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Attention, Social Security recipients: Here's what your next raise might look like

The average senior on Social Security today collects $1,471 a month, which amounts to $17,652 a year. That's not a ton of money, given the expenses retirees face, from mounting healthcare costs to basics like housing, food, and transportation.

Yet 21% of married seniors and 45% of unmarried seniors depend on Social Security for 90% or more of their income. It therefore stands to reason that millions of retirees are anxious to learn what their cost-of-living adjustment, or COLA, will look like for 2020.

Automatic COLAs were implemented in the 1970s to help seniors on Social Security maintain their buying power in the face of inflation, and they're determined based on data from the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Though the CPI-W is by no means an accurate measure of what seniors spend, it's the current benchmark used for establishing COLAs. And while it hasn't yet released its September data, the nonpartisan Senior Citizens League is estimating a 1.6% COLA for seniors going into the new year.

That's both good news and bad news.

First, the positive: COLAs are by no means guaranteed, and when the CPI-W doesn't indicate a general uptick in cost of living, seniors can get stuck with no raise at all. That's happened three times already over the past 10 years, and in 2017, seniors saw an almost negligible 0.3% COLA. In comparison, a 1.6% raise seems generous.

On the other hand, seniors got a 2.8% raise going into 2019, so by comparison, 1.6% doesn't look all that great, especially when we consider that it only puts another $23.50 a month into the average beneficiary's pocket. That's hardly enough to make a difference in the lives of seniors who are already on shaky financial ground.

Medicare could be a problem too

Another issue with a not-so-stellar COLA boils down to Medicare's hold harmless provision -- a provision that's technically designed to protect seniors but often comes back to haunt them. The provision states that seniors can't face a dip in Social Security benefits when Medicare premium increases outpace COLAs. If the cost of Medicare goes up a lot this year, seniors who pay their premiums directly from their benefits could see a large chunk of their COLA wiped out -- or, in some cases, see their *entire* COLA eaten up by Medicare.

Don't count on those COLAs

Seniors who are heavily dependent on Social Security and struggling financially as a result must recognize that even a sizable COLA isn't the answer to their money-related woes. Rather, the solution often lies in making lifestyle adjustments (difficult as those may be) and boosting their income in other ways. For example, downsizing can make housing expenses more manageable in retirement, while cutting back on non-essentials, like restaurant meals, could give seniors more financial wiggle room in their budgets.

Getting a part-time job is a good bet as well. Doing so guarantees an income boost, and one that's apt to be far more substantial than a COLA-driven raise.

The Social Security Administration won't announce its official 2020 COLA until October 10. Till then, the best seniors can do is sit tight, hope for the best, and start thinking about active steps they can take to improve their financial picture.

Statement by Richard Fiesta, on the release of H.R. 3

Executive Director of the Alliance for Retired Americans, on the release of H.R. 3, The Lower Drug Costs Now Act

"Seniors and all Americans will pay less for their prescription drugs when the House legislation released today by House Speaker Nancy Pelosi becomes law. This bill is a huge step toward helping retirees and all Americans afford their medications by empowering the government to negotiate lower prices and lowering out of pocket costs. The Alliance for Retired Americans applauds Speaker Pelosi and the House Democratic leadership for their work.

"Americans pay the highest prices in the world for prescription drugs. Each month more and more seniors are not filling their prescriptions or skipping doses because they simply cannot afford them. This bill ensures that the prices Americans pay for the most expensive drugs are in line with the lower prices of the same drugs in other countries.

"Seniors who need more medications to stay healthy will get immediate relief thanks to the $2,000 annual cap on out of pocket costs. This is a great improvement over current law.

"The Secretary of Health and Human Services will be allowed to negotiate lower prices for as many as 250 of the most expensive drugs covered by Medicare -- including insulin -- and those lower prices will be available to all insurance plans in the country. Notably, pharmaceutical corporations that refuse to come to the negotiating table will be required to pay steep, escalating penalties on their gross sales that could cost them billions of dollars.

Rich Fiesta

"The 4.4 million members of the Alliance for Retired Americans strongly support this bill and urge the House and Senate to pass it immediately. Retirees can't wait."

Pelosi drug proposal would bring down drug prices

Politico reports on House Speaker Nancy Pelosi's drug pricing proposal. If Politico's information about key elements is accurate, Americans could see prices cut in half for scores of the most widely used drugs. And, the **Medicare Part D drug benefit** finally will have an out-of-pocket limit.

The Pelosi proposal, as Politico describes it, could link the cost of 250 commonly used brand-name drugs to their average price in six wealthy nations. Since Americans tend to pay about twice as much for drugs as people in Canada and Great Britain, we could see these drug prices drop by 50 percent.

The government would negotiate drug prices for drugs responsible for the highest costs to Medicare and the US health care system. These drugs represent about half of Part D spending and include insulin. Why Pelosi's proposal only covers 250 drugs and not every drug is an open question.

If the federal government is unable to negotiate fair drug prices with drugmakers, it would use international reference pricing to set these drugs' prices. They would be set at no more than 1.2 times the average price in six countries: Australia, Canada, France, Germany, Japan and the United Kingdom. **International reference pricing** is a policy, originally introduced in the Senate by Bernie Sanders and in the House by Ro Khanna, which **President Trump has said he supports**.

Under the draft proposal, if drugmakers refuse to negotiate with the federal government or sell at the established price to both the government and private health insurers, they would face severe financial penalties. They would pay an excise tax of 75 percent of the gross sales of the drug the prior year. Pharmaceutical companies would face penalties if they offered the drug at the negotiated price to Medicare but did not offer the drug at the negotiated price to private insurers.

While the financial penalty should be severe enough to induce pharmaceutical companies to sell their drugs at the established price, the **Khanna and Sanders bills** go a step further to ensure drug availability. Their bills would take away a pharmaceutical company's exclusive license and give licenses to generic drugmakers if the pharmaceutical company set its drug's price higher than the average in five wealthy nations.

Pharmaceutical companies would not be permitted to increase the price of a drug more than the rate of inflation for as long as there was little or no competition for that drug. Pharmaceutical companies would incur financial penalties if they raised the price of any drug covered under Medicare Parts B or D above the rate of inflation after 2016 and did not either lower the drug's price or refund the excess charge to Medicare.

Government savings from paying lower prices for drugs under Medicare Part D would go to the NIH to fund more drug research.

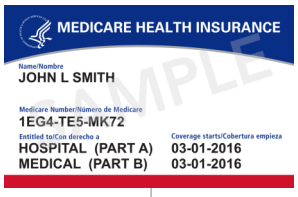
Your Medicare card

When you're enrolled in Medicare, you'll get your red, white, and blue Medicare card in the mail. **If you're automatically enrolled**, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or your 25th month of getting disability benefits. Your Medicare card shows that you have Medicare health insurance. It shows whether you have Part A (Hospital Insurance), Part B (Medical Insurance) or both, and it shows the date your coverage starts.

Be sure to carry your card with you when you're away from home. Let your doctor, hospital, or other health care provider see your card when you need hospital, medical or other health services.

5 things to know about your Medicare card

1. Your card has a Medicare Number that's unique to you, instead of your Social Security Number. This helps to protect your identity.
2. Your card is paper, which is easier for many providers to use and copy.
3. If you're in a Medicare Advantage Plan (like an HMO or PPO), your Medicare Advantage Plan ID card is your main card for Medicare—you should still keep and use it whenever you need care. And, if you have a Medicare drug plan, be sure to keep that card as well. Even if you use one of these other cards, you also may be asked to show your Medicare card, so keep it with you.
4. Only give your Medicare Number to doctors, pharmacists, other health care providers, your insurers, or people you trust to work with Medicare on your behalf.
5. If you forget your card, you, your doctor or other health care provider may be able to look up your Medicare Number online.



Watch out for scams

Medicare will never call you uninvited and ask you to give us personal or private information.

Scam artists may try to get personal information, like your Medicare Number. If someone asks you for your information, for money, or threatens to cancel your health benefits if you don't share your personal information, hang up and call us at 1-800-MEDICARE (1-800-633-4227). **Learn more about the limited situations in which Medicare can call you.**

How can I replace my Medicare card?

If you need to replace your card because it's damaged or lost, sign in to your **MyMedicare.gov** account to print an official copy of your Medicare card. If you don't have an account, visit **MyMedicare.gov** to create one.

If you need to replace your card because you think that someone else is using your number, call us at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

How do I change my name or address?

Medicare uses the name and address you have on file with Social Security. To change your name and/or address, visit your online **my Social Security account**

Note

Medicare is managed by the Centers for Medicare & Medicaid Services (CMS). Social Security works with CMS by enrolling people in Medicare

Social Security COLA Drops to 1.6 Percent For 2020

.The Social Security cost-of-living adjustment (COLA) for 2020 will be considerably lower than the 2.8 percent COLA received this year, according to a new estimate from **The Senior Citizens League (TSCL)**. "The government's consumer price index data for August indicates that COLA recipients can expect to get a benefit boost of about 1.6 percent in 2020," says TSCL's Social Security policy analyst, Mary Johnson. "That would raise an average retiree benefit of $1,460.00 by about $23.40 per month, a big drop from the $40.90 that people with that level of benefits received this year," Johnson says.

The COLA for 2020 will be announced in less than a month. A COLA of 1.6 percent would be the lowest COLA since 2017, when the annual boost was just 0.3 percent. Over the past decade COLAs have averaged 1.4 percent, less than half the 3 percent they averaged during the previous decade from 2000 to 2009.

The below average COLAs are having a significant impact on lifetime Social Security income and the standard of living of retirees, particularly those who have been retired since 2009. According to an analysis by Johnson, Social Security benefits are about 17.5 percent lower today than they would have been if inflation had averaged the more typical 3% over the same period. "Over ten years that's about $17,299 less in retirement income for someone with average benefits," Johnson notes.

Because low COLAs compound over time, this loss of income due to low COLAs will continue to grow deeper as beneficiaries age. "This has not gone unnoticed by those who depend on these annual adjustments," she says. "Many Social Security recipients tell us their standard of living has declined," Johnson says.

While retirees won't be getting as much in their Social Security checks in 2020, the Part B premium, on the other hand, is expected to go up considerably more than it did this year. In 2019, most beneficiaries paid $1.50 per month more than in 2018. In 2020, however, the Medicare Trustees have forecast that Part B premiums will increase from $135.50 to $144.30 per month — $8.80 per month more. After the deduction for Part B premiums, that would leave the retirees with average benefits, roughly $15 per month more to cover all other rising costs which typically include higher Medicare supplemental and prescription drug insurance premiums and out - of - pocket costs.

Social Security recipients with the lowest benefits may not see much, if any increase at all. "If premiums rise by $8.80 or more, and if the cost-of-living adjustment (COLA) is 1.6 percent as we estimate, then Social Security recipients with benefits of about $550 or less are at risk of seeing the Part B premiums take their entire COLA, leaving nothing extra to deal with other rising costs," Johnson says.

When an individual's Part B premium rises more than the dollar amount of their COLA, that doesn't necessarily mean that the premium deduction would cut into existing Social Security benefits. Due to a special provision of law known as the Social Security "hold harmless" provision, the Medicare Part B premium is adjusted to prevent a reduction in Social Security benefits from December of the previous year. The provision only applies to about 70% of all Medicare beneficiaries, however, and those who are not protected include people whose overall income is so low that their Medicare Part B premium is paid by state Medicaid programs, and individuals with incomes above $85,000 or married couples with incomes above $175,000.

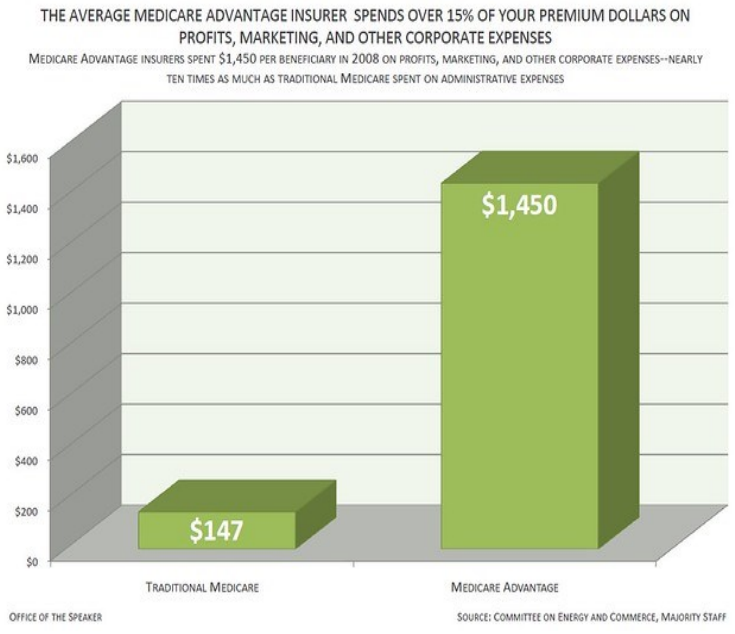
When a retiree's actual costs climb faster than their COLA, the buying power of Social Security erodes. A study by The Senior Citizens League has found that Social Security benefits have lost one third (33 percent) of buying power since 2000.

To protect Social Security benefits from an erosion in buying power, The Senior Citizens League supports legislation that would strengthen the COLA.

Senate asks CMS why it is not holding Medicare Advantage plans accountable

On September 13, 2019, six Democratic Senators sent a **letter to CMS** Administrator, Seema Verma, detailing their concerns about the well-being of people enrolled in Medicare Advantage plans and the integrity of the Medicare Advantage program. The Senators ask CMS why it is not holding Medicare Advantage plans accountable for violating their contractual obligations; rather, Medicare Advantage plans are jeopardizing the health and safety of their members and overbilling taxpayers to the tune of around $10 billion a year.

The letter, signed by Senators Sherrod Brown, Debbie Stabenow, Chris Murphy, David Blumenthal, Amy Klobuchar and Bernie Sanders, urges prompt action of Administrator Verma to ensure that Medicare Advantage plans are held accountable for meeting their contractual obligations and managing the health care needs of their members. The Senators want to ensure that deficiencies in oversight of Medicare Advantage plans are addressed. The Senators pose 19 questions to Verma on six areas of concern….**Read More**



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Social Security Works Applauds Elizabeth Warren's Bold Plan to Expand Social Security

The following is a statement from **Nancy Altman**, President of **Social Security Works**, on Senator Elizabeth Warren's newly released plan to expand Social Security:

"Senator Elizabeth Warren (D-MA) is a **powerful leader** in the movement to expand Social Security. Her bold new plan tackles the nation's looming retirement income crisis head-on, as well as rising income and wealth inequality and the squeeze on working families. It is a solution for all generations.

Warren recognizes that Social Security's retirement, disability and survivor benefits are vital, but inadequately low. Her plan increases benefits significantly for both current and future beneficiaries. To ensure that benefits do not erode over time, she proposes a more accurate measure for calculating yearly cost-of-living adjustments.

She knows that caregivers — disproportionately women — who take time out of the workforce to care for loved ones provide invaluable work for their families and the nation. Her plan gives those family caregivers credit towards their future Social Security benefits, so that those who perform this essential work will have the secure retirements they have earned.

To ensure that no one retires into poverty after a lifetime of hard work, she updates and improves the special minimum benefit. In addition, knowing that widows disproportionately live in poverty, she improves their benefits.

Warren understands that parents help their children pay for higher education and, when those parents have died or become disabled, Social Security should step into that role. Until 1981, Social Security did. Warren restores this vital student benefit and extends it to age 24, because most students today do not complete their college degrees by age 22.

Warren appreciates the important contributions of state and local employees. She repeals the WEP/GPO provisions, which substantially reduce their Social Security benefits. She also fully funds the Social Security Administration (which Republicans **have slashed** over the last decade) so all of us can promptly and conveniently access our earned benefits. After all, those administrative costs do not add a penny to the deficit. America's working families have prepaid for them through our dedicated Social Security contributions.

Warren's bold plan expands Social Security and ensures that all benefits can be paid in full and on time. Her plan addresses rising income and wealth inequality by requiring the wealthiest two percent to contribute their fair share.

All Americans owe her a debt of gratitude for standing up for our Social Security system."

Medicare Forms You May Need

To get the Medicare form you need, find the situation that applies to you. **Get forms in alternate formats.**

I want to expandI want to make sure Medicare can give my personal health information to someone other than me (Authorization to Disclose Personal Health Information form/CMS-10106).

Fill out **Authorization to Disclose Personal Health Information. Get this form in Spanish.**

I want to file a claim for services and/or supplies that I got (Patient Request for Medical Payment form/CMS-1490S).

Fill out the **Patient Request for Medical Payment form** (CMS-1490S).You'll find the address for form submission in the instructions. Follow the instructions on the second page to submit the form to your carrier. Get this form in **Spanish.**

If you don't know the address for your carrier, you can:

Find it under the "Downloads" section of **this page**. Select one of the links with "instructions" in the name.

Look at your "**Medicare Summary Notice**" (MSN). To view an electronic version of your MSN, **log into MyMedicare.gov**.

I want to start, stop, or change bank accounts for automatic monthly deductions of my Medicare premium (Authorization Agreement for Pre-authorized Payments form/SF-5510).

Fill out the **Authorization Agreement for Pre-authorized Payments form** [PDF, 117 KB] (SF-5510). Get this form in **Spanish.**

Enrollment forms

expandI have Part A and want to apply for Part B (Application for Enrollment in Part B/CMS-40B).

Fill out the **Application for Enrollment in Part B (CMS-40B).** Get this form in Spanish.

I want to sign up for Part B while I'm employed or during the 8 months after employment or my employer/union coverage has ended, and I need to provide employment information (Request for Employment Information/CMS-L564).

Fill out an **Application for Enrollment in Part B (CMS-40B)** and a **Request for Employment Information (CMS-L564)**. Get the Application for Enrollment in Part B (CMS-40B) in **Spanish**. Get the Request for Employment Information (CMS-L564) in **Spanish**.

Appeals forms

I want to appoint a representative to help me file an appeal (Appointment of Representative form/CMS-1696).

Fill out the **Appointment of Representative form** [PDF, 47.7 KB] (CMS-1696). Get this form in Spanish.

I want to transfer my appeal rights to my provider or supplier (Transfer of Appeal Rights form/CMS-20031).

Fill out the **Transfer of Appeal Rights form** [PDF, 36.2 KB] (CMS-20031).

I want to request an appeal (redetermination) because I disagree with a coverage or payment decision from Medicare (1st level of the appeals process) (Redetermination Request form/CMS-20027).

Fill out the **Redetermination Request form** [PDF, 100 KB] (CMS-20027).

I want to request a reconsideration because I'm not satisfied with the decision made during the 1st level of my appeal (Medicare Reconsideration Request form/CMS-20033).

Fill out the **Medicare Reconsideration Request form** [PDF, 180 KB] (CMS-20033).

I want to request a hearing by an Administrative Law Judge (ALJ) because I'm not satisfied with the decision made during the 2nd level of my appeal (Request for Administrative Law Judge (ALJ) Hearing or Review of Dismissal form/OMHA-100).

Purdue Pharma, drugmaker accused of fueling the opioid epidemic, files for bankruptcy

Purdue Pharma, the drug manufacturer accused of triggering the nation's epidemic of opioid addiction through its sale of the profitable but highly addictive painkiller OxyContin, filed for bankruptcy Sunday.

The Chapter 11 filing is expected to lead to the ultimate demise of a company that sold a fraction of the opioid prescriptions in the United States but nonetheless is most closely identified with the epidemic because of its pioneering role in the sale of narcotic pain pills. The company used aggressive, allegedly misleading, sales tactics to push physicians to prescribe millions of doses of its dangerously addictive pills.

The company's move to seek financial shelter, part of a tentative settlement with thousands of litigants, will shift the focus to new wrangling over how potential proceeds will be divvied up by communities reeling under the burden of addiction and overdose deaths.

The bankruptcy also will raise the stakes on legal sparring over how much of the personal fortunes of the billionaire Sackler family, which owns Purdue, will be available to compensate plaintiffs. Multiple states that have rejected the proposed settlement have accused the family of improperly stripping billions of dollars out of the company's coffers in the past decade to protect the cash from expected court judgments.

"The controversial piece is going to be about how much the Sacklers need to kick in for the deal to work,'' said Adam J. Levitin, a professor specializing in bankruptcy at Georgetown Law.

Under the settlement announced last week, more than 2,000 small government plaintiffs and 24 states have agreed to the dissolution of the company and a contribution from the Sacklers, valued at $10 billion to $12 billion. But the settlement valuation is in dispute, and a number of states have balked at those terms. The settlement, which does not include any admission of wrongdoing, would reorganize Purdue during the bankruptcy into a trust that would continue to produce OxyContin, as well as overdose "rescue'' drugs that would be distributed at no cost to communities across the country.

"We are hopeful of and expectant that a growing number of states will see this is a much better outcome for them than for us to go into the swamp of litigation that would basically eat up all the resources of the company,'' Purdue Chairman Steve Miller said in a conference call with reporters Sunday night.

A person familiar with the matter, who spoke on the condition of anonymity to discuss non-public company matters, said Purdue has spent $250 million on litigation costs this year.

The proposed minimum contribution from the Sackler family of $3 billion, which could be derived from the sale of a related, family-owned international drug company called Mundipharma, has been called insufficient by state attorneys general who have rejected the plan.

New York, Massachusetts, Connecticut and other states argue that the Sackler family has far more money stashed in a number of trusts and investment firms, including in offshore tax havens such as the Channel Islands, that should be made available to plaintiffs. Forbes has estimated the Sackler family's total worth at $13 billion.

The family is expected to argue that billions of dollars moved out of Purdue Pharma were legitimate dividends. Levitin said there will be restrictions on what can be "clawed back'' from the family's far-flung financial empire, partly because state statutes of limitations prevent plaintiffs from examining transactions going back more than a few years….**Read More**

Live-In Senior Care: Is It a Good Idea?

There are many different ways of addressing care needs in older adults. From home-based care offered by family or a visiting aide to **assisted living** or nursing homes, there's a care solution that can work for just about every senior and every family.

One option is live-in senior home care. This type of care features **a full-time caregiver** who lives in the home of a senior, much like some families hire a live-in nanny to care for small children. This type of care is best suited for seniors who need around-the-clock care, especially at night. If the caregiver needs to wake up several times a night to tend to a senior or help them take medication, a live-in caregiver might be the right solution.

There are two general ways that a live-in caregiver arrangement can be set up::

- **Live-in caregivers who maintain their own, separate residences.** In this type of caregiving situation, there are actually two or more live-in caregivers who rotate the nights they work. Each caregiver will spend a night (or more) in the home of the senior and then trade off with the other caregiver when they go "off-shift."
- **Live-in caregivers who live only in the home of the person they care for.** In these situations, the caregiver probably doesn't have his or her own separate residence, but lives in the home of the senior full-time. This person is usually the sole night-time caregiver for the senior, but may have support from a visiting nurse or aide during the day so that he or she can have some off hours to attend to his or her own personal needs or work another job during the day. In some cases, the senior may go to adult day care during the day, and the caregiver typically has a couple nights a week off.

In both situations, the live-in caregiver needs to have a private room in which to sleep. In addition, the senior typically covers the cost of food while the caregiver is on duty. The caregiver's duties can range widely depending on the senior's specific needs. Typically, a live-in caregiver will perform tasks similar to a **home health aide**, which may include helping the senior with bathing and dressing, housekeeping, administering medications, making meals and running errands.

"Home care is the largest entity within senior care," says Eleonora Tornatore-Mikesh, chief experience and memory care officer at Insp?r, a new senior living community in Manhattan. "About 70% of seniors are cared for in the home-care sector." Finding the right combination of care can take some effort and patience, whether that care is round-the-clock or only part time….**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Fall is in the air: Get your flu shot early!

It's important to get the flu shot every year, no matter how old you are. It's particularly important, and should be a priority, for older adults. With summer coming to a close, it's time to get your flu shot!

Talk to your doctor about getting the flu shot and about whether you should get a **special vaccine** available for people over 65. The good news: **Medicare covers the full cost of a flu shot**.

Why get the flu shot now? That's how you best protect yourself, the people you love and your community. The flu vaccine takes between two and four weeks to become effective. So, even if you get it now, it might not protect you from the flu until mid-October.

And, yes, sometimes the flu shot will not keep you from getting the flu. However, even if you get the flu, the flu shot reduces the odds that it will be a severe case. The flu shot may keep you from being hospitalized for the flu or, worse still, from being in the intensive care unit of the hospital. It also reduces your risk of death.

Many people do not realize that the flu kills thousands of people in the US each year. In 2018, **80,000 people died of the flu**. And **older adults are more likely to die from the flu** than younger people.

Should you wait to get the flu shot? No. No one knows whether the flu season will begin early. Can you wait? If you need to wait, the Centers for Disease Control recommends you not wait any longer than the end of October.

Virtually everyone over six months old needs the flu shot even if they have not gotten the flu before. (The only exceptions are people who are allergic to the flu vaccine.) There is only benefit from getting the flu shot. The flu shot cannot give you the flu. The flu shot is killed virus.

In Search Of Age-Friendly Health Care, Finding Room For Improvement

A month ago, during a visit to her doctor's office in Sequim, Wash., Sue Christensen fell to her knees in the bathroom when her legs suddenly gave out.

The 74-year-old was in an accessible stall with her walker, an older model that doesn't have brakes. On her left side was a grab bar; there was nothing to hold onto on the right.

Christensen tried to pull herself up but couldn't. With difficulty, she rearranged her clothing and, inching forward on her knees, exited the stall. There, she tried calling the front desk on her cellphone but was placed on hold by the automated phone system.

Altogether, Christensen, who has a herniated disk in her back, was on the floor for almost half an hour before a nurse and her husband, who'd been parking the car, lifted her to her feet.

"I just wish there had been a button that I could have pushed indicating that someone in the restroom needs assistance," she said.

For older adults, especially those who are frail, who have impaired cognition, or who have trouble seeing, hearing and moving around, health care facilities can be difficult to navigate and, occasionally, perilous.

Grab bars may not be placed where they're needed. Doors may be too heavy to open easily. Chairs in waiting rooms may lack arms that someone can use to help them stand up.

Toilets may be too low to rise from easily. Examination tables may be too high to get onto. Lettering on signs may be too small to read. And there may not be a place to sit down while walking down a hallway if a break is needed.

"Most hospitals and clinics have been designed for 40- or 50-year-olds, not 70- or 80-year-olds," said Dr. Lee Ann Lindquist, chief of geriatrics at Northwestern University's Feinberg School of Medicine in Chicago. "Additional thought has to be given to seniors who have functional disabilities."

What changes could be made to better accommodate older adults' needs? I asked geriatric specialists and seniors to identify practical issues that should be addressed. Here are a number of suggestions that came up repeatedly.

Parking

Difficulties start in the parking lot, which may not be adjacent to the medical center.

That's the case at Long Island Jewish Medical Center, a large teaching hospital in New Hyde Park, N.Y. Every day, Dr. Maria Torroella Carney, a geriatrician at the hospital, crosses a busy road from the parking lot to the hospital's entrance.

"It's challenging. There isn't clear signage indicating where to cross safely, and if you need to stop and rest there aren't any benches nearby," said Carney, who is also chief of geriatrics at Hofstra/Northwell School of Medicine.

Dr. Michael Wasserman, a California geriatrician on the board of the American Geriatrics Society's **Health in Aging Foundation,** observed that accessible parking spaces are often in short supply. "Even then, not all older adults who need help have a handicap sticker," he noted.

The University of Florida's Senior Care Clinic has a solution: valet services. "When an older patient comes by themself, if they need help, the valet will call our clinic and someone will come down and take the patient up," said Dr. Bhanuprasad Sandesara, division chief of geriatrics.

Signage

All too often, easy-to-read signs indicating where patients should go can't be found, either inside or outside medical centers. For older patients, this can lead to confusion and unnecessary wandering, accompanied by pain, fatigue and annoyance.

Last year, a committee examining how Long Island Jewish Medical Center should handle patients with special needs (for instance, people with cognitive impairments or hearing or speech problems) identified better signage as a priority.

Now, signs in the parking lot and outside the medical center are bigger, with larger type. Inside the medical center, large signs have been placed at bathrooms, showing clearly if they're accessible to those with disabilities. And the staff is creating a comprehensive map of the hospital campus — a handout — ...**Read More**

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Live longer, avoid sugary and diet sodas

Live longer, avoid sugary and diet sodas! **CNN** reports that a 19-year study published in **JAMA Internal Medicine** found that people who drank as few as two glasses (16 ounces) of soda a day, including diet soda, had a greater chance of dying from any cause than people who drank fewer than 12 glasses of soda a year.

The 451,743 study participants from 10 European countries were in good health at the outset, without signs of cancer, diabetes, heart disease or stroke. But, after 19 years of drinking sugar-sweetened sodas, including diluted syrups, both men and women had a greater risk of dying from digestive disorders than people who did not. It goes without saying that consumption of sugar-sweetened drinks also leads to **weight gain and obesity**.

Men and women who drank diet drinks over 19 years had a greater risk of dying from circulatory diseases such as cardiovascular disease. The long-term physiological and health consequences of drinking artificially-sweetened drinks is unknown.

People who drank as little as 16 fluid ounces of soft drinks a day also had an increased risk of Parkinson's disease. Of note, they did not have an increased risk of deaths from breast or prostate cancer. But, drinking one or more eight-ounce soft drinks a day–sugar-sweetened and artificially-sweetened–was associated with more **colorectal cancer** deaths than drinking fewer than one glass a month. That said, the researchers could not determine whether the sugary or artificially-sweetened drinks were factors in this association. N.B. A July 2019 study published in **BMJ** did show an 18 percent higher risk of overall cancer and a 22 percent higher risk of breast cancer from drinking as little as a third of a can of soda a day.

The researchers also found that people who drank more than one glass of diet soda a month but fewer than two a day had a greater risk of disease than those who did not.

The JAMA study was an observational study. It does not show that drinking soft drinks necessarily increases risk of death. Other studies in the US have shown associations between diet sodas and **stroke**, **dementia** and **Type 2 diabetes**.

If you want to reduce your soft drink intake, consider doing so gradually rather than going cold turkey. You have a greater likelihood of success. You might try substituting ice water for soft drinks. And, if you like carbonated drinks, you can substitute soda water for soft drinks. For extra flavor, you can add a small amount of juice to the soda water

Migraine may raise dementia, Alzheimer's risk

New research examines the associations between migraine and Alzheimer's disease, as well as related forms of dementia. The study finds that migraine is "a significant risk factor" for Alzheimer's and all□cause dementia.

According to the American Migraine Association, about **36 million** people of all ages in the United States regularly experience migraine. That is about 12% of the population.

Alzheimer's disease and related forms of **dementia** were affecting **5 million** U.S. adults in 2014, according to official estimates, and the figures are only expected to increase.

While dementia is the most prevalent neurological condition in older adults, **headaches** are the most prevalent neurological condition across all ages, and migraine headaches are the most severe form.

So, new research set out to investigate whether migraine is a risk factor for dementia. Identifying what raises the risk of dementia may enable more timely treatment interventions.

Detecting dementia **early on** and starting treatment as soon as possible can improve the effectiveness of therapies and empower people with the condition and their families to make the right decisions at the right time.

Suzanne L. Tyas, Ph.D., of the University of Waterloo, in Ontario, Canada, is the senior author of the new paper, which appears in the ***International Journal of Geriatric Psychiatry***.

….**Read More**

How to Fight Hidden Causes of Inflammation

Tamping down inflammation is a must for people with a chronic inflammatory diseases like rheumatoid arthritis or lupus. But you can be exposed to damaging inflammation without having a specific medical condition.

Inflammation prevents the body from adequately reacting to stressors and puts the aging process on an unwanted fast track, increasing the likelihood of problems like heart disease. The negative effects of inflammation can be so significant that leading researchers from the University of Bologna in Italy coined the phrase *inflamm-aging*. So making anti-inflammation lifestyle choices is good for everyone.

How to Avoid Inflamm-aging

- Eat a heart-healthy diet focusing on foods like fatty fish, fruits and vegetables. Keep in mind that sugar is highly inflammatory.
- Get active with moderate cardio exercise. Remember: Good health guidelines call for 30 minutes a day on at least five days per week.
- Lose excess weight, especially if you're carrying those pounds around your middle.
- Avoid exposure to all forms of secondhand smoke, and of course, if you smoke, quit.
- Limit alcohol to one drink per day if you're a woman, two if you're a man.
- Clock seven to eight hours of sleep every night. Some people need more, others need less, but this is the sweet spot between not enough and too much.
- Manage stress. Stress is often unavoidable, but you can minimize its effects with techniques like deep breathing and meditation.
- Stay social with strong connections to friends and family.

Also, talk to your doctor about ways to boost heart health and any other steps appropriate to your needs to counter inflammation.

More information

Learn more about **preventing inflammation** from Berkeley Wellness.

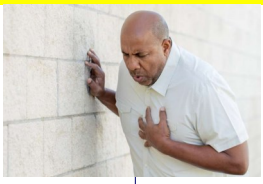
What to Do If Someone Is Having a Heart Attack

About 790,000 Americans have a heart attack each year, according to the Centers for Disease Control and Prevention (CDC). The cause is an obstruction of the blood supply to the heart muscle (usually by a clot in the coronary blood vessels). The outcome depends on how much of the muscle is affected and how quickly help can be given. If you think someone is having a heart attack, always call for help rather than waiting to see if the symptoms subside. The longer you wait, the more damage can occur to the heart muscle, says the CDC. Be sure you're aware of these nine things to **know about heart attacks** before you have one.

Heart attack symptoms

These are the **common signs and symptoms of a heart attack**, according to the American Heart Association. A patient will experience some but not necessarily all. If the pain subsides with rest, it could be angina (see below).

- Suddenly feels faint or dizzy
- Severe chest pain (persistent and vise-like, spreading up to the jaw and down one or both arms) that does not subside when the patient rests
- Discomfort high in the abdomen (may feel like severe indigestion)
- Breathlessness (patient may be gasping for air)
- Fear (feels an impending sense of doom)
- Pale, gray, clammy, or sweaty skin
- Rapid, weak, and irregular pulse
- Collapses, often without warning
- Possible loss of consciousness
- Warning signs of a heart attack are often different in women than in men. Read about the nine physical and emotional ways **heart disease is different for women**. It's also smart to know these **silent signs of a heart attack**.



Here's how the American Heart Association recommends you should proceed:

Help for a conscious patient

- **Ease the strain on the heart.** Make the person having a heart attack as comfortable as possible in a half-sitting position, with his head and shoulders well supported and knees bent to ease the strain on the heart. Loosen clothing at the neck, chest, and waist.
- **Call for emergency help.** Keep bystanders away from the patient.
- **Give angina medication.** If the patient has medication for angina, help him to take it. Keep him calm and encourage him to rest.
- **Give aspirin.** If the patient is fully conscious, give him a full-dose (300 mg) aspirin tablet. Tell him to chew it slowly so that it dissolves and is absorbed into the bloodstream more quickly when it reaches the stomach. Aspirin helps to break down blood clots, minimizing muscle damage during a heart attack.
- **Monitor patient.** Regularly check and make a note of consciousness, breathing, and pulse.

Help for an unconscious patient

- **Call 911.** This is always the first thing to do if you're helping someone who is unconscious.
- **Open airway.** Check for breathing and **be prepared to begin CPR.**
- **Send for AED.** Ask someone to bring an AED (automated external defibrillator), if possible, while you treat the patient. AEDs deliver a shock to correct an abnormal heart rhythm called ventricular fibrillation, which is the cause of some heart attacks. The machines are found in most public places, such as shopping centers and train stations.
- **Operate the AED.** An AED is simple to use. Attach the pads as indicated on the machine; then the machine will talk the operator through the process. An AED will only deliver a shock if the patient's condition indicates that it is necessary. If you have attached an AED to a patient, leave the machine switched on at all times and leave the pads attached, even if the patient recovers. The American Red Cross has more on **how to use an AED**.

What's next?

Wait for the emergency medical technicians. The earlier a person receives advanced medical help, the greater the chances of survival.

A diagnosis will be confirmed at the hospital with an electrocardiogram (ECG) and blood tests. Advanced care may include a stay in the intensive care unit and treatment with drugs or even surgery. The aim is to minimize pain, restore the blood supply to the damaged heart muscle, and prevent complications.

If it's angina

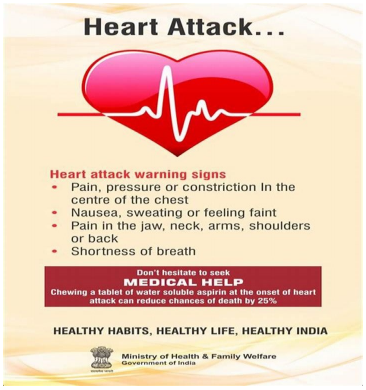
If the pain subsides after the person rests for a few minutes, it is likely that it is an angina attack. This is a chronic condition in which the coronary (heart) arteries have narrowed so that the heart muscle cannot get enough blood to meet its demands. Someone diagnosed with angina will have medication to use in case of an attack.

- **Reassure.** Keep the patient calm; sit her down.
- **Assist with medication.** Help the patient find her medication (usually a tablet or spray). If necessary, help her take it. If a patient has no medication at hand, call for emergency help immediately. Treat as described above.
- **Keep watch.** The attack should ease within a few minutes. If the pain does not ease or the person has no medication, treat as a heart attack.

Get more information about handling health emergencies and natural disasters in the book *Reader's Digest Quintessential Guide to Handling Emergencies.* You'll get must-know tips and tactics for preparing your home, stocking the right supplies, preventing and handling accidents, coping with medical situations, and keeping your family safe. **Learn more and buy the book here**.

Heart attack facts

- **A heart attack results when a blood clot completely obstructs a coronary artery supplying blood...**
- **The blood clot that causes the heart attack usually forms at the site of rupture...**
- **The most common symptom of heart attack is chest pain.**
- **The most common complications of a heart attack are heart failure and ventricular fibrillation.**



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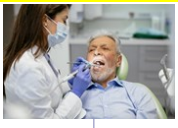
Does poor oral health impact brain function?

Perceived stress may detrimentally impact oral health which, in turn, may lead to cognitive decline among specific elderly communities, according to two new studies.

New research finds connections between oral health in older adults and cognitive function.

Oral health can be a surprisingly good indicator of a person's well-being. Not only can oral diseases reduce a person's **quality of life**, but they can also increase the risk of other serious conditions.



Researchers have **linked gum disease** and tooth loss to the occurrence of **stroke.** An article published in the *Journal of Indian Society of Periodontology* in 2010 concluded that gum disease could raise a person's risk of **heart disease** by around 20%. It is, however, necessary to carry out more research in these areas.

Teams at Rutgers University in New Brunswick, NJ, have now focused on a different link — the one between oral health and cognitive decline.

A recently published **review** of 23 studies found evidence of a relationship between oral health and cognitive aspects, such as memory and executive function.

Now, a team from Rutgers University carried out two separate studies into cognitive decline and perceived **stress.** Both papers appear in the ***Journal of the American Geriatrics Society***..

The Chinese American focus

The studies focused on Chinese American adults with a minimum age of 60. "Racial and ethnic minorities are particularly vulnerable to the negative consequences of poor oral health," ...**Read More**

Eye Exams in Nursing Homes

IT'S A FACT OF AGING: Eye health changes over time. For many people, the changes begin around age 40 and over time, can cause eye problems.Age also affects other aspects of health. Many older adults may find they need to move into a **nursing home** for more intensive, round-the-clock care when they can no longer live on their own or require skilled nursing care.

While **nursing homes**, also called skilled nursing facilities and long-term care facilities, are not hospitals and the level of care is typically limited to nursing or rehabilitative care, an **optometrist or ophthalmologist** may – and should – visit regularly to help look after residents' eye health.

Regular eye exams should be part of your routine health care, particularly as you age. Dr. Mona Adeli, an **ophthalmologist** with the Havener Eye Institute at The Ohio State University's **Wexner Medical Center** in Columbus, says "after the age of 40, people should start to see their eye care provider, whether that's an ophthalmologist or optometrist for an exam." Get a baseline eye exam and follow up regularly to keep your eyes healthy.

And this recommendation doesn't change for older adults living in skilled nursing facilities or nursing homes. Although eye exams aren't necessarily a regular part of the care a resident receives in a nursing home, they can and should be made available. Maintaining good eye health is an important part of caring for the health of the entire person.

What to Expect from an Eye Exam Performed in a Nursing Home

Eye exams performed in a nursing home are often quite similar to those performed in an optometrist's office and should provide the same information as any other eye exam, says Barbara Horn, a doctor of optometry and president of the American Optometric Association. The doctor will go over the patient's health history and conduct a variety of tests to check your vision and look for signs of eye disease, just as would occur during a normal vision test in an optometrist's office.

The range of problems an eye doctor may encounter among nursing home residents are similar to those found among any other elderly population. "Nursing home facility residents have many of the same vision problems other patients have," Horn says. "They may simply need a comprehensive exam to update their glasses and monitor eye health."

When evaluating a senior in a nursing home, the eye doctor should also be looking for eye diseases that are specifically associated with aging such as:

- **Cataracts.** Every person will eventually develop cataracts if they live long enough. **Cataracts** are simply a clouding of the natural lens inside the eye. Symptoms include gradual or progressive decreases in vision. Glasses may not be enough to correct your vision, and it might feel like you're looking through a lens smeared with Vaseline. The American Academy of Ophthalmology reports that "cataracts affect more than 24.2 million Americans age 40 and older. By 75, approximately half of all Americans have cataracts."
- **Glaucoma. Glaucoma** cause s damage to the optic nerve, and its prevalence increases with age. It's also more common among diabetics. The AAO reports that glaucoma affects more than 2.7 million Americans aged 40 and older.**Macular degeneration.** The macula is a small area of the retina, which is a thin film at the back of the eye that organizes visual information and transmits it to the optic nerve. That information is then transmitted onward to the brain for interpretation. When this macula degenerates, or deteriorates, that can cause vision loss. "The risk of macular degeneration goes up with age," says Dr. Dianna L. Seldomridge, clinical spokesperson for the AAO and an **ophthalmologist** at the Duke Eye Center of Winston-Salem in North Carolina. "Typically, we don't see macular degeneration before the age of 50 or so."
- **Diabetes-related eye disease.** The National Eye Institute reports that about 40% to 45% of diagnosed diabetics "have some degree of **diabetic retinopathy**," a form of eye disease in which the retina is damaged. Diabetes is a chronic disease associated with aging. Though estimates vary, several studies have indicated that 25% or more of America's nursing home residents have diabetes….**Read More**

What's the secret to a very long life?

Today 110 million Americans are over 50 years old. And, half of people born today are expected to live past 100. What's the secret to a very long life? Here are a few.

Harvard Health offers the usual advice for living a long and healthy life: **Don't smoke**, **maintain a healthy weight**, **exercise your mind** and **body,** engage **socially** , get preventive care and visit the dentist regularly. Also, take the medications your doctor prescribes to control chronic conditions such as **high blood pressure** and cholesterol.

Professor Nir Barzilai, Albert Einstein School of Medicine, gives **a lot more weight to genes** than to a healthy lifestyle as cause for a person's long life.

Barzilai studiesdifferences between chronological and biological age — actual years of life relative to a body's health. He believes that people whose chronological age is much greater than their biological age hold the information to what it takes to live longer.

Barzilai has found that many people who live past 100 did not lead especially healthy lifestyles. One group of siblings, who all lived past 100, included a man who worked in a high-pressure job past 100 and his sister who smoked for 90 years. Other people who lived past 100, whom Barzilai studied, were overweight, did not exercise, and did not eat particularly healthy meals.

Barzilai says that what centenarians all have in common is a "longevity gene," a gene that resists aging. And, because of this longevity gene, Barzilai believes it is possible to erase cellular aging in people.

An **NIH-funded study**, the Longevity Project, found that cautious and less happy people lead longer lives than the happiest people. The more cautious people took fewer risks, which extended their lives and kept them healthier.

Yet another study out of the **University of Washington** found that having a **greater sense of purpose** led to a longer life.

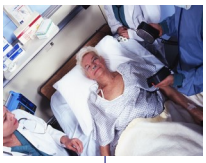
Wealth also appears to be a significant factor in living a long life. The US **Government Accountability Office** just published a report finding that wealthy people tend to live longer than poor people.

Of course, living longer should not be a goal in and of itself. We should be careful about wishing to live longer if that means being old and unhealthy. Leading a healthy life may be a better goal and also likely leads to a longer life.

Quick Test Helps Predict Hospital Readmission Risk After Heart Attack

For elderly heart attack survivors, how well they perform on a simple mobility test could help predict whether they will be back in the hospital within a month, researchers say.

Nearly one in five of these heart patients are readmitted with complications such as heart failure, bleeding or irregular heart beat within 30 days after leaving the hospital.



The new study included more than 3,000 heart attack patients, average age 81, at 94 U.S. hospitals. Within 30 days of leaving the hospital, about 18% had been readmitted, the findings showed.

Before they left the hospital, patients' thinking, vision, hearing and mobility were assessed. In the mobility assessment, the seniors were timed on how long it took them to rise from a chair, walk 10 feet and then return to the chair.

This "Timed Up and Go" test was the only functional assessment associated with readmission within 30 days….**Read More**

How to Keep Your Bones Strong and Prevent Fractures

If you're a young adult, start thinking about your bone health, an expert advises.

Most people reach peak bone mass -- the strongest bones they'll ever have -- between 25 and 30 years of age, according to Dr. Philip Bosha, a physician with Penn State Sports Medicine in State College, Pa.

"To some extent, genetics determines the peak, but lifestyle influences, such as diet and exercise, are also factors," Bosha said in a Penn State news release.

According to the American Academy of Orthopaedic Surgeons, bone mass starts to slowly decrease after age 40. Taking 1,000 milligrams of calcium and 1,000 International Units (IU) of vitamin D a day can help maintain your bones. You should also do weight-bearing exercises such as running and brisk walking, as well as resistance training to maintain bone and muscle strength.

After age 50, the daily recommended calcium intake for men remains 1,000 milligrams per day, but rises to 1,200 milligrams for women, including those who are entering or have gone through menopause.

Declining estrogen levels due to menopause can lead to rapid bone loss. All women 65 and older -- and those between 60 and 64 who have an increased risk of fractures -- should get a bone density study, according to Bosha.

"If the bone density study shows osteoporosis, it may be reasonable to start taking a medication called a bisphosphonate, which you can get in a variety of forms," he said. "Some are pills taken on a weekly or monthly basis and other varieties can be taken intravenously."

Other medications to improve bone density include calcitonin, which can be used as a nasal spray; parathyroid hormone, which is taken by injection; and medications called selective estrogen receptor modulators.

Bosha said men and women who are 70 and older should take 1,200 milligrams of calcium per day and 800 IU of vitamin D. At this age, men become far more likely to have lower bone density, increasing their risk of fractures. Some men should consider a bone density study, Bosha said.

"For people of this age, avoiding falls is crucial," he said. "Maintaining balance and muscle strength through exercise and maintaining strong bones through adequate calcium and vitamin D intake can help decrease the risk of severe fractures from falls."

More information

The U.S. National Institutes of Health has more on **bone**