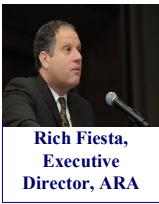




Message from Alliance for Retired Americans Leaders

Biden and House GOP are at an Impasse as Nation Hits Key Debt Ceiling Deadline



Rich Fiesta,
 Executive Director, ARA

The Biden administration and House Republicans passed an initial January 19 debt ceiling deadline this week without a plan for resolution, ensuring a long standoff that's likely to rattle financial markets amid worries about a recession. However, for things to move forward, Republicans need to agree among themselves on what to ask for in exchange for raising the ceiling.

The nation hit the \$31.4 trillion debt limit set by Congress on Thursday, forcing the Treasury Department to start taking extraordinary measures to keep the government paying its bills and escalating pressure on Capitol Hill to avoid a cataclysmic default. Because Thursday was not a hard deadline, the department can still use "extraordinary measures" to

pay the bills for another few months.

Many ultra-conservative House Freedom Caucus members demanded that House Speaker Kevin McCarthy not raise the debt ceiling unless President Biden and Democrats agree to their demands to slash Social Security, Medicare, and other spending. In 2011, a standoff between the GOP and former President Obama over raising the debt ceiling led to a nose-dive in stock prices, spiking mortgage rates and a drop in consumer confidence.

In a speech this week, President Biden mocked Republicans for talking about "big-spendin' Democrats," when in fact the deficit dropped by roughly \$350 billion in fiscal 2021 and more than \$1 trillion in fiscal 2022 under his party's control.

On Wednesday, Sen. Joe Manchin (WV) added to the drama when he said that he had spoken briefly with Speaker McCarthy about possible

"compromise" with the House GOP. He suggested adding a bill he co-sponsored with Sen. Mitt Romney (UT) in the last Congress to create a "rescue committee" for the Social Security, Medicare and highway trust funds to raise the debt ceiling.

Sen. Romney first introduced rescue committee legislation in 2019 as a vehicle to pave the way for cuts to Social Security and Medicare by recommending changes to the Trust Funds in the name of "long-term solvency." The TRUST Act called for the creation of committees to meet behind closed doors without public input, and for recommendations to then be fast tracked to the floor of the House and Senate for an up or down vote without amendments. "It is time for us to fight back and defend the Social Security and Medicare benefits we've earned over a lifetime," said Richard Fiesta, Executive Director of the Alliance. "This is the most serious threat to Social Security and Medicare we've seen in more than a decade and it will take dramatic and strong action between now and June to stop these dangerous ideas in their tracks."

Democrats in Michigan Unite to Roll Back Tax on Pension Benefits

Half a million retirees in Michigan could save an average of \$1,000 per tax year under a Democratic-backed plan unveiled last week. Michigan Alliance President Jim Pedersen joined Governor Gretchen



Joseph Peters
 ARA Sec.-Trea.

Whitmer at an event announcing the legislation. The plan seeks to roll back a tax on certain retirement pensions and raise a tax credit for low- and moderate-income working families. A pair of retirement pension tax cut plans offered by the state House and Senate are identical and offer a tiered approach to relief. They would allow retired Michiganders born between 1945 and 1959 to deduct up to 25% of the maximum amount of retirement or pension benefits in the 2023 tax year.

Those deductions would jump to 50% for those born between 1945 and 1963 in the 2024 tax year, and then 75% in the 2025 tax year for those born between 1945 and 1967.

"Twelve years ago, Republican Governor Rick Snyder signed highly controversial legislation establishing a state retirement tax that applies a 4.25% income tax on pensions," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "The new legislation would roll back that tax. Michigan retirees strongly applaud this move to offer them much-needed financial relief."

ADD YOUR NAME **Get The Message Out: SIGN THE GPO/WEP PETITION!!!!**

House speaker McCarthy opens door to Medicare and Social Security cuts

In an opinion piece for **The Hill**, Max Richtman, CEO of National Committee to Preserve Social Security and Medicare, writes about the House speaker, Kevin McCarthy's likely intent to cut Social Security and Medicare, notwithstanding the slim margin by which Republicans took control of the House. Americans were not voting for representatives who would cut their earned benefits.

McCarthy had to make concessions to win the position of House Speaker. One of those was to commit to tying the lifting of the debt ceiling to cuts in federal spending. The Republicans have **always**

wanted cuts to Medicare and Social Security.

Of course, President Biden can veto any legislation that slashes Medicare and Social Security. And the Democratic majority in the Senate is not likely to support these cuts in the first place. Still, Biden cannot allow the federal government to default on its financial obligations.

Congress must lift the debt ceiling. Last time the Republicans held a Democratic administration hostage over lifting the debt ceiling, the Obama administration had to agree to limits on spending.



Already, Speaker McCarthy has established new rules for the House that makes it more difficult for Congress to pay for critical programs.

What might the House propose in the way of cuts under McCarthy's leadership? For one, raising the eligibility age for Medicare and Social Security. For two, making Medicare more expensive for people with annual incomes as low as \$49,000.

The House could also slash Social Security benefits, if not for current retirees, for future ones. This policy is designed to keep voters at bay. More than four in five Americans support

expanding Social Security. And, they want to pay for it through **eliminating the cap on Social Security payroll contributions**. They want wealthy Americans to contribute a more proportionate and fairer share of their income to Social Security relative to middle and lower-income Americans.

Thankfully, President Biden has promised not to cut Social Security and Medicare. But, he will be under a lot of pressure to do so. We must all speak up and contact the White House and our representatives in Congress. We need to make sure they know voters want Medicare and Social Security expanded, not slashed.

Kaiser Health News: Numbers Don't Lie. Biden Kept His Promise on Improving Obamacare.

By Julie Appleby

Promise: "I'll not only restore Obamacare; I'll build on it." In a **speech** on Nov. 2, 2020, then-presidential candidate Joe Biden promised, "I'll not only restore Obamacare; I'll build on it." Two years and counting since then, how is he doing in meeting that promise?

KHN has teamed up with our partners at PolitiFact to monitor

100 key promises — including this one — made by Biden during the 2020 presidential campaign. The pledges touch on issues related to improving the economy, responding to calls for racial justice, and combating climate change. On health care, they range from getting covid-19 under control and improving



veterans' health care to codifying Roe v. Wade. KHN has recently done progress checks on the administration's pledges to lower the costs of prescription drugs and to reduce the nation's maternal mortality rate.

Eight days into his tenure as president, Biden signed an **executive order** aimed at

strengthening Medicaid and the Affordable Care Act, or Obamacare. A couple of months later, he signed his first major piece of legislation, the American Rescue Plan, which included provisions expanding eligibility for subsidies and increasing premium tax credits available to help low- and moderate-income Americans purchase ACA coverage....**Read More**

H.R. 25 - FairTax Act of 2023

FairTax Act of 2023

Introduced in House (01/09/2023) by Representative Earl L. Carter (R-GA)

This bill imposes a national sales tax on the use or consumption in the United States of taxable property or services in lieu of the current income taxes, payroll taxes, and estate and gift taxes. The rate of the sales tax will be 23% in 2025, with adjustments to the rate in

subsequent years. There are exemptions from the tax for used and intangible property; for property or services purchased for business, export, or investment purposes; and for state government functions.

Under the bill, family members who are lawful U.S. residents receive a monthly sales tax rebate (Family Consumption Allowance) based upon criteria



related to family size and poverty guidelines. The states have the responsibility for administering, collecting, and remitting the sales tax to the Treasury.

Tax revenues are to be allocated among (1) the general revenue, (2) the old-age and survivors insurance trust fund, (3) the disability insurance trust fund, (4) the hospital insurance

trust fund, and (5) the federal supplementary medical insurance trust fund.

No funding is authorized for the operations of the Internal Revenue Service after FY2027.

Finally, the bill terminates the national sales tax if the Sixteenth Amendment to the Constitution (authorizing an income tax) is not repealed within seven years after the enactment of this bill.

Social Security: Do I Need to File a Tax Return?

If your entire income is from monthly **Social Security payments**, you might not need to file a federal tax return if you fall under a certain financial threshold. But even when that's the case, there could be times when you're better off filing a return. As a general rule, if Social Security benefits were your only income, your benefits are not taxable and you probably don't

need to file a federal income tax return, according to the Social Security Administration. But if you received Social Security benefits plus other income, your tax obligation depends on how much you earned.

You must pay taxes on your Social Security benefits if you file a federal tax return as an



individual and your combined income exceeds \$25,000 a year.

If you file a joint return, you must pay taxes if you and your spouse have a combined income of more than \$32,000. If you are married and file a separate return, you probably will have to pay taxes on your benefits, the SSA says.

For example, if you had any tax withheld during the year — either from Social Security payments themselves or from any other sources, such as quarterly estimated tax payments or carried-over refunds from prior years — you should file a return, MarketWatch reported. In many cases you'll get most, if not all, of those taxes back in a refund ...**Read More**

Traditional Medicare at risk with ACO REACH

This month, the Biden administration is launching ACO REACH, a program that pits the financial interests of corporate health insurers, private equity firms, and the primary care doctors they employ against the health and well-being of their patients in Traditional Medicare. Is there any chance that REACH will deliver better quality care at lower cost, or even just lower costs without harming quality? More than two million people in Traditional Medicare are at risk.

How does REACH work? The Centers for Medicare and Medicaid Services (CMS), which oversees Medicare, is contracting with middlemen—insurers, private equity and other companies—which assume the risk of keeping health care costs down for people with Medicare. These companies engage primary care doctors (PCPs) to oversee patient care, with the goal of keeping them out of the hospital and away from costly specialty care. If they succeed, the companies can keep 25 percent or more of the savings.

How do REACH entities

keep costs down? They incentivize their primary care doctors financially to keep their patients from getting specialty care and other costly health care services. Best case scenario, they keep people from unnecessary hospitalizations and duplicate tests. Worst case scenario, they keep people from getting critical care they desperately need.

How do people enroll in REACH? Generally, they do not. Rather, the Centers for Medicare and Medicaid Services involuntarily enrolls them in the program if their primary care doctors are employed by a REACH entity. If you are enrolled, you should receive a letter letting you know.

How many people are enrolled in REACH? All told, the Biden administration is contracting with 132 health insurers, private equity firms and other entities to “coordinate” care for some 2.1 million people enrolled in Traditional Medicare.

What do these REACH entities know about health care? The Medicare Innovation

**PROTECT
MEDICARE**

Center (CMMI), an arm of CMS, claims that it has vetted all the REACH entities to ensure that they understand health care and are invested in the initiative from a quality and cost perspective. At the same time, the Innovation Center’s director, under questioning about how the government protects enrollees from bad actors, said that CMMI could “not draw lines between good guys and bad guys.” That’s a serious problem because it means that entities that inappropriately keep people from getting needed care will be able to do so.

What’s the worst case scenario? Primary care doctors keep people from getting the care they need in order to help the REACH entity maximize its profits as well as to maximize their own income. We know from Medicare Advantage that insurers engage in all sorts of fraudulent and wasteful behaviors to maximize their profits. There’s every reason to believe that the REACH entities, including private equity firms

and insurers, will engage in the same acts. They know that CMS does not have the resources or the tools or the political will to hold them accountable in a meaningful way for their bad acts.

What can you do to protect yourself if you’re in traditional Medicare? CMS suggests that all the entities with which it has contracted to “coordinate” care will do their jobs well. It also suggests that it will oversee them to make sure that “they don’t stint on care.” Don’t believe that. Question your primary care doctor. Make sure he or she is not part of a REACH entity. If so, make sure your PCP is ensuring you get the care you need. If you’re not sure, you have the right to opt out by leaving your primary care physician and moving to another one.

Make your voice heard: Go to protectmedicare.net and sign the petition to President Biden. He can end REACH.

This Social Security change would be ‘easiest and quickest,’ Manchin says.

As Democrats and Republicans negotiate over the nation's debt ceiling, some worry changes to Social Security benefits could be on the line.

Sen. Joe Manchin, D-W.Va., said on Sunday that increasing the payroll taxes wealthy pay may help shore up the program.

Now that the U.S. **has hit the debt ceiling**, lawmakers need to revisit the federal budget and find ways to make cuts, Sen. Joe Manchin, a Democrat representing West Virginia, said in interviews this weekend.

But that should not include **cuts to Social Security and Medicare benefits**, he said.

"I've got 60% of my population that that's all they have is Medicare and Social Security," Manchin **told NBC's "Meet the Press"** on Sunday.

"You think I'm going to go down that path and put them in jeopardy? No," he said.

In a separate interview on **CNN's "State of the Union,"** Manchin called for a key change to help shore up

Social Security's ailing funds — raising the cap on payroll taxes that are used to fund the program.

"The easiest and quickest thing that we can do is raise the cap," he said, while also curbing "wasteful spending."

How raising payroll tax cap could aid Social Security

In 2023, wages up to \$160,200 are **subject to a 6.2% tax** for employees and employers that goes to Social Security.

A **1.45% Medicare tax** is also paid by employees and employers, though there is no wage limit to those taxes.

Both programs face the prospect of a funding shortfall in the coming years if lawmakers fail to act. Social Security's combined trust funds are projected to **become depleted in 2035**, at which point 80% of benefits will be payable, according to an annual report released in June.

The fund that covers Medicare Part A, which pays for



inpatient hospital care and other services, will be able to pay full benefits until 2028, after which point 90% of benefits will be payable.

"Social Security and Medicare basically is running out of cash because we stop at a certain level where people pay into FICA," Manchin said. (FICA stands for the Federal Insurance Contributions Act and represents the U.S. federal payroll tax.) Other Democrats have also proposed raising payroll taxes to help shore up Social Security. Sens. Bernie Sanders, I-Vt., and Elizabeth Warren, D-Mass., have proposed reapplying payroll taxes **for those earning over \$250,000** along with a host of other changes to shore up the program. A separate bill to reform the program from Rep. John Larson, D-Conn., calls for applying payroll taxes **starting at over \$400,000.**

Republicans have proposed program changes

The problem, according to Maria

Freese, senior legislative representative at the National Committee to Preserve Social Security and Medicare, is raising payroll taxes on wages of more than \$400,000 alone may not bring the program to solvency.

That may prompt some lawmakers to call for benefit cuts to the program, she said.

Republicans have proposed a host of changes to Social Security and Medicare in the 2023 **Republican Study Committee budget** including raising the retirement age, changing the way cost-of-living adjustments are measured and changing rules for ancillary benefits, Freese noted.

Even if those changes were included in formal legislation and passed by the chamber, it would not get the 60 votes required to pass in the Senate, Freese said. Nor would President Joe Biden support it... **Read More**

[Scrap The Cap Video](#)

What Role Does Marketing Play in Medicare Decision-Making?

The Commonwealth Fund recently released an **explainer** delving into the role Medicare Advantage (MA) and Part D marketing has on people with Medicare. This explainer comes as MA marketing has attracted **more scrutiny** because of complaints about misleading practices and as federal agencies have begun **looking more closely** at how MA products are sold.

Marketing information overshadows objective information, according to the

explainer. When people look for Medicare information online, one out of three results—and 87% of search engine ads—will be Medicare agents, brokers, and insurers. These entities have a personal stake in steering people with Medicare toward their products.

This surge in advertising coincides with a **surge in MA plan offerings**—the average beneficiary has 43 plans to choose from for 2023. An



abundance of choice makes shopping for a plan harder, and many people with Medicare already **do not review or change plans each year**, even when it makes financial sense.

The explainer shows that few beneficiaries base their decision on advertising, at least knowingly. However, around one in three used insurance agents or brokers to choose a plan rather than an objective source like the federal

government or their **State Health Insurance Assistance Program (SHIP)**.

The Commonwealth Fund flags that marketing abuses and misinformation are on the rise in other forms of insurance as well and that more data and resources are needed to help ensure that people receive the right information to help them make informed choices that fit their coverage needs.

Read the explainer.

Studies Show That Medicaid Expansion Helps Hospitals and Providers

This week, the Kaiser Family Foundation (KFF) released a new **issue brief** about the effects of Medicaid expansion on hospitals and other providers. KFF found that recent studies agree with previous data and generally show positive effects in reducing uncompensated care and uninsured status, as well as increasing revenues for providers.

To reduce the number of uninsured people in the United States, the Affordable Care Act (ACA) expanded Medicaid for adults with low incomes. The Supreme Court limited the expansion to states that chose to opt in. Today, **39 states and the District of Columbia have expanded Medicaid**, 11 states have not expanded their Medicaid programs, and one

state, South Dakota, will have an expansion going into effect in July of 2023.

For the issue brief, KFF surveyed the results of 24 studies on the economic effects of expansion during the last two years and compared those study findings to previous work that explored a similar topic. These pandemic-era studies are especially important given the huge stresses COVID-19 has put on the health care system and the massive increase in the **number of people covered by Medicaid**. This surge in Medicaid enrollment is likely to decline sharply as states **resume normal processes** in 2023.

Previous studies found a huge improvement in the number of uninsured patients and the



amount of uncompensated care hospitals provide in Medicaid expansion states. Where the more recent studies touch on this issue, most found the same improvement, though the effect was not seen in studies that focused on critical access and safety-net providers.

Previous studies found that Medicaid expansion improved provider operating revenues, and some studies show that expansion may reduce annual hospital closures. The more recent studies have similar findings, though the effect is again variable and may not be helping critical access hospitals or free and charitable clinics.

Notably, most of the favorable effects are also concentrated in hospitals that do not have

obstetrics units, and the **latest news shows these units are at risk of closure** nationally.

KFF also notes that these studies do not investigate the effects of Medicaid expansion on states but that previous studies found positive effects on state finances, including budgets, revenues, and economic growth.

Medicaid expansion has been a useful tool most states can use to help decrease their uninsured population and bolster local hospitals. We will continue to urge the 11 holdout states to expand Medicaid to ensure that people who cannot afford health care on their own can gain access to the care they need.

Read the issue brief.

Get ready for more prescription drug price hikes

We know pharmaceutical companies are greedy. Most, if not all, companies are greedy and will do what they can to maximize profits. But, Congress continues to allow that greed. As long as it does, we will pay increasing amounts for our prescription drugs.

It's no surprise that **Accountable.us**, a government watchdog group reports that the big Pharma companies are prepared to raise prices significantly on more than 350 drugs. However many billions the pharmaceutical companies earned in 2022 is irrelevant if they can make more in 2023.

For example, Pfizer is raising prices on more than 90 drugs. Ibrance and Xalkori, cancer drugs, will see 7.9 percent price increases. Why would Pfizer want to put an end to soaring profits in 2021 and 2022 if it does not have to?

Higher drug prices allow the pharmaceutical companies to say that they can invest more money for research. The truth is that these companies put more money into stock buybacks and dividends than on research. And, when they conduct research, the research generally focuses on drugs that are similar to what's already on the market, where



they know they can find huge demand, rather than drugs for rare conditions that have no treatments available.

The Republican-controlled House of Representatives is unlikely to pick up where their predecessors left off on drug price negotiation, in the **Inflation Reduction Act**. Pharma gives oodles of money to them to make sure. So, for now, we have simply the possibility of Medicare negotiating drug prices for 60 drugs over the next several years—if Pharma does not succeed at blocking those negotiations.

One reform, with some bi-

partisan support, that Congress has a small chance of enacting, would allow Americans to import drugs from around the world from verified pharmacies. Ideally, the proposal would also require insurers to cover those drugs, as they would cost a lot less than the same drugs in the US.

Today, millions of Americans import drugs from abroad for personal use, with no reported safety concerns, although it is not legal for them to do so. At the same time, tens of millions of other Americans can't afford the drugs they need in the US, compromising their health.

Pandemic Funding Saved More Americans From Medical Debt

The number of Americans who had trouble paying their medical bills dropped precipitously between 2019 and 2021, and funds from the American Rescue Plan and other federal pandemic relief programs may have been a reason why.

Overall, 10.8% of Americans responding to a federal survey in 2021 said they had had problems covering medical bills that year, down from 14% in 2019, according to researchers at the National Center for Health Statistics (NCHS), part of the U.S. Centers for Disease Control and Prevention.

The latest stats follow "a significant trend downwards from 2011," following the 2010 passage of the Affordable Care Act (also known as Obamacare), the NCHS authors noted.

In 2011, "nearly 20% of people were in families having problems paying medical bills," they said.

Positive change over the past few years in medical bill coverage has been even more dramatic among adults too young to qualify for Medicare, the

report found.

"Estimates from the Health Reform Monitoring Survey found that problems paying medical bills among adults aged 18-64 decreased from 23.6% in March 2019 to 16.8% in April 2021," according to the report, authored by NCHS researchers **Robin Cohen** and **Amy Cha**.

Their study wasn't designed to figure out why fewer people are overwhelmed by medical costs now.

"However, the impact of the COVID-19 pandemic on problems paying medical bills cannot be discounted," Cohen and Cha wrote.

Specifically, three pieces of federal legislation enacted in 2021 -- the Coronavirus Aid, Relief, and Economic Security Act (CARES), the Consolidated Appropriations Act, and the American Rescue Plan Act -- "may have helped indirectly to mitigate the impact of the pandemic on people having problems paying medical bills," the report said.



The legislation "provided direct monetary payments, flexibility with payments to creditors, additional unemployment assistance, subsidized payroll for affected small businesses, and improvements in paid sick leave," the report found.

The American Rescue Plan also expanded access to health insurance by expanding COBRA insurance premium coverage, while at the same time expanding access to Medicaid, it said.

According to the report, the percentage of people unable to pay for medical bills was smaller in states that had expanded access to Medicaid compared to people living in states without expanded access.

One other factor that might have influenced the number of Americans overwhelmed by medical bills: Lower demand in 2021 for medical services, as COVID fears had people cutting back on ER and outpatient hospital visits, as well as routine medical screenings.

Even though the report saw

encouraging declines in the number of people saddled with unmanageable medical debt, "medical debt continues to be the major form of debt in the United States," Cohen and Cha stressed.

Medical debt can have a disastrous "domino effect" on household debt overall.

"People who have medical debt may pay off these bills by taking on other forms of debt, including credit cards and bank loans, or negotiate payment plans with health care providers, or just fail to pay them," the study authors noted.

In the meantime, finances can get so tight that people forgo needed medical care and have trouble covering the cost of the basic necessities of life. Bankruptcy becomes all too common, the team said.

So, "despite the decreasing trend in the percentage of people with problems paying medical bills, the burden associated with unpaid medical bills remains a public health concern," the researchers concluded.

Amazon launches a subscription prescription drug service

Amazon is adding a prescription drug discount program to its growing health care business.

The retail giant said Tuesday that it will launch RxPass, a subscription service for customers who have Prime memberships. Amazon said people will pay \$5 a month to fill as many prescriptions as they need from a list of about 50 generic medications, which are

generally cheaper versions of brand-name drugs.

The company said the flat fee could cover a list of medications like the antibiotic amoxicillin and the anti-inflammatory drug naproxen.

Sildenafil also made the list. It's used to treat erectile dysfunction under the brand name Viagra and also treats a



form of high blood pressure.

Amazon sells a range of generic drugs through its pharmacy service.

Some already cost as little as \$1 for a 30-day supply, so the benefit of this new program will vary by customer.

The program doesn't use insurance, and people with government-funded Medicaid or Medicare coverage are not

eligible. It will be available in 42 states and Washington, D.C. at launch.

Any program that gets low-cost generic drugs to more patients "is a good thing," said Karen Van Nuys, an economist who studies drug pricing at the University of Southern California. But she added that she wasn't sure how much of an impact RxPass will have.

Scams targeting seniors have more than doubled since 2020

Senior citizens have long been the target of scammers, but according to the **AARP**, the **rate of elder financial exploitation has more than doubled since 2020**.

Director of the **AARP's Bank Safe program** Jilene Gunther authored a report on elderly financial exploitation and the ways in which they were swindled.

Gunther attributed the rise in senior scams in part to the pandemic. She said the social

isolation and increased dependency on online shopping created opportunities fraudsters could not resist.

"Criminals go where the money is," Gunther explained. "So, when that becomes a popular method of payment, and it's so fast, they're going to lean into that."

Experts said it's not just overseas scammers defrauding the elderly. Gunther said family members were also a big part of



the problem, stealing twice as much money from seniors as strangers do.

The Office of Older Americans with the **Consumer Financial Protection Bureau** (CFPB) investigates cases of financially abused seniors. They

Assistant Director of the Office of Older Americans Deborah Royster said educating consumers and reporting incidents are the best methods to stop scams. Royster urged seniors

to be wary of any communication they receive, especially if it is delivered with a sense of urgency.

She said banks and other financial institutions can help combat fraud by keeping an eye out for any suspicious transactions requested by seniors.

You can report any kind of suspicious activity to **consumerfinance.gov/complaint**.

Have Arthritis? Design Your Office to Ease the Strain

Whether your job is remote or takes you to an office, you'll feel better and offset joint pain by having a workspace that's designed to work for you instead of against you.

The biggest problem isn't sitting itself but holding a single position for long periods often with a posture that causes strain, such as leaning forward, said **Ben Horonjeff**, an ergonomics and human factors consultant in New York City. (Ergonomics refers to office comfort and efficiency).

"People think the opposite of sitting is standing. Unless you're moving around when you stand up, that's not the case," Horonjeff said in a news release from the Arthritis Foundation. "The real opposite of both sitting or standing still is moving. And moving frequently is what we need to be doing to avoid causing work-related pain, muscle strain and fatigue."

Repetitive tasks that tire the same muscles and being still for long periods can strain the neck, shoulders, back, hands, wrists and legs, according to the foundation.

Move often, the foundation

suggests. Get up about every 20 to 30 minutes and walk around. Adjust your position frequently.

"Shifting positions and moving around are the best ways to combat pain, stiffness and fatigue," Horonjeff said.

Here are some of the foundation's other suggestions for setting up a healthy workspace:

The desk

Take a look at your computer monitor. Eyes should be level with the top of the screen. The center should be 15 degrees below your line of sight and approximately an arm's length away. Oversize monitors are an exception.

Use a laptop riser to bring a laptop to eye level. Get a separate keyboard so you can type at the proper height.

At your desk, sit so your upper back is straight and your shoulders are relaxed. Make sure your shoulders don't creep toward your ears during the day.

Support your arms with adjustable arm rests. Your upper and lower arm should form a 90-degree angle and you should be



positioned so you can keep your wrists straight and fingers relaxed.

Your feet should firmly touch the floor. Use a footrest if your feet don't easily reach the floor.

Keep tools you use regularly within arm's reach. This prevents contorting into an awkward position or leaning forward to reach them.

The chair

Your chair can make a difference in a space that fits you. You may be able to request a workplace accommodation if your office doesn't provide an appropriate chair.

If you're buying a chair, try it first, and try sitting in many chairs.

Select a chair that offers lumbar support. This lets you sit in a natural, neutral posture. You should sit with your bottom at the back of the chair and with your body leaning back, so your spine hugs the lumbar curve of the chair.

Your chair should also swivel and roll, and have a five-point base for stability and ease of

movement.

The chair should also fit you, with at least a 1-inch gap between the edge of the seat and the backs of your knees when sitting back. The seat should be at least an inch wider than your hips and thighs. The chair's back should be wide enough for your back, but without restricting arm movements by being too wide.

With an adjustable chair, you can alter seat height, seat tilt, backrest height and tilt, and armrest positions.

Having a chair with a headrest can reduce neck and shoulder strain.

Using a document holder can raise materials to eye level, so you won't need to bend toward your desk.

Use a headset to avoid cradling a phone. This reduces neck and shoulder strain.

Try an ergonomic keyboard and mouse to keep hands and forearms in a more neutral position. A vertical mouse lets you use it in an upright, neutral position, which can help if you have carpal tunnel syndrome.

What to Know About XBB, the New COVID Variant

The new coronavirus continues to dodge, duck, dip and dive, mutating again and again to find its way past people's immune defenses.

The latest COVID variant to gain a foothold in America is called XBB.1.5, which has rapidly started to crowd out other competing variants.

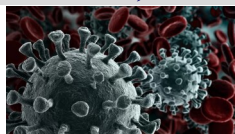
XBB.1.5 is the first recombinant COVID variant expected to become dominant in the United States, according to the viral surveillance company Helix. This variant is called "recombinant" because it was created by two Omicron subvariants merging through evolution.

The new strain also took two evolutionary steps instead of just one, gaining a mutation for immune evasion as well as an unsuppressed ability to bind to and infect human cells, Helix said in its **report**.

These rapid-fire mutations -- as well as the battle for supremacy that Omicron variants are now waging in human bodies -- are relatively unprecedented, said **Dr. Greg Poland**, director of the Mayo Clinic's Vaccine Research Group.

"There was not one virologist I know of, including myself, not one of us thought we would see anything other than Delta subvariants," Poland said. "Instead, out of nowhere came Omicron. None of us expected that."

"And now what Omicron is demonstrating is something I have never really seen in my career before called convergent evolution, which means that what we're seeing is a swarm of Omicron subvariants battling one another for dominance," Poland added.



How widespread is XBB.1.5?

Omicron XBB.1.5 is currently the dominant strain across the United States, accounting for 43% of cases, according to the **U.S. Centers for Disease Control and Prevention**.

However, the variant is raging even harder in some parts of the nation

In the Northeast, where XBB.1.5 is suspected to have first emerged, the variant makes up at least 82% of new cases, the CDC **said**.

"In my neck of the woods, it's probably four out of five at least," said **Dr. Aaron Glatt**, chief of infectious disease at Mount Sinai South Nassau in Oceanside, N.Y.

Is it more transmissible?

The World Health Organization has called XBB.1.5 the most transmissible COVID-19 variant ever, said **Dr. Bhavna Lall**, a

clinical assistant professor of adult medicine at the University of Houston College of Medicine.

"It's spreading pretty rapidly and it's the most contagious Omicron variant yet," Lall said. "It's the most contagious COVID-19 variant that we've had so far."

The XBB.1 variants are dramatically better at evading the neutralizing antibodies in humans that protect against initial infection, according to a new study published Jan. 18 in the ***New England Journal of Medicine***.

XBB.1 variants escape neutralizing antibodies 17 times more effectively than the BA.5 variant -- and that's if someone's gotten a booster dose of the standard mRNA vaccine, a Beth Israel Deaconess Medical Center team led by renowned virologist **Dr. Dan Barouch** reported....**Read More**

Gut Microbiome May Play Role in Irritable Bowel Syndrome

Researchers believe they have found a link between lower bacterial diversity in the intestine's microbiome and irritable bowel syndrome (IBS).

Normally, "more than 10,000 species of microorganism live in the human intestine," noted study co-author **Dr. Jung Ok Shim**, a professor of pediatric gastroenterology, hepatology, and nutrition at Korea University College of Medicine in Seoul.

To study this, the investigators combined their own dataset with nine other published datasets,

involving a total of 576 IBS patients and 487 healthy "control" patients.

What did they find? The gut bacteria was less diverse in IBS patients than in healthy people, Shim said.

The level of abundance of 21 specific bacterial species also differed between IBS patients and healthy controls, though the findings were not statistically significant, the study authors noted.

The findings were published



online Jan. 18 in *Microbiology Spectrum*, a journal of the American Society for Microbiology.

The study proved this disturbed gut bacterial community "is associated with IBS, though this does not mean that the relationship is causal," Shim said in a society news release.

"Functional studies are needed to prove whether the change in gut microorganisms contributes to development of IBS."

IBS is a common affliction,

causing bloating, diarrhea, stomach pain and cramps. Its cause is unknown, and there is no effective treatment.

"Based on the epidemiological studies of IBS patients, altered gut microbiota was proposed as one of the possible causes of IBS," the researchers wrote. "Acute bacterial gastroenteritis can cause chronic, asymptomatic, low-grade intestinal wall inflammation sufficient to alter neuromuscular and epithelial cell function."

U.S. Proposes to Make COVID Shot Annual, Much Like Flu Shot

The U.S. Food and Drug Administration on Monday asked its vaccine advisory panel to weigh a proposal to turn COVID vaccines into an annual shot for most Americans.

Such a move would simplify future vaccination efforts, a critical point given the fact that efforts to get people to get COVID booster shots have fallen far short of expectations. While over 80% of Americans have had at least one dose of the original COVID-19 vaccine, only 16% of those over the age of 5 have gotten the updated booster shots that were approved last August, **according** to the U.S. Centers for Disease Control and Prevention.

The committee will consider the FDA proposal at its Jan. 26 meeting. If it recommends the concept be turned into policy and the agency follows those recommendations, COVID shots would likely become much like

annual flu shots.

In **documents** filed with the Vaccines and Related Biological Products Advisory Committee, the FDA noted that "the totality of the available evidence on prior exposure to and vaccination against SARS-CoV-2 suggests that, moving forward, most individuals may only need to receive one dose of an approved or authorized COVID-19 vaccine to restore protective immunity for a period of time."

Who might need more than one dose per year? For the very young, seniors and the immunocompromised, the agency noted that two doses may be needed to induce enough immunity to protect against COVID-19 infection.

In its proposal, the FDA suggested an annual vaccine approval system similar to the one used for the flu.

"The FDA anticipates



conducting an assessment of SARS-CoV-2 strains at least annually and to engage

[the vaccine advisory committee] in about early June of each year regarding strain selection for the fall season. Subsequently, a decision on the recommended vaccine composition would be made in time for any updated vaccine to be in production in time to be deployed for use no later than September of each calendar year," the agency added.

Along with simplifying when a COVID-19 vaccine should be given, the FDA also wants to switch all COVID vaccines to target the same strains, because that would make the shots interchangeable and simpler to administer. The agency proposes to use the updated bivalent booster shots, which protect against both the original strain of SARS-CoV-2 and the Omicron variants that now dominate in the

United States. According to the CDC, the XBB variant now accounts for just over 49% of all U.S. infections.

Some vaccine experts were surprised by the proposal, including some FDA vaccine advisory committee members.

"I'm choosing to believe that they are open to advice, and that they haven't already made up their minds as to exactly what they're going to do," **Dr. Paul Offit**, one of the panel advisers and director of the Vaccine Education Center at Children's Hospital of Philadelphia, told *TheNew York Times*.

"I'd like to see some data on the effect of dosing interval, at least observational data," **Dr. Eric Rubin**, one of the panel advisers and editor-in-chief of the *New England Journal of Medicine*, told the *Times*. "And going forward, I'd like to see data collected to try to tell if we're doing the right thing."

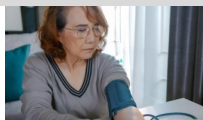
Intensive Blood Pressure Control May Lower Risk For Cognitive Problems in More People

Several years ago, researchers published in JAMA a promising discovery: intensively lowering blood pressure appeared to reduce the risk for cognitive decline in people 50 and older with high blood pressure. But questions remained about whether the strategy was safe or effective in people whose diastolic blood pressure – the bottom number in a blood pressure reading – was low. Some data suggested intensive control might raise the risk for dementia in this group.

A new study led by researchers

in China suggests otherwise. The findings, published Monday in the American Heart

Association journal Hypertension, show no evidence that intensive systolic (top number) blood pressure control is harmful to people whose diastolic blood pressure is low. Compared to people whose systolic blood pressure was lowered to standard levels, people who intensively reduced their systolic levels had a lower risk for probable dementia or mild cognitive impairment, regardless of whether their



diastolic levels were high or low before treatment.

"I think this further supports the general notion that for most people, intensive blood pressure control is safe and has potential benefits," said Dr. Rebecca Gottesman, chief of the stroke branch at the National Institute of Neurological Disorders and Stroke Intramural Research Program in Bethesda, Maryland.

Gottesman, who was not involved in the research, said the study addressed an important gap

in the scientific literature about who could benefit from intensive blood pressure control. "It gives us at least some confidence that across diastolic blood pressure levels, it is similarly safe."

A blood pressure reading has two numbers. The top number measures systolic pressure, the force against artery walls when the heart beats. The bottom number, diastolic pressure, measures the same force between beats....**Read More**

Feds to Investigate Overuse of Antipsychotic Drugs by Nursing Homes

U.S. health officials say they plan to investigate whether some nursing homes are falsely labeling patients as schizophrenic so they can administer sedating antipsychotic drugs to them.

The Centers for Medicare and Medicaid Services (CMS) noted that evidence of this abuse has grown over decades. It plans to launch an investigation of select nursing homes this month, the *Associated Press* reported.

"No nursing home resident should be improperly diagnosed with schizophrenia or given an inappropriate antipsychotic," **HHS Secretary**

Xavier Becerra said in a statement Wednesday. "The steps we are taking today will help prevent these errors and give families peace of mind."

In 2022, a government report found that some facilities may be coding residents as having schizophrenia without having signs of the disorder, the *AP* reported.

The powerful drugs may help those who actually have the mental illness, which is characterized by delusions, hallucinations and disordered thinking. But the medications can



also have dangerous side effects, including death. While less than 1% of people have

schizophrenia, 99 U.S. nursing homes have claimed that at least 20% of their residents have the condition, the news report noted.

Antipsychotic drug use by nursing home residents had dropped before skyrocketing between 2015 and 2019, according to a report issued by the Health and Human Services Office of the Inspector General.

"The number of unsupported schizophrenia diagnoses increased and in 2019 was

concentrated in relatively few nursing homes," the report concluded.

The agency will use targeted audits to seek documentation of schizophrenia diagnoses in nursing homes that have coded patients as having schizophrenia. CMS plans to monitor those facilities to ensure the improprieties are corrected.

Finding a pattern of inaccurate coding will affect rating scores for the facilities, CMS said. It did not say that it would fine facilities, change patient care or notify patients' relatives.

Why Is American Food So Unhealthy?

It's no secret: The standard American diet is at the root of the obesity epidemic and many of its associated diseases.

But why is American food so unhealthy? It's not just that Americans eat too much, which they do, but it's also what they eat that's unhealthy: fat, sugar, salt and ultra-processed foods.

According to the **Dietary Guidelines for Americans**, the average American diet consists of excess salt, saturated fat, refined grains, calories from solid fats and added sugars.

Americans also eat fewer vegetables, fruits, whole grains, dairy products and oils than recommended. Nearly 42% of American adults are obese, **statistics** from the U.S.

Centers for Disease Control and Prevention show.

One reason may be that healthy foods are often more expensive than packaged foods. Packaged foods tend to have higher amounts of salt, refined grains, sugar and unhealthy oils not recommended by the Dietary Guidelines for Americans. The **CDC** notes that high blood pressure and high cholesterol caused by consuming too much salt are the leading causes of heart disease and stroke. Current guidelines recommend getting less than 2,300 milligrams (mg) of salt a day, but most Americans consume more than 3,400 mg a day, on average.

The culprit? More than 70% of



the salt that Americans eat comes from packaged, processed, store-bought and restaurant foods, the CDC says.

"Ultra-processed foods are designed to fire up cravings and desire for these foods, and advertising — which is everywhere — reinforces those urges," **Samantha Heller**, a senior clinical nutritionist at NYU Langone Health in New York City, **said** recently. "It is not the fault of the consumer that they long for ultra-processed foods. But it is up to us to recognize the manipulation by food companies and to take control of what we choose to eat."

Choosing unhealthy foods does more than pack on the pounds:

Being overweight or obese ups the odds of developing type 2 diabetes. Among U.S. adults, 96 million have pre-diabetes, according to the CDC. Diabetes can lead to poor circulation resulting in amputations, and the blood sugar disease is also linked to vision loss and kidney disease.

In addition, the CDC says an unhealthy diet can increase the risk of some cancers. Eating unhealthy food and drinks can lead to chronic conditions that put people at higher risk of at least 13 types of cancer, including uterine cancer, breast cancer in postmenopausal women, and colon cancer. Colon cancer is also associated with eating red and processed meat....**Read More**

Surgery Brings Added Risks to People With COPD

Major surgery is a challenge for people with chronic obstructive pulmonary disease (COPD), raising their odds of death within a year by 61%, new research shows.

The researchers also found these patients incurred 13% higher health care costs in the year after their operation, compared to patients without the respiratory condition.

"These increased risks and costs were evident long after the immediate 30-day postoperative period," said lead researcher **Dr. Ashwin Sankar**, a clinician investigator in anesthesiology at the University of Toronto, in Canada.

The study quantifies the additional risks COPD patients face, which doctors should discuss before surgery, he said.

"Informing patients of the risk of surgery is an important component of the informed-consent process prior to surgery. We suggest that clinicians and patients weigh these risks when deciding to proceed with surgery," Sankar explained.

This study can't prove that COPD caused the deaths after surgery as most of the COPD patients had other chronic health conditions, which could have contributed to the outcomes.

"What we suggest to clinicians



is to use COPD as a flag for other conditions, and to ensure that modifiable risk factors are optimized prior to surgery," Sankar said.

Also, because patients with COPD are at risk beyond 30 days after surgery, it may be worthwhile to support these patients' recovery beyond the first month after surgery, he added.

In the United States, about 16 million people have COPD, according to the U.S. Centers for Disease Control and Prevention. COPD includes a group of diseases, emphysema and chronic bronchitis among them, that block airflow and restrict

breathing.

For the study, Sankar and his colleagues collected data on nearly 933,000 patients who had major surgery, including total hip or knee replacement, gastrointestinal surgery, vascular surgery or other elective operations. More than 170,000 of these patients suffered from COPD.

The COPD patients were older, more likely to be male, frail, have lower income and have pre-existing conditions, such as heart disease, diabetes and lung cancer, the researchers noted....**Read More**

Do Fasting Diets Work? Study Finds Meal Size, Not Timing, Key to Weight Loss

When it comes to weight loss, what seems to matter most is how often and how much you eat, rather than when you eat.

That's the conclusion of a new study that focused on the eating habits of about 550 adults.

For six months, all were asked to use a phone app to report both the timing and size of all their meals.

"What we found is that, on average, the more meals people ate throughout the day, or the more large meals they ate throughout the day, the more likely they were to gain weight over time," said study author **Dr. Wendy Bennett**.

By contrast, "eating more small meals during the day was associated with more weight loss," added Bennett, an associate professor of medicine at Johns Hopkins School of Medicine, in Baltimore.

They found no link between when in the day people ate and any change in their weight.

Bennett stressed that the findings do not speak to the pros and cons of intermittent fasting, a popular dietary practice that involves abstaining from eating

for fixed periods of time.

That's because "we didn't know people's intentions," she explained. "We really just followed everyday free-living people, without asking anyone to change their behavior, and without knowing who did or did not want to lose weight."

So, she noted, "We can't draw any conclusions about intermittent fasting."

According to the American Heart Association (AHA), 4 in 10 Americans are obese. Bennett and her team wanted to gain some insight into the relative importance of when, how often and what people eat when it comes to weight control.

In 2019, the team recruited 547 adults who were primary care patients in three health systems across Maryland and Pennsylvania.

The patients' average age was 51, and about three-quarters were women. Roughly four in five were white, 12% were Black and 3% were Asian. More than 70% had a college education.

The average body mass index



(BMI) pre-enrollment was pegged at nearly 31. A BMI of 30 or more is considered obese. Those with a higher BMI tended to be Black, older and more likely to have high blood pressure and/or diabetes.

All of the participants got a mobile application called "Daily24." The app enabled them to record their sleeping and eating routines on a daily basis for half a year, and to calculate meal habits.

The study participants' weight was tracked over six years.

After crunching the numbers, the research team concluded that regardless of current weight status there was no apparent link between when people ate their meals and any weight change.

On the other hand, routinely eating more large meals (1,000 calories and up) and/or more medium meals (between 500 and 1000 calories) was linked to a greater likelihood for gaining weight. Eating fewer meals and smaller meals (below 500 calories) was linked to weight loss.

Bennett pointed out that the

demographic breakdown of the patients in the study is not representative of all Americans. And given the study's observational nature, it cannot prove cause and effect, she added.

Even so, "we have seen other studies that demonstrate that the key (to weight loss) is portions and calories," said **Connie Diekman**, a food and nutrition consultant and former president of the Academy of Nutrition & Dietetics.

Diekman suggested that simply developing conscious eating routines — whether involving strict fasting or not — could be helpful to many seeking to lose weight.

"Many Americans eat more in a grab and go fashion, which decreases our recognition of how much we have eaten," she noted.

"As a registered dietitian, I help my clients assess where they struggle with eating," Diekman explained. "If it is evident that they do not have any routine, we work on that first," identifying the kind of meal portions and frequency that will work best for the patient at hand.

Only Half of Folks With Stool Test Positive for Colon Cancer Get Follow-Up Colonoscopy

Many people undergo a stool test to screen for colon cancer but a new study finds too few follow up with a colonoscopy when that test warns of a possible cancer.

Not following up undermines the point of screening, said study-co-author **Jeff Mohl**, director of research and analytics for the American Medical Group Association, a trade organization.

In this study of almost 33,000

people at average risk for colon cancer, just 56% who had a positive result from a stool test had followed up with a colonoscopy within a year.

Poorer people and the COVID-19 pandemic were associated with lower follow-up rates.

"Obviously, that's a huge problem," said Mohl. "If you're trying to estimate how many lives



are saved, you're assuming that everyone gets follow-ups if they have a positive result, and if half of them don't do that, obviously you'll only save half as many people."

The findings were published Jan. 18 in **JAMA Network Open** and based on screenings between 2017 and 2020.

"Colorectal cancer is definitely

a significant health problem and increasing, particularly in younger patients," said **Dr. William Dahut**, chief scientific officer with the American Cancer Society. Rates have been increasing by 1% to 2% a year since the mid-1990s in Americans younger than 50, the cancer society says....**Read More**

Aspirin OK After Fracture to Help Avoid Blood Clots

When people undergo surgery for broken arms or legs, they are often injected with prescription blood thinners to reduce their risk of developing potentially life-threatening blood clots in their lungs and legs.

But a large, **new study** suggests it may be time to rethink this practice. It found that aspirin may be as effective as injections of low-molecular-weight heparin when it comes to staving off blood clots and their related complications.

"Patients all over North America who come in for surgery for fractures are at risk for blood clots in their legs and lungs, and the standard treatment is injections of low-molecular-weight heparin in the hospital and for weeks after discharge," said study author **Dr. Robert O'Toole**, chief of orthopaedics at the University of Maryland Medical Center's R Adams Cowley Shock Trauma Center in Baltimore.

"It's a shot given twice a day,



and patients hate it," he said. These heparin shots also have a much heftier price tag than aspirin.

The study included more than 12,000 patients with arm or leg fractures that required surgery or pelvic fractures regardless of treatment. They were treated at 21 trauma centers.

Of these, half received injections of low-molecular-weight heparin twice a day, and half received low-dose baby aspirin twice daily. All

participants were followed for 90 days to see how they fared.

Outcomes were similar for both groups. There were no differences in terms of death, blood clots in the lungs, bleeding complications, infection, or wound healing problems, the study showed.

Folks in the aspirin group were more likely to develop blood clots below their knee. O'Toole noted these are not considered as serious as other types of blood clots....**Read More**

What Older Americans Need to Know About Taking Paxlovid

A new coronavirus variant is circulating, the most transmissible one yet. Hospitalizations of infected patients are rising. And older adults represent **nearly 90%** of U.S. deaths from covid-19 in recent months, the largest portion since the start of the pandemic

What does that mean for people 65 and older catching covid for the first time or those experiencing a repeat infection?

The message from infectious disease experts and geriatricians is clear: Seek treatment with antiviral therapy, which remains effective against new covid variants.

The therapy of first choice, experts said, is Paxlovid, an antiviral treatment for people with mild to moderate covid at high risk of becoming seriously

ill from the virus. All adults 65 and up fall in that category. If people can't tolerate the medication — potential complications with other drugs need to be carefully evaluated by a medical provider — two alternatives are available.

"There's lots of evidence that Paxlovid can reduce the risk of catastrophic events that can follow infection with covid in older individuals," said **Dr. Harlan Krumholz**, a professor of medicine at Yale University.

Meanwhile, develop a plan for what you'll do if you get covid. Where will you seek care? What if you can't get in quickly to see your doctor, a common problem? You need to act fast since Paxlovid must be started no later than five days after the onset of



symptoms. Will you need to adjust your medication regimen to guard against potentially dangerous drug interactions?

"The time to be figuring all this out is before you get covid," said **Dr. Allison Weinmann**, an infectious-disease expert at Henry Ford Hospital in Detroit.

Being prepared proved essential when I caught covid in mid-December and went to urgent care for a prescription. Because I'm 67, with blood cancer and autoimmune illness, I'm at elevated risk of getting severely ill from the virus. But I take a blood thinner that can have life-threatening interactions with Paxlovid.

Fortunately, the urgent care center could see my electronic medical record, and a physician's

note there said it was safe for me to stop the blood thinner and get the treatment. (I'd consulted with my oncologist in advance.) So, I walked away with a Paxlovid prescription, and within a day my headaches and chills had disappeared.

Just before getting covid, I'd read an **important study** of nearly 45,000 patients 50 and older treated for covid between January and July 2022 at Mass General Brigham, a large Massachusetts health system. Twenty-eight percent of the patients were prescribed Paxlovid, which had received an emergency use authorization for mild to moderate covid from the FDA in December 2021; 72% were not. All were outpatients....**[Read More](#)**

Poll Finds Nearly Half of Americans Unprepared for Medical Emergency

A medical emergency can happen at any moment. Will you be prepared?

Nearly half of American adults will not, according to a new **poll** from the American College of Emergency Physicians (ACEP) and Morning Consult.

About 76% felt prepared to communicate with a 911 operator, but only 55% said they could provide hands-only cardiopulmonary resuscitation (**CPR**).

Meanwhile, just 47% said they were prepared to apply a tourniquet to control severe bleeding, the same number who

said they could move a victim to safety. Fewer than 29% said they felt prepared to use an automatic external defibrillator (AED).

"A medical emergency can happen at any time and quick action by a bystander can be the difference between life or death," said ACEP president **Dr. Christopher Kang**. "Everyone can learn some easy steps to take so that they can help in an emergency."

About 83% of adults who've had some kind of emergency training say they're willing to act during a medical crisis while



waiting for professional emergency responders to arrive.

The ACEP noted that the heart stops during cardiac arrest, which means blood isn't flowing to the brain and vital organs, and brain cells start to die in minutes. Response by bystanders is critical.

Nearly 90% of cardiac arrests that happen outside of a hospital are fatal, according to the U.S. National Heart, Lung, and Blood Institute.

CPR performed in the first few minutes of cardiac arrest can double or triple the likelihood

that a person will survive, according to the U.S. Centers for Disease Control and Prevention.

While a person may still be able to talk or breathe during a heart attack, it's not the same as a cardiac arrest, the ACEP noted. A person who has had a heart attack should only be given CPR if they lose consciousness, do not have a pulse or stop breathing.

If a bystander witnesses an apparent cardiac arrest, the bystander should verify the scene is safe, call 911 or ask another person to do so, and then start CPR or use an available AED as soon as possible. **[Read More](#)**

Is There a Best Diuretic Drug for Heart Failure?

It doesn't matter which water pill you're prescribed to treat your heart failure, because new trial data shows that one works as well as the other.

Two diuretics widely used to treat heart failure, furosemide and torsemide, showed no difference in their ability to improve patient survival, according to the U.S. National Institutes of Health (NIH)-sponsored trial.

"We're not saying that patients don't need diuretics. We're saying that there's no difference in the survival benefit of these two therapies," said study co-leader **Dr. Robert Mentz**, chief of the heart failure section at

Duke University Medical Center in Durham, N.C.

"This suggests we should be spending more time focusing on the right diuretic dose for our patients and working to treat patients with therapies that improve clinical outcomes in heart failure," Mentz added in an NIH news release.

More than 6 million American adults live with heart failure, which is most common in people aged 65 and older, according to the U.S. Centers for Disease Control and Prevention. It occurs when the heart grows too weak to pump enough blood to meet the



body's needs. Diuretics help relieve congestion and breathing difficulties caused by fluid build-up in patients with heart failure.

Furosemide is the most used diuretic for heart failure and has been around for decades, while torsemide is comparatively newer. The investigators launched the new clinical trial after previous studies suggested that torsemide might be better at reducing deaths.

For the trial, the researchers studied more than 2,800 patients hospitalized with heart failure at 60 hospitals throughout the

United States. The patients randomly received one of the two diuretics, and doctors followed them for an average of 17 months.

During follow-up, 26% of patients taking either torsemide or furosemide died, the study authors said.

"Overall, our study showed that torsemide did not improve survival compared to furosemide in this high-risk population of patients with heart failure, and we also observed similar rates of hospitalization with the two medications," Mentz said....**[Read More](#)**