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More Than 2,900 Health Care Workers Died This Year — And the Government Barely Kept Track

More than 2,900 U.S. health care workers have died in the COVID-19 pandemic since March, a far higher number than that reported by the government, according to a new analysis by KHN and The Guardian.

Fatalities from the coronavirus have skewed young, with the majority of victims under age 60 in the cases for which there is age data. People of color have been disproportionately affected, accounting for about 65% of deaths in cases in which there is race and ethnicity data. After conducting interviews with relatives and friends of around 300 victims, KHN and The Guardian learned that one-third of the fatalities involved concerns over inadequate personal protective equipment.

Many of the deaths — about 680 — occurred in New York and New Jersey, which were hit hard early in the pandemic. Significant numbers also died in Southern and Western states in the ensuing months.

The findings are part of "Lost on the Frontline," a nine-month data and investigative project by KHN and The Guardian to track every health care worker who dies of COVID-19.

One of those lost, Vincent DeJesus, 39, told his brother Neil that he'd be in deep trouble if he spent much time with a COVID-positive patient while wearing the surgical mask provided to him by the Las Vegas hospital where he worked. DeJesus died on Aug. 15.

Another fatality was Sue Williams-Ward, a 68-year-old home health aide who earned $13 an hour in Indianapolis, and bathed, dressed and fed clients without wearing any PPE, her husband said. She was intubated for six weeks before she died May 2.

"Lost on the Frontline" is prompting new government action to explore the root cause of health care worker deaths and take steps to track them better. Officials at the Department of Health and Human Services recently asked the National Academy of Sciences for a "rapid expert consultation" on why so many health care workers are dying in the U.S., citing the count of fallen workers by The Guardian and KHN.

"The question is, where are they becoming infected?" asked Michael Osterholm, a member of President-elect Joe Biden's COVID-19 advisory team and director of the Center for Infectious Disease Research and Policy at the University of Minnesota. "That is clearly a critical issue we need to answer and we don't have that."

The **Dec. 10 report** by the national academies suggests a new federal tracking system and specially trained contact tracers who would take PPE policies and availability into consideration.

Doing so would add critical knowledge that could inform generations to come and give meaning to the lives lost….**Read More**

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Biden has power to authorize free Medicare for everyone

President-elect Biden could guarantee everyone in the US affordable healthcare if he wanted to. David Dayen writes for **The American Prospect** that, because of the pandemic, a Biden administration–without Congress–has the power to ensure everyone in the country free health care coverage through Medicare. Will Biden have the courage to act and save millions of lives in the process?

Dayen reports that the Social Security Administration and the Department of Health and Human Services have the authority to give people Medicare for free during the pandemic. A provision in the Affordable Care Act allows this coverage for all people who are subject to an "environmental exposure." Consequently, the COVID-19 pandemic could make everyone in the country eligible for Medicare, if the incoming administration chose to exercise its authority to do so.

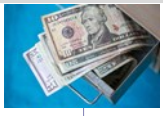
Congress might not be planning to enact Medicare for All any time soon. But, in a real way, **Section 1881A of the Social Security Act** specifically confers the authority on the administration to put in place Medicare for all who want it. Today, more than 2,500 people of Libby, Montana have free Medicare. These people have Medicare because they were exposed to an environmental hazard that could lead to medical issues. So, the federal government is covering their medical costs.

It's hard to imagine that President-elect Joe Biden will use this power even in a limited way to provide Medicare to millions of Americans with COVID-19 or who have tested positive for COVID and who otherwise might not be able to afford needed care during this pandemic. But, the ACA provides his administration the authority to establish "optional pilot programs" throughout the country, because of President Trump's public health emergency declaration. Individuals can then choose to apply for Medicare benefits. They will meet the criteria so long as they are in the middle of a "public health hazard to which an emergency declaration applies . . ." There is nothing to stop HHS from establishing such a pilot program.

Indeed, HHS could establish the program for everyone in the country, as everyone is at risk of COVID. Cost of testing and treatment should not impede people's access to care and would promote the public health. And, Biden has said that he supports free coronavirus treatment and a free vaccine.

What's more radical: Giving everyone free Medicare or letting tens of thousands of Americans die because the federal government did not do so?

New stimulus package versus CARES Act: What's different this time?



After weeks of back and forth, Congress has approved a new **$900 billion stimulus package** to follow up the CARES Act from March, which included a $1,200 stimulus check, $600 in weekly federal unemployment insurance and a raft of other benefits. However, the new stimulus bill comes in at less than half of the budget, reducing many of the benefits of the original CARES Act.

For example, a **second stimulus check** would provide a fraction of the **amount for qualified Americans** (a **$600 maximum** per **adult**, going to fewer households). And the **weekly federal unemployment benefit** is cut in half at $300 extra per week, for far fewer weeks. The same goes for **eviction protections** and other programs.

The **$900 billion stimulus bill** is seen as a short-term relief package until early 2021, where **President-elect Joe Biden** and his administration are expected to **introduce yet another stimulus package** to address some of what the $900 billion bill leaves out.

While we wait for President Donald Trump to sign it into law, let's dig into the key aspects of each proposal, showing how they're similar, and exploring all the differences. This story has been updated with new information.

Read more: **Calculate your second stimulus check total now**

Surprise! Congress Takes Steps to Curb Unexpected Medical Bills

Most Americans tell pollsters they're worried about being able to afford an unexpected medical bill.

Late Monday, Congress passed a bill to allay some of those fears. The measure is included in a nearly 5,600-page package providing coronavirus economic relief and government funding for the rest of the fiscal year.

Specifically, the legislation addresses those charges that result from a long-running practice in which out-of-network medical providers — from doctors to air ambulance companies — send insured Americans "surprise bills," sometimes for tens of thousands of dollars.

The legislation itself was a bit of a surprise, coming after two years of debate that featured high-stakes lobbying by all who stood to gain or lose: hospitals, insurers, patient advocacy groups, physicians, air ambulance companies and **private equity firms**, which own a growing number of doctor practices. A similar effort failed at the last minute a year ago after intense pressure from a range of interests, including **those private equity groups.**

This time around, no group got everything it wanted. Lawmakers compromised — mainly over how to determine how much providers will ultimately be paid for their services.

"No law is perfect," said **Zack Cooper**, an associate professor of public health and economics at Yale who studies health care pricing. "But it fundamentally protects patients from being balance-billed," he said, referring to out-of-network medical providers billing patients for amounts their insurer did not cover. "That's a remarkable achievement."

The bottom line: Patients may still be surprised by the high cost of health care overall. But they will now be protected against unexpected bills from out-of-network providers.

Here's a rundown on what this legislation means for consumers:

Fewer Surprise Bills

Starting in 2022, when the law goes into effect, consumers won't get balance bills when they seek emergency care, when they are transported by an air ambulance, or when they receive nonemergency care at an in-network hospital but are unknowingly treated by an out-of-network physician or laboratory.

Patients will pay only the deductibles and copayment amounts that they would under the in-network terms of their insurance plans.

Medical providers won't be allowed to hold patients responsible for the difference between those amounts and the higher fees they might like to charge….**Read More**

Medicare Rights Provides a Summary of Policy Priorities for the Biden-Harris Administration

The Medicare Rights Center looks forward to working with the Biden-Harris administration to advance policies that protect and strengthen Medicare as well as the health and economic well-being of those who rely on its coverage. To facilitate this dialogue, in the coming weeks we will release a set of detailed administrative actions for their consideration—and possible adoption—in 2021. We will also outline our legislative priorities for the 117th Congress.

Below, we offer a brief summary of those recommendations and urge the transition team to:

- **Immediately Respond to COVID-19** in ways that prioritize older adults and people with disabilities.
- **Simplify Medicare Enrollment** to ensure active, informed, and meaningful beneficiary choice.
- **Reduce Barriers to Care** by making coverage more available, accessible, and affordable.
- **Address Disparities and Inequities** to improve health care and coverage for all.

Immediately Respond to COVID-19

The COVID-19 pandemic and its attendant economic fallout will have a lasting impact on people with Medicare and on the program itself. While additional solutions will be necessary as the situation continues to evolve, we urge the Biden-Harris administration to first focus on the following reforms, all of which are urgently needed to help people with Medicare maintain their health, safety, and independence:

- Reinstate COVID-19 related Medicare enrollment flexibilities.
- Promote quality of life and quality of care in nursing homes.
- Ensure affordable care and treatment for all Americans.
- Provide needed economic relief.
- Support increased funding for Medicaid and other community living programs.

Simplify Medicare Enrollment

A rapidly aging population, complex Medicare rules and timelines, and an ever-evolving health care landscape means an increasing number of individuals will face increasingly complicated Medicare coverage decisions in the coming months and years. Policymakers must act without delay to better empower current and future beneficiaries to make optimal choices, both initially and annually. To that end, we suggest making Medicare decisions simpler and plan options better in the following ways.

- **Modernize Part B Enrollment**
- *Support the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act.* This bipartisan bill would update Medicare Part B enrollment rules for the first time in over 50 years—filling gaps in notice and education and eliminating needless breaks in coverage.
- *Effectively Engage Consumers.* The U.S. Department of Health and Human Services (HHS) could further empower beneficiaries through updates to its outreach strategies, decision-making tools, and educational materials.
- *Invest in Unbiased Counseling and Assistance.* Champion sufficient, sustainable funding for Medicare State Health Insurance Assistance Programs (SHIPs), and for outreach to low-income beneficiaries under the Medicare Improvements for Patients and Providers Act (MIPPA).
- *Align Enrollment Periods.* Shifting Medicare's General Enrollment Period (GEP) to the fall would align it with sign up periods for other types of coverage, greatly reducing the likelihood of consumer confusion and enrollment mistakes.

Strengthen Plan Offerings and Oversight

- *Reinstate Plan Guardrails.* We recommend restoring important, recently weakened rules governing plan quality, benefit design, and marketing tactics.
- *Enhance Consumer Protections.* Using administrative levers to prevent discriminatory benefit designs and deceptive marketing practices, as well as to minimize default and sub-optimal enrollments, is also critical.
- **Fill Gaps in Public Data and Reporting**
- *Identify Equitable Relief Patterns and Barriers.* Regular reporting could increase public understanding of the equitable relief process and inform future policymaking.
- *Identify Part B Late Enrollment Penalty (LEP) Rates and Efficacy.* Similarly, enhanced data collection on beneficiary experiences with the Part B LEP could improve both agency documentation and policy**….Read More**

Many US Health Experts Underestimated the Coronavirus … Until It Was Too Late

A year ago, while many Americans were finishing their holiday shopping and finalizing travel plans, doctors in Wuhan, China, were battling a mysterious outbreak of **pneumonia** with no known cause.

Chinese doctors began to fear they were witnessing the return of severe acute respiratory syndrome, or SARS, a coronavirus that emerged in **China in late 2002** and spread to 8,000 people worldwide, killing almost 800.

The **disease never gained a foothold in the U.S.** and disappeared by 2004.

Although the disease hasn't been seen in 16 years, SARS cast a long shadow that colored how many nations — and U.S. scientists — reacted to its far more dangerous cousin, the novel coronavirus that causes COVID-19.

When Chinese officials revealed that their pneumonia outbreak was caused by another new coronavirus, Asian countries hit hard by SARS **knew what they had to do**, said **Dr. Amesh Adalja**, a senior scholar at the Johns Hopkins Center for Health Security. **Taiwan** and **South Korea** had already learned the importance of a rapid response that included widespread testing, contact tracing and isolating infected people.

The U.S., by contrast, learned all the wrong lessons.

This country's 20-year run of good luck with emerging pathogens —including not just SARS, but also **the relatively mild H1N1 pandemic, Middle East respiratory syndrome, Ebola, Zika virus and two strains of bird flu** — gave us a "false sense of security," Adalja said.

KHN's in-depth examination of the year-long pandemic shows that many leading infectious disease specialists underestimated the fast-moving outbreak in its first weeks and months, assuming that the United States would again emerge largely unscathed. American hubris prevented the country from reacting as quickly and effectively as Asian nations, Adalja said...**Read More**

How can I appeal my skilled nursing facility (SNF) discharge?

Dear Marci,
I have been recovering from surgery at a skilled nursing facility (SNF), but recently was told I am being discharged this week. How can I appeal my discharge from a SNF?
- Matthew (Rochester, NY)

Dear Matthew,

If you are receiving care in a non-hospital setting and are told that Medicare will no longer pay for your care (and you will be discharged), you have the right to file a fast appeal if you do not believe your care should end. Non-hospital settings include skilled nursing facilities, Comprehensive Outpatient Rehabilitation Facilities (CORFs), hospice, or home health agencies.

If your care at a non-hospital setting is ending because your provider believes Medicare will not pay for it, you should receive a **Notice of Medicare Non-Coverage**. You should get this notice no later than two days before your care is set to end. If you receive home health care, you should receive the notice on your second to last care visit. If you have reached the limit in your care or do not qualify for care, you do not receive this notice and you cannot appeal.

If you feel that your care in a non-hospital setting should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with the **Quality Improvement Organization (QIO)** by noon of the day before your care is set to end. Once you file the appeal, your provider should give you a **Detailed Explanation of Non-Coverage.** This notice explains in writing why your care is ending and lists any Medicare coverage rules related to your case.

The QIO will usually call you to get your opinion. You can also send a written statement. If you receive home health or CORF care, you must get a written statement from a physician who confirms that your care should continue.

If you have **Original Medicare,** the QIO should make a decision no later than two days after your care was set to end. If you have a **Medicare Advantage Plan, the** QIO should make a decision no later than the day your care is set to end. Your provider cannot bill you before the QIO makes its decision. If the QIO appeal is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it.

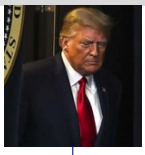
If your appeal is denied at this first level, you can continue to appeal by following instructions on the denial notices you receive. There are five levels of appeal in total; the timing and agency involved depend on whether you have **Original Medicare** or a **Medicare Advantage Plan**. You have the right to continue appealing if you are not successful.

Expedited appeals have tight deadlines, so it is important to pay attention to the timeframes for appealing at each level. Keep copies of any appeal paperwork you send out, and if you speak to someone on the phone, get their name and write down the date and time that you spoke to them. It is helpful to have all of your appeal documents together in case you run into any problems and need to access documents you already mailed. Note that the appeal process is different if your **inpatient hospital care is ending or if your care is being reduced** but not ending, and you do not agree with that reduction.

- Marci

Trump goes on rampage with pardons, veto threats and Covid denial

Donald Trump's presidency is blazing into history in a way that epitomizes his corrupt excess, with **pardons for cronies and war crimes, assaults on democracy**, fresh Covid-19 denial and impunity for Russia. And in a trademark bombshell that blindsided aides, Trump on Tuesday also issued a sudden pre-Christmas demand for changes to a desperately needed **$900 billion pandemic relief bill** that risked shattering a fragile bipartisan compromise he had made no effort to shape. His move could send global markets into free fall and prolong the deprivation of millions of Americans who are going hungry or have lost their jobs.



The antics of the outgoing President in recent hours further weighed down the yet-to-begin presidency of his successor, Joe Biden, who already faced the most challenging debut of any US leader since Franklin Roosevelt in 1933.

"I think it's a nightmare that everyone is going through, and they all say it's got to end," Biden said Tuesday when asked whether he expected "a honeymoon" of early political goodwill to help extricate the nation from the pandemic and its consequences.

The sleazy final days of the Trump White House later hit new lows when the President wielded his unassailable pardon power, substituting political payoffs for justice in yet another morally questionable use of executive authority….**Read More**

Pandemic Backlash Jeopardizes Public Health Powers, Leaders

Tisha Coleman has lived in close-knit Linn County, Kansas, for 42 years and never felt so alone.

As the public health administrator, she's struggled every day **of the coronavirus pandemic** to keep her rural county along the Missouri border safe. In this community with no hospital, she's failed to persuade her neighbors to wear masks and take precautions against COVID-19, even as cases rise. In return, she's been harassed, sued, vilified — and called a Democrat, an insult in her circles.

Even her husband hasn't listened to her, refusing to require customers to wear masks at the family's hardware store in Mound City.

"People have shown their true colors," Coleman said. "I'm sure that I've lost some friends over this situation."

By November, the months of fighting over masks and quarantines were already wearing her down. Then she got COVID-19, likely from her husband, who she thinks picked it up at the hardware store. Her mother got it, too, and died on Sunday, 11 days after she was put on a ventilator.

Across the U.S., state and local public health officials such as Coleman have found themselves at the center of a political storm as they combat **the worst pandemic in a century**. Amid a fractured federal response, the usually invisible army of workers charged with preventing the spread of infectious diseases has **become a public punching bag**. Their expertise on how to fight the coronavirus is often disregarded.

Some have become the target of far-right activists, conservative groups and anti-vaccination extremists, who have coalesced around common goals — fighting mask orders, quarantines and contact tracing with protests, threats and personal attacks.

As Social Media Use Rises, So Does Belief in COVID Misinformation

You can't believe everything you read on social media, but those who rely on it for their news tend to think otherwise.

A new study found that the more a person turned to social media as their main source of news, the more likely that person was to believe misinformation about the COVID-19 pandemic. Levels of worry about the coronavirus amplified people's belief in that misinformation.

Conversely, having a preference for talking with people who hold different views and having faith in scientists weakened beliefs in false information, according to the findings.

"It seems that the more you use social media, the more likely you become worried about COVID-19, perhaps because there is a lot of unfounded and conspiracy theories on social media," said study author Yan Su, from Washington State University's Murrow College of Communications. "Then this in turn can trigger a higher level of worry, which leads to further belief in misinformation."

Su analyzed the 3,080 responses to the 2020 American National Election Studies Exploratory Testing survey, which was conducted at the start of the pandemic. A little more than 480 people said they believed at least one of two pieces of misinformation about COVID-19 at that point: that the coronavirus was developed intentionally in a lab and that there was a vaccine for the virus.

Su compared this data to the participants' other responses on the survey related to social media use, levels of worry and trust in scientists, as well as how much the respondents valued discussions with people of differing viewpoints. A Pew Research Center survey from around the same time found that 3 in 10 Americans believed that coronavirus was created in a lab. There was no evidence for this. A third believed a vaccine already existed.

The findings point to solutions that could disrupt the spread of misinformation, Su said.

"Fact-checkers are important for social media platforms to implement. When there is no fact-checker, people just choose to believe what is consistent with their preexisting beliefs," he said in a university news release. "It's also important for people to try to get out of their comfort zones and echo chambers by talking with people who have different points of view and political ideologies. When people are exposed to different ideas, they have a chance to do some self-reflection and self-correction, which is particularly beneficial for deliberation."

Continued proliferation of false and misleading stories around the pandemic suggest more research is needed, Su said.

"During the COVID-19 pandemic, social media has spread a lot of conspiracy theories and misinformation, which has negative consequences because many people use these false statements as evidence to consolidate their preexisting political ideologies and attack each other," Su said. "It's important to understand the antecedents and motivations for believing and circulating misinformation beliefs, so we can find ways to counteract them."

Medicare Pay Cuts to Doctors Stopped for Now

Every year since the late 1990's, Congress has 'balanced' the budget by declaring a pay cut to doctors' Medicare services. Every year, after the budget for the next year is revealed, this cut is rescinded.

Again, next year, a number of physicians and medical specialists were facing sharp Medicare pay cuts. This was to come, of course, in the face of the worst pandemic in our lifetimes and one which has worn so many physicians and nurses to the point of exhaustion.

Medicare's 2021 physician fee schedule would've cut payments for radiology by 10%; physical/occupational therapy by 9%; anesthesiology and cardiac surgery by 8%; critical care by 7%; general surgery by 6%, and infectious disease by 4%.

As part of the economic stimulus bill just passed by Congress those sharp cuts have been put on pause.

According to the president and CEO of the Federation of American Hospitals, "The bill throws a lifeline to caregivers by continuing the pause in the 2% Medicare sequester, and making adjustments to buffer the impact of an ill-conceived change in physician payments during a pandemic."

The legislation now calls for a "one-time, one-year increase in the Medicare physician fee schedule of 3.75 percent" in 2021 "to provide relief during the COVID-19 public health emergency."

This is good news. While we have disagreements with some doctors over things like surprise medical billings, this year has taught us how critical and valuable to us all are our medical personnel. This certainly was no time to try to balance the budget on the backs of those who have borne the weight of so many of us this year.

Long-Term Care Workers Often Hold Multiple Jobs

Movements from first to second jobs, often in health care or other essential work, may spread COVID-19

Long-term care workers in nursing homes commonly hold multiple jobs, which may be contributing to the spread of COVID-19 in nursing homes, according to a study published online Nov. 19 in *Medical Care Research and Review*.

Reagan A. Baughman, Ph.D., from the University of New Hampshire in Durham, and colleagues used data from the Current Population Survey (2010 to 2019) to document the rate of nursing and long-term care workers who hold second jobs.

The researchers found that on average, 6.41 percent of personal care and nursing aides and 6.23 percent of licensed practical nurses and registered nurses held second jobs. These rates are 35 and 32 percent higher than those of other workers, respectively. The probability of holding a second job for personal care and nursing aides was associated with both wages and hours in the primary job. For registered nurses and licensed practical nurses, fewer hours were more strongly correlated with a second job. Moving across health settings from first to second jobs was common. Fifteen percent of second jobs for personal care and nursing aides were in other "essential" occupations.

"Federal and state-level initiatives aimed at raising wages through bonuses that are higher than unemployment benefits could potentially help decrease the likelihood that these essential care workers must take on a second job and help reduce exposure for COVID-19 transmission," a coauthor said in a statement.

What You Need to Know About the New Variant of COVID-19

For Americans who are worried about the new coronavirus variant that is circulating in Britain, experts in the United States urge everyone to stay calm.

So far, the new variant only seems to spread more easily, with no evidence of higher virulence (ability to cause harm), researchers at Northwestern Medicine in Chicago explained.

"There's no reason to get scared or panic, we just need to closely monitor this variant," said Dr. Ramon Lorenzo-Redondo, a scientist who studies COVID-19. Still, he predicted that it won't be long before the variant is detected in the United States.

Three Northwestern experts -- Lorenzo-Redondo, a research assistant professor in infectious diseases; Dr. Michael Ison, a professor of infectious diseases; and Dr. Marc Sala, an assistant professor of pulmonary and critical care -- answer some key questions people might have about the new variant.

How soon before this variant makes it to the U.S.

"The variant might already be present here and observed soon," Lorenzo-Redondo said. "That's due to the number of patients that have been infected by this variant, the increase observed in November and the high connectivity between the U.S. and the U.K. It has already been detected in other countries."

Sala noted that "the time frame of the variant's [spread] depends entirely on human behavior, including government-imposed travel restrictions."

What is known about the variant's contagiousness and virulence?

"Right now, we know this variant has increased rapidly in the U.K. and accounts for a high proportion of new cases there," Lorenzo-Redondo said. This suggests a higher transmission rate, but this and other viral properties need to be confirmed in the lab. Meanwhile, the first analyses don't suggest increased virulence, only increased transmission, he added.

For the most part, Sala agreed. "Epidemiologic and modeling data suggests it is more transmissible and indeed appears to be outcompeting the other COVID-19 variants," he said. "It does not seem to cause more severe illness. However, this is all very preliminary and lacks experimental confirmation."

Can a variant limit the effectiveness of the vaccine?

"These mutations do not seem to impact vaccine efficacy, but they need to be fully characterized," Lorenzo-Redondo said. "Theoretically, new mutations can impact vaccine efficacy as in other viruses, but the low mutation rate of this virus compared to others like flu or HIV-1 makes this more difficult," he explained.

"However, it is possible that if the vaccine starts to be deployed and is effective, we could observe changes in the virus to adapt and escape from the immune response promoted by the vaccine," he cautioned. "But again, the low mutation rate makes the adaptation of this virus to a vaccine less likely."

How common are variants of viruses and do they generally impact effectiveness of vaccines or treatments?

"Sometimes variants can have great impacts on vaccines or treatments. That's why it is so important to keep monitoring the variants circulating, to detect any possible mutation that could make vaccination or treatment less effective," Lorenzo-Redondo explained. But, "this virus seems to be adapting to spread as much as possible and, so far, all mutations seem to be increasing transmission, not virulence. That's probably because there is no evolutionary advantage for this virus to increase virulence."

What is a variant?

Ison explained that "variants occur when there is a change in the genetic material of the virus that results in a change in proteins the virus makes. In this case, there were a few changes related to the spike protein. These have changed the spike, but [the] changes are not predicted to change the efficacy of the vaccine."

Still, studies are ongoing to understand the impact of the variant, Ison noted.

How does the discovery of the variant impact our social distancing behaviors?

"This variant spreads the same way as the previous ones," Lorenzo-Redondo said. "Therefore, the safe behavior measures must remain the same. This variant shows we can't relax our social precautions." He added that with such high numbers of infections around the world, spikes in the virus will keep happening.

Ison stressed that people should still focus on not traveling, wearing a mask, maintaining social distance and hand hygiene.

According to Lorenzo-Redondo, "Because the virus keeps changing continuously, the greater the number of infected people, the more chances the virus gets to get better at infecting us."

More information

Visit the U.S. Centers for Disease Control and Prevention for more on the coronavirus pandemic.

Why doesn't HHS penalize pharmaceutical companies for disregarding rules requiring drug discounts at hospitals?

It's not surprising that pharmaceutical companies are disregarding the rules for discounting drug prices at hospitals serving low-income populations. What is concerning is that HHS has done nothing to penalize them about this violation. Now, Ed Silverman, **STAT**, reports that at least 25 state attorneys general are suing HHS to penalize the drug companies.

The discounts the pharmaceutical companies are supposed to offer are part of a federal program–340B–to ensure that hospital patients with low incomes can afford their outpatient drugs. About 12,700 hospitals participate in the program.

But, pharmaceutical companies do not like it when hospitals do not dispense these drugs themselves. Many hospitals send the drugs to retail pharmacies for pickup or delivery. As a result, drug companies do not see patient claims data.

Many advocates argue that the drug companies are violating federal law. At the same time, the pharmaceutical companies are making it harder for low-income populations to get needed drugs, in the middle of a pandemic, no less.

The attorneys general say that the drug companies have no authority to make these data demands. HHS should not allow them to flout the law. Pharmaceutical companies that are denying hospitals 340B discounts include Novartis, Eli Lilly, AstraZeneca, Novo Nordisk, Sanofi and United Therapeutics.

Republicans and Democrats support the 340B drug discount program. But, the agency at HHS in charge of overseeing the 340B program, said it did not have the authority to enforce the discounts. Since then, hospitals and hospital pharmacists have sued HHS for not acting.

PhRMA, the trade group that represents the pharmaceutical companies, argues that the 340B program does not have the force of law.

RI ARA HealthLink Wellness News

COVID-19 Is Far More Lethal, Damaging Than Flu, Data Shows

COVID-19 is far more harmful and deadly than the seasonal flu, new studies confirm.

Researchers analyzed U.S. Department of Veterans Affairs data on more than 3,600 patients hospitalized with COVID-19 between Feb. 1 and June 17 of this year, and more than 12,600 hospitalized with the flu between Jan. 1, 2017 and Dec. 31, 2019. The average age of patients in both groups was 69.

The death rate among COVID-19 patients was 18.5%, while it was 5.3% for those with the flu. Those with COVID were nearly five times more likely to die than flu patients, according to the study published online Dec. 15 in the *BMJ*.

COVID-19 patients with the highest risk of death included those aged 75 and older who also had chronic kidney disease or dementia, and Blacks who were obese, or who had diabetes or kidney disease.

The study also found that COVID-19 patients were four times more likely to require breathing machines, nearly 2.5 times more likely to be admitted to intensive care, and stayed in the hospital an average of three days longer than flu patients.

A separate study from France, published online Dec. 17 in *The Lancet Respiratory Medicine* journal, arrived at similar conclusions: Nearly twice as many people were admitted to the hospital for COVID-19 at the height of the pandemic than were for influenza at the peak of the 2018/2019 flu season. And the death rate was almost three times higher.

The French team, led by Dr. Pascale Tubert-Bitter, research director at L'Institut National de la Santé et de la Recherche Médicale (Inserm), and Catherine Quantin, from the University Hospital of Dijon and Inserm, compared data from COVID-19 patients admitted to the hospital over a two-month period in spring 2020 with influenza patients admitted over a three-month period during the seasonal flu outbreak of 2018/2019.

"The finding that the COVID-19 death rate was three times higher than for seasonal influenza is particularly striking when reminded that the 2018/2019 flu season had been the worst in the past five years in France in terms of number of deaths," Quantin noted in a *Lancet* news release.

Tubert-Bitter added, "Taken together, our findings clearly indicate that COVID-19 is much more serious than seasonal influenza. At a time when no treatment has been shown to be effective at preventing severe disease in COVID-19 patients, this study highlights the importance of all measures of physical prevention and underlines the importance of effective vaccines."

U.S. researchers said a big surprise in their study was that COVID-19 patients had a higher risk of developing diabetes, with 9 more cases per 100 than flu patients.

"These patients didn't have diabetes until they got COVID-19," said study senior author Dr. Ziyad Al-Aly, an assistant professor of medicine at Washington University in St. Louis. "Then their blood sugar spiked, and they needed huge doses of insulin. Is the diabetes reversible, or will it require long-term management? Will it be type 1 or type 2 diabetes? We just don't know because COVID-19 barely existed a year ago."

Another finding was that COVID-19 patients had a higher risk of acute kidney damage and severe sepsis shock. For both complications, there were an average of 6 more cases per 100 COVID-19 patients than among flu patients.

Also, COVID-19 patients were more likely to need medications to treat severely low blood pressure, a condition that can lead to organ damage and death. The rate was 11.5 more cases per 100 patients than among flu patients.

"Many high-profile, public comparisons between COVID-19 and the flu have been made; however, those comparisons mostly were drawn using disparate data and statistical methods that have resulted in a lot of conjecture. Our research represents an apples-to-apples comparison between the two diseases," Al-Aly said in a university news release.

"A deeper understanding of the health risks of COVID-19 helps to anticipate demand for health care services and to project mortality with greater accuracy," he added.

"We know so little about COVID-19 because of its newness," Al-Aly noted. "I'm not sure why Black patients suffer and die more. My hunch is that the cause relates to racial disparities in health care, but there could be other factors that we don't yet know."

Allergists' Group Updates Guidelines on COVID-19 Vaccines

In very rare cases, some people have had severe allergic reactions after receiving the new COVID-19 vaccines, leading the American College of Allergy, Asthma, and Immunology (ACAAI) to issue updated guidance for Americans with allergies.

The U.S. Food and Drug Administration has given emergency use authorization to COVID-19 vaccines from Pfizer-BioNTech and Moderna.

The ACAAI's COVID-19 Vaccine Task Force offers guidance on the risk of an allergic reaction from the vaccines.

In general, reactions to vaccines are rare, and the incidence of severe allergic reaction ("anaphylaxis") is estimated at 1.31 per 1 million doses given to patients, according to the ACAAI.

The mRNA COVID-19 vaccines should be given in a setting where anaphylaxis can be treated. All patients must be monitored for 15 to 30 minutes after injection for any adverse reaction. All anaphylactic reactions should be managed immediately with epinephrine as the first-line treatment, the experts advised in a college news release.

The shots shouldn't be given to people with a known history of severe allergic reaction to any component of the vaccines, the ACAAI said. The specific COVID-19 vaccine component causing anaphylaxis hasn't been identified, but an ingredient called polyethylene glycol has been known to cause anaphylaxis.

When deciding whether to receive either of the mRNA COVID-19 vaccines, the ACAAI recommended consulting your health care provider, who can advise you about the benefits and risks.

People with common allergies to medications, foods, inhalants, insects and latex don't have a higher risk of an allergic reaction to the mRNA COVID-19 vaccines than people in the general public, the ACAAI said.

The mRNA COVID-19 vaccines are not live vaccines and can be given to people with weakened immune systems. Health care providers should advise these patients that they may have a weaker immune response to the vaccines.

If you have questions about the risk of an allergic reaction to the mRNA COVID-19 vaccines, contact an allergist/immunologist, the ACAAI advised.

The U.S. Centers for Disease Control and Prevention said that people who have a severe allergic reaction after the first shot should not get the second shot.

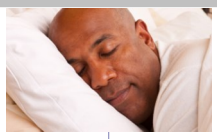
Patients who have a severe allergic reaction may be referred to an allergy/immunology specialist for further care or advice, according to the CDC.

How you sleep could turn on what you eat

.Trouble sleeping? Typically, people who **exercise** and stay away from computer screens sleep better at night. Anahad O'Connor writes for the **New York Times** that recent studies show that how well you sleep could turn on what you eat.

Research reveals that unhealthy eating habits–such as eating a lot of **sugary foods**, saturated fats and processed foods–might mean poor sleep. Not surprisingly, healthy eating habits–such as eating fish, plants, fiber and foods that have lots of unsaturated fat–can help to promote a good night's sleep.

The research is based on observational studies, which can never show causal effects. But, these studies can find relationships between diet and sleep. Some research involves asking people to eat particular foods and then measuring their sleep as compared to other people who do not eat those foods.



Many of these studies cannot be trusted. For example, a banana company might fund a study on the value of bananas, much like Medicare Advantage plans might fund a study on the value of Medicare Advantage plans. Whoever is being paid has an interest in pleasing the funder and delivering the results the funder is looking for.

Some researchers studying the relationship between diet and sleep believe that the relationship might not be between eating particular foods and a good sleep but about eating a healthy diet and a good night's sleep.

Some researchers have found that eating a diet rich in carbohydrates can help people fall asleep more quickly than if they eat a high fat or high protein diet. In this case, the kind of carbohydrates could affect sleep. People who eat a lot of white bread and pasta tend not to sleep soundly through the night. To sleep soundly, you want to eat complex carbohydrates with fiber, which can keep your blood-sugar level stable.

Researchers recommend **a Mediterranean diet** for sound sleep.

All this said, researchers also believe that people who sleep poorly are often hungrier than people who sleep soundly. And, they might be more inclined to eat an unhealthy diet, including lots of sugary and processed foods.

There's more. Researchers have found that people who sleep well often have greater will power not to eat junk food. So, if you want to sleep well, try eating a healthy diet. And, if you eat a healthy diet, you might find that you sleep better. For sure, the research is not definitive, but what's there to lose?

Blood Oxygen Tests Can Be Inaccurate for Black Patients, Raising COVID Risks: Study

The fingertip devices that hospitals use to monitor patients' oxygen levels might be less accurate in people with dark skin, a new study suggests.

At issue are pulse oximeters -- small medical devices that clip onto a fingertip and estimate how much oxygen is making it into the blood. They are routinely used in hospitals to help providers make treatment decisions.

And during the COVID-19 pandemic, pulse oximeters have increasingly made their way into the hands of lay people. Fairly cheap home devices are available, and people with milder cases of COVID have used them to monitor their oxygen levels.

But the new study suggests that Black patients are at greater risk of having a falsely reassuring reading on pulse oximetry than white patients are.

Researchers at the University of Michigan Hospital found that in cases where Black patients appeared to have adequate oxygen levels on pulse oximetry, their blood oxygen was actually low 12% of the time.

In contrast, the mismatch happened in white patients less than 4% of the time, the researchers report in the Dec. 17 issue of the *New England Journal of Medicine.*

"It really surprised us all," said lead researcher Dr. Michael Sjoding, an assistant professor of internal medicine at Michigan Medicine.

The impetus for the study was, like so many things in medicine, the pandemic.

Early on, when Sjoding and his colleagues were seeing more and more COVID patients -- many of whom were Black -- they noticed a recurring discrepancy: Some patients' pulse oximetry readings were not matching up with arterial blood gas tests, which sample patients' blood to directly gauge oxygen saturation.

To dig further, the doctors looked back at over 10,000 instances where patients had nearly simultaneous pulse oximetry and arterial blood gas measurements. The readings came from 1,333 white patients and 276 Black patients treated between January and July of this year.

Overall, the study found, discrepancies were nearly three times more common among Black patients than white patients.

Sjoding's team then looked at data from intensive care units at 178 other hospitals, collected in 2014 and 2015. The same pattern emerged: Among Black patients with normal pulse oximetry readings, arterial blood gas measurements were abnormal 17% of the time.

That compared with 6% among white patents.

The notion of a racial bias in pulse oximetry is not new. Back in 2005, a small study found that the devices tended to overestimate oxygen levels in dark-skinned patients.

But the finding did not "permeate" practice, Sjoding said, and many providers may not be aware of the issue.

Dr. Albert Rizzo is chief medical officer of the American Lung Association. He said there are various well-known limitations of pulse oximeter readings. Factors ranging from heart rate to blood circulation in the fingers to nail polish can affect measurements from the finger-clip devices.

This study, Rizzo said, "does point out that there is limited data regarding accuracy, depending on racial groups."

As for why skin tone would matter, Sjoding explained the basic theory: Pulse oximeters work by emitting certain wavelengths of light, and skin pigment may absorb some of that light.

Both he and Rizzo stressed that hospital staff need to consider factors other than pulse oximetry numbers.

"Pulse oximetry is not a stand-alone result or value," Rizzo said, "but needs to be used in the patient context."

The same goes for people using a home device to monitor a milder case of COVID.

Sjoding said that anyone with worsening breathing problems should heed those symptoms, rather than going by a seemingly "good" pulse oximetry reading.

The findings also point to a broader issue, Sjoding said. Historically, medical devices have been developed using studies of mostly white individuals. And the discrepancies seen with pulse oximetry illustrate the shortcomings of that.

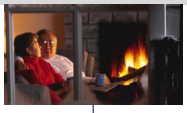
"We need to double down in evaluating these technologies, to make sure they work equally well for all of the patients we treat," Sjoding said.

How to Guard Against Home Heating Hazards

Many Americans are working at home or attending school virtually during the COVID-19 pandemic, leading to increased use of home heating and its potential risks, an expert says.

Heating sources can pose electrical hazards and fire dangers, noted Purnima Unni, manager of the pediatric trauma injury prevention program at Monroe Carell Jr. Children's Hospital at Vanderbilt University in Nashville, Tenn.

"With pandemic restrictions in place, there are more people in the home during a time when it would traditionally be empty," Unni said in a Vanderbilt news release. "Folks are needing to stay warm. And for some who are not working, they are trying to figure out how to stay warm on less income."



That could lead to the use of unsafe heating sources, she cautioned.

"During this time, it is so important that people know what heating sources are the safest and which ones to steer clear from to prevent a potentially hazardous situation," Unni said.

A major threat from heating sources is carbon monoxide, often called the silent killer.

In the United States, 170 people a year on average die from carbon monoxide poisoning not associated with vehicles, according to the U.S. Consumer Product Safety Commission.

Causes include: malfunctioning fuel-burning appliances such as furnaces, ranges, water heaters and room heaters; engine-powered equipment such as portable generators; fireplaces, and charcoal burning in enclosed areas.

The hospital's experts offer these tips to prevent carbon monoxide poisoning:

- Install CO alarms near all sleeping areas in your home and test them monthly;
- Have gas, oil or coal-burning appliances, chimneys and fireplaces checked by a professional every year;
- Never use a kitchen stove or oven to heat your home;
- Never use a grill, generator or camping stove inside your home, garage or basement;
- Never leave a vehicle running inside a garage, even with the garage door open.

To ensure electrical safety, they recommend:

- Keep electric space heaters, humidifiers and vaporizers at least 3 feet from beds, curtains and other flammable items;
- Use grounded (three-pronged) cords with all major electrical appliances;
- Make sure that electrical cords are properly insulated, and that insulation shows no signs of wear or fraying;
- Never run electrical wires under carpeting.

Pandemic Closures, Fears Keep Patients From Lung Cancer Screening

When the COVID-19 pandemic hit the United States, many routine cancer screenings were put on hold. Now a new study suggests that lung cancer screenings have yet to rebound.

The findings come from one hospital system, but experts said they add to worries about the pandemic's impact on cancer care.

In the spring, when many U.S. hospitals were overrun with COVID-19 patients and stay-at-home orders were issued, elective medical care -- including cancer screenings -- was largely delayed.

Research since then has pointed to the early consequences. One study found that in March and April, the United States saw a 46% drop in new diagnoses of six common cancers -- a sign that many cases were being missed for lack of screening.

When it comes to lung cancer screening -- which is done via low-dose CT scan -- rates were already low pre-pandemic.

"Only about 4% of eligible patients were getting screening nationally," said Dr. Robert Van Haren.

So any sustained decrease in that figure would be concerning, said Van Haren, the lead researcher on the new study and assistant professor of surgery at the University of Cincinnati College of Medicine.

For their study, his team looked at how the situation at their health system has changed during the course of the pandemic.

In March, the university suspended its lung cancer screening program, ultimately canceling more than 800 appointments. The program began reopening in May, with priority given to patients who needed follow-up scans of previously detected growths.

But while screening numbers went up, they remained below pre-pandemic numbers.

Between 2017 and February 2020, 15% of screening appointments were "no shows" -- meaning the patient never showed or did not reschedule a canceled appointment. During the pandemic (through the end of July), the no-show rate was 40%.

And the number of new patients going in for a first-time scan ticked up only slightly after reopening.

The pandemic essentially created "a perfect storm," according to Dr. William Cance, chief medical and scientific officer for the American Cancer Society.

First, he said, it forced shutdowns that later created a backlog of appointments that had to be rescheduled -- making it hard for patients to get new appointments.

Then there's the fear. It's known, Cance noted, that the pandemic made many Americans hesitant to receive even routine medical care in a doctor's office.

"There's also the economic side," said Cance, who wasn't part of the study. "So many people lost their jobs and health insurance. For them, it might have been a matter of, 'Can I put food on the table, or get my mammogram?'"

The full impact of the pandemic -- its effects on timely cancer diagnoses and people's survival -- will take time to sort out.

But Van Haren pointed to a concerning finding in this study: a sharp increase in the proportion of patients with potentially cancerous lung growths -- from 8% in pre-pandemic times, to 29% during the pandemic.

In many cases, those patients were returning for follow-up after a previous scan showed a growth. But in about 40%, Van Haren said, the growths were new.

Screening can catch lung tumors when they are small enough to remove by surgery, and research suggests it reduces the risk of dying from lung cancer by 20%, Van Haren said.

Right now, annual screening is recommended starting at age 55 for people who have smoked at least 30 "pack-years" over a lifetime, and who either still smoke or have quit in the past 15 years. That translates to one pack a day for 30 years, or two packs a day for 15 years, for example.

Van Haren said medical centers have safety protocols to protect patients who visit for screening. One measure at his health system, he noted, was to move CT screenings from the hospital to an outpatient center.

Cance urged Americans who have missed any cancer screening to talk to their provider about rescheduling and any safety questions they have.

With U.S. COVID-19 cases now soaring, another question arises: Will screening programs shut down again?

It's possible, Van Haren said. And that's yet another reason, he said, that the surge needs to be brought under control.

Weight-Loss Surgery Lowers Long-Term Heart Risks for Diabetic Teens

Weight-loss surgery significantly reduces the risk of heart problems in obese teens with type 2 diabetes, a new study finds.

Teens who have the surgery can see their long-term risk for heart attack, congestive heart failure, stroke and coronary death lowered nearly threefold, compared with obese teens whose diabetes is medically managed, researchers say.

"The mitigation in risk does not seem to be completely activated or ascribed to weight loss, but largely to the remission of diabetes," said lead researcher Dr. Petter Bjornstad, an assistant professor of pediatric endocrinology at the University of Colorado.

After surgery, patients need to make significant changes in diet and lifestyle, he said.

"So even though we're seeing these great results, I think it's really important to acknowledge that this is a huge commitment, and it's not an easy fix," Bjornstad said.

The surgery itself is relatively safe and in the hands of an experienced surgeon results in few complications, though bleeding and damage to nearby organs is possible, Bjornstad said.

After surgery, patients are closely monitored to make sure they are getting enough nutrients and vitamins. They typically have a short hospital stay, but recovery continues at home for months as patients get used to their new diet and psychological adjustments, he said.

"If you're not prepared for these changes, that can be pretty stressful mentally," Bjornstad said. "That's part of this huge commitment that you need to prepare for before surgery and have really good follow-up after surgery, and that's why we encourage a multidisciplinary approach to try to mitigate these risks."

For the study, Bjornstad's team compared the odds for cardiovascular disease over five years in two groups of teens with type 2 diabetes. One group of 30 had weight-loss surgery; the other 63 teens did not.

While teens who had surgery saw their long-term risk for heart disease fall, those who didn't have surgery saw their risk rise. Researchers used a formula to calculate risk over 30 years.

Bjornstad said that obesity and type 2 diabetes are complex conditions in teens, and genetics and family history can play important roles. Weight-loss surgery is not a cosmetic procedure but one designed to improve health and help people live a long, productive life, he said.

"I think maybe people don't appreciate that -- this surgery is so much more than weight loss," Bjornstad said.

His team attributed the lower risk for heart disease after weight -loss surgery to lower blood sugar levels, lower weight, lower blood pressure and higher levels of good cholesterol (HDL).

Treatment of obesity is far more complex than eating less and exercising more, according to Dr. Mitchell Roslin, chief of obesity surgery at Lenox Hill Hospital in New York City, who reviewed the findings.

"It is time for physicians, insurers and the general public to rethink the treatment of obesity and diabetes," he said.

Roslin said teens treated with weight-loss surgery not only have a lifetime reduction in the risk of heart disease, but previous studies have also shown that they do better in school, have improved emotional health and higher incomes when they enter the workforce.

He said many severely obese teens face prejudice, bullying and are then denied the best treatment for their condition.

"We can do better, and barriers for surgical intervention placed by insurers need to be removed," Roslin said.

What to know about vision loss

Vision loss refers to either complete or partial loss of vision. Depending on the cause, it may occur suddenly or gradually over time, and in one or both eyes. Some types of vision loss are temporary or reversible.

Vision loss is relatively common. According to the **Centers for Disease Control and Prevention (CDC)**, vision problems are among the top 10 disabilities in adults, and one of the most prevalent disabilities in children.

The CDC estimate that 12 million people age 40 or older in the United States have some form of visual impairment, including over 1 million people who are blind.

Experts predict that this number could more than double by 2050 due to the rising rates of diabetes and other chronic diseases in the U.S., along with a rapidly aging population.

There are many possible causes of partial or complete vision loss, including medical conditions, injuries, migraine, and aging.

This article looks at different types of vision loss, the causes of sudden or gradual vision loss, treatments, and coping methods.

Types of vision loss

Vision loss is the term for losing the ability to see properly. There are different types of vision loss, and these can be caused by different diseases or conditions, including:

- central vision loss, or difficulty seeing things in the center of vision
- peripheral vision loss, or difficulty seeing things out of the corner of the eyes
- general vision loss, when a person may not be able to see anything at all **night blindness**, when a person has trouble seeing in low lightblurry or hazy vision, when a person's vision feels out of focus or like looking through a filter.

A person may also find themselves unable to see shapes, or only able to see shadows.

Causes of sudden vision loss

Sudden vision loss is vision loss that occurs over a period of a few seconds or minutes to a few days. It can be caused by a variety of conditions.

Migraine

Many people who have **migraine** experience visual symptoms, known as **migraine aura.**

Around 25–30% of people with migraine have visual aura symptoms. For some, this involves seeing zig-zag lines, sparkles, or spots. For others, it involves tunnel vision, a complete loss of vision, or vision loss to the left or right side.

These visual disturbances are often, but not always, accompanied by a **headache**. They tend to last less than an hour, and typically persist for 10 –30 minutes. Some are gone after a few seconds.

Treatment for migraine may involve painkillers and staying in a darkened room, away from bright lights and loud sounds.

Keratitis

Keratitis, or **inflammation** of the cornea, is a condition that may occur more frequently in people who wear contact lenses than those who do not.

Keratitis can be caused by an infection or injury to the eye. Symptoms include blurred vision, pain, sensitivity to light or vision loss.

This condition is temporary. A doctor will treat it with prescription medication.

Conjunctivitis

Also known as pinkeye, **conjunctivitis** can cause vision loss. Conjunctivitis is an infection or inflammation of the conjunctiva. It can also cause blurriness, redness, pain, or difficulty seeing.

Conjunctivitis is temporary and usually resolves on its own. For bacterial conjunctivitis, antibiotic eye drops **may help**…….**Read More**