: Your Everyday Guide*. This illustrated booklet describes ways for older people

to exercise safely and stay motivated. Drawings and, in the online version, animations show the correct positions for specific exercises. Also included are worksheets to help older adults track their progress as well as a chapter on healthy eating. NIA also has developed Go4Life videos on exercise that are available via YouTube.

For more information, visit www.nia.nih.gov/health/exercise-physical-activity. The Go4Life videos on YouTube can be found at www.youtube.com/user/NatlInstituteOnAging/featured.

stress management, nutrition, and environmental awareness and action. An experimental group ($n = 90$) was recruited from the community, and a comparison group ($n = 44$) was recruited through social groups. Follow-up studies revealed that the project was most effective in the short term—up to 6 months following graduation from the program. Participants reported sustaining behavior changes initiated in physical fitness, stress management, and nutrition; these behavioral changes declined, however, when measured 6 months later. With regard to retaining health information, participants sustained their increase in health information over pretest levels, except for nutrition information. The project was ineffective in reducing health service use among participants. Pogge and Eddings (2013) evaluated the effect of a 12-week nutrition and wellness program for older adults. While the changes from pretest to posttest on nutritional knowledge were positive, the evaluation of participants' anthropometric and blood pressure measurements preprogram and 6 months after the program found no significant difference. In contrast, Buchner and colleagues (1997) examined the impact of a community-based exercise program where participants engaged in aerobic exercise and strength training. Researchers found positive outcomes in strength, aerobic capacity, and fall reduction at the end of the program. Moreover, 58% of the participants were engaging in unsupervised exercise three or more times per week 9 months after they started the program. In a review of 29 physical activity health promotion programs, A. C. King, Rejeski, and Buchner (1998) found that the majority of studies reported that the respondents had physical activity levels or fitness levels that were greater than their baseline levels and better than control groups.

More recently, researchers have been examining the factors associated with interest in and adherence to health promotion activities. Effective strategies for promoting participation include the use of behavioral or cognitive-behavioral strategies, such as goal setting, along with health education and instruction (Ettinger et al., 1997), locations that are easily accessible (Grove & Spier, 1999), providing individualized assessments and counseling (Fox, Breuer, & Wright, 1997), using a combination of group and home-based program delivery format (A. C. King, Haskell, Taylor, Kraemer, & DeBusk, 1991; Rejecki & Brawley, 1997), and taking into account cultural differences (Zhan, Cloutterbuck,

Best Practice

EnhanceFitness

EnhanceFitness is a health promotion program managed by Senior Services of Seattle/King County in collaboration with Group Health Cooperative and the University of Washington Health Promotion Research Center. The program is a low-cost, evidence-based exercise program that can help active and near-frail older adults become more active, energized, and empowered to sustain independent lives. EnhanceFitness focuses on stretching, flexibility, balance, low-impact aerobics, and strength-training exercises. The EnhanceFitness program does not require expensive equipment or a large space and is led by certified fitness instructors who receive training and a detailed manual, which give them the expertise they need to lead three 1-hour classes each week. Empirical research from more than 80 sites around the country showed that the program significantly improved overall fitness and health. Results

found that 13% of participants reported improvement in social function, 52% reported improvement in depression, and 35% reported improvement in physical functioning. Another study of participants in ethnic minority community sites with nutrition programs showed that these participants, although less physically fit to start with when compared with White community members, showed greater improvement than their White counterparts. EnhanceFitness has won awards from the National Council on Aging, the AoA, and the USDHHS. For the results of the research on program effectiveness, see Belza et al. (2006).

For more information about EnhanceFitness, contact Project Enhance, Senior Services of Seattle/King County, 2208 Second Avenue, Suite 100, Seattle, WA 98121, 206-448-5725, www.projectenhance.org/EnhanceFitness.aspx.

Keshian, & Lombardi, 1998). Martinson, Sherwood, and colleagues (2010) found that encouraging older adults to maintain their activity levels after they have completed a health promotion program can be successful. They found that telephone and mail-based physical activity maintenance reminders for older adults who completed the Keep Active Minnesota program were effective at helping participants maintain their physical activity levels up to 24 months after the program ended. Clearly, more rigorous studies are needed to evaluate and compare the effectiveness of different types of health promotion and wellness programs offered to older adults.

Challenges for Health Care and Health Promotion Programs

Serving Diverse Groups of Older Adults

Extending health promotion and prevention programs to all elderly individuals, especially those hard-to-reach populations, will be critical as the aging population increases in number. Outreach efforts and programs must endeavor to serve elders with lower education and incomes, who are ethnically and racially diverse, as well as those who are

physically frail and have multiple chronic conditions. Effective health promotion intervention programs must take into consideration the social and environmental barriers to participation that are unique to those with lower socioeconomic characteristics (Manson, Tamim, & Baker, 2017; Prohaska et al., 2006). Health promotion programs must also be sensitive to the cultural characteristics of their participants and be cognizant of differences in language, perceptions, and life experiences (Liljas et al., 2017; Zhan et al., 1998). For example, Ralston (1993) identified programmatic strategies for health promotion programs targeting older Blacks, including using an educational framework with scheduled classes to deliver information, using Black churches to sponsor programs, and using peer leaders to act as liaisons between older adults and the health care delivery system. In addition, health promotion programs must be sensitive to participants' social and environmental context. Something as simple as instructing older inner-city participants to take daily walks may be unsuccessful if they fear walking in their neighborhood or simply lack sidewalks that are safe to walk on (Brawley, Rejeski, & King, 2003; Minkler & Pasick, 1985; Wang & Lee, 2010). Although providing education about preventive health behaviors is an important factor in changing personal behavior, scholars have criticized health promotion programs for focusing too much on individual behaviors while ignoring social factors that negatively impact poor health, including poverty, racism, sexism, ageism, and environmental hazards (Hickey & Stilwell, 1991; Minkler & Pasick, 1985).

Health promotion programs will be meaningless if issues such as access and affordability to health care services continue to be problematic for many low-income older adults. Moreover, older adults should not be overlooked when developing health promotion programs because of an erroneous perception that older adults are unwilling or unable to make healthy lifestyle changes (Chernoff, 2001).

Increasing Research and Program Evaluation

Empirical research must continue to examine the factors associated with participation in and benefits of health promotion programs. Researchers should continue to investigate models that can assist in identifying the motivational forces that are associated with participation in a wide variety of formal health promotion programs (Pascucci, 1992). Professionals designing health promotion programs must also develop evidence-based programs based on health behavior theories (e.g., Health Belief Model, Theory of Reasoned Action/Theory of Planned Behavior discussed in Chapter 3) and research findings that demonstrate what “works,” and it is equally important that these programs be evaluated for their effectiveness and sustainability (Bryant, Altpeter, & Whitelaw, 2006). White House Conference on Aging (2006) delegates recommended that state health departments and local aging network agencies promote, implement, and evaluate evidence-based health promotion and disease prevention programs at the local level for all citizens.

Supporting Health Programs and Policies in the Future

Traditional health care, with its focus on acute care, does not adequately address the health care needs of older adults who must live with and manage chronic conditions. Older adults need regular primary care to help them prevent illness and maintain their health. Preventive services for the control of high blood pressure, cancer screenings,

immunizations, and therapies to help manage chronic conditions are key to extending a healthy life in later life. The changes made to Medicare, via the ACA, that extend access to preventive and wellness services by eliminating copayments for those services have already seen positive results. According to CMS (2017g) an estimated 40.1 million Medicare beneficiaries took advantage of an Annual Wellness Visit in 2016, nearly 1 million more people than in 2015 (6.6 million compared with 5.8 million).

Delegates to the White House Conference on Aging (2006) recommended a number of strategies and resolutions designed to enhance the health status of older adults. These included

- expanding Medicare to include oral health services, vision services and eyeglasses, hearing services, and other emerging preventive services; and
- increasing federal funding to the National Institutes of Health, the Centers for Disease Control and Prevention, and Title III of the OAA to reduce health disparities and promote health promotion programming for all minority populations, including lesbian, gay, bisexual, and transgender seniors as well as seniors with disabilities.

Finally, the delegates adopted four resolutions related to health and health promotion:

- Reduce health care disparities among minorities by developing strategies to prevent disease, promote health, and deliver appropriate care and wellness.
- Improve the health and quality of life of older Americans through disease management and chronic care coordination.
- Prevent disease and promote healthier lifestyles through educating providers and consumers on consumer health care.
- Improve health decision making through the promotion of health education, health literacy, and cultural competency.

Participants at the 2015 White House Conference on Aging

- noted the important role of Medicare in preventing disease and promoting health but expressed concerns that beneficiaries frequently find Medicare coverage difficult to understand and recommended that the administration implement a federal interagency process to improve notification and support for individuals nearing Medicare eligibility;
- noted the many preventive benefits now provided at no cost to Medicare beneficiaries as a result of the Affordable Care Act, but several advocates and clinicians noted that there has been slow uptake of these preventive benefits by older adults of color and others; and
- expressed concern about the lack of preventive benefits in Medicare to provide for dental, hearing, and vision care.

Indeed, one challenge facing U.S. society in the next century is creating a health care system that provides all its members, of every age, with access to health care, including

regular preventive care, primary care, long-term care and support services, and health promotion programs.

Case Study

Health Concerns After Retirement

David, 65, retired a year ago from a high-level executive position with a major auto company. His retirement meant the end to 25 years of long hours in fast-paced, high-stress management work. It also meant the end to grueling overseas travel and weeks of separation from his family. During this past year, David has been helping his wife, Evelyn, move into a smaller, but new, home. He has had a lot of time to think about what he would like to do next, and he has decided to use his experience by developing a part-time international consulting business that would allow him to work in his home office part time.

Lately, David has been feeling tired and sleeping poorly. He decided that he should take advantage of Medicare's new "Welcome to Medicare" preventive visit with his doctor and have a complete checkup before launching into his new endeavor. He was both anxious and excited about meeting his new doctor, recommended by another retired executive who told David not to expect to leave this doctor's office with a prescription in hand after a 30-minute visit. The friend was right. The checkup ended up taking 2 weeks and consisted of a thorough recounting of David's medical history, family medical history, and lifestyle choices. It also included an examination and a series of laboratory tests.

When David returned for the results of his evaluation, he was presented with some startling facts. His doctor told him frankly that he was headed into a lifetime of chronic health problems unless he drastically changed his lifestyle. Specifically, his blood pressure and blood sugar levels were too high, and his insomnia problems were probably due to too much alcohol consumption on a daily basis. The doctor complimented David for quitting

smoking 10 years earlier. However, because of the other factors, and because David's father died of heart disease, David was still at risk of heart disease and other complications. The doctor strongly recommended some major lifestyle interventions.

Case Study Questions

1. Would you say that David's doctor is being responsible by strongly recommending lifestyle changes for David? What research supports your answer? Why might David not have encountered such medical recommendations 10 or 15 years ago?
2. In what ways does David fit or not fit the profile of someone who would participate in a health promotion program? Would you say that David has a preventive attitude about his situation?
3. The chapter describes four possible models of health promotion programs. Describe each model and explain how each might apply to David's situation.
4. Without knowing the specific community in which David and his doctor live, where generally might David look for health promotion support for his lifestyle-change work? Find out what health promotion programs are available in your city. Based on what you find, what would you recommend for David?
5. First and foremost, David's doctor is concerned with David's health and well-being. In light of current health care trends, how is this case an economic concern for the doctor and for society?

LEARNING ACTIVITIES

1. Interview an older adult about his or her physical health. What chronic conditions does the individual have? How do these interfere with activities of daily living? What has the person done to adjust to any impairments? Does the person use any assistive technology devices (low or high tech) to help with activities?
2. Ask an older family member or friend to share with you a recent hospital or doctor's bill and the Medicare invoice that corresponds to that health care episode. After gaining the person's permission (and ensuring confidentiality), report to the class the type of health care episode, the amount the health care provider charged, the amount Medicare paid, the amount paid by a Medigap policy (if there is one), and the amount paid by the patient. How easy or difficult was it to gather this information from the invoices sent by each provider?
3. Go to the Medicare.gov site and investigate whether PPOs or HMOs are in your area. Check the website and find out what model of PPO or HMO they adhere to and compare the plans with Medicare and a standard Medigap policy. What are the differences in coverage?
4. What health promotion programs for older adults are available in your community? Who sponsors these programs? What services and information are offered in these programs?

FOR MORE INFORMATION

International Resources

1. **World Health Organization: Ageing and Life Course:** www.who.int/ageing/en/

WHO is the directing and coordinating authority for health within the United Nations and is responsible for providing leadership on global health matters, setting norms and standards, providing technical support to countries, and monitoring and assessing health trends. The WHO website has health and wellness information about older adults from across the globe.

2. **EuroHealthNet—Healthy Ageing:** www.healthyageing.eu

This EuroHealthNet website presents an expansive range of practical examples of health promotion interventions and initiatives that promote healthy aging in the European Union. It also makes available key resources you can use to promote healthy aging.

3. **Healthy Seniors Network:** www.mayoresaludables.org/en/

The Healthy Seniors Network has a number of resources including a directory of international policies designed to promote health, links to individuals and institutions committed to the health and well-being of older adults in the Americas, and aging and health resources.

4. **AGE Platform Europe:** www.age-platform.eu

AGE Platform Europe is a European network of around 167 organizations of and for people age 50 and older that aims to promote the interests of senior citizens in the European Union. Check out its publication *How to Promote Ageing Well in Europe: Instruments and Tools Available to Local and Regional Actors*. The site has a number of publications and other resources addressing healthy aging.

5. **Canadian Fitness and Lifestyle Research Institute:** www.cflri.ca

The mission of the Canadian Fitness and Lifestyle Research Institute is to enhance the well-being of Canadians through research and communication of information about

physically active lifestyles to the public and private sectors. The site has links to numerous publications on staying active and fit, many directed toward older adults.

National Resources

1. **American Heart Association**, 7272 Greenville Avenue, Dallas, TX 75231, 800-242-8721, www.heart.org/HEARTORG/

The American Heart Association funds research and conducts public education programs on the prevention and control of heart, stroke, and cardiovascular disease. It distributes a number of pamphlets in English and Spanish for older adults, including *Benefits of Physical Activity for Older Adults* and *Exercise Tips for Older Americans*.

2. **Center for Healthy Aging, National Council on Aging**, 1901 L Street NW, 4th Floor, Washington, DC 20036, 202-479-1200, www.ncoa.org/center-for-healthy-aging/

The Center for Healthy Aging encourages and assists community-based organizations serving older adults to develop and implement evidence-based health promotion/disease prevention programs. Evidence-based programming translates tested program models or interventions into practical, effective community programs that can provide proven health benefits to participants. The website contains information and support for evidence-based health promotion programs in the areas of chronic disease, disabilities, fall prevention, health promotion, medication management, mental health/substance abuse, nutrition, and physical activity. Examples of evidence-based programs are also available on the website.

3. **Centers for Medicare and Medicaid Services**—P.O. Box 340, Columbia, MD 21045, 410-786-3000 or 800-638-6833, www.cms.gov and Medicare.gov

The Centers for Medicare and Medicaid Services coordinates the Medicare program and has publications for consumers, including *Medicare and You* and *Guide to Health Insurance for People on Medicare*.

4. **National Caucus and Center on Black Aging**, 1220 L Street NW, Suite 800, Washington, DC 20005, 202-637-8400, www.ncba-aged.org

The National Caucus and Center on Black Aging has publications on its website including *The Healing Zone Health Update Newsletter* and *Health Status of Older African Americans*.

Web Resources

1. **National Institute on Aging**: www.nia.nih.gov/

The National Institute on Aging offers a wealth of health promotion–related information. It recently launched the Go4Life program, an exercise and physical activity campaign designed to help older adults fit exercise and physical activity into their daily life. Motivating older adults to become physically active for the first time, return to exercise after a break in their routines, or build more exercise and physical activity into weekly routines are the essential elements of Go4Life. The program offers exercises, motivational tips, and free resources to older adults to get ready, start exercising, and keep going. The Go4Life campaign includes an evidence-based exercise guide in English and Spanish, an exercise video, an interactive website, and a national outreach campaign. You can stay connected through Facebook or by following the helpful exercise tips shared via Twitter.

2. **National Center for Chronic Disease Prevention and Health Promotion**: www.cdc.gov/chronicdisease/index.htm

The Center has a website with links to statistical and educational information about chronic disease, disease prevention and control, and community health promotion.

3. **Henry J. Kaiser Family Foundation, Health Reform:** www.kff.org/health-reform/

There's no doubt about it . . . the health care landscape has changed over the past 10 years and continues to evolve. The ACA has brought significant changes to health care access in the United States, and there is a great deal of misinformation about what the law does and does not require. In addition, as this book goes to press, the Trump administration and the majority of the Republican members of

Congress have been seeking to eliminate the ACA and make changes to Medicare and Medicaid as well. The Henry J. Kaiser Family Foundation is a nonpartisan source of facts and analysis for the health policy community and the public. Its information on health care policy research, basic facts and numbers, and in-depth health policy news coverage is always provided free of charge. We highly recommend the KFF be your go-to site when you have questions about any health care policy and programs.