Message from Alliance for Retired Americans Leaders

**Caregiving Crisis Looms as Number of Older Americans Soars**

Experts examining numbers from the U.S. Census predict that long-term care issues will become more serious as Americans live longer, given a national shortage of workers who provide caregiving services. At the outset of the COVID-19 pandemic, in early 2020, about 4.5 million Americans were paid to work in eldercare, most at nursing homes, assisted-living facilities or as in-home aides. Over the next 24 months, more than 240,000 of those workers left the profession, a decline that made eldercare one of the country’s hardest-hit industries in terms of pandemic-related job losses.

With the nation undergoing a surge in the number of older Americans, the fastest growing cohort is the oldest of the old, people 85 and up. America currently has about 7 million people in that age range; by 2050, the number will be 18.6 million. And, within that group, the number of Americans age 100 and older is forecast to grow from about 90,000 today to nearly 400,000.

In addition, between now and 2060 the number of Americans with Alzheimer’s is expected to grow from 6 million to about 13.8 million, or slightly more than the current population of Pennsylvania, according to federal data and studies by the national Alzheimer’s Association.

“During his recent State of the Union address, President Biden called for increasing support and benefits for caretakers who provide seniors and people with disabilities with home care services,” said President Roach. “The country needs Congress to act on his directive.”

**Take Action: Sign the Alliance’s Petition to Save Social Security**

Even though the extremist Republicans stood during the State of the Union to supposedly show “support” for Social Security and Medicare, they are scheming to cut our earned benefits. They aren’t even keeping it a secret, going on television to promote their wacky plans and drafting legislation to cut the benefits we earned.

Please click now, Sign our petition and tell Congress not to mess with the Social Security benefits we’ve earned.

A growing number of anti-retiree politicians are hawking plans that raise the retirement age to 70 (or higher); to privatize Social Security (and let Wall Street gamble with our retirement); or to reduce benefits. Those aren’t just bad ideas – they are CUTS to the benefits we’ve earned. “We need all hands on deck. Please, sign our petition now,” said Richard Fiesta, Executive Director of the Alliance.

“While we must continually remind Congress that Social Security is earned, and that they need to keep the promise made to generations of Americans,” Click here. Let’s make sure Congress is on notice that we won’t let anyone cut Social Security.

**Battle Over ‘Orphan Drugs’ Leads to Higher Drug Prices**

An “orphan drug” is a designation that rewards drug corporations for developing treatments for rare diseases. When a drugmaker wins approval for an orphan drug, the company is entitled to seven years of exclusive rights to the marketplace, which means the Food and Drug Administration (FDA) won’t approve another company’s application for a competitive drug for the same use during that period.

For example, Zolgensma, a one-time treatment for spinal muscular atrophy, carries a $2.25 million price tag, so nearly all U.S. patients taking the drug as approved by the FDA are covered by commercial or government insurance. However, an ongoing legal battle over whether a drug is truly new or is a slight variation of something that was introduced previously. Congress must act so that uncertainty does not lead to confusion — and additional astronomical drug prices.”

**Get The Message Out:**

SIGN THE GPO/WEP PETITION!!!!!

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**Lambert-Eaton myasthenic syndrome, depends on an orphan drug to stay mobile.**

“Without it, I would be in a wheelchair,” she says.
A new survey by The Senior Citizens League (TSCL) suggests that fifty-four percent of older consumers remain unconvinced that their 8.7 percent Social Security cost-of-living adjustment (COLA) will keep pace with rising costs this year. Roughly the same number of survey respondents report that their household costs in 2022 rose by more than the 8.7 percent COLA increased benefits.

January inflation as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), the same index that’s used to calculate the COLA, has moderated to 6.3% from one year ago, but many prices remain stubbornly high. Will 2023 be the year that seniors catch up? Ninety-six percent of survey respondents do not think so. There are good reasons for that.

A new analysis by Mary Johnson, Social Security and Medicare policy analyst for the Senior Citizens League, indicates that during the three-year period from the start of the COVID-19 pandemic in 2020 through December 2022, Social Security benefits have fallen short of COLAs by about $1,054 on average. Johnson calculated how much benefits would have needed to increase each month from January 2020 to December 2022 to keep pace with actual inflation and compared it to the amount of the average COLA. The shortfall was prior to the deduction for Medicare Part B premiums. Today’s retirees have never experienced this level of inflation, which hasn’t been seen in more than 40 years. The moderation of inflation just announced would shrink the shortfall, by only about $40.34 per month for January and February before the deduction for the monthly Medicare Part B premium which is $164.90.

Social Security recipients can owe taxes on a portion of their Social Security benefits when their “combined income” is greater than $25,000 (single filers) or $32,000 (couples filing jointly). A growing percentage of older taxpayers are hit with the tax on Social Security every year because the income thresholds subjecting benefits to taxation are fixed, unlike tax brackets which are adjusted for inflation.

Had these income thresholds been adjusted since the tax on Social Security benefits became effective in 1984, the $25,000 level today would be about $73,000 and the $32,000 level would be about $93,200. About 51 percent of survey respondents worry they will pay more in taxes this year due to the 5.9 percent COLA received last year. About one in five worry they may be subject to a tax on their Social Security benefits for the first time this tax season.

Finally, 62 percent of survey respondents think Congress should enact legislation to protect Social Security and Medicare benefits from delays or automatic cuts due to failure to lift the debt limit or come to a federal budget agreement by the deadline.

Paige Minemyer reports for Fierce Healthcare that hospitals treating Medicare Advantage enrollees faced a higher likelihood of claim denials last year than the year before. Medicare Advantage plans, administered by private health insurers, use tools that limit coverage for inpatient hospital care more often than traditional Medicare.

In 2022, there was an 18.5 percent increase in Medicare Advantage hospital inpatient claim denials over 2021. All in, the Medicare Advantage plans denied nearly six percent of inpatient claims. While people in Medicare Advantage plans won’t have to pay for care that their Medicare Advantage plans deny, they are likely to face more instances in which hospitals refuse to provide them with the care their doctors say they need; the hospitals need to protect themselves financially. The Medicare Advantage inpatient claim denials can hit hospitals hard. They are not getting paid for the services they delivered. But, they also affect patients in Medicare Advantage. Other than appealing the denials, which takes time and energy, the hospitals’ easiest response to these denials is to not provide the care they believe their patients need since they know that some Medicare Advantage plans will not pay them for it. Hospitals that deliver care to Medicare Advantage patients that the Medicare Advantage plans don’t end up paying for have to eat the bill. In 2022, hospitals wrote off 8.5 percent of revenue. Few hospitals can afford to do that. The 8.5 percent write off is nearly 4 percent more than in 2021, when they wrote off 4.7 percent.

Last year, hospitals wrote off a total of nearly 6 percent of inpatient revenue. In 2021 they wrote off 3.6 percent of inpatient revenue.

Most people likely do not even know what a Pharmacy Benefit Manager (PBM) is. PBMs allegedly add value to your prescription drug benefit through negotiating drug discounts with pharmaceutical companies on behalf of health insurance companies. However, based on everything we know, PBMs pocket a lot of those savings or share them with the health insurance companies covering your prescription drugs and drive up your prescription drug costs.

Last week, the Senate Commerce Committee held a hearing in which members expressed tremendous frustration over potentially “anticompetitive” PBM activities that drive up costs for people. In Senator John Tester’s words: “I gotta be honest with you, the way I see the situation on PBMs I don’t know why the hell they even exist.”

The Committee is considering the Pharmacy Benefit Manager Transparency Act of 2023. The bill is designed to ensure better state and federal oversight of PBMs. Instead of bringing down drug prices for people, PBMs are putting neighboring pharmacies out of business and running away with enormous profits.

The Senators on the committee want “better transparency” as to what is going on with PBMs. That would be fine, but that won’t stop the PBMs from keeping the discounts they secure from manufacturers for themselves and not passing them along to patients.

The lack of transparency in PBMs helps them to profit. They used to work independently of health insurers, designing formularies with lower-cost drugs, steering people to generics and mail-order options. But, that all has changed dramatically. Today there are three PBMs, all owned by insurance companies, which control 80 percent of the prescription drug market. CVS Health alone controls one third of the market. Cigna controls more than a quarter of the market (26 percent). And UnitedHealthcare controls more than a fifth of the market (21 percent).

Senator Grassley pointed out that PBMs can move people to buy more expensive drugs in order to increase their profits. We have seen this with CVS Health, which has been found not to include some generic drugs in their formularies or in their drugstores as a way to get people to buy more costly brand-name drugs.

Here’s an example of how PBMs drive up costs to people. Ro-su-vas-tatin is a low-cost gener-ic drug to lower cho-les-terol. It costs a phar­ma­cy $805.40 for 90 day-sup-ply. Somehow, the PBMs make the av-er-age whole-sale price for rosvastatin $805.40 for a 90 day-sup-ply——Read More

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Dr. Timothy McAvoy, an internist from Waukesha, Wisconsin, held his infant granddaughter Tuesday while standing in the Longworth House Office Building, waiting to talk to a congressional aide about increasing Medicare pay for doctors.

Facing a highly partisan Congress where Republicans have vowed to cut federal spending, McAvoy hoped his Midwestern charm, along with a dose of supporting data, would sway members to remember physicians’ cause.

“‘Wisconsin nice’ is a real thing,” said McAvoy, who graduated from medical school in 1973. “Whether it will translate to the votes we need, we will have to see.”

McAvoy was one of about 350 physicians who came to Capitol Hill this week to lobby Congress on behalf of the American Medical Association. Although they left their white coats at home, they were still there as doctors. Their goal was to build support for the organization’s “Recovery Plan for America’s Physicians” — a wish list that includes a pay raise, relief from insurance company prior-authorization demands, and more federally funded residency slots to train more physicians.

The campaign motto packs a pat on the back for these medical professionals: “You took care of the nation. It’s time for the nation to take care of you.”

The AMA represents about 250,000 doctors, roughly a quarter of the U.S. physician workforce. And sending its members in droves to Washington to make their case is nothing new. But this was the first organized group effort in more than three years, because of the covid-19 pandemic.

In that time, many congressional offices have been claimed by new members with different legislative aides. As a result, physicians say, they need to spend in-person time teaching them about the complexities of Medicare payment rules and other topics important to the practice of medicine.

While the AMA has a full staff of lobbyists in Washington, association officials say their best weapon is often doctors themselves, who wrestle with insurance company red tape and bureaucratic reimbursement rules every day. “There is nothing quite like telling members of Congress how things work in their district,” said Dr. Jack Resneck Jr., AMA president and a dermatologist at the University of California-San Francisco.

Unable to produce Medicare, surprise ambulance bills are common

Unless you have Medicare, surprise ambulance bills continue to be a serious concern for most Americans, even Americans with health insurance. Often the local ambulance is out of network and comes with a high price tag. If you have Medicare (or Medicaid), thankfully, you should never see a surprise bill of any type.

While federal law protects people with Medicare and Medicaid against all surprise medical bills, the federal law that protects working people from surprise bills does not include bills from ground ambulance companies. People needing ambulance services are at grave financial risk. More than eight in ten ground ambulance rides are not in network.

At the moment, Congress is not addressing this issue. Rather it has established an ambulance advisory committee, which has yet to meet, as Bob Herman explains in Stat News. Some suggest that the ambulance rate should be based on Medicare’s rate of around $500. But, ambulance companies argue that rate is too low. Until Congress acts, Congress is subjecting people to unreasonable health care costs and putting them at risk. You cannot easily shop around for ambulance services.

What can you do to protect yourself against a surprise ambulance bill? The best you can do is find out from your health plan the names and phone numbers of the ambulance services in your network and post that on your fridge. If you need an ambulance and it’s not a dire emergency, you will know who to call….Read More

Senators Say Health Worker Shortages Ripe for Bipartisan Compromise

Senators are eying the growing shortage of health care workers in the United States as one of the few problems where there is room for bipartisan solutions, even in a deeply divided Congress gearing up for a presidential election cycle.

The shortage that’s only worsened since the pandemic is a prescription for skyrocketing costs, suffering, and unnecessary death, Sen. Bernie Sanders (I-Vt.), the new chairman of the Senate’s top health committee, warned in his committee’s first hearing Thursday.

“We are going to produce legislation, and I think people will be surprised about the level of bipartisan supporters,” Sanders said in a brief interview during a break from the hearing. He called for the committee to “produce something meaningful.”

The shortage of health care workers of all sorts is a widespread problem, but is especially acute in rural areas and minority communities. Sanders pointed to the startling numbers of Americans living in medical care deserts to illustrate the point. There are nearly 100 million people who don’t have easy access to a primary care physician, almost 70 million with no dentist at hand, and some 158 million people who have few local mental health providers, Sanders said.

The covid-19 pandemic contributed to the nation’s existing worker shortage as many left the workforce as the crisis worsened. Some contracted the virus themselves, and large numbers of health care providers died. An investigation by KHIN and The Guardian revealed more than 3,600 health workers in the United States died during the pandemic’s first year alone. Some got burned out or sought higher-paying jobs elsewhere.

“Despite all of our health care spending, we don’t have enough doctors, nurses, nurse practitioners, dentists, dental hygienists, pharmacists, mental health providers, and other medical professionals,” Sanders said, pointing to data that suggest the nation faces a shortfall of about 450,000 nurses and 120,000 doctors in the coming years, and 100,000 dentists now.

While Democrats and Republicans alike acknowledged the shortages hobbling care for hundreds of millions of Americans, any legislative solution must pass not only the Senate Health, Education, Labor and Pensions Committee, but also the full Senate and House of Representatives. Far-right House Republicans have threatened to go so far as forcing the federal government to default on its debts as they demand spending cuts, and high government spending on health care could make new legislation a ripe target.

Sen. Bill Cassidy of Louisiana, the committee’s top Republican who is also a doctor, cited a few programs the committee is responsible for updating this year, such as an expiring program that trains many of the nation’s pediatricians. He said funding should reflect what works in the health care system and come “with the appropriate spending offsets.”

“We have to make sure that we’re not wasting the money we’re trying to productively spend,” he said….Read More
Shopping for cataract surgery, a heart valve replacement or a colonoscopy?
You're better able these days to compare what one hospital charges against the prices at another, according to a new report from the U.S. Centers for Medicare and Medicaid Services. A majority of hospitals are now complying with U.S. federal rules that require them to post the prices of their procedures. Medicare Director Dr. Meena Seshamani wrote in a post for the journal Health Affairs. Only 27% of hospitals complied with new federal price transparency rules in 2021, but compliance leaped to 70% in 2022, Seshamani said.
However, she said more progress is required, and health care consumer advocates agree. "Our 2022 analysis showed that after two years of these requirements being in place, at least 30% of hospitals are still not fully in compliance with the regulations," Seshamani wrote. "That represents a marked improvement over the 2021 analysis, but it is not sufficient and CMS will continue working to ensure -- via technical assistance and enforcement activity -- that all hospitals fully comply with the law," she added.

**Consumer-friendly price lists**
The federal transparency rules, which went into effect in January 2021, require hospitals to provide a consumer-friendly list of at least 300 "shoppable" procedures -- non-emergency medical services for which a patient could theoretically compare prices at different facilities.
"Making health care decisions is a complex situation. A lot of the care that you seek, you're not actually shopping for it," said Lovisa Gustafsson, vice president of the Controlling Health Care Costs Program at the Commonwealth Fund. "For example, if you have a heart attack, you're not going to start looking up prices before you decide where you're going to go. An ambulance is going to take you wherever the closest facility is."
She added that services you can shop for are those where you could actually plan in advance and take the time to compare prices. "But a lot of health care is not really shoppable," Gustafsson added.

Hospitals also are required to make those prices available in a comprehensive file that anyone with a computer can download and review. The list must include information that has long been withheld from consumers -- discounted cash prices for services, prices negotiated with specific insurance companies, and the lowest and highest amounts that a hospital has charged any insurer for an item or service... Read More

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**Government lets health plans that ripped off Medicare keep money**
Medicare Advantage plans for seniors dodged a major financial bullet recently as government officials gave them a reprieve for returning hundreds of millions of dollars in government overpayments — some dating back a decade or more.
The health insurance industry had long feared the Centers for Medicare & Medicaid Services would demand repayment of billions of dollars in overcharges the popular health plans received as far back as 2011.
But in a surprise action, CMS announced last month that it would require next to nothing from insurers for any excess payments they received from 2011 to 2017. CMS will not impose major penalties until audits for payment years 2018 and beyond are conducted, which have yet to be started.
While the decision could cost Medicare plans billions of dollars in the future, it will take years before any penalty comes due. And health plans will be allowed to pocket hundreds of millions of dollars in overcharges and possibly much more for audits before 2018. Exactly how much is not clear because audits as far back as 2011 have yet to be completed.
In late 2018, CMS officials said the agency would collect an estimated $650 million in overpayments from 90 Medicare Advantage audits conducted from 2011 to 2013, the most recent ones available. Some analysts calculated overpayments to plans of at least twice that much for the three-year period.
CMS is now conducting audits for 2014 and 2015. The estimate for the 2011-13 audits was based on an extrapolation of overpayments found in a sampling of patients at each health plan. In these reviews, auditors examined medical records to confirm whether patients had the diseases for which the government reimbursed health plans to treat.
Through the years, those audits — and others conducted by government watchdogs — have found that health plans often cannot document that they deserved extra payments for patients they said were sicker than average.
The decision to take earlier audit findings off the table means CMS has spent tens of millions of dollars conducting audits as far back as 2011 — much more than the government will be able to recoup.
In 2018, CMS said it pays $54 million annually to conduct 30 of the audits. Without extrapolation for years 2011-17, CMS won’t come near to recouping that much... Read More

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**Don’t rely on Mark Cuban’s Cost Plus Drugs for the lowest prices**
I promoted Mark Cuban’s Cost Plus Drugs a while back as a way to get low-cost generics. As it turns out, Darius Tahir reports for Kaiser Health News that Cost Plus Drugs does not always offer the lowest prices. Bottom line, if you have Medicare Part D, you should shop around if you want the lowest prices on your drugs.
Cost Plus Drugs now offers more than 1,000 prescription drugs. But, it does not manufacture them. So, your local pharmacy could offer the drugs you need at lower prices. You can also check PharmacyChecker.com for low-cost drugs around the world.
Cost Plus Pharmacy negotiates prices. And, then it is charging you a 15 percent markup from the manufacturer’s price, plus $3.00 for labor for each medicine and then a flat $5 fee to ship as many drugs as you order.
In a cost comparison of drugs beginning with the letter A, Kaiser Health News (KHN) found Cost Plus Pharmacy did not offer the lowest drug price for residents of Washington DC most of the time. But, sometimes it offered massive savings. One expensive drug, aprepitant, an anti-nausea medicine, was nearly $1,000 less through Cost Plus Drugs than through GoodRx, $4,815.30 v. $5,740.
Cost Plus Drugs is really taking out a lot of the PBM (Pharmacy Benefit Manager) and pharmacy markups, since it replaces the PBM as the middleman. Amazon and Walmart are also offering a bunch of low-cost generic drugs.
Cost Plus Drugs is not a pharmacy but uses Truepill, a mail-order pharmacy. Bottom line, you Part D drug coverage should offer you some savings on some drugs, particularly brand-name drugs. But, don’t count on it to give you the lowest out-of-pocket costs. The copays can be higher than the total cost of your drugs through Costco or Cost Plus Drugs, at least for now.
The good news, if you take a lot of drugs, is that beginning in 2026, you will not pay more than $2,000 in total for your prescription drugs on formulary through your Part D drug plan. That is one of the big benefits of the Inflation Reduction Act passed in 2022.

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Independent vs. Senior Living: Understanding the Pros and Cons

Explore the contrast between independent living and senior living communities. Learn if independent living is right for you and what senior living entails.

The difference between “independent living” and “living independently” is more than just grammatical; the two terms have distinct meanings for older adults. Living independently simply entails continuing on as always in your own home. Independent living, on the other hand, represents a choice within the range of senior living communities.

If you’re considering a move to independent living – with the amenities, convenience and sense of togetherness it offers – read on as experts in geriatric care and senior life describe what it entails and where it fits among senior living community options.

Types of Senior Living Residences

- **Independent living.**
- **Assisted living.**
- **Group homes.**
- **Memory care.**
- **Continuing care retirement.**

**Community.** “Senior living is kind of an umbrella, more of an overarching term that incorporates the aspects of independent living, assisted living and memory care primarily,” says Kevin Bowman, former executive vice president of community operations at Brookdale Senior Living, the largest senior living provider in the U.S.

Traditional nursing home facilities, however, tend to fall outside the senior community realm. “Sometimes we think of skilled nursing as a bit separate, as some senior living providers don’t provide skilled nursing services,” says Bowman.

Here are basic categories of senior residence types, with some overlap among them:

**Independent living**
For active older adults with little to no need for personal care or assistance, independent living settings such as apartments or villas offer meals, services, activities and social gathering sites that promote ease, convenience and a sense of community for residents. There may be an on-site or on-call health care provider available.

**Assisted living**
For older adults with health or mobility issues requiring more support, assisted living residences offer services such as medication management and assistance with personal activities and activities of daily life, including toileting, grooming and dressing. These facilities may also provide meals, housekeeping, laundry and transportation. Activities that foster mental and physical stimulation and social engagement are a major focus in assisted living.

**Group homes**
Also known as adult family homes, these relatively small residences are located in regular neighborhoods. Licensed caregivers provide meals and assistance with personal activities like hygiene and dressing for about six to 10 older adults, who tend to have some level of cognitive impairment. Often, these are single-level homes, which make mobility easier and help residents avoid fall risks from stairs.

**Memory care**
Memory care may be necessary for older adults with cognitive impairment or dementia. Safety and security are a paramount concern in memory care residences. Staff or team members undergo additional training and development to work with these residents and provide tailored activities and programs to connect with them wherever they are cognitively and emotionally day to day.

**Continuing care retirement community**
Also known as life plan communities, CCRCs represent a specific product line encompassing a spectrum of residence and care levels. These can range from independent living through assisted living, memory care and skilled nursing facilities. CCRCs represent a significant financial investment, typically requiring an upfront membership fee known as a buy-in… Read More

Proposed Medicare Advantage Changes Cannot Accurately Be Called ‘Cuts,’ Experts Say

More than 60 million people rely on Medicare for health coverage, and raising the alarm about potential cuts to the program is a perennial talking point among both Republicans and Democrats.

On Feb. 6, Sen. Tom Cotton (R-Ark.) took a swing at President Joe Biden on Twitter after Biden tweeted that House Republicans were threatening to cut Social Security and Medicare.

“It’s President Biden who is proposing to cut Medicare Advantage, a program used by almost 4 in 10 Arkansas seniors,” Cotton wrote.

It wasn’t clear from Cotton’s tweet which Biden proposal he was referring to, and his office did not respond to requests for comment.

**Medicare Advantage** policies, administered through Medicare-approved private insurance companies, bundle the traditional Medicare program’s separate hospital, medical, and prescription drug coverage into one plan. The plans are optional and can lower out-of-pocket costs while offering other benefits, including vision and dental services, that are not included in the original Medicare program.

About 28 million people, or nearly half of those eligible for Medicare, were enrolled in Medicare Advantage plans in 2022, according to KFF.

The Centers for Medicare & Medicaid Services recently announced two proposed changes that could affect Medicare Advantage insurers:

- One is a rule change, set to take effect April 3, that’s intended to increase the government’s ability to audit Advantage’s risk adjustment model, which determines how much the government pays insurers for beneficiaries’ reported health conditions. Health care policy experts said it is most likely that Cotton’s tweet was referring to the rule change intended to increase the government’s ability to recover overpayments. The rule change would return billions of dollars to the federal government and is likely to reduce private insurers’ profits, though experts say the reductions would be minimal compared with overall spending.

Those companies might, in turn, increase enrollees’ out-of-pocket costs or reduce benefits, experts said. But it is unclear if that will happen.

Meanwhile, the second change — an annual update to the rates paid to Medicare Advantage insurers — will reduce payments to Medicare Advantage insurers. But the reductions will be offset by other program modifications that are projected to yield a 1% increase in Medicare Advantage spending per person in 2024.

A group that lobbies for Medicare Advantage plans sent a memo to lawmakers that said proposed changes would affect 30 million beneficiaries. Politico reported.

What Is the Proposed Rule Change to Medicare Advantage?… Read More
You're in your doctor's office, and the nurse checks your blood pressure as a matter of course. But your numbers are high, and the doctor steps in with some advice, and possibly a prescription for medications that can lower it.

So, now that you have high blood pressure, what is it and what can you do about it?

The American Heart Association (AHA) describes blood pressure as the measure of the force pumping blood through the arteries, which carry blood from the heart throughout the body.

Measured by two numbers, the top number (the systolic pressure) is the force of the blood when your heart pumps, and the bottom number (diastolic pressure) is when your heart is resting and filling with blood.

Normal blood pressure can vary from individual to individual, and it can rise and fall throughout the day, said Dr. Michael Blaha, a Johns Hopkins cardiologist. He recommends regularly measuring blood pressure at home and keeping track of trends. Generally, blood pressure is considered healthy when it is 120/80 or less.

"As a physician, I'm much more interested in what a patient's blood pressure looks like at home, under their normal conditions, than what it looks like at a single point in time in my office," Blaha said. "Knowing your blood pressure over time best helps your doctor identify whether you have a problem."

What is high blood pressure?

High blood pressure, or hypertension, is when the force of blood flow remains consistently elevated.

The AHA considers high blood pressure to be any reading that is 130/80 or higher. If your blood pressure reaches 180/120 or higher, you are in a hypertensive crisis and you should call your doctor immediately.

Prolonged and uncontrolled blood pressure can damage blood vessels leading to complications like heart disease, stroke, kidney failure and problems with vision.

What causes high blood pressure?

Many things can cause high blood pressure. Chronic hypertension usually develops over time due to poor diet, lack of regular exercise, smoking, too much alcohol, obesity and uncontrolled diabetes, according to the AHA.

Stress and anxiety also play a role in elevating blood pressure. In certain cases, hypertension can happen during pregnancy, causing life-threatening conditions: preeclampsia, eclampsia and stroke. Dr. Sara Hallum of the University of Copenhagen said this can increase women's risk of early-onset heart disease.

Symptoms of high blood pressure

Nearly half of the adult American population has high blood pressure and is unaware that damage is being done, according to the AHA. Although the risk for high blood pressure increases with age, Dr. Rita Melkonian told HealthDay News that it can also occur at younger ages in women. There are usually no signs or symptoms, hence its nickname of "the silent killer." Melkonian said the best way to determine blood pressure status is to have it checked by a health care professional.

High blood pressure medications

There are many ways to lower high blood pressure. Johns Hopkins lists lifestyle changes as the first line of defense.

- Adding physical activity — at least 30 minutes, five days per week — is recommended
- Incorporating the DASH diet, a high blood pressure diet that lowers salt while increasing consumption of fresh fruits, vegetables and whole grains
- Quitting smoking
- Limiting or avoiding alcohol
- Losing weight

U.S. Deaths Involving Meth Are Skyrocketing, Fentanyl a Big Factor

Deaths from methamphetamine among Americans increased 50-fold between 1999 and 2021, a chilling new study reports.

Most of these deaths also involved heroin or fentanyl, according to researchers.

"The staggering increase in methamphetamine-related deaths in the United States is largely now driven by the co-involvement of street opioids," said lead researcher Rachel Hoopsick, an assistant professor of epidemiology at the University of Illinois at Urbana-Champaign.

"Mixing methamphetamine and opioids isn't a new phenomenon," she said. "Although there has been an increase in the popularity of using these types of substances together, what has truly changed is the toxicity of the unregulated street drug supply, predominantly of fentanyl and other synthetic opioids. I believe that this is the primary driver of the increase in deaths."

But that's not the only factor that contributes to fatal meth overdoses, Hoopsick added. Methamphetamine overdose can be hard to recognize. While many people can recognize the signs of an opioid overdose, the signs of meth overdose are variable in terms of presentation and severity. That may contribute to the likelihood of a fatal overdose.

Signs of a meth overdose include anger, aggressiveness and restlessness; confusion; dark urine; dizziness and fainting; fast breathing; irregular heartbeat; muscle cramps, pain or stiffness; seeing, hearing or feeling things that are not there; seizures; sweating; tremor; unusual tiredness or weakness; stomach cramps and vomiting, according to the Mayo Clinic.

Hoopsick doubts the epidemic of drug deaths in the United States will abate anytime soon. "Humans have been using substances for longer than we have historical records," she said. "A number of behavioral studies suggest that methamphetamine use is increasing in the United States, particularly among people who use other substances," Hoopsick said. "Yet, the more strict our policies become around illicit drugs, the more deadly the unregulated supply becomes.

When there aren't safe, regulated sources of substances for people to use, it fuels organized crime and the development of more potent street drugs, particularly illicitly manufactured fentanyl." ...Read More
Irregular Heartbeat: What Is It and How Do You Treat It?

Many things can make your heart skip a beat — the words to a song, a case of the nerves or a near car accident — but these temporary palpitations aren’t usually cause for concern.

But much more serious, and sometimes deadly, things can throw off the heart’s rhythm, including dehydration, a history of heart disease or a heart defect. Medications, intense exertion or anxiety can also trigger heart rhythm changes, or arrhythmias. According to Dr. Mark Anderson of Johns Hopkins University in Baltimore, “the heart’s system is not unlike the electrical system in a car,” which helps the car run properly. The electrical pulses keep the heart’s rhythm smooth and even, he explained in a recent article.

But when the electric signals that control the pace of your heartbeat malfunction, that is a heart arrhythmia, according to the American Heart Association (AHA).

What is heart arrhythmia?
Arrhythmias can feel like flutters or butterflies in your chest or that your heart is racing or pounding. Heart arrhythmias can also cause the heart rhythm to slow down or skip. Most of the time, they are harmless, but they can signify something more serious.

What are the types of heart arrhythmia?
The Mayo Clinic groups heart arrhythmias into two main types, tachycardia (faster heartbeats) and bradycardia (slower heartbeats).

Types of tachycardia
Atrial fibrillation (a-fib) is one of the most common types of arrhythmia. According to the U.S. Centers for Disease Control and Prevention, more than 12 million people will experience a-fib by 2030. It is described as a rapid, chaotic heartbeat and is associated with an increased risk of blood clots and stroke. Atrial flutter is like a-fib. It starts with an electrical short-circuit in the upper heart chamber. The heartbeats are rapid, but not chaotic like with a-fib. It is also associated with an increased risk of stroke.

Supraventricular tachycardia (SVT) is categorized as a sudden pounding of the heart. It is an umbrella term for arrhythmias that start above the lower heart chambers. SVT can also lead to serious complications such as stroke and other heart diseases.

Ventricular fibrillation is a heart rhythm issue in the heart’s lower ventricles. It is a misfire in the electrical signals of the heart that cause the ventricles to flutter randomly. If normal heart rhythm is not restored, it can lead to death. Ventricular fibrillation is most found in those with underlying heart disease or those who have experienced trauma. Ventricular tachycardia is also due to defective electrical pulses in the heart’s lower ventricles. It is usually harmless for people with healthy hearts, but it can be life-threatening for a heart already weakened by heart disease.

Types of bradycardia
Sick sinus syndrome is due to defective sinus nodes. The sinus nodes are the natural pacemakers in the heart. Heart rhythms will beat too quickly or, more commonly, too slowly when malfunctioning.

Conduction block is a heart rhythm condition caused by a breakdown in the flow of the electrical pulses that make the heart pump. The blockage slows the heart rate because the messages of when to pump and contract are not coming on time…. Read More

Spinal Cord Stimulation Gives Big Boost to Arm Function After Stroke

It’s a brutal reality that confronts many recovering stroke patients: After six months or so of rehab, any arm and hand movement not yet restored is unlikely to return.

But new cutting-edge research aims to use electrical stimulation to jumpstart stroke-interrupted communication between the brain and the spinal cord, restoring lost motor control. The technique is already widely used as a treatment for chronic pain.

Preliminary testing in patients who have had moderate to severe strokes suggests it can return significant arm and hand function to patients who, in some cases, haven’t had any upper limb control in years.

"Most of the time [stroke patients] get physical therapy, improve a little bit, and then remain with permanent deficits which are considered chronic," said study author Marco Capogrosso, an assistant professor of neurological surgery at the University of Pittsburgh. "For such patients, "no additional therapy seems to be beneficial," he said.

Capogrosso and his colleagues spoke about their work at a news briefing Feb. 15, ahead of publication of their research in the current issue of Nature Medicine.

Stroke is the largest cause of paralysis in the world, Capogrosso said at the briefing. In the United States alone, he noted, roughly half of the 800,000 Americans who experience a stroke each year are left "with permanent motor deficits."

But Capogrosso and his colleagues saw potential for a therapeutic breakthrough. That's because even though stroke often weakens communication between the brain and the spinal cord, it is not cut off completely.

With that in mind, the researchers set out to use electrical stimulation in order to "leverage and amplify" the stroke -diminished signaling, he said.

Initial testing focused on two patients with chronic loss of hand and arm movement: a 31-year-old woman who suffered five strokes at the age of 22, and a 47-year-old woman.

Each was outfitted with an array of thin electrode wires that "kind of look like a spaghetti noodle," said study author Douglas Weber, a professor of mechanical engineering at Carnegie Mellon University, in Pittsburgh.

In what Weber described as a "minimally invasive" process, the electrodes were inserted by needle into each patient's back, and placed "at the point where the sensory nerves from the limb enter the spinal cord."

Then, for a couple of hours a day, five days a week over one month investigators delivered a series of controlled but continuous electric pulses into targeted nerve cells in each patient's spinal cord, said co-author Elvira Pirondini of Rehab Neural Engineering Labs at the University of Pittsburgh.

Capogrosso, Weber and Pirondini said the stimulation technique produced almost immediate improvements in both arm and hand strength and function.

For example, Capogrosso said both patients were newly able to do previously difficult tasks, such as opening a lock, eating with utensils, or grasping and holding objects…. Read More

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A person seeing a barely noticeable tremor in one hand could be witnessing the first signs of Parkinson's disease. This progressive condition affects the nervous system, according to the Mayo Clinic in Rochester, Minn., which offers information about the disease. While tremors are common, Parkinson's can also cause stiffness or slow movement.

Medications can significantly improve a person's symptoms. While the disease can't be cured, surgery may help regulate certain regions of the brain and improve symptoms.

In early stages, a person's face may show little or no expression. Arms may not swing when someone walks. Speech may become soft or slurred. Symptoms can worsen as the condition progresses.

They often begin on one side of the body. Typically, they are worse on that side, even after the condition begins affecting limbs on both sides.

The Mayo Clinic offers additional information on the classic symptoms. Tremor, or rhythmic shaking, typically begins in the hand or fingers. A person may rub their thumb and forefinger back and forth. This is known as a pill-rolling tremor. The hand may also tremble when it's at rest, but that may decrease when a person is doing tasks.

Another common symptom is slowed movement, also called bradykinesia. This is seen when simple tasks become more difficult: Steps may be shorter, it's difficult to get out of a chair, or there's dragging or shuffling feet when walking.

Muscle stiffness can occur in any part of the body, may limit range of motion and can be painful. Posture may become stooped, and a person with Parkinson's disease may fall or have balance problems.

It may become more difficult to blink, smile or swing arms. Speech can also change, becoming softer, quicker, slurred or hesitant. A monotone may develop, according to the Mayo Clinic.

Handwriting may appear smaller and it can become harder to write.

It's important to see a doctor if you or a loved one has any of those symptoms to get a diagnosis or rule out other causes, the Mayo Clinic urges.

### Dine Your Way to Lower Cancer Risk

Having the information to make good food choices and being physically active can help prevent disease, including cancer.

Ahead of National Nutrition Month in March, the Academy of Nutrition and Dietetics offers some tips for Americans who want to improve their nutrition.

"Fruits, vegetables and whole grains provide you with nutrients and dietary fiber that can help lower your risk of developing cancer in the long term," said Amy Bragagnini. She is a registered dietitian nutritionist and oncology nutrition specialist who serves as national spokeswoman for the Academy of Nutrition and Dietetics.

"Eating a variety of foods from all food groups keeps your meals interesting and healthful. Fresh, frozen, canned or dried fruits and vegetables all make your meal preparations easy," Bragagnini said.

She recommends filling half of your plate with fruits and veggies at each meal. "Add fresh berries to your low-fat or fat-free yogurt in the morning. Eat a dark green leafy kale salad for lunch. Stir fry some spinach, broccoli and cabbage to add atop a bed of riced cauliflower for dinner," Bragagnini suggested. Getting in more legumes — such as beans, peas and lentils — can also add nutrition. She suggests adding black beans to an omelet and using a carrot stick as an edible spoon with hummus for a snack. A big pot of chili or lentil soup can be a healthy dinner.

Making sure whole grains are also in meals is important. This can include a warm bowl of oatmeal with dried fruit for breakfast, a whole grain barley bowl with baked chicken for lunch and a whole wheat roll with dinner.

While making all these additions, there are some foods that it's better to subtract. Bragagnini suggests replacing red and processed meats with a tuna salad at lunch time, a grilled chicken breast at dinner or having a meatless meal, such as a whole wheat pasta primavera.

Also limit the amounts of added sugars and saturated fat, information that can be found on a packaged food's label. A registered dietitian nutritionist can help you develop a nutrition and physical activity plan that meets your health goals, now and throughout life, she said.

### Understanding the Stroke-Depression Link – And What Survivors and Families Can Do

News that one of America's best-known stroke survivors was being treated for depression highlights a common and serious connection between the two afflictions.

Last May, Sen. John Fetterman made national headlines after his near-fatal stroke. On Thursday, his staff announced he had checked into a hospital for depression. He'd experienced depression off and on throughout his life, but it had worsened in recent weeks.

The prepared statement did not explicitly link his stroke with depression. But depression commonly follows stroke, and it is important for patients, caretakers and physicians to be aware of the connection, said Dr. Ricardo Jorge, professor of psychiatry and behavioral sciences at Baylor College of Medicine in Houston. "Stroke not only brings about physical changes and physical impairment but also psychological or behavioral impairment, and these need to be recognized," said Jorge, who also holds the college's Beth K. and Stuart C. Yudofsky Chair in Brain Injury Medicine.

According to a 2016 American Heart Association scientific statement that Jorge helped write, poststroke depression affects about a third of stroke survivors at any one time, although he said estimates vary based on how depression is defined. The likelihood is greater during the first year after a stroke and slowly declines after.

Dr. Nada El Husseini, an associate professor of neurology at Duke University in Durham, North Carolina, said that over time, up to half of stroke survivors may experience depression at some point.

The best-established predictors for poststroke depression include a previous history of depression and the stroke's severity, said El Husseini, who also helped write the 2016 statement. Significant physical disability and cognitive impairment also "go hand in hand" with poststroke depression risk. Depression that happens after a stroke is similar in many ways to depression without a stroke, she said. "It may manifest as a sense of sadness, hopelessness, feeling unworthy, having guilty feelings over minor things or having little interest or pleasure in doing things." A person with depression might have difficulty concentrating, have little energy, become fidgety, or might not want to eat or might eat too much. They might not be able to sleep or might sleep too much. They might contemplate suicide. Symptoms typically must occur at least several days over two weeks to qualify as depression... Read More
While people with type 1 diabetes can see some benefit from newer medications prescribed off-label, there is also risk, and these patients should be monitored closely, according to a new study. Type 1 diabetes is universally treated with insulin injections, but only about one-fifth of patients achieve blood sugar control with it, the study authors noted.

So, doctors are increasingly prescribing medications known as glucagon-like peptide-1 receptor agonists (GLP-1RAs) and/or sodium-glucose cotransporter-2 inhibitors (SGLT2is) for these patients.

An autoimmune disease, type 1 diabetes destroys insulin-producing cells in the pancreas. About 1.5 million Americans have the condition.

In people with type 1 diabetes, their cells can’t take in glucose on their own, which can lead to dangerously high blood sugar levels that can cause diabetic coma, blindness, neuropathy and an emergency condition called diabetic ketoacidosis, in which the blood becomes dangerously acidic.

Both classes of these off-label medications have helped decrease heart disease risk and kidney events in people with type 2 diabetes, while promoting weight loss. Those benefits could also help type 1 patients, but the risks and benefits haven’t been fully assessed, the study authors explained.

The medications have also been associated with increased risk of severe hypoglycemia (low blood sugar) and diabetic ketoacidosis when used in patients with type 1 diabetes.

To study this, the researchers searched medical records for type 1 diabetes patients treated at UT Southwestern Medical Center in Dallas who had used any GLP-1RAs and/or SGLT2is for at least 90 days.

The investigators found 104 patients: 65 who had used GLP-1RAs exclusively; 28 who had used SGLT2is exclusively; and 11 who had used both together or sequentially.

After a year of use, patients on GLP-1RAs had significant reductions in weight, glycated hemoglobin A1C (which is a three-month-average measure of blood sugar) and total daily dose of insulin.

The SGLT2i users had significant reductions in hemoglobin A1C and basal insulin, a dose delivered outside of meals.

The SGLT2i users were about three times more likely than GLP-1RA users to experience diabetic ketoacidosis, the researchers found.

Slightly over 25% of patients taking either class of drugs stopped due to side effects such as gastrointestinal problems. "These findings, from our real clinic experience, show both benefits and some risk to patients with type 1 diabetes who take these medications in addition to insulin treatment," study leader Dr. Ildiko Lingvay said in a university news release. She’s a professor of internal medicine at UT Southwestern.

While the study results showed that both drugs can benefit patients with type 1 diabetes, the authors urged close monitoring. They recommended extreme caution when using SGLT2is, selecting patients with the lowest diabetic ketoacidosis risk and offering them detailed education about that risk.

"When viewed holistically at the person level, all of these small changes can add up to substantial overall clinical benefits, especially considering that improving glycemic control in patients with long-standing [type 1 diabetes] can be challenging," the researchers concluded.

COVID Vaccine Bonus: Lower Heart Attack Risk If You Get Infected

A COVID-19 shot may protect a person from more than the virus alone, new research suggests.

Researchers from the Icahn School of Medicine at Mount Sinai in New York City linked vaccination with fewer heart attacks, strokes and other cardiovascular issues among people who later got COVID-19.

The investigators described their study as the first to examine both full and partial vaccination and the link to major adverse cardiac events (MACE) in the United States. It confirmed similar analyses done using the Korean COVID-19 registry.

For the study, the researchers used data from a national database of more than 1.9 million COVID-19 patients. Nearly 218,000 had received mRNA vaccines made by Pfizer-BioNTech or Moderna or viral vector technology from Johnson & Johnson.

"We sought to clarify the impact of previous vaccination on cardiovascular events among people who develop COVID-19 and found that, particularly among those with comorbidities, such as previous MACE, type 2 diabetes, high cholesterol, liver disease and obesity, there is an association with a lower risk of complications," said senior study author Dr. Girish Nadkarni. He is a professor of medicine at the Icahn School and director of the Charles Bronfman Institute of Personalized Medicine.

"While we cannot attribute causality, it is supportive evidence that vaccination may have beneficial effects on a variety of post-COVID-19 complications," Nadkarni said in a Mount Sinai news release.

The study findings were published Feb. 20 in the Journal of the American College of Cardiology.

The research is also scheduled for presentation in New Orleans on March 5 at a joint conference of the American College of Cardiology and World Heart Federation.

"To our surprise, even partial vaccination was associated with lower risk of adverse cardiovascular events," said first study author Joy Jiang, an MD/PhD candidate in Nadkarni’s lab.

"Given the magnitude of SARS-CoV-2 infection worldwide, we hope our findings could help improve vaccination rates, especially in individuals with coexisting conditions."

GOOD NEWS ABOUT THE BRAIN OF AN ELDERLY PERSON

The director of the George Washington University School of Medicine argues that the brain of an older person is much more practical than is generally believed. At this age, the interaction of the right and left hemispheres of the brain becomes harmonious, which expands our creative possibilities. This is why among people over 60 you can find many personalities who have just started their creative activities.

Of course, the brain is not as fast as it was in youth. However, it becomes more flexible. As a result, with age we are more likely to make the right decisions and we are less exposed to negative emotions. The peak of human intellectual activity occurs around the age of 70, when the brain begins to function fully.

Over time, the amount of myelin in the brain increases, a substance that facilitates the rapid passage of signals between neurons. As a result, intellectual capacity increases by 300% over the average.

It is also interesting to note that after the age of 60, a person can use two hemispheres at the same time. This allows you to solve much more complex problems. Professor Monchi Uri, from the University of Montreal, believes that the brain of the elderly chooses the path that consumes the least energy, eliminates the unnecessary and leaves only the appropriate options to solve the problem. A study was conducted in which different age groups participated. The young people were very confused when they passed the tests, while the over 60s made the right decisions. Read More
Bad Sleep Can Raise Heart Risks for Seniors

Sticking to a consistent sleeping routine may help keep your arteries clear as you age, new research suggests.

Conversely, older adults who slept for a varying number of hours each night and tended to fall asleep at different times were more likely to develop hardening of the arteries, which can lead to heart attack or stroke, the researchers reported.

"Sleep is super important to our overall health and well-being, and anything we can do to improve sleep will improve our [heart health] and overall well-being and happiness," said study author Kelsie Full. She is an assistant professor of medicine in the division of epidemiology at Vanderbilt University Medical Center in Nashville, Tenn.

The study wasn't designed to show how sleep irregularity causes heart disease, but researchers have some theories. "One potential mechanism is that sleep irregularity may lead to a disruption of our circadian function, which can lead to inflammation, a known risk for heart disease," Full said. (Circadian rhythm is the 24-hour internal clock that controls the release of the hormone melatonin to encourage sleep.) What's more, irregular sleep patterns may also travel with unhealthy behaviors such as late-night eating, poor diet or lack of exercise, she noted.

Her advice? "Set a regular bedtime, and just pay attention to how much you are sleeping each night, and strive for sleep that is as regular and routine as possible," she said.

If you really struggle with sleep, bring it up with your doctor. "You may have an underlying sleep disorder that needs further treatment," Full said.

For the study, researchers monitored sleep in more than 2,000 adults (average age, 69) for one week. People wore watch-like devices that detected when they were asleep and awake. They also completed a sleep diary for seven consecutive days and did an in-home sleep study to check for underlying sleep disorders. No one in the study had been diagnosed with heart disease.

Sleep duration was defined as the total amount of time spent in bed fully asleep, while sleep timing was described as the time a person falls asleep each night.

Lifelong Bachelors Fare Worse When Heart Failure Strikes

When heart failure strikes, being a lifelong bachelor may mean you might die sooner than women or previously married men diagnosed with the same condition, a new study suggests.

Lifetime marital history appears to be an important predictor of survival in men with heart failure, but not women. Specifically, lifelong bachelors had significantly worse long-term survival than men who had been married, separated, divorced or widowed, said senior researcher Dr. David Kao, an associate professor of medicine at the University of Colorado School of Medicine in Aurora.

In contrast, women with heart failure who had never been married did not appear to be at higher risk of death than those who had, he added.

"These findings suggest that marriage has some kind of beneficial effect for men that helps them survive longer after developing heart failure," Kao said. "At present, we have not identified precisely what these effects are, but they could include health-seeking behaviors, socioeconomic and family support in older age, or differences in factors like frailty and nutrition, and mood."

The lack of difference in survival between women with different marital histories could indicate that either the same factors are not as clinically beneficial in women or possibly that there are fewer deficits in those traits that are affected through marriage, Kao said.

With heart failure, the heart becomes too weak or stiff to pump blood to the body effectively. There is no cure for heart failure, but medications, dietary modifications and regular physical activity can help patients live longer and reduce symptoms such as shortness of breath, fatigue and swelling.

For the study, Kao's team used data on 6,800 American adults aged 45 to 84. Among the 94 participants who suffered from heart failure at year 10 of the study, the researchers compared survival rates from when heart failure was diagnosed and marital status over an average follow-up of five years.

The investigators found that men who had never been married were more than twice as likely to die within roughly five years after diagnosis than women of any marital status.

Lifelong bachelors were about two times more likely to die than men who were married. Moreover, widowed, divorced or separated men were not at an increased risk of dying, compared with married men, the researchers noted.

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