RI ARA

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"NOW, more than ever!!!"

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To All The Rhode Island Alliance for Retired Americans Members, Associates, Their Families and Friends
A Very Merry Christmas &
A Happy, Healthy New Year

Message from RI ARA President, John A. Pernorio

John A. Pernorio
RI ARA President

On Tuesday, December 14, 2021, I received the 2021 AFSCME Chapter 94 Retirees John H. Slavin, Jr. Award.

The following is my Award acceptance speech:

Good afternoon, President Connelly, Chapter 94 Retirees Executive Board, members, and guest.

Due to my physical disability, I am not able to attend today. I have asked Roger Boudreau to accept the Award on my behalf. Thank you to the Chapter 94 Retirees Executive Board for selecting me for the 2021 Brother John H. Slaven, Jr. Award, who founded the Chapter 94 in 1980 and was its first president.

I am honored, and humbled to accept this 2021 Brother John H. Slaven, Jr. Award and to join past recipients, like Brother Milton H. Bronstein and Brother Roger Boudreau.

For the last 33 years I have been involved in labor retiree issues. In 1988 to help organize the Teamsters Local 251 Retirees Chapter. In 1992, I became the president and I then formed two other organizations, the New England Association of Labor Retirees to create discount benefits such as dental, eye glass and hearing aids discount programs all at no premium cost for members and spouses. With the help of then Congressman Kennedy and Dr. Joseph Boffa, the NEALR created HealthLink Wellness a community-based health initiative program through the CDC that linked its members to the professionals that care for them by controlling blood pressure, cholesterol, and diabetes.

HealthLink conducted two big Health Fairs that was attended by about eight hundred retirees and it tracked five hundred in quarterly Mimi Health Fairs throughout the state in union halls and other volunteer sites. Retirees or their insurance companies were not charged for any testing. Once Congress eliminated Ear Marked funding, HealthLink could not continue with the Mimi health fair screenings. Many of the Chapter 94 members participated in the HealthLink Wellness Project.

Next, I formed the New England Coalition of Teamster Retiree Chapters to give retirees a voice they did not have after retirement and to fight for COLAs in pensions for older Teamster Retirees. They told us we couldn't do it, but after a massive demonstration that I organized and attended by eight hundred (800) New England Teamster retirees at the Pension Fund building in Boston, in the worse rainstorm in Boston history, we did!

Then I became President of the RI ARA. As president, I've tried to continue to advocate along with the RI ARA members like Roger Boudreau and the Chapter 94 Retirees President, Michael Connelly, on issues that are of importance to them, like Social Security, Medicare, Medicaid, prescription drugs and now a very important issue for municipal workers, teachers, police, fire fighters and federal employees, the repeal of the Windfall Elimination Prevision and Government Pension Offset of the Social Security Act.

I started a petition that has over 85,000 signers. Roger Boudreau and I are part of a national Task Force pushing the repeal of the WEP/GPO. I also created the RI ARA weekly E-Newsletter that consist of two parts. One is information that pertains to national retiree issues, and HeathLink Wellness that focuses on retiree health issues and is shared across the country to retiree organizations.

As RI ARA President, I also serve on the RI AFL-CIO Executive Board.

I am the type of person that says what I mean and does what I say. I have been known to make people angry because of my persistence to help labor retirees. So, I guess I must be doing something right. I will continue to fight for all retirees to have a better way of life, if God allows me to.

Again, I am very appreciative to receive this award, thank you. Merry Christmas and Happy and healthy New Year to all.

PLEASE NOTE: Due to the Christmas and New Years holidays, there will be no December 26, 2021 ARA E-Newsletter. The next one will be January 9, 2022

I would like to take this opportunity to thank everyone that receives and distributes the E-Newsletter. Merry Christmas & Happy, Healthy New Year.

ADD YOUR NAME

Get The Message Out:
SIGN THE GPO/WEP PETITION!!!!!

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Democrats, Employee Groups Rally Around Social Security Reform Bill

Legislation with nearly 200 sponsors would change how annual cost of living adjustments are calculated, temporarily eliminate the controversial Windfall Elimination Provision, and restrict the agency's ability to close field offices.

Federal employee groups this week became the latest to embrace legislation from House Democrats aimed at reforming Social Security, which has a number of implications for federal retirees and Social Security Administration employees.

Social Security 2100: A Sacred Trust (H.R. 5723), introduced by Rep. John Larson, D-Conn., and cosponsored by 196 other Democrats, would revamp how benefits are calculated for retirees—including former federal employees—as well as make it harder for the agency to reduce the number of field and hearing offices across the country.

On the benefits side, the bill would provide an average 2% increase in Social Security benefits for retirees, equivalent to around $30 per month. It also would change the metric used to calculate annual cost of living adjustments from the consumer price index for workers (CPI-W) to the consumer price index for the elderly (CPI-E), which advocates say is a more accurate reflection in the changing cost of living that retirees experience on an annual basis. President Biden endorsed that proposal on the campaign trail last year.

Additionally, the bill temporarily scraps two Social Security provisions that have been a sore subject for federal, state and local government employees for years: the Government Pension Offset and the Windfall Elimination Provision. The bill would eliminate both provisions from 2022 through 2026.

The GPO cuts the Social Security survivor benefits of spouses, widows and widowers with a public pension—including federal employees covered by the Civil Service Retirement System—by two-thirds. The Windfall Elimination Provision cuts Social Security retirement benefits—unfairly, in the eyes of public sector retirees—in instances where a former federal, state or local employee spent a portion of their career in the private sector. The Windfall Elimination Provision primarily affects federal retirees enrolled in CSRS.

On the operations side, the bill would bar the Social Security Administration from reducing the total number of field offices below the level in operation at the end of fiscal 2021, and requires the agency to meet a series of criteria to move forward with any field office closures. In order to close a field office, Social Security officials would have to provide advance public notice, a chance for public comment on the plan, as well as "a robust consideration" of the burdens closing a field office would have on the community it serves.

American Federation of Government Employees Director of Legislation Julie Tippens wrote in a letter to lawmakers that the bill's changes to benefits calculations are a much-needed update to the law.

"This legislation will strengthen Social Security benefits by increasing the across-the-board benefit to seniors, more accurately calculating the cost of living adjustment to make up for inadequate benefits since 1983, [and by] increasing the minimum benefit for lifetime low earners based on years in the workforce," she wrote. "[This] bill is a critical first step in repealing the Windfall Elimination Provision and Government Pension Offset for Social Security to provide workers, including many federal employees, a fairer Social Security benefit. Federal employees under the Civil Service Retirement System did not contribute to Social Security for those earnings, but often have sufficient non-federal earnings and they are getting short changed."

Ken Thomas, national president of the National Active and Retired Federal Employees Association, applauded the inclusion of proposed changes to cost-of-living adjustments.

"CPI-E better accounts for seniors' spending habits, notably that of health care," he wrote. "Simply, seniors spend more on health care—while health care accounts for about 8% of spending for the general population, it accounts for 12% of spending for those age 62 and older. Meanwhile, health care costs have risen faster than the cost of other goods."

Bette Marafino, Connecticut ARA President and ARA Task Force member, testified at a congressional hearing on the Larson, H. R. 5723 Bill, Social Security 2100: A Sacred Trust .

She testified on how important it is to repeal the WEP/GPO for all those affected.

The Repeal the WEP/GPO Petition now has 85,310 signers. Bette submitted the petition for the record at the hearing.

Senior Citizens League News

Also last week, we reported that the House of Representatives was expected to take up legislation to prevent billions of dollars in cuts to Medicare payments to health care providers. Those cuts would have taken place next year if Congress failed to vote to stop them.

As it turned out, both the House and the Senate voted for the legislation to stop the cuts and the bill was sent to President Biden for his signature.

The bill will delay 2% cuts to Medicare rates through March of next year and stop a separate round of 4% Medicare cuts totaling about $36 billion until 2023.

The 2% cuts were the result of legislation passed in 2011 that required spending reductions across the federal government beginning in 2013. Congress paused the cuts last year in response to COVID-19. The bill that passed Thursday would keep that pause in place until April 1, after which providers will see a 1% cut until June 30 and a 2% cut until the provisions in the 2011 law expire in 2031.

The 4% Medicare cuts are the consequence a budget law known as PAYGO that requires increases in the deficit be offset by raising revenue or reducing spending. The COVID-19 relief legislation enacted this year resulted in a larger budget deficit, triggering spending reductions.

The bill also includes a 3% increase in pay for providers paid under the Medicare Physician Fee Schedule, partially offsetting some cuts that are set to take effect next year. Providers have urged Congress all year to avert the cuts, arguing they are still struggling financially under COVID-19.

Most House Republicans voted against the bill because it takes steps toward raising the debt ceiling, but it has enough support from Republicans in the Senate to pass.

Panel Recommends Medicare Cuts in Nursing Home Payments

A congressional advisory panel on Friday moved to recommend that Medicare payments for nursing homes, home health agencies and inpatient rehabilitation facilities be cut by 5% in 2023, citing adequate reimbursement rates for the facilities.

Only long-term care hospitals would see a payment increase in 2023 under the draft recommendations adopted by the Medicare Payment Advisory Commission on the final day of its December meeting. The panel's draft recommendation calls for 2% increase in the Medicare base payment rate for long-term hospitals, minus an applicable productivity adjustment.

Final commission recommendations will be voted on in January 2022. All final recommendations for 2023 will be included in the commission's March 2022 report to Congress on Medicare payment policy.

CMS Announces New Strategies to Encourage People with Medicare to Get a COVID-19 Booster

MEDICARE RIGHTS CENTER Getting Medicare right Blog

According to the latest Kaiser Family Foundation (KFF) **polling,** the number of fully vaccinated adults who have received a booster dose more than doubled in the last month. Nearly one-fourth of all adults and one-third of those over age 50 say they have received a booster, and many more plan to get a booster soon. However, 27% of adults and 11% of those over 65 remain unvaccinated. The share of adults who say they "definitely won't" get a COVID-19 vaccine holds steady at around 14%.

As states across the country face a new COVID-19 **variant** and rising **infection rates**, the Centers for Medicare & Medicaid Services (CMS) announced new strategies they will employ in the coming weeks to encourage vaccine and booster uptake among people with Medicare:

- **Send a letter to everyone with Medicare:** All 63 million people who currently have Medicare will receive a letter encouraging them to get their COVID-19 vaccine booster as soon as possible.
- **Conduct campaigns and paid advertising:** This outreach will focus on those with Medicare who are not fully vaccinated against COVID-19 and will include reminders about getting the annual flu shot.
- **Include 1-800 MEDICARE reminders:** Approximately two million people call 1-800 -MEDICARE each month. They will hear a reminder to get their COVID-19 boosters at the beginning of their call.
- **Include a message in Medicare Summary Notices:** For people with Original Medicare, CMS will include a COVID-19 booster message in their Medicare Summary Notice (the explanation of benefits people receive when a claim is filed) over the next several months.
- **Send email reminders:** CMS will send COVID-19 vaccine booster reminder emails to the more than 14 million people who are signed up to receive Medicare email communications.
- **Deliver consistent communication via social media:** The @MedicareGov Twitter handle will continue to tweet about the importance of COVID-19 vaccine boosters.
- The agency also plans to engage local and national partners, health plans, nursing homes, and the media to help spread the word.
- Studies show that being fully vaccinated against COVID-19 remains **effective** in preventing severe disease, and that a **booster dose increases** immune response, further improving protection.

By way of reminder, people with Medicare pay nothing when they get the COVID-19 vaccine and booster and there is no applicable copayment, coinsurance, or deductible. In addition, nearly all Medicaid and CHIP beneficiaries, and many with private health insurance, must receive coverage of COVID-19 vaccines and boosters without cost-sharing.

Read the CMS announcement, **CMS Encourages People with Medicare to get COVID-19 Vaccine Booster Shot.**

Read the KFF analysis, **COVID-19 Vaccine Monitor: November 2021**.

Suit by Doctors, Hospitals Seeks Change in How Arbitrators Settle Surprise Billing Cases

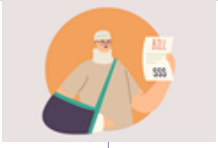
Two of the largest lobbying groups representing physicians and hospitals filed a lawsuit Thursday challenging a Biden administration decision on how to implement the law shielding patients from most surprise medical bills.

The **lawsuit** from the American Hospital Association and the American Medical Association does not seek to halt the law from going into effect in January. **Instead, it seeks a change** in a key provision in regulations issued in September.

At issue is how arbitrators will decide the amount insurers pay toward disputed out-of-network bills.

That was a main point of dispute in the long and contentious debate leading up to the passage of the No Surprises Act in late 2020 — and remains so a year later.

"Our legal challenge urges regulators to ensure there is a fair and meaningful process to resolve disputes between health care providers and insurance companies," AMA President Gerald E. Harmon said in a written release.



Two other **lawsuits** — one from the Texas Medical Association and one from the Association of Air Medical Services — have been filed over the regulation.

"There has been a lot of political pressure, and now they are turning to the courts to get the outcome they want to see," said Katie Keith, director of the Health Policy and the Law Initiative at Georgetown University Law Center.

The administration has defended its interpretation of the law, with Health and Human Services Secretary Xavier Becerra **telling KHN and NPR last month** that if the arbitration process were "wide open" costs would go up, so it set up a system that "provides the guideposts to keep us efficient, transparent and cost-effective."

The No Surprises law is designed to address a common practice: providers sending large, unexpected bills to patients who receive out-of-network care from physicians, laboratories, hospitals or air ambulance services. Starting in January, the law bars most such balance bills. Instead, insured patients will pay only what they would have if the care had been provided by an in-network facility or physician. It directs insurers and the medical providers to work out whether any more is owed.

If they can't agree, the dispute moves to "baseball-style" arbitration, in which both sides put forth their best offer and an arbitrator picks one, with the loser paying the arbitration cost, which the rule sets for next year as between $200 and $500.

The **regulation issued Sept. 30** directs arbitrators to lean toward picking the amount closest to the median in-network rate negotiated for the type of care involved, although they can also consider other factors, such as the experience of the provider, the type of hospital and the complexity of the treatment.

Congress wrote into the legislation that arbitrators could not consider "billed charges," which are often highly inflated amounts hospitals and doctors set as what they want to be paid, nor could they consider the lowest payment amounts, including reimbursement rates from Medicaid and Medicare.

The lawsuit, filed in U.S District Court for the District of Columbia, alleges that giving weight to the in-network median rate "places a heavy thumb on the scale" against medical providers and "barely resembles" the process Congress created.

Congress, **it alleges**, prescribed "no particular weight or presumption for any one factor," instead directing arbitrators to consider all factors. Focusing on median in-network rates will "prevent fair and adequate compensation."

The rule has also drawn a bipartisan **rebuke from 152 lawmakers**, although most members of Congress **who helped shepherd the law** to passage **support the regulation**….**Read More**

Biden Administration Moves to Repeal Damaging SUNSET Rule

Various branches of the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services (CMS), are **currently accepting comments** on a proposal to repeal the Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) rule. The agencies have determined the rule to be statutorily questionable, procedurally unsound, and overly burdensome.

Rushed through at the end of the Trump administration, the SUNSET rule would require federal health agencies to reassess and rereview all regulations periodically. Any failure to do so, whether deliberately or as a result of insufficient time, would cause a rule to automatically expire. This would create a significant new administrative burden, forcing agencies to engage in hundreds of hours of pointless busywork each year, necessarily reducing their capacity to manage other, more critical issues—like ensuring access to care and coverage during a public health emergency. It would also lead to regulatory uncertainty, and potentially chaos, for Medicare beneficiaries, providers, and payers. Lastly, it would also allow administrations to withdraw regulations surreptitiously, through silence and inaction, without going through the required steps that mirror the process of creating a new rule. This would mean no notice-and-comment rulemaking for the repeal of some rules, a significant weakening of the public's right to be heard. Medicare Rights **opposed** finalization of this rule and flagged it as **almost certain** to lead to litigation for violating the Administrative Procedures Act.

The SUNSET rule was controversial from the start. The Trump administration proposed it on November 4, 2020, requiring that comments on most aspects of the rule be submitted within a month. Only Medicare program regulation comments had more time, not being due until January 4, 2021. The proposal faced widespread objections and criticism, both for its substance and the rushed rulemaking process. Despite these objections, the Trump administration moved forward, drafting a final rule before the comment period had even ended. The administration eventually finalized the rule on January 19, 2021, in one of its final acts. Unsurprisingly, the rule immediately **faced litigation** for its procedural shortcuts and content. The incoming Biden administration put the effective date on hold for one year, **citing the litigation and procedural concerns,** until March 22, 2022. Now, the Biden administration **proposes to withdraw the rule** in its entirety before it can go into effect.

In addition to our concerns about regulatory uncertainty and burden, Medicare Rights objects to any attempt like the SUNSET rule to undermine or shortchange notice-and-comment rulemaking. We use comment periods to share the experiences of people with Medicare with administrations of both political parties. Whether the rulemaking is to establish a new rule, modify existing rules, or repeal rules, administrations are required to read comments and take them into account in deciding whether and how to move forward. The SUNSET rule would allow administrations to simply allow a rule to disappear, shortchanging the ability of stakeholders to make their voices heard.

Read the proposed rule to repeal the SUNSET rule.

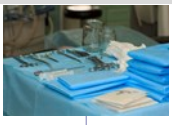
Never Mind Toys, It's Time to Ask Santa for Crutches and Catheters

America's hospitals, strained by nearly two years of fighting the covid-19 pandemic, are now scrounging for basic medical supplies.

In another consequence of the global supply chain crisis, hospitals managing holiday covid surges and all their other patients are running short of many necessities of care: crutches, syringes, needles, tubing, gloves, catheters, drapes for surgery, suction canisters for medical waste and even urine cups.

After the difficulties that health care workers faced in securing personal protective equipment in 2020, supply chain managers and other experts say shortages and delays of other common supplies escalated this year.

President Joe Biden's promises to speed supplies into the country have repeatedly focused on ensuring that holiday gifts fill U.S. store shelves. "Only Santa Claus" can make sure they arrive on time, Biden said in a **Dec. 1 speech** about his administration's efforts. Medical supplies received a passing reference.



In the meantime, clinicians describe making do, which sometimes requires piecing together what's needed with odds and ends. And while they play MacGyver, their attention can be diverted from patient care.

In late November, executives at CentraCare in Minnesota said a lack of the urine collection kits the health system uses forced them to secure four alternatives and even order individual parts to make their own. Some of the cups can't be transported through normal hospital tube systems, so workers must walk samples to the lab instead of tending to patients.

Dr. George Morris, CentraCare's physician incident commander for covid response, worries about higher risk of harm for patients: "Now our supply shortage is actually affecting our ability to do the care."

"When you throw in all these variations — four different types of collection kits, an infinite number of different types of crutches — there's always that little slight chance of error," Morris said. "And that's unfortunate, but that's the reality."

"We just can't get enough volume," said Kelsey Ochsner, CentraCare's manager of procurement. Federal emergency medical teams were **dispatched to Minnesota** in late November to help hospitals — including CentraCare's St. Cloud Hospital, the system's largest — manage a spike in covid infections.

The scarcity of supplies is driven by raw material shortages, port backlogs, shipping delays and a dearth of truck drivers for transporting goods. Another factor making things worse for hospitals in general: staff shortages.

"If you don't have health care workers, you can't do the work," said Debbie White, a registered nurse and president of Health Professionals and Allied Employees, a union in New Jersey. "Whatever supplies you have are kind of a moot point if you can't even take care of your patients."

A global aluminum shortage has left hospitals short on crutches, so clinicians have organized donation drives for gently used items. "Imagine trying to get around after hip surgery or after breaking your leg without the aid of these devices," read one **recent call** for walkers, canes and crutches from Utah hospitals, including Intermountain Healthcare and University of Utah Health.

The campaign, called Lean on Utah, collected items on three Saturdays this fall, bringing in 963 sets of crutches, 652 walkers, 333 canes and 153 nonmotorized wheelchairs.

Gordon Slade, Intermountain's senior director of supply chain logistics, said lead times are so long that the health system has paid for expedited shipping, pushing costs ever higher.

"In some cases, you're paying more for freight than the product," he said….**Read More**

West Virginia Sen. Manchin Takes the Teeth Out of Democrats' Plan for Seniors' Dental Care

Sharon Marchio misses having teeth for eating, speaking and smiling.

For the past few years, after the last of her teeth were extracted, she's used dentures. "My dentist calls them my floating teeth because no matter how much adhesive you use, if you eat something hot or warm, they loosen up and it is a pain," said Marchio, 73, of Clarksburg, West Virginia.

Marchio believes that losing her teeth was merely part of getting older. It's quite common in West Virginia, where a **quarter of people 65 and older** have no natural teeth, the highest rate of any state in the country, according to federal data.

Like half of Medicare enrollees nationally, Marchio has no dental insurance. Worries about the costs led her to skip regular cleanings and exams, crucial steps for preventing infections and tooth loss.

Medicare doesn't cover most dental care, but consumer advocates had hoped that would change this year after Democrats took control of the White House and Congress. President Joe Biden and progressives, led by Sen. Bernie Sanders, sought to add the benefit to a major domestic spending package, the Build Back Better Act, that Democrats are seeking to pass. But those chances are **looking slim** because at least one Democratic senator — Joe Manchin of, yes, West Virginia — opposes adding dental and other benefits for Medicare beneficiaries. He says it will **cost the federal government too much**.

In a Senate split evenly between Republicans and Democrats, losing Manchin's vote would likely sink the proposal, which is unlikely to get any Republican votes.

Last month, the House passed the roughly $2 trillion package of Democrats' domestic priorities that include health measures, free preschool, affordable housing programs and initiatives to fight climate change. It added hearing services coverage to Medicare but no dental benefit. The package is expected to undergo revisions in the Senate, and Democratic leaders hope a vote will happen in the chamber before the end of the year.

In West Virginia, one of the most heavily Republican states in the country, oral health advocates and progressives say it's disappointing that Manchin would stand in the way of adding dental coverage for Medicare recipients — particularly given the state's poor oral health record.

"It is unfortunate that our senator — who I respect and agree with on a lot of things — is going to draw the line on this issue," said Fotinos Panagakos, associate dean for research at the West Virginia University School of Dentistry and a member of the Santa Fe Group, a think tank made up of scholars, industry executives and former government officials pushing for a Medicare dental benefit. "It would be a huge benefit."

West Virginia has the third-highest share of people 65 and older, behind only Florida and Maine. Panagakos said that nearly 300,000 West Virginia Medicare recipients would gain dental benefits under the bill. Yet, Manchin's efforts aren't likely to cost him politically. He is not up for reelection until 2024….**Read More**

House Committee Report: Medicare Could have Saved Billions

After a three-year investigation into how pharmaceutical companies set their prices, the House Oversight and Reform Committee released its report last week that said Medicare could have saved more than $25 billion if allowed to negotiate better prices for the most expensive medicines over a five-year period.

According to the report, drug makers such as **Pfizer Inc.**, **Teva Pharmaceutical Industries Ltd.**, and **Celgene Corp.** specifically target the U.S. for price increases because there's no government effort to control the price of medicine, according to internal documents released by the committee.

The findings show that companies studied by the committee raised prices of common brand-name drugs during the past five years by nearly four times the rate of inflation. The report seeks to debunk industry contentions that companies' price strategy is needed to plow money back into researching and developing new medicines, finding that revenue is substantially greater than those investments.

The report found the government could have saved $25 billion from 2014 through 2018 if it were able to peg the price of just seven costly medicines in Medicare Part D, which covers outpatient drugs, to their cost to other federal programs that negotiate directly with drug makers.

Negotiating the price of insulin over a seven-year period would have saved an additional $16 billion.

Because of legislation allowing Medicare to negotiated drug prices with the drug manufacturers has passed the House of Representatives and is pending in the Senate, the big drug companies have launched a massive lobbying campaign to try and stop it in the Senate.

One of their tactics is to blame others for the huge price increases in drugs, specifically the "middle men" called Pharmacy Benefit Managers (PBMs), something most Americans were totally unaware even existed until this fight over reducing drug prices began.

The PBMs are fighting back with their own lobbying effort and as a result, adds attacking both sides are now widely broadcast on TV and other media.

Republicans on the Oversight Committee have sided with the big drug companies and countered the Oversight Committee's report with **a report** of their own on the role pharmaceutical industry middlemen play in raising drug prices.

The Republican report outlined how pharmacy benefit managers distort drug markets to reap profits and, in some cases, make it harder for patients to access their preferred medicines.

The Democrats' report seeks to rebut some of the pharmaceutical industry's main arguments against allowing the government to seek lower drug prices, including that high profits are needed to afford development of innovative new drugs. It does this by showcasing how much money the companies spent on stock buybacks and executive bonuses, some of them tied to revenue targets achieved by price increases.

The 14 largest pharmaceutical companies in the U.S. spent $577 billion on stock buybacks and dividends from 2016 to 2020, $56 billion more than they spent on research and development over that time. This meant the companies spent more rewarding shareholders than on developing new medicines, the report said.

The 10 brand-name pharmaceutical companies at the center of the committee's investigation paid their top executives more than $2.2 billion from 2016 to 2020, the report found. The highest paid executives on that list were paid $347.7 million in those four years.

The Democrats' report also cited internal documents obtained by the committee finding that patient assistant programs—deployed by drug companies to cover copayments for some people who can't afford them—actually drove up profits instead of operating as charitable enterprises.

Pfizer's copay program kept patients on its brand-name drug Lyrica even after low-cost generics hit the market, the committee revealed. Teva and AbbVie noted in documents that donations to third-party organizations that subsidize the cost of medicines for people on Medicare attracted patients to their products.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Breathlessness With 'Long COVID' May Point to Heart Damage

(HealthDay News) -- Shortness of breath in people with "long COVID" might not just be about the lungs — it may indicate heart damage from the disease, new research suggests.

"The findings could help to explain why some patients with long COVID still experience breathlessness one year later, and indicate that it might be linked to a decrease in heart performance," explained study author Dr. Maria-Luiza Luchian, of the University Hospital Brussels in Belgium.

Her team presented the findings Thursday at a virtual meeting of the European Society of Cardiology (ESC).

The new study included 66 patients, average age 50, who had no history of heart or lung disease before being hospitalized with COVID-19 between March and April 2020 at Luchian's hospital in Brussels.

One year after leaving the hospital, 35% of the patients still experienced **shortness of breath** during physical activity.

All of the patients underwent imaging of their lungs and heart, including a new imaging technique called "myocardial work," which provides more precise information on heart function than previous methods, the researchers said.

The results revealed poorer heart performance in people with shortness of breath compared to those without shortness of breath. There was also a significant and independent association between abnormal heart function and persistent shortness of breath ("dyspnea"), the study authors noted.

"Our study shows that more than a third of COVID-19 patients with no history of heart or lung disease had persistent dyspnea on effort a year after discharge from hospital," Luchian said in an ESC news release.

"When looking in detail at heart function by cardiac ultrasound, we observed subtle abnormalities that might explain the continued breathlessness," she noted.

"Future studies, including different COVID-19 variants and the impact of vaccination, are needed to confirm our results on the long-term evolution and possible cardiac consequences of this disease," Luchian suggested.

Two experts based in the United States said the new findings were interesting, but more study is needed.

Dr. Michael Goyfman is chief of cardiology at Long Island Jewish Forest Hills, in New York City. He said myocardial work is still largely unavailable in routine clinical practice, and "it remains unclear what treatments would be helpful for patients with shortness of breath a year after COVID who display these specific echocardiographic abnormalities. Additional studies would be helpful to apply these findings to patients."

Dr. Roshini Malaney is a cardiologist at Staten Island University Hospital, also in New York City. She explained that "shortness of breath is one of the most common symptoms of many heart conditions, such as a heart attack, heart failure and inflammation of the heart muscle, also known as **myocarditis** or pericarditis."

Malaney added that "COVID-19 is known to cause high amounts of inflammation in the body, which can accelerate or induce a heart condition that was not present before." Certain risk factors — smoking, high cholesterol, high blood pressure and diabetes — can raise a person's risk even further, she said.

"Persisting symptoms after an infection with COVID-19, especially shortness of breath, should warrant prompt evaluation by a cardiologist due to the possibility of underlying heart muscle damage from the infection," Malaney believes. **Echocardiograms** can help confirm a diagnosis.

"This is an easy, accessible and noninvasive test that can be done in the office, which gives us a lot of information about the heart and its function and can detect damage due to COVID-19," Malaney said.

Because the Belgian findings were presented at a medical meeting, they should be considered preliminary until published in a peer-reviewed journal.

A Patient's Guide to Heart Arrhythmias

Know the basics on symptoms, diagnosis and treatment to help you deal with this condition

An arrhythmia is an irregular heartbeat – a heart rate that's faster or slower than normal, or with extra or skipped beats. You may have irregular heartbeats that are just normal variants and pose no risk.

However, some arrhythmias increase the risk of cardiovascular conditions such as stroke or heart failure. A minority of arrhythmias are life-threatening if undetected or untreated.

Arrhythmia patients at the highest risk sometimes require heart implant devices. However, most types of arrhythmia can be managed with medications or catheter procedures. With proper treatment and routine precautions, you can lead a normal life.

What Is an Arrhythmia?

Heart arrhythmias are usually grouped in two ways. The first is by heartbeat frequency. A slow heart rate is called a bradyarrhythmia. In general, a heart rate under 60 beats per minute is considered slow. A fast heart rate is called a tachyarrhythmia – in general, above 100 beats per minutes.

Arrhythmias can also be classified by the location in the heart where they originate. Supraventricular arrhythmias occur in the upper heart chambers, or atria, or in other cardiac structures.

Atrial fibrillation is one of the most common arrhythmias. Up to 6 million people in the U.S. have AFib, according to the Centers for Disease Control and Prevention. Older adults face higher risk: About 9% of all people 65 and older have AFib, whereas about 2% of adults under 65 are affected.

"Atrial fibrillation is a chaotic, irregular beating of the heart," says Dr. Bruce Koplan, a cardiovascular medicine specialist at **Brigham and Women's Hospital** in Boston. "The chamber of the heart that is fibrillating is basically quivering and not beating in any kind of organized manner."

Ventricular arrhythmias occur in the lower heart chambers, or ventricles. Ventricular tachycardia is a rapid, regular heartbeat that prevents the ventricles from fully contracting. Ventricular fibrillation is an extremely rapid, chaotic heart rhythm – and a **medical emergency**.

Heartbeat Basics

"The heart is a muscle and it's a muscular pump," says Dr. Joseph H. Levine, director of the Arrhythmia & Pacemaker Center at St. Francis Hospital in Long Island, New York. "Like any mechanical pump, electrical signals turn it on and off. In the heart, the electrical signals are built into the heart muscle itself. Every heart cell has the ability to have electrical activity that tells the individual cell to contract. The overall electrical system in the heart allows the contractions to be synchronous and organized."...**Read More**

What to know about senile osteoporosis

Senile osteoporosis is bone loss that results from aging. It may cause no symptoms at first, but it can lead to fractures and difficulty moving.

Senile **osteoporosis** causes bone loss, and it develops as an adult grows older. It can weaken bones and increase the risk of **fractures** and other injuries.

What is it?

Osteoporosis causes bone mass and strength to decrease. This increases the risk of bones breaking.

Senile osteoporosis is a type that results from aging, and it typically begins in a person's **70sTrusted Source**.

Osteoporosis can stem from a variety of factors. It becomes **more commonTrusted Source** as people age, and particularly during menopause. "Postmenopausal osteoporosis" refers to bone loss after menopause.

Any older adult can develop senile osteoporosis.

Symptoms of senile osteoporosis

This may cause no symptoms at first. The first sign may be a broken bone or **vertebral fracture**, which is a collapse of a vertebra in the spine.

Symptoms of a vertebral fracture include:

- severe **back pain**
- height loss
- a change in posture, which may result from a stooped or hunched back

Senile osteoporosis can make the bones fragile, so they can break easily. This may mean that a bone fractures due to something that would not break a healthy bone, such as:

- a minor fall, such as falling from standing height
- bending over
- lifting
- coughing

People with senile osteoporosis **typically** experience a progressive loss of bone mass. In this case, the effects worsen over time.

Causes and risk factors

People experience bone loss and a slower rate of bone growth as they age. A decrease in bone mass means that the bones can weaken over time, which increases the risk of senile osteoporosis.

Anyone can develop senile osteoporosis, but it is **more commonTrusted Source** and sometimes more severe in women, due to hormonal shifts, such as the rapid changes in estrogen levels resulting from **menopause**. Men experience a more gradual reduction in **testosterone** as they age.

Risk factors for senile osteoporosis, beyond aging, include:

- **Body size:** People with smaller or thinner bones have a greater risk of osteoporosis.
- **Race:** White and Asian women have a higher risk of osteoporosis than African American and Mexican American women. White men also have a higher osteoporosis risk than African American and Mexican American men.
- **Family history:** Osteoporosis is more common in people with a family history of osteoporosis or hip fractures.
- **Diet:** A diet low in **calcium, vitamin D**, or protein can increase osteoporosis risk.
- **Lifestyle factors:** Low levels of physical activity, excessive alcohol consumption, and smoking can increase the risk of osteoporosis….**Read More**

Holidays Are Peak Time for Heart Attack: Protect Yourself

This time of year can be hard on the heart.

The United States has more heart attack deaths between Christmas and New Year's Day than at any other time of year, so the American Heart Association (AHA) offers some holiday health tips.

"The holidays are a busy, often stressful, time for most of us," said Dr. Donald Lloyd-Jones, volunteer president of the **AHA**. "Routines are disrupted; we may tend to eat and drink more and exercise and relax less. We also may not be listening to our bodies or paying attention to warning signs, thinking it can wait until after the new year. All of these can be contributors to increasing the risk for heart attack at this time of the year."

This may be even greater for folks who didn't get to be with family and friends last year due to COVID-19 restrictions, he noted in an association news release.

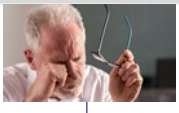
"It's incredibly important to be aware of these risks," said Lloyd-Jones, who is also head of preventive medicine at Northwestern University's Feinberg School of Medicine, in Chicago. "Take a few simple steps that can help keep you heart healthy with much to celebrate in the new year."

Lloyd-Jones offers these ideas to stay safer:

- **Know the warning signs:** It's important to know **the signs of heart attack** — they vary in men and women — and to call 911 immediately. The sooner a person starts receiving treatment, the better the chances of survival and preventing heart damage.
- **Practice moderation:** During the holidays, **eat and drink in moderation,** try to choose healthy foods and watch your sodium intake.
- **Look after yourself: Aim to reduce stress** from family interactions, financial struggles, hectic schedules, travel and other challenges during the holidays.
- **Be sure to exercise: Find creative ways to be active,** such as going for a family walk or another fun activity you can do with your loved ones.
- **Stick to your medications:** Busy holidays can lead to skipping medications, forgetting them when away from home, or not getting refills in a timely manner. It's also important to keep tabs on your blood pressure numbers.

Fatigue in Older Adults

Everyone feels tired now and then. But, after **a good night's** sleep, most people feel refreshed and ready to face a new day. If, like Liang, you continue to feel tired for weeks, it's time to **see your doctor**. He or she may be able to help you find out what's causing your fatigue. In fact, your doctor may even suggest you **become more active**, as exercise may reduce fatigue and improve quality of life.



Some illnesses cause fatigue

Sometimes, fatigue can be the first sign that something is wrong in your body. For example, people with **rheumatoid arthritis**, a painful condition that affects the joints, often complain of fatigue. People with **cancer** may feel fatigued from the disease, treatments, or both.

- **Some illnesses cause fatigue**
- **Can emotions cause fatigue?**
- **What else causes fatigue?**
- **How can I feel less tired?**
- **When should I see a doctor for fatigue?**

For more information about fatigue
Centers for Disease Control and Prevention (CDC)
cdcinfo@cdc.gov
www.cdc.gov

Fear Keeps Some Cancer Patients From Getting COVID Vaccine

(HealthDay News) -- Cancer patients are at risk for serious COVID-19 illness, but some are still afraid to get vaccinated against the virus, new research shows.

Study authors surveyed nearly 200 high-risk cancer patients at the Mays Cancer Center in San Antonio, Texas. Only 56% said they'd received at least one COVID-19 vaccine dose, compared to the community vaccination rate of 76%.

The three most common reasons patients gave for not getting vaccinated were: "My doctor has not told me to get the vaccine," or "I do not think it is safe for me because I have cancer," or "I'm afraid of the side effects."

Patients were given six options to select for declining the vaccination. Aside from the three top reasons, other options included, "I already had COVID, so I don't think I need the vaccine" and "I want the vaccine but have not been able to schedule an appointment."

"We concluded that the reasons cancer patients declined the COVID-19 vaccination can all be addressed by improving patient/physician communication regarding the known safety of the COVID-19 vaccines," said study lead author Dr. Kate Lathrop. She's a medical oncologist and breast cancer specialist at the cancer center and associate professor of medicine at University of Texas Health San Antonio.

"The COVID-19 pandemic has created many challenges and barriers to care for patients on active cancer treatments," Lathrop noted in a UT Health news release.

The Mays Cancer Center -- home to UT Health San Antonio MD Anderson Cancer Center -- implemented a system to remind patients about COVID-19 vaccines.

The study found that before discussing it with their oncologist, 45% of high-risk cancer patients had not received at least one COVID-19 vaccine, but that fell to 20% after a reminder.

The patients were surveyed when they arrived at an outpatient infusion clinic between May and June 2021. The survey results are being presented this week at the San Antonio Breast Cancer Symposium. Studies presented at meetings are usually considered preliminary until published in a peer-reviewed medical journal.

More information

The American Cancer Society has more on **COVID-19 vaccines**.

Overactive Bladder, Dangerous Falls Often Go Together for Seniors

(HealthDay News) -- An overactive bladder isn't just a nuisance and a source of embarrassment. For the elderly, it can also trigger a potentially fatal fall, a Canadian **study** says.

"**Falls** are the leading cause of accidental death in seniors, and many people don't know that having bladder control problems makes you about twice as likely to fall over," said study lead author William Gibson, an assistant professor of geriatric medicine at the University of Alberta.

"There's not previously been a lot of evidence that treating people's incontinence reduces their risk of falling. So this is a jumping-off point, because now we've demonstrated that the sensation of urgency is a source of distraction," Gibson said in a university news release.

The study included nearly 30 older adults with **overactive bladder**. Their gait was monitored as they walked the length of the lab and back three different times: under normal conditions; while doing a simple mental test meant to distract them; and after drinking enough fluids to make them have the urge to pee.

The need to urinate caused gait changes similar to those seen when doing the distracting mental task: The gait tended to become slower and narrower, which is associated with an increased risk of falling, the researchers said.

"This is pretty good evidence that people with incontinence are being distracted by their bladders, which means that they're less able to concentrate on walking," Gibson said.

"Being balanced and walking require some cognitive inputs, and for young, healthy people, they don't have to think about walking," he explained. "But when you're older, with changes to the brain, it requires more cognitive input to maintain balance. If you've then got a distracting factor of your bladder, it makes you more likely to fall."

Incontinence is a common issue in older adults, but it's not talked about much, even between doctors and patients, Gibson said.

"If you're a family physician looking after someone who is having problems with falls, one of the things that should be asked is, 'Are you also having problems with your bladder?' If so, then what can be done about that?" he noted.

Gibson said the study -- published in ***PLOS ONE*** -- "opens up a big field of potential research."

More information

The U.S. National Institute on Aging has more on preventing **falls and fractures**.

Drug Combo May Fight a Tough Form of Breast Cancer

An experimental drug, added to chemotherapy, may benefit women with an aggressive form of breast cancer, suggests an early study offering much-needed good news.

The study involved women with "triple-negative" breast cancer, which accounts for about 15% to 20% of breast cancers among U.S. women. It is so called because the cancers lack receptors for the hormones estrogen and progesterone, and for the protein HER-2.

That means women with **triple-negative cancer** cannot benefit from two key breast cancer treatments: hormonal therapies and drugs that target HER-2.

Traditionally, surgery and chemotherapy have been the mainstays of treatment for triple-negative breast cancer. Unfortunately, the disease often resists, or becomes resistant to, chemotherapy — and that was the case for women in the new study.

So the researchers tried a new approach. They added an experimental agent, dubbed L-NMMA, to the standard chemotherapy drug docetaxel. Twenty-four patients received up to six three-week cycles of the combo.

By the end of treatment, 11 patients had responded, showing a regression in their cancer. For two women, there were no more signs of cancer in the breast.

The study group included both women with metastatic cancer, which means it had spread to distant sites in the body, and those with locally advanced cancer. Those are advanced tumors that have not yet spread throughout the body.

Women with locally advanced cancer responded better to the experimental treatment combo: nine out of 11 had at least a partial response. That was true for two of 13 women with metastatic cancer, according to the report.

The findings, reported Dec. 15 in *Science Translational Medicine*, lay the foundation for larger trials, the researchers said.

One next step is a larger study of women with advanced triple-negative cancer, said study author Dr. Jenny Chang, director of Houston Methodist Cancer Center in Texas.

The researchers also want to test the approach against **metaplastic breast cancer**, a rare form of the disease that is often triple-negative...**Read More**

Who Gets a Flu Shot? Having a Doctor Is Key

(HealthDay News) -- Public health experts have long recommended getting a seasonal flu shot, but a new study suggests there's hesitancy about that vaccine, too. Physicians and pharmacists can play a key role in flu shot uptake, the research shows.

Only about 44% of people who had a health care provider got their flu shots, the study found, but it was even worse among those who didn't have a doctor: Only one in five of those folks got flu shots.

"This research reminds us that under-vaccination and vaccine hesitancy are not limited to COVID-19," said researcher Sinmileoluwa Okegbile, a Pharm.D. candidate at Midwestern University in Arizona. "Low vaccination rates for the flu persist among those living in the United States even though vaccines can prevent severe illnesses, hospitalization and death. Our study suggests a need for a fresh approach to counteract hesitancy."

In the study, Okegbile's team analyzed more than 2.5 million health records of adults aged 18 and older from the 2015, 2017, and 2019 databases of the U.S. Centers for Disease Control and Prevention.

The study found flu vaccination was lower among Hispanics (31%) and Black people (32%), compared to white individuals (41%).

Vaccination rates were higher among older adults, with nearly 60% of those over age 65 vaccinated compared to less than one-third of those aged 18 to 25. They were especially high among those with four or more obesity-related conditions (82%).

Pharmacists might step in to help raise vaccination rates and "develop targeted services to support those less likely to be vaccinated," Okegbile said. He spoke in a news release from the American Society of Health-System Pharmacists (ASHP).

"Pharmacists are accessible to most people, even those without a consistent relationship with another health care provider, and they have a unique opportunity to initiate conversations about vaccines and then order and administer the vaccine," added said Anna Legreid Dopp, ASHP's senior director of clinical guidelines and quality improvement.

"Having open and respectful conversations around vaccines, including both COVID-19 and influenza, while easing access for patients, is the best way to increase vaccination rates," she said.

The findings were presented Tuesday at an ASHP virtual meeting.

More information

The U.S. Centers for Disease Control and Prevention has more on **flu shots.**

U.S. Fentanyl Deaths Soaring, Especially in West

Synthetic forms of the potentially lethal opioid fentanyl are flooding the illicit drug market, leaving a soaring number of fatal overdoses in their wake, a new U.S. report finds.

The latest data from the U.S. Centers for Disease Control and Prevention finds that between May 2020 and April 2021, nearly two-thirds (64%) of the more 100,000 drug overdose deaths in the country were tied to illicitly manufactured fentanyl or its chemical cousins.

The trend began months before that, however: New data released Tuesday by the CDC found rising rates of fentanyl-linked fatal overdoses across the nation between 2019 and 2020.

These deaths "increased sharply in Midwestern states (33.1%), Southern (64.7%) and Western (93.9%) jurisdictions," according to a CDC report summarizing data from July 2019 through December of 2020.

Fentanyl is extremely potent and kills quickly. In fact, more than 56% of people who died from fatal overdoses involving the drug "had no pulse when first responders arrived" on the scene, said a team of researchers led by Julie O'Donnell. She's with the Division of Overdose Prevention at the CDC's National Center for Injury Prevention and Control.

One expert was struck by that statistic.

"Given that over half of the decedents were reported to have no pulse upon arrival by medical responders, it is important to improve time to response in reported emergencies with these agents," said Dr. Scott Krakower, a child and adolescent psychiatrist at Zucker Hillside Hospital in Glen Oaks, N.Y., who specializes in treating substance abuse among teens.

Looking at the demographics of who is dying, the study found that men made up the bulk of these tragedies (73%). Many overdoses are killing the young: About 1 in 5 fentanyl-related deaths in the West now involve males under 25 years of age, according to the data.

Fatal overdoses most often involved injection drug use, although in Western states "evidence of snorting, smoking or ingestion, but not injection, was reported in 57.1% of deaths," O'Donnell's team noted.

These fatalities are moving beyond the abuse of opioids: According to the CDC stats, 4 in every 10 fentanyl-linked deaths now involve a stimulant drug, such as **cocaine** or **methamphetamine**…..**Read More**

Boosters give 70%-75% protection against mild disease from omicron, UK says

Booster Covid-19 vaccine shots give an estimated 70% to 75% protection against mild disease from the new omicron variant, the UK Health Security Agency said on Friday, citing initial findings from a real-world study.

The findings are some of the earliest data on the protection against omicron outside of lab studies, which have shown reduced neutralizing activity against omicron.

The early real-world data suggest that while omicron could greatly reduce the protection against mild disease from an initial two-dose vaccination course, boosters restored the protection to an extent.

"These early estimates should be treated with caution but they indicate that a few months after the second jab, there is a greater risk of catching the omicron variant compared to delta strain," said Dr. Mary Ramsay, Head of Immunization at the UKHSA, adding that protection against severe disease was expected to remain higher.

"The data suggest this risk is significantly reduced following a booster vaccine, so I urge everyone to take up their booster when eligible."

In an analysis of 581 people with confirmed omicron, two doses of **AstraZeneca** and **Pfizer-BioNTech**, vaccines provided much lower levels of protection against symptomatic infection compared to what they provide against delta.

However, when boosted with a dose of Pfizer vaccine, there was around 70% protection against symptomatic infection for people who initially received AstraZeneca, and around 75% protection for those who received Pfizer.

That compares to estimated protection against infection from Delta following a booster of around 90%. UKHSA said that, at current trends, omicron would account for more than 50% of all Covid-19 infections by mid-December, with Britain exceeding one million infections by the end of the month.

Dealing With Medical Emergencies

Medical emergencies can be frightening, especially if you are unprepared. Being familiar with first aid instructions can help you prevent or minimize serious injury. It can even save lives. Knowing what to do will give you the confidence to act calmly and quickly.

How can you be better prepared for emergencies?

Keep a list of emergency numbers by the telephone or on your cell phone. If you have a cell phone, program these numbers into your telephone book:

- Police
- Fire department
- Poison control center
- Local hospital
- Ambulance service
- Family doctor

Make a list of medications you and your family take. Get to know the names of your medicines and why you take each one of them. Note the dosages and how often you are supposed to take them each day. Know the names of all medications that have caused you to have severe allergies in the past. Write all of this information down and keep the list in the medicine cabinet at home, and make a copy to carry in your wallet or purse. In case of emergency, knowing the medications you and your family members are taking will help emergency personnel avoid dangerous drug interactions.

Have basic first aid supplies ready. At least twice a year, check your supplies to be certain they are up-to-date and complete. A basic-first aid kit should include:

- Aspirin, acetaminophen, and ibuprofen (But remember, never give aspirin to children or teens with a cold or fever.)
- Antibiotic ointment
- An over-the-counter antihistamine such as Benadryl
- Bandages
- Cold packs
- Hydrogen peroxide
- Latex gloves
- Rehydrating fluids
- Safety pins
- Scissors
- Soap
- Thermometer
- Tweezers
- Anything you or your family may require for conditions such as diabetes, a heart condition, or a severe allergy.

Keep a first aid kit in your house and in your car, in case you need it when you are away from home. Don't forget to refurbish your car kit yearly, as well as the one in your home.

Prepare for a possible emergency: If you live in an area prone to earthquakes, hurricanes, flooding, or other natural disasters, keep three days' worth of water (estimate a half gallon per person per day), nonperishable food (especially canned or dried products that don't need to be cooked), a first-aid kit, a manual can opener, water purification tablets, flashlights, and other essentials in a watertight container. Put this container in a location you'll be able to reach in the event of a disaster. Check and update the contents twice a year.

Learn CPR (cardiopulmonary resuscitation). The American Red Cross and American Heart Association, along with local fire departments and some hospitals, offer short courses in CPR techniques. Taking the time to learn CPR can mean the difference between life and death. The Red Cross also offers first aid classes in English and Spanish and gives safety classes for children and babysitters.

What should you do during an emergency?

Note: Both the American Red Cross and American College of Emergency Physicians recommend the "AID" rule of thumb: **ask for help, intervene, do no further harm.**

Make sure the scene is safe. Survey the area for dangers, such as a gas leak, fire, or falling objects. Do what you can to secure the scene and prevent further accidents. You may need to set up flares or markers around an auto accident or move the victim from an unsafe place, away from oncoming cars or fires. However, only move victims if you absolutely must.

Try to determine what happened. Quickly identify the number of victims involved and the extent of their injuries or illnesses. Ask bystanders and look for emergency medical information such as bracelets or cards.

Call for help. The faster you call 911 or local emergency services, the sooner the victim will be treated.

Intervene. Be careful to do no further harm to the victim. Never move anyone who could have a spinal injury, unless the scene is unsafe. Check the person's airway, breathing and circulation. If the victim is not breathing, perform chest compressions immediately. Don't stop until either the patient revives, the rescuer gets too tired to continue, or emergency personnel arrive.

Remain calm and focused. Knowing what to do and having the necessary supplies will give you confidence to act quickly. If you feel yourself panicking, stop and take two or three deep breaths. Count slowly from one to 10. Tell yourself that you can handle the situation. If an injured person is confused or agitated, reassure him or her if possible. Then calmly review what you need to do.

Did Pandemic Lockdowns Worsen the Epidemic of Opioid Abuse?

Pandemic lockdowns may have led fewer Americans to seek pain treatment last year, but folks who did seek help had higher-than-usual odds of receiving dangerous opioid painkillers, a new study says.

And that could lead to a worsening of the opioid epidemic, researchers suggest.

"It is likely that more patients may have become addicted to opioids than would have been the case absent the pandemic," said study lead author Byungkyu Lee, an assistant professor of sociology at Indiana University Bloomington.

Lee and his team tracked treatment patterns for millions of patients struggling with limb, extremity, joint, back and/or neck pain. They found that prescriptions for highly addictive opioid medications like oxycodone (OxyContin) rose 3.5% during the first half-year of the pandemic compared with the prior year -- despite a 16% plummet in pain diagnoses.

That may be because, in the face of lockdowns, doctors were less likely to turn to nonmedicinal treatments such as massage therapy and other forms of "**complementary medicine**" like acupuncture and osteopathy. Scripts for such approaches fell by 6% during the same time frame.

"One reason for rising opioid prescriptions during the pandemic is lack of access to non-pharmacologic treatments that require person-to-person contact," explained Lee.

"Prescribing opioids for pain is a faster and easier 'no-contact' solution than physical therapy or complementary medicine," he noted. "Opioids can be prescribed through telemedicine, for example."

The findings were published Dec. 10 in ***JAMA Network Open,*** just weeks after U.S. health officials reported **drug overdose deaths** in the United States increased dramatically during the pandemic -- jumping nearly 30% from April 2020 to April 2021 compared to the prior 12-month period.

In the new study, the investigators examined data from two time periods: January through September 2019 and January through September 2020 (including the first six months of the pandemic)….**Read More**