

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Matt Barry to Chris Jennings re: phone number (partial) (1 page)	05/04/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
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FOLDER TITLE:

Prevention [Folder 5]

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Other Important Things To Think About

- In the Original Medicare Plan, Medicare pays doctors and other healthcare providers directly for each service that you receive. For all other Medicare health plans, Medicare pays the health plan a lump sum amount of money; the plan oversees the services you receive.
- Plan benefits and costs can change each year. These changes are usually effective the first day of the new year.
- Medicare health plans may terminate their contract with Medicare at any time. If the plan terminates its contract with Medicare, you would be notified by the plan and automatically returned to the Original Medicare Plan. See page 32 for information on how this would affect your ability to get a Supplemental Insurance Policy should you want to stay with the Original Medicare Plan. You may join another plan in the area, but you will be covered by the Original Medicare Plan until the new coverage is in effect.
- Except for Medicare MSA Plans, you may leave (disenroll from) most Medicare health plans at any time and either return to the Original Medicare Plan, or switch to another plan. Special rules may apply if you choose to return to your Supplemental Insurance Policy or your employer's health insurance (see page 26). Contact your State Health Insurance Advisory Program, your State Insurance Department, or your employer for more information (see 19 d).
- As a Medicare beneficiary, you have rights. All Medicare health plans are required to have an appeal and grievance (complaint) process and must respond to your concerns (see pages 27 and 28).

Learning About Medicare Health Plans - Step 2

Original Medicare Plan

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Original Medicare Plan

The Original Medicare Plan is the traditional system, run by the Federal government, that covers your Part A and Part B services. Medicare pays its share of the bill and you pay the balance.

Cost: You pay the \$43.80* Part B premium, Part A and Part B deductibles, and the coinsurance.

Original Medicare Plan With a Supplemental Policy Managed Care Plans

A group of health plans that include:

HMO:

Health Maintenance Organization

POS:

HMO with a Point of Service Option

PSO:

Provider Sponsored Organization

PPO:

Preferred Provider Organization

Private Fee-for-Service Plan

A private insurance plan that accepts Medicare beneficiaries.

Providers: You can go to any doctor or hospital that accepts Medicare.

Extra Benefits: You receive all the Medicare covered services listed on pages 6 - 8, but no extra benefits.

Original Medicare Plan with a Supplemental Policy

The Original Medicare Plan is the traditional system that covers your Part A and Part B services. Medicare pays its share of the bill, and you pay the balance. You may purchase one of ten standard Supplemental Insurance Policies (Medigap or Medicare SELECT) for extra benefits (see pages 29 - 30). Some policies help pay Medicare's coinsurance amounts and deductibles.

Cost: You pay the Part B premium of \$43.80*. You also pay an additional monthly premium for your Supplemental Insurance Policy. The premium varies by State and insurer, and often varies by age. Most policies pay Medicare's coinsurance amounts and some also pay for Medicare's deductibles.

Providers:

Medigap: You can go to any doctor or hospital that accepts Medicare.

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can check the Internet at www.medicare.gov.

Medicare Medical Savings Account (MSA) Plan

A test program for 390,000 Medicare beneficiaries. If you choose a Medicare MSA Plan, you must stay in it for a full year. Medicare MSA Plans first become available in November 1998.

Religious Fraternal Benefit Society Plans

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can check the Internet at www.medicare.gov.

Medicare SELECT: You must use plan hospitals and in some cases plan doctors in order to be eligible for full Medigap benefits.

Extra Benefits: You receive all the Medicare covered services listed on pages 6 - 8. Some Supplemental Policies also cover services the Original Medicare Plan doesn't (see pages 29 - 30).

Managed Care

A Managed Care Plan involves a group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Managed Care Plans include HMOs, HMOs with a POS option, PSOs, and PPOs.

Cost: You pay the Part B premium of \$43.80.* Some plans charge you an extra monthly premium. You may also pay the plan a copayment per visit or service. You will also pay more if you don't follow plan rules. No Supplemental Insurance Policy is necessary if you join a Managed Care Plan (see page 29).

Providers: Your choice of doctors and hospitals varies by the type of Medicare Managed Care Plan you choose. HMOs and PSOs are usually more restrictive - you must use the plan's doctors and hospitals. PPOs and HMOs with POS options are generally less restrictive - you may use doctors and hospitals outside of the plan for an additional cost.

Extra Benefits: You receive all the Medicare covered services listed on pages 6-8. Many Medicare Managed Care Plans offer additional benefits not covered under the Original Medicare Plan.

Private Fee-for-Service Plan

You choose a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much to reimburse for the services you receive. You may have extra benefits the Original Medicare Plan doesn't cover.

Cost: You pay the Part B premium of \$43.80*, any monthly premium the Private Fee-for-Service Plan charges, and an amount per visit or service. Providers are allowed to bill beyond what the plan pays, and you will be responsible for paying whatever the plan doesn't cover. You may pay more for services.

Providers: You can go to any doctor or hospital.

Extra Benefits: You receive all the Medicare covered services listed on pages 6-8. Some Private Fee-for-Service Plans may offer additional benefits that the Original Medicare Plan

doesn't cover.

Medicare Medical Savings Account (MSA) Plan

This is a test program for 390,000 eligible Medicare beneficiaries. You choose a Medicare MSA Plan D a health insurance policy with a high deductible. Medicare pays the premium for the Medicare MSA Plan and makes a deposit to the Medicare MSA that you establish. You use the money deposited in your Medicare MSA to pay for medical expenses. If you don't use all the money in your Medicare MSA, next year's deposit will be added to your balance. Money can be withdrawn from a Medicare MSA for non-medical expenses, but that money will be taxed. If you enroll in a Medicare MSA Plan, you must stay in it for a full year. You can only sign up for a Medicare MSA Plan in November of each year, or during special enrollment periods. Medicare MSA Plans first become available in November 1998.

Cost: You pay the Part B premium of \$43.80.* You use the money in your Medicare MSA to pay for medical expenses. Unlike other Medicare health plans, there are no limits on what providers can charge you above the amount paid by your Medicare MSA Plan. If you use all your Medicare MSA money, you are responsible for paying all of your medical expenses until you meet the deductible for your Medicare MSA Plan. The deductible can be considerably higher than those of other Medicare health plans. Your Medicare MSA can help pay these costs.

Providers: Depending on the Medicare MSA Plan you choose, you may be able to go to any doctor or hospital, or you may be limited to a network of providers.

Extra Benefits: Money in your Medicare MSA pays for things that the Original Medicare Plan covers, plus other services it does not cover. A Medicare MSA Plan may offer additional benefits the Original Medicare Plan doesn't cover, but it doesn't pay for them until you meet your annual deductible.

Religious Fraternal Benefit Society Plans

These plans are offered by a Religious Fraternal Benefit Society for members of the society. Only members of the society may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization. No other information on Religious Fraternal Benefit Society Plans is available at this time.

Learning About Medicare Health Plans - Step 3 - 6

Step 3: Review the Medicare Health Plan Choices Available Where You Live

The Internet, at www.medicare.gov, lists health plans available in your local area (see page 1).

Step 4: Get Information About Available Medicare Health Plan Choices

Call specific Medicare health plans for more detailed information.

Step 5: Make the Medicare Health Plan Choice That is Right for You

You may want to talk with family, friends, or your doctor about your health plan choices before making a final decision. You may also call your State Health Insurance Advisory Program for assistance (phone number listed on page 19 d). For more help, please see the worksheet on pages 20-25.

Step 6: Enrolling (Disenrolling) in a Medicare Health Plan

You don't need to do anything if you want to keep the Original Medicare Plan or your current Medicare Managed Care Plan. If you have another health plan, you must disenroll to return to Original Medicare.

How to enroll/disenroll: Medicare Managed Care or Private Fee-for-Service Plan	How to enroll/disenroll: Medicare Medical Savings Account (MSA) Plan
You can enroll in a Medicare Managed Care Plan or a Private Fee-for-Service Plan at any time. To enroll: • Call the plan to request an enrollment form (plan numbers are available on the Internet at www.medicare.gov, or in your local phone book). • Complete and mail the form to the plan. • You will receive a letter from the plan telling you when your membership begins. • The plan cannot refuse to enroll you. To disenroll: • You may disenroll (leave) a plan at any time for any reason. • Call the plan or the Social Security Administration (see 19 a) and tell them you want to disenroll. • Your disenrollment becomes effective as early as the first of the month after your request for disenrollment is received.	You can only enroll in a Medicare MSA Plan: • During the 3-month period before you are entitled to Part A and Part B, or • During November of each year starting in 1998. (The first time you enroll in November, you have until December 15 of the same year to change your mind. If you do not change your mind, you must stay in the Medicare MSA for one full calendar year.) To enroll: • You set up a special Medicare MSA at a bank/savings institution. • You choose from among available Medicare MSA plans. • Your enrollment will be effective January 1. To disenroll: • You can leave the Medicare MSA Plan by filing a request for disenrollment in November. Your disenrollment will be effective

Your disenrollment will be effective
December 31.

Special rules may apply if you choose to disenroll from a health plan and return to your Supplemental Insurance Policy or your employer's health insurance policy (see page 26).

Telephone Directory

Phone Numbers for Assistance

The following are organizations that can help you if you have questions or need more information. Phone numbers for these organizations are available in the Who to Contact section of the print publication *The 1999 Guide To Health Insurance For People With Medicare*, or the section of this website. You can also call 1-800-633-4227 (1-800-MEDICARE) or TTY for the hearing impaired at 1-877-486-2048.

Call your...	If you have questions or need information about...	Call number on page...
Social Security Administration (SSA)	Lost Medicare card, address change, Social Security benefits, Medicare enrollment, Medicare premium amounts	19a
State Health Insurance Advisory Program	Medicare bills, information on Supplemental Insurance Policies & long term care insurance, payment denials and appeals, Medicare rights and protections, treatment complaints, and help choosing a Medicare health plan	19d
Medicare Carrier	Part B coverage and bills, medical services, and recognizing fraud and abuse	19b-c
Durable Medical Equipment Regional Carrier (DMERC)	Bills and coverage for durable medical equipment and a list of Medicare approved suppliers	19e
Fiscal Intermediary (FI)	Part A coverage and bills, hospital care and skilled nursing care	19f-g
Health Care Financing Administration (HCFA) Regional Office	Local seminars and health fairs on your new Medicare health plan choices	19n
Medicare Hotline	Ordering other Medicare publications	19a
Office for Civil Rights	Discrimination	19n
Office of the Inspector General	How to report Medicare fraud and abuse	19a
Peer Review Organization (PRO)	Complaints about quality of care	19j-k
Regional Home Health Intermediary (RHHI)	Information on coverage for home health care and hospice care	19h-i
State Insurance Department	Medicare Supplemental Insurance Policies available in your area	19-l
State Medical Assistance Office	Medicaid, low-income assistance	19m
Railroad Retirement Board (Railroad Retirement beneficiaries only)	RRB - Medicare bills and coverage	19a
	RRB benefits, lost Medicare card, Medicare premium amounts, enrolling in Medicare	19a

Worksheet for Comparing Medicare Health Plans

Worksheet for Comparing Medicare Health Plans

Medicare doesn't pay for everything, and Medicare doesn't cover everything. To get more coverage, you may purchase a Medicare Supplemental Insurance Policy (see pages 29-30), or you may consider joining a different Medicare health plan, which may provide you with extra benefits.

All Medicare health plans must provide all Medicare covered services described on pages 6-8.

You may choose from many types of health plans. There may be real differences among them, such as cost, choice of providers, extra benefits, quality, paperwork, complaints, and convenience. Use the worksheet on pages 20-25 to ask questions and compare answers. The information you gather will help you compare plans and make the health plan choice that is right for you. Write in the plan names and the answers from each plan to keep a record.

Each worksheet section begins with important information about the Original Medicare Plan and about the differences among the Medicare health plans.

All of the Medicare health plans approved by the Health Care Financing Administration (HCFA) have met a wide variety of standards. However, HCFA does not rate its plans. You can compare plans with the information you get from the Internet at www.medicare.gov or from the plans themselves. Your doctor, friends, and relatives also may be able to help you make your choice. Your decision should be based on your health care needs and personal preferences.

Cost

In all Medicare health plans, including the Original Medicare Plan, you must pay the monthly Part B premium.

In the Original Medicare Plan, you must pay additional costs such as hospital deductibles and coinsurance. The Original Medicare Plan does not pay for prescription drugs. You may be able to cover these out-of-pocket costs by purchasing a Supplemental Insurance Policy or by joining one of the other Medicare health plans. The additional costs with these health plan choices depend on the plan's monthly premium (if any), copayments, and whether providers are allowed to bill extra. Costs vary from plan to plan.

In some Medicare health plans, you must get all covered services from doctors and hospitals that belong to the plan. **If you are in one of these plans, you may get services from doctors or hospitals outside your Medicare health plan, but you will be responsible for paying for these services. The exception is an emergency, or when you require urgently needed care and are out of the health plan's service area. Emergency and urgently needed care are described on page 26.**

Write the plan names in the blocks below.			
Call the Plan. Does the plan..	Plan	Plan	Plan
Charge a premium in addition to the Medicare Part B premium?			
Charge copayments for doctor visits?			
Pay for prescriptions? How much?			
Charge more if I use a doctor or hospital outside the plan? How much?			
Have maximum amounts it will pay for different services?			
Set limits on what doctors and hospitals charge you?			
Charge a deductible or coinsurance for inpatient hospital services, home health, or skilled nursing facility services?			

Doctors, Hospitals, and Other Health Care Professionals

In the Original Medicare Plan and the Original Medicare Plan with a Supplemental Insurance Policy, you may use any provider who accepts Medicare. Private Fee-for-Service Plans provide similar choice. In a Medicare MSA plan, you may be able to go to any doctor or hospital, or you may be limited to a network of providers. Many Medicare Managed Care Plans require that you use the plan's doctors, hospitals, and other health care providers. They also may require a referral from your primary care doctor to a specialist. Some allow you to visit certain specialists within the plan like optometrists, gynecologists, or psychiatrists without a referral. If you like your current doctor, first ask if he or she belongs to any of the plans you are considering.

Call the Plan, then ask..	Plan	Plan	Plan
Are my doctors in the plan?			
Is there a selection of the doctors, health professionals, and hospitals that I might need?			
Can I get the doctor I want? Is he/she accepting new patients under that plan?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
What's the plan's policy if it does not have the type of specialist I need?			
Does the plan cover the drugs I use?			
May I use my regular pharmacy?			
Are mail-order pharmacies available?			
What is the annual or quarterly dollar limit on prescription drug coverage?			
Will I have to pay more if I prefer to use brand name instead of generic drugs?			
Is there a maximum out-of-pocket cost for prescription drugs? What is it?			
Does the plan limit the drugs it pays for to those on a list of drugs (called a formulary)?			

Quality

All Medicare doctors must be licensed in their State. Medicare certifies hospitals, nursing homes, and suppliers. Medicare also requires that Medicare Managed Care Plans establish quality assurance programs to get a Medicare contract. Once operating, Medicare Managed Care Plans must meet standards set by State and Federal governments.

Beyond these basic standards, the quality of care in plans may vary. Three main types of information will tell you about the quality of care in a Medicare health plan.

- 1) Accreditation. This is an additional seal of approval by a private independent non-profit group, which evaluates a plan and gives it an official status based on that evaluation. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Healthcare Commission.
- 2) Satisfaction surveys. These surveys ask beneficiaries how well they believe a plan meets their needs.
- 3) Performance measures. These are special reports that describe the provision of care, such as whether a plan regularly provides mammograms for women. In late 1998, some of these reports will be available on the Internet at www.medicare.gov.

Ask..	Plan	Plan	Plan
The plan: Is the plan accredited by an independent group?			
Your friends and relatives: Do they like the plan? do they get the care they need, when they need it?			
Where available: How does the plan compare on performance measures and consumer satisfaction surveys? (You can get some of this information on the Internet at www.medicare.gov in late 1998.			

Paperwork

For most services, Medicare Managed Care Plans do not require you to file a claim form. With the Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and Medicare MSA Plans, you may have more paperwork. You may have to pay for covered services when you receive them, and then wait to be reimbursed.

Call the plan, and ask..	Plan	Plan
Do I have to file claims myself?		

Complaints

You have a right to appeal many decisions concerning your Medicare benefits. In the Original Medicare Plan, you are entitled to an appeal, in most cases, if you believe Medicare did not pay enough for services, or if you believe that you have inappropriately been denied payment of health care services you received. You can also appeal to a Peer Review Organization if you believe that you are being discharged too soon from a hospital.

To participate in Medicare, each health plan must have an appeal and grievance (complaint) process for members. If you have any concerns or problems with the plan, you have a right to complain. The first step is to contact the plan. If your problem with a service or payment denial is not resolved with the plan, follow the instructions in the Questions and Answers regarding appeals on page 27.

Call the plan, and ask..	Plan	Plan	Plan
If the plan has a patient advocate/ombudsman to assist members?			
What is the plan's record regarding complaints?			

Convenience

Location, hours of operation, and similar details, may be important to you. Contact each plan to decide if it is convenient for you.

Call the plan, and ask..	Plan	Plan	Plan
Are the hours and location of its doctors, clinics and other health care providers convenient?			
Is my access to emergency care convenient?			
Are the doctors' offices, labs, and other services convenient?			
How fast can I be seen for urgent (non-emergency) care?			
Is there a telephone hotline I can call for medical advice?			

Other Medicare Health Plans**Q: What are primary care doctors?****Questions and Answers (Q & A's)**

A: Primary care doctors are trained to provide basic care. In many Medicare Managed Care Plans, they coordinate and provide most or all of your health care. Many plans require you to see your primary care doctor for a referral to a specialist. When you join a Medicare Managed Care Plan, you may be asked to choose a primary care doctor from among the doctors who belong to the plan. If you already have a doctor you would like to keep seeing, ask your doctor if he or she is in the plan and accepting new patients under that plan.

Q: May I change my primary care doctor? What if my primary care doctor leaves the health plan?

A: Yes, you may change. To change your primary care doctor, check your health plan member handbook for instructions. You may also call the plan's member services number. In some cases, the effective date of such a change may be the end of the current month. If your doctor leaves the plan, you may choose a new doctor in the plan.

Q: What is a referral?

A: A referral is permission from your primary care doctor to see a certain specialist or receive certain services. Some Medicare health plans may require referrals. Important: if you either see a different doctor than the one on the referral, or the service isn't for an emergency or urgently needed care, you may be responsible for the entire bill.

Q: Can I leave a Managed Care Plan or Private Fee-for-Service Plan and return to the Original Medicare Plan?

A: Yes. You may disenroll from a Medicare Managed Care Plan or Private Fee-for-Service Plan any time, for any reason. However, beginning January 1, 2002, disenrollment opportunities will be limited. To disenroll, give a signed written request to the plan, a SSA Office, or the RRB. You must receive services from the plan until you are disenrolled. Your Original Medicare plan coverage can start as early as the first day of the month after your request is received.

Q: What happens to my Supplemental Insurance Policy (Medigap) if I join a Medicare health plan, drop my Supplemental Insurance Policy, and then later disenroll from the health plan?

A: You can return to your Medigap policy if you dropped it to enroll in a Medicare health plan or a Medicare SELECT policy. However: (1) this must be the first time that you enrolled in a health plan or a SELECT policy; (2) you must leave the health plan or SELECT policy within one year after joining; and (3) after leaving your health plan or SELECT policy, you must choose a Medigap policy within 63 days. If you meet these requirements, you can return to your original Medigap policy, if it is still offered, or policies A, B, C, or F (see pages 29, 30 and 32). Call your State Health Insurance Advisory Program for information (see 19 d).

A: A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness that you believe may cause serious danger to your health if you do not get immediate medical care. Your plan is required to provide access to emergency and urgently needed care services 24 hours a day, 7 days a week. Your plan must pay for your emergency care and cannot require prior

Q: What is a medical emergency? How do I get emergency care?

authorization for emergency care you receive from any provider. You can receive emergency care anywhere in the United States. When you receive emergency care, the doctor or hospital that provides the service will bill either you or your plan. If you receive the bill, give it to your plan, and keep a copy for your own record. Following a medical emergency, your plan must also pay for care you need before your condition is stable enough for you to return to your plan's provider. If your condition lets you return to the plan service area, you will need to get follow-up care from your Medicare Managed Care Plan. You should let your plan know of emergencies as soon as medically possible. If what you believed was an emergency turns out not to be, the plan must still pay. Your plan can require that you pay the entire cost of care received in an emergency room for a problem that you knew was not an emergency. You can appeal a denial of payment for emergency services (see pages 27 and 28).

A: Unexpected illness or injury that needs immediate medical attention, but is not life threatening, is urgently needed care. Your primary care doctor generally provides urgently needed care. If you are temporarily out of the plan's service area and cannot wait until you return home, the health plan must pay for urgently needed care.

A: If you travel a lot or live in another State part of the year, you should contact the plan and ask if the plan provides coverage for services when you are out of the service area. The Original Medicare plan does not cover care outside the United States. Some Managed Care Plans and Private Fee-for-Service Plans, as well as some of the more expensive Supplemental Insurance Policies, cover care outside of the U.S. (Railroad Retirement Board [RRB] beneficiaries have different rules. Contact the RRB or RRB carrier for information (see 19 a)).

Q: What is "urgently needed care"? How do I get urgently needed care?

A: No. When you enroll in a Managed Care Plan or Private Fee-for-Service Plan, you are still entitled to all the covered services of the Medicare program. All Medicare Managed Care Plans and Private Fee-for-Service Plans must provide, at least, all the services covered under the Original Medicare Plan. This includes Part A (Hospital Insurance) and Part B (Medical Insurance). Hospice benefits are provided by a Medicare approved hospice in your service area. Medicare Managed Care Plans and Private Fee-for-Service Plans also may provide additional benefits.

Q: Does travel affect my health care? How does the health plan handle coverage when I'm not in the service area?

A: You have a right to appeal many decisions about your Medicare covered services. You have this right whether you are enrolled in a Medicare Managed Care Plan, Private Fee-for-Service Plan, or a Medicare Medical Savings Account Plan. Your health plan must provide you with written instructions on how to appeal. You may file an appeal if your health plan denies a service, or terminates or refuses to pay for services that you believe should be covered. After you file an appeal, the health plan reviews its decision. Then, if your health plan does not decide in your favor, the appeal automatically

Q: If I join a Medicare Managed Care Plan or Private Fee-for-Service Plan, will I lose any of my Medicare covered services?

goes to an independent review organization that contracts with Medicare. You may be eligible for a fast decision (within 72 hours) if your health or ability to function could be seriously harmed by waiting the amount of time needed for a standard decision. See the health plan's membership materials or contact your health plan for details about your Medicare appeal rights. If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization (PRO) (see 19 j-k). During the immediate review, you may be able to stay in the hospital at no charge and the hospital cannot discharge you before the PRO reaches a decision.

A: Medicare Managed Care Plans current members and those interested in joining the plan have a legal right to know (in writing) how the plan pays its doctors. If you want this information, call the plan.

Q: How do I question or appeal a Medicare Managed Care Plan or Private Fee-for-Service plan or Medicare Medical Savings Account Plan coverage decision?

Q: Can I find out how a Medicare Managed Care Plan pays its doctors?

Medicare Patients' Rights

Medicare Patients' Rights

As a Medicare beneficiary you have certain guaranteed rights that:

- Protect you when you get health care.
- Assure your access to needed health care services.
- Protect you against unethical practices.

They protect you whether you are in the Original Medicare Plan or one of the Medicare health plans now available to you. Your rights include, but are not limited to:

The Right to Receive Emergency Care: If you have severe pain, an injury, sudden illness, or a suddenly worsening illness that **you believe** may cause your health serious danger without immediate care, you have the right to receive emergency care.

- You never need prior approval for emergency care.
- You may receive emergency care anywhere in the United States.

The Right to Appeal the Original Medicare plan's or Your Medicare Health plan's Decisions About Payment or Services: If you are in the Original Medicare Plan, you have the right to appeal a denial of payment for a service you have been provided. Likewise, if you are enrolled in one of the other Medicare health plans, you have the right to appeal the plan's denial for a service to be provided. As a Medicare beneficiary you always have the right to appeal these decisions.

The Right to Information About All Treatment Options: You have the right to information about all your health care treatment options from your health care provider. Medicare forbids its health plans from making any rules that would stop a doctor from telling you everything you need to know about your health care, including treatment options. If you think your Medicare health plan may have kept your health care provider from telling you everything you need to know about your health care treatment options, you have a right to appeal.

The Right to Know How Your Medicare Health Plan Pays Its Doctors (You must request this information.):

- If you request information on how a Medicare health plan pays its doctors, the plan must give it to you in writing.
- You have the right to know whether your doctor has a financial interest in a health care facility (such as a laboratory) since it could affect the medical advice he or she gives you.

Private Supplemental Insurance Policies

Supplemental policies	Supplemental Policies If you choose the Original Medicare Plan rather than a Managed Care Plan or Private Fee-for-Service Plan, you may decide that you need more coverage than Medicare provides. Supplemental Insurance Policies only work with the Original Medicare Plan. Many private insurance companies sell Medicare Supplemental (Medigap) Insurance Policies for the specific purpose of filling the "gaps" in Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health plan. Other types of insurance may also be available to you (see page 31).
Medicare Supplemental (Medigap) Insurance	In all States except Minnesota, Massachusetts, and Wisconsin, Federal law forbids insurers from selling you Medicare Supplemental (Medigap) Policies that are not one of 10 standard supplemental policies. These 10 types of policies must be labeled with the letters A through J, to make it simple for consumers to compare policies. State law may limit the types of policies that are actually sold in your State.
Medicare SELECT	These policies may pay for some or all of the Medicare coinsurance amounts; some or all deductibles; and certain services not covered by the Original Medicare Plan at all. These may include outpatient prescription drugs, some preventive screenings, some care in your home, and emergency medical care for travel outside the United States. Some policies provide coverage of health care provider charges over the amount Medicare will pay.
For More Information on Medicare Supplemental Insurance Policies, get a copy of the <i>The Guide to Health Insurance for People with Medicare</i> or contact your State Health Insurance Advisory Program (see 19d)	Medicare SELECT refers to a type of Medigap Policy. It must meet all of the requirements that apply to a Medigap Policy, and it must be one of the 10 prescribed benefit packages. The only difference is that a Medicare SELECT Policy may require you to use doctors and hospitals within its network in order for you to be eligible for full benefits. Because of this limitation, a Medicare SELECT Policy will generally have a lower premium than a regular Medigap Policy. The types of Supplemental Insurance Policies are listed on the next page.

Supplemental Insurance (Medigap or Medicare SELECT)

Comparison Information The following chart is provided to assist you in comparing the Original Medicare Plan with Supplemental Insurance Policies to the Medicare health plan choices. The benefits offered by these policies are not completely described. For more complete information, you can request a copy of *The Guide to Health Insurance for People with Medicare*, or call your State Health Insurance Advisory Program (see 19 d).

What's Most Important to You	Supplemental Insurance Policy A	Supplemental Insurance Policies B, C, D, E, F*, G	Supplemental Insurance Policies H, I, J*
COST Doctor Visits	You pay the first \$100 only	You pay nothing ***	You pay the first \$100 only
Inpatient Hospital	You pay \$764 for days 1-60, nothing for days 61-90, and \$382 per day for days 91-150**	You pay nothing for days 1-60, nothing for days 61-90, and \$382 per day for days 91-150**	You pay nothing for days 1-60, nothing for days 61-90, and \$382 per day for days 91-150**
PRESCRIPTION DRUGS	You pay 100% for most drugs.	You pay 100% for most drugs.	You pay 50% per prescription. After meeting a \$250 per year deductible, Policies H & I cover up to \$1,250 of your prescription drugs. Policy J covers up to \$3,000 of your prescription drugs.
EXTRA BENEFITS Physical Exams	Physical Exams not covered.	Physical Exams not covered except under Policy E.	Physical Exams not covered except under Policy J.

* New high deductible policies will become available in most States beginning in 1998. Some supplemental policies may not be available in your state.

** If you have exhausted your 60 lifetime reserve days (see page 6).

*** Policies C, F, and J pay the first \$100.

Doctor Choice:

Medigap - You may see any doctor, specialist, or provider who accepts Medicare.

Medicare SELECT - You must use plan hospitals and, in some cases, plan doctors to be eligible for full benefits.

Premiums: In addition to your Part B premium, you will pay a Supplemental Insurance Policy premium. These premiums vary by State and usually by age. In general, Supplemental Policies A, B, and C are less expensive than H, I, and J. Policies D, E, F, and G are usually in between. **Vision:** Cataract related benefits only.

Dental: In general, you are not covered for dental services.

Employer and Union-Provided Health Insurance: Some employer and union-provided health insurance policies can continue or switch over to provide coverage for you when you are 65 and retired. Contact your former employer or union for information on your plan.

Medicare has special rules that apply to beneficiaries who have group health plan coverage through their own or their spouse's **current employment**. Group health plans of employers with 20 or more employees must offer these people the same health insurance benefits under the same conditions that younger workers and spouses receive. If your group health plan (participation is based on current employment) denies you coverage, or offers you different coverage, call your State Insurance Department (see 19 I).

If you or your spouse stops working and you are already enrolled in Part B:

- Notify your Medicare carrier by phone or in writing that you or your spouse's employment situation has changed (§ 19 b-c).

Give the carrier the name and address of the employer plan, your policy number with the plan, the date coverage stopped, and why.

- When receiving health care services, tell the provider that Medicare is now your primary payer and should be billed first. Give the date your group health coverage stopped.

If you have employer or union-provided health insurance and disenroll from that group health plan to join another Medicare health plan, you may or may not be able to get the same policy back for the same premium.

Other Types of Private Insurance

The following types of private insurance don't work with Medicare, but may help pay for services not covered by Medicare health plans, such as custodial care. However, these policies should not be confused with Medicare Supplemental Insurance Policies (Medigap), which are required by Federal law to meet certain minimum standards for your protection.

Long-Term Care Insurance can help pay for skilled nursing care or custodial care by paying a cash amount for each day of covered nursing home or at-home care. For a free copy of A Shopper's Guide to Long-Term Care Insurance, write to: National Association of Insurance Commissioners (NAIC), Publications Dept., 120 West 12th Street, Suite 1100, Kansas City, MO 64105, or call your State Health Insurance Advisory Program (see 19 d).

Hospital Indemnity Policies pay cash amounts to you for each day of inpatient hospital services.

Specified Disease Policies pay for services only when you need treatment for the insured disease.

Questions and Answers - Original Medicare Plan

Q: What is a Private, Contract and what does it mean?

A: A Private Contract is a contract between a Medicare beneficiary and a doctor or other practitioner who has decided not to provide services through the Medicare Program (Not bill for any service or supplies to any Medicare beneficiary for at least 2 years). Under a Private Contract:

- **No Medicare payment will be made for the services you receive**
- You will have to pay whatever the doctor or practitioner charges you with no limit on the charges (the limiting charge will not apply).
- Medicare Managed Care Plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- If you have a Supplemental Insurance Policy, it will not pay anything for this service. Contact your insurer before you receive the service.
- Many other insurance plans also will not pay for the service

The Private Contract only applies to the services provided by the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Advisory Program (see 19d) before signing a Private Contract. If you

want to pay on your own for services the Original Medicare Plan doesn't cover, your doctor does not have to leave Medicare to ask you to sign a Private Contract. You are always free to obtain non-covered services on your own if you choose to pay for the service yourself.

A: If you lose your health plan coverage under certain circumstances, you will have a right to purchase a Medigap Policy (A, B, C or F) that is sold in your State, as long as you apply within 63 days of losing your other health coverage. Special protections apply for pre-existing conditions. The circumstances include the following:

- Your Medicare Managed Care Plan, Medicare MSA Plan or Private Fee-for-Service Plan terminates or stops providing care in your area.
- You move outside the plan's service area.
- You leave the plan because it failed to meet its obligations to you.
- You were in an employer health plan that terminated coverage.
- Your Supplemental insurer terminates your policy (and you're not at fault).

A: All Medicare payments are made on the condition that you will pay Medicare back if benefits could be paid by insurance that is primary to Medicare. Types of insurance that should pay before Medicare include employer group health plans, no-fault insurance, automobile medical insurance, liability insurance, and workers' compensation. Call your Medicare carrier (see 19b-c) or Fiscal Intermediary (see 19f-g).

Q: If I lose my health plan coverage will I be able to get a Supplemental Insurance Policy?

A: There are two situations in which a doctor must give you an Advance Beneficiary Notice (ABN) in writing. One is before he or she gives you a service that he or she knows or believes Medicare doesn't consider medically necessary, and the other is when he or she knows or believes that Medicare will not pay for the service. If you are not given an ABN before you get the service, you are not responsible for paying for that service. But, if you do receive written notice, sign an agreement, receive the service, and Medicare does not pay for the service, then you must pay for it.

A: Medicaid is a joint Federal and State program that provides

payment for some medical costs for certain individuals who are older, have low incomes and limited assets, or are disabled. Coverage and eligibility vary from State to State, but most of your health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid recipients may also receive benefits such as nursing home care and outpatient prescription drugs.

A: Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain older, low-income, or disabled individuals entitled to Medicare Part A. If you do not have Part A or do not know if you are eligible, check with your local Social Security office, or call 1-800-772-1213.

Q: When would other insurance pay first? (Medicare would be a secondary payer)

If you have Part A, and your bank accounts, stocks, bonds, or other resources do not exceed \$4,000 for an individual, or \$6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI).

Q: What is an Advance Beneficiary Notice (ABN)?

Monthly Income Limit*			
	Individual	Couple	Benefit - Pays Medicare's
QMB	\$707	\$942	Premiums, deductibles and coinsurance
SLMB	\$844	\$1,126	Part B premium
QI-1	\$947	\$1,265	Part B premium
QI-2	\$1,222	\$1,633	Part of the Part B premium

If you think you may qualify, contact your State, county, or local medical assistance office (phone number listed on page 19 m) - not a Federal office.

***Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 1999.**

Q: What is Medicaid?

A: When you receive services covered by the Original Medicare Plan, your provider sends the bill (claim) to a private insurance company that contracts with Medicare. These companies are called the Fiscal Intermediary (for Part A services) or the Medicare carrier (for Part B services). After they process the claim, you receive a Medicare Summary Notice (MSN), or an Explanation of Medicare Benefits (EOMB) (for Part B services) or a Medicare Benefits Notice (for Part A services).

You have a right to request an itemized statement from the provider of the service. You must receive it within 30 days of your request. Please check the notice to be sure you were not billed for services, medical supplies, or equipment that you did not receive. If you have

Q: How can Medicaid help low-income Medicare beneficiaries

HCFA publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can request these publications by telephone (see 19a) or on the Internet at www.medicare.gov.

any questions about bills or services listed on the notice, contact the carrier or Fiscal Intermediary (the name and phone number are on the notice). If you disagree with a claims decision, you have the right to file an appeal. The notices tell you how to file an appeal. See below.

A: If you are dissatisfied, you have a right to appeal any decision concerning your Medicare covered services in the Original Medicare Plan. You can file an appeal if you believe Medicare did not pay enough for services or should have paid for health care services you received. Your appeal rights will be detailed on the back of the Medicare Summary Notice (MSN) or Explanation of Medicare Benefits (EOMB) that is mailed to you.

A: If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization (PRO) (phone number listed on page 19 j-k). You can stay in the hospital at no charge and cannot be discharged before the PRO makes a decision.

A: Every Medicare Skilled Nursing Facility (SNF) must meet quality standards. They can't require you to pay a deposit or other payment to be admitted to the facility unless it is clear that Medicare does not cover the cost of services. If the SNF staff decides you don't need the level of skilled care covered by Medicare, you must be told immediately. If you disagree with this decision, the SNF must request an official Medicare decision on coverage. The SNF can't require you to pay a deposit for services that Medicare may not cover until Medicare gives its decision. You must pay for any coinsurance while your claim is being processed, and for services not covered by Medicare. If you have questions about SNF care, contact your Fiscal Intermediary (phone number listed on page 19 f-g).

Q: How are my bills (claims) paid in the Original Medicare Plan?

Q: How do I appeal a Medicare payment or coverage decision under the Original Medicare Plan?

Q: What can I do if I think I'm being discharged from the hospital to soon?

Q: Are there rules that protect me in a Skilled Nursing Facility (SNF)?

Protect Yourself Against Discrimination, Fraud and Abuse

Fraud and Abuse

Medicare is improving its capability to crack down on those who take advantage of this program. We are using four methods to fight fraud and abuse: prevention, early detection, coordination with other government agencies, and prosecution of wrongdoers.

We need your help to make this work. Every year millions of dollars are stolen from Medicare, and beneficiaries pay for it with higher premiums. You can help protect Medicare and yourself by reporting a suspected instance of fraud and abuse.

Whenever you receive a payment notice from Medicare, review it for errors. Make sure Medicare did not pay for services, medical supplies, or equipment that you did not receive.

If you have a questionable charge on your bill, call the provider, your Fiscal Intermediary (for Part A bill your Medicare carrier (for Part B bills). If you believe that a health care provider may be cheating or abusing the Medicare program, call the Medicare carrier or intermediary that sent you the payment notice. The carrier's or intermediary's name, address, and telephone number will be on the payment notice.

You may also call the Inspector General's hotline to report suspected cases of fraud (see 19 a).

Medicare will not disclose your name if you request confidentiality.

Protect Yourself Against Health Care Fraud

- Never give your Medicare or Medicaid number over the telephone or to people you do not know.
- Beware of providers and suppliers that use phone calls and door-to-door selling as a way to sell you goods or services.
- Be suspicious of companies that offer free medical equipment or offer to waive your co-payment without first asking about your ability to pay.
- Beware of health care providers who say they represent Medicare or a branch of the Federal government, or providers who use pressure tactics to get you to accept a service or product.

Discrimination

Every facility or agency that participates in Medicare must comply with the law. Laws ban discrimination on the basis of race, color, sex, national origin, disability, or age. If you believe that you have been discriminated against based on any of these categories, contact the Office for Civil Rights in your State (see 19 n).

Jerry White
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Project Wellness: A Collaborative Health Promotion Program for Older Adults

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Abstract

The health promotion program described in this article brought nurses, nursing students, interdisciplinary health professionals from the hospital setting, and community aging advocates together for the purpose of assisting senior citizens to maintain and improve their health. The 12 week course included pre- and posttesting of health promotion behaviors and physiologic outcomes of healthy behaviors. The article describes the planning, content, and outcomes as measured at 12 weeks and 6 months. Suggestions are given for replication of the course in other settings.

"Heady life," generally defined as the ability to remain functionally independent in activities of daily living, is a challenge for adults aged 65 and older. It will soon become more of a societal issue since this group will comprise 13% of the United States population by the year 2000 (National Center for Health Statistics, 1990). Health care professionals have traditionally attempted to help older adults to attain and maintain this healthy life by providing disease prevention and risk avoidance information at times of medical system contact.

Descriptive research on elderly persons is showing, however, that elders view health promotion activities as self-care behaviors and obtain

health-related information from a variety of sources (McDougal, 1992). Many older adults see health as a holistic concept that involves functional independence, good nutrition, exercise, a positive sense of well-being, social support, and stress management (Davis et al., 1991; Maynard, 1990). The majority of seniors view themselves as active and in good health despite chronic illness or disability (Vivier-Dresler & Richardson, 1991). On the basis of these findings, the project described in this paper investigated an interdisciplinary wellness approach to increasing health-promoting behaviors of two groups of older adults.

Project Wellness was planned and conducted by three partners of the Aging Network in a Southern metropolitan area with a population of approximately 164,000, some 8.3% of whom are aged 65 or older. The Aging Network, a loosely organized consortium of service providers, educators, older adults, and business persons, was formed to develop a

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coordinated approach to identifying and meeting the needs of seniors.

The partners for Project Wellness included the city-operated Senior Center, the Older Adult Services of a local community hospital, and the college of nursing of the local university. All partners had a history of planning and providing health promotion services for the community's older adults, and each recognized the need for a comprehensive program that included education, screening, and measurement of outcomes.

Representatives of the Project Wellness partners met to develop the content of the course and to plan the most effective way to involve older adults in the project. The organizers decided to offer two classes with identical content and selected class times to coordinate with regularly scheduled activities at the Senior Center (i.e., an exercise class in the morning and a bingo group in the afternoon). The planners elected to offer two groups based on the following assumptions: (1) The exercise group would consist of older adults actively interested in improving their health. (2) The bingo group would be more likely to include a less physically active group.

A month before the beginning of the classes, a project representative known to the older adults made a personal appeal to both groups for participants.

She described (1) the goals, content, and duration of the course, (2) the importance of the participants' feedback for future development of the project, and (3) the commitment expected from participants as well as the anticipated benefits. Interested seniors signed a preregistration sheet, and follow-up phone calls were made a week before the first class.

A total of 22 older adults, whose average age was 72.82 years, participated in the 12-week course. Twelve seniors participated in the morning ("postexercise") group, and ten participated in the afternoon ("postbingo") group. Table 1 illustrates the demographic comparisons of the total group and of each of the separate groups.

Course

The two groups of Project Wellness participants met weekly at the senior center for 12 one-hour sessions. During the first session and the last session, nursing students administered the pre- and posttests. The ten other class sessions focused on areas identified and measured in the Health Promoting Lifestyle Profile (HPLP) (Walker, Sechrist, & Pender, 1987).

Pretesting and posttesting for each person in the project included the HPLP and physiologic measures of blood pressure, total cholesterol, weight, and triceps skinfold thickness. The HPLP, a Likert scale of 48 items, was used to

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Table 1
Demographic profile comparisons

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Demographic Data	Total Group (N = 22)	Morning (Exercise) Group (N = 12)	Afternoon (Bingo) Group (N = 10)
Age			
Mean	72.82	70.67	75.40
Range	62-83	62-82	69-83
Race			
White	21	12	9
Black	1	0	1
Sex			
Male	4	3	1
Female	18	9	9
Marital status			
Widowed	11	4	7
Married	7	5	2
No response	4	3	1
Education (mean years)	12.56	13.56	11.29
Chronic health problems (No.)	1.61	1.11	2.11

measure health-promoting behaviors, as a total measure and on six subscales: (1) self-actualization, (2) health responsibility, (3) exercise, (4) nutrition, (5) interpersonal support, and (6) stress management (Walker et al., 1987).

An initial demographic data form elicited data on the age, sex, race, and educational level of the participants. See Table 1. Six months later, a follow-up of project participants repeated the HPLP and the physiologic measures.

Each of the 48 HPLP scale items is scored thus: *Routinely* (4 points), *Often* (3), *Sometimes* (2), and *Never* (1). The overall health-promoting lifestyle score is calculated as the mean of the subject's responses to all 48 items; six

subscale scores are obtained as the mean of the subscale items. (Walker et al., 1987) Scores for the total scale and all subscales range from a low of 1, indicating no health-promoting behaviors as measured by the items, to a high of 4, indicating routine health promotion behaviors on all the items measured.

Project classes were planned jointly by university nursing students enrolled in the community health course and by resource professionals from the local hospital. A gerontologic clinical nurse specialist employed by the hospital Wellness Center worked with the students to develop the two health responsibility classes. An exercise specialist provided consultation for the

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Table 2
Comparison of HPLP scores for the entire group and subgroups

HPLP scale	Total Group (N = 22)			Morning (Exercise) Group (N = 12)			Afternoon (Bingo) Group (N = 10)		
	PR	PS	FU	PR	PS	FU	PH	PS	FU
HPLP	3.08	3.44	3.24	3.14	3.52	3.26	3.02	3.34	3.19
SA	3.33	3.56	3.35	3.34	3.40	3.40	3.27	3.33	3.26
HR	2.81	3.30	3.17	2.76	3.36	3.10	2.92	3.24	3.03
EX	3.39	3.59	3.47	3.44	3.69	3.47	3.29	3.37	3.47
NU	3.20	3.44	3.41	3.13	3.52	3.39	3.33	3.23	3.44
IS	3.29	3.44	3.30	3.37	3.41	3.30	3.14	3.48	3.29
SM	2.91	3.39	3.05	2.89	3.48	3.07	2.94	3.35	3.00

Key: PR, Pretest; PS, Posttest; FU, Follow-up test; HPLP, total scale; SA, Self actualization subscale; HR, Health responsibility subscale; EX, Exercise subscale; NU, Nutrition subscale; IS, Interpersonal Support subscale; SM, Stress management subscale.

two classes on exercise. Social workers assisted with two classes on interpersonal support and two on stress management. The two nutrition classes were developed jointly by the nursing students and a clinical dietician. These hospital resource persons were available at many of the classes to contribute to the discussions and provide additional information.

Project Wellness planners held a "graduation" program on the last day of the course. They awarded certificates of completion to recognize the new wellness knowledge and behaviors acquired by the seniors. The graduation program provided a point of closure for the course and brought organizers, instructors, participants, and students together for a formal course evaluation. A local TV channel's weekly "Senior News Report" featured the graduation

ceremony and interviewed several of the Project Wellness participants.

The senior citizens appreciated the opportunity to gain knowledge and skills for maintaining and improving their health.

Results

Comparisons of pretest scores to posttest scores and of posttest scores to follow-up scores were made for each group and for the group as a whole, using *t* tests and multivariate analysis of variance (MANOVAs). Comparisons were also made between the morning group and the afternoon group, using the same tests. Table 2 compares the

HPLP pretest, posttest, and follow-up scores for the total group, the morning group, and the afternoon group. Significant HPLP results were as follows:

1. The total HPLP score and the Health Responsibility subscale score for the total group of 22 participants increased significantly from the pretest to the posttest.
2. The total HPLP score and subscale scores of Health Responsibility, Exercise, Nutrition, and Stress Management for the morning group increased significantly from the pretest to the posttest.
3. For the morning group the only significant change in scores between the posttest and the follow-up test was a decrease in the subscale of Stress Management.
4. No significant changes were found in any of the scores for the afternoon group.
5. Before the Project Wellness classes, the morning group had significantly higher scores than the afternoon group on the total HPLP and the subscales of Exercise and Nutrition.
6. After the classes, the only subscale score that remained significantly higher for the morning group was Exercise.

Results of the physiologic pre-, post-, and follow-up measurements for the total group are shown in Table 3. The physiologic measurements of the morning and afternoon groups are shown in Table 4. Significant findings included these:

Table 3
Mean physiologic measurements for the entire group ($N = 22$)

Measure	Pretest	Posttest	Follow-up
Height (in.)	64.62	—	—
Weight (lb.)	163.14	167.27	169.17
Systolic blood pressure (mm. Hg)	134.48	127.22	137.67
Diastolic blood pressure (mm. Hg)	76.81	71.91	75.17
Total cholesterol (mg.)	215.67	187.22	198.92
Triceps skinfold thickness (mm)	20.05	16.44	19.75

1. There were no significant changes in the physiologic measurements for the *total group* between the pre- and posttests or between the posttest and follow-up.
2. Significant decreases were found between the pre- and posttests of the morning group for both mean systolic and mean diastolic blood pressures.
3. Significant decreases were found between the pre- and posttests of the afternoon group in the mean diastolic blood pressure and the mean triceps skinfold thickness.

Evaluation

At the conclusion of the course participants completed a written evaluation of seven items. Of the 17 who

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Table 4

Comparison of mean physiologic measurements for the morning group and the afternoon group

Measure	Morning Group (N = 12)			Afternoon Group (N = 10)		
	PR	PS	FU	PR	PS	FU
Height (in.)	66.33	—	—	62.33	—	—
Weight (lb.)	167.50	172.75	167.88	157.33	161.00	171.75
Systolic blood pressure (mm. Hg)	132.00	120.00	131.00	137.78	134.44	151.00
Diastolic blood pressure (mm. Hg)	76.67	72.22	72.50	77.00	71.67	80.50
Total cholesterol (mg.)	208.25	191.00	204.00	225.56	183.44	188.75
Triceps skinfold thickness (mm.)	28.83	16.44	20.50	21.67	16.43	18.25

Key: PR, Pretest; PS, Posttest; FU, Follow-up test

completed the evaluation, only one responded that some of the information was "not useful." All participants indicated that the class materials were appropriate to their level of knowledge and recommended that the program be offered to other seniors.

Two items on the evaluation form asked the participants what they liked about the classes and requested suggestions for improving the course. Participants agreed that the class design met their needs and had no specific suggestions for improving the course. They appreciated the opportunity to gain knowledge and skills for maintaining or improving their health. They also commented that the friendly, caring instructors motivated them to attend the classes.

An informal evaluation conducted with the nursing students and the hospital consultants indicated that (1) they felt the course was useful for the

participants, (2) pairing students and consultants provided additional resources for participants and was a useful learning experience for the students, and (3) the role of the consultant was ill-defined with respect to the amount of input into session content and structure.

Discussion and Recommendations

The overall design of Project Wellness proved effective for delivering wellness education resources to seniors in a familiar and comfortable setting. At the outset, the planners were concerned that participants' interest in the course would wane over the 12-week period; however, 100% of the enrolled participants completed the course. Factors that may have contributed to their sustained interest included the rapport that developed between participants, nursing students, and consultants; the accessibility of the course in relation to time and location; and the demonstration of outcomes

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through the posttests and follow-up tests.

The Project Wellness model may be easily replicated and adapted to various settings. Several recommendations for improving the effectiveness of the course might be considered:

1. Use a control group not involved in the course, to better measure the effect of the course on health-promoting lifestyle changes.
2. Have project participants set one or two individual goals they wish to achieve by the end of the course, (2) at the end of 6 months, and (3) at the end of 1 year.
3. Focus on developing a support network for participants. The network might consist of other seniors involved in the course and/or the health professionals who serve as teachers or consultants for the classes.
4. Hold "Train the Trainer" sessions for group members who want to reach other elders with health and wellness education information.

Conclusion

Project Wellness successfully used an interdisciplinary approach to help senior citizens to increase their overall health-promoting behaviors. The

collaborative efforts of Project Wellness planners demonstrated a method for pooling resources to meet identified community needs. Through programs like Project Wellness, seniors can acquire healthy living skills to add quality to their years.

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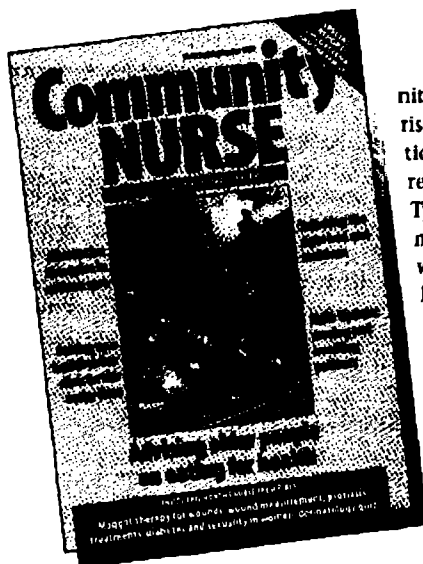
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care of the older person

Advising older people on healthy dietary change

Whether they need care packages or not, many older people welcome advice on eating for health. June Copeman outlines what advice to give



Older people can be broadly divided into two categories – the fit older individual and the frail older person – depending on their age and health profile.

The fit older individual is typically retired, independent and aged 65-74 years, with a health profile similar to many middle-aged people. The frail older person, often with a combination of chronic medical conditions, requires support to live in the community. This support may vary from involving friends and neighbours in shopping to a complex 24-hour care package with home care assistants, nurses and other professionals.

Identifying those at risk of malnutrition

During normal nursing duties it is useful to look for opportu-

nities to assess those at risk and provide nutrition information in response to queries. Typical visual signs of malnutrition include weight loss, loose hanging clothes, muscle wasting and loss of subcutaneous fat.

Many community and acute trusts have developed nutrition screening tools. These include questions

related to recent weight change, current food intake, appetite, medication, ability to swallow, and medical and physical conditions. Some screening tools have a scoring system which allows the nurse or health professional to refer at-risk clients, whose scores are outside the acceptable range, for more advice and assistance.

Over-75s screening

Since 1990 GPs have had a legal obligation to arrange an annual health check for all over-75s on their register. The health check assesses sensory function, mental state, physical condition, social environment and the use of medicines. This total screening package can identify relatively new direct and indirect nutrition problems. These include impaired mobility, dementia,

diabetes and, in some cases, under-nutrition as well as chronic conditions such as obesity.

Under-nutrition and diabetes are clearly nutrition-related issues. Impaired mobility and the social environment can affect the availability and consumption of food and hence the nutritional status of an individual.

The fit older individual

Healthy eating

As people become older it is important to maintain an adequate food intake, consuming a wide variety of foods.

Pre-retirement is an ideal opportunity to evaluate eating habits. Cooking methods should be modified to encourage grilling, boiling, baking and roasting instead of frying.

The current nutritional guidelines for healthy adults recommend:

- Reducing sugar intake by half
- Reducing the total amount of fat including saturated fat
- Eating less salt
- Increasing dietary fibre intake by half.

Obesity

Obesity can dramatically reduce mobility in older people. In many cases active intervention should be considered. Obesity worsens conditions such as osteoarthritis, heart failure, asthma, chronic

obstructive airways disease, arthritis and hypertension, making control of symptoms more difficult.

Central obesity, where excess fat is stored around the middle of the body, is associated with a greater risk of premature death, strokes, diabetes and hypertension than when the excess fat is situated around the hips.

Realistic goals in relation to time and weight loss should be agreed. Half a pound to one pound weight loss per week is satisfactory and the client needs to accept that a slow, steady loss is more likely to be effective in the longer term. A starvation diet is not recommended but regular eating of low-fat, low-sugar, high-fibre foods is encouraged.

A restricted income will have an impact on the type and variety of food purchased and sometimes older people feel it is not worthwhile losing any excess weight. Some people need the support of others and could benefit from a slimming group.

Hyperlipidaemia

For older people with a raised cholesterol level, there is evidence that a three-pronged intervention – weight control, lowering blood pressure and the reduction of cholesterol in the diet – is of value.

Specific dietary advice depends on how many of a

care of the older person

number of variables – weight, serum cholesterol and triglycerides – are abnormal. Advice includes:

- Reducing total fat in the diet to 30% of food energy
- Increasing the quantity of complex carbohydrates and dietary fibre
- Increasing consumption of oily fish.

In addition, if the serum triglyceride levels are raised the consumption of alcohol and simple sugars should be reduced even if the individual is of normal weight.

Other lifestyle risk factors, such as smoking and inactivity, should be modified. Finally, it should be remembered that with many older people it is the quality of life that is important and the diet should be palatable, acceptable and as near-normal as possible.

Diabetes

Effective diabetes treatment is important for all ages. In fact, many older people are keen to make modifications to their diet to achieve better health. Older people with diabetes will benefit from modification of their fat intake to reduce the increased risk of vascular disease.

The same principles of healthy eating in the general population should be applied. As most people with non-insulin dependent diabetes are overweight it is important to encourage physical activity and reduce the total food energy intake to enable a slow, steady weight loss. Artificial sweeteners such as aspartame and saccharin are useful.

Diabetic products are unnecessary and in many cases contain a similar amount of energy to their equivalent normal food items, although they may be more expensive.

Illness

If someone is ill and has a reduced appetite it is important to encourage eating and

drinking. Alternative food and drink items may need to be offered, but a return to a low-fat, low-sugar, high-fibre diet should be achieved as soon as possible. These alternative foods should be easy to eat, pleasant in taste and texture, and not very bulky.

Constipation

Constipation is a common problem among older people due to a the lack of mobility, reduced fluid intake or increased fluid loss. With some drugs, such as codeine and morphine, constipation is a potential side-effect.

Increasing the fluid intake to at least eight full cups of liquid (non-alcoholic) a day, encouraging mobility and increasing the amount of dietary fibre in the diet can help treat and prevent constipation. These measures are preferable to the use of laxatives, suppositories or enemas.

Dietary fibre affects bowel function by improving stool consistency, increasing stool weight and reducing transit time through the colon. Fibre-rich foods include wholegrain breakfast cereals, wholemeal bread, brown rice, fruit and vegetables, especially with their edible skins, and dried fruit and nuts.

Bran should be used only if medically prescribed and must be introduced slowly. When included in a previously low-fibre diet it may lead to stomach pains, diarrhoea and flatulence. In addition, it may reduce the absorption of calcium and iron by the body. If taken it is vital that extra fluid is consumed.

The frail older person

In 1992 it was recommended¹ that all older people should be:

- Offered a wide range of nutrient-dense foods
- Provided with a diet that is generous in energy. Nutrient requirements are unlikely to

be met when energy consumption is inadequate

- Encouraged to increase their intake of vitamin C. This is destroyed in cooking therefore fortified fruit drinks and citrus fruit should be included in the diet every day

- Given a diet rich in fibre from wholegrain cereals, fruit and vegetables, with adequate fluid. Many older people suffer from constipation exacerbated by a low-fibre intake. During illness, bulky high-fibre foods may be too filling and prevent someone from eating enough

- Encouraged to expose skin to sunlight regularly from May to September. The recommended requirement for vitamin D cannot be met from food alone. Ultraviolet rays from the sun act on exposed skin to produce vitamin D. Housebound individuals should be considered for prescribed supplements.

Frail elderly people are often more susceptible to malnutrition due to a range of eating difficulties such as a dry or sore mouth, physical limitations following a stroke or as a consequence of a chronic condition such as arthritis or Parkinson's disease.

Stimulating a small appetite

In illness the appetite may become depressed therefore small nourishing meals, snacks and drinks should be offered regularly throughout the day and evening. If someone's appetite is small it can sometimes be difficult to consume sufficient food to meet dietary requirements and the use of supplements may be indicated. There are several types of supplements:

- Snacks between meals
- Ordinary food enriched with energy-rich foods that do not increase the volume of the meal. For example milk powder, double cream, margarine and sugar
- Supplementary products.

When supplements are being consumed it is important that the quantity and type of supplement, total fluid consumed and concurrent intake of ordinary food is monitored and a review system agreed. Dehydration is a potential problem as many supplement drinks have a high-energy concentration and some older people may consume these instead of a normal drink.

Reference

1. Department of Health. *The Nutrition of Elderly People*. Report of the Working Group on the Nutrition of Elderly People of the Committee on Medical Aspects of Food Policy. London: HMSO, 1992.

Useful publications by the Nutrition Advisory Group for Elderly People (NAGE)

- *Nutrition Assessment Checklist and Guidance Notes*. Price £2.00.
- *Taking Steps to Tackle Eating Problems*. Price £7.00.
- *Stimulating a Small Appetite*. Price £20.00.
- *Eating Through the 90s*. Price £5.00.
- *Supermarket Shopping and the Store Cupboard*. Price £20.00.

All the above can be obtained by sending a cheque or postal order (made payable to NAGE) to: NAGE, Unit 21, Goldthorpe Industrial Estate, Goldthorpe Rotherham, South Yorkshire S63 9BL.

Useful Address

The British Dietetic Association
7th Floor, Elizabeth House,
22 Suffolk Street, Queensway,
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EMPIRICAL RESEARCH

EVALUATION OF CHAMPS, A PHYSICAL ACTIVITY PROMOTION PROGRAM FOR OLDER ADULTS^{1,2}

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ABSTRACT

We evaluated physical activity changes resulting from a six-month public health model intervention that encouraged seniors (N = 89) 62–91 years of age (mean = 76) living in two low-income congregate housing facilities to increase their physical activity by participating in existing community-based physical activity classes and programs of their choice. The program was offered to everyone regardless of their health problems. Enrollees were encouraged to adopt activities tailored to their preferences, physical abilities, health status, income, and transportation resources. Using a comparison-group design, the intervention group was more active for all comparison months of the intervention period (p values < .05). The intervention also was associated with improvements in self-esteem (p < .05), though not with an array of other measures of health-related quality-of-life. Those who adopted and maintained a new physical activity over the six-month intervention period experienced improvements in anxiety, depression, and overall psychological well-being relative to those who did not. The intervention was subsequently replicated through a senior center (N = 22). A much larger proportion of the senior center sample adopted and maintained a new activity for six

months (68%) compared to the congregate facilities sample (35%), which may have been due to differences in recruitment methods and sample characteristics in the two settings. An intervention promoting increased physical activity through the use of existing community resources may help increase physical activity in older adults.

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INTRODUCTION

Despite the plethora of evidence supporting the importance of physical activity for health and functioning as people age (1–11), two-thirds to three-fourths of the older U.S. population remain underactive (12–14). This may be due in part to the special barriers to physical activity that older adults face, including chronic health problems, fear of falling, transportation difficulties, limited income, and a variety of psychological barriers such as beliefs that exercise will not benefit one's health and that persons with chronic health problems should not exercise (15–18).

Interventions are needed that promote and encourage physical activity by specifically addressing these barriers across the entire older adult population. Such programs have been particularly lacking for those with lower socioeconomic status, those with poor health, and the oldest-old (19,20). To address the known barriers, programs need to provide: (a) information regarding the importance of physical activity for older adults and what activities are available, appropriate, and affordable in the community; and (b) skills training, encouragement, and support to begin and maintain new physical activity patterns (21). Programs aimed at minimizing the amount of staff time per participant are especially indicated to increase potential cost-effectiveness as well as generalizability through existing service providers such as senior centers or health maintenance organizations.

The current study was designed to evaluate the effectiveness of an intervention to promote physical activity in older adults by

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encouraging them to participate in community-based physical activity classes and programs of their choice and by providing information, personal counseling, support, and skills training to overcome barriers to increasing their physical activity levels. The intervention sought out those previously underserved, namely, those with low incomes. It also was designed to be inclusive of persons with chronic conditions and to be practical so that it could be adopted by other communities. By utilizing a variety of community classes, we hoped to address the needs of a broad sector of the older adult population and allow participants to continue their activities once the program ended. We addressed two main questions: (a) How effective was the intervention in increasing physical activity of older adults proactively recruited from congregate housing facilities? and (b) Did changes in physical activity affect health-related quality-of-life? In addition, we explored the effectiveness of a replication conducted in a small sample from the community at large through the auspices of a senior center.

METHODS

Setting/Target Population

The study was conducted in Palo Alto, California, a mid-sized community near San Francisco. The target population consisted primarily of residents in two government-subsidized congregate housing residential facilities. These two particular settings in the community were chosen because of their close match on a number of demographic and organizational variables. Congregate housing facilities are good settings in which to conduct health promotion interventions because they provide a well-defined population base that facilitates use of proactive recruitment strategies and intervention strategies offered to the entire facility. Government-subsidized facilities also provide the advantage of including lower income individuals who, as noted before, are typically underrepresented in health promotion programs.

In addition, to test whether the intervention could be replicated in a group of individuals living in the community at large, we targeted older persons utilizing the community senior center. The senior center was viewed as a good setting for such an intervention because it offers a variety of services and health promotion programs and thus could potentially provide such a program on an ongoing basis.

This community offered a range of physical activity classes or programs, such as organized walking groups, open swimming for seniors, and classes in general conditioning, tai chi, strength training, dancing, and recreational sports. These classes and programs were offered year-round, although many were repeated quarterly and had to be enrolled in each quarter. Classes were available for the general older adult population as well as for special segments (e.g. a therapeutic swim center for persons with disabilities, exercise for persons with back problems, arthritis-specific exercise). These classes were offered at various locations throughout the community such as the recreation department, community college, YMCA/YWCA, and senior center. At each congregate housing facility, a general conditioning class was offered on a regular basis and a fitness room was available with a variety of exercise machines (e.g. stationary bicycles).

Design

The main study design was a comparison-group design in which one congregate housing facility received the intervention and the other served as a wait-list comparison group (receiving the intervention at the end of the comparison period). While the focus

on the housing facilities as a whole required use of a quasi-experimental (comparison-group) design, we attempted to bolster this design by replicating the intervention in the comparison group and the senior center (22).

The comparison-group design was implemented beginning in April. During the wait-list period, the comparison group completed the same measures as the intervention group, and at the end of this time, the comparison group received the intervention. Before starting the intervention in the comparison group, a "booster" meeting was held to provide a reminder about the nature of the program and to offer enrollment to additional residents in that facility. In order to accommodate physical activity class schedules in the community, the comparison group began their program in mid-September, which was five months after enrollment. The replication in the senior center group also began in September.

Program Description

The Community Healthy Activities Model Program for Seniors (CHAMPS) was a six-month intervention designed to promote increased levels of physical activity among those enrolled by encouraging participation in moderate-intensity physical activity classes and programs already available in the community. CHAMPS focused on referring participants to community-offered class-based activities for several reasons: (a) to utilize resources already available, thereby minimizing program costs; (b) to increase the likelihood that participants would maintain their new activities because of the social contact, variety, and regular scheduling; (c) to increase the likelihood that participants would continue their activities when the intervention ended; and (d) to enhance replicability in other community settings.

Instead of asking enrollees to adhere to a prescribed protocol, the intervention encouraged enrollees to try one or more activities suited to their interests, abilities, income, and transportation resources, and to aim for a target frequency of three to five times per week but increase activities in a progressive manner. For those who enrolled in the program who were already participating in some form of physical activity, we encouraged adoption of a complementary activity to encourage a more balanced fitness program (e.g. addition of strength training if they were already walking, or vice versa).

The intervention was based on principles derived from social cognitive theory which explains human behavior in terms of the interaction of behavior, personal factors, and environmental influences (23,24). From this theory, we utilized the following strategies: (a) a motivational informational meeting emphasizing the health benefits of physical activity for all seniors, especially those with health problems; (b) one-on-one assistance in selecting a physical activity class or program tailored to their interests, abilities, income, and transportation resources; (c) assistance in self-monitoring techniques through the use of activity logs; (d) a Physical Activity Directory providing detailed information on all moderate-level physical activity classes and programs in the community suitable for seniors, updated quarterly; (e) six monthly group meetings providing information to counter common myths about exercise, assistance in recognizing and overcoming barriers, a sense of belonging to a program, and the possibility of meeting others with whom to exercise; (f) written materials and a monthly newsletter providing helpful information such as tips and strategies for starting and maintaining activities as well as information to correct possible misperceptions; (g) encouragement and support provided by staff at group meetings and via telephone (about ten calls per subject over the six months); and (h) incentives such as

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chances to win small prizes for attending the meetings. These program support mechanisms were designed to collectively address many of the barriers that older persons face in attempting to exercise and are described in more detail elsewhere (25).

Eligibility/Sampling/Recruitment

A two-phased recruitment strategy was used in all settings. Individuals were first recruited to attend an informational meeting at which time they were invited to enroll. This strategy allowed us to address a variety of potential barriers during the meeting, rather than attempting to do so individually.

In the congregate housing facilities, proactive population-based strategies were used to attempt to recruit a representative sample of the target population to the meeting. All residents were personally invited to a series of these meetings via flyers distributed to their apartments, advertisements in the facility newsletter, presentations by staff at congregate meals and resident meetings, and personal letters. To recruit a convenience sample of older individuals from the community through the senior center, a more traditional media-based approach was used in which the study was advertised along with an invitation to an informational meeting held at the senior center via flyers posted at the senior center and an article in the senior center newsletter.

At the informational meetings, the following points were emphasized: (a) the importance of physical activity to the health and functioning of older adults; (b) the appropriateness of some type of physical activity for everyone regardless of health problems; (c) that physical activity need not be strenuous to be beneficial; and (d) that light to moderate physical activity can be fun and provide social opportunities. The use of the term "exercise" was minimized to avoid intimidating potential enrollees; instead, we used the term "physical activity." Recruitment is described in more detail elsewhere (26).

Requirements of enrolling in CHAMPS included a one-year commitment to the project, during which time participants completed quarterly questionnaires and monthly activity logs and received telephone calls from CHAMPS staff. Although not a requirement, enrollees were encouraged to attend six monthly group meetings.

No restrictions were placed on eligibility and individuals with health problems were encouraged to join. Because we referred individuals to community-offered classes, medical clearance was considered the responsibility of each class or program that the person planned to attend. However, prior to enrollment, potential enrollees completed an informed consent and medical history form. If a medical history indicated a condition that could limit involvement in physical activity, the person was advised to inform his or her physician regarding the program.

Physical Activity Measures

Two approaches were used to measure physical activity: (a) daily reporting on activity logs and (b) point-prevalence self-reports of activity measured by a self-administered questionnaire at baseline and six months.

Activity Logs: Subjects recorded on a daily activity log when they participated in any physical activity class or program or did a physical activity on their own. A physical activity class or program was defined as any organized, regularly scheduled function which had the primary goal of engaging individuals in physical activity. Physical activities that were counted included endurance activities (walking, swimming, dancing, exercise machines), general condi-

tioning, strengthening exercises (weight training), stretching/balance exercises (yoga, tai chi), and recreational sports (tennis, golf, bowling). When participants were active on their own, the duration of the activity was also recorded. These data were collected monthly and were verified through exercise class attendance records and telephone contacts. For all months across all sites, 98% of all logs were completed. This completion rate included the wait-list period of the comparison group. Activity log data were determined to be valid compared to class attendance records. Ninety two percent of classes attended were accurately reported. Of the total number of classes reported, 88% were actually attended.

For each individual, four measures were derived each month from the activity logs: (a) participation in a class/program (yes/no); (b) frequency of participation in a class/program; (c) participation in a physical activity on their own, defined as a physical activity occurring outside of a formal group structure that lasted for at least 30 minutes; and (d) frequency of participation in an activity on their own. Although we considered attendance of at least one class in a particular month as participation, there were very few instances in which only one class was reported for a given month. We set a 30-minute minimum criterion for "on-their-own" activities to make them comparable to a class-based activity which would be of at least a 30-minute duration. Further, although 20 minutes is often considered an episode of activity, our experience is that older adults slightly overestimate the duration of their physical activities, thus the 30-minute criterion adjusted for this.

Patterns of change in physical activity levels over the six months of each group's respective intervention period were also described based on activity log data. Thus, the patterns of change measures for the comparison group facility were calculated during their intervention phase. Each individual in the sample was classified into one of five mutually exclusive patterns, as follows: (a) started (adopted) a new physical activity (class/program or activity on their own) and continued (maintained) for six months; (b) started a new physical activity but discontinued; (c) did not start a new physical activity but was already involved in some physical activity prior to CHAMPS and continued it; (d) did not start a new physical activity but was already involved in some activity prior to CHAMPS, however, discontinued it; and (e) did not start a new physical activity and was initially sedentary. The patterns were hierarchical so that if an individual was classified into category "a" (adopted a new activity and maintained it for six months), he/she was not included in any other categories.

Questionnaire Measures: Point-prevalence reports of other aspects of physical activity were assessed on a self-administered questionnaire using an instrument developed specifically for this study to be appropriate for older adults. Two primary measures were derived from questions on this instrument: (a) frequency per week of all physical activities (e.g. walking, general conditioning, swimming, bicycling, etc.) and (b) calories per week expended in all physical activities (derived by applying metabolic cost weights to each activity participated in, adjusted for body weight) (27). Three-month stability coefficients (assessed in the comparison group) were .57 for the frequency measure and .84 for the caloric expenditure measure. Several construct validity studies provided evidence of the validity of the self-reported measures. When the measures were compared with interviewer-collected data on baseline levels of activity, both frequency and caloric expenditure were significantly higher in those who were already at least moderately active at baseline relative to those who were inactive (p val-

ues $< .001$). In addition, scores on the two measures were compared across four groups varying in the frequency of participation in physical activities in the sixth month of the study based on activity log data; both measures exhibited increasing values as the frequency increased (p values $< .001$). For example, weekly caloric expenditure in the sixth month ranged from 794 for those with no activities to 2,557 for those with more than 18 days of activities ($p < .001$).

Health-Related Quality-of-Life Measures

Measures of physical functioning, energy, pain, perceived sleep adequacy, self-rated health, depression, anxiety, overall psychological well-being (summarizing anxiety, depression, and positive affect), and limitations in social activities due to health from the Medical Outcomes Study (MOS) were included in the baseline and six-month questionnaires (28). These measures have been shown to be reliable and valid in studies of a large sample of chronically ill patients (28,29). In addition, we included a measure of self-esteem (30) and sense of mastery (31). Life satisfaction was assessed using a nine-point ladder scale that has been validated (32,33); a parallel item was developed to assess satisfaction with social life. Internal consistency reliability of the multi-item measures ranged from .62 to .92.

Methods of Analysis

Physical Activity Outcomes: To determine how effective the intervention was in increasing physical activity levels of enrollees, we compared monthly rates of participation in physical activity classes/programs between the intervention and the comparison group during the comparison-group period. The denominator for the percentage of those participating in a class or program was those who were enrolled in CHAMPS during that month, were not on medical leave (e.g., surgery), and were in town for at least half of the month. The differences between the two groups for each month were tested using McNemar's test for correlated proportions (34). We examined changes in each questionnaire measure of physical activity using analysis of covariance (ANCOVA). The endpoint measure was used as the dependent variable; intervention group was the independent (classification) variable; and covariates included age, sex, education, non-White ethnicity, and number of chronic conditions.

Health-Related Quality-of-Life Outcomes: To investigate whether changes in physical activity affected quality-of-life, we conducted two analyses. First, using an intention-to-treat approach, ANCOVA was used to evaluate changes in each six-month health-related quality-of-life score as a function of group (intervention versus comparison), controlling for the five covariates (age, sex, education, non-White ethnicity, and the number of chronic conditions). This analysis represents a conservative approach, since not all individuals enrolled were responsive to the intervention. Therefore, we also explored whether those who increased their physical activity over their six-month intervention period experienced quality-of-life changes relative to those who did not. For this analysis, each quality-of-life change score was compared between those who adopted and maintained a new activity and those who did not using ANCOVA and controlling for the five covariates. The second analysis combined data across congregate housing facilities over their respective intervention period. Because of the exploratory nature of these questions, tests were considered significant if the probability was less than 0.05. A more conservative Bonferroni-type correction was not considered appro-

priate because this would tend to overcorrect individual comparisons (Type II error), leading to insensitivity to true effects (35,36). Because the number of significant effects overall is inflated by chance, we interpret our results with this in mind.

RESULTS

Sample Characteristics

The sample from the two congregate housing facilities over the first six months consisted of 59 persons from the intervention group and 30 individuals from the comparison group (total $N = 89$). This represents 91% of those who began the program in the intervention site and 100% of those who enrolled in the comparison group. Dropout was due to relocation out of the area and loss of interest. The characteristics of the two groups are described in Table 1. No significant differences were found between the intervention and comparison groups at baseline on demographic, health, and life-style characteristics, except that more of those in the intervention group did not speak English as their primary language. We were successful in recruiting individuals from all age groups (e.g., 11% were 85 and older) and with a variety of health problems. Self-reported chronic health problems were common and included arthritis (48%), back problems (44%), hypertension (38%), angina (11%), and other heart problems (34%). Twenty-eight percent of enrollees reported that their health was either poor or fair. These 89 enrollees represent 19% of the total number of residents at the two facilities (18% in the intervention facility and 23% in the comparison group facility). There are few other studies of older adults against which these rates can be compared, since most physical activity studies do not recruit from a well-defined population. However, this level of participation—nearly 1 in 5 residents agreed to commit to this one-year study and participate in the program—is substantially higher than the 11% obtained in a population-based study of adults 50–65 years of age requiring participation in a one-year physical activity intervention (37). In the Minnesota Heart Health Program, the rates were 1%–5% for smoking cessation programs and 3%–12% for weight loss programs (38). Based on an enumeration survey of residents of both facilities, those who enrolled in the study were generally representative of those who did not enroll in terms of their demographic, health, and life-style characteristics, although they were slightly younger, more likely to speak English as their primary language, and more likely to be overweight (26).

Change in Physical Activity

At baseline, a significantly higher proportion of the comparison group relative to the intervention group reported participating in physical activity classes or programs during the year prior to the intervention (37% compared to 17%, $p < .05$). Despite this initial difference, the percentage of those in the intervention group who subsequently participated in community-based physical activity programs and classes during the intervention period was substantially greater than in the comparison group for each month of the comparison period (p values $< .05$) (see Figure 1). The proportion of intervention group subjects participating in classes peaked at three months (64%) and declined to 41% at six months, which was still substantially higher than rates prior to the intervention (17%) ($p < .05$). During the subsequent five-month follow-up period, when the intervention was no longer offered, the overall class participation in the intervention group remained relatively stable at an average of 35%.

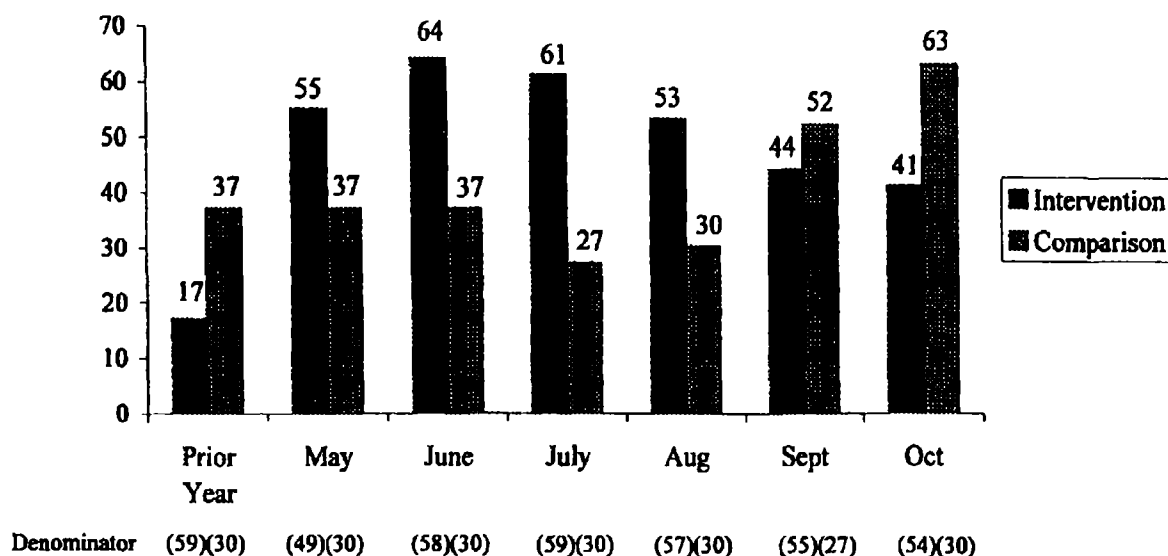
Of those in the intervention group who participated in any classes during the six months, the average frequency of attendance

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TABLE 1
Sample Description

	Setting A Intervention Group N = 59	Setting B Wait-List Comparison Group N = 30	A + B Combined N = 89	Senior Center N = 22
Age in years				
Mean (SD)	77.1(6.9)	76.4(6.8)	76.9(6.9)	73 (8)
Range	62-91	63-90	62-91	57-87
Categories (%)				
Advanced middle-aged (57-64)	3	6	3	14
Young-old (65-74)	27	39	31	43
Old-old (75-84)	58	45	54	33
Oldest-old (85+)	12	10	11	10
Years of education				
Mean (SD)	13.6(3.7)	14.2(3.1)	13.8(3.5)	16 (3)
Range	3-22	8-22	3-22	12-22
Minorities (%)	12	3	9	17
Women (%)	85	81	83	77
Married (%)	15	19	16	42
Primary language not English (%)	15	0	10*	10
Number of chronic conditions	2.7	2.3	2.6	3.0
Has the following condition:				
Arthritis (%)	54.2	36.7	48.3	72.7
Back problems (%)	47.5	36.7	43.8	59.1
Hypertension (%)	38.0	36.7	37.5	38.1
Angina (%)	10.2	13.3	11.2	18.2
Heart trouble (%)	28.8	43.3	33.7	40.9
Rated health as fair or poor (%)	25	33	28	18

* Significantly different at $p < .05$ for setting A vs. setting B.

NOTE: Comparison group began the intervention in September.

FIGURE 1. Percent Participating in Community Classes or Programs Each Month (Intervention vs. Comparison Group)

was 4.0 to 6.9 classes per month (median = 5.5) across the six months. The range was from 0-20 classes per month. Note that in mid-September, as shown in Figure 1, the comparison group began the intervention (in order to accommodate community class

schedules), with the percent participating in classes increasing significantly in relation to prior months.

These changes in physical activity measured via monthly activity logs were not detected when comparing differences from

TABLE 2
Patterns of Change in Physical Activity During Respective Intervention Period, Based on Activity Log Data

	Congregate Facilities ¹ (N = 91) ² N (%)	Senior Center (N = 22) N (%)
INCREASED PHYSICAL ACTIVITY:		
Adopted new physical activity and maintained for 6 months	32(35)	15(68)
Adopted new physical activity but discontinued	21(23)	3(14)
Total adopted new physical activity	53(58)	18(82)
DID NOT INCREASE PHYSICAL ACTIVITY:		
Already somewhat active, remained active	22(24)	3(14)
Already somewhat active, discontinued	3 (3)	1 (4)
Sedentary, remained sedentary	13(14)	0 (0)
Total did not increase physical activity	38(42)	4(18)

¹Congregate facilities are combined, as the differences between them were not significant.

²Includes two additional subjects who enrolled at the beginning of the program at the comparison facility.

baseline to six months using the two questionnaire measures. No differences were observed in the two questionnaire measures of frequency of physical activity and caloric expenditure between the intervention and comparison group at six months using ANCOVA (p values > .10).

The percentage of subjects in each pattern of change category is shown in Table 2, which combines data across the two congregate housing facilities during their respective intervention periods. As shown, 53 persons (58%) adopted a new activity during their respective intervention periods; of these, 60% ($N = 32$) maintained their activity throughout their six-month intervention period. Thus, 35% of the total congregate facilities sample adopted and maintained a new activity for six months and 23% adopted a new activity but discontinued. The majority of new activities (75%) were classes, which is consistent with the emphasis of the program. Forty-two percent of the congregate facilities sample made no changes in their activity level, including those who were previously active (24%) and previously sedentary (14%) and 3% that discontinued existing activities. Information in Table 2 is combined for the two congregate facilities, as there were no significant differences between the facilities.

Those who adopted and maintained a new physical activity in the congregate facilities ($N = 32$) had an increase in their weekly caloric expenditure of approximately 125 calories from baseline and increased their weekly frequency of all physical activities by approximately four times according to questionnaire measures. Between-group analyses indicated that while the questionnaire-based measure of caloric change was not significantly greater in those who adopted and maintained a new activity, the questionnaire-based measure of frequency of activity was significantly greater in this subgroup relative to the rest of the sample ($t = 3.27, p < .01$).

Health-Related Quality-of-Life Outcomes

Intervention Versus Comparison Group: Using ANCOVA to evaluate changes in six-month health-related quality-of-life scores, with group (intervention/comparison) as the classification variable, self-esteem improved in the intervention group relative to the comparison group ($F = 4.05, p < .05$). No differences were found

between the two groups in physical functioning; limitations in social activities due to health, energy, pain, sleep adequacy; self-rated health; sense of mastery; psychological well-being; and life satisfaction.

Those Who Adopted and Maintained versus Those Who Did Not: For the entire congregate housing sample, ANCOVA of six-month change scores in quality-of-life indicated that those who adopted and maintained a new activity regardless of their group assignment ($N = 32$) had greater improvements in overall psychological well-being/distress ($F = 6.52, p < .05$) relative to those who did not adopt and maintain a new activity ($N = 57$). On examining the components of this index, we found that they had greater reductions in anxiety ($F = 10.50, p < .01$) and depression ($F = 5.14, p < .05$), but no changes in positive affect. No other differences in health-related quality-of-life were observed between these two groups.

Replication in the Senior Center

From the senior center, 22 individuals completed the six-month program, representing a program completion rate of 88%. Sample characteristics of the senior center are described in Table 1. As seen there, the senior center sample was somewhat younger than the congregate facilities sample (73 years of age compared to 77) and slightly more educated (16 years versus 14 years). The program was extremely well received by those who enrolled. Regarding the patterns of change in physical activity (Table 2), 82% adopted a new activity; of these, 83% maintained the new activity over the six months. Thus, 68% of the senior center sample adopted and maintained a new activity (compared to 35% of the congregate housing sample). The senior center group that adopted and maintained a new activity increased their weekly caloric expenditure by about 750 calories and their frequency per week by about 1.8 times based on questionnaire measures of activity.

DISCUSSION

The relatively simple physical activity promotion intervention that was applied in a congregate housing facility population is among the first that we are aware of that attempted to increase the general physical activity levels of older adults using available community resources. The fact that the intervention was able to achieve adoption and maintenance of a new physical activity over six months in a sizable proportion of the congregate housing enrollees (35%) is encouraging, especially considering that the sample included a substantial proportion of individuals in the old-old and oldest-old age groups, was primarily lower-income, and included individuals with a variety of health problems.

For those who tried a new physical activity, the six-month physical activity discontinuation rate of 40% is encouraging in light of typical findings that 50% or more of individuals in younger age groups discontinue their new activities within six months (39). However, it is difficult to compare these rates to other studies, as most studies request subjects to adhere to prescribed exercise regimens; our program encouraged subjects to join a physical activity class or program of their choice. The rate of discontinuation of activity in our study slows over time, a pattern that is typical in exercise interventions (40) as well as other behavior change programs (41).

The more favorable impact of the program offered through the senior center, despite similar levels of health problems, was not completely surprising. Our recruitment methods in the senior center were more traditional (simple advertisements), which tend

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to recruit highly motivated individuals who are in more advanced stages of readiness to begin a program. Those in the congregate facilities were recruited proactively, hence that group included many who might not otherwise have responded to such a program. Further, individuals living in the community as opposed to congregate housing facilities tend to be more independent. Interestingly, participants from the senior center differed from those in the congregate facilities in their ratings of the helpfulness of various components of the CHAMPS program, suggesting greater self-reliance in taking advantage of the program features (25). Although the sample is small, the strong response to the program is provocative and suggests that such a program could potentially be highly effective for those who are ready to increase their activity levels. It also suggests that such a program can be offered in a wide range of settings.

Similar programs could be implemented through a variety of community-based non-profit agencies such as senior centers, recreation departments, YMCAs, the American Heart Association, public health departments, and community centers. They could also be offered through the health education division of health maintenance organizations. The program could take as little as about six hours of direct (interactive) staff time per enrollee over the six months, which includes time to explain the program and conduct a one-on-one planning session and subsequent telephone follow-up (about nine 15-minute calls over the six months). Optional 1½-hour group workshops were also held, enabling staff to work with many enrollees at a time. In addition, direct costs such as printing of materials and postage for mailing information and newsletters were approximately \$5 per enrollee. These costs could be funded through direct fees and/or through the individual's health insurance plan.

There were no differences in most of our health-related quality-of-life indicators between the intervention and comparison group with the exception of self-esteem, which could be due to a Type I error, given the number of indicators that were tested. The general lack of effect of the program on quality-of-life could be due to the fact that only a proportion of enrollees changed their physical activity levels. When we explored changes in health-related quality-of-life associated with changes in physical activity, those who increased their physical activity evidenced improvements in anxiety and depression as well as overall psychological well-being. It is plausible that the increased physical activity contributed to the improvements, given other studies that show psychological benefits of increased physical activity. For example, these results corroborate those from a recent study of sedentary adults aged 50–65 years showing that participation in moderate-intensity endurance exercise at least twice a week can lead to improvements in psychological outcomes such as anxiety, stress, and depressed affect (42). However, it could also be the case that the improvements in health-related quality-of-life were due to other features of being more active such as getting out, doing something new, increased self-efficacy, and being in a social setting more often during the week.

The only quality-of-life outcomes that were affected in any analysis were primarily components of mental health. Because of the importance of physical functioning to the continued independence of older adults, one of the key goals of physical activity promotion programs is to improve this outcome. It is possible that we did not observe improvements in physical functioning because of the limited duration of the program (six months). A study of adults aged 50–65 years suggests that participation in moderate-intensity activities three or more times per week over a one-year

period may be necessary to detect increases in ratings of physical functioning (43). Thus, we may have needed to monitor activities and outcomes over a one-year period in order to detect such improvements in this population. It is also possible that a more intensive intervention that aggressively encouraged achievement of recommended levels of physical activity (e.g. three to five times weekly for at least 30 minutes per session) would be more likely to result in improvements in some of the physical health components of health-related quality-of-life such as physical functioning. It is further possible that the MOS measures of physical functioning and other physical health measures are not sufficiently sensitive to detect change in this population. Finally, because of the relatively high level of physical functioning at enrollment, further improvements in physical functioning may have been difficult to achieve; a better goal of such programs in high-functioning populations may be to maintain functioning over the long-run rather than to improve it. Programs aimed at rehabilitating individuals already in decline (e.g. frail elders, those with recent injuries or illnesses) would be more likely to observe improvements in physical functioning with such interventions.

The magnitude of change in activity levels was modest in the congregate facility samples. Participants might, however, realize subsequent health benefits since the literature suggests that the most benefit is obtained when sedentary individuals adopt any activity (9,44–46). However, because greater benefits would be obtained with larger increases in activity, it is important to continue to develop methods to facilitate higher rates of adoption of a new activity as well as enhanced maintenance in those who attempt to change their activity levels. This could perhaps be accomplished through more systematic application of processes/stages of change research (47).

A major limitation of the study is the lack of a randomized design. Because a goal of the study was to intervene in the residential housing setting as a whole, randomization of individuals within settings to the intervention and comparison groups was precluded. Other limitations of the study include potential lack of generalizability to other samples, settings, and communities due to enrollment of a fairly well-educated, mostly non-minority English-speaking sample; to use of congregate housing settings in which in-house exercise classes were offered; and to use of a community with a substantial number of physical activity classes and programs for seniors.

A limitation of primarily utilizing community-offered classes is that most classes were offered only once or twice a week, thus limiting potential frequency of activity. Indeed, the average frequency of participation in class sessions for those who participated regularly was about six times per month, which is only about half of the recommended goal of exercising three to five times per week (48). In order to achieve the desired frequency, communities would need to offer more frequent classes. However, the cost could preclude lower-income seniors from joining them. A possible solution to both problems would be to encourage supplementation of use of community-based classes with home-based physical activities which have been found to be successful in facilitating sustained participation in older as well as younger populations (37). Offering home-based activities would also be responsive to preferences of some of those enrolled for home-based exercise (49). Another limitation of relying on community-based classes is the possible variation in the quality of the classes (i.e. in the skills and experience of the instructors in working with older adults).

Despite these limitations, we are encouraged by the results of this program and hope that others might attempt and evaluate

similar programs in other settings and communities. It remains a challenge to reach those who enrolled but did not succeed in changing their activity levels, as well as to continue to develop interventions and recruitment strategies to attract those who did not enroll. Future programs may need to be more intensive in working with individuals in such settings to achieve higher rates of adoption and maintenance. However, the current results suggest that seniors of all ages and with diverse health status can be helped to successfully utilize existing community resources to facilitate physical activity.

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Title

Preventing patient falls.

Author

Wilson EB

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AACN Clin Issues, 1998 Feb, 9:1, 100-8

Abstract

Falls are among the most common, yet potentially preventable, adverse events experienced by patients in hospitals. Such serious outcomes as physical and emotional injury, increased dependence, admission to a long-term care facility, and poor quality of life can result from falling. Traditionally, elderly patients have been at highest risk for falling, with many falls resulting in serious injury. These injuries cost billions of dollars and expose hospitals and their staff to liability. As the elderly population continues to increase, it is imperative that falls and associated injuries be prevented whenever possible identification of nontraditional patients at high risk for falls is emerging in the professional literature. Nurses are the first line of care in prevention of falls. Educating nurses about risk factors, prevention strategies and application of fall index and fall injury statistics can improve the safety of fall-prone patients. Refining, modifying and individualizing fall risk factors and prevention interventions for traditional and nontraditional high-risk groups is a necessary focus for future research.

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English

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Accidental Falls|*PC/SN; Inpatients|*; Safety|*

MeSH Heading

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Title

The estimated costs and savings of medical nutrition therapy: the Medicare population [see comments]

Author

Sheils JF; Rubin R; Stapleton DC

Address

The Lewin Group, Inc, Falls Church, VA 22042, USA.

Source

J Am Diet Assoc, 1999 Apr, 99:4, 428-35

Abstract

OBJECTIVES: To measure the potential savings from medical nutrition therapy (MNT) and to estimate the net cost to Medicare of covering these services for Medicare enrollees. This includes developing an estimate of the cost of providing medical nutrition services to the Medicare population and estimating the savings in hospital and other spending resulting from the use of these services. **DESIGN:** Analysis of longitudinal data from the Group Health Cooperative of Puget Sound (Seattle, Wash) for persons aged 55 years and older who have coverage for MNT services. **SUBJECTS/SETTING:** Persons aged 55 years and older who had diabetes (n = 12,308), cardiovascular disease (n = 10,895), or renal disease (n = 3,328) and who were covered under the Group Health Cooperative of Puget Sound, including Medicare beneficiaries enrolled in the plan's Medicare risk contract program. Extrapolation to the US Medicare population is based on data for persons served by the Group Health Cooperative of Puget Sound. **INTERVENTION:** The use of MNT. **MAIN OUTCOMES MEASURE:** Differences in health care utilization levels of persons with diabetes, cardiovascular disease, and renal disease who do and do not receive MNT. Differences in utilization were estimated for hospital discharges per calendar quarter, physician visits per quarter, and other outpatient visits per quarter. **STATISTICAL ANALYSES PERFORMED:** Multivariate regression models of changes in utilization for persons after they receive MNT services. **RESULTS:** Our analysis showed that MNT was associated with a reduction in utilization of hospital services of 9.5% for patients with diabetes and 8.6% for patients with cardiovascular disease. Also, utilization of physician services declined by 23.5% for MNT users

with diabetes and 16.9% for MNT users with cardiovascular disease. The net cost of covering MNT under Medicare is estimated to be \$369.7 million over the 1998 through 2004 period. The total cost of benefits is estimated to be \$2.7 billion over this period. This would be partially offset by estimated savings of \$2.3 billion resulting in net costs of \$369.7 million. The program would actually yield net savings after the third year of the program, which would continue through 2004 and beyond. **CONCLUSION:** After an initial period of implementation, coverage for MNT can result in a net reduction in health services utilization and costs for at least some populations. In the case of persons aged 55 years and older, the savings in utilization of hospital and other services will actually exceed the cost of providing the MNT benefit. These results suggest that Medicare coverage of MNT has the potential to pay for itself with savings in utilization for other services.

Language of Publication

English

Unique Identifier

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Cost Savings[*]; Dietary Services[*EC]; Medicare[*EC]

MeSH Heading

Aged; Cardiovascular Diseases|DH/EC; Cost-Benefit Analysis; Costs and Cost Analysis; Diabetes Mellitus|DH/EC; Family Practice|EC; Female; Health Maintenance Organizations|EC; Hospitalization|EC; Human; Kidney Diseases|DH/EC; Longitudinal Studies; Male; Middle Age; Multivariate Analysis; Office Visits|EC; Regression Analysis; Support, Non-U.S. Gov't; United States

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Comments: HCFA welcomes your comments and suggestions about Medicare & You. HCFA will be unable to respond to you directly, but your comments may help us make improvements to future versions of this handbook.

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Baltimore, MD 21244-1850

Medicare & You explains the Medicare Program, but it is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Dear Medicare Beneficiaries:

Recent legislation included Medicare+Choice, which will result in changes to the Medicare program. This new legislation will help keep Medicare well funded. Importantly, you now have new preventive health benefits and new patient protections. In addition, starting in 1999, Medicare will offer new health plan choices. You may want to look at these choices.

To help you understand these changes, we have revised Your Medicare Handbook and given it a new name – Medicare & You. It includes a description of the new preventive benefits available to you (see page 8), the rights you have as a patient (see page 28), and the new health plan options available to you (see pages 9-17). It will help you identify some of the important questions you will want to ask and includes a list of important resources for you to use to get more information (see page 18). Medicare information is also available on the Internet at www.medicare.gov. If you don't have a computer, your local library or senior center may be able to help you access the Medicare website.

As you read this handbook, it is very important for you to remember that if you are happy with the way you get your health care now, you don't have to do anything. The choice is yours. No matter what you decide, you are still in the Medicare program and will receive all the Medicare covered services.

It is also important to remember that Medicare doesn't pay for everything, and Medicare doesn't cover everything. To get more coverage, you may purchase a Medicare Supplemental Insurance Policy (see pages 29-30), or you may consider joining a different health plan that may provide extra benefits.

If you are interested in changing the way you receive your care, one of the new choices may be right for you. Caution: Changing the way you receive your health care is an important decision. You may wish to ask your family, friends, or doctor for help. Special rules may apply if you choose to disenroll from a Medicare health plan and return to the Original Medicare Plan with a Supplemental Insurance Policy (see page 26). If you or your spouse has health care coverage that supplements Medicare through a former employer or union, contact your benefits representative before you make a new health plan choice. If you have Medicaid coverage, do not make changes until you contact the State Medical Assistance Office.

Whether you are new to the Medicare program or not, we want you to know of our deep commitment to keep Medicare working for you.

Donna E. Shalala
DeParle

Secretary, Department of
Health and Human Services
Administration

Nancy-Ann Min

Health Care
Financing

Plan?**What is the Original Medicare****Medicare Is a Health Insurance Program for:**

- People 65 years of age and older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (people with permanent kidney failure who need dialysis or a transplant).

What is the Original Medicare Plan?

The Original Medicare Plan is the traditional pay-per-visit arrangement (see page 6-8). You can go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the **deductible**. Then Medicare pays its share, and you pay your share (**coinsurance**). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). If you are in the Original Medicare Plan now, the way you receive your health care will not change unless you enroll in another Medicare health plan.

Deductible:

The amount you must pay before Medicare begins to pay:

- each benefit period for Part A. (Benefit periods are explained on Page 6.)
- each year for Part B.

Coinsurance:

The percent of the approved charge that you have to pay:

- after you pay the Part A deductible. (See page 6)
- after you pay the first \$100 deductible each year for Part B.

Premium:

Monthly payments for health care coverage to:

- Medicare
- an insurance company, or
- a health care plan.

Fiscal Intermediary:

A private insurance company that has contracted with Medicare to process bills (claims) for Part A services

What is Part A (Hospital Insurance)?

Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. If you are eligible, Part A is **premium** free -- that is, you don't pay a premium because you or your spouse paid Medicare taxes while you were working. Your **Fiscal Intermediary** can answer your questions on what Part A services Medicare will pay for and how much will be paid (see page 19 f-g).

You are eligible for premium-free Medicare Part A (Hospital Insurance) if:

- You are 65 or older. You are receiving or eligible for retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65. You have received Social Security disability benefits for 24 months, or
- You are under 65. You have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered

- government employment, or
- You are under 65 and have End-Stage Renal Disease.

If you don't qualify for premium-free Part A, and you are 65 or older, you may be able to buy it. (Contact Social Security Administration - See page 19a).

What is Part B (Medical Insurance)?

Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. Part B covers all doctor services that are medically necessary. Beneficiaries may receive these services anywhere (a doctor's office, clinic, nursing home, hospital, or at home). Your **Medicare carrier** can answer questions about Part B services and coverage (phone number listed on page 19 b-c).

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older. Part B cost \$43.80 per month in 1998.*

Part B is voluntary. If you choose to have Part B, the monthly premium is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement payment. Beneficiaries who do not receive any of the above payments are billed by Medicare every 3 months.

If you didn't take Part B when you were first eligible, you can sign-up during 2 enrollment periods:

- **General Enrollment Period:** If you didn't take Part B, you can only sign up during the general enrollment period, January 1 through March 31 of each year. Your Part B coverage is effective July 1. Your monthly Part B premium may be higher. The Part B premium increases 10% for each 12-month period that you could have had Part B but did not take it.
- **Special Enrollment Period:** If you didn't take Part B because you or your spouse currently work and have group health plan coverage through your current employer or union, you can sign up for Part B during the special enrollment period. Under the special enrollment period, you can sign up at any time you are covered under the group plan. In addition, if the employment or group health coverage ends, you have 8 months to sign up. The 8-month period starts the month after the employment ends or the group health coverage ends,

Medicare Carrier:

A private insurance company that has contracted with Medicare to process beneficiary bills (claims) for Part B Services.

whichever comes first. Generally, your monthly Part B premium is not increased when you sign up for Part B during the special enrollment period. Contact the Social Security Administration, or the Railroad Retirement Board to sign up for Part B (see 19 a).

What Are Your "Out-of-Pocket" Costs?

The Original Medicare Plan pays for much of your health care, but not all of it. Your "out-of-pocket" costs for health care will include your monthly Part B premium. In addition, when you get health care services, you will also have to pay **deductibles** and **coinsurance** or **copayments**.

Generally, you will pay for your outpatient prescription drugs. You also pay for routine physicals, custodial care, most dental care, dentures, routine foot care, or hearing aids. Physical therapy and occupational therapy services, except for those you get in hospital outpatient departments, are subject to annual limits. The Original Medicare Plan does pay for some preventive care, but not all of it.

Your Out-of-Pocket Costs May Depend On:

- Whether your doctor accepts assignment.
- How often you need health care.
- What type of health care you need.

If You Choose Another Medicare Health Plan or Purchase a Supplemental Policy, Out-of-Pocket Costs May Also Depend On:

- Which Medicare health plan you choose.
- What extra benefits are covered by the plan.
- What your supplemental health insurance covers.

Help for Low-Income Medicare Beneficiaries

For certain older, low-income or disabled individuals entitled to Medicare Part A, your State **Medicaid** program will pay some or all of Medicare's premiums, and may also pay Medicare's deductibles and coinsurance if you have Part A, and your bank accounts, stocks, bonds, or other resources do not exceed \$4,000 for an individual, or \$6,000 for a couple, you may qualify for assistance. If you think you may qualify, contact your State, county, or local medical assistance office (see 19 m). (Income limits will change slightly in 1999.) See page 33.

Copayment:

In some health plans, the amount you pay for each medical service, like a doctor visit.

Medicaid:

A joint Federal and State program that provides medical help for certain individuals with low income and limited resources (see page 33).

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can

check the Internet at
www.medicare.gov.

Medicare Part A (Hospital Insurance) Covered Services

Covered Services	What You Pay*
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies (but not private duty nursing, a television or telephone in your room, or a private room unless medically necessary).	For each benefit period you pay: • A total of \$764 for a hospital stay of 1-60 days. • \$191 per day for days 61-90 of a hospital stay. • \$382 per day for days 91-150 of a hospital stay.** • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies. More information on SNFs can be found on page 34.	For each benefit period you pay: • Nothing for the first 20 days. • Up to \$95.50 per day for days 21-100. • All costs beyond the 100th day in the benefit period. Contact your Fiscal Intermediary with questions about Skilled Nursing Facility Care and conditions of coverage (see 19 f-g).
Home Health Care: Intermittent skilled nursing care, physical therapy, speech language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	You pay: • Nothing for Home Health Care services. • 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Call your Regional Home Health Intermediary with questions about Home Health Care and conditions of coverage (see 19 h-i).
Hospice Care***: Pain and symptom relief, and supportive services for the management of a terminal illness. Home care is provided. Also covers necessary inpatient care and a variety of services otherwise not covered by Medicare.	You pay: • Limited costs for outpatient drugs and inpatient respite care (care given to a hospice patient so that the usual care giver can rest). Call your Regional Home Health Intermediary about Hospice Care and conditions of coverage (see 19 h-i).
Blood: From a hospital or skilled nursing facility during a covered stay.	You pay: • For the first 3 pints.

*1999 Part A & B premium, coinsurance, and deductible amounts will be available before January 1,

1999.

******You have 60 reserve days that may only be used once. For each reserve day, Medicare pays all covered costs except for a daily coinsurance (\$382 in 1998).

*******You must meet certain conditions in order for Medicare to cover these services.

Benefit Period: Starts the day you are admitted to a hospital or Skilled Nursing Facility and ends when you haven't received hospital inpatient or Skilled Nursing Facility care for 60 consecutive days.

Call your Fiscal Intermediary for general questions about your Medicare Part A coverage (see 19 f-g).

Medicare Part B (Medical Insurance) Covered Services

Covered Services	What You Pay*
Medical Expenses: Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment (DME).	You pay: • \$100 deductible (pay once per year). • 20% of approved amount after the deductible, except in the outpatient setting. • 50% for most outpatient mental health. • 20% of first \$1,500 for all physical therapy services and 20% of first \$1,500 for all occupational therapy services, and all charges thereafter. (Hospital outpatient therapy services do not count towards limit.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	You pay: • Nothing for services.
Home Health Care: (If you don't have Part A.) Intermittent skilled care, home health aide services, DME and supplies, and other services.	You pay: • Nothing for services. • 20% of approved amount for DME.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	You pay: • No less than 20% of the Medicare payment amount (after the deductible).
Blood: As an outpatient, or as part of a Part B covered service.	You pay: • For the first 3 pints plus 20% of approved amount for additional pints (after the deductible).

*1999 Part A & B premium, coinsurance, and deductible amounts will be available before January 1, 1999.

Note: Actual amounts you must pay for coinsurance are higher if the doctor does not accept assignment (see page 5).

Call your Medicare Carrier if you have general questions about your Medicare Part b coverage (see 19 b-c).

Part B also helps pay for:

- X-rays
- Speech language pathology services
- Artificial limbs and eyes
- Arm, leg, back, and neck braces
- Kidney dialysis and kidney transplants
- Under limited circumstances, heart, lung, and liver transplants in a Medicare-approved facility
- Preventive services (see next page)
- Very limited outpatient drugs
- Emergency care
- Limited chiropractic services
- Medical supplies: items such as ostomy bags, surgical dressings, splints, and casts
- Breast prostheses following a mastectomy
- Ambulance services (limited coverage)
- The services of practitioners such as clinical psychologists, clinical social workers, and nurse practitioners
- One pair of eyeglasses after cataract surgery with an intraocular lens

Medicare Preventive Services-Added Benefits to Help You Stay Healthy

Covered Service	Eligible Beneficiaries	What You Pay
Screening Mammogram: Once per year.	All female Medicare beneficiaries age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once per year if you are at high risk for cervical or vaginal cancer, or if you are of child bearing age and have had an abnormal Pap Smear in the preceeding three years.	All female Medicare beneficiaries.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Colorectal Cancer Screening: Fecal Occult Blood Test Once every year. Flexible Sigmoidoscopy	All Medicare beneficiaries age 50 and older, however, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the annual

Once every four years.		Part B deductible.
Colonoscopy Once every two years if you are high risk for cancer of the colon.		
Barium Enema Doctor can substitute for sigmoidoscopy or colonoscopy.		
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All Medicare beneficiaries with diabetes (insulin users and non-users).	20% of the Medicare approved amount after the annual Part B deductible.
Bone Mass Measurements: Varies with your health status.	Certain Medicare beneficiaries at risk for losing bone mass.	20% of the Medicare approved amount after the annual Part B deductible.
Vaccinations: Flu Shot: Once per year. Pneumococcal Vaccination: One may be all you ever need - ask your doctor. Hepatitis B Vaccination: If you are high or intermediate risk for hepatitis.	All Medicare beneficiaries.	No coinsurance and no Part B deductible for flu or pneumococcal vaccinations. For Hepatitis B vaccination, 20% of the Medicare approved amount after the Part B deductible.

Learning About Medicare Health Plans

Introduction to Learning About Medicare Health Plans.

If you are happy with the way you get health care now, you don't have to do anything. If you do nothing, you will continue to receive your Medicare health care in the same way you always have

More Medicare Health Plan Choices

Starting in 1999, Medicare offers more health plan choices. One of the new health plan choices might be right for you. The choice is yours. No matter what you decide, you are still in the Medicare program. All Medicare health plans must provide all Medicare covered services described on pages 6-8.

To be eligible for the other Medicare health plan choices*:

- You must have Part A (Hospital Insurance) and Part B (Medical Insurance).
- You must not have End-Stage Renal Disease. (ESRD is permanent kidney failure that requires dialysis or

*All health plan choices may not be available in your area. For the most current list of your local Medical health plan choices, look at the Internet at www.medicare.gov.

Have you heard that Medicare now offers more health plan choices?

a transplant.) However, ESRD beneficiaries currently in a health plan will be able to remain in the plan they are in.

- You must live in the service area of a health plan. The service area is the geographic area where the plan accepts enrollees. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area. If you are disenrolled, you are automatically covered under the Original Medicare Plan. You can also choose to join a Medicare health plan in your new area.

Your out-of-pocket costs may depend on:

- Which Medicare health plan you choose.
- How often you need health care.
- What type of health care you need.
- Which extra benefits are covered by the plan.
- What your supplemental health insurance covers.
- Whether your doctor accepts assignment (Original Medicare Plan only).

Understand Your Medicare Health Plan Choices

Medicare has new health plan choices.

If you want to learn about the new health plan choices, please keep reading. Think about your current health care needs or the needs you may have in the future. Consider how each health plan would meet your needs. No matter what you decide, you are still in the Medicare program. You will continue to receive at least all the Medicare covered services (see pages 6-8).

If you are happy with the way you get health care now, you don't have to do anything! If you do nothing, the way you receive your health care now will not change.

If you want to look at the choices, the steps below will help you compare your Medicare health plan choices.

Steps to Choosing a Health Plan:

Different health plan choices may affect you:

Cost:

What you pay.

Extra Benefits:

What extra benefits you get, like prescription drugs.

Providers:

How much choice you have among doctors, and hospitals, and other health care providers.

Steps 1 - 6 are on the following pages.

Step 1: Review your Medicare health plan choices.

Step 2: Evaluate what's important in a Medicare health plan.

Step 3: Review the Medicare health plan choices available where you live.

Medicare health plan information is available on the Internet at www.medicare.gov. If you don't have a computer, your local library or senior center may be able to help you get information on the plans available in your area.

Step 4: Get information about available Medicare health plan choices.

Step 5: Make the Medicare health plan choice that is right for you.

Step 6: Enrolling/Disenrolling in a Medicare health plan.

Learning About Medicare Health Plans - Step 1

Step 1: Review Your Medicare Health Plan Choices

All of the Medicare health plan choices are listed below. However, they may not all be available in your area.

- The Original Medicare Plan
- the Original Medicare Plan with a Supplemental Insurance Policy
- Medicare Managed Care Plans

Health Maintenance Organizations (HMO's)
HMO's with Point of Service Options (POS)
Provider sponsored Organizations (PSO's)
Preferred Provider Organizations (PPO's)

- Private Fee-for-Service Plans
- Medicare Medical Savings Account Plans (MSA's)
- Religious Fraternal Benefit Society Plans (RFB's)

These health plan choices are explained in pages 14 - 16.

Caution

If you answer yes to any of these questions, your health plan choices may be different or better.

If you answer yes to this question	Please follow these instructions...
Are you (or your spouse) retired? Do you have health insurance through the former employer or union?	Contact your former employer or union before you make a health plan choice.
Are you (or your spouse) still working? Do you have health insurance through the employer or union?	Contact your or your spouse's employer or union before you make a health plan choice.
Do you have Medicaid or is your income low enough that you may qualify for Medicaid?	Contact your State Medical Assistance Office (Ph. # page 19 m) See Page 33.
Are you a military retiree?	Contact your local military base.
Are you a veteran entitled to Veterans Administration (VA) benefits?	Contact your local Veterans Administration office.
Do you have End-Stage Renal Disease (ESRD)?	You are only eligible for the Original Medicare Plan. You may be eligible for the Original Medicare Plan with Supplemental Insurance (see page 29).
Do you have only Medicare Part A or only Part B?	You are only eligible for the Original Medicare Plan. You may be eligible for the Original Medicare Plan with Supplemental Insurance (see page 29).

Learning About Medicare Health Plans - Step 2

Step2: Evaluate What's Important in a Medicare Health Plan

Remember: The Original Medicare plan doesn't pay for or cover everything. To get more coverage, you may purchase a Supplemental Insurance Policy, or you may consider joining a Medicare Managed Care

Plan or Private Fee-for-Service Plan. Another choice is the Medicare Medical Savings Account (MSA)

Plan (see Enrolling (Disenrolling) in a Medicare Health plan on page 17.) You should look at how all the health plan choices differ on cost, choice of doctors and hospitals, and benefits.

Cost

What you pay:

- All beneficiaries pay the Part B premium of \$43.80 (in 1998).
- Monthly premiums tend to be lower in Medicare Managed Care Plans (if you follow the plan rules) than in most Supplemental Insurance Policies and some Private Fee-for-Service Plans.
- Your out-of-pocket costs (what you must pay) tend to be lower in most Managed Care Plans and the Original Medicare Plan with some Supplemental Insurance Policies. Costs often are higher in the

Original Medicare Plan without a Supplemental Insurance Policy.

- In Medicare MSA Plans, there is no monthly premium. You pay for all the costs of services prior to meeting the high deductible for your plan. Your Medicare MSA can help pay the costs of services prior to your meeting the high deductible (page 16).
- In Private Fee-For-Service Plans and Medicare MSA Plans, you may be asked to pay extra charges by doctors, hospitals, and other providers who don't accept the plan's fee as payment in full.

Providers

How you choose doctors and hospitals:

- The Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and certain Medicare MSA Plans have the widest choice of doctors and hospitals.
- In most Medicare Managed Care Plans, and in some Medicare MSA Plans, you must choose your doctors and hospitals from a list provided by the plan. You may want to check if your current doctor is on the plan's list, and is accepting new Medicare patients under that plan. There is no guarantee that a particular doctor will stay with the plan.
- You can go to any specialist who accepts Medicare in the Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and some Medicare MSA Plans. Most Medicare Managed Care Plans and some Medicare MSA Plans require a referral from your primary care doctor for you to see a specialist.
- In Private Fee-For-Service Plans and Medicare MSA plans, you may be asked to pay extra charges by doctors, hospitals, and other providers who don't accept the plan's fee as payment in full.

Extra Benefits - What Services You Get

- In Medicare Managed Care Plans or Private Fee-For-Service Plans, you may get extra benefits, like vision or dental care Ñ beyond the benefits covered by the Original Medicare Plan or the Original Medicare Plan with a Supplemental Insurance Policy. In lieu of extra benefits, enrollees in Medicare MSA Plans receive a deposit in their Medicare MSA from Medicare. Look on the Internet at www.medicare.gov for more information.

Prescription Drugs - An Important Extra Benefit

- In general, the Original Medicare Plan does not cover outpatient prescription drugs. Many Medicare Managed Care Plans and a few of the more expensive Supplemental Insurance Policies cover certain prescription drugs up to a specified dollar limit. In general, the Original Medicare Plan only covers medication while you are in a hospital or skilled nursing facility.
-

Physical Activity and Health Promotion for Older Adults in Public Housing

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Introduction: Designing health promotion and disease prevention (HPDP) programs for older residents of public housing is hampered by a lack of information about residents' needs and interests. This study addressed whether residents have greater needs for lifestyle modification or for preventive care and assessed interest in programs emphasizing physical activity. **Methods:** Older residents ($n = 199$) of public housing facilities in Seattle were surveyed to assess HPDP needs. A comparison of residents with older HMO enrollees ($n = 2,289$) identified which needs were relatively greater in residents of public housing. Residents' interest in physical activity programs was assessed by interviewing residents and by observing their interest in an exercise class.

Results: The majority of residents could benefit from physical activity programs (75% of residents reported less than 60 minutes per week of exercise); fewer residents could benefit from smoking cessation programs (21%) and alcohol counseling

(4%). The largest difference between residents and HMO enrollees was the greater need of residents for physical activity promotion. Residents and HMO enrollees reported similar use of preventive care services. Though residents seldom identified physical inactivity as a major concern, residents demonstrated interest in physical activity programs. Eighteen (41%) of 44 residents participated regularly or irregularly in an exercise class offered at their facility. When the class was scheduled to be discontinued, residents successfully lobbied city government to sustain the class.

Conclusions: The results suggest promoting physical activity should be a major goal of HPDP programs for older residents of public housing.

Medical Subject Headings (MeSH): aged, health promotion, public housing, poverty, exercise. [Am J Prev Med 1997; 13(Suppl 2):57-62]

Healthy People 2000 sets special objectives for older, low-income, and minority adults.¹ Because older residents of subsidized public housing have low incomes and are ethnically diverse, health promotion and disease prevention (HPDP) programs for these adults are important to addressing our national objectives. But lack of information about HPDP needs and interests of residents hampers the design of appropriate programs. Older residents of public housing are infrequently studied. The

few available studies focus on medical and psychiatric conditions.²⁻⁴

More information about HPDP needs of older residents of public housing would be useful. It is unclear, for example, whether HPDP programs for older residents should emphasize mainly preventive care or mainly lifestyle modification. Possibly programs that address barriers to preventive care services underused by older adults, such as flu shots⁵ and mammography,⁶ could have more impact. Though covered by Medicare, residents could still face barriers to access of preventive care services, such as lack of transportation. Or, possibly programs that address the lifestyle risk factors of smoking, physical inactivity, inadequate diet, and alcohol use could have more impact. These risk factors are prevalent in low-income adults¹ and are the major preventable causes of premature death.⁷

More information about residents' interests in participating in HPDP programs would also be useful. Resident characteristics—old age, low income, and mixed ethnicity—are known risk factors for nonparticipation in HPDP activities.⁸⁻¹⁰ Information is needed on which HPDP programs residents will participate in, and on how to increase participation. However, methods of

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assessing interest may need to go beyond resident interviews. Research has suggested low-income older adults may not express interest in HPDP because they are preoccupied with immediate problems in life, such as personal safety and lack of transportation.¹¹ Once such problems are addressed, residents may express more interest. Assuming any successful program must address life concerns that act as barriers to HPDP, then assessing interest simultaneously with interventions to reduce barriers may be the best strategy. For example, if an outreach worker helps residents address their concerns (e.g., personal safety and transportation), then will residents participate in HPDP activities, and if so, which activities?

This article describes the initial study done by four Seattle organizations to develop appropriate HPDP programs for older residents living in public housing. The study had two aims. The first aim was to identify the HPDP needs of older public housing residents, and in particular to determine if the greater need was for lifestyle modification or for preventive care. The study met this aim by conducting a needs assessment survey and by comparing residents' needs to needs of community older adults in the Seattle area.

As it turned out, the needs assessment showed a major need for programs that promote physical activity. The second aim was to determine and understand residents' interest in HPDP programs emphasizing physical activity. The study addressed this aim using the strategy discussed above: (1) the study interviewed residents about major life concerns and interest in health and HPDP activities, and (2) the study simultaneously intervened to reduce barriers and observed residents' interest in on-site exercise classes.

METHODS

In the late 1980s, four Seattle organizations began to collaborate on a project to address the HPDP needs of older residents living in subsidized public housing managed by the Seattle Housing Authority (SHA). The four organizations were SHA (a public, municipal corporation that manages 54 public housing facilities with about 4,150 residents), the Northwest Prevention Effectiveness Center of the University of Washington, the Seattle-King County Department of Public Health, and the Seattle Department of Parks and Recreation. The project could not have occurred without the collaboration among these agencies, as no single agency had the necessary resources and experience. For example, SHA provided insight into logistics of conducting a survey, the Prevention Center provided research expertise, the Department of Public Health provided experience in community needs assessments, and Parks and Recreation provided resources for an exercise class. The project was approved by the University of Washington human subjects review committee.

Aim 1: Describing HPDP Needs of SHA Residents

Study design. The HPDP needs of SHA residents were described by conducting a cross-sectional survey of SHA residents and by comparing residents' responses to responses of older enrollees in Group Health Cooperative of Puget Sound (GHC), a large, consumer-governed HMO.

Survey design. Standard questions were used to measure demographic characteristics, health status, and HPDP needs. Health

status measures included restricted activity days,¹² the CES-Depression scale,¹³ the SF-36,¹⁴ the Perceived Quality of Life (a measure of life satisfaction),¹⁵ social support questions,¹⁶ hearing and vision questions,¹⁷ and life stress.¹⁸ Questions on physical activity came from the National Health Interview Survey,¹⁷ and the Paffenbarger physical activity questionnaire.¹⁹ Questions on smoking and drinking are described elsewhere.²⁰ Diet and nutritional needs were not assessed. Most questions on use of preventive care services were developed for this study. The survey was interviewer-administered at the SHA facility; interviews lasted about one hour. Residents received \$15 for completing an interview.

SHA sample. SHA records showed that (in 1990) about 50% of SHA residents were aged 65 or older. Because older residents were unevenly distributed among SHA facilities, the study recruited adults ≥ 65 at the 21 facilities where most older residents lived. The initial goal of the study was to survey a random sample of residents at these 21 facilities. But SHA managers warned that response rates with a random sample would be low, unless interviewers could spend days or weeks building rapport with residents, prior to attempting the interview.

To gain experience with the resources needed to conduct a survey, at two of the 21 facilities the study sought to interview all the residents ≥ 65 . Ultimately, interviewers expended considerable time and effort to obtain responses from 74 of 107 residents at these two facilities, a response rate of just 70%. This experience showed the study lacked the resources to interview, with acceptable response rates, a random sample of older SHA residents in the other 19 facilities.

Hence, the study recruited a nonrandom, quota sample. The quota was to interview 10% of the older adults at each of the remaining 19 SHA facilities. SHA managers helped to identify adults likely to consent to interviews, given the study could not build much rapport with residents prior to interviews. SHA managers also attempted to identify as representative a sample as possible. In total, 199 residents living in the 19 facilities were interviewed.

To assess the amount of selection bias in the sampling, two analyses were done. First, a comparison of health status and HPDP needs between the 19 facility quota sample and the 2-facility sample showed no significant differences. Second, a comparison of the age/gender mix of the 19-facility sample showed the mix did not differ significantly from the known age/gender mix of older residents in the 21 facilities obtained from SHA administrative records.

HMO sample. A survey at GHC of Puget Sound provided a comparison group of older adults living in the Seattle area.²¹ The GHC elderly population has been studied and found representative of national samples in terms of health status, though the GHC sample has demographics typical of the Pacific Northwest (except GHC enrollees are relatively well educated). GHC has historically emphasized HPDP activities in all age groups.

Statistical analysis. The differences in demographic, health status, and HPDP needs between SHA and GHC samples were adjusted for age and gender using the Mantel-Haenszel procedure (categorical variables) or analysis of covariance (ANCOVA, continuous variables). The actual age- and gender-adjusted rates and means were quite similar to unadjusted rates and means and are not shown.

Table 1. Demographic characteristics

Characteristic	SHA sample (%) (n = 199)	GHC sample (%) (n = 2289)	P
Age (years)			
65-75	43	65	<.001
>75	57	35	
Gender			
Female	74	61	<.001
Male	26	39	
Education			
High school only	64	45	<.001
Some college	26	29	
College graduate	10	26	
Income			
Under \$1000/year	84	14	<.001
\$10,000-\$15,000/year	13	17	
Over \$15,000/year	3	69	
Married			
Married	8	56	<.001
Widow, single, divorced	92	44	
Ethnicity			
Caucasian	75	88	<.001
Non-Caucasian	25	12	
Living status			
Live alone	91	34	<.001
Live with others	9	66	

P values for education, income, married, ethnicity, and living status adjusted for age and gender differences between groups.

Aim 2: Describing Interest of SHA Residents in HPDP Programs

Study design and methods. Two methods were used to determine interest in HPDP programs along the lines described in the introduction. First, older residents at two SHA facilities answered open-ended questions about major concerns in life, health concerns, and interest in HPDP activities.

Second, interest in physical activity programs was determined by simultaneously intervening to reduce barriers to participation and observing interest and participation in an exercise class at one SHA facility. The purpose of this article is not to describe the barrier reduction intervention in detail. In brief, the intervention depended upon an outreach worker and followed the approach used with low-income older adults in San Francisco.¹¹

RESULTS

SHA Resident Characteristics

The demographic and health status characteristics of SHA residents are shown in Tables 1 and 2. Fifty-seven percent of older SHA residents were more than 75 years in age, and 74% were women. Older adults who qualify for subsidized public housing have low incomes, and 84% of SHA residents reported an annual income below \$10,000. Because most SHA apartments are designed for one person, only 8% of SHA residents were currently married, and 91% lived alone. Health status measures indicated many SHA residents have substantial health problems.

Table 2. Health status indicators

Measure	SHA sample (mean or %) (n = 199)	GHC sample (mean or %) (n = 2,289)	P
Restricted activity days			
None	55	73	<.001
1-7	6	9	
8-30	8	9	
31-179	6	5	
180-365	25	4	
SF-36 Scales			
Role-physical	53	68	<.001
General health	55	65	
CES-D score	8.8	4.7	<.001
Life satisfaction			
Physical health	5.5	6.4	<.001
Income	5.4	7.3	
Purpose in life	7.3	7.4	
Vision			
No trouble	45	89	<.001
Some trouble	54	11	
Hearing			
No trouble	48	86	<.001
Some trouble	52	14	
Stress			
0-2 (none)	21	37	<.001
3-4	17	24	
5-6	25	16	
7-8	19	12	
9-10 (great deal)	18	11	
Social support			
Has close circle of friends	76	73	NS
Attends meetings/clubs	64	74	<.001

SF-36 scales scored 0-100 with higher scores indicating better health; CES-Depressive scale scored 0-60 with higher scores indicating more depressive symptoms; life satisfaction scales score 0-10 with higher scores indicating more satisfaction; stress scale score 0-10 with higher scores indicating more stress; P values adjusted for age and gender differences between groups.

Twenty-five percent of SHA residents reported more than 180 restricted activity days per year. Average SF-36 scores for general health and role-physical were relatively low for a community sample.

The demographic and health status characteristics of SHA residents differed significantly (after adjustment for age and gender) from older enrollees in GHC on all measures except one measure of social support (Tables 1 and 2). SHA residents constitute an economically and educationally disadvantaged population, with substantially more health problems on average than other older adults living in the community.

HPDP Needs of SHA Residents

The results of the HPDP needs assessment are shown in Table 3. SHA residents had greater need for lifestyle modification programs than for preventive care programs. The most prevalent lifestyle risk factor was physical inactivity, as 75% of SHA residents did not exercise at least 60 minutes per week. Smoking was less

Table 3. Assessment of health-related behaviors and use of preventive care services

	SHA sample (%) (n = 199)	GHC sample (%) (n = 2,289)	P
Health-related behaviors			
Physical activity			
<60 minutes/week of exercise	75	51	<.001
Smoking			
Current smoker	21	8	<.001
Alcohol use			
Daily	4	15	<.001
1-6 days per week	9	19	
<1 drink/week	87	66	
Preventive care services use in past 12 months			
Had general physical examination	72	52	<.001
Had influenza immunization	59	59	NS
Had vision tested	63	58	<.05
Had hearing tested	27	20	<.05
Had stool test for occult blood	48	51	NS
Had breast examination (women only)	66	65	NS
Had mammography (women only)	43	46	NS

P values adjusted for age and gender differences between groups.

prevalent than physical inactivity, as 21% of SHA residents were current smokers. Only 4% of residents reported drinking alcohol daily. For activity and smoking, HMO enrollees reported healthier lifestyles than SHA residents: only 51% of HMO elderly did not exercise 60 minutes per week, and only 8% were smoked. But more HMO enrollees (15%) reported daily use of alcohol.

Given all these differences between SHA residents and GHC enrollees, it was unexpected that SHA residents and HMO elderly reported roughly comparable use of most preventive health services (Table 3). Preventive health services studied included general physical examination, vision testing, hearing testing, flu shots, hearing exam, stool occult blood test, breast exam, and mammography. When there were significant differences in use of preventive care (general physical examination, vision test, hearing test), SHA residents reported greater use.

SHA Residents' Interest in Physical Activity

The survey demonstrated that the majority of SHA residents could benefit from HPDP programs emphasizing physical activity. Therefore, efforts to determine resident's interest in HPDP programs focused on determining interest in physical activity programs.

Open-ended interviews. In responses to open-ended questions about major life concerns, SHA residents expressed few concerns about health-related issues and did not specifically mention physical inactivity as a concern. Instead, the concerns of the 74 residents interviewed focused on neighborhood safety (40% of residents), building safety (25% of residents), and lack of transportation/lack of social activity/confinement to the building (5% of residents). In some ways, residents did express concern their lives were not "active" enough. But "active" was used in a broad sense to refer to playing cards, going on senior tours, shopping, etc, and residents did not focus on physical activity per se.

Interest in physical activity after barrier reduction. To reduce barriers to interest in HPDP programs, an outreach worker spent

eight hours per week in one SHA facility for 16 months. The worker helped residents address concerns along the lines of the approach used by Minkler.¹¹ A detailed discussion of the success of the barrier reduction is beyond the scope of this article. In brief, it appeared the intervention did activate residents to address their concerns, which did reduce some barriers. After barrier reduction had begun, the Seattle Parks and Recreation Department offered an on-site exercise class for one year at the intervention facility. Interest in physical activity was judged by use of the class and by the reaction of SHA residents when the class was scheduled to be discontinued.

The exercise class was used regularly by SHA residents. Of the 44 older adults at the intervention facility, 18 (41%) participated at some point in time in the exercise program organized by Parks and Recreation. A small group of 8-12 residents became regular users. The fact more residents did not use the class may be due to the fact the class was designed for adults with low levels of physical ability (adults who used wheel chairs could participate in the class). The activities of the class would not have been attractive to healthier SHA residents. Also, some residents were already active and thereby demonstrated interest in physical activity, but simply chose to do activities besides the class.

The fact the class was scheduled to be discontinued after 12 months provided an opportunity to observe the level of resident interest in exercise. *Residents organized, wrote letters, and protested the discontinuation of the program to city officials.* This involved a protest by a group of SHA residents at public meeting of city officials and publishing articles in a newsletter. City officials decided to continue the program for another year.

DISCUSSION

The results suggested promoting physical activity should be a major goal of HPDP programs for older residents of public hous-

ing. The majority of SHA residents could benefit from physical activity programs, as 75% of residents did not meet a commonly recommended level of physical activity ("20 minutes of exercise, three times per week") in 1991. Consistent with national survey data showing that low-income is a strong risk factor for inactivity,²² low-income residents of public housing were disproportionately inactive compared to other elderly in the community. Programs addressing smoking, alcohol use, and preventive care are also appropriate, but address the needs of fewer residents. In particular, smoking cessation programs are important for older adults,^{23,24} though smoking cessation programs would target only about 20% of SHA residents.

The results also suggest that older residents in public housing will participate in HPDP programs emphasizing physical activity, at least if efforts are made to address major concerns in life. When an exercise class was offered at an SHA site, a subgroup of older adults became regular users. Residents dramatically demonstrated their interest in physical activity programs by organizing themselves and lobbying city officials. As a result, classes were not discontinued.

As anticipated, prior to the HPDP program and to barrier reduction, residents expressed few concerns about health-related problems and did not specifically mention physical inactivity as a concern. As mentioned in the introduction, one interpretation is that immediate concerns of daily life act as barriers to interest in HPDP programs. Once barriers are reduced, residents may show more interest in HPDP programs. However, the study did not rule out the possibility that residents might have demonstrated the same amount of interest without a barrier reduction intervention.

An important study limitation is the possibility of bias due to recruiting a nonrandom sample of residents. Probably healthier, more socially active residents participated in the survey. Yet it is possible less healthy residents were more likely to participate, if healthier residents were commonly out of the building and less available for interviews. In either case, the comparability of responses between the 19-facility quota sample with the two-facility sample argues against substantial amounts of bias.

There are other limitations to the study. Participation rates in the exercise class may underestimate resident interest in physical activity programs, because the exercise class was not designed to appeal to the healthier SHA residents. Also, participation rates did not take into account residents who were already active, and therefore interested in physical activity, but simply chose to do activities besides the class. Finally, the study did not assess the HPDP needs of SHA residents related to diet.

In summary, the results support the conclusion that promoting physical activity should be a major goal of health promotion programs for older adults in public housing. Further research is needed to determine if study results are generalizable and to test and to compare specific approaches to promoting physical activity.

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Chapter 7

Health Promotion in Old Age

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ABSTRACT

The empirical literature on health promotion in old age was reviewed. A developmental perspective was used to examine 42 studies: studies relating health behaviors to health outcomes, descriptive studies of health promotion in old age, studies of the outcomes of health promotion programs in old age, and studies of factors related to older adults' participation in health promotion activities. In general, elderly adults perceived health promotion activities as beneficial, engaged in health behaviors more frequently than younger adults, and participated in community-based and other health promotion programs. There is little definitive evidence that health promotion activities result in better health outcomes for older adults, however. Identifying appropriate outcomes related to health promotion in old age is a critical need.

Keywords: Health Promotion, Health Behaviors, Health Practices, Health Lifestyle, Old Age, Aging

This chapter includes a review of the empirical literature on health promotion in old age. The focus on old age is important for a number of reasons. First, the aging of the population means that large numbers of people will soon be entering old age, which is the time of life when the majority of health care use, expenditure, and cost occurs. For this reason, efforts at health promotion

are seen as potentially of great benefit in reducing the costs of health care. There are two conflicting views in the literature about health promotion in old age, however. One view holds that health promotion efforts in old age are beneficial to both the individual and society because they potentially extend the healthy years of life while compressing the years of disability through disease prevention. They may also increase the quality of life by limiting the impact of disease and illness, allowing older adults to remain independent and able to engage in meaningful pursuits. A number of assumptions underlie the positive view of the efficacy of health promotion and disease prevention in old age. One is that aged persons are able to change their behaviors regarding health. A second is that these behavior changes will result in more positive outcomes, that is, they will have an effect.

An opposing view of health promotion in old age is that such efforts are of limited benefit because the positive effects of health promotion efforts are a result of lifelong health practices, thus to begin health promotion in old age is too late to reap any positive effects. This position is sometimes couched in cost-benefit terms. A related view is that aged persons are resistant to health promotion efforts based on an assumption that learning new behaviors is difficult in old age and that lifelong health practices are resistant to change. Some of the research efforts to date have examined which of these perspectives is closest to the truth.

This review was conducted from a developmental perspective. That is, we considered whether age is an important variable in the study of health promotion. In what ways does age influence health promotion or the precursors, mediators, or outcomes of health promotion efforts? Answers to these questions are important in tailoring nursing interventions that take into account individual and developmental differences in behavior.

For the purposes of this review, health promotion is defined broadly as strategies related to individual lifestyle behaviors that influence health (e.g., physical activity, nutrition), health protection strategies (e.g., fall prevention, oral health), and disease prevention strategies (e.g., health counseling, screening, immunizations). An objective of *Healthy People 2000* (U.S. Department of Health and Human Services [USDHHS], 1991) related to people over 65, focuses on improving functional independence, not just length of life, and increasing the years of healthy life.

This review is organized in four sections. The first section reviews articles relating age and health behaviors to particular outcomes, generally mortality. The second section consists of descriptive studies of health behaviors or health promotion activities in old age. The third section addresses outcomes related to health promotion programs for older adults. The last section is concerned with factors related to older adults' participation in health promotion activities.

CRITERIA

This review was reviewed journal elderly persons with at least one defined as 65 years in gerontologic old" are those. However, some what lower (e.g., samples who usage rates than

This review or health behavior with a range of studies (not reviewing preventing behavior studied jointly management, and early diagnosis depression, and beyond the scope current and important in old age focus studies reviewed there is little reviewed elderly.

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CRITERIA FOR REVIEW

This review was limited to research articles published since 1980 in peer-reviewed journals. Articles included examined either health promotion in elderly persons only or age differences in some aspect of health promotion, with at least one age group of the study being elderly persons. Old age was defined as 65 years or older. This cut-off was based on the current convention in gerontological research that "young-old" are those aged 65 to 74, "middle-old" are those aged 75 to 84, and "old-old" are those aged 85 and over. However, some studies were included in which the age range extended somewhat lower (e.g., 55 years). The intent was to exclude primarily middle-aged samples who generally have different health profiles and lower health care usage rates than the elderly.

This review was also limited to research that examined health promotion or health behaviors in a comprehensive manner. The studies were concerned with a range of health behaviors or practices. This is in contrast to numerous studies (not reviewed) that examine one specific health-promoting or disease-preventing behavior or intervention. Typically, the range of health behaviors studied jointly or separately included: exercise, nutrition, immunization, stress management, oral health, smoking cessation, fall prevention, and screening and early diagnosis of cancer, cardiovascular disease, arthritis, osteoporosis, depression, and diabetes. Examining each of these topics independently is beyond the scope of this chapter. It should be noted, however, that much current and important research on health promotion interventions and outcomes in old age focuses on single behaviors. Also, although not planned, all of the studies reviewed were of community-dwelling persons. Despite great need, there is little research involving nursing home residents or the institutionalized elderly.

The literature search used three computer databases: the Cumulative Index of Nursing and Allied Health Literature (CINAHL) from 1982 to 1996, MEDLINE from 1980 to 1996, and PsycLIT from 1980 to 1996. The search concentrated most heavily on studies of the last 10 years, however. These searches were augmented with archival methods. The following terms were searched: "health promotion and aging," "health behaviors and aging," "successful aging," "disease prevention and aging," "health beliefs and aging," "wellness and aging," "self-care and aging," and "quality of life and aging." For each of these, health promotion activities or behaviors had to have been included as a variable. For example, a study examining successful aging would only be reviewed if health promotion activities were linked to successful aging in some way. In addition, searches were conducted by names of authors who are

known researchers in the area of health promotion. The search was restricted to English-language articles.

HEALTH BEHAVIORS AND HEALTH OUTCOMES: LONGITUDINAL STUDIES

In the 1970s, an association was found between mortality and seven common health practices: physical activity, cigarette smoking, alcohol consumption, obesity, sleeping habits, daily consumption of breakfast, and snacking between meals (Belloc, 1973; National Center for Health Statistics [NCHS], 1979a, 1979b). This sparked numerous investigations into disease prevention and health promotion efforts. These efforts dovetailed with nursing's commitment to wellness and the enhancement of health, and spurred research in nursing and other disciplines regarding health promotion. It was not clear from the early studies linking health habits to mortality whether this association continued into old age, however. This question is important because it speaks to the efficacy of health promotion activities in old age and to the cost-benefit ratio of spending health care dollars on health promotion in old age.

Four studies were reviewed that examined the relationship between health practices and health outcomes in old age. Two studies examined this relationship for old adults only (Branch & Jette, 1984; Strawbridge, Camacho, Cohen, & Kaplan, 1993), and two compared age groups (Breslow & Enstrom, 1980; Kaplan, Seeman, Cohen, Knudsen, & Guralnik, 1987).

Branch and Jette (1984), using data from the Massachusetts Health Panel Study, examined the relationship between five health practices and mortality in individuals aged 65 and over who were interviewed in 1974, 1976, and 1980. After controlling for age, socioeconomic status, and baseline health status, no significant predictors of mortality in men were found; and only one practice, never smoking, predicted mortality in women. Strawbridge et al. (1993) examined predictors of change in functional health (e.g., ability to perform instrumental and other activities of daily living) over 6 years in 356 adults, aged 65 and over, from the Alameda County study. The Alameda County studies included data on seven health practices as well as demographic, personality, and social support measures. In this study, the number of positive health practices performed was related to increased functional health over 6 years, but the specific predictors differed for men versus women. For men, these were income, education, marital status, never smoking, physical activity, and regular social contact. For women, predictors were never smoking, going out, regular social contact, and internal health locus of control.

Two studies in which age groups were compared suggested that the relationship between health practices and mortality persists in old age (Bres-

low & Enstrom, 1980). In the first, the number of health practices was related to mortality in 6,928 adults in the Alameda County Study. This relationship was stronger for men than for women. In the second, Enstrom et al. examined the relationship between health practices and mortality in the Alameda County Study, controlling for gender, race, and education. The relationship was related to mortality in men but not in women.

The major findings of these studies were that health practices and health outcomes were related in old age and that they were long-term behaviors. Health behaviors have a cumulative effect on health behavior (e.g., health promotion was more effective in older adults). There is a need for more research on the promotion of health behaviors in old age. The results of these studies suggest that health promotion might benefit older adults. These results were consistent with the survival effect of health promotion in already old adults (Kaplan, 1993) examined the prevalence of health behaviors, which may be even more important for health promotion in old age.

Descriptive Patterns, and

A number of health behaviors were grouped into two categories: health behaviors and their outcomes and those examined in the Alameda County studies.

Age Differences in Health Behavior Patterns, and

Before health promotion, older adults had a higher prevalence of health behaviors than older adults.

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low & Enstrom, 1980; Kaplan et al., 1997). Breslow and Enstrom found that the number of health practices had an inverse relationship with mortality in 6,928 adults in the Alameda Study who were followed from 1965 to 1974. This relationship persisted at older ages, but was weaker. How these analyses were performed was not explicitly described in the article, however. Kaplan et al. examined 17-year mortality in three age cohorts from the Alameda County Study (38-49, 50-59, and 60-74 at baseline). After adjusting for gender, race, and baseline health status, smoking and physical activity were related to mortality in all three age groups.

The majority of these studies support the relationship between health practices and mortality in old age. The strengths of these studies are that they were longitudinal and based on probability samples. Only a few health behaviors have typically been included in these studies, however, and many health behaviors and practices associated with disease prevention and health promotion were not examined (e.g., screening, immunizations, stress reduction). There is also little evidence to suggest which health practice or combination of health practices might be affecting mortality or which individuals might benefit most from positive health practices. It is also unclear whether these results were due to a lifetime of healthy living leading to a selective survival effect in old age or whether changing health practices when one is already old can still affect mortality. Only one study (Strawbridge et al., 1993) examined an outcome other than mortality: functional health. Given the prevalence of chronic illness in old age, outcomes such as functional health, which are typically viewed as important to quality of life in old age, may be even more important than mortality when assessing the impact of health promotion at older ages.

Descriptive Studies of Health Behaviors and Their Correlates, Patterns, and Predictors

A number of studies have examined correlates, patterns, and predictors of health behaviors and health promotion activities. These studies have been grouped into two categories: those examining whether health promotion behaviors and their correlates, patterns, or predictors differ for different age groups and those examining correlates, patterns, and predictors of health promotion activities in samples of older adults only.

Age Differences in Health Behaviors and Their Correlates, Patterns, and Predictors

Before health promotion was studied empirically, conventional wisdom was that older adults would be less likely to engage in health behaviors because

by old age it was too late for changes in lifestyle behaviors to make any significant differences in health outcomes. National surveys in the 1970s (Belloc, 1973; Breslow & Enstrom, 1980; NCHS, 1979a, 1979b) demonstrated, however, that health practices were more, rather than less, prevalent at older ages. This led to studies conducted to specifically examine the relationship between age and health behaviors.

Prohaska, Leventhal, Leventhal, and Keller (1985) and Leventhal and Prohaska (1986) examined age differences in the frequency and perceived efficacy of 21 health practices in 396 adults aged 20 to 89. The 21 health practices included 15 health actions and 6 cognitive/affective health strategies, thus increasing the domain of health behaviors from the typical 7 that had been studied in the past. They found that the frequency of 10 of 15 health actions and 4 of 6 cognitive/affective strategies significantly increased from young adulthood to old age. There were no age differences in the perceived efficacy of these behaviors. That is, young adults perceived these activities to be just as important to health as did older adults, but the young adults practiced them less frequently.

Similarly, Bausell (1986) used telephone interviews of 1,254 randomly selected adults, including 177 aged 65 and over, to examine the frequency and efficacy of 20 health behaviors. These included four safety, seven dietary, two health monitoring, and seven general lifestyle behaviors. Compared to young adults, the elderly were more compliant with recommendations for 9 of the 20, particularly for diet, blood pressure monitoring, and home safety. They were less likely to engage in vigorous exercise or visit the dentist. The older adults also perceived health behaviors as more efficacious than younger adults.

Finally, Walker, Volkan, Sechrist, and Pender (1988) examined age differences in a health-promoting lifestyle and its correlates. A convenience sample of 452 adults, aged 18 to 88, responded to questionnaires that included the Health Promoting Lifestyle Profile (HPLP) (Walker, Sechrist, & Pender, 1987). The HPLP is a 48-item scale assessing the frequency of health-promoting behaviors in six areas: self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management. Older adults had significantly higher scores (meaning more frequent health-promoting behaviors) for the total HPLP and for the health responsibility, nutrition, and stress-management subscales. HPLP total and subscale scores were also regressed on age, marital status, income, employment status, and gender. Age explained the most variance in health responsibility, nutrition, and stress management and was also a significant predictor of self-actualization.

These studies are consistent with previous surveys indicating that older adults are as likely or more likely to engage in positive health practices as

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young or middle-aged adults. They also extended the range of health practices and included health-promoting activities related to social, cognitive, and affective strategies that have been implicated in more positive health outcomes. Because they are all cross-sectional, these studies did not answer the question of whether adults are more likely to change to health-promoting lifestyles as they age or whether these findings reflect lifelong differences in health practices that persist into old age. These studies also did not address whether the broader range of health practices examined was related to any health outcomes or mortality. Comparisons across studies are also difficult because of the different kinds of measures used to assess health behaviors, from simple checklists to more comprehensive instruments like the HPLP. In addition, the few studies that examined age difference did not take into account the health status of the respondents and whether changes in health status with age are related to changes in the frequency of or perceptions about health behaviors.

Correlates, patterns, and predictors of health behaviors in old age.

Seventeen descriptive studies were reviewed that examined health behaviors in samples restricted to older adults. Some examined health behaviors in specific samples of older adults (e.g., older women, rural elders), whereas others examined specific variables theoretically related to health promotion practices (e.g., health locus of control). Thus, in contrast to most of the studies previously reviewed, a number of these studies had a theoretical basis. By type of sample or conceptual model there was an insufficient number of studies to come to conclusions about proposed relationships. For this reason, these studies are reviewed together to give an indication of the range of demographic and other variables examined in relation to health behaviors. A number of these studies were also concerned with whether different health behaviors are correlated. That is, are individuals likely to engage in a set of health behaviors or are these behaviors essentially independent?

Jensen, Counte, and Glandon (1992), using data from the first phase of a 3-year longitudinal study, interviewed enrollees in a health maintenance organization (HMO) ($n = 258$) and a random sample of community controls ($n = 144$), aged 62 and over. The majority were White females. This investigation was based on a health belief model in which internal control expectancies were proposed to predict health maintenance behaviors and subsequent health status. Health maintenance behaviors included a number of health practices as well as a preventive health visit to a health care provider within the last 6 months. Differences between HMO enrollees and controls were not reported in this study. Health maintenance behaviors were predicted by higher socioeconomic status and an internal health locus of control, however. Few significant

correlations were found among the different health practices, suggesting that health practices are independent.

Martin and Panicucci (1996) also investigated health locus of control in relation to health behaviors in 40 Black female church members. These women had a mean age of 71 and in contrast to many samples found in studies of health, were primarily of low socioeconomic status, with 50% having less than an eighth-grade education. For the 20 health practices examined, adherence to 17 was found; and high importance ratings were given to all 20. High adherence was significantly correlated ($r = .55$) with self-rated health. Lowest adherence was found for preventive dental care, use of smoke detectors, and use of seat belts, suggesting a need for intervention in these areas. Although the small sample size limits the generalizability of the findings, it is important that support for the importance and practice of preventive health behaviors in an older, Black, less educated female population was identified.

At a hypertension clinic, Whetstone and Reid (1991) interviewed 30 rural volunteers aged 55 to 70 regarding barriers to self-care management of hypertension. Respondents completed a health risk appraisal instrument that included lifestyle behaviors related to health. The authors did not present any data regarding responses to this instrument, however. The authors also identified, from open-ended interview responses, that diet and lack of social support were barriers to self-care management. Again, how these barriers were identified was not explicitly stated. The lack of reporting of both data and methods limits the importance or utility of the findings.

Using a very different approach, Quinn, Johnson, and Martin (1996) examined intraindividual differences in older women's health-seeking behaviors. This study used a single-subject design in which the sample was the number of occasions rather than persons. Data from the Georgia Centenarian study (Poon et al., 1992) regarding health-seeking behaviors and diet were examined in a time-series analysis from four women in their 60's and four in their 80's. For the 60-69-year-olds, health-seeking behaviors consisted of both diet and activity items. For 80-89-year-olds, only activity items were related to health-seeking behaviors. For both groups, the health-seeking behaviors were stable over 100 days, suggesting the traitlike nature of these behaviors in old age.

Six studies examined correlates or predictors of a health-promoting lifestyle using the HPLP. Foster (1992) studied 200 Black volunteers (mean age = 73) at a senior center. Significant correlations were found between the HPLP and a measure of life satisfaction, but not with current health, age, or socioeconomic status. The range of these variables may have been restricted, however. There was a significant inverse relationship between HPLP scores and smoking.

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Huck and Arner (1996) recruited 50 Roman Catholic nuns, aged 65 to 89, from a blood pressure screening clinic. The majority had been health care professionals and had 16 years of education. Descriptive data on the HPLP were presented. The highest mean subscale scores were found for nutrition and self-actualization and the lowest for exercise. In open-ended descriptions of health-promoting behaviors, the most frequently named were: exercise, nutrition, contact with health care provider, recreation, and sleep. Although health locus of control was also measured, no analysis in relation to health-promoting behaviors was reported.

In contrast, Speake, Cowart, and Pellet (1989) found significant positive correlations between the HPLP and internal health locus of control in a convenience sample of 297 older adults in Florida (mean age = 72, 29% were Black). Predictors of HPLP were examined in a regression analysis in which age, gender, race, marital status, income, and education were controlled. Both internal health locus of control and perceived health were significant predictors of the HPLP subscales of exercise, nutrition, stress management, interpersonal support, health responsibility, and self-actualization. Conceptually, this study differs from many because perceived health was considered a predictor of a health-promoting lifestyle rather than the outcome. Of course the causal direction cannot be determined from this cross-sectional study.

Speake, Cowart, and Stephens (1991) compared HPLP scores of rural ($N = 106$) and urban ($N = 237$) elderly. Participants were recruited from senior centers and fairs. Their mean age was 71, and the rural elderly had a higher proportion of female, Black, poor, and less educated persons. The researcher also examined whether an internal locus of control and better perceived health were related to HPLP scores. Regression analyses indicated that the different subscales of the HPLP had different predictors. The most consistent predictors were current health and locus of control. There were no differences between rural and urban elderly. The researchers suggested this was because the rural and urban counties were adjacent so that the environments were more similar than different.

Riffle, Yoho, and Sams (1989) examined the relationships among HPLP, self-reported health, and social support in 113 older (mean age of 74) Appalachian elderly attending nutrition sites. Mailed and on-site surveys were used, but no information was given regarding response rates. The elders were mostly White, female, poor, with an 11th-grade education. Significant but small ($r = .22, .30$) correlations were found between HPLP, social support, and self-rated health.

Duffy (1993) hypothesized that HPLP scores would be higher for younger, male, White, married, higher income, higher internal locus of control, lower chance and powerful others locus of control, better perceived health, and

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higher self-esteem. A convenience sample ($N = 471$) of persons associated with retirement communities or centers, with a mean age of 75 years, was interviewed. The hypotheses were tested using canonical correlations. The majority of the hypotheses were supported except that males with higher income and self-esteem but poorer current health were less likely to exercise or use good nutrition. Higher internal locus of control and self-esteem were related to higher HPLP scores.

Frenn (1996) did not use the HPLP, but did examine a health-promoting lifestyle. She used both interviews and participant observation techniques with 31 older adults, aged 62 to 88, to identify patterns of health-promoting behaviors in older adults. Three main patterns were identified from the qualitative data: maintaining relationships, attending to health behaviors, and staying active. In addition, Frenn described patterns that influence health promotion (e.g., learning about health, making choices in the direction of health) and contextual factors influencing health promotion patterns (e.g., life history, financing health care). The purpose of this study was to develop a theory of health promotion for nursing practice and suggest ways in which models of health promotion need to be expanded, rather than to demonstrate empirical evidence for these relationships.

The six studies using the HPLP were carried out with diverse samples, in terms of ethnicity and socioeconomic factors, which adds to the body of knowledge about the HPLP. A number of the studies examined the same correlates and predictors, for example, locus of control, and offer some evidence that an internal locus of control and better perceived health are related to HPLP. On the other hand, some of the samples were small, nonrepresentative of the elder population, and biased in that many were recruited from senior centers, health fairs, or clinics. These persons may be more likely to be interested in lifestyle modification than other elderly. The researchers did not address the possible conceptual overlap between some of the HPLP subscale and some of the hypothesized predictors. For example, there may be some redundancy in the measures of locus of control and the health responsibility subscale, or there may be redundancy between measures of social support and the interpersonal support subscale. These theoretical and measurement issues have not been clearly delineated. Finally, seven studies broadly identified correlates of health behaviors in old age. Rakowski, Julius, Hickey, and Holter (1987) asked whether there were common predictors across numerous different health practices. They grouped health practices into four conceptual areas: health routines, information seeking, medical and self-examinations, and risk avoidance. The correlates examined were demographic characteristics, number of illnesses, health perceptions (locus of control, concerns, and interference), life outlook (morale and future orientation), and social network. They inter-

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viewed 172 community-dwelling adults whose mean age was 75 and who were somewhat more educated, White, and Jewish than the general population of elderly. They found that the most consistent correlates across the four health practice groups were gender (female) and a supportive family environment. Each health practice group also had different predictors, however, and health practice groups did not consistently predict each other, suggesting that health practices are somewhat independent. A strength of this study is its comprehensive approach to identifying correlates. One limitation is that the reliabilities of the health practice scales were quite low.

Hickey, Rakowski, and Julius (1988), using the same data, also examined gender differences in health practices in old age. They found few significant relationships between gender and health practices or the correlates identified in the previous study. The authors speculated that it may be more informative to examine the interaction of age and gender over time because of gender differences in morbidity and changing gender-stereotyped behaviors with age.

Johnson (1991) described the health care practices of a randomly selected sample ($N = 250$) of rural (communities of fewer than 4,000 persons) elders (mean age of 84 years). The majority were women who identified at least one chronic health problem. A 24-item personal lifestyle questionnaire was used that measured the frequency of engaging in health practices. Of the 24 health practices, only 7 were engaged in often in this much older group of rural elderly. Fifty percent reported no yearly physical exam; 64% no dental exams; and 73% no self-breast exam ever. The majority also reported never exercising, rarely getting enough sleep, never using a seat belt, and not communicating problems to another. Nutrition was also poor, but few reported smoking. More frequent health practices were associated with younger age, being female, married, and having more education.

The relationship among social support, health-promotive beliefs, and preventive health behaviors was examined for one wave of a longitudinal study of HMO enrollees (Potts, Hurwicz, Goldstein, & Berkanovic, 1992). The sample consisted of 1,099 mostly female elderly (mean age = 73) with a high-school education. Health-promotive beliefs were the extent to which persons endorsed the importance (on a 5-point scale) of five health behaviors. Regression analyses were used to predict health behaviors after controlling for self-rated health and frailty. Social support predicted six of eight behaviors, but after health beliefs were added, this dropped to three behaviors. Health beliefs and gender (being female) explained the most variance in health behaviors, suggesting that interventions should be aimed at bolstering beliefs in the importance of health behaviors.

Brown and McCreedy (1986) surveyed 386 men and women, aged 55 and over, about the extent of their health practices, correlates of health practices

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(specifically, age, gender, socioeconomic status, and marital status), and their current health status. Respondents were randomly selected from a 7,000-member senior citizen organization. Three age groups were compared: 55 to 64, 65 to 74, and 75 and over. Health status was measured using an index of symptoms, the number of days activities were limited due to illness, physician visits due to illness in the last 2 weeks, and self-rated health. Health protective behaviors were measured by a checklist of 30 behaviors that comprised five subscales: health practices, safety practices, preventive health care, environmental hazard avoidance, and harmful substances. Respondents practiced an average of 17 health behaviors; the most frequent were nutrition, sleep, and smoking behaviors. The least frequent were flossing teeth and using seatbelts. Age was not related to the number of health behaviors, but gender (female) and education (higher) were. Using stepwise multiple-regression procedures, the most variance in health behaviors found was due to gender, with occupation and marital status having small effects. Within gender the strongest predictor of health behaviors for women was socioeconomic status and for men was being married. There were no differences in health status by age (although self-rated health only was lower in the oldest age group), nor was there any significant relationship between health behaviors and health status.

Bergman-Evans and Walker (1996) examined use of clinical preventive services by older women. Using data from the National Health Interview Survey, compliance with recommendations from the U.S. Preventive Services Task Force regarding screening, counseling, and immunizations by health care providers was examined for 5,574 women in three age groups: 65 to 74, 75 to 84, and 85 and over. In stark contrast to studies concerning self-reported individual health behaviors in old age, low compliance across preventive health behaviors and services was found. For instance, fewer than 1% of women received all of the health-history questions, and only 7% received all recommended exams (e.g., height, weight, blood pressure, visual acuity, hearing, and clinical breast exam). The proportion receiving laboratory exams declined with age; pap smears were the exam with the lowest prevalence. Fifty percent of women received health counseling in at least one area (e.g., diet, exercise), but only 5% received all recommended immunizations.

The discrepancy between the results of the Bergman-Evans and Walker study and others points to some of the gaps in the literature and theory concerning health promotion in old age. Although health promotion as a concept is based on what individuals can do to maximize their health related to lifestyle behaviors, disease prevention also is considered an important aspect of health promotion. Many disease prevention and health-screening activities, and perhaps some health promotion activities for some individuals require interaction with and direction from health care providers. This raises the

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question of the relative efficacy or importance to health of these different activities. If older adults engage in appropriate health behaviors but do not receive recommended disease prevention interventions, are any positive effects of their individual health promotion activities lost? Are efforts better spent educating older adults to advocate for appropriate preventive health services or educating health care professionals to provide them in terms of both health outcomes and costs?

As a group, these studies support the prevalence of health behaviors and a health-promoting lifestyle in old age. These studies also suggest some early attempts at increasing the generalizability of this finding by examining health behaviors in more socially and culturally diverse samples. In general, however, these studies rely on nonrandom samples with few attempts at comparisons among different cultural, socioeconomic, or at-risk groups. Most studies suggest that gender, income, and education are positively correlated with numerous health promotion activities, but again, specific comparative research has rarely been done. A major limitation of the majority of the studies is the reliance on self-report of health behaviors. Whether self-reports of behavior are valid indicators of actual behaviors is an area that deserves the attention of health promotion researchers. Linkages between expanded health behaviors or health-promoting lifestyles and health outcomes have rarely been made.

HEALTH PROMOTION PROGRAMS—OUTCOMES

A number of studies examined the impact of participation in specific health promotion programs on health outcomes. The actual health promotion programs differ in substantial ways as do the outcomes examined, making comparisons and conclusions difficult. Some of these studies were reports of demonstration projects, and replication studies have not been done. Studies reviewed in this section have been grouped by method to make comparisons more meaningful. The first group of studies are those in which volunteers were used and control groups were sometimes employed. The second group of studies used randomized trials.

Health Promotion Programs—Volunteer Samples

A number of studies examined the outcomes of community-based health promotion programs for older adults. Barbaro and Noyes (1984) compared attenders and nonattenders at a monthly wellness program held at a congregational living center for older adults. Of the 300 residents, approximately 30% (mean

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age = 82) attended at least some of the sessions, which were based on health topics identified by residents. Six months postprogram, residents were asked about behavior changes made regarding skin care, bowel habits, memory and learning, nutrition, vision, and exercise. Attenders were more likely to say they had changed their behavior compared to nonattenders in four of the six areas. Actual behavior was not assessed.

"Staying Healthy After Fifty" was a community-based health promotion project studied in 16 communities to assess its effects on participants' satisfaction, perceived benefits, direct effects (health actions, health skills, health care costs), and indirect effects (health status, use of physician services, and health-related quality of life) (Benson et al., 1989; Simmons et al., 1989). The demonstration project, carried out from 1985 to 1987, consisted of eleven 2-hour sessions covering health concerns, emergencies, lifestyle, consumer planning, and instituting a self-change plan. These were presented to groups of 15 to 20 persons. In addition, 26 workshops were held to prepare 38 instructors and 390 educational team members to teach the workshops. Participants in the demonstration project were 2,600 individuals whose mean age was 66. The majority were female, had a high-school education, reported at least one chronic illness, and 70% were American Association of Retired Persons (AARP) members (AARP was one sponsor of the project). Simmons et al. and Benson et al. reported on data from 161 participants and 161 neighbors (comparison group) from 20 of these courses in 16 communities. Preprogram, postprogram, and 6-months-posttest data were compared. Participants scored higher than nonparticipants on their perceived ability to perform self-care tasks (e.g., taking temperature, blood pressures, pulse), use of seat belts, changes in diet, exercise, and stress reduction. There were no differences in health perceptions, health status, or physician usage, or in variables related to quality of life (life satisfaction, social activities) between pre- and postresponses.

A similar community-based health promotion project, the "Self Care for Senior Citizens Program," consisted of 13 2-hour classes on clinical topics and lifestyle behavior changes held in three demographically similar communities (Nelson et al., 1984). Participants were 415 women, aged 60 and over, who generally were high-school educated but low income. Two hundred and four attended the program. The control group ($n = 126$) attended one health education lecture on foot care and hypertension. Pretests and 3- and 12-month posttests were conducted on health skills and health behaviors. Participants reported more confidence than controls in performing health skills (e.g., taking a pulse), more attempts at lifestyle changes (e.g., weight loss, exercise), and more confidence in communicating with physicians. There were no significant group differences in self-reported health status or health care usage.

Similar results were thus found for two different community-based health promotion programs. Although the programs were effective in teaching some

positive health behaviors, the results were not as evident.

In a demonstration project in a 5-year period, the results were: (a) motivated individuals given written materials followed health care advice, and (d) a demonstration project included a pilot study, and promotion materials compared to control were 1,224. At baseline, health care. At the end of the study, the groups exceeded to fourfold their health care ratings in the study, whether the costs of care.

Except for the demonstration at the end of their use of the programs, the care delivered was what aspects of the personal context of the study also do not. Again, these studies samples, age groups, and health outcomes.

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In a different vein, Belcher (1990) compared three models of care delivery in a 5-year trial at the Seattle Veterans Affairs Medical Center. The models were: (a) physician oriented, meaning that physicians were educated and motivated to provide preventive services; (b) patient education—patients were given written materials advising them to ask their physicians for certain preventive services; (c) health promotion, in which patients self-referred and were followed by nurse practitioners who practiced health-promotion-based care; and (d) a usual-care control group. The health promotion clinic services included a physical exam and health history, screening laboratory tests, immunizations, and health counseling. Patients were randomized to all but the health promotion clinic. Because of the extra clinic visits required for these activities compared to the other models, veterans had to volunteer to attend. Participants were 1,224 veterans with a mean age of 59; the majority were chronically ill. At baseline, less than 25% of participants had received any health promotion care. At the end of the trial, there was no change in baseline for any of the groups except the health promotion clinic. This group of patients had a three- to fourfold increase in the number of health promotion activities recorded in their charts. There were also higher participation rates and higher satisfaction ratings in this group compared to the other models. This study did not examine whether these differences were related to any changes in health outcomes or costs of care.

Except for one (Belcher, 1990), these studies relied on volunteers' attendance at educational programs. A positive aspect of a number of these studies is their use of control groups to assess the effect of educational health promotion programs. In the Belcher study, the program also consisted of actual health care delivery. A difficulty with all of these studies is that it is not known what aspect of a program might be responsible for changes in health behaviors or perceptions. Is the critical component the actual content of the program, the person delivering the program, the time (e.g., number of classes), or the context of the program in terms of overall health care delivery? These studies also do not explain why some health behaviors are affected and others are not. Again, this is a critical question for health promotion researchers. Finally, these studies, although a number have adequate and somewhat representative samples, again rely mainly on self-report of changes in behaviors or in perceptions and offer little information about actual behavior change or change in health outcomes.

Randomized Trials

Four studies employing randomization with control and experimental groups were reviewed. Vickery, Golaszinski, Wright, and Kalmer (1988) examined

the impact of a health promotion program aimed at encouraging self-care on health care use outcomes in 1,294 Medicare Health Maintenance Organization enrollees. Medicare patients in the HMO were randomly assigned to an experimental or control (usual treatment) group. The intervention consisted of written materials including two reference books, a monthly newsletter, lifestyle brochures and self-care education packages, and a telephone intervention service. Service usage was measured 1 year before and 1 year after entry into the program. Eleven risk behaviors (e.g., exercise, smoking, seat belt use, immunization, blood pressure) were measured at 6 and 12 months after the program. No differences in overall use were found; however, there was a decrease in the number of high service users in the experimental compared to the control groups. This resulted in an overall cost savings for the experimental group. The authors suggested that health education programs are feasible for older adults, however, the mechanism by which health education led to changes in behavior needs to be identified.

In a similar study, Mayer et al. (1994) examined the impact of a preventive services program on health behaviors in 1,800 enrollees in a Medicare HMO. Again, participants were randomly assigned to the preventive services or control (usual care) groups. The preventive services package consisted of clinical tests, immunizations, individualized health risk appraisals with individual counseling, and group health promotion sessions covering physical and mental health topics. Mayer et al. reported on a 1-year follow-up of health behaviors. At baseline, the experimental and control groups were comparable in terms of demographic (mean age = 73, the majority were White females with higher education and income) and health risk status ("good" health by self-rating). At 12 months, the experimental group scored significantly higher than the control group in frequency of aerobic exercise, other exercise, decreased dietary fat, and decreased caffeine. There were no differences in blood pressure, sodium intake, general nutrition, and safety. Health care usage or health status was not reported in this article.

Williams et al. (1996), using the same data, attempted to identify specific components of health promotion programs hypothesized to result in improved outcomes. Because previous studies suggested that changes in health attitudes or behaviors did not necessarily result in changes in health status, attention was paid to identifying outcomes for high-risk participants. Three groups of attendees in the prevention group were identified: those attending no health promotion workshops, those attending one or two, and those attending three to four. Smokers and the oldest participants (aged 75 and over) were more likely to be nonattenders, but generally attendance was not associated with any specific health risks, illnesses, or social-psychological factors. Attendance had no effect on measures of physical health status but was associated with an increase in scores on a coping index, suggesting improved coping skills.

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Bank of America retirees ($N = 4,712$) participated in a randomized trial of a preventive services program (Fries, Bloch, Harrington, Richardson, & Beck, 1993). In this case, there were two experimental groups. The first group received an individualized health promotion program by mail based on a health-risk assessment. The second experimental group received only the health risk appraisal in year 1, but the full intervention in year 2. The control group received usual care, and only claims data were collected. There was a significant reduction in health risks for both experimental groups after 2 years. This reduction was found in three age groups: 55 to 64, 65 to 74, and 75 and over. There was also a 10% reduction in claims in the experimental groups compared to the control. The risk factors for which there was a significant change at 12 months included systolic blood pressure, seat belt use, weight, salt intake, dietary fat, and total score. No differences were found for dietary cholesterol, smoking, alcohol use, exercise, and stress levels. Although specific physical health parameters were not assessed, the change in claims data suggested better physical health outcomes for the health promotion groups.

Overall, these studies, with more rigorous designs and somewhat similar health promotion interventions, offer some limited support for the impact of health promotion programs. There does appear to be some change in reported health behaviors after participation in structured programs of health promotion. Whether these changes result in better health status is not clear from these studies; however, the time frame is somewhat short (usually 1 or 2 years) for detecting changes in morbidity. Likewise, in terms of the use of preventive services, the data do not clearly indicate a positive impact on health outcomes, although there is some indication of decreased use of health services. Whether decreased usage is an indication of better physical health or some other factor (particularly since most of these samples were drawn from HMOs) is not known, however. Another issue in these studies is the lack of attention to effect size. Although large sample sizes are commendable and necessary when trying to detect small effects, a drawback is that somewhat small effects can achieve statistical significance, but their practical or clinical significance is not clear. These studies, similar to those reviewed in the previous section, also shed little light on which aspects of a health promotion program are of the greatest benefit in terms of outcome. The one study (Williams et al., 1996) that examined the number of sessions attended generally found no differences in outcomes.

What is clear from these studies is that health promotion activities and educational efforts can be used by older adults, and these efforts result in some behavior changes (albeit by self-report) that persist for 1 or 2 years, at least. This is particularly evident from the Medicare studies, which employed random samples more representative of older adults than found in some of the community-based studies.

PARTICIPATION IN HEALTH PROMOTION PROGRAMS

Although the previously reviewed studies suggest that older adults are likely to participate in and benefit from health promotion efforts, a number of studies specifically examined factors related to participation by older adults. Of primary concern is whether those most likely to benefit from health promotion activities actually take part in educational or clinical services. Three studies were reviewed that addressed this question. Buchner and Pearson (1989) investigated factors related to participation in a voluntary 10-week health promotion program offered to all HMO enrollees aged 55 and over in the Group Health Cooperative of Puget Sound. Participants ($n = 103$) from 21 clinics were compared to a random sample ($n = 531$) of nonparticipants. Participants were significantly more likely to be White, better educated, and have higher incomes than nonparticipants, which is similar to previous reports in the literature. Participants were also significantly more likely to report less positive affect and fewer emotional ties than nonparticipants, however. This was true for both men and women.

Durham et al. (1991) examined data from 2,713 members, aged 65 and over, in the same Puget Sound HMO who received health promotion services as part of a demonstration project. Increased participation in health promotion activities was related to younger age and physician involvement, after controlling for chronic illness and proximity to the clinic. Those who were high users of medical services (more than six clinic visits per year) in different age groups were compared to others in terms of participation in health promotion activities. Lower participation was found only for those over the age of 74, particularly if they had multiple chronic illnesses.

Watkins and Kligman (1993) assessed predictors of different attendance patterns at a community-based senior-citizen health promotion program. Lowest attendance was related to lower income, living alone, fewer social contacts, and activity being limited by health problems.

Together these studies suggest that those elders with the most health problems or who may be the most frail or isolated, although not necessarily the oldest, are the least likely to participate in formal health promotion programs. Comparisons are difficult as different studies examined different sets of predictors, however. For instance, some controlled for health status, whereas others did not. Some examined factors like transportation, whereas others did not. It is also not known whether differences among studies may be due to differences in the types of health promotion programs offered; that is, some programs may have been more popular or successful than others due to content, presenters, or the agency involved. Although some studies compared attenders

and nonattenders.
These differences

SUMMARY RESEARCH

The studies reviewed here suggest that health promotion activities as more frequent benefits from health promotion does not provide health promotion activities reviewed here on a large scale, longitudinal, the extremely health behavior is relatively stable, the number of

A number of studies in this important outcomes related to health promotion reviewed here narrowly defined. These are important of quality of life, be the most important of-life research being, and provide a predefined what point can successfully on reference to the links between and important be important should be addressed living in the productive activities control, and

and nonattenders, others examined predictors of high versus low attendance. These differences, again, make conclusions difficult.

SUMMARY AND DIRECTIONS FOR FUTURE RESEARCH

The studies reviewed here indicate that aged adults view health promotion activities as beneficial to their health, engage in numerous health behaviors more frequently than do younger adults, and both participate in and report benefits from health promotion programs. On the other hand, research to date does not provide definitive evidence that health behaviors and health promotion activities result in better health outcomes for older adults. The types of research reviewed here ranged from small, descriptive, cross-sectional studies to large-scale, longitudinal investigations using national probability samples. Given the extremely large number of studies published since 1980 that addressed health behaviors and health promotion, the number concerned with old age is relatively small. Given nursing's long-standing interest in health promotion, the number of studies published in nursing journals seems very small.

A number of important questions and issues should guide further research in this important area. One of the most pressing is identifying appropriate outcomes related to health promotion in old age. Very few of the studies reviewed here examined health status or cost of care outcomes, except in narrowly defined ways (e.g., mortality, self-rated health, physician visits). These are important outcomes but do not take into account important issues of quality of life in old age. Quality of life is an important outcome and may be the most important outcome for aged adults (USDHHS, 1991). Quality-of-life research includes perspectives on successful aging, psychological well-being, and productive aging, as well as physical health status. There is neither a predefined upper limit on quality of health nor on health, however. At what point can one consider life to be of acceptable quality, or that one has successfully or productively aged, or that one is "healthy"? There is no agreed-on reference against which to measure success. Theoretical work examining the links between health promotion activities or a health-promoting lifestyle and important quality of life and other health outcomes is lacking and will be important in guiding future work in this area. Some of the outcomes that should be addressed include functional status, ability to maintain independent living in the community, symptom management, health care utilization, productive activity, and psychological well-being related to mastery, autonomy, control, and positive relations with others (Heidrich & Ryff, 1996).

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Few investigators have addressed the important issue of measurement and self-report data, in particular, in the study of health behaviors. No studies were found that examined whether self-reports of behavior or behavior change reflected actual behaviors. Often health behavior measures consisted of checklists with dichotomous format or used Likert scales that have descriptors such as "rarely" and "most of the time." This type of scaling gives little indication of the amount or quality of different health behaviors that may be linked to different types or levels of health outcomes. The validity of these measures remains an open question and needs further research.

Related to scaling problems is the question of whether the relationship between health promotion and health status in old age is linear. Current conceptualizations seem based on the notion that a more healthy lifestyle results in better health. But there may be both lower and upper limits to the effects of health behaviors on health status, particularly in old age.

One way in which these questions, and many others, could be examined is by doing more comparative research and more research on individual differences in health promotion. Older adults are more heterogeneous than younger and middle-aged adults in every aspect of behavior. Thus, research from an individual-differences perspective is essential. Although there are some descriptive studies examining health behaviors in different cultural groups, studies using comparison groups are rare. In old age, research comparing frail and healthy elders, individuals with different chronic illnesses that have different profiles of symptoms and functional impairments, and elders living in different environments (e.g., family, neighborhood, and cultural factors) would help in describing the range of health behaviors and factors influencing health behaviors in old age. Theoretical work in this area is also needed to inform hypotheses-testing research and the development of theory-based interventions with older adults. For instance, what interventions or strategies are the most effective and health promoting, and whom do these strategies benefit most?

Further research is also needed to better understand the relationship among different health practices as well as their differential effects on health outcomes. And more thought needs to be given to the question of whether to examine health behaviors individually or together, that is, as a health-promoting lifestyle. The few studies that have examined the relationship among health practices suggest that there is little relationship but are short on explanations as to why. In old age health promotion may mean efforts that can enhance health relative to baseline, and these efforts may be related to specific, individualized behaviors rather than a more global conception of health promotion.

Another important question rarely addressed concerns the developmental profile of health promotion behaviors. Is a health-promoting lifestyle a reflection

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tion of lifelong habits or do these behaviors change with age? If health behaviors change with age, what factors influence this change and are these factors related to age or some other characteristics? Identification of these factors could guide interventions tailored to persons of different ages. More attention to developmental theory and research would enrich the study of health promotion.

In summary, there are important theoretical and empirical questions that remain regarding the impact and importance of health promotion in old age. The studies reviewed here provide an important descriptive base to guide future studies that should address the heterogeneity of older adults, the development of health-promoting lifestyles, and the links between health promotion and important health and quality-of-life outcomes in old age. Such research is necessary to inform nursing practice in health promotion and disease prevention over the lifespan.

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Medicare: Few Beneficiaries Use Colorectal Cancer Screening and Diagnostic Services (Testimony, 03/06/2000, GAO/T-HEHS-00-68).

Pursuant to a congressional request, GAO discussed Medicare beneficiaries' use of screening and diagnostic services to prevent colorectal cancer, focusing on: (1) the extent to which Medicare beneficiaries (both aged and disabled) are using colorectal cancer screening and diagnostic services; and (2) efforts to address barriers identified as limiting use.

GAO noted that: (1) the use of colorectal cancer screening and diagnostic services by Medicare beneficiaries is very low relative to recommended use rates and has remained almost unchanged over the past 5 years; (2) although guidelines recommend annual fecal occult blood testing for all people aged 50 and older, only 9 percent of fee-for-service beneficiaries received that test each year; (3) use rates for flexible sigmoidoscopy are significantly lower and have also remained constant at about 2 percent of beneficiaries; (4) women's use of some colorectal cancer screening and diagnostic services was slightly higher than men's, and white beneficiaries received the services at somewhat higher rates than African Americans, Asians, and Hispanics; (5) although use data are not available for Medicare beneficiaries in health maintenance organizations, research suggests that enrollees in managed care plans are at least as likely to have colorectal cancer screening as those in fee-for-service Medicare; (6) various factors contribute to the low use of screening and diagnostic services, some of which are beginning to be addressed by public health agencies and private organizations; and (7) key among these is poor patient awareness of recommendations and coverage for screening, physician reluctance to perform the procedures because of the time and complexity involved, and lack of monitoring systems to encourage greater use.

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 Cancer research
 Health surveys
 Elderly persons
 IDENTIFIER: Medicare Choice Program
 Medicare Program
 NCQA Health Plan Employer Data and Information Set

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MEDICARE

Few Beneficiaries Use Colorectal Cancer Screening and Diagnostic Services

Statement of William J. Scanlon, Director

Health Financing and Public Health Issues

Health and Human Services Division

Testimony

Before the Special Committee on Aging,

U.S. Senate

United States General Accounting Office

GAO

Medicare: Few Beneficiaries Use Colorectal Cancer Screening and Diagnostic Services

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the use of Medicare-covered screening and diagnostic services to prevent colorectal cancer and minimize its effect on beneficiaries' health status through early detection and treatment. Colorectal cancer is the second leading cause of cancer death in the United States. Currently, only about a third of all colorectal cancers are diagnosed at an early stage. Widespread screening aims to detect the disease early, and in many cases, the detection and removal of precancerous growths may actually prevent colorectal cancer. The Balanced Budget Act of 1997 expanded Medicare coverage to include colorectal cancer screening services. The Congress' decision to include colorectal cancer screening as a Medicare benefit reflected an awareness that early screening and detection are important to maintaining beneficiaries' health.

At your request, we examined the extent to which this new preventive health service has been used since its addition to the Medicare benefit package. Accordingly, my remarks will focus on (1) the extent to which Medicare beneficiaries (both aged and disabled) are using colorectal cancer screening and diagnostic services and (2) efforts to address barriers identified as limiting use. To do this analysis, we determined patient use rates from Medicare claims data from 1995 through June 1999. We could not measure use rates for screening services alone because of coding and other technical issues. In addition, we reviewed recent literature and obtained information from medical specialty organizations, patient advocacy groups, agencies in the Department of Health and Human Services (HHS), and several health maintenance organizations (HMO) with Medicare contracts.

In brief, we found that the use of colorectal cancer screening and diagnostic services by Medicare beneficiaries is very low relative to recommended use rates and has remained almost unchanged over the past 5 years. Although guidelines recommend annual fecal occult blood testing for all people aged 50 and older, only 9 percent of fee-for-service beneficiaries received that test each year. Use rates for flexible sigmoidoscopy are significantly lower and have also remained constant at

about 2 percent of beneficiaries. Women's use of some colorectal cancer screening and diagnostic services was slightly higher than men's, and white beneficiaries received the services at somewhat higher rates than African Americans, Asians, and Hispanics. Although use data are not available for Medicare beneficiaries in HMOs, research suggests that enrollees in managed care plans are at least as likely to have colorectal cancer screening as those in fee-for-service Medicare. Various factors contribute to the low use of screening and diagnostic services, some of which are beginning to be addressed by public health agencies and private organizations. Key among these is poor patient awareness of recommendations and coverage for screening, physician reluctance to perform the procedures because of the time and complexity involved, and lack of monitoring systems to encourage greater use.

Background

Research shows that the number of people developing and dying of colorectal cancer could be reduced through screening (identifying people with precursors to or early signs of the disease) and surveillance (monitoring people with previously diagnosed colorectal disease). Studies have shown that in the majority of colorectal cancers, noncancerous polyps grow slowly for 10 years or longer in the colon in a benign state before becoming cancerous. Identification and removal of the polyps during that time can prevent colorectal cancer from developing. In 1997, a consortium led by the American Gastroenterological Association produced clinical practice guidelines to address uncertainty about the choice and frequency of screening tests for different groups of patients. For people at average risk of developing colorectal cancer, the practice guidelines recommend that people aged 50 and older have a fecal occult blood test annually, a flexible sigmoidoscopy every 5 years, an optional double-contrast barium enema every 5 to 10 years, and a colonoscopy every 10 years. For groups at high risk, experts recommend more frequent screening through colonoscopy.

The Medicare benefit for colorectal cancer screening addresses several of the clinical practice recommendations. Before January 1, 1998, Medicare covered the fecal occult blood test, sigmoidoscopy, colonoscopy, and barium enema only for diagnosis and treatment, such as for evaluating a specific complaint or monitoring an existing medical condition. The Balanced Budget Act of 1997 extended coverage of these services for screening purposes, with no coinsurance and deductible for the fecal occult blood test. For all other tests, the cost sharing is the same as for treatment services, which is payment of 20 percent of the Medicare approved amount after the yearly deductible. For people at average risk for colorectal cancer (those with no predisposing factors), Medicare now pays for a screening fecal occult blood test every year and a screening sigmoidoscopy every 4 years for beneficiaries aged 50 and older. In addition, for individuals at high risk, Medicare covers a screening colonoscopy every 2 years. For both risk groups, a double-contrast barium enema may be substituted at the same frequency as the sigmoidoscopy or the colonoscopy, if the physician believes that it is appropriate.

Few Beneficiaries Have Colorectal Cancer Screening or Use Diagnostic Services

Overall use of colorectal cancer screening and diagnostic services among Medicare beneficiaries is generally low. Despite the issuance of the clinical practice guidelines in 1997 and the expanded Medicare benefit that became effective in 1998, use has not changed significantly since 1995. Use rates for these services varied slightly among demographic groups and across states. Studies show that the use of colorectal cancer screening services in managed care health plans is the same as or higher than in fee-for-service arrangements.

Overall Use of Colorectal Cancer Screening and Diagnostic Services Remains Low

Among the colorectal cancer screening and diagnostic services, the most common and least invasive is the fecal occult blood test. In 1999, the use rate for this service was 9.1 percent of beneficiaries, well below the recommended rate of once a year. In the same year, the use rate for flexible sigmoidoscopy, which is covered every 4 years, was 1.9 percent, while 3.8 percent of beneficiaries received a colonoscopy. Figure 1 shows use rates for these services over the past 5 years.

Source: GAO analysis of Health Care Financing Administration claims data.

Similar data are not available on the use of colorectal cancer services by enrollees in the Medicare managed care program, called Medicare+Choice, because the Health Care Financing Administration (HCFA) does not require Medicare+Choice plans to report patient-specific data. However, evidence suggests that colorectal cancer screening rates among Medicare HMO beneficiaries may be similar to or higher than use rates among fee-for-service beneficiaries. In a recent synthesis of studies on the use of preventive care, researchers found that enrollees in managed care plans were at least as likely as those in other plans to obtain colorectal cancer screening services. One-third of comparisons of colorectal cancer screening use found that managed care enrollees were more likely to use the services and two-thirds of comparisons found no difference in use between enrollees in managed care plans and nonmanaged care plans. Enrollees in group and staff model HMOs—which accounted for 4.4 percent of Medicare beneficiaries in 1998—were significantly more likely than those in fee-for-service Medicare or other types of HMOs to obtain preventive services in general.

The Use of Screening and Diagnostic Services Varied Slightly Among Demographic Groups and States

- * Women had higher use rates in 1999 for fecal occult blood test (about 10 percent, compared with 8 percent for men) and similar rates for flexible sigmoidoscopy and colonoscopy.
- * Beneficiaries aged 70 to 79 were most likely to use screening and diagnostic services, but their use rates were only about 13 percent higher than for those aged 65 to 69 or 80 to 84.
- * White beneficiaries received the screening and diagnostic services at consistently higher rates (about 15 percent in 1999) than Asians (about 13 percent), African Americans (approximately 9 percent), or Hispanics (approximately 8 percent).
- * In general, a higher percentage of beneficiaries in Massachusetts and Rhode Island (18 to 20 percent) received screening and diagnostic services consistently over the 5-year period than beneficiaries in other states. (See figure 2 for more information about use rates across states.)

Source: GAO Analysis of Health Care Financing Administration claims data.

Efforts To Overcome Barriers To Colorectal Cancer Screening

Patient Barriers

Although information for patients is essential, it may not be enough. In 1998, the Centers for Disease Control and Prevention (CDC), in partnership with HCFA, conducted 14 focus groups with adults aged 50 and older to examine the factors that inhibit appropriate use of colorectal cancer screening. Consistent with AHRQ's 1997 study, CDC found that the participants were not aware that colorectal cancer is the third most prevalent cancer, nor were they aware of the benefits of screening and early detection. However, the focus groups also revealed that older adults, particularly those older than 65, are unwilling to discuss issues of colorectal cancer screening, even with their physicians. Representatives of several physician and patient groups echoed these results, telling us that many people find colorectal cancer screening tests inconvenient or

embarrassing or that they may be concerned about potential discomfort during the screening.

Because Medicare now covers colorectal cancer screening services, HCFA is taking steps to promote beneficiary awareness of the new benefit, as are other agencies within HHS. For example,

- * HCFA's Medicare and You handbook, which was mailed last year to all beneficiaries, describes the colorectal cancer screening benefit along with other covered preventive services. In addition, HCFA has distributed pamphlets regarding colorectal cancer screening to beneficiary groups, posters for senior citizen centers, and television and radio public service announcements, some of which target women and African Americans.
- * Along with the American Cancer Society, CDC has established the National Colorectal Cancer Roundtable to bring together state health departments, professional medical societies, and other public and private organizations to promote colorectal cancer screening among medical providers and the public. The roundtable seeks to determine clinical and consumer barriers to screening, assess current public awareness of and interest in screening, and develop and disseminate promotional messages.
- * In collaboration with HCFA and the National Cancer Institute (NCI), CDC has launched a public awareness campaign, "Screen for Life," to promote colorectal cancer screening that includes public service announcements and brochures in both English and Spanish, press kits, and a Web site on colorectal cancer (www.cdc.gov/cancer/screenforlife). CDC has also supported studies regarding participation in screening.

In addition, some health plans that participate in Medicare+Choice have set up programs to encourage the appropriate use of screening services. While these activities do not represent those of the managed care industry overall, they illustrate a variety of approaches to improving patients' use of colorectal cancer screening tools. For example:

- * Kaiser Permanente in Northern California has screened more than 300,000 members older than 50 with sigmoidoscopy and has reported a one-third reduction in advanced colorectal cancer cases among the targeted population.
- * Group Health Cooperative in Puget Sound has used mailings to members to provide information about the importance of regular screening and to improve familiarity with the screening procedures.
- * Aetna U.S. Healthcare mails a fecal occult blood test kit to members aged 50 and older, along with instructions for completing the test, and educational materials about colorectal cancer. The plan's Prudential Center for Health Care Research is conducting a study to determine the rate of colorectal cancer screening among plan members older than 50, assess barriers to screening, and improve screening rates.

Physician Barriers

Physicians practices, too, can affect rates of colorectal cancer screening. In a 1999 report, CDC stated that physicians may lack skills (such as training in prevention) or time to counsel patients, or they may be unfamiliar with updated colorectal cancer screening guidelines (which now have broad-based support). A study of primary care physicians in a large health care system found that half of those trained in flexible sigmoidoscopy chose not to perform this procedure. The reasons most often given were the time required for the procedure, the availability of adequately trained staff, and the availability of flexible sigmoidoscopy services from other clinicians. One study has also attributed the reluctance of primary care physicians to provide this screening to their impression that reimbursement rates are inadequate to cover their costs.

Federal agencies, physicians' groups, and others have special programs to

address the lack of widespread physician use of these services. For example,

- * To obtain nationally representative data on barriers to colorectal cancer screening and early intervention, NCI is supporting a survey of primary and specialty care physicians and health plan medical directors that will assess physicians' knowledge, attitudes, and practice patterns.
- * Both the American Association of Family Physicians (AAFP) and the American College of Physicians have guidelines for their members. In addition, AAFP distributed information to its members about the new Medicare coverage for these services and the importance of screening patients.
- * A program developed by a large academic medical center in Louisiana has an arrangement with local primary care physicians that allows patients to be referred to the clinic one morning every week, without appointments, for screening flexible sigmoidoscopies.

Health System Barriers

Unlike other preventive care services, such as cholesterol screening, breast cancer screening, and cervical cancer screening, colorectal cancer screening is not a component of the Health Plan Employer Data and Information Set (HEDIS), a standardized, voluntary HMO performance reporting system developed by the National Committee on Quality Assurance (NCQA). NCQA plays an influential role in prevention by including HEDIS reporting in its accreditation standards. That is, plans seeking accreditation encourage their network physicians to improve the delivery and reporting of measured services. AHRQ, with support from CDC, is working with NCQA and researchers at RAND and the Harvard University School of Public Health to develop measures of colorectal cancer screening that could possibly be included in HEDIS. Developing effective measures to determine whether enrollees are screened appropriately is more challenging because only one of the screening services is recommended annually.

Concluding Observations

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please call Jan Heinrich, Associate Director, Health Financing and Public Health at (202) 512-7250. Other individuals who made key contributions include Jenny Grover, Rosamond Katz, and Debbie Spielberg.

Appendix

Medicare Beneficiaries' Use Rates for Colorectal Cancer Screening and Diagnostic Services, 1995-99

The table shows demographic and geographic differences in use rates. The rates represent the percentage of Medicare beneficiaries having a fecal occult blood test, flexible sigmoidoscopy, colonoscopy, or barium enema. The rates include use of these services for screening, diagnostic, and, in the case of colonoscopy, treatment purposes.

	1995	1996	1997	1998	1999
Total	13.6%	13.2%	12.6%	13.1%	14.1%
Gender					
Male	12.8	12.4	11.9	12.1	13.2
Female	14.2	13.8	13.2	13.8	14.8
Race					
White	14.2	13.8	13.3	13.9	14.9
Black	9.0	8.9	8.5	8.4	9.1
Asian	11.8	11.2	8.9	11.2	12.6
Hispanic	8.0	8.2	5.9	7.7	8.1
Other and unknown	10.5	10.5	11.9	9.0	10.6

Age					
Younger than					
65	4.6	4.6	4.5	4.5	4.9
65-69	15.0	14.6	13.7	14.7	15.6
70-74	16.6	16.2	15.6	16.3	17.6
75-79	16.8	16.4	15.7	16.4	17.9
80-84	15.2	14.8	14.4	14.8	15.9
85 and older	10.9	10.5	10.3	10.0	11.0
State					
Alabama	15.1	15.1	9.5	10.5	12.4
Alaska	11.1	10.9	8.3	9.9	10.7
Arizona	14.8	11.6	11.4	12.8	14.6
Arkansas	13.3	11.7	9.6	11.1	11.4
California	15.5	15.6	15.4	13.2	14.9
Colorado	6.3	5.9	5.9	9.9	9.6
Connecticut	9.8	9.2	8.7	12.9	15.3
Delaware	15.5	15.5	15.0	15.0	17.1
District of					
Columbia	16.5	16.0	14.6	13.1	13.8
Florida	15.6	15.6	15.2	16.9	18.6
Georgia	13.6	11.4	10.7	12.1	13.5
Hawaii	15.6	12.9	13.8	16.7	20.3
Idaho	7.4	7.4	7.0	10.2	9.8
Illinois	12.4	12.3	12.0	11.5	11.8
Indiana	6.8	6.5	6.2	10.0	10.5
Iowa	15.5	11.0	7.7	12.1	12.3
Kansas	13.1	9.4	10.7	11.9	12.9
Kentucky	12.1	11.6	11.8	12.5	13.5
Louisiana	7.3	6.7	7.1	8.2	8.8
Maine	17.8	16.9	15.7	16.5	16.9
Maryland	18.2	17.2	17.2	17.0	19.5
Massachusetts	19.4	19.9	19.1	18.3	19.9
Michigan	16.2	16.2	16.3	15.8	15.6
Minnesota	10.6	12.0	12.7	13.7	14.9
Mississippi	10.9	11.1	10.5	10.9	11.9
Missouri	11.4	10.2	10.6	11.9	12.5
Montana	7.8	7.7	7.5	9.1	10.9
Nebraska	10.6	7.0	8.2	9.6	10.7
Nevada	9.7	7.5	8.2	9.0	10.4
New Hampshire	16.6	16.8	15.7	16.9	16.6
New Jersey	15.8	16.0	15.5	14.9	16.1
New Mexico	8.3	8.5	9.1	10.1	8.2
New York	17.2	17.4	15.2	14.4	15.7
North					
Carolina	13.6	12.9	12.8	12.7	14.2
North Dakota	12.3	8.4	8.0	12.4	11.9
Ohio	14.4	13.5	13.1	12.1	11.4
Oklahoma	10.3	10.6	10.9	12.1	11.9
Oregon	11.8	13.6	11.8	12.0	14.5
Pennsylvania	14.4	14.1	13.7	14.0	15.5
Rhode Island	18.1	19.1	20.2	17.5	17.8
South					
Carolina	16.2	16.7	15.6	15.4	14.5
South Dakota	12.8	7.1	7.2	10.7	12.8
Tennessee	12.4	12.4	11.8	10.2	10.9
Texas	13.1	13.2	13.1	13.0	14.1
Utah	7.3	6.8	6.6	8.1	10.2
Vermont	17.8	17.0	16.0	16.4	15.6
Virginia	9.7	10.4	10.5	12.8	14.9
Washington	10.5	10.9	11.0	13.5	15.0
West Virginia	11.3	11.2	10.4	10.2	10.4
Wisconsin	7.6	7.7	7.5	11.8	12.9
Wyoming	10.6	8.1	6.7	9.6	10.0

Note: Rates for 1999 are estimated from claims paid January through June

1999.

Source: GAO analysis of Health Care Financing Administration claims data.
(201026)

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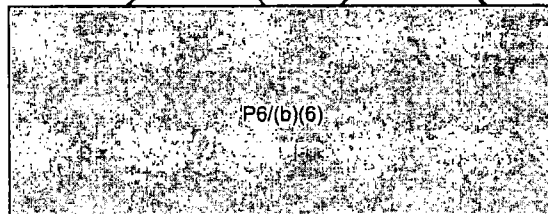
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SUBJECT: Update on Medicare Reform Discussions

DATE: May 4, 1999

I just wanted to touch base briefly in response to the meeting we had a few weeks ago where you came in to talk about Medicare reform with Senator Graham. Last week, you should have received a letter from Senator Graham (dated April 26) indicating some items both our offices were going to follow up on. I just wanted to confirm that you received the letter and to indicate that Senator Graham has asked me for an update, particularly on the items involving the historical BCBS analysis and the Federal tobacco suit/prescription drug piece. I also wanted to send you a revised version of our Medicare prevention proposal which has become much more detailed since the last draft you were provided (see attachment). FYI, we are going to draft this proposal into a bill in the next few days and then intend to circulate it for support prior to introduction in the next week or two.

Attachment

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**MEDICARE MODERNIZATION AND
QUALITY OF LIFE IMPROVEMENT ACT OF 1999**

SECTION I. APPLIED AND GENERAL RESEARCH

A. NEW APPLIED RESEARCH INITIATIVE

1. Despite significant advancements in general research for health promotion and disease prevention among the elderly, there has been a failure in translating that research into practical interventions.
2. \$25 million shall be made available to the Department of Health and Human Services to conduct new applied research in the field of health promotion and disease prevention for the elderly. Any new applied research effort must reflect the medical, behavioral, and social aspects of care for the elderly, including the cost-effectiveness and quality of life impacts stemming from any initiative.
3. The Health Care Financing Administration shall exercise appropriate administrative discretion in responding to preventive health issues affecting Medicare beneficiaries. In addition, Section 1861(a)(1)(A) of the Social Security Act is amended to read "prevention and treatment".
4. Any new applied research effort shall be developed, monitored and evaluated by an inter-agency work group and be based upon approaches of proven utility as reflected in the recommendations of the U.S. Preventive Services Task Force. This inter-agency work group shall be chaired by the Secretary of Health and Human Services, and consist of the agency heads, or their designees, of the Health Care Financing Administration, the Centers for Disease Control and Prevention, the Agency for Health Care Policy Research, the Administration on Aging, and the National Institute on Aging.
5. Among the topics that shall be the subject of new applied research are:
 - a. A study on the effectiveness of using different types of providers of care (e.g., non-physicians) and alternative settings (e.g., community-based settings such as senior centers) for the implementation of a successful health promotion and disease prevention strategy.
 - b. A study to identify the most effective means of educating and incentivizing beneficiaries and providers about the importance of health promotion and disease prevention for the elderly and increasing utilization of both new and existing prevention services.
 - c. Other study topics can be added by the Secretary with timely notification to the Congress of any additions.
6. We encourage the Health Care Financing Administration to expand its efforts to study and

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test the most promising behavioral modification of risk factors associated with health promotion and disease prevention for all Medicare beneficiaries.

7. We recommend that the National Library of Medicine develop and maintain a national clearinghouse of innovative and successful health promotion and disease prevention interventions targeting all Medicare beneficiaries in a variety of settings from both published and unpublished sources.
8. The Secretary of Health and Human Services shall provide a report to Congress by no later than December 31, 2002 that addresses the following:
 - a. the results of the overall applied research efforts,
 - b. whether or not (as a result of the applied research efforts) certain health promotion and disease prevention benefits or education efforts should be added to the Medicare program (including discussions on quality of life and cost-effectiveness for each proposal),
 - c. the utility of, potential for, and issues surrounding Medicare-sponsored health risk appraisals and targeted follow-up, and
 - d. how best to increase utilization of existing and recommended health promotion and disease prevention services (including an education and public awareness component, discussion of financial incentives - for providers and beneficiaries - to improve utilization, and other administrative means of increasing utilization).

B. ADVANCING ORIGINAL RESEARCH IN THE FIELD OF PREVENTION AND THE ELDERLY

To encourage ongoing, original research in the field of health promotion and disease prevention for the elderly, new funding in the amount of \$100 million over five years shall be made available to the National Institute on Aging. Research efforts shall focus on ways to improve quality of life for the elderly, to develop better ways to prevent or delay the onset of chronic illness and disability, and to develop new means of assessing the long-term cost effectiveness of health promotion and disease prevention efforts for the elderly. Research findings, funded by this title, that are scientifically valid and are demonstrated to prevent or delay the onset of chronic illness or disability among the elderly shall be forwarded, in accordance with Section VI of this title, to the National Academy of Sciences' Institute of Medicine for consideration in their efforts to assess all current literature and best practices in the field of health promotion and disease prevention among the elderly.

SECTION II. NEW PREVENTION BENEFITS

1. Individual Benefits - The following preventive benefits are added to the existing Medicare Preventive Benefits Package:
 - a. counseling for smoking cessation by a physician or when prescribed by a

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- physician,
 - b. screening for hypertension,
 - c. counseling for hormone replacement therapy, and
 - d. screening for early detection of glaucoma.
2. **Elimination of Co-Payments** - In order to promote increased utilization of the preventive benefits described in Section II(1), co-payments shall be eliminated for these benefits.
 3. **Population-Based Education Effort** - The Health Care Financing Administration, in collaboration with the Centers for Disease Control and Prevention, shall develop a national falls prevention education and awareness campaign to reduce the number of injuries and disabilities stemming from falls among at-risk Medicare beneficiaries.
 4. **Program Integrity** - The Health Care Financing Administration, in collaboration with the Office of the Inspector General, shall integrate the benefits described in Section II(1) with existing program integrity measures.

SECTION III. NEW, LIMITED PREVENTION-RELATED OUTPATIENT PRESCRIPTION DRUG BENEFIT

1. **Limited prevention-related outpatient drug formulary for all Medicare beneficiaries, regardless of their enrollment in fee-for-service or Medicare +Choice, including -**
 - a. outpatient drugs used as part of an approved smoking cessation program,
 - b. outpatient drugs used in the treatment of hypertension,
 - c. outpatient drugs used as part of an approved hormone replacement therapy program, and
 - d. outpatient drugs used in the treatment of glaucoma.
2. **Financial Assistance** - Financial assistance would be provided to low-income Medicare beneficiaries below 135% of the Federal poverty level in the form of eliminating drug co-payments and deductibles as described in Section III(5)(a) and (e).
3. **Administration of Outpatient Drug Benefit** - The drug benefit shall be administered through a competitive bidding model that utilizes pharmacy benefit management organizations or entities similarly qualified to negotiate and administer an outpatient prescription drug benefit under contract with the Health Care Financing Administration.
4. **Comprehensive Medicare Drug Benefit Study** - The National Academy of Sciences' Institute of Medicine shall conduct a study of the feasibility and issues involved in developing, administering, and financing a comprehensive Medicare outpatient prescription drug benefit and shall report to Congress by no later than June 30, 2001. As part of the report, the Institute of Medicine shall develop a prioritized list of drug

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categories that could be added to the benefit based on the availability of funding.

5. **Payment Structure -**

- a. **Deductible - \$50** (except as noted in Section III(2)).
 - b. **Co-Insurance - 20% percent beneficiary co-insurance.**
 - c. **Annual Cap on Benefit - \$600.**
 - d. **Part B Premium Increase for Drug Benefit - \$10** (indexed to annual cost of living increases).
 - e. **Co-Payments - \$5** (except as noted in Section III(2)).
 - f. **Medicare +Choice Payments - Payments to Medicare +Choice plans shall be adjusted to reflect the cost of adding the benefits described in Section III(1).**
6. **Adding additional drug benefits - In the event the Federal government recovers funds stemming from its efforts to sue the tobacco industry for the recovery of Federal dollars related to the treatment of tobacco related illness, those funds shall be used to enhance the drug benefit described in Section III(1), and consistent with the recommendations of the Institute of Medicine's recommendations as described in Section III(4), by paying for new categories of outpatient prescription drugs.**

SECTION IV. BI-ANNUAL REPORT

1. **Beginning January 1, 2001, and every subsequent two years, the Medicare Payment Advisory Commission shall report to Congress on its assessment of the Medicare program's benefit package and evaluate the degree to which it is actuarially equivalent to private sector health benefit programs.**
2. **Included in the report, MedPAC shall make recommendations on benefit changes that should be considered by Congress that would keep Medicare a modern and competitive program in relation to private sector health benefit programs.**

SECTION V. INSTITUTE OF MEDICINE FIVE YEAR MEDICARE PREVENTION BENEFIT REPORT AND RECOMMENDATIONS

1. **Beginning five years after the date of enactment of this title, and every subsequent five years, the National Academy of Sciences' Institute of Medicine shall conduct a comprehensive study of current literature and best practices in the area of health promotion and disease prevention for all Medicare beneficiaries.**
2. **This five year study will assess clinical and cost effectiveness issues, utilization of covered benefits (including any barriers to or incentives to increase utilization), and quality of life issues associated with both covered and non-covered health promotion and disease prevention benefits or outpatient prescription drugs that would effect all Medicare beneficiaries.**
3. **The IOM's report shall include recommendations that prioritize the benefits, including**

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outpatient prescription drugs, and make any modifications to the existing Medicare preventive benefit package.

4. Congress shall have the opportunity, upon reviewing the IOM's recommendations, to reject the IOM's recommendations and continue funding the existing benefit package or approve the IOM's recommendations and make funding available for the modified benefit package.