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Government Experts Paint Bleak Picture of the Pandemic

Two of the federal government's top health officials painted a grim picture of the months ahead on Tuesday, warning a Senate panel that the coronavirus pandemic was far from contained, just a day after **President Trump declared** that "we have met the moment and we have prevailed."

The officials — Dr. Anthony S. Fauci, the nation's top infectious disease expert, and Dr. Robert R. Redfield, the director of the Centers for Disease Control and Prevention — predicted dire consequences if the nation reopened its economy too soon, noting that the United States still lacked critical testing capacity and the ability to trace the contacts of those infected.

"If we do not respond in an adequate way when the fall comes, given that it is without a doubt that there will be infections that will be in the community, then we run the risk of having a resurgence," said Dr. Fauci, the longtime director of the National Institute of Allergy and Infectious Diseases, who is at the forefront of efforts to find a coronavirus vaccine.

If states reopen their economies too soon, he warned, "there is a real risk that you will trigger an outbreak that you may not be able to control," which could result not only in "some suffering and death that could be avoided, but could even set you back on the road to trying to get economic recovery."

Dr. Fauci's remarks, during a high-profile — and partly virtual — hearing before the Senate Committee on Health, Education, Labor and Pensions, along with those of Dr. Redfield, made clear that the nation had not yet prevailed.

They appeared to rattle the markets, driving the S&P 500 down as investors weighed the potential of a second wave of infections against Mr. Trump's promises that the economy would bounce back once stay-at-home restrictions were lifted. Worrisome reports of spikes in infections in countries like China, South Korea and Germany, where lockdowns had been lifted, seemed to confirm the American officials' fears.

Here in Washington, Dr. Fauci and Dr. Redfield, who have been barred by the White House from appearing before the Democratic-controlled House, drew a very different picture of the state of the pandemic than the president, who has cheered for a swift reopening, **championed protesters** demanding an end to the quarantine and predicted the beginning of a "transition to greatness."

Dr. Fauci told senators that coronavirus therapeutics and a vaccine would almost certainly not be ready in time for the new school year, that outbreaks in other parts of the world would surely reach the United States and that humility in the face of an unpredictable killer meant erring on the side of caution, even with children, who have fared well but have recently shown new vulnerabilities.

Dr. Redfield pleaded with senators to build up the nation's public health infrastructure, even as he acknowledged that the C.D.C. had not filled 30 jobs authorized by Congress last year to expand its capacity to track outbreaks, and had yet to put in place a "comprehensive surveillance" system to monitor outbreaks in nursing homes, which have been hard hit by the pandemic.

"We are not out of the woods yet," he said, "but we are more prepared.".

The two were among four government doctors — the others were Dr. Stephen Hahn, the commissioner of food and drugs, and Adm. Brett P. Giroir, an assistant secretary for health — who testified remotely during the hearing...**Read More**

Trump may let workers take Social Security benefits early in exchange for reduced payments later

President Donald Trump is reportedly considering another way to get more money to struggling Americans by letting them take an advance on their Social Security benefits.

Many Americans are eager for more financial help from the effects of the coronavirus as the government wraps up sending millions of $1,200 checks to individuals who qualify.

However, some Republican lawmakers are digging in their heels at the thought of sending more money, due to the high price tag.

The Trump administration is said to be considering prepaying Social Security retirement benefits to workers before they are eligible, according to The Washington Post. Generally, workers have to be at least 62 and have worked and paid into the system for at least 10 years in order to collect benefits.

One proposal the White House is reportedly considering calls for letting Americans take up to $5,000 from Social Security now in exchange for delaying their benefits in the future.

The $5,000 would be structured as a loan with a government-set interest rate that would reimburse the Social Security trust fund with interest. Individuals who opt into the program would pay that money back when they start collecting Social Security benefits. Their first checks would go toward repaying the loan, for a period of up to three months. After that, they would receive normal benefits.

The plan was developed by Andrew Biggs of the American Enterprise Institute and Joshua Rauh of the Hoover Institution at Stanford University.

Social Security advocates fear this could be the beginning of efforts to curtail the program.

Rich Fiesta,
Executive Director, ARA

Currently, about 45 million retired workers depend on Social Security, with average monthly benefits totaling $1,503.

In a statement, Richard Fiesta, executive director of the Alliance for Retired Americans, slammed the proposal.

"Asking working Americans to give up even one dime of their future Social Security benefits to survive today's economic crisis is a harebrained idea that would hurt families for decades to come," Fiesta said.

CMS Releases Temporary Policy Changes to Expanded Medicare Telehealth Services

The Centers for Medicare & Medicaid Services (CMS) recently took several steps to further expand the availability of Medicare telehealth services during the coronavirus emergency. Last week, the agency **announced** several temporary policy changes, and released an **updated** version of its coronavirus-related blanket waiver guidance that reflects these developments. **According to CMS, t**he revisions are intended to "increase access to telehealth for Medicare patients so they can get care from their physicians and other clinicians while staying safely at home." Notably, these flexibilities are in addition to those previously made by Congress and CMS, including via the **CARES Act** and the **federal rulemaking process**. Below is a summary of key changes.

Telehealth Providers. For the duration of the public health emergency, and pursuant to authority granted under the CARES Act, CMS is waiving the statutory provision that limits Medicare reimbursement for telehealth services to certain types of providers—such as doctors, nurse practitioners, and physician assistants. As a result, any type of Medicare provider may bill for telehealth services during the pandemic, including physical therapists, occupational therapists, and speech language pathologists.

Audio-Only Telehealth. As part of CMS's coronavirus-related telehealth expansion efforts, CMS previously **announced** that Medicare would temporarily pay for some **telephone evaluation and management** services provided via audio-only devices. CMS is now using new authority under the CARES Act to permit this reimbursement, and to broaden the scope of services that can be delivered in this manner to include behavioral health counseling and education. CMS is also increasing payment for these telephone visits to align with reimbursement for similar in-person services, retroactive to March 1, 2020.

Importantly, this expansion of audio-only telehealth is limited. It only applies to (1) telephone evaluation and management services; and (2) behavioral health counseling and educational services. **CMS states** that all "other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner." A list of Medicare services that are now payable when furnished via telehealth during the emergency—including for which audio-only interaction is allowed—is available **here**.

Future Changes to Telehealth Services. For the remainder of the coronavirus emergency, CMS is planning to add new Medicare services to the list of those that may be furnished via telehealth on a sub-regulatory basis. Until now, these changes were made through federal rulemaking. CMS notes this will "speed up the process of adding services."

In addition to these changes to Medicare, CMS is working with states to expand telehealth under Medicaid during the pandemic. The agency recently issued a **Toolkit** of policy consideration for states that "is intended to help states identify which aspects of their statutory and regulatory infrastructure may impede the rapid deployment of telehealth capabilities in their Medicaid program." For more information about state Medicaid program efforts and opportunities, please see the National Health Law Program's (NHeLP) **Fact Sheet on Telehealth and Medicaid during COVID-19**.

Medicare Rights will continue to weigh in on regulatory proposals and advocate for program improvements that are needed during and beyond the current emergency.

Many callers to our national helpline are confused about the new telehealth rules, and their providers may be as well. For example, providers may think that some telephone-only consultations are covered when those particular services require video. Or providers may say there is no cost-sharing for some services, only to charge cost-sharing later. As the rules continue to shift, we continue to urge CMS to make those changes very clear for providers and to ensure that beneficiaries have access to accurate information and are never surprised by their health bills. If you have any questions about the rules or your Medicare coverage, we encourage you to reach out to our helpline counselors today at 800-333-4114.

For more information about these and other recent Medicare changes, please see our regularly updated blog post, **What You Need to Know About Coronavirus and Medicare Coverage**.

Pharma Cash To Congress

Every year, pharmaceutical companies contribute millions of dollars to U.S. senators and representatives as part of a multipronged effort to influence health care lawmaking and spending priorities. Use this tool to explore the sizable role drugmakers play in the campaign finance system, where many industries seek to influence Congress. Discover which lawmakers rake in the most money (or the least) and which pharma companies are the biggest contributors. Or use our search tool to look up members of Congress by name or home state, as well as dozens of drugmakers that KHN tracks.

Methodology

Kaiser Health News uses campaign finance reports from the Federal Election Commission (FEC) to track donations from political action committees (PACs) registered with the FEC by pharmaceutical companies. Totals include donations to the principal campaign committees and leadership PACs for current members of Congress. We include only donations to members for election cycles in which they hold office (even if they weren't in office for the full cycle, in the case of special elections). Donations are assigned to the quarter in which they were given, regardless of when they are reported by the receiving committee or PAC. Exact amounts can change as amendments and refunds are reported; KHN will update the analysis quarterly. Occasionally, refunds are reported in a different cycle from the original contribution, resulting in a negative total for the cycle.

There is a legal limit to how much each PAC can give to a member of the Senate or House of Representatives: $5,000 per election (including primaries and general elections) and per committee, or $10,000 per cycle. Each cycle is two calendar years, e.g. Jan. 1, 2017-Dec. 31, 2018.

When calculating changes in contributions from one cycle to another, we compare the latest quarter in the current cycle to the same point in the previous cycle for all drugmakers and for members of the House, who run for re-election every two years. For senators, who run for re-election every six years, we compare the current cycle to the cycle six years prior. We use the **ProPublica Congress API** to gather some information about past and present members. We use both **Open Secrets and CQ Political Moneyline** to collect additional information about PACs and verify our work….**Read More**

Nurses protest for PPE outside White House: 'You throw us to the wolves'

Nurses protested outside the White House on Thursday over a lack of personal protective equipment (PPE) for health care workers on the front lines of the coronavirus pandemic.

Nurses with the union National Nurses United stood outside the White House alongside pairs of empty shoes lined up to represent the nurses who died due to "insufficient PPE" during the COVID-19 pandemic.

"You talk about how essential, how needed, how grateful you are, and yet you throw us to the wolves," Jean Ross, president of National Nurses United, **told CNN in an interview**. "You throw us out onto a battlefield without armor and the more we complain we don't see anything being done."

During the demonstration, the nurses protesting read the names of 88 nurses who died, according to CNN.

The union is calling on the federal government to help protect nurses with proper gear.

In response to the protests, White House spokesman Judd Deere said nurses are the "true heroes in this ongoing war" and said they have President Trump's "admiration for the lives they are saving."

"As the President has said, this is a locally executed, state managed, federally supported response to a global pandemic," Deere added. "The White House has been working with governors and their teams since January on COVID-19 coordination and supplies. Every level of government needs to deliver data -driven solutions and that is what we are doing in partnership."

Thursday's protest was not the first time the union demonstrated outside the White House.

The union staged **a similar protest** outside the White House last month, demanding the administration take action to acquire more PPE.

CMS Announces Limited Enrollment Flexibilities for People Affected by the Public Health Crisis

This week, the Centers for Medicare & Medicaid Services (CMS) announced new opportunities for people to enroll in Medicare or make certain changes to their coverage during the coronavirus emergency. While these temporary policies are a step in the right direction, they are too narrow and leave some without relief. More needs to be done.

First, CMS made clear that there is a Special Enrollment Period (SEP) that will allow people to make changes to their Medicare Advantage (MA) and Part D enrollment under limited circumstances. This SEP allows people to make a change to their coverage if they already had a right because of a different SEP or the **MA Open Enrollment** Period, but did not exercise it in time due to the coronavirus emergency. Importantly, people must use this SEP by July 13.

This SEP does not help people who discovered, because of the health emergency, that their plan is not a good fit or who wish to change plans because of a coverage or other issue. As always, if a plan will not cover a particular medication or service that a person needs, they can seek an appeal.

CMS also announced a new basis for requesting Equitable Relief, which may enable some people who missed previous enrollment opportunities to enroll into Parts A and B. Like the coronavirus SEP, these provisions are overly narrow—only people who could have enrolled into premium Part A or Part B during the time period from March 17 – June 17 but did not can access this help. It is also quite short; people must request relief by June 17, 2020.

The announcement includes FAQs stating that coverage will be effective as if the person used the another applicable enrollment period, but it does not go into detail about how that will be applied. For example, it is unclear when coverage will start for some people who were in their **Initial Enrollment Period**. Such people may face gaps in coverage that are especially dangerous given the public health emergency.

While Medicare Rights appreciates CMS making these policies public and transparent, and we applaud CMS for realizing that enrollment-related flexibilities are needed, these actions do not go far enough. We are particularly concerned about the short timeline for equitable relief for premium Part A and Part B. Some individuals may not even realize that they made a mistake or missed their enrollment period, or they may not have the appropriate resources to seek relief by the June 17 deadline, especially if local Social Security offices and other avenues for assistance remain closed past that date. The need for **additional enrollment protection**s remains.

Read the CMS announcement related to Part A and B.

Coronavirus: Trump wants to kill the ACA

In the midst of the coronavirus pandemic, President Trump just confirmed that he wants to kill the ACA and, with it, health care coverage for about 30 million Americans. The Washington Post **reports** that the Trump administration is supporting a lawsuit against the ACA that is now in the Supreme Court.

For sure, the Affordable Care Act (ACA) does not offer the guaranteed universal coverage we all need. Rather, it delivers health insurance that is too often unaffordable and generally also comes with very restricted networks of doctors. People with coverage through state health insurance exchanges also cannot count on the insurance they buy being there for them from one year to the next.

That all said, the ACA offers some excellent protections. If the Trump Administration kills the ACA, it will end federal protections that ensure people with preexisting health conditions can get health insurance. It will also end a mandate on health insurers to cover dependent children up to age 26 on their parents' policies. And, it will end Medicaid coverage for people with incomes up to 135 percent of the federal poverty level.

Moreover, if 30 million people lose health care coverage, premiums would likely rise significantly for everyone else and Medicare costs would rise. The more people with health insurance, the lower the cost of health care coverage. People who are uninsured drive up costs for everyone with insurance. Put differently, the more people with coverage before they go on Medicare, the lower the costs to Medicare when they enroll. In addition, everyone benefits when everyone is insured. Universal coverage promotes the public health.

Several Republican states brought the lawsuit against the Affordable Care Act. A group of Democratic states is defending the ACA. The Supreme Court has already upheld the ACA twice. But, this time around, it is not clear it will. It will hear arguments in this case next month. But, it might not issue a decision until 2021.

Congress and Administration Seek to Shield Nursing Home from Lawsuits

Some 20,000 people have died in American nursing homes from the coronavirus to date and the long term care industry is asking Congress to allow the industry to **protect themselves from lawsuits that claim care was inadequate**. Watchdogs, patient advocates, and elder care lawyers say that these immunity proposals are misguided because legal liability is the last safety net that keeps facilities accountable to residents and their families.

Before COVID-19 the Trump administration **eased regulations for nursing homes**, relaxing requirements for safety inspections and **shielding operators from potential lawsuits**. Amid the coronavirus crisis, the administration has not required universal and immediate testing for residents and staff. At the same time, Senate Majority Leader **Mitch McConnell** (KY) has focused on providing **legal immunity** to all businesses for lawsuits related to their actions amid the pandemic.

The lobbying efforts of the long term care industry have led at least 15 states to provide protection from lawsuits claiming a lack of testing and shortages of personal protective equipment. However, the crisis is just bringing to light previously existing, chronic issues within the industry, including staff shortages and poor infection control. Almost 70% of the country's nursing homes are for-profit and immunity from legal action has been on the industry's wish list for years "We must keep the corporations that provide critical care to our most vulnerable citizens accountable," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "Rep. **Jan Schakowsky** (IL) has introduced new legislation, **H.R. 6698**, the 'Quality Care for Nursing Homes Residents and Workers During COVID-19 Act,' to protect residents."

Joseph Peters, Jr.

Why the Government Pension Offset is WRONG!

Social Security Fairness
Repeal the Government Pension Offset and Windfall Elimination Provision!

The Government Pension Offset reduces the spousal or survivor Social Security benefit by 2/3 of the amount of the pension earned from a public agency which doesn't pay into Social Security for its workers. Most people affected are women. This penalty usually eliminates ALL the Social Security retirement benefits a public worker's spouse has paid in for them.

1. This particularly affects women who have earned only a partial pension. Women usually have made less money over their lifetimes than men have. In addition to the well-known pay inequities, women often work fewer years than men. As homemakers and family caregivers they may be out of the workforce for many years. This often results in their having fewer years to build up either Social Security credits or a robust pension. It contributes to greater poverty among retired women.

2. The way the Government Pension Offset works, it ignores the number of years a spouse may be truly dependent on the earner, earning neither a public pension nor a FICA-Social Security contributing income. If the not-employed spouse at a later date earns a pension, the years of dependency are not counted, despite the spouse's having been in a marriage situation which normally would qualify that person for spousal or survivor benefits. There are ways the Federal Government could use these years of "no pension/no FICA" information to calculate a lesser GPO reduction for many spouses, but even this level of mitigation is not being attempted. Receiving a public pension should not nullify the spousal or survivor Social Security benefits rightfully earned during other parts of a person's life.

3. The effects of the Government Pension Offset can be erratic and produce unequal results that are grossly unfair.

Social Security regulations generally are designed to provide a higher-percent return for their investment for low-income retirees than for higher-income retirees. Both the GPO and WEP subvert this purpose and produce crude inequities that would be nearly impossible to correct.

Here is an example using the GPO survivor benefit. For a higher-earning retiree with a governmental pension of $3,600 a month and a deceased spouse with the average monthly Social Security benefit of $1,470, the GPO would reduce the survivor's benefit income by 29%. For a lower-earning retiree with a pension of $2,400, and a deceased spouse with the same monthly average Social Security benefit of $1,470, the GPO would reduce the survivor's monthly income by 38%. (The two charts below demonstrate these figures.)

Trying to make the offset "more fair" by correcting for individual income anomalies would be a logistically daunting effort for the Social Security Administration.

4. A particularly onerous provision of the GPO is that, because of the way the law was written, every time you get a cost-of-living increase in your non-Social Security pension, the Social Security Administration is supposed to reduce your spousal or survivor SS benefits by two-thirds of that amount. For example, when you get a $30-a-month cost-of-living raise in your pension, the SSA is supposed to reduce your spousal or survivor benefit by $20. Everyone else gets a fair cost-of-living raise, but you don't. You are responsible for informing the SSA of this raise in your pension. **https://secure.ssa.gov/poms.nsf/lnx/0204030090**

5. The most prominent argument in favor of maintaining the Government Pension Offset is that its application is necessary to maintain a parallel process with the Social Security Dual Entitlement Reduction. According to current law, a retired dependent spouse is entitled to an amount equal to half of the amount the worker spouse receives; or the person can choose to receive their own earned benefit instead. This lower reimbursement for the lower earner runs counter to the ideas of equality in marriage and community property, which mandate that earnings by either spouse during the marriage must be shared equally. To be fair, the Social Security retirement earnings of both partners gained during the marriage should be added together, and each marriage partner should be allotted half. The fact that the Social Security Dual Entitlement rule discriminates unfairly against the spouse who earns a smaller retirement benefit does not justify the indefensible treatment of spouses by the Government Pension Offset….**Read More**

Here are options for easing Medicare costs if your income has dropped

Medicare isn't free. And for beneficiaries whose income suddenly has dropped, that fact may now be more challenging.

More than a third (37%) of Medicare recipients have experienced income loss due to the coronavirus crisis, according to a **recent survey from ehealth.com**. Younger beneficiaries are more likely to have suffered: 40% of respondents age 65 to 70 said they have experienced an income loss, compared with 30% of those age 80 or older.

Roughly 62 million people are on Medicare, the majority of whom are age 65 or older. In addition to premiums for certain parts of the program, beneficiaries pay deductibles and other out-of-pocket costs.

While it depends on your circumstances — i.e., what you already were paying for your coverage, your current income and why it is suddenly lower — there may be options available to ease your how much you're paying for Medicare.

Reducing monthly surcharges

If you've been paying more than the standard premium amounts for Part B (outpatient care coverage) or Part D (prescription drugs) through so-called income-related monthly adjustment amounts, or IRMAAs, a sudden reduction in income may justify eliminating or reducing those surcharges.

Of Medicare's 62 million beneficiaries, about 7% — 4.3 million people — pay IRMAAs, which kick in if your **modified adjusted gross income** is more than $87,000. For married couples filing joint tax returns, they start above $174,000.

The standard monthly premium for Part B this year is $144.60, which is what most Medicare beneficiaries pay. (Part A, which is for hospital coverage, typically comes with no premium.) The surcharge for higher earners ranges from $57.80 to $347, depending on income. That results in premiums ranging from $202.40 to $491.60.

For Part D, the surcharges range from $12.20 to $76.40. That's in addition to any premium you pay, whether through a standalone prescription drug plan or through an Advantage Plan, which typically includes Part D coverage. While the premiums vary for prescription coverage, the **average for 2020 is about $42**.

The process to get rid of IRMAAs (or getting them lowered) involves asking the agency to reconsider. However, local Social Security offices are closed because of the coronavirus pandemic, and there are long waits to get through on the phone, said Patricia Barry, author of "Medicare for Dummies." The alternative is to appeal via **an online form** you can download and mail in. (The Social Security Administration did not have information immediately available about whether there is any delay in processing these requests.)

You'll also need to provide supporting documents to justify your appeal. Suitable proof may include a letter from your former employer or something similar showing evidence that your income has dropped.

The required form includes a list of "life-changing" events that qualify as reasons for reducing or eliminating the IRMAAs, including marriage, death of a spouse, divorce, loss of pension or the fact that you stopped working or reduced your hours.

"This could result in Social Security re-assessing your Part B premium and lowering it now," said Danielle Roberts, co-founder of insurance firm Boomer Benefits in Fort Worth, Texas.

And, as long as you meet one of the qualifying reasons, "most of the time it gets adjusted," said Elizabeth Gavino, founder of Lewin & Gavino in New York and an independent broker and general agent for Medicare plans.

If it doesn't, you can appeal the decision to an administrative law judge, although the process could take time and you'd continue paying those surcharges in the meantime….**Read More**

Medicare Part D 2020 adjustments

Filing Individually		Married, Filing Jointly		Married, Filing Separately	
Bracket	Amt. Due	Bracket	Amt. Due	Bracket	Amt. Due
Up to $87,000	0.00	Up to $174,000	0.00	Up to $87,000	0.00
$87,000-$109,000	12.20	$174,000-$218,000	12.20	$87,000-$413,000	70.00
$109,000-$136,000	31.50	$218,000-$272,000	31.50		
$136,000-$163,000	50.70	$272,000-$326,000	50.70	$413,000 or more	76.40
$163,000-$500,000	70.00	$326,000-$750,000	70.00		
$500,000 or more	76.40	$750,000 or more	76.40		

SOURCE: Centers for Medicare & Medicaid Services

CNBC

COVID Bailout Cash Goes To Big Players That Have Paid Millions To Settle Allegations Of Wrongdoing

The Trump administration has sent hundreds of millions of dollars in pandemic-related bailouts to health care providers with checkered histories, including a Florida-based cancer center that agreed to pay a $100 million criminal penalty as part of a federal antitrust investigation.

At least half of the top 10 recipients, part of a group that received $20 billion in emergency funding from the Department of Health and Human Services, have paid millions in recent years either in criminal penalties or to settle allegations related to improper billing and other practices, a Kaiser Health News review of government records shows.

They include Florida Cancer Specialists & Research Institute, one of the nation's largest U.S. oncology practices, which in **late April** said it would pay a $100 million penalty for engaging in a nearly two-decade -long antitrust scheme to suppress competition. A top Justice Department lawyer described the plot as "limiting treatment options available to cancer patients in order to line their pockets." The company, which is required to pay the first $40 million in penalties by June 1, received more than $67 million in HHS bailout funds.

HHS distributed emergency funding to hospitals and other providers to help offset revenue losses or expenses related to COVID-19. In April, it distributed the first $50 billion based on providers' net patient revenue, a calculation that gives more money to bigger systems or institutions charging higher prices.

Companies that have attested to receiving payments as of May 4 collectively received roughly $20 billion. The list is likely to change in the coming days as other companies confirm they've received money.

In total, the CARES Act, signed into law by President Donald Trump in March, provides $100 billion in emergency funding. Subsequent coronavirus relief legislation added another $75 billion. Money has also been steered to hot spots with high numbers of COVID-19 patients, rural health care providers and the Indian Health Service.

Of the companies documented to date, other top recipients — including Dignity Health in Phoenix, the Cleveland Clinic, Houston's Memorial Hermann Health System and Massachusetts General Hospital in Boston — have paid millions in recent years to resolve allegations related to improper billing in federal health programs, false claims to increase their payments or lax oversight that enabled employees to steal prescription painkillers.

Dignity Health, one of the largest hospital systems in the West, received $180.3 million in HHS bailout funds, making it the top recipient listed. It has settled civil accusations by DOJ that it submitted false claims to Medicare and TriCare, the military health care program. ...**Read More**

How can I access supplemental benefits?

Dear Marci,
I have Medicare, and I'm interested in getting services like dental, transportation, and home-delivered meals. Do I need a Medicare Advantage Plan to get these supplemental benefits? Is there a way to get these services if I have Original Medicare?
-Xavier (Ogden, UT)

Dear Xavier,

A **supplemental benefit** is an item or service covered by a Medicare Advantage Plan that **is not covered by Original Medicare.** These items or services do not need to be provided by Medicare providers or at Medicare-certified facilities. To receive them, you just need to follow your plan's rules. Some commonly offered supplemental benefits are dental care, vision care, hearing aids, and gym memberships. Supplemental benefits must be primarily health-related, with some exceptions for people with chronic conditions. Some supplemental benefits are offered to everyone who is enrolled in a plan, but for an additional premium, such as to add dental coverage. Other benefits may be covered for everyone enrolled in the plan, regardless of whether you use the benefit, such as a gym membership.

Medicare Advantage Plans can also cover supplemental benefits that are not primarily health-related for beneficiaries who have chronic illnesses. These benefits should address environmental factors that may affect the health, functioning, quality of life, and risk levels of beneficiaries with chronic conditions. Some examples of these benefits are meal delivery, transportation for non-medical needs, and home air cleaners. In order to be eligible for this category of supplemental benefits, you must be considered chronically ill. This means that you:

- Have at least one medically complex chronic condition that is life-threatening or significantly limits your health or function
- Have a high risk of hospitalization or other negative health outcomes, and Require intensive care coordination

If you meet these criteria, a Medicare Advantage Plan may offer you one of these benefits if it has a reasonable expectation of improving or maintaining your health or function. Medicare Advantage Plans will be able to create sets of supplemental benefits for people with specific chronic illnesses, which means not every member of a Medicare Advantage Plan will have access to the same set of supplemental benefits. For example, a plan might cover services like home air cleaning and carpet shampooing for members with severe asthma. A member of that plan who has severe asthma may be able to get that service covered, while a member who does not have asthma, or whose asthma is mild, may not.

In some cases, there may be no Medicare Advantage Plan in your area that covers the supplemental benefits that you need, or you might find that Original Medicare offers better coverage of services that are important to you. You may still be able to access services that Original Medicare does not cover.

- Medigaps: Generally, Medigaps, which are insurance policies that supplement Original Medicare, pay second to Medicare when Medicare covers a service and pays first. All Medigaps also offer additional days of inpatient hospital care beyond what is covered by Original Medicare, and some cover emergency medical services received outside of the United States, which are not covered by Original Medicare. Medigaps can also offer fitness benefits or other targeted supplemental coverage in some states.
- Medicaid: Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets. In some states, Medicaid covers services that are not covered by Medicare, including dental, vision, long-term care, and transportation. A state may also have a Medicaid waiver program that covers additional services, too. To learn more about your state's Medicaid program, contact your local State Health Assistance Program (SHIP). Contact information for your SHIP is on the last page of this document.
- Reduced-cost or free clinics: You may be able to access the services you need through a free or reduced-cost clinic in your area. Use resources available at **needymeds.org**, **healthcare.gov**, **freeclinics.com**, and **hhs.gov** for more information.
- Donated dental service programs or dental schools: Donated dental services programs operate in some states. Dentists in these programs offer free dental services if you qualify. You may also be able to get low-cost dental care at a dental school, where dental students work with patients under the supervision of experienced, licensed dentists.
- Administration for Community Living (ACL) eldercare locator: Visit eldercare.acl.gov to learn about other resources in your community, such as long-term care and legal aid.

-Marci

GOP Senator Admits Goal To Eliminate Medicare, Medicaid, And Social Security

Chuck Todd and Katy Tur gave us *yet another* reason to pronounce most Beltway media worse than useless today while interviewing Republican Senator Mike Braun from Indiana. In discussing the COVID-19 pandemic, the more than 80,000 citizens killed by it, and the selfish priority the GOP is placing on "opening up" the states before ANY of these things is under control, Tur asked Sen. Braun about his thoughts on our social safety net.

He responded in classic Republican style: the GOP hates Social Security, Medicare, Medicaid, and this global tragedy is *just* the catalyst they need to burn them to the ground, even though tens of millions of rely on them for health care, housing, and food. What do hard-hitting, insightful journalists like Tur and Todd do?

Nothing. Move on to the next question.

TUR: Senator, has this made you rethink the social safety net in this country, the social contract we have? Do we need to rework how we go about our regular business?

BRAUN: I think so. And I'm one of the most outspoken critics of structural deficits we've got. And probably two-thirds of that is driven by the programs that everybody likes, Social Security, Medicare, and Medicaid. We have to have an honest discussion, can we keep those healthy? The Medicare trust fund gets completely depleted here in six years. I'm gonna talk about that kinda stuff, because, you're right. This is just a catalyst, in my opinion, to kinda relook the whole way we've been doing things over the last few decades. And it's going to take some tough choices and some discipline to actually fix it. Very little political will I've seen here since I've been here.

TODD: And Senator, very quickly, the House is going to have their bill. How soon do you want the Senate to put up a response?

Now, I'm no journalist, but I do have synapses that fire, and I would want a few follow-up questions answered, if I were them. Let's see, I don't know, how about:

- Why do you think, as you yourself say, "everybody likes Social Security, Medicare, and Medicaid?"

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Thousands of Health Care Workers Lack Insurance If COVID-19 Strikes: Study

The coronavirus pandemic has put a spotlight on the sacrifices of America's health care workers, yet many of them live in poverty and can't afford health insurance. A new study finds that more than 600,000 health care workers are poor and potentially without insurance or paid sick leave, and up to 4 million have health problems that put them at risk of dying from COVID-19.

"It's nice that politicians want to label health care workers heroes and that people are going out and banging pots for them. That's clearly raising people's morale. But it also is important to make sure they -- and everyone else in the country -- has health insurance and decent wages and sick leave when they need it," said lead researcher Dr. David Himmelstein. He's a professor of public health and health policy at Hunter College in New York City.

"There's no reason why Congress couldn't pass one of the measures that's before them that expands health insurance and also gives hazard pay to frontline workers," Himmelstein said. "Frankly, we need a $15 an hour minimum wage and universal health insurance and sick leave."

The pandemic has highlighted economic inequalities in the United States, Himmelstein said.

Americans who do essential and dangerous work -- including health workers, grocery workers, bus drivers and delivery drivers -- "can't make ends meet or afford medical care," he noted.

The researchers also found that nearly 29% of health care workers who care for patients don't have paid sick leave, and more than 1 million of these workers suffer from their own health problems.

Also, about 275,000 health care workers with medical conditions are uninsured, including 11% with diabetes and 21% with chronic lung disease, other than asthma.

For the study, Himmelstein and his colleagues used data from two surveys that included thousands of health workers.

The researchers identified doctors, nurses and nursing aides who worked with patients and determined how many of them were over 65 or had an underlying medical condition that put them at risk of illness and death from COVID-19.

These conditions included heart disease, chronic lung disease, diabetes, severe obesity, moderate or severe asthma and liver disease.

Among nursing home workers, 12% were uninsured, compared with 9% of the general population, the findings showed. Of home care workers, most of whom don't have personal protective equipment, 15% didn't have health insurance.

"The lack of health insurance and the low wages and lack of sick leave are a problem for the health workers, but also put other people at risk, because that means that those frontline workers often can't afford to take a day off if they have some mild symptoms that could be coronavirus. So they may go to work when they're infectious," Himmelstein said.

The report was published April 28 in the Annals of Internal Medicine.

The pandemic points out many of the problems with health care in America, said Dr. David Katz, president and founder of the True Health Initiative, in Hamden, Conn. The nation suffers from a burden of chronic disease and obesity, which increases risk for severe infection and death from COVID-19, he said.

And, "despite the improvements associated with the Affordable Care Act, we still have a sizable population without health insurance," Katz added.

This study shows that those who are protecting others during this historic pandemic are risking their own health, and many don't have the protections they need, he said.

"Immediately, there should be policies to ensure that those on the frontlines of care in this crisis may seamlessly access any care they may need," Katz said.

"When prevailing health and health care access are acute threats to our nation's capacity for crisis response, it's an indication that both need to figure among the nation's top priorities," Katz added.

Frequently Asked Questions about the "Observation Status" Court Decision

On March 24, 2020, a federal court issued a decision in a nationwide class action, *Alexander v. Azar*, finding that certain Medicare beneficiaries who are switched to "observation status" at hospitals after being admitted as "inpatients," have the right to appeal to Medicare to challenge that status. Here are some answers to frequently asked questions about the decision:

Why is my hospital status important? Why does it matter if I am labeled an "inpatient" or placed on "observation status"?

Inpatients are covered by Medicare Part A. They must be hospitalized for at least three consecutive days (not including the date of discharge) as Part A-inpatients to be eligible for Medicare to cover their care in a skilled nursing facility after hospitalization.

People who are in observation status at hospitals are covered by Medicare Part B. Any time spent in observation status does **not** count toward the three-day inpatient hospitalization that is required for coverage of nursing facility care. Thus the right to appeal your status may be important, especially if you required costly nursing home care after your hospitalization. It may also be important if you were not enrolled in Medicare Part B and were thus responsible for the entire cost of your observation hospital stay.

How do I know if I now have the right to appeal under the court's decision?

To be a member of the class that now has a right to appeal your hospital status, you must have:

1. been hospitalized since January 1, 2009; *and*,
2. been a Medicare beneficiary with original/traditional Medicare during the hospitalization in question (*e.*, not a Medicare Advantage member); *and*,
3. been admitted as an inpatient but then **changed** to observation status during the hospitalization; *and*,
4. received a "MOON" notice from the hospital, or, a Medicare Summary Notice from Medicare, indicating that you will receive or did receive hospital observation services that are not covered by Medicare Part A; *and*,

EITHER:

have Medicare Part A *only* (no Part B).

OR

have both Medicare Part A and Part B, ***AND*** have been hospitalized for at least three consecutive days but for fewer than three days as an inpatient, ***AND*** you were or still could be admitted to a skilled nursing facility within 30 days of hospital discharge.

Note that it may be necessary to request and examine the hospital medical records to determine whether a doctor admitted you as an inpatient and whether your status was later changed to observation.

The class is open-ended, meaning it applies to people who meet the above criteria in the future. The class definition excludes people who already appealed their status and received a final decision before September 4, 2011, but that is not a common situation….**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Coronavirus-induced anxiety can be just as damaging as the virus

Cathy Borland sits on a lawn chair at the end of her daughter's driveway. She's with her husband, Bob. The two watch from afar as their grandchildren chase one another around the front yard. While she smiles on the outside sadness lies within. Cathy and Bob are social distancing—times five. That is, if the couple were at a ball game, they'd be in the nosebleed section.

Borland lives just north of New York City, the epicenter of the **novel coronavirus**. Aside from the one visit to her daughter's house, Borland hasn't left her home in four weeks.

"You worry because it doesn't seem to be getting any better and I'm just so afraid for my kids and my grandchildren," Borland said. "You just don't know what's going to happen. It's stressful… it's stressful."

Borland will pick weeds in her garden to ease her anxiousness, watch a movie or experiment with new recipes. At the end of the day, Borland says her prayers, lays her head on her **pillow** and falls asleep. The next six hours will be her only respite from worry.

Health experts are urging people to stay calm during the COVID-19 pandemic— to try meditating, exercising or learning a new skill to name a few. People know what to do, but the question is why they should do it.

A bidirectional relationship exists between chronic disease and anxiety. The more one worries, the more likely a person will develop a chronic condition. At the same time, a chronic condition induces anxiety.

"Anxiety is meant to pass through the body," Carol Ewing-Garber, PhD and director of the applied physiology lab at Columbia University, Teachers College, told Fox News. "When a person holds onto stress, harmful biological changes occur causing damage making a person more susceptible to heart disease, high blood pressure, cancer among other illnesses including the coronavirus."

The biological changes activate a person's sympathetic nervous system -- the part of the body that is responsible for our fight or flight response. When under stress, the system releases hormones called catecholamines. Under the umbrella of catecholamines are hormones, including adrenaline, epinephrine noradrenaline and norepinephrine, Ewing-Garber said.

"The release of these catecholamines ramps up the cardiovascular system and affects blood flow to the body. In itself, this response does not cause damage to the body—it facilitates necessary bodily functions to meet immediate needs and is quickly resolved," she said.

However, if the response remains consistently in high gear and a person remains in a chronic period of stress, the result is damaging and reduces our immune function. This potentially puts a person at-risk of contracting a COVID-19 infection. Also, if an anxious individual contracts the virus, the person is more likely to experience complications.

John Allegrante, PhD and professor of health education, also of Columbia University, agreed. Anxiety has a deleterious impact on bodily functions such as breathing, the heartbeat and digestion, he said.

"What's so damaging about the current situation, where there is not only the uncertainty of the seriousness of infection with COVID-19 and the uncertainty of what we face in the aftermath, is that chronic stress and the prolonged state of heightened vigilance can be exhausting to the human spirit, which only furthers the spiral of anxiety," he said.

That is, not getting the pause from anxiety is likely to be almost as debilitating as the risk of acquiring the virus itself.

But it's not only about the anxiety-related risk of a coronavirus infection. It's also about what's to come in terms of economic repercussions. The economy is in turmoil. Businesses are closing. Unemployment has skyrocketed. And people are glued to the stock market as they watch their retirement funds disappear.

This is called financial anxiety, according to Dan Gertrude, CPA and founder of New Jersey-based Gertrude and Company, and it has the same deadly effects.

"As far as anxiety and financial anxiety [during the COVID-19 pandemic]…I've been dealing with it as much as my clients," he said. "That fear comes from the unknown. The unknown triggers financial anxiety especially now and I have to get my clients to a point where they can be certain about uncertainty."

Part of that is, Gertrude, also the author of best- selling book, Positive Financial Karma, said, is getting his clients to recognize that everyone is going through this. But if his clients are so caught up in anxiety, they aren't listening making it difficult for them make good financial decisions.

"The world is not going to be the same after this and those who are going to be most financially successful are going to be the ones who adapt to the new normal and we can't be afraid of that," he said.

But aside from the economic anxieties, worrying that a loved one will become infected with COVID-19 or die as a result of complications from it seems to be hitting people the hardest, at least for Borland.

"The fear and anxiety that someone I love will contract the coronavirus is a feeling that might never go away," she says. "I'm trying to be strong, but it's heartbreaking. It's just heartbreaking."

Coronavirus Care: How to Stop the Spread of Germs When Caring for Someone Sick

Prevention and precaution are everything

If you're **spending time at home** caring for a sick family member, loved one or friend**,** it's important to take steps to maintain your own health along with preventing the spread of germs in your home or to other people.

While it may seem like a daunting task, there are precautions you can — and should — take. Sourced from the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), the Red Cross and other experts in the field, here are things you can do to help limit the spread of the coronavirus infection.

- **Designated spaces**
- **Ventilation**
- **Single caregiver**
- **No sharing**
- **Protective gear**
- **Frequent handwashing**
- **Daily surface cleaning**
- **Wash laundry often**
- **No visitors**
- **Paper towels**
- **Avoid touching your face**

- **Monitor your health**
- **Check with a healthcare provider before ending precautions**

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Drugs with high prices are often no better than lower-cost drugs

The US famously **pays far more for medications** than other countries, putting stress on the health care system and **individual patients who often bear this cost**. The pharmaceutical industry often justifies these high prices by claiming that they **create the opportunity for more *innovation*** in the drug space, and that lowering prices would diminish the ability of drugmakers to create new and better drugs.

Given this argument that higher prices leads to better drugs, one would expect that the price of a drug should be correlated with its clinical benefit. It's common sense–if we are paying more for a certain drug, it should be because it works better.

Unfortunately that does not appear to be the case, according to two recent studies on drug prices. **In *The Lancet Oncology***, researchers at the University of Zurich analyzed the prices and clinical benefit of 65 cancer drugs approved by both the US Food and Drug Administration and the European Medicines Agency over the past ten years.

The median monthly treatment costs for these new drugs in the US was $13,200, more than twice as high as in England, Switzerland, Germany, and France. However, they also found that cost of the drugs were not correlated with clinical benefit, according to value frameworks from the American Society of Clinical Oncology and the European Society of Medical Oncology.

"We have so many drugs on the market and we found that some don't have the value you'd expect," said study author Kerstin Vokinger, **in *STAT News*.** "The prices of cancer drugs should be better aligned with their clinical importance in order to improve access."

It's not only cancer drugs that are being priced regardless of effectiveness. In a **recent piece in *Health Affairs* blog,** Harvard Medical School professors Richard G. Frank, Jerry Avorn, and Aaron S. Kesselheim asked the question, "Are the drugs we approve in the US considered effective according to other countries' assessments?" They looked at 46 new drugs approved by the FDA in 2017 and **compared evaluations of the drugs' effectiveness** using assessments from independent boards in Canada, Germany, and France.

Of the 27 drugs that were evaluated in these other countries, 17 of these drugs were found to offer little or no added clinical benefit by all of the boards that evaluated them. For 6 drugs, there was not consistent agreement between the different boards about the effectiveness of the drugs. Only 4 drugs were determined to have at least minor added benefit by all of the boards that evaluated them. These drugs were Fasenra for asthma, Dupixent for excema, Imfinzi for urothelial carcinoma, and Rydapt for leukemia.

The authors noted that many of the drugs found to be not effective when evaluated by international boards are very expensive. Eli Lilly's breast cancer drug Verzenio was found to have no added benefit in both Germany's and France's reviews; the **list price of the drug is more than $12,000 a month.** Gilead's Vosevi, a combination drug to treat Hepatitis C, was found to have only minor clinical benefit by one of the international boards– **the drug costs $26,000 for 28 pills.**

Figuring out **whether a drug is priced "fairly"** is tricky, but at the least we should agree that paying thousands more for drugs than other countries without a corresponding clinical benefit is a bad deal.

'No Intubation': Seniors Fearful Of COVID-19 Are Changing Their Living Wills

Last month, Minna Buck revised a document specifying her wishes should she become critically ill.

"No intubation," she wrote in large letters on the form, making sure to include the date and her initials.

Buck, 91, had been following the news about COVID-19. She knew her chances of surviving a serious bout of the illness were slim. And she wanted to make sure she wouldn't be put on a ventilator under any circumstances.

"I don't want to put everybody through the anguish," said Buck, who lives in a continuing care retirement community in Denver.

For older adults contemplating what might happen to them during this pandemic, ventilators are a fraught symbol, representing a terrifying lack of personal control as well as the fearsome power of technology.

Used for people with respiratory failure, a signature consequence of severe COVID-19, these machines pump oxygen into a patient's body while he or she lies in bed, typically sedated, with a breathing tube snaked down the windpipe (known as "intubation").

For some seniors, this is their greatest fear: being hooked to a machine, helpless, with the end of life looming. For others, there is hope that the machine might pull them back from the brink, giving them another shot at life.

"I'm a very vital person: I'm very active and busy," said Cecile Cohan, 85, who has no diagnosed medical conditions and lives independently in a house in Denver. If she became critically ill with COVID-19 but had the chance of recovering and being active again, she said, "yes, I would try a ventilator."

What's known about people's chances?

Although several reports have come out of China, Italy and, most recently, the area around New York City, "the data is really scanty," said Dr. Carolyn Calfee, a professor of anesthesia at the University of California-San Francisco.

Initial reports suggested that the survival rate for patients on respirators ranged from 14% (Wuhan, China) to 34% (early data from the United Kingdom). A **report from the New York City area** appeared more discouraging, with survival listed at only 11.9%.

But the New York data incorporated only patients who died or were discharged from hospitals — a minority of a larger sample. Most ventilator patients were still in the hospital, receiving treatment, making it impossible for researchers to draw reliable conclusions.

Calfee worries that data from these early studies may not apply to U.S. patients treated in hospitals with considerable resources.

"The information we have is largely from settings with tremendous resource gaps and from hospitals that are overwhelmed, where patients may not be treated with optimal ventilator support," she said. "I would be very worried if people used that data to make decisions about whether they wanted mechanical ventilation."

Still, a sobering reality emerges from studies published to date: Older adults, especially those with underlying medical conditions such as heart, kidney or lung disease, are least likely to survive critical illness caused by the coronavirus or treatment with a ventilator.

"Their prognosis is not great," said Dr. Douglas White, a professor of critical care medicine at the University of Pittsburgh. He cautioned, however, that frail older adults shouldn't be lumped together with healthy, robust older adults, whose prospects may be somewhat better....**Read More**

The Most Common In-Home Injuries for Seniors

As we age, our ability to care for ourselves begins to diminish. This happens slowly at first, and you may start to notice that bruises last longer, or small cuts take longer to heal. These issues become more pronounced and frequent as we get older. There are a number of **common conditions that affect seniors**, such as:

• Cataracts • Glaucoma • Macular Degeneration • Arthritis • Osteoporosis • Diabetes • Depression • Incontinence • Dementia • Parkinson's disease • Cardiovascular disease • Lung disease • Shingles

The **most common injuries** experienced by seniors who still live independently include:

• Car accidents • House fires • Falls (which may result in brain injuries, or hip, vertebrae or pelvis fractures) • Bedsores • Infections • Burns • Lacerations • Sprains • Joint dislocation.

Home invasions are also becoming a common occurrence for seniors and may lead to severe injury.

7 WAYS TO HELP SENIORS RECOVER FROM SURGERY

Recovering from surgery can be extra challenging for older adults and extra stressful for caregivers. ***Dr. Chris Dickson*** *shares 7 ways to promote faster healing and make the recovery process easier and more comfortable.*

Surgery can be tough on anyone. But it's especially important that seniors get proper post-surgery care because they heal more slowly and are at increased risk of complications.

Fortunately, there are ways to promote faster healing and make your older adult's recovery easier.

Here, we'll describe 7 ways to help speed up the healing process while making their post-surgery experience better overall.

. Create a list of items your older adult will need

Most people bring home new medications after surgery, but seniors may require additional items.

Wheelchairs, hospital beds, compression socks, and leg braces are just a few examples of what seniors may need for the recovery process.

Scrambling at the last minute to find and purchase these items can be stressful.

To reduce stress for both of you, talk with the nurses and doctors ahead of time and start making a list of items that will be needed upon your older adult's return home.

Some medications can only be picked up at the pharmacy after hospital discharge, but you'll be able to get most of the necessary items in advance.

2. Prepare the home for their return

For a smooth transition home, clean the house and re-arrange furniture to **remove obstacles and hazards.** This helps make their recovery as easy as possible.

Begin by clearing pathways and removing any throw rugs or other items that could cause a fall or slip. Place remote controls, phones, books, and other frequently-used items within easy reach.

If your older adult lives in a two-story home, consider making them a bed on the main level to avoid the need to climb stairs.

Anything you can do to make it easier to get around the house will benefit their recovery.

Lastly, make sure to stock the pantry with healthy foods that are easy to prepare. Nutritious, easy-to-make meals will encourage eating and **promote faster wound healing.**

3. Make them as comfortable as possible

For seniors, recovery from major surgery can be a slow, frustrating process. To keep them as comfortable as possible during their return home, there are a few things you can do.

If they had knee, ankle, or leg surgery, their doctor may have instructed them to elevate their legs.

Be warned – although it seems simple, improperly elevating the legs can have negative effects. A **leg elevation pillow** helps keep their legs in a raised position that promotes healing.

In addition to making them physically comfortable, don't forget to offer them emotional comfort as well.

Having surgery can trigger feelings of helplessness and sadness. Grabbing a few of their favorite things – like magazines, movies, or special food items that are doctor-approved – can boost their spirits.

4. Accompany them to follow-up appointments

Even if your older adult doesn't have any memory problems, it can be beneficial to accompany them to follow-up doctor appointments.

As their caregiver, you may able to fill in details about their health and recovery that they may not immediately remember when the doctor asks questions.

Taking notes while the doctor is speaking also helps both your older adult and you remember the most important parts of the conversation.

And if you have any questions, this is a good time to ask the doctor to ensure that your older adult is getting the best care possible.

5. Know their limitations

Doing too much too soon after surgery can cause a setback in their recovery.

The healing process is already slow for older bodies – the last thing you want is for them to do something that puts them back at square one.

The doctor should provide information on any post-operation restrictions. This may be difficult for some seniors to follow due to cognitive impairments or a stubbornly self-sufficient attitude.

For example, seniors who have cataract surgery should avoid bending over because it puts too much pressure on the eye.

If your older adult forgets their restrictions, gently remind them of the doctor's instructions and offer to complete the task for them.

6. Be aware of hospital delirium

Even if your older adult doesn't have **dementia,** they could become confused after surgery.

Post-operation delirium is common in older adults so caregivers should be prepared in case it happens. Delirium can mean slower healing and it can be a scary experience for seniors.

If your older adult has experienced abnormal confusion in the past, it's important to let hospital staff know.

And if delirium does occur, it's important to be a calm presence to support your older adult.

Then, contact their doctor immediately and ask them to identify the triggering factors and recommend changes to improve the situation.

Although it can take weeks or months for delirium to be fully resolved, most cases aren't life-threatening.

7. Ask for help when you need it

If you're caring for a parent, it's normal to feel overwhelmed. If you feel yourself becoming stressed out and irritable, **don't be ashamed to ask for help.**

Professional care workers are available to relieve some of the pressure by caring for your older adult while you take much-needed breaks.

This could mean hiring a home health aide or a registered nurse to provide **home health care** services. Or, hiring an **in-home caregiver** to help with dressing, moving around, meals, companionship, and light housekeeping.

Taking care of yourself helps both you and your older adult. If you're **burned out**, seniors will likely notice your irritability. That could make them feel guilty or angry and potentially decrease their healing ability.