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President Trump's 2021 proposed budget would most hurt vulnerable older adults

Monique Morrissey writes for the **EPI blog** about President Trump's proposed **2021 budget**. Morrissey explains that this White House budget would hurt vulnerable older adults, even though it claims to benefit them.

President Trump's proposed budget would cut Medicare and Medicaid spending significantly. It would also cut discretionary spending unrelated to defense. In other words, funding for programs that help older Americans would be cut. Programs at risk include HEAP, which provides home emergency assistance to low-income older adults.

The President proposes **more than $750 billion dollars in cuts to Medicare over ten years**, which is likely to jeopardize access to care for older adults and people with disabilities. However, we don't yet know what the President means when his proposed budget says that it will find Medicare savings by ending "**excessive spending and distortionary payment incentives**." It also says that it would "**preserve benefits and access to care**."

One Medicare provision in the proposed budget makes sense–to equalize payments for particular health care services across different venues. Right now, Medicare pays wildly different amounts for the same procedures depending upon whether they are performed in an outpatient or inpatient setting.

The proposed Medicare budget cuts would likely increase people's out-of-pocket health care costs and undermine access to care. The President would like to cut government payments to providers that cover unpaid medical bills. Consequently, providers may be less inclined to treat people with Medicare with limited incomes. In addition, hospitals and clinics in low-income areas may be forced to shut down. These potential issues would likely end up affecting middle-class older adults as well.

The President also wants to cut back on Medicaid expansion, which could leave more older adults without adequate health care coverage and put more health care providers serving people with low incomes at risk. In addition, he wants to increase copays for emergency room visits for people with Medicaid, which would deter them from getting needed care. And, the President wants to repeal the Affordable Care Act, which would not only increase the number of uninsured Americans dramatically but also drive up costs in Medicare. For example, it would mean the **Part D prescription drug coverage** gap would be reinstated.

The President proposes to cut Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) by $76 billion over ten years. He intends to reduce the number of people who benefit from SSDI by five percent. He also wants to cut **Social Security administrative costs**, which are already too low. Further reductions in spending on administration could mean the closing of more Social Security offices or reductions in their hours of operation.

CDC Warns It Expects Coronavirus to Spread in U.S.

Federal health authorities said Tuesday they now expect a wider spread of the coronavirus in the U.S. and are preparing for a potential pandemic, though they remain unsure about how severe the health threat could be.

Nancy Messonnier, director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention, said Tuesday the agency expects a sustained transmission of the virus and called for businesses, schools and communities to brace themselves and plan for potential outbreaks.

"We expect we will see community spread in this country," meaning the virus circulating within local communities, said Dr. Messonnier. She added that the question isn't if the virus will expand in the U.S., but when.

In the U.S., 14 locally diagnosed cases have been confirmed, with an additional 40 from the outbreak on the Diamond Princess cruise ship in Asia and three among Americans who returned from China aboard U.S.-chartered flights.

So far, American public-health systems have sought to contain the virus by isolating confirmed cases while monitoring close contacts of these patients for signs of infection. This strategy is most effective when the case count is relatively low and each case can be epidemiologically linked to each other and traced to an original source, health authorities say. That is the current situation with the confirmed U.S. cases.

But if the virus spreads more widely, it might become difficult or impossible to contain it with the current methods, experts say. Instead, the efforts would shift to strategies such as closing schools, canceling mass gatherings and requiring employees to work from home.

"The disruption to everyday life might be severe," Dr. Messonnier said.

Meantime, the Trump administration's response to the virus was challenged Tuesday in Congress. Health and Human Services Secretary Alex Azar, who heads the U.S. coronavirus task force, was questioned about whether his agency is doing enough, especially in light of its request for $2.5 billion in emergency funding—less than what was granted to fight earlier threats of pandemics.

"It seems to me at the outset that this request for the money… is lowballing it," said Sen. Richard Shelby (R., Ala.), the committee's chairman. "You can't afford to do that."

Democrats at the hearing pushed back on recent upbeat assurances about the virus by President Trump on Twitter. "We are disregarding scientific evidence and relying on tweets," said Sen. Patty Murray (D., Wash.). "I'm deeply concerned we are way behind the eight ball on this."

Mr. Trump this month said the coronavirus could go away with warm weather. But the CDC's Dr. Messonnier said in a Feb. 12 media call that she would caution against "overinterpreting that hypothesis."...**Read More**

Federal Appeals Court Rules Against Medicaid Work Requirements in Arkansas

In another setback for the Trump administration's plan for the Medicaid program, a federal appeals court **ruled**last week that Arkansas cannot impose onerous work and reporting requirements on Medicaid recipients as a condition of receiving coverage. In its decision, a three-judge panel of the D.C. Court of Appeals unanimously rejected the administration's claim that work requirements promote a primary objective of Medicaid.

The state's plan has been on hold since March 2019, when a federal court in Washington, D.C. **found the administration's approval of Arkansas' waiver to be "arbitrary and capricious**." Federal law allows states a great deal of administrative flexibility to try **"experimental, pilot, or demonstration**" projects that are likely to promote Medicaid's primary objective. Though the administration deemed Arkansas' project to be in compliance with these guidelines, both courts disagreed, finding that "the principal objective of Medicaid is providing health care coverage," and work requirements do not promote this goal. The courts agreed that the administration should have considered the demonstration's impact on access to Medicaid but failed to do so. In the project's first six months, **over 18,000** Arkansans were kicked off the state's Medicaid rolls.

Federal officials have not yet said whether they will appeal the ruling to the Supreme Court.

In a **statement**, the Centers for Medicare & Medicaid Services, the federal agency which oversees Medicaid, said it "is reviewing and evaluating the opinion and determining next steps. CMS remains steadfast in our commitment to considering proposals that would allow states to leverage innovative ideas."

The **National Health Law Program, Legal Aid of Arkansas**, the **Southern Poverty Law Center**, and **Jenner & Block** represented the Medicaid enrollees affected by the Arkansas waiver project.

Friday's decision applies only to Arkansas, but similar requirements have either been proposed or are underway in another **20 states. Some states** have paused their programs citing ongoing litigation.

Medicare Rights continues to oppose efforts to restrict access to Medicaid coverage, including through burdensome and unnecessary conditional requirements. The **evidence is clear** — such rules leave more people uninsured, fail to move people out of poverty, and do not eliminate the need for health coverage. **Nor are they needed**. A large majority of adults with Medicaid are already working. Among those who are not, most report significant barriers to employment such as illness, disability, or retirement. As a result, these type of barriers often **disproportionately harm people who are nearing Medicare eligibility** and others who are already having difficulty finding and maintaining work.

The Medicaid program was designed to provide health coverage to people who are struggling to afford care. Conditioning this coverage on compliance with punitive work requirements and bureaucratic tasks does nothing to advance this statutory goal. We are relieved the courts continue to recognize the program's lawful purpose, and we urge the Trump administration to do the same.

Read the decision
Read about the risks of work requirements for older adults.

Congressional Candidates Go Head-To-Head On Health Care — Again

The California Democrats who fought to flip Republican congressional seats in 2018 used health care as their crowbar. The Republicans had just voted to repeal the Affordable Care Act in the U.S. House — and Democrats didn't let voters forget it.

Two years later, Democrats are defending the seven seats they flipped from red to blue in California. And once again, they plan to go after their Republican opponents on health care in this year's elections.

But this time around, it's not just about the Affordable Care Act, **whose fate** now rests with the federal courts. Democrats are highlighting the high costs of prescription drugs, surprise medical bills and cuts to safety-net programs.

Health care "remains the single-biggest priority for most voters in 2020," said U.S. Rep. Josh Harder, a Democrat who represents California's 10th congressional district, in the northern San Joaquin Valley, which includes the cities of Modesto, Turlock, Tracy and Manteca.

Harder, who defeated Republican Jeff Denham in 2018, made the case then that eliminating the federal health law and its protections for people with **preexisting conditions** would harm thousands of people in his district, including his younger brother, whose premature birth yielded $2 million in hospital bills.

Health care affordability — from drug costs to premiums — is still the No. 1 issue his constituents raise in conversations with him, he said.

"The problems haven't been solved," said Harder, who blamed the Republican-controlled U.S. Senate for stalling on **health care legislation** addressing prescription and other health care costs. "A lot of folks out here feel like there's still an unbelievably long period before they can see a doctor, and they think that the costs are way too high."

Multiple calls and emails to Republican congressional candidates and the California Republican Party requesting comment were not returned. California voters will select their party's congressional candidates in the Super Tuesday primary March 3.

Health care is indeed a top issue for voters, confirmed Mollyann Brodie, executive director of public opinion and survey research for the Kaiser Family Foundation. (Kaiser Health News, which produces California Healthline, is an editorially independent program of the foundation.)

"What concerns people the most is health care costs and their own affordability of health care," Brodie said. "And when we asked people what they thought Congress should be working on, prescription drug costs came right on top."

A national Kaiser Family Foundation tracking poll from September 2019 found that 81% of Democrats and 62% of Republicans surveyed said lowering prescription drug costs should be a top priority for Congress. Voters in both parties also want Congress to maintain protections for people with preexisting conditions and limit surprise medical bills.

Both Democratic and Republican candidates are taking note and are likely to feature health care prominently in their campaigns, but their messages will be different, said Nathan Gonzales, editor and publisher of **Inside Elections**, a campaign analysis site.

For example, progressive Democrats often advocate for "Medicare for All," a national health care program that would cover everyone in the U.S.

Republicans oppose this idea fervently….**Read More**

Trump's Medicaid Chief Labels Medicaid 'Mediocre.' Is It?

"Yet, for all that spending, health outcomes today on Medicaid are mediocre and many patients have difficulty accessing care."

The Trump administration's top Medicaid official has been increasingly critical of the entitlement program she has overseen for three years.

Seema Verma, administrator of the Centers for Medicare & Medicaid Services, has warned that the federal government and states need to better control spending and improve care to the 70 million people on Medicaid, the state-federal health insurance program for the low-income population. She supports **changes to Medicaid** that would give states the option to receive capped annual federal funding for some enrollees instead of open-ended payouts based on enrollment and health costs. This would be a departure from how the program has operated since it began in 1965.

In an early February **speech to the American Medical Association**, Verma noted how changes are needed because Medicaid is one of the top two biggest expenses for states, and its costs are expected to increase 500% by 2050.

"Yet, for all that spending, health outcomes today on Medicaid are mediocre and many patients have difficulty accessing care," she said.

Verma's sharp comments got us wondering if Medicaid recipients were as bad off as she said. So we asked CMS what evidence it has to back up her views.

A CMS spokesperson responded by pointing us to a CMS **fact sheet** comparing the health status of people on Medicaid to people with private insurance and Medicare. The fact sheet, among other things, showed 43% of Medicaid enrollees report their health as excellent or very good compared with 71% of people with private insurance, 14% on Medicare and 58% who were uninsured.

The spokesperson also pointed to **a 2017 report** by the Medicaid and CHIP Payment and Access Commission (MACPAC), a congressional advisory board, that noted: "Medicaid enrollees have more difficulty than low-income privately insured individuals in finding a doctor who accepts their insurance and making an appointment; Medicaid enrollees also have more difficulty finding a specialist physician who will treat them."

We opted to look at those issues separately….**Read More**

45 Percent of Retirees See Little Growth in Social Security Benefits

Forty- five percent of retirees, report that that their net monthly Social Security benefit grew by less than $10 in 2019 despite receiving a 2.8 percent cost-of-living adjustment according to new survey results from The Senior Citizens League (TSCL). In 2020, this lack of growth in net Social Security benefits will affect even more people, "because retirees received a much lower COLA (1.6 percent) while their Medicare Part B premiums grew more quickly than in 2019," says Mary Johnson, a Social Security and Medicare policy analyst for The Senior Citizens League.

Johnson gives an example from her case files, of a 70 - year old retired welder with a gross Social Security benefit of $1,267.50 in 2019. After deductions of $135.50 for Part B and $52.80 for his Medicare Advantage plan, his net Social Security benefit was $1,079.20 — $29.10 per month more than the $1,050.10 he received in 2018. This individual was among the 55 percent of survey participants whose net benefit grew by more than $10 per month in 2019.

But in 2020, after the 1.6 percent COLA and deduction of $144.60 Medicare Part B, and $58.60 for Medicare Advantage plan premiums, the same individual receives a net Social Security benefit of only $1,084, just $5.20 per month more than in 2019.

The Senior Citizens League's survey question asked:

COLAs have averaged just 1.4% over the past 11 years, but Medicare premiums, which are growing several times faster than COLAs, consume most, or even all of the annual COLA for a significant segment of retirees. The Senior Citizens League supports legislation that would provide a modest boost in benefits for all retirees and would strengthen the annual COLA by tying the annual boost to the Consumer Price Index for Elderly Consumers. The League's surveys have also found strong support among older Americans for legislation that would guarantee that the annual COLA boost would be no less than 3 percent.

Which of the following amounts most closely resembles your monthly Social Security benefit increase this year (2019), AFTER the deduction for the Medicare Part B increase?

$0 - and your Social Security Benefit is less than received in 2018	5%
$0 — and your Social Security benefit is the same as received in 2018	9%
.01- $5.00	11%
$5.01-$10.00	20%
$10.01 - $25.00	25%
More than $25.00	30%

10 Best States for Older Americans

Six of the 10 best states for Americans at least 65 years old sit on the East Coast, with four in the geographic Northeast, according to a new report from **24/7 Wall Street** that ranks states.

The report scored states' viability for seniors based on income, health, education and environment, and accessibility. Variables included violent crime rates, the percentage of states' seniors with supplemental retirement incomes such as 401(k)s and pensions, life expectancy after the age of 65, and the share of older Americans with a bachelor's degree or higher, among others. Data were pulled from the Census Bureau and the Centers for Disease Control and Prevention.

Southern states largely fell to the bottom of the list, with the bottom five and nine of the bottom 10 sitting in the geographic South. **West Virginia, Arkansas, Mississippi, Louisiana and Alabama** represented the five worst states for America's elderly population.

A group of mostly East Coast states, however, ranked among the best for America's seniors, with Mountain states such as **Colorado** and **Utah** also performing well. Several states at the top of the 24/7 Wall Street methodology also ranked among the best in a U.S. News **Best States for Aging** analysis. Maine topped the U.S. News analysis of the country's best states for the country's aging population.

Medicare's Private Option Is Gaining Popularity, and Critics

As more Americans sign up for Medicare Advantage, detractors worry that it's helping private insurers more than patients.

When Ed Stein signed up for Medicare eight years ago, the insurance choice seemed like a no-brainer.

Mr. Stein, a Denver retiree, could choose original, fee-for-service Medicare or its private managed-care alternative, Medicare Advantage. He was a healthy and active 65-year-old, and he picked Advantage for its extra benefits.

"The price was the same, I liked the access to gyms, and the drug plan was very good," he recalled. After a pause, he added: "Never in my wildest dreams did I think I'd be facing a crisis like the one I'm having now."

In November, at age 72, Mr. Stein received a diagnosis of aggressive bladder cancer that would require chemotherapy and a complex surgical procedure. The doctor who he determined was the best local specialist for his condition was not in his network, so Mr. Stein decided to switch to original Medicare for 2020 — a move that would allow him to see nearly any health care provider he chose.

That was when he ran up against one of the least understood implications of selecting Advantage when you enroll in Medicare: The decision is effectively irrevocable.

Most enrollees in traditional Medicare buy supplemental coverage to protect them from potentially high out-of-pocket costs. In 2016, out-of-pocket spending in the program averaged $3,166, excluding premiums, according to the **Kaiser Family Foundation**.

Supplemental coverage sometimes comes from a former employer, a union or Medicaid, although many people buy a commercial Medigap plan. But the best, and sometimes only, time to buy a Medigap policy is when you first join Medicare.

During the six months after you sign up for Part B (outpatient services), Medigap plans cannot reject you, or charge a higher premium, because of pre-existing conditions. After that time, you can be rejected or charged more, unless you live in one of four states (Connecticut, Massachusetts, Maine and New York) that provide some level of guarantee to enroll at a later time with pre-existing condition protection.

His coverage problems led to a frenzied scramble in November that ultimately involved treatment at four hospitals — and a last-minute switch to a different Advantage network that includes his preferred physician.

The problems have taken their toll. "When you're in the middle of a health crisis, the last thing you need is to be negotiating with health providers and insurance," said Mr. Stein's wife, Lisa Hartman. "We spent as many hours talking with all these people about squaring away our insurance as we did actually getting treatment.".

Medicare Advantage is growing quickly — enrollment is expected to jump to 47 percent of all Medicare beneficiaries in 2029 from 34 percent this year, according to a **Kaiser analysis** of Congressional Budget Office projections.

Some of the growth stems from heavy investment by health insurance companies in geographic expansion and marketing. The industry points to **high rates of consumer satisfaction** with Advantage, noting extra services offered by many plans, such as health clubs, dental, vision and hearing care.

"Advantage plans are partnering with hospitals, doctors and other care providers to improve outcomes for patients, deliver care more efficiently and add more value compared with the fee-for-service model," says Greg Berger, vice president of Medicare policy at America's Health Insurance Plans, the national association of health insurance companies.

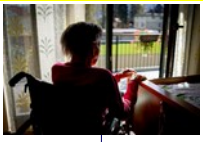
The rise of Advantage has also been aided by changes in federal law and regulation in recent years. And under the Trump administration, critics say, Medicare's administrators have been tipping the scales improperly in favor of Advantage…..**Read More**

Where Do the Democratic Candidates Stand on Health Reform

Our newly updated slideshow explains where the Democratic primary candidates stand on health reform, as they prepare for tonight's debate in Nevada. The slideshow includes information on candidates' positions on Medicare-for-all, a public option, changes to existing Medicare and Medicaid programs, and drug prices.

Watch the side show here

More people are choosing to die at home, instead of in a hospital



It's the first time in more than half a century that deaths at home surpassed deaths in the hospital.

Home is now the most common place people are choosing to spend their final days of life, outpacing hospital deaths for the first time in more than half a century, according to a study published Wednesday in the **New England Journal of Medicine**.

The findings are reflective of an end-of-life trend that's been growing since the early 2000s.

From 2003 to 2017, the percentage of people dying at home increased from 23.8 percent to 30.7 percent, researchers found. At the same time, deaths that occurred in hospitals fell from 39.7 percent in 2003, to 29.8 percent in 2017. The research is based on an analysis of federal death certificate data from natural deaths during that time period

The flip-flop may be attributed in part to growth in home hospice care, which is covered by Medicare, said study co-author Dr. Haider Warraich, associate director of the heart failure program at the VA Boston Healthcare System. Hospice provides pain management, along with emotional support and care to terminally ill patients nearing the end of their lives, as well as their families.

The number of Medicare beneficiaries receiving hospice care has steadily grown over the past decade. The **National Hospice and Palliative Care Organization** reports there were 1.49 million such recipients in 2017, a 4.5 percent increase from the year before.

But the rise in at-home deaths also "reflects that perhaps we're able to honor more people's wishes and help them pass away in a place that's most familiar to them," said Warraich, who is also a cardiologist at Brigham and Women's Hospital and an instructor in cardiology at Harvard Medical School.

Dying at home was less common among younger patients, the study found. That's likely because of two reasons: young people in life-threatening situations are more likely to undergo emergency medical interventions in a hospital, and insurance other than Medicare may not cover hospice care….**Read More**

CMS warns of tougher survey enforcement

State survey agencies will be stepping up their long-term care enforcement efforts, the Centers for Medicare & Medicaid Services administrator suggested Tuesday.

Enhanced enforcement is the agency's next step in the previously announced **five-part initiative** to improve nursing home quality and safety standards. The effort also focuses on strengthening oversight, increasing transparency, improving quality and putting "Patients Over Paperwork," CMS Administrator Seema Verma noted in **a blog post**.

The agency has done a comprehensive review of its enforcement mechanisms and is making "significant [and] creative enhancements" to its enforcement efforts, according to Verma.

Targeted improvement areas included oversight of state survey agencies (SSAs) and better communication with SSAs and providers on expectations. The agency also is focusing on collaborating directly with corporate leaders of nursing home chains and staffing levels at facilities.

"Federal regulations are clear with respect to RN staffing, and that's because we know patients and residents are safer when sufficient staffing levels are maintained. Unfortunately, all too often, we found that nursing homes weren't complying with federal rules," Verma wrote. "That's unacceptable, so we've implemented a few strategies to bring nursing homes into compliance."

CMS also plans to "take a hard look" at its civil money penalties that it imposes on nursing homes for noncompliance. The agency plans to announce new policies regarding penalties that promote equity and reduce variation.

The agency has also requested $442 million for survey and certification work — a $45 million increase from last year — for the FY 2021 budget.

"The increased funding would enable CMS to continue to meet the statutory survey requirements while dealing with the increase in volume and severity of complaints, and rising survey costs," Verma wrote.

Also as part of its work on the five-part initiative, on Friday, CMS **released a memo to surveyors** announcing the release of two additional toolkits as part of the five-part initiative.

The first toolkit — the Developing a Restful Environment Action Manual (DREAM) Toolkit — offers educational resources and practical interventions for residents with dementia that can be implemented by nursing home administrators, directors of nursing and staff to promote high-quality sleep.

The second — the Head-to-Toe Infection Prevention (H2T) Toolkit — includes resources for staff to help prevent common infections by improving activities of daily living care.

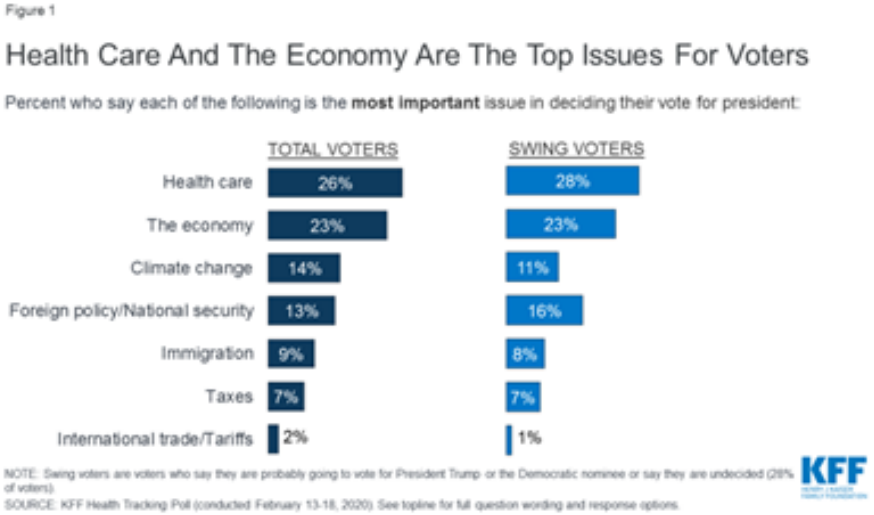
KFF Health Tracking Poll – February 2020: Health Care in the 2020 Election

Key Findings:

- The U.S. Supreme Court will decide today whether to take up *Texas v. United States*, which challenges the constitutionality of the 2010 Affordable Care Act (ACA). The February KFF Health Tracking Poll finds attitudes towards the ACA has hit its highest favorability since KFF began tracking opinions nearly ten years ago. The latest KFF poll finds a clear majority of the public viewing the law favorably (55%), while slightly more than one-third (37%) of the public hold unfavorable views.
- The Affordable Care Act took center stage in the Nevada Democratic presidential debate with Vice President Biden **attacking** Mayor Bloomberg's record on the ACA. Nearly nine in ten Democrats (85%) and Democratic voters (86%) view the ACA favorably and while most Republicans view the unfavorably, significantly fewer Republicans offer repealing the 2010 health reform law as their top health care issue. Voters, overall, and across party identification, prioritize other health care issues such as health care costs.
- Health care remains a top issue for Democratic voters, independent voters, and the crucial group of voters who haven't made up their minds yet – swing voters. More than one-third of Democratic voters (36%) say health care is the "most important" issue in their 2020 vote choice as do three in ten independent voters and 28% of swing voters. Yet, when asked what is the one thing that will motivate them to vote in 2020, a larger share of voters offer responses related to defeating President Trump and electing a Democrat than any issue, including health care. When voters who have decided to vote for the Democratic nominee are asked what is most important when choosing a Democratic candidate, a larger share say "a candidate with the best chance to defeat President Trump" (59%) than one "who comes closest to your views on issues" (39%).
- Both a national Medicare-for-all plan and a government-administered public option continue to garner majority support in the KFF Health Tracking Polls, including large shares of Democrats who express positive attitudes towards both proposals. Yet, the public option holds the advantage over a national Medicare-for-all plan when supporters of both are forced to choose one. The public option garners more support among many key groups in the 2020 Democratic primary including swing voters (49% v. 25%).
- Health Care Among Top Issues for Voters, But Trump Looms Large

More than eight months before the 2020 general presidential election, health care (26%) and the economy (23%) are the top issues that registered voters say will be most important in deciding their vote for president. This is followed by climate change (14%), foreign policy (13%), immigration (9%), taxes (7%), and international trade and tariffs (2%)….**Read More**

Figure 1



Health Policy Choices at the State Level Have Huge Impact on Resident Access to Care

While coverage and access to Medicaid and the Affordable Care Act's (ACA) individual marketplaces are rooted in federal law, both programs are also shaped by policy choices at the state level. These decisions can be influenced by state demographics, budgets, and ideologies or politics. The resulting laws and guidance can greatly affect whether older adults or people with disabilities have access to the care they need to live healthy, independent lives.

The Kaiser Family Foundation (KFF), a national nonprofit that analyzes health policy, put together three valuable resources that lay out some of the decisions states have made regarding Medicaid and the ACA, and what effect some of those decisions have had on care.

- **In Election 2020: State Health Care Snapshots**, KFF compiled demographic and health coverage statistics for each state, including at what income levels the state has chosen to set eligibility for Medicaid.
- **In Key State Policy Choices About Medicaid Home and Community-Based Services**, KFF shows the significant variation and flexibility states have when it comes to providing access to care that help older adults and people with disabilities stay in their homes rather than an institution.
- **In Medicaid Home and Community-Based Services Enrollment and Spending**, KFF reveals the effect of those choices and what impact they have on state budgets and the people who need care. For example, states may restrict how many people can receive home-based services, which might force others onto waiting lists or into nursing facilities.

Each of these resources is exceptionally valuable as we move closer to the 2020 election and candidates establish health care positions. The choices states make are vitally important to how their residents access care, even when the program they are administering is a federal-state partnership, like Medicaid. By comparing state choices and the resulting impacts, we can better determine which policy options are truly beneficial to the people who rely on the health care and coverage these programs provide.

Nine takeaways for the US from other health care systems

Dylan Scott at **Vox** traveled to Taiwan, Australia and the Netherlands to gain a better understanding of their health care systems and how they differ from ours. Here are his nine takeaways.

1. **The US is the only developed country that is not committed to universal health care.**

Unlike Taiwan, Australia, the Netherlands and the UK, policymakers in the US have not reached consensus that the federal government should guarantee everyone in the country access to health care, much less that health care should be affordable to all.

2. **There's no perfect universal health care system.**

Every other developed country covers everyone, and their residents pay far less for their care than we do in the US. Still, some countries do not have enough health care providers and costs are rising.

Australia recently adopted a two-tiered system, offering everyone public health insurance and those who can afford it, private insurance. The government is investing a lot of money in the private system. As a result, there is less needed funding for the public system. Also, there are longer wait times for people in the public system.

Meanwhile, the Dutch system now relies on private insurers which has driven up health care spending. Administrative costs are higher, deductibles are now almost $500, and health care is less affordable for people.

3. **Governments spend a lot to guarantee their citizens health care.**

In other countries, governments negotiate health care prices, set rules for what is covered and when and how much people can be charged for copays. Private insurers are really claims processors, without the liberty to decide how care is covered, unlike in the US, where they must each negotiate their own rates and have tremendous freedom to restrict access to care and set copay amounts.

4. **To ensure health care affordability, governments impose cost controls.**

Some countries rely on global budgets–they set aside a fixed amount to pay for health care each year. The Australian government sets prices for doctors' services. And, Australia has a system for evaluating whether a prescription drug offers value.

Moreover, governments tend to rely on national electronic health records databases to see what's working and not. Governments determine what care is covered, at what price, and how much patients will pay for their care. Insurers operate more like claims processors. They cannot set their own rules.

5. **Many countries are struggling to deliver and cover long-term care.**

Long-term care costs for older adults and people with disabilities are growing. And, it's not clear whether and how countries will deliver the care people need or help to cover the costs of long-term care.

The US government today spends far less on long-term care than every western European country except Portugal.

6. **Private insurance is sometimes part of the health care system, but with lots of controls and challenges.**

Scott sees private insurance as a political compromise in other countries, not a policy solution. The insurance industry has a lot of financial and political power to sway policy in their favor. In Australia, private insurance gives people with means more health care choices, but it has hurt everyone else to some degree.

7. **Physicians will never be completely happy with a universal health care system.**

Curiously, in every country almost twice as many doctors or more are satisfied or very satisfied with their health care system than are dissatisfied or very dissatisfied. Only Germany has less doctor satisfaction (63 percent) than the US (65 percent) and more dissatisfaction (36 percent v. 34 percent). Norway had the highest doctor satisfaction (91 percent), with Australia close behind (88 percent).

8. **Health insurance coverage is not the same as guaranteeing people the health care they need.**

Health care delivery system reforms need to be part of the picture if you want everyone to have access to care. Coverage is not enough. For example, some underserved regions might need hospitals or specialists. Or, as in the Netherlands, doctors might be required to provide care during the evening and weekends and make home visits. To share the load, doctors formed cooperatives.

9. **What works in the US might be different from what works in other countries.**

The US effectively has more than 50 health care systems. It has one for people with Medicare, one for people with Medicaid, one for Vets, and one in each state. And, the US has substantial racial disparities in our health care system.

Health care in the US varies depending upon which system you are in, your race and your ability to pay. And, it is profoundly inequitable. So long as policymakers are beholden to the corporate health insurers, it's not likely much will change.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Stalked by The Fear That Dementia Is Stalking You

Do I know I'm at risk for developing dementia? You bet.

My father died of Alzheimer's disease at age 72; my sister was felled by frontotemporal dementia at 58.

And that's not all: Two maternal uncles had Alzheimer's, and my maternal grandfather may have had vascular dementia. (In his generation, it was called senility.)

So what happens when I misplace a pair of eyeglasses or can't remember the name of a movie I saw a week ago? "Now comes my turn with dementia," I think.

Then I talk myself down from that emotional cliff.

Am I alone in this? Hardly. Many people, like me, who've watched this cruel illness destroy a family member, dread the prospect that they, too, might become demented.

The lack of a cure or effective treatments only adds to the anxiety. Just this week, news emerged that another study trying to stop Alzheimer's in people at extremely high genetic risk had failed.

How do we cope as we face our fears and peer into our future?

Andrea Kline, whose mother, as well as her mother's sister and uncle, had Alzheimer's disease, just turned 71 and lives in Boynton Beach, Florida. She's a retired registered nurse who teaches yoga to seniors at community centers and assisted-living facilities.

"I worry about dementia incessantly. Every little thing that goes wrong, I'm convinced it's the beginning," she told me.

Because Kline has had multiple family members with Alzheimer's, she's more likely to have a genetic vulnerability than someone with a single occurrence in their family. But that doesn't mean this condition lies in her future. A risk is just that: It's not a guarantee.

The age of onset is also important. People with close relatives struck by dementia early — before age 65 — are more likely to be susceptible genetically.

Kline was the primary caregiver for her mother, Charlotte Kline, who received an Alzheimer's diagnosis in 1999 and passed away in 2007 at age 80. "I try to eat very healthy. I exercise. I have an advance directive, and I've discussed what I want [in the way of care] with my son," she said.

"Lately, I've been thinking I should probably get a test for APOE4 [a gene variant that can raise the risk of developing Alzheimer's], although I'm not really sure if it would help," Kline added. "Maybe it would add some intensity to my planning for the future."

I spoke to half a dozen experts for this column. None was in favor of genetic testing, except in unusual circumstances.

"Having the APOE4 allele [gene variant] does not mean you'll get Alzheimer's disease. Plenty of people with Alzheimer's don't have the allele," said Mark Mapstone, a professor of neurology at the University of California-Irvine. "And conversely, plenty of people with the allele never develop Alzheimer's."

Tamar Gefen, an assistant professor of psychiatry and behavioral sciences at Northwestern University's Feinberg School of Medicine, strongly suggests having an in-depth discussion with a genetic counselor if you're considering a test.

"Before you say 'I have to know,' really understand what you're dealing with, how your life might be affected, and what these tests can and cannot tell you," she advised.

Karen Larsen, 55, is a social worker in the Boston area. Her father, George Larsen, was diagnosed with vascular dementia and Alzheimer's at age 84 and died within a year in 2014.

Larsen is firm: She doesn't want to investigate her risk of having memory or thinking problems.

"I've already planned for the future. I have a health care proxy and a living will and long-term care insurance. I've assigned powers of attorney, and I've saved my money," she said. "Eating a healthy diet, getting exercise, remaining socially engaged — I already do all that, and I plan to as long as I can."

"What would I do if I learned some negative from a test — sit around and worry?" Larsen said.

Currently, the gold standard in cognitive testing consists of a comprehensive neuropsychological exam. Among the domains examined over three to four hours: memory, attention, language, intellectual functioning, problem-solving, visual-spatial orientation, perception and more.

Brain scans are another diagnostic tool. CT and MRI scans can show whether parts of the brain have structural abnormalities or aren't functioning optimally. PET scans (not covered by Medicare) can demonstrate the buildup of amyloid proteins — a marker of Alzheimer's. Also, spinal taps can show whether amyloid and tau proteins are present in cerebrospinal fluid.

A note of caution: While amyloid and tau proteins in the brain are a signature characteristic of Alzheimer's, not all people with these proteins develop cognitive impairment.

Several experts recommend that people concerned about their Alzheimer's risk get a baseline set of neuropsychological tests, followed by repeat tests if and when they start experiencing worrisome symptoms.

...**Read More**

What to Do If Your Friend Posts About Being Depressed on Social Media

With discussions of **mental health** and **self-care** becoming much more frequent and frank these days, you've probably seen some of your friends or family members write Facebook posts about their struggles with **mental health issues**. Of course, it can be hard to know how to respond in order to **help a friend with depression** and show that you support them. And according to a new study published in the journal ***JMIR Research Protocols***, unfortunately, it turns out we don't tend to do the right thing.

In the research out of Ohio State University, 33 students said they had "reached out on Facebook for help when depressed." Half of them reported symptoms consistent with moderate to severe depression and around a third reported recently having suicidal thoughts. Only one of the students in the study directly asked for help, and only three actually mentioned the word "depression." The others hinted at their depression by using quotes about sadness (5 percent), a negative emoji (5 percent), sad song lyrics (15 percent), or by writing sentences like "Things couldn't get any worse" (45 percent).

"They didn't use words like 'depressed' in their Facebook posts. It may be because of the stigma around mental illness," **Scottye Cash**, an associate professor of social work at Ohio State University and lead author of the study, said in a statement. "Or maybe they didn't know that their symptoms indicated that they were depressed."

Here's Why Heart Attack Symptoms Can Be So Hard to Spot in Women

Women's **heart attack** symptoms fly under the radar all too often. And a lot of that has to do with our own assumptions about what a heart attack actually looks like.

For example, do a quick Google image search of the phrase "**heart attack**" and you'll probably see an older man in his 50s or 60s, hand on his chest, clearly in severe pain. That's a somewhat fair depiction, given that men are at greater risk of heart attack than women, and that the most common symptom of a heart attack is chest pain or discomfort, according to the **American Heart Association** (AHA). But that generalization can obscure the reality that heart disease is the leading cause of death for both men *and* women in the United States, according to the **Centers for Disease Control and Prevention** (CDC)—and that there can be other symptoms of heart attacks besides chest pain, especially in women. Let's get to the truth about **heart attack symptoms** in women.

Let's talk about the causes and symptoms of a heart attack.

Although heart attacks can happen the same way in men and women], they can sometimes look different. A heart attack, or myocardial infarction, usually occurs when a blood clot in one of the coronary arteries cuts off or seriously restricts the flow of blood and oxygen into the heart, the **U.S. National Library of Medicine** explains. This can happen when fatty plaque builds up inside an artery, narrowing the passageway into the heart. If the plaque in that artery breaks open, a blood clot forms, restricting or stopping the flow of blood into the heart. The heart cells that are deprived of oxygen start to die, which leads to a heart attack.

The most common sign of a heart attack, in both men and women, is pain or discomfort in the middle or left side of the chest, which can range from mild to intense and last several minutes or come and go, the **National Heart, Lung, and Blood Institute** (NHLBI) explains.

But women are also more likely to have less expected signs of a heart attack, according to the **NHLBI.** (Sometimes these are called atypical or nontraditional heart attack symptoms.) These include heartburn, indigestion, nausea, vomiting, shortness of breath, extreme fatigue, and pain in the back, arms, neck, throat, or jaw. Lightheadedness and breaking out in a cold sweat are also potential symptoms, the AHA says. Women are even more likely than men to have no obvious symptoms at all, which is called a silent heart attack, according to the **Office on Women's Health**. (Doctors can tell that you had a silent heart attack in the last few days to months using an electrocardiogram test.)

"We don't really know exactly why women [with heart attacks] present differently than men," **Heba Wassif**, M.D., M.P.H., a cardiologist at the Cleveland Clinic, tells SELF. According to a 2016 statement from the AHA, this is a complex and understudied issue. (And, as Dr. Wassif points out, the mere fact that these symptoms are sometimes labeled atypical may perpetuate our overlooking of them.)

Scientists believe it has to do, at least in part, with biological differences in how heart disease tends to develop in men and women—like the characteristics of the plaque, the arteries where it tends to form, and the pathophysiological mechanisms or causes underlying the heart attack, according to **the AHA statement.**

Here's why it's easy to miss women's heart attack symptoms.

"It's a combination of factors that contribute to this," **Jacqueline Tamis-Holland, M.D.**, a cardiologist at Mount Sinai Morningside at Mount Sinai, tells SELF. Underpinning nearly all of them is a lack of awareness of heart health as an important issue for women. "People are understanding and recognizing these things more now" thanks to public awareness campaigns, Dr. Tamis-Holland says. "But I think [there are] some residual [stereotypes]." Although awareness has increased over the past few decades, only 56 percent of women know that heart disease is the number one cause of death for women overall, according to the **CDC**.

Because of that, "Women may be less likely to realize they're having a heart attack," Dr. Tamis -Holland says. Yes, that's in part because the heart attack symptoms women often experience can just seem random—less obviously heart-related, and more easily attributable to some other health issue. Shortness of breath, **jaw pain**, and indigestion don't set off those alarm bells the way chest pain does.

But there's also evidence suggesting that this lack of awareness may lead women to try to rationalize or minimize their symptoms if they don't totally align with those of the standard heart attack. In a 2015 study published in ***Circulation***, where researchers interviewed 30 women aged 30 to 55 hospitalized with a heart attack, a recurring theme was that women were hesitant to believe they could be having a heart attack because their symptoms did not reflect descriptions of heart attacks by doctors or depictions of them in TV or movies. ….**Read More**

How Much Coffee Is Too Much?

The desire to feel like a functioning human is reason enough for most coffee-lovers to consume the drink on the reg. But for anyone who's not sold, research has also linked coffee to health benefits like **a longer lifespan, lowered cancer risk**, and **boosted athletic performance**.

Still, it's always possible to have too much of a good thing—even cold brew. After all, while we know coffee is chock-full of disease-fighting antioxidants like quinines and flavonoids, one espresso shot too many can leave you feeling shaky and anxious, and sometimes with an upset stomach. Plus, too much caffeine has been linked to high blood pressure, which ups your risk of heart disease. (Related: **Turns Out It's Possible to Die of a Caffeine Overdose**)

So how many cups can you get away with before the risks outweigh the benefits? **A new coffee study** published in *The American Journal of Clinical Nutrition* provides an answer. Thankfully, the turning point that researchers landed on is pretty high: six cups per day.

To arrive there, researchers analyzed data from more than 347,000 people, which focused on participants' daily coffee intake and whether they had heart disease. They found that compared to people who drink 1–2 cups per day, those who don't drink coffee have an 11 percent higher risk of heart disease, and those who drink more than six daily cups have a 22 percent higher risk.

"In order to maintain a healthy heart and a healthy blood pressure, people must limit their coffees to fewer than six cups a day," study author, Elina Hyppönen, Ph.D., **stated in a press release**. "Based on our data six was the tipping point where caffeine started to negatively affect cardiovascular risk."

This isn't the first study to provide a java sweet spot. Here's what else science has to say about your coffee habit….**Read More**

Kids Raised by Grandparents More Likely to Pile on Pounds: Study

Grandparents can be a bad influence on kids' weight, researchers say.

That's the upshot of an analysis of 23 studies conducted in the United States and eight other countries by a team from the Brown School at Washington University in St. Louis.

The study found that kids who were cared for by grandparents had nearly 30% higher odds for being overweight or obese.

While Grandma and Grandpa may mean well, they can affect their grandchildren's weight in various ways, including eating habits, physical activity and perceptions of what represents a healthy lifestyle, according to the researchers.

"Through offering wisdom, teaching traditions, providing guidance and making memories, grandparents are often able to leave behind a legacy that their grandchildren will cherish and benefit lifelong," said lead author Ruopeng An, an assistant professor.

"However, some negative influences from grandparental care may also be present and cannot be overlooked," he added in a university news release.

One of those negative influences affects a child's diet and exercise habits.

"The notion of 'the bigger the healthier' is still relevant," An said.

Some grandparents may urge their grandkids to eat bigger and more frequent meals, and will offer sweets and fried foods as a way to show love, he pointed out.

"In fact, in some cultures, grandparents may also be more likely to excuse children from doing household chores, a key form of physical activity," An added.

He said he was surprised that the studies -- from the United States, the United Kingdom, China, Japan and five other nations -- showed similar trends across cultures.

"Affluence and being well fed is valued and desirable to many grandparents as they had experienced hunger and poverty in their youth, which they may pass on to their grandchildren, who, to the opposite, are fighting against a world of food swamps and ever-expanding portion sizes," An said.

What to do if you're having a heart attack after calling 911

- Some signs of a heart attack are chest discomfort that radiates into the neck and down the arms, shortness of breath, nausea, and sweating.
- If you believe you are having a heart attack, the first thing you should do is call 911, since getting to the emergency room ASAP may help make treatment methods more effective.

Once you have called 911, take four chewable baby aspirin, which can work as blood thinners and help dissolve the clot.

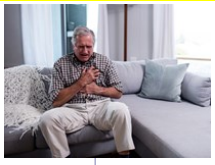
Before you try to stop a heart attack, you'll first need to make sure that the major **symptoms are indicating a heart attack**.

"People complain of discomfort in the middle of their chest that may radiate up to their neck, to their jaw, and to their arms," says Lawrence Phillips, MD, a cardiologist and assistant professor at NYU Langone. "They may feel shortness of breath, nausea, and sweating with it."

If you or someone else is experiencing these symptoms, you'll want to act fast. The **quickest response to a heart attack** is associated with the best outcome and recovery.

What to do if you're having a heart attack

"There's no real way to stop a heart attack at home," says On Chen, MD, an interventional cardiologist and Director of the Lipid Program at Stony Brook Medicine. "The first thing to do is call 911 immediately and get to the nearest emergency room to confirm that you are actually having a heart attack."



Phillips says by getting to the ER quickly, you may be able to decrease the damage to the heart. The journal ***Circulation*** has found that getting to the emergency room within the first hour of symptoms can make common treatment methods more effective - however, only about one in five patients get to the hospital within an hour.

Furthermore, the *Journal of American College of Cardiology* has reported on a campaign to improve the timeliness of angioplasty and stent procedures, as individuals who receive this treatment within **90 minutes** of a heart attack have a higher likelihood of survival.

If you are in the presence of someone else who may be having a heart attack, there are a few ways to help improve their outcome. The first thing you should do is call 911 - fast medical attention is imperative. If the person suddenly collapses, they are experiencing **cardiac arrest**, which is far more dangerous, and you should administer CPR or use an automated external defibrillator *(*AED), if possible.

For more information on treating someone with cardiac arrest as opposed to a heart attack, read our article, "The difference between cardiac arrest and a heart attack."

Aspirin can help stop a heart attack in certain cases

Aspirin can be an **important part of heart attack intervention**. It is a blood thinner, which can help dissolve the clot that is blocking blood flow to the heart.

Phillips recommends taking four chewable baby aspirins at the onset of symptoms (in addition to calling 911). Baby aspirin is preferable, as the smaller dose has been associated with fewer potential side effects, and a large dose isn't necessary to inhibit clotting.

However, On Chen also notes the possible risks of taking aspirin, such as an **allergic reaction or bleeding.** "You have to know that you're actually having a heart attack and not something else," Chen says. "The problem is if you are having another medical issue that the aspirin could worsen."

If you think you or someone else may be experiencing a heart attack, call 911 first and double-check with the operator to see if taking aspirin is a good idea. If you're at high risk for a heart attack or have already had one, you may also want to talk with your doctor about **daily aspirin therapy.**

Nitroglycerin can help relieve chest pain, if it's been prescribed

Lastly, if you have a history of heart disease and have been prescribed nitroglycerin, you should take it at the onset of chest pain, even if it isn't accompanied by other heart attack symptoms, according to Phillips.

These pills are placed under the tongue and may be recommended for individuals with high-risk cardiac health conditions, as they dilate blood vessels. "The idea is that, if there is a narrow end of the blood vessel, but it's not completely blocked, by dilating the blood vessel you are able to get some blood flow around the blockage," Phillips says.

However, this doesn't change the need to seek emergency care if the pain continues. Nitroglycerin will **relieve pain if it's caused by angina,** but it won't stop a heart attack, so make sure you get to the hospital and follow up with your doctor if you take nitroglycerin.

The Power of a Number: How Your Birthday Could Influence Your Care

There may be something about a patient's age of 80 that makes doctors alter their heart attack treatment decisions -- consciously or not, new research suggests.

In a study of U.S. heart attack patients, researchers found that just one month in age made a difference in whether doctors performed bypass surgery -- one of the treatments for the artery blockages that cause heart attacks.

Among patients who had turned 80 within the past two weeks, just over 5% received bypass surgery. In contrast, the rate was 7% among patients who were about to turn 80 in the next couple weeks.

Researchers said the finding points to a "left-digit bias" -- where doctors may be more concerned about surgery complications just because a patient's age starts with an 8 rather than a 7.

"These patients were really all the same age, with just a few weeks separating them," said lead researcher Dr. Anupam Jena, an associate professor at Harvard Medical School. "But this study suggests doctors were seeing them differently."

Coronary bypass surgery involves taking a healthy blood vessel from a patient's leg, arm or chest, and using it to reroute blood flow around a blockage in a heart artery.

The surgery is not the only option for heart attack patients. Doctors often perform an alternative called angioplasty, where a catheter is threaded into a blocked artery and a stent is inserted to prop the vessel open.

In general, patients in their 80s have more health problems and tend to be frailer than younger patients -- and they are more likely to have bypass surgery complications, such as new blood clots, infections and heart arrhythmias.

So it's perfectly reasonable, Jena said, for doctors to have that in mind when there's a decision between surgery or a less invasive option like angioplasty.

But it's "unlikely" that poorer health could explain the lower rate of bypass among 80-year-olds in this study, he added.

The findings, published Feb. 20 in the *New England Journal of Medicine*, are based on Medicare data from 2006 through 2012. Jena's team focused on more than 4,400 heart attack patients who were admitted to the hospital during the two weeks before their 80th birthday, and another roughly 5,000 patients who were admitted within two weeks of turning 80.

Overall, the "older" group was less likely to receive bypass surgery -- even though they were no different from the "younger" group in terms of chronic health conditions and disabilities, Jena said.

In a sense, such left-digit bias is not surprising: It's a common phenomenon of the human mind, Jena pointed out.

"It's why you go to the store and things cost $9.99 instead of $10," he said. "The mind sees the 9 as cheaper."

And while grocery shopping is not the same as medical decision-making, Jena said, the findings suggest that a similar bias can creep into doctors' thinking.

Dr. Patrick Coll is medical director for senior health at UConn Health, in Farmington, Conn. He agreed that the findings likely point to a bias in doctors' views.

But age alone should not keep patients from a particular treatment, said Coll, who is also a member of the American Geriatrics Society's Board of Directors.

"We have a saying that once you've seen one 80-year-old patient, you've seen one 80-year-old patient," said Coll, who wasn't part of the study.

Age does make a difference in whether a given treatment is a good option, according to Coll. "But age is not the primary determinant," he said. "It's the 'medical baggage' that can go along with age."

Coll said it's probably wise for doctors to think about their own biases, and how they might be affecting patient care.

According to Jena, left-digit bias may be "both conscious and unconscious" -- in that doctors know that elderly patients have relatively higher complication risks, but may not fully realize they're using such a mental "short-cut" in presenting treatment options to a patient.

As for patients, simple awareness is important, Jena said. "They should know that the biases doctors have may affect the treatment options they offer," he said.

How to Exercise with Limited Mobility

Don't let injury, disability, illness, or weight problems get in the way. These chair exercises and other simple fitness tips can keep you active.

Limited mobility doesn't mean you can't exercise

You don't need to have full mobility to experience the health benefits of exercise. If injury, disability, illness, or weight problems have limited your mobility, there are still plenty of ways you can use exercise to boost your mood, ease depression, relieve stress and anxiety, enhance your self-esteem, and improve your whole outlook on life.

When you exercise, your body releases endorphins that energize your mood, relieve stress, boost your self-esteem, and trigger an overall sense of well-being. If you're a regular exerciser currently sidelined with an injury, you've probably noticed how inactivity has caused your mood and energy levels to sink. This is understandable: exercise has such a powerful effect on mood that it can treat mild to moderate depression as effectively as antidepressant medication. However, an injury doesn't mean your mental and emotional health is doomed to decline. While some injuries respond best to total rest, most simply require you to reevaluate your exercise routine with help from your doctor or physical therapist.

If you have a disability, severe weight problem, chronic breathing condition, diabetes, arthritis, or other ongoing illness, you may think that your health problems make it impossible for you to exercise effectively, if at all. Or perhaps you've become frail with age and are worried about falling or injuring yourself if you try to exercise. The truth is, regardless of your age, current physical condition, and whether you've exercised in the past or not, there are plenty of ways to overcome your mobility issues and reap the physical, mental, and **emotional rewards of exercise**.

What types of exercise are possible with limited mobility?

It's important to remember that any type of exercise will offer health benefits. Mobility issues inevitably make some types of exercise easier than others, but no matter your physical situation, you should aim to incorporate three different types of exercise into your routines:

- **Cardiovascular exercises**
- **Strength training exercises**
- **Flexibility exercises**

Rear More On

- **Setting yourself up for exercise success**
- **Starting an exercise routine**
- **Staying safe when exercising**
- **Getting more out of your workouts**
- **Overcoming mental and emotional barriers to exercise**
- **How to exercise with an injury or disability**
- **How to exercise in a chair or wheelchair**

…….and more