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Let's put the vote-by-mail 'fraud' myth to rest

Widespread calls to conduct the 2020 elections by mail, to protect voters from COVID-19 exposure, are being met with charges that the system inevitably would lead to massive voter fraud. This is simply not true.

Vote fraud in the United States is exceedingly rare, with mailed ballots and otherwise. Over the past 20 years, about 250 million votes have been cast by a mail ballot nationally. The Heritage Foundation maintains an **online database of election fraud** cases in the United States and reports that there have been just over 1,200 cases of vote fraud of all forms, resulting in 1,100 criminal convictions, over the past 20 years. Of these, 204 involved the fraudulent use of absentee ballots; 143 resulted in criminal convictions.

Let's put that data in perspective. One hundred forty-three cases of fraud using mailed ballots over the course of 20 years comes out to seven to eight cases per year, nationally. It also means that across the 50 states, there has been an average of three cases per state over the 20-year span. That is just one case per state every six or seven years. We are talking about an occurrence that translates to about 0.00006 percent of total votes cast.

Oregon is the state that started mailing ballots to all voters in 2000 and has worked diligently to put in place stringent security measures, as well as strict punishments for those who would tamper with a mailed ballot. For that state, the following numbers apply: With well over 50 million ballots cast, there have been only two fraud cases verifiable enough to result in convictions for mail-ballot fraud in 20 years. That is 0.000004 percent — about five times less likely than getting hit by lightning in the United States.

This hardly seems like a world in which "**thousands and thousands of people** [are] sitting in somebody's living room, signing ballots all over the place."

We should make two things clear. First, there is no excuse for any type of voter or election fraud, by any method. States are justified in creating systems that are intended to deter and detect fraud, and for prosecuting it when discovered. All do.

Voting by mail presents challenges to the prevention of voter fraud that voting in person lacks. Most obviously, in-person voting occurs in public. A voter must announce their name out loud, and it is checked against the voter registration list. All states make provisions for some form of objectors, who can question the identity of the person at the check-in table, within the constraints of state law. Some states require a photo ID to be shown. Many states require the voter to sign a poll book. These and other procedures have been in place for a century-and-a-half, since the widespread election reforms of the 1880s and 1890s.

Second, no voting methodology is perfect. In-person voting has its own examples of fraud, however rare. It is also full of stories of missing power cords, missing keys, an inadequate number of ballots, machines that switched the voter's intent, improper application of ID requirements, long lines and more. Nonetheless, in-person voting also has a role to play even in states that use the 100 percent mail-ballot election model.

As with in-person voting, states have methods to guard against fraudulently casting votes by mail too. Most have signature-matching requirements, either to scrutinize the application, the returned ballot, or both. We have seen this done effectively using a mix of human oversight and technology. Many states restrict who can return a ballot for a voter, or require those who return ballots on the behalf of others to identify themselves on the return envelope. Finally, the states with the most expansive vote-by-mail systems — such as Colorado, Oregon, Utah and Washington — send ballots to all registered voters and rely on the steady stream of mail between election offices and voters to keep the rolls clean, and to minimize the number of stray ballots that might be distributed.

Expanding voting by mail will be a challenge in most states in 2020. Logistical and security issues will need to be reviewed to ensure that every registered voter can do so safely and effectively, and that no one votes more than once. But we reiterate: There is no evidence that mail-balloting results in rampant voter fraud, nor that election officials lack the knowledge about how to protect against abuses.

Trump predicts "most corrupt election" in US history, making false claims

President Trump is lying about voting by mail in this country. The fact is that Americans have voted by mail since the Civil War!

And for seniors who need to protect their health during the COVID-19 pandemic, voting by mail is the best way to cast their ballot.

Since the coronavirus outbreak in the United States, absentee ballot requests have increased by 300%. This puts a strain on state and local election workers, and they need more resources to make the process safe and smooth for everyone.

Sign our petition to tell Congress to help fund resources for vote by mail ASAP.

Of course President Trump, members of his family and the cabinet all vote by mail. If it's good enough for them, it should be good enough for all of us.

No one should have to risk their health to vote this November. The stakes are high, and Congress needs to help make sure states are ready for this pandemic election.

Rich Fiesta, Executive Director, ARA

This problem isn't going to fix itself. We must ensure that every voter who wants to cast their ballot by mail can do so before it's too late.

ADD YOUR NAME

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

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2021 Health Plans Granted Leeway To Limit Consumers' Benefit From Drug Coupons

Without medication to manage her plaque psoriasis, Jennifer Brown's face, scalp, trunk and neck periodically become covered in painful red, flaky patches so dry they crack and bleed.

She has gotten relief from medications, but they come at a high price. For a while she was on Humira, made by AbbVie, with an average retail price of roughly $8,600 for two monthly injections. When that drug stopped working for her, Brown's doctor switched her to a different drug. Today she is using another injectable, Skyrizi, also by AbbVie, which costs about $36,000 for two quarterly injections — nearly 40% more annually than Humira.

The pharmaceutical company offers an assistance program to help consumers like Brown pay their share of the drug, and that has helped her cover her copayments. However, she faces the possibility of higher drug costs under **a federal rule** finalized this spring by the Trump administration.

The rule, an annual directive that sets health plan standards for 2021, permits employers and insurers not to apply drug company copayment assistance toward enrollees' deductibles and out-of-pocket maximums for any drug. That means only payments made by the patients themselves would factor into the calculations to reach those spending targets and could make individuals responsible for thousands of dollars in drug costs.

Advocates for consumers with chronic conditions say the rule will make it harder for patients with conditions such as cancer and multiple sclerosis who rely on very expensive drugs to afford them.

"I understand that the administration doesn't want to encourage patients to take higher-priced drugs," said Carl Schmid, executive director of the HIV + Hepatitis Policy Institute. "But … these are people who have HIV and other chronic conditions who take drugs that don't have generics."

Patient advocates had hoped the administration would allow employers and insurers to apply these restrictions only if a patient was taking a brand-name drug that had an appropriate generic alternative. In the rule that set standards for 2020, the administration **initially seemed** to take that approach. But, faced with criticism by employers and insurers, it said last summer that it **would reconsider the position**.

Drug company programs that provide copayment assistance to consumers have long been controversial. Employers and insurers say they encourage people to take expensive brand-name drugs instead of equally effective but cheaper generics.

Consumer advocates counter that many of the drugs consumers take for chronic conditions have no alternative. Research has shown that generics exist for **about half of the drugs** that offer copayment assistance.

Drugs to treat patients with hemophilia cost an average $275,000 annually, said Kollet Koulianos, senior director of payer relations at the National Hemophilia Foundation. There are no generic alternatives.

"We're not talking about $5 coupons in the Sunday paper," Koulianos said. "We're talking about high-cost specialty drugs, where they have to take this drug month in and month out for years. [Patients] just can't make the math work" without financial help.

The Business Group on Health, which represents large employers, supported the provisions in the final rule that allow employers to opt not to apply the value of drug company copayments for any drug toward their employees' out-of-pocket spending limits, said Steve Wojcik, vice president of public policy….**Read More**

Novartis, Sanofi and Pfizer engaged in illegal kickbacks and bribery

There's a long history of pharmaceutical companies engaged in **bribery** and other **illegal activities**. The pharmaceutical industry routinely puts its interests before the public health every way it can. In the last week, Novartis, Sanofi and Pfizer have been called out for engaging in illegal kickbacks and bribery.

Stat News reports that Sanofi is paying nearly $12 million for violating the Anti-Kickback Statute, in this case, paying kickbacks to people with Medicare through charitable donations. Older adults and people with disabilities using Lemtrada to treat multiple sclerosis received the money to cover their copays. In addition to Sanofi, Johnson and Johnson, Amgen, Pfizer, Biogen and Novartis have settled similar lawsuits.

The federal Anti-Kickback Statute forbids pharmaceutical companies from paying money to people with Medicare and others in federal programs to use their medicines. Sanofi refused to admit guilt, claiming it was simply supporting charitable organizations.

Stat News reports that Novartis is paying $345 million to the Securities and Exchange Commission and the US Department of Justice to settle a federal criminal case. The government had charged Novartis with bribing doctors, hospitals and clinics in South Korea, Vietnam and Greece to prescribe its prescription drugs, in violation of the Foreign Corrupt Practices Act. The health care providers allegedly cooked their books in order to hide the bribes.

If this weren't bad enough, Novartis also allegedly inappropriately conducted clinical trials in an effort to better market its drugs. An audit found no compelling scientific reason for the trials. Novartis paid health care providers who prescribed its drugs to attend conferences around the world.

High level Novartis executives were implicated. They appear to be getting off scot-free.

Meanwhile, Pfizer has brought **a lawsuit** that challenges the legality of laws that prohibit it from paying Medicare Part D drug copays for people with a severe heart condition. It says it wants to help people pay for tafamidis which is prescribed to treat the heart condition and costs $225,000 a year. Of course, the easiest way to help patients would be to lower the cost of the drug.

Instead, Pfizer wants either to pay copays directly or to pay copays through charities. But, the underlying motive is to boost sales for the very expensive drug, while keeping the drug price high. And, the Office of the Inspector General treats such activities as **fraud**.

Pfizer's argument is that there is no other drug for this condition. So, it cannot be engaged in illegal steering for this drug. It further claims that it is unconstitutional, violating the equal protection clause and the first amendment, to bar the company from supporting charitable organizations. People with Medicare not poor enough to qualify for Medicaid or other federal programs to cover the cost of the drug and not wealthy enough to pay for the drug's out-of-pocket costs themselves are hurt.

Senator Sheldon Whitehouse and Senator Elizabeth Warren are leading a charge to fight these pharmaceutical company practices. Drug companies get big tax breaks and profits from their "charitable donations." Their drug prices need to be lower.

Coronavirus: Pharmaceutical companies raise prices on COVID-19 drugs

Between January and June of this year, pharmaceutical companies increased prices on 245 drugs, in a series of price hike similar to price hikes in 2019, according to a new report from **Patients for Affordable Drugs.** Three out of four of these drugs are related to treatment for COVID-19.

Pharmaceutical companies raised prices on 61 drugs used to treat COVID-19. They also raised prices on 30 drugs used in clinical trials for treatment of COVID-19. And, they raised prices on 118 drugs that treat chronic conditions.

The price of certain cancer drugs has increased between $129.93 for Arimidex, used to treat breast cancer, and $3,487.77 for Provenge, used to treat prostate cancer. Other drugs for breast and prostate cancer, as well as for multiple myeloma, have also increased in price significantly in the last six months.

In addition, the price of Ativan and other drugs for anxiety and depression are up significantly. Increases are between five percent and nine and a half percent.

Patients are skipping or rationing their medicines because they cannot afford them, even with insurance. In fact, insurance can drive up the price of some drugs. **The New York Times** reports on two people who got COVID-19 tests at the same time, one with insurance and one without. The one without insurance paid $199. The one with insurance received a bill for $6,408 and was stuck with a copay from her insurer of $928.

Congress should regulate drug prices, as every other wealthy country does. People in the US should not be paying more for drugs than the Germans or the Japanese. Instead, Congress has allowed pharmaceutical corporations to hike up prices as much as they please. Pharmaceutical corporations have raised the price of many drugs by far more than the rate of inflation and insurers have not stopped them from keeping drug prices high for people with coverage.

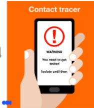
Congress should pass **H.R. 3,** which passed in the House of Representatives earlier this year. It would give the Secretary of Health and Human Services the right to negotiate the cost of high-priced drugs. The price could not be more than 20 percent above the cost in other wealthy nations.

Government Issues Warning about "Contact Tracing" Scams

You've probably been hearing a lot about contact tracing. It is the process of identifying people who have come in contact with someone who has tested positive for COVID-19, instructing them to quarantine and monitoring their symptoms daily.

Contact tracers are usually hired by a **state's department of public health**. They work with an infected person to get the names and phone numbers for everyone that infected person came in close contact with when they could have been infected. Those names and phone numbers are often kept in an online system.

People who had contact with someone infected with COVID-19 may first get a text message from the health department, telling them they will get a call from a specific number.



The tracer who calls will not ask for personal information, like a Social Security number. At the end of the call, some states ask if the contact would like to enroll in a text message program, which sends daily health and safety reminders until the 14-day quarantine ends.

But tracers will not ask you for money or information like your Social Security, bank account, or credit card number. Anyone who does is a scammer.

There is no question, contact tracing plays a vital role in helping to stop the spread of COVID-19. However, scammers, pretending to be contact tracers and taking advantage of how the process works, are also sending text messages. But theirs **are spam text messages** that ask you to click a link. Unlike a legitimate text message from a health department, which only wants to let you know they will be calling, the phony message includes that link to click.

Do not take the bait. ***Clicking on the link will download software onto your device, giving scammers access to your personal and financial information. Ignore and delete these scam messages.***

The U.S. Justice Department, Department of Health and Human Services and the Federal Trade Commission encourage anyone who has spotted a contact tracing scam or any fraud connected to COVID-19 to report it to the National Center for Disaster Fraud at 866-720-5721 or online at **www.Justice.gov/DisasterComplaintForm** or **ftc.gov/complaint.**

Center for Medicare Advocacy Releases Issue Brief Regarding Medicare and Family Caregivers

The Center for Medicare Advocacy has written an Issue Brief, *Medicare and Family Caregivers*, as part of collaborative work to advance the *RAISE Family Caregivers Act*, Public Law 115-119 (1/22/2018). The *RAISE* Act directs the Department of Health and Human Services to develop and maintain a national family caregiver strategy that identifies actions and support for family caregivers in the United States. The Center's Issue Brief explores the role Medicare does, and could, play in supporting older and disabled beneficiaries and their caregivers. The Issue Brief was written with support from The John A. Hartford Foundation.

Over 62 million Americans who are 65 or older, and certain younger people with significant disabilities, rely on Medicare for health care coverage and access to care. Many Medicare beneficiaries depend on family members to provide or supplement their care. As the population ages, and lives longer with chronic conditions, the need for family caregiving, and support for caregivers, is increasing. Concurrently, however, access to Medicare-covered home health aide care continues to decline. This is often true even for individuals who meet the Medicare law's qualifying criteria.

In order to better meet the needs of Medicare beneficiaries and their caregivers, the Center for Medicare Advocacy's *Issue Brief* makes several recommendations, including:

- Ensure the scope of current Medicare home health benefits, generally, and home health aides, specifically, are actually provided. Simply put, ensure that current law is followed;
- Create a new stand-alone home health aide benefit that would provide coverage without the current skilled care or homebound requirements, using Medicare's existing infrastructure as the vehicle for the new coverage; and
- Identify other opportunities for further exploration within and without the Medicare program, including additional Medicare revisions, demonstrations, and initiatives overseen by the Center for Medicare and Medicaid Innovation (CMMI).

70-year old Man Gets $1.1 Million Surprise Medical Bill

The Senior Citizens League has had the issue of ending surprise medical billing as one of its key issues this year and we have written about it several times in the past few months.

While the issue is not as much of a problem for seniors as it is for younger people, it is still possible for seniors to get hit with major medical bills they thought they would never face.

A story recently appeared on the WebMD internet site about a 70-year old man in Seattle who had undergone treatment for COVID-19 for several months. When he finally recovered and went home, he got slammed with a $1.1 million hospital bill. Luckily for him, the company through which he has Medicare Advantage agreed to wave most of his out-of-pocket costs for his treatment.

However, hundreds or maybe even thousands of people who get the virus may not be nearly as fortunate.

More than 250,000 people have been hospitalized for COVID infection in the United States, according to a new study. As we know by now, seniors have been hit the hardest by the virus. So, unless their Medicare supplement plans are willing to waive their out-of-pocket costs as happened for the Seattle man, many seniors could be facing another financial crisis. And seniors who are still working and either not eligible for Medicare or still using their employer-provided health insurance could also be in real financial trouble.

Congress passed legislation waiving all out-of-pocket expenses for COVID-19 testing, and many private insurance companies have voluntarily extended such cost-sharing waivers to treatment as well.

But about 60% of employer-sponsored health plans are self-funded plans, where the employer provides direct reimbursement for health benefits and assumes all the financial risk of medical care for their employees. Such plans are not obliged to waive cost-sharing for COVID-19 treatment, even if the insurance company operating the plan has said it will.

A study done in March found that respiratory patients put on a ventilator for four days or more ran up hospital bills of $88,000 on average. Pneumonia patients faced average out-of-pocket costs of between $1,300 and $1,464.

In some ways, the COVID-19 pandemic has revealed the pitfalls of using cost-sharing measures like deductibles and co-pays to reduce costs by making patients think twice before seeking medical care, according to Matthew Rae, associate director of the Kaiser Family Foundation's Program on the Health Care Marketplace.

"We have for the last 15 years or so had this theory that we wanted people to have more skin in the game, more exposure to the cost of health care," Rae said. "That is coming up against the fact that sometimes we really want people to get the care they need to get, and they don't have the financial assets to cover the cost. The theories that help us in normal times aren't helping us during a pandemic."

There are a couple of ways that financial disaster could be averted for COVID-19 patients and their families, experts said. Congress could pass a law that would waive cost-sharing requirements for COVID treatment, just as it has done for COVID testing. Companies also could step forward and announce that they will waive cost-sharing on their own initiative. No doubt some companies will do that, but others will not.

House Passes another Bill to Lower Prescription Drug Prices

Last week the House of Representatives passed a bill that would bolster the Affordable Care Act by raising government premium subsidies and providing subsidies to states to expand Medicaid. The bill, which passed largely along party lines, is highly unlikely to pass in the Senate, where the Republican majority is having a hard time coming up with its own legislation to lower the costs of prescription drugs.

The Trump administration issued a veto threat on Monday criticizing the House bill and threatened to veto it if in some miraculous way it should manage to pass in the Senate. White House officials denounced the drug-price negotiation provision in the bill, which is designed to bring prices for expensive, single-source drugs closer to prices paid in other countries. Republicans argue the drug-pricing measure will stifle innovation by reducing drug makers' research and development budgets during a pandemic.

To offset the cost of the entire bill, Democrats attached the drug-price negotiation provision that the Congressional Budget Office estimated would save $582 billion over 10 years. The Trump administration attacked Democrats for leaving out other components of their signature drug-pricing legislation that had garnered more bipartisan support, such as capping outpatient drug costs for seniors.

Trump now in open dispute with health officials as virus rages

Five months into a still-raging **pandemic** that has killed more than 130,000 Americans, the long-simmering tensions between **President Donald Trump** and the **health experts who staff his government** have escalated from private griping to shrugging disagreement to now open dispute.

The result, people at those agencies say, is a new sense of demoralization as they continue their attempts to fight a once-in-a-generation health crisis while simultaneously navigating the whims of a President who has shown little interest or understanding of their work.

That Trump does not trust nor follow the advice of experts such as **Dr. Anthony Fauci**, the nation's top infectious disease specialist, is hardly new. The President has not attended a meeting of his coronavirus task force in months and recently its sessions have been held outside the White House, including on Wednesday at the headquarters of the Department of Education. Fauci was told to participate in the meeting remotely by videoconference, preventing him from participating in a midday task force press briefing.

White House press secretary Kayleigh McEnany said later that it's a "decision for the task force" who appears at coronavirus briefings. Asked if the President still has confidence in Fauci, McEnany said only that Trump "has confidence in the conclusions of our medical experts."

Still, the President has complained to aides in meetings for months that Fauci's television appearances -- **which have been sharply curtailed by the White House** -- often seem to contradict his own message. As early as March, Trump was growing frustrated that Fauci's forecasts for the virus seemed less optimistic than his own, but largely avoided public rebukes….**Read More**

KFF's Kaiser Health News (KHN), AP Investigate the State of the Nation's Public Health Infrastructure as It Confronts the Challenge of the COVID-19 Pandemic

A new investigation from KFF's Kaiser Health News (KHN) and The Associated Press examines the troubling state of the public health infrastructure the nation is relying on to navigate the health and economic threats presented by the COVID-19 pandemic.

The multipart investigation, which launched today, finds that the public health workforce in the United States is underfunded and under threat, lacking the basic tools to confront the worst pandemic in a century. The novel coronavirus has infected at least 2.6 million people in the U.S., killed more than 126,000 people and cost tens of millions of jobs and $3 trillion in federal rescue money.

Among the key findings in the series's first story, "**Hollowed-Out Public Health System Faces More Cuts Amid Virus**":

- Since 2010, spending on state health departments has dropped by 16% per capita, and in local health departments by 18%, in 2019 dollars after adjusting for inflation, according to the KHN and AP analysis.
- At least 38,000 state and local public health jobs have been eliminated since the Great Recession in 2008, leaving an inadequate workforce in what was viewed in the mid-20th century as one of the world's best public health systems.
- At least 14 states have already cut or are actively considering cuts to health department budgets or positions. States, cities and counties, facing declining revenues amid the economic downturn, are laying off and furloughing the already limited staff.

For their first investigative collaboration, KHN and AP journalists interviewed more than 150 public health workers, policymakers and experts, analyzed state and federal financial records, and surveyed statehouses around the country. Their investigation finds that governments at every level have failed to provide the public health system with the resources — both human and financial — that are required to protect the nation from pandemics.

The reporting also shows how public health officials, who already work on an array of tasks for their communities — such as administering vaccination programs, tracking and preventing infectious diseases, screening infants, monitoring water and air quality, and conducting food and restaurant inspections — are stretched thinner than ever as they work to reduce and monitor the effects of the pandemic. Departments are having to spend already constrained budgets on adequate supplies to keep workers safe as they try to implement preparedness plans and mount effective contact tracing efforts with limited staff. And they have been targeted for criticism by frustrated elected officials and members of the public who blame them for unpopular lockdowns and safety restrictions.

"Bringing together the resources of both The Associated Press and KHN enabled us to marry hard-to-wrangle data with compelling stories from the front lines of the nation's public health system as it grapples with this pandemic," said KHN national editor Kytja Weir.

"We are pleased to be working with Kaiser Health News to take a deep look at what is really happening inside the U.S. public health system," said AP investigative editor Alison Kodjak. "This is important public service journalism at a critical time."

Through the collaboration, AP and KHN have shared data and offered guidance to news organizations that are AP members and customers to help them localize the findings of the investigation for their regions. KHN and AP expect to publish more stories in **the series** over the coming weeks and months.

Lower wealth linked with faster physical and mental aging

People with lower household wealth (or socioeconomic status) have a higher risk of many diseases, including heart disease, diabetes, and depression. They also have shorter lifespans. Some lifestyle factors may play a role. For example, people with lower incomes have higher rates of smoking. However, other factors—including chronic stress and reduced access to resources—also likely contribute.

Less is known about how socioeconomic status influences the general aging process. To look more closely at this question, Drs. Andrew Steptoe and Paola Zaninotto from University College London followed more than 5,000 adults, aged 52 and older, for 8 years beginning in 2004. The team broke the study participants into four groups based on household wealth.

The researchers measured 19 different outcomes. These fell within six general "domains" of health: physical capabilities, hearing and vision, inflammation and organ health, cognitive functioning, emotional well-being, and social engagement. They then compared changes in these health domains over time between the four groups. The study, which was funded in part by NIH's National Institute on Aging (NIA), was published on June 15, 2020, in the *Proceedings of the National Academy of Sciences*.

Differences in health between the groups were seen in all the domains over time. All four measures of physical capability declined more in the groups with less wealth. For example, people in the lowest wealth group had a 38% greater reduction in walking speed over 8 years compared to those with the highest wealth.

Almost 16% of people in the lowest wealth group reported developing problems with vision over the course of the study, compared to about 10% of people in the wealthiest group. The groups with lower wealth showed higher levels of inflammation markers over time and greater decline in lung function.

People in all the groups showed a drop in cognitive function—the ability to clearly think, learn, and remember—over the course of the study. However, larger reductions were seen in the group with the least wealth. People with less wealth also reported greater reductions in their enjoyment of life over time and more symptoms of depression.

These trends continued in measurements of social engagement. People with more wealth were more likely to keep up with social activities over time, including volunteering and maintaining friendships, than people with less wealth.

The declines seen were independent of participants' age, gender, ethnicity, or education received, and whether or not they had grown up in poverty. Almost all of the associations remained after the researchers accounted for other factors that can affect health during aging, such as smoking, whether or not participants were married, and self-reported overall health.

"We know that people of lower socioeconomic status are at increased risk of disease in older age, but it has not been clear whether they are also at risk of a faster decline in age-related function not directly related to health conditions," Steptoe says.

These results add to the growing evidence showing that socioeconomic status can affect physical and mental health over time. However, more study is needed to understand how wealth impacts the aging body and mind.

—*by Sharon Reynolds for* NIH Research Matters

COVID-19 Death Risk Twice as High in New York City as Some Countries

New York City's COVID-19 death rate was more than double that of some countries, and the city's oldest people had the highest risk of death, researchers report.

They used a computer model to analyze over 191,000 lab-confirmed COVID-19 cases along with more than 20,000 confirmed and probable COVID-19 deaths in New York City from March 1 to May 16.

During that time, the city's death rate was 1.45% -- meaning between 1% and 2% of New Yorkers infected with COVID-19 died.

That's more than twice the rate already reported elsewhere. For example, COVID-19 death rates in both China and France, where most estimates have come from, were about 0.7%, according to the researchers.

So far, the U.S. death rate is unclear, researchers from Columbia University and the New York City Department of Health and Mental Hygiene said.

They found that New York City's COVID-19 death rate was highest among those 75 and older (13.83%) and those between 65 and 74 (4.67%).

"These dire estimates highlight the severity of COVID-19 in elderly populations and the importance of infection prevention in congregate settings," wrote the authors led by Wan Yang, an assistant professor of epidemiology at Columbia's Mailman School of Public Health, in New York City.

"Thus, early detection and adherence to infection control guidance in long-term care and adult care facilities should be a priority for COVID-19 response as the pandemic continues to unfold," they said in a Columbia news release.

Infection death rates were 0.011% among those under 25 and 0.12% in 25- to 44-year-olds.

But the researchers warned that the risk to young people should not be taken lightly. Some children have developed post-infection Multi-System Inflammatory Syndrome.

Yang and her colleagues noted that public and private health systems in New York City are stronger than many other places in the United States, so COVID-19 death rates may be even higher in other parts of the country and other nations.

"It is thus crucial that officials account for and closely monitor the infection rate and population health outcomes and enact prompt public health responses accordingly as the pandemic unfolds," the authors wrote.

"As the pandemic continues to unfold and populations in many places worldwide largely remain susceptible, understanding the severity, in particular, the IFR [infection fatality rate], is crucial for gauging the full impact of COVID-19 in the coming months or years," they concluded.

The study was published July 1 on the preprint server medRxiv.org, ahead of peer review.

More information

The U.S. Centers for Disease Control and Prevention has more on **COVID-19.**

'Please Tell Me My Life Is Worth A LITTLE Of Your Discomfort,' Nurse Pleads

Health care workers on the front lines of the COVID crisis have spent exhausting months working and self-quarantining off-duty to keep from infecting others, including their families. Encountering people who indignantly refuse face coverings can feel like a slap in the face.

When an employee told a group of 20-somethings they needed face masks to enter his fast-food restaurant, one woman fired off a stream of expletives. "Isn't this Orange County?" snapped a man in the group. "We don't have to wear masks!"

The curses came as a shock, but not really a surprise, to Nilu Patel, a certified registered nurse anesthetist at nearby University of California-Irvine Medical Center, who observed the conflict while waiting for takeout. Health care workers suffer these angry encounters daily as they move between treacherous hospital settings and their communities, where mixed messaging from politicians has muddied common-sense public health precautions.

"Health care workers are scared, but we show up to work every single day," Patel said. Wearing masks, she said, "is a very small thing to ask."

Patel administers anesthesia to patients in the operating room, and her husband is also a health care worker. They've suffered sleepless nights worrying about how to keep their two young children safe and schooled at home. The small but vocal chorus of people who view face coverings as a violation of their rights makes it all worse, she said.

That resistance to the public health advice didn't grow in a vacuum. Health care workers blame political leadership at all levels, from President Donald Trump on down, for issuing confusing and contradictory messages.

"Our leaders have not been pushing that this is something really serious," said Jewell Harris Jordan, a 47-year-old registered nurse at the Kaiser Permanente Oakland Medical Center in Oakland, California. She's distraught that some Americans see mandates for face coverings as an infringement upon their rights instead of a show of solidarity with health care workers. (Kaiser Health News, which produces California Healthline, is not affiliated with Kaiser Permanente.)

"If you come into the hospital and you're sick, I'm going to take care of you," Jordan said. "But damn, you would think you would want to try to protect the people that are trying to keep you safe."

In Orange County, where Patel works, mask orders are particularly controversial. The county's chief health officer, Dr. Nichole Quick, resigned June 8 after being threatened for requiring residents to wear them in public. Three days later, county officials **rescinded the requirement.** On June 18, a few days after Patel visited the restaurant, Gov. Gavin Newsom **issued a statewide mandate**.

Meanwhile, cases and hospitalizations **continue to rise in Orange County**.

The county's flip-flop illustrates the national conflict over masks. When the coronavirus outbreak emerged in February, officials from the **U.S. Centers for Disease Control and Prevention** discouraged the public from buying masks, which were needed by health care workers. It wasn't until April that federal officials began advising most everyone to wear **cloth face coverings in public**.

One recent study showed that masks can **reduce the risk of coronavirus infection**, especially in combination with physical distancing. Another study linked policies in 15 states and Washington, D.C., mandating community use of face coverings with a **decline in the daily COVID-19 growth rate** and estimated that as many as 450,000 cases had been prevented as of May 22.

But the use of masks has become politicized. Trump's inconsistency and nonchalance about them sowed doubt in the minds of millions who respect him, said Jordan, the Oakland nurse. That has led to a "very disheartening and really disrespectful" rejection of masks….**Read More**

Will Medicare cover my skilled nursing facility care?

Dear Marci,
I have a surgery scheduled soon and will probably need to stay in a skilled nursing facility to recover afterward. Will Medicare cover my stay in the skilled nursing facility?
-Megumi (Honolulu, HI)

Dear Megumi,

Skilled nursing facility (SNF) care is post-hospital care provided at a SNF. Skilled nursing care includes services such as administration of medications, tube feedings, and wound care. Keep in mind that SNFs can be part of nursing homes or hospitals.

Medicare Part A may cover your SNF care if:

- You were formally admitted as an inpatient to a hospital for at least three consecutive days
- You enter a Medicare-certified SNF within 30 days of leaving the hospital, and receive care for the same condition that you were treated for during your hospital stay
- And, you need skilled nursing care seven days per week or skilled therapy services at least five days per week

The day you become an inpatient counts toward your three-day inpatient stay to qualify for Medicare-covered SNF care. However, the day you are discharged from the hospital does not count toward your qualifying days. Also remember that time spent receiving emergency room care or under observation status does not count toward the three-day hospital inpatient requirement for SNF coverage.

If you meet all the above requirements, Medicare should cover the SNF care you need to improve your condition, maintain your ability to function, or prevent your health from getting worse.

Note: Because of the **coronavirus public health emergency**, Medicare has removed the three-day qualifying hospital stay requirement for beneficiaries who experience dislocation or are otherwise affected by the coronavirus public health emergency. According to Medicare, this waiver includes but is not limited to beneficiaries who:

- Need to be transferred to a SNF, for example, due to nursing home evacuations or to make room at local hospitals
- Need SNF care as a result of the current public health emergency, regardless of whether they were previously in the hospital

Speak to your doctor or hospital discharge planner if you need help finding a SNF that meets your needs. Ask them to find Medicare-certified SNFs in your area that will address your medical needs. If you are in a Medicare Advantage Plan, contact your plan to find out which SNFs are in their network.

-Marci

FDA commissioner refuses to defend Trump claim that 99% of Covid-19 cases are 'harmless'

The commissioner of the US Food and Drug Administration on Sunday declined to defend President Donald Trump's **unfounded claim** that 99% of coronavirus cases are "totally harmless" and repeatedly refused to say whether Trump's remark is true or false.

"I'm not going to get into who is right and who is wrong," Dr. Stephen Hahn, a member of the White House coronavirus task force, told CNN's Dana Bash on "State of the Union."

During his remarks Saturday at the White House Independence Day event, **Trump claimed without evidence** that 99% of coronavirus cases "are totally harmless."

The US Centers for Disease Control and Prevention estimates that 35% of cases are asymptomatic, but even people with mild or no symptoms can spread the virus to others.

While the World Health Organization has said the global fatality rate is likely less than 1%, the WHO also said about 20% of all people who are diagnosed with coronavirus are sick enough to need oxygen or hospital care.

"I totally support the CDC and the information that they're putting out with respect to this pandemic," Hahn said Sunday.

Hahn said the coronavirus pandemic is "a rapidly evolving situation" but stressed that the US "absolutely must take this seriously."

Pressed by Bash on the program whether the President's comment is true or false, Hahn again did not defend the President's claim.

"What I'll say is that we have data in the White House task force. Those data show us that this is a serious problem. People need to take it seriously," Hahn said.

There have been more than 2.8 million cases of coronavirus in the United States and at least 129,000 people in the US have died, according to **Johns Hopkins University's latest tally**.

Trump celebrated the Fourth of July at Mount Rushmore on Friday and at the **White House's "Salute to America" on Saturday**, where many attendees were seen neither socially distancing nor wearing masks at both events.

"if you don't follow local and state guidelines about what to do, if you're not following the CDC and White House task force guidelines, you are putting yourselves and you're putting your loved ones at risk," Hahn said.

Asked if he was uncomfortable by the President holding those events that put Americans at risk, Hahn said the circumstances are different.

"I think in terms of that specific instance at the White House, it's important for everyone to remember that it's a different set of circumstances. People are tested regularly. The President is tested regularly," Hahn said.

Hahn was also questioned about the President's recent doubling down in a Fox Business interview of his belief that coronavirus will "sort of just disappear."

"No, we're seeing the surge in cases, particularly across the Sun Belt. And so this virus is still with us," the FDA commissioner told CNN.

Lost on the Frontline

America's health care workers are dying. In some states, medical personnel account for as many as 20% of known coronavirus cases. They tend to patients in hospitals, treating them, serving them food and cleaning their rooms. Others at risk work in nursing homes or are employed as home health aides.

"Lost on the Frontline," a collaboration between KHN and The Guardian, has identified **765** such workers who likely died of COVID-19 after helping patients during the pandemic.

We have published profiles for **133** workers whose deaths have been confirmed by our reporters.

Some cases are shrouded in secrecy. Our team contacts family members, employers and medical examiners to independently confirm each death. Many hospitals have been overwhelmed and workers sometimes have lacked protective equipment or suffer from underlying health conditions that make them vulnerable to the highly infectious virus. In the chaos, COVID casualties might otherwise get overlooked.

This project **aims to document** the lives of U.S. health workers who die of COVID-19, and to understand why so many are falling victim to the pandemic.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Mental Exercises to Keep Your Brain Sharp

No matter how hard we try to slow or stop its movement, time marches inevitably on. As it does, our bodies and their abilities change, too. For some people that means certain changes that can alter how we interact with and perceive the world around us.

"Aging is a natural process," says Dr. Douglas Scharre, director of the division of cognitive neurology and memory disorders at the Ohio State University **Wexner Medical Center** in Columbus. Some of those changes involve the accumulation of gray hairs and wrinkles and the development of **osteoarthritis** in the joints. Along with those very obvious changes, the brain also loses neurons, Scharre says. "Normal aging will lead to slower mental processing speed. We can still figure things out, it just takes longer."

Signs of this delayed processing may include difficulty recalling names of people and becoming a bit more forgetful. "However, if we're given some context, the name of the person and the memories all return intact," he explains.

This is all very normal and shouldn't worry you in excess, as these changes are just a continuation of normal processes that follow us throughout life, says Heather M. Snyder, vice president, medical and scientific relations at the Alzheimer's Association in Chicago. "From the time we're born and to becoming a toddler and beyond, there's lots of changes with the brain. And those changes don't stop because you reach a certain age. Changes are reflected across our entire lives."

However, concerns surrounding changes in cognitive function and age do crop up when brain disorders such as **Alzheimer's disease** and **other forms of dementia** develop. The memory problems associated with these conditions are quite **different from normal aging** and may include:

- **Difficulty finding the right word**.
- Disruptive memory loss, typically noticed by a partner or other family member.
- Loss of spatial abilities, such as getting lost while driving to familiar locations.
- Difficulty with planning and organizing.
- Feeling confused or disoriented.
- Changes in personality or mood, such as increased agitation, behaving inappropriately or becoming anxious or paranoid.
- **Depression.**

Scharre adds that even if **dementia** is not at work, "some people lose more cognitive acuity than others as they age because they've had other brain diseases or have had some damage to their brain over their life." For example, if you had a head injury, a series of small strokes or exposure to certain toxins that can damage the brain, that could cause you to lose more acuity than someone who has a healthy brain and no such complicating factors. ...**Read More**

What Seniors Should Know Before Going Ahead With Elective Procedures

For months, Patricia Merryweather-Arges, a health care expert, has fielded questions about the coronavirus pandemic from fellow Rotary Club members in the Midwest.

Recently people have wondered "Is it safe for me to go see my doctor? Should I keep that appointment with my dentist? What about that knee replacement I put on hold: Should I go ahead with that?"

These are pressing concerns as hospitals, outpatient clinics and physicians' practices have started providing elective medical procedures — services that had been suspended for several months.

Late last month, KFF reported that 48% of adults had skipped or postponed medical care because of the pandemic. **Physicians are deeply concerned** about the consequences, especially for people with serious illnesses or chronic medical conditions.

To feel comfortable, patients need to take stock of the precautions providers are taking. This is especially true for older adults, who are particularly vulnerable to COVID-19. Here are suggestions that can help people think through concerns and decide whether to seek elective care:

Before you go in. Give yourself at least a week to learn about your medical provider's preparations. "You want to know in advance what's expected of you and what you can expect from your providers," said Lisa McGiffert, co-founder of the Patient Safety Action Network.

Merryweather-Arges' organization, Project Patient Care, has developed a **guide** with recommended questions. Among them: Will I be screened for COVID-19 upon arrival? Do I need to wear a mask and gloves? Are there any restrictions on what I can bring (a laptop, books, a change of clothing)? Are the areas I'll visit cleaned and disinfected between patients?

Also ask whether patients known to have COVID are treated in the same areas you'll use. Will the medical staffers who interact with you also see these patients?

If you're getting care in a hospital, will you be tested for COVID-19 before your procedure? Is the staff being tested and, if so, under what circumstances?

Hospitals, medical clinics and physicians are offering this kind of information to varying degrees. In the New York City metropolitan area, Mount Sinai Health System has launched a comprehensive "**Safety Hub**" on its website featuring extensive information and videos.

Mount Sinai also encourages physicians to reach out to patients with messages tailored to their conditions. People "want to hear directly from their providers," said Karen Wish, the system's chief marketing officer.

Don't hesitate to press for more details, said Dr. Allen Kachalia, senior vice president of patient safety and quality at Johns Hopkins Medicine: "Where people get in trouble is when they're afraid to bring their concerns forward."

Seeking care. Wendy Hayum-Gross, 57, a counselor who lives in Naperville, Illinois, had been waiting since mid-March to get blood tests that would help doctors diagnose the underlying cause of a new condition, a goiter. A few weeks ago, she decided it was time.

The hospital lab she went to, operated by **Edward-Elmhurst Health**, told Hayum-Gross to wear a mask and gave her a number to call when she arrived in the parking lot. Outside the front door, she was met by a staffer who took her temperature, asked several screening questions and gave her hand sanitizer.

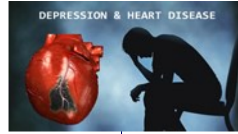
"Once I passed that, a phlebotomist met me on the other side of the door and took me to a chair that was still wet with disinfectant. She wore a mask and gloves, and there was no one else around," Hayum-Gross said. "When I saw the precautions they had put in place and the almost military precision with which they were carrying them out, I felt much better."...**Read More**

What's the link between depression and heart disease?

Depression and loneliness put a terrible strain on the heart, and not just in the emotional sense: Psychological distress can turn a survivor of heart disease into a victim. Consider the words of physician Dean Ornish in his book Love and Survival: The Scientific Basis for the Healing Power of Intimacy. "Among heart patients, depression is as good a predictor of imminent death as smoking, obesity, or a previous heart attack," he says. "Study after study shows that people who are lonely, depressed, and isolated are three to five times more likely to die prematurely than people who feel connection in their life."

Here are a few studies that back up Dr. Ornish's point. Researchers in France looked at nearly 6,000 men and women found that those who were depressed and had heart disease had at least a three times higher risk of dying early than those who were neither depressed nor had heart disease. Researchers at the Montreal Heart Institute tracked 222 heart attack survivors and found that those suffering from depression were roughly six times more likely than others to die within six months of their attack. The researchers later found that depression also led to an eight-fold increase in death rates 18 months after a heart attack.

Loneliness takes a similar toll. In a Duke University Medical Center study of 1,400 men and women with at least one severely blocked artery, the unmarried patients without close friends were three times more likely than the others to die over the next five years.



Depression may even help heart disease get its start. Several studies have suggested that depressed people who are otherwise healthy are more likely to develop heart disease than peers who aren't depressed. For example, a 13-year study of 1,500 subjects conducted at Johns Hopkins University found that an episode of depression increased the risk of a heart attack more than four-fold. These studies take smoking and other factors into account, providing strong evidence that depression alone is enough to cut down a once-healthy heart.

Women may be at particular risk, according to a study supported by the National Heart, Lung, and Blood Institute. After studying more than 6,000 men and women over a period of six years, researchers concluded that women who suffered depression were more likely to have risk factors for heart disease. Specifically, the study found that depressed women were twice as likely to have "metabolic syndrome" -- a condition in which at least three of five known risk factors for heart disease are present. Depressed men in the study didn't show any increase in metabolic syndrome.

Finally, a study from the Centers for Disease Control and Prevention found that severe depression and anxiety could more than double the risk of developing hypertension, a major contributor to heart disease.

Why is depression so hard on the heart?

Doctors don't know exactly why the blues appear to be so dangerous, but it's clear that depression affects the heart in numerous ways. Some research into the connection is straight forward and shows that depression leads to poor health behaviors like not exercising, which in turn leads to a higher risk of heart disease. Other research shows no difference in physical activity levels in depressed patients, but does show a connection between depression and increased belly fat -- which suggests a biological link. One large study published in the Journal of the American College of Cardiology shows that people who are mentally distressed have higher levels of C-reactive protein, a substance in the body that increases with the risk of heart disease. Some experts speculate that depression tends to smooth out the normal ups and downs in heart rate, a sign that the organ may be weaker and less flexible. And for unknown reasons, mental distress seems to encourage blood cells called platelets to clump together, possibly setting the stage for artery-clogging blood clots.

Can depression treatments fight heart disease?

If you suffer from heart disease, easing your mind just might prolong your life. A recent study from Duke University Medical Center found that a stress-management program cut the chances that a heart patient would suffer a heart attack or need surgery by 74 percent. And while nobody knows if anti-depressants can help fight heart disease, there's reason to be optimistic. A psychiatrist at Emory University School of Medicine has found that giving the antidepressant paroxetine to heart attack survivors made their platelets less "sticky" and reduced their risks of blood clots. Although antidepressant use has been linked in different studies to both increased and decreased heart problems, sertraline and citalopram are safe and effective for depressed patients with coronary heart disease, according to the American Heart Association.

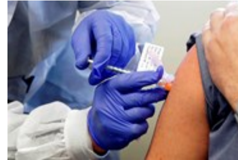
Analysis: How A COVID-19 Vaccine Could Cost Americans Dearly

The United States is the only developed nation unable to balance cost, efficacy and social good in setting prices.

Yes, of course, Americans' health is priceless, and reining in a deadly virus that has trashed the economy would be invaluable.

But a COVID-19 vaccine will have an actual price tag. And given the prevailing business-centric model of American drug pricing, it could well be budget breaking, perhaps making it unavailable to many.

The last vaccine to quell a global viral scourge was the polio inoculation, which ended outbreaks that **killed** thousands and paralyzed tens of thousands each year in the United States. The March of Dimes Foundation covered the nominal drug cost for a free national vaccination program.



It came in the mid-1950s, before health insurance for outpatient care was common, before new drugs were protected by multiple patents, before medical research was regarded as a way to become rich. It was not patented because it was not considered patentable under the standards at the time.

Now we are looking for viral deliverance when drug development is one of the world's most lucrative businesses, ownership of drug patents is disputed in endless court battles, and monopoly power often lets manufacturers set any price, no matter how extraordinary. A new cancer treatment can cost a half-million dollars, and old staples like insulin have risen manifold in price to thousands of dollars annually.

And the American government has no effective way to fight back.

Recent vaccines targeting more limited populations, such as a meningitis B vaccine for college students and the shingles vaccine for older adults, have a retail cost of $300 to $400 for a full course.

If a COVID-19 vaccine yields a price of, say, $500 a course, vaccinating the entire population would bring a company over $150 billion, almost all of it profit.

Dr. Kevin Schulman, a physician-economist at the Stanford Graduate School of Business, called that amount "staggering."

Investors already smell big money for a COVID-19 vaccine. ….**Read More**

75 or Older? Statins Can Still Benefit Your Heart

Older adults with healthy hearts probably would benefit from taking a cholesterol-lowering statin, a new study contends.

People 75 and older who were free of heart disease and prescribed a statin wound up with a 25% lower risk of death from any cause and a 20% lower risk of heart-related death, researchers reported July 7 in the *Journal of the American Medical Association*.

"Based on these data, age is not a reason to not prescribe statins," said lead researcher Dr. Ariela Orkaby, a physician-scientist at the VA Boston Healthcare System and associate epidemiologist with Brigham and Women's Hospital in Boston.

Statins are drugs used to prevent buildup of plaques that can narrow or block arteries, leading to heart attack and stroke.

Until recently, guidelines recommended halting statin therapy at age 75, said Dr. Mary Ann McLaughlin, medical director of the Cardiac Health Program at Mount Sinai Hospital in New York City.

"In 2018, the guidelines changed to say statins are a reasonable choice for those older than 75 without a life-limiting disease" like cancer or organ failure, she said.

This new study provides evidence that changing the guidelines to allow statin therapy to continue was the right move, said McLaughlin, who wasn't part of the research.

"This age group is one of the fastest-growing groups," she said. "The over-75 cohort is living even longer, and the first evidence of atherosclerotic disease or cardiovascular disease can be sudden death. There are many patients who are living very active and full lives into their late 80s and 90s these days."

For this study, Orkaby's team analyzed data from more than 300,000 veterans 75 or older who used VA health care services between 2002 and 2012. None had experienced a heart attack, stroke or other heart problem.

Of those vets, more than 57,000 started taking statins during that period. Researchers compared those who used statins against those who did not, and found that their risk of heart-related death was significantly lower.

The benefits remained for veterans at advanced ages, including those 90 or older, and also were strong among vets with dementia, results showed.

Patients on statins also had a lower risk of heart attacks and strokes, researchers said.

Because the study relied on VA data, the patients involved were overwhelmingly male (97%) and white (91%), McLaughlin noted.

But randomized clinical trials now underway will provide additional evidence about statin use in a broader mix of older people, Orkaby and McLaughlin said.

There's been an age bias in statin clinical trials, because older folks tend to have more medical problems and including them can confuse the results, Orkaby said.

"Older adults usually have more than one thing going on," she said. "It's much easier to study people in their 50s who may just have high blood pressure or just have diabetes. When you're running a big trial, you may not want to include people who are going to get hospitalized for some other issue -- for example, because they fell."

As a result, "almost all the data that exists right now for statins is in younger people, even though it's really older adults who have the highest risk of having a heart attack or a stroke," Orkaby said.

These new results indicate it's time to stop discriminating based on age alone and saying there is no data to support statin use in older folks, she said.

"We have some reasonably good data to suggest that statins could save lives," Orkaby said. "If you got to 75 and you weren't yet put on a statin, you may actually be a healthier older adult who's likely to live another 10 or 15 years. Those people may be the ones who would benefit the most from that, long-term."

U.S. Air Pollution Still at Deadly Levels, Study Finds

Fine particulate air pollution remains at levels deadly to older Americans, a new study finds.

If U.S. air quality standards for fine particulate pollution ((PM2.5) complied with World Health Association guidelines, more than 140,000 lives could be saved over a decade, say researchers from the Harvard T.H. Chan School of Public Health, in Boston.

"Our new study included the largest-ever dataset of older Americans and used multiple analytical methods, including statistical methods for causal inference, to show that current U.S. standards for PM2.5 concentrations are not protective enough," doctoral student Xiao Wu said.

The standards "should be lowered to ensure that vulnerable populations, such as the elderly, are safe," Wu added in a Harvard news release.

Tiny particles of pollution are a main cause of haze in the United States. They can be inhaled deep into the lungs and cause serious health problems, according to the Environmental Protection Agency.

For the study, researchers looked at data on nearly 69 million Medicare patients. They matched these participants' zip codes with air pollution data from locations across the United States.

The researchers found that a yearly decrease of 10 μg/m3 in PM2.5 pollution would result in a 6% to 7% decrease in the risk of dying.

If the United States lowered its annual PM2.5 exposure to 10 μg/m3 -- the WHO guideline -- more than 143,000 lives would be saved in 10 years.

"The Environmental Protection Agency has proposed retaining current national air quality standards. But, as our new analysis shows, the current standards aren't protective enough, and strengthening them could save thousands of lives," said researcher Francesca Dominici, a professor of biostatistics, population and data science at Harvard.

Hot Weather Help Tip

Spending too long in high temperatures can be dangerous for anyone, and your risk of heat-related illness can increase as you get older. The National Institute on Aging provides these **tips for lowering your risk of heat-related illnesses**:

- Drink plenty of liquids, like water or fruit or vegetable juices, and avoid drinks containing caffeine or alcohol.
- If you live in a home or apartment without fans or air conditioning, try to keep your house as cool as possible. Limit your use of the oven, keep your shades closed during the hottest part of the day, and open your windows at night

- If your house is hot, and you need help getting to a cool place, as a friend or relative. Some religious groups, senior centers, and **Area Agencies on Aging** provide this service.
- Dress for the weather.
- Don't try to do exercise or a lot of activities outdoors when it's hot.

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