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Senate Special Committee on Aging

Statement 1-15-25 Session: Improving Wellness Among Seniors

Good morning. I am Dr. Susan Hughes. I am the Founding Director of the Center for Research on Health and Aging at the University of Illinois Chicago. I have served as the Director of five successfully funded iterations of our National Institute on Aging Midwest Roybal Center for Health Promotion and Translation.

I am also a Professor in the Division of Community Health Sciences in the UIC School of Public Health where I taught Long Term Care Policy for 20 years. My work involves the design and testing of evidence-based health promotion programs that improve the functioning of older adults and can be brought to scale nationally.

Let me start by thanking you very much for this opportunity to talk with you today about this vital topic of *Improving Wellness Among Seniors*.

Today, I would like to address the limitations of our current funding for health promotion programs for older adults and recommend a transformational re-thinking of our current focus on acute and post acute care using an example of UIC's Fit & Strong! program for persons with arthritis

When Medicare was designed in 1966, it addressed a compelling need among seniors to access acute hospital care. The designers modeled the program after the Blue Cross and Blue Shield plans of the 60's to help seniors pay for acute care from reduced post-retirement incomes.

Medicare has served this purpose beautifully but has two important missing pieces. The first is the capacity to provide long-term care to older adults with chronic conditions and disabilities. The second is a tragically missed opportunity to invest in wellness programs that have the potential to pay for themselves many times over. Medicare did not provide reimbursement for even the most basic form of health promotion- screenings- until 1990 when it first covered pap smears, followed in 1991 by mammograms (Gornick et al 1996). Recently, Medicare mandated the implementation of a single annual wellness visit which is a necessary step in the right direction but horribly insufficient in terms of dose needed to achieve behavior change.

As you all know, Medicare Advantage (MA) plans are voluntary options for Part B services for older adults who prefer managed care to customary fee for service care. Enrollment in these plans now encompasses 54% of beneficiaries (Kaiser Family Foundation, 2024). MA plans must offer all of the customary screenings provided by fee for service Medicare but they can supplement that package any way that they choose. Many plans offer vision services, glasses or other covered benefits to attract enrollment.

This ability to offer supplementary services makes these plans very logical providers or payors of health promotion programs, assuming that they perceive advantages, either in the form of reimbursement, savings, marketing and/or quality rankings, that will redound to themselves by doing so. The Administration for Community Living (ACL) and the Administration on Aging (AoA)

aging services network have vetting procedures in place for evidence-based and best practice health promotion programs. Although it is important to preserve consumer choice regarding enrollment, this Committee can work on making the offering of evidence-based programs customary practice among MA plans. The recently mandated inclusion of systematic screening for exposure to Social Determinants of Health during the annual wellness visit could be a way to assess the need for these programs and facilitate referral to them.

Changing Medicare will take time. In the meantime, it is critically important to reauthorize the third leg of the programs passed in 1966 to help seniors; namely, the Older Americans Act (OAA). OAA services are administered at the local level and engage multiple types of community providers. The federal funding for and impact of these programs is multiplied by large amounts of private funding contributed by community organizations. During the pandemic, home delivered meals were used very creatively in Illinois and saved thousands of seniors from hunger. Research has also shown that these meals can significantly reduce Emergency Department visits (Berkowitz et al., 2018).

The renewal of OAA is part of a contract with seniors in which we, as a society, acknowledge that we are indebted to them for their service. Included in the OAA renewal is an important opportunity to expand the funding for Title III D and create a new title that explicitly supports PA programs. Total national FY24 funding for Title III D was $55.5 million dollars. This amounts to an average of $671K per state. Divided by the total number of persons over age 60, this amounts to 31 cents per senior in Illinois. That amount is used to fund all programs including falls prevention and chronic disease management programs (Colello & Napili, 2024). Physical activity can only be funded as an adjunct to those programs despite its demonstrated direct and independent impact on mortality, falls, mobility, brain health, etc. This is an untenable situation that must be fixed.

Why do we care? Despite overwhelming evidence supporting the importance of physical activity for healthy aging, participation in and maintenance of physical activity is still sub-optimal. Overall, 13.9% of adults aged 65 and older met federal physical activity guidelines for both aerobic and muscle-strengthening activities in 2022. Only 5.0% of older adults with disabilities met the guidelines; while 10.2% of Black older adults and 10.5% of Hispanic older adults met the guidelines (Elgaddal et al. 2022). Moreover, 30.9% of older adults over 65 reported performing NO physical activity in the past 30 days (America's Health Rankings, 2025).

We know that 84% of older adults (65+) are sedentary (Yang et al 2019**)**, a condition that is associated with obesity, diabetes, heart disease, and all-cause mortality (Biswas et al., 2015).

The good news is that we also know that *any, I repeat any* physical activity is associated with lower mortality risk (Ekelund et al., 2019; US Department of Health and Human Services, 2018). We also know that short bouts of physical activity are as effective as hours on a treadmill (Saint-Maurice et al., 2018)**.** These findings matter because we can use them to create more positive messages to persuade older adults to engage in activity.

What else can we do? We can foster a culture that makes engagement in and maintenance of PA as easy as possible. This culture can start in grade school; we can have kids walk to school whenever possible. These efforts can be maintained in worksites over the life course. We know that older adults prefer destination over recreational walking opportunities. We can design senior housing

that is in proximity to downtowns and provide sidewalks in communities for seniors whenever possible.

We can also examine causes of sedentary behavior in older adults. I began my research career working with homebound older adults in Chicago who reported that arthritis was their most common chronic condition AND that it interfered most frequently with their functioning. To learn more, we conducted a longitudinal study over four years with 600 older adults. Our study found that persons who had osteoarthritis (OA) in their lower extremity joints at baseline were much more likely to become disabled four years later.

Once we understood the pivotal role of lower extremity joints, we developed an intervention to break the disability chain. Our program- Fit & Strong!— meets three times per week for 8 weeks. It is different from other programs because it combines flexibility with low impact aerobics and systematic lower extremity strength training. Every session uses group problem solving to reinforce the importance and feasibility of using physical activity to manage OA symptoms (Hughes et al., 2004; 2006).

Our clinical trials of F&S found gains in physical activity engagement at 8 weeks that were maintained out to 18 months. If you maintain engagement in PA over time other good things happen. We found improved joint pain, and timed performance measures of lower extremity strength and mobility (risk factors for falls) as well as improved anxiety and depression at the same time points (Hughes et al., 2010). During this trial, we were asked by program participants on the south side of Chicago to include more information in the health education sessions about diet and weight management. We responded to this request by testing a new version of the program –Fit & Strong! Plus—that combined physical activity with diet. The new program demonstrated a decrease in BMI and improved mobility and arthritis symptoms at 8 weeks that were maintained at 6 and 12 months (Hughes et al., 2020; Fitzgibbon et al., 2020).

Medicare spent $11.3 billion on lower extremity joint replacement surgery in 2017 (Liang et al., 2017). Our program clearly benefits people with OA and costs $300 per participant. It has no harmful side effects and large effect sizes. However, our program and others like it that are cost-effective and popular have no place to go. NIA is investing millions of dollars developing and testing high-quality, low-cost programs that demonstrate impact. Drugs have a clear pipeline from bench to uptake. We have no way at present to communicate the benefits of effective health promotion programs to clinicians who can recommend them or ways to market the programs directly to patients themselves.

We also have no effective way to reimburse Senior Centers and other organizations that market and offer the programs to seniors. Finally, we have no pass through funding mechanism that supports teams that are needed to manage the programs. The aging network is beginning to contract with Medicare Advantage plans to offer home and community based long term care services but collaborations to offer health promotion programs are very rare. Newly funded ACL Community Care Hubs are attempting to bridge the divide between aging and health care services by centralizing administrative functions like managing referrals, information security, data collection and reporting. They could be key players in this effort to disseminate and support EB programs in the future.

Meanwhile, Title III D of OAA is *the only reliable source of funding for our program right now*. At a minimum, we need to reauthorize the Older Americans Act. We also need to increase funding for Title III D and create a new title explicitly for physical activity programming.

Ultimately, however, we will see much bigger returns if we develop demonstrations and/or regulations or reimbursement mechanisms that support the dissemination of and access to EB health promotion programs as extensively as possible through Medicare.

To conclude, my recommendations are, in the near term, renew OAA, increase funding for Title III D and create a specific funding line for PA. Longer term, use whatever means you can find to promote wellness through MA programs that include assessments, referrals and reimbursement with EB programs.

Thank you, again, for this opportunity to share our work with the Committee. I look forward to your questions.

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