

Is a Pre-Existing Condition Insurance Plan the Right Fit for You?

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Saul J. Morse

In March, 2010, the U.S. Congress passed, and President Obama signed, legislation called the “Affordable Care Act.” While some refer to this as Obamacare, it is the legislation which, if fully implemented, is likely to significantly change the ways Americans receive and pay for health care.

While much of this legislation will not go into effect until 2014, and while it is under legal challenge with a likely U.S. Supreme Court decision coming next summer, there are portions of the law already in effect. Some may benefit post-polio survivors. The law includes a mechanism to provide insurance coverage for individuals who had a pre-existing health condition and were unable to secure health insurance.

State Plans

Each state was given the option of establishing and running such an insurance program in partnership with the federal government. Twenty-seven states opted to run such a Plan themselves while 23 did not. In those 23 states which did not wish to operate such a program, the federal government, through its Department of Health and Human Services, is operating the Plan.

The Plan provides health insurance in a manner similar to the way individuals who do not have a prior health condition get insurance. Individual policies are issued and premiums are paid. Each state has different levels of premiums based upon a number of factors. While most states charge premiums based upon age and locale within the state, some states, such as

Pennsylvania, have opted to use what is termed “Community Rating” in which everyone in the program pays the same premium.

Eligibility

To be eligible for the insurance coverage, individuals must show proof that they are U.S. citizens or permanent legal residents of the United States. This can be shown through various methods including a birth certificate, passport or copy of papers documenting permanent residence. Individuals must then show that they are residents of the state in which they are applying. This is generally easily shown by documentation such as driver’s licenses or government-issued ID cards.

Individuals meeting those two criteria then must show that they have not

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PHI's mission is to enhance the lives and independence of polio survivors and home mechanical ventilator users through education, advocacy, research and networking.

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PHI Board of Directors Honors Larry Becker

Lawrence (Larry) Becker, Roanoke, Virginia, is the newest member of PHI's Honorary Board. At its 2011 Strategic Planning Board Meeting, the PHI Board of Directors acknowledged his years of service to the organization by voting this unanimous designation.

Larry served on the PHI Board from 2001 to 2011 and served as its chair from 2006–2009. Throughout his tenure on the board, he was active in its strategic planning, fundraising and educational efforts.

His current major activity is finalizing his latest book, *Habilitation, Health, and Agency, A Framework for Basic Justice*, to be published this year by Oxford University Press. This is the fifth book that he has written in his chosen field of philosophy.

After completing his undergraduate degree at Midland College in Fremont, Nebraska, he received his doctorate in 1965 from the University of Chicago. He and his wife of 44 years, Charlotte Becker, co-edited two editions of *The Encyclopedia of Ethics*, a reference work by and for academic philosophers and their students.

He taught full-time at the university level from 1965–2001, first at Hollins College (now Hollins University), and then at the College of William & Mary. Since formally retiring in 2001, he has continued to work part-time in the graduate school at Hollins University.

Becker contracted polio in 1952 at age 13, and, except for a three-month experiment in 1955 without breathing assistance, has used nighttime ventilation ever since. ▲



Lawrence C. Becker

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More Research About Bisphosphonate Treatment in Polio Survivors

Joan L. Headley, Post-Polio Health International, Executive Director, St. Louis, Missouri, director@post-polio.org

About the time I was writing “Calcium, Vitamin D and Bisphosphonates. Oh My!” (*Post-Polio Health*, Vol. 27, No. 3) in response to the many questions PHI had received, another article of note was published.

Response of Postpoliomyelitis Patients to Bisphosphonate Treatment by a group of researchers from McGill University, Montreal, Quebec, Canada, was published in *PM&R* (Volume 2, Issue 12, Pages 1094-1103), the official scientific journal of the American Academy of Physical Medicine and Rehabilitation.

The design of the study, funded in part by the Polio Quebec Association, was a retrospective chart review. The review included 144 post-polio and 112 non-post-polio patients who had at least two bone mineral density (BMD) assessments on record.

The purpose was to compare the rate of change of BMD at the hip in post-polio patients treated with bisphosphonates to those post-polio patients who did not receive treatment, and to compare with non-polio patients treated with bisphosphonates. They also wanted to compare the fracture rate in post-polio people before and after treatment. For this, they used the charts of 32 post-polio patients who had been treated with bisphosphonates and had a history of a fracture.

Bisphosphonates Raise BMD Levels

After statistical analysis, the study concluded that the 54 post-polio patients treated with bisphospho-

nates had a greater rate of change (significant increase) in BMD than the 90 patients not receiving this treatment. The effect of bisphosphonates for post-polio people was similar to that observed in non-polio people. When looking at the 32 people with a history of fractures, evidence indicated that treated patients had a lower risk of fracture.

Bisphosphonates include: pamidronate (Aredia®) and zoledronic acid (Zometa®) given by intravenous infusion, and alendronate (Fosamax®), ibandronate (Boniva®) and risedronate (Actonel®) given in tablet form.

One of the researchers, Daria A. Trojan, MD, states, “Bisphosphonates are one of several treatment options for osteoporosis and fall/fracture prevention. Other treatments can include calcium and Vitamin D supplementation as necessary, safety and fall prevention strategies with muscle strengthening and balance training when possible, use of assistive devices and home modifications.

“Although the use of bisphosphonates appears to be beneficial in post-polio patients, a definitive recommendation regarding the use of these medications in post-polio patients cannot be made

based on this study. However, the results are encouraging, and provide support for future clinical trials in the area.”

FDA Opinion

A quick check of the U.S. Food and Drug Administration (FDA) website tells us that it continues to review data from published studies, and, because there have been conflicting findings, issued the following statement on July 21, 2011:

“At this time, FDA believes that the benefits of oral bisphosphonate drugs in reducing the risk of serious fractures in people with osteoporosis continue to outweigh their potential risks ...” It “has not concluded that patients taking oral bisphosphonate drugs have an increased risk of esophageal cancer. It is also important to note that esophageal cancer is rare, especially in women.”

In October of 2010, the agency described “... the risk of atypical fractures of the thigh, known as subtrochanteric and diaphyseal femur fractures, in patients who take bisphosphonates for osteoporosis.” Information was added to the *Warnings and Precautions* section of the labels of all bisphosphonate drugs approved for the prevention or treatment of osteoporosis.

They continue, “These fractures are very uncommon and appear to account for less than 1 percent of all hip and femur fractures overall. Although it is not clear

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Updates from The PHI Research Fund's 2011 Grantees

The two teams that each received a \$25,000 grant from PHI's Research Fund in 2011 have submitted their reports.

Oral Glutathione and Health Outcomes Among Persons With Post-Polio Syndrome is the official name of a study being done at the University of Michigan under the direction of Principal Investigator Claire Z. Kalpakjian, MS, PhD.

The project was designed to take two years. The team is currently recruiting participants, and the study is listed in the U.S. National Institutes of Health website <http://clinicaltrials.gov/ct2/search>.

According to the site, "Subjects will take a glutathione supplement by mouth for three months after an initial medical visit, blood draw and physical exam. There are four points during the three months when subjects will fill out surveys and record food intake and sleep times in diaries for seven days. They will also wear a small device, a SenseWear® monitor, for seven days that records physical activity, body temperature and other measures.



The SenseWear® monitor

"After the fourth point during the three-month study period, they will return to the medical center for

another physical exam and blood draw. Physicians trained in physical medicine and rehabilitation will be monitoring the study."

Dr. Kalpakjian said, "The SenseWear® device is an innovative technology that allows us to track a person's sleep patterns, physical activity and even the

calories they burn each day. Each research subject fills out diaries to report their sleep, diet and moods. An objective method such as a device and a subjective one like a diary complement each other. As a result we have a more genuine picture of a person's sleep and activity. This study, although small and preliminary, will make an important contribution to research on post-polio syndrome."

Please note that the team is still seeking participants who need to be within traveling distance to Ann Arbor, Michigan, as two visits to a University of Michigan clinic are required.

Post-Polio in Jerusalem

The other 2011 study was called *Characteristics of poliomyelitis and post-polio patients among Jews and Arabs in Jerusalem* under the leadership of Zeev Meiner, MD, Principal Investigator, Department of Physical Medicine and Rehabilitation, Hadassah Medical Center, Jerusalem, Israel.

The team has submitted a final report to PHI but the work continues as they analyze and summarize the data for publication and for presentations at international conferences. Drs. Meiner and Schwartz presented a poster at the Post-Polio Syndrome – A Challenge of Today, the international post-polio conference in Copenhagen held last summer (2011).

The data they will be reporting compares medical, demographic, socioeconomic and psychological information of polio survivors in Jerusalem with people in

Jerusalem of the same age and gender who did not have polio. This data will help distinguish the characteristics of polio people as they age from those without polio.

The results to date showed that polio survivors, in spite of their severe disability, succeeded in having a family life similar to the general population. They completed higher education, and, despite their disabilities and advanced age, were still in the work force. Similar to other studies from Norway, Holland and Japan, the team found that polio survivors presented higher incidences of co-morbidities such as cardiovascular problems, chronic pain and diabetes, reflecting their sedentary life style.

The group also compared the data of polio survivors who had post-polio syndrome (PPS) using the March of Dimes criteria (2001) with those who were not diagnosed, looking for factors that distinguish the two groups.

The only significant difference between the PPS and non-PPS patients was the marital status. Only 65.8 percent of PPS patients were married as opposed to 81.5 percent of non-PPS patients. The rate of PPS found in the study – 58 percent – was similar to that found in previous studies. Polio survivors, especially those with PPS, showed significant difficulties in ambulation at home and work and in ADL function (activities of daily living) in comparison to the general population.

The data comparison of Jewish and Arabic polio survivors showed

Dr. Meiner's co-investigators included Isabella Schwartz, MD, Head of the Department of Physical Medicine and Rehabilitation, Hadassah Medical Center; Irina Gartsman, MD, Department of Physical Medicine and Rehabilitation, Hadassah Medical Center; Yechiel Friedlander, PhD, The Hebrew University-Hadassah, Braun School of Public Health – Biostatistics and Epidemiology; and Orly Manor, PhD, Head of Braun School of Public Health, The Hebrew University-Hadassah Medical Center, Biostatistics and Epidemiology.

that polio survivors in the Arabic community are younger and have a higher level of difficulties and disabilities as compared to the Jewish polio population, which reflects the paucity of medical infrastructure in the Arabic quarters of Jerusalem.

The researchers also were interested in what rehabilitation methods work and developed a special multidisciplinary rehabilitation program for post-polio patients in the day care unit of the department of Physical Medicine & Rehabilitation in Hadassah Medical Center.

Survivors were placed into homogeneous groups according to their grade of disability using the severity of PPS symptoms according to their IPPS (index of post-polio sequelae) developed by researcher Kalpakjian's team in 2005. (Kalpakjian CZ, Toussaint LL, Klipp DA, Forchheimer MB. Development and factor analysis of an index of post-polio sequelae. *Disabil Rehabil*. 2005 Oct 30; 27(20):1225-33.)

Each group received a series of 12 group and individual therapy sessions provided twice a week for a total of six weeks. The treatments were provided by rehabilitation teams with special training in the specific needs of polio patients. The treatment program included physiotherapy, occupational therapy, gait analysis, orthotics evaluation and management, assistive devices prescription, hydrotherapy and adjusted physical activities.

In addition, the patients received psychological and social support,

including psychotherapy social evaluation, art therapy and group therapy led by a social worker. Polio patients received dietetic assessment and care by a rehabilitation dietician and respiratory rehabilitation as well as speech therapy as needed. They also attended educational sessions provided by specialized rehabilitation staff regarding coping with the disability and other related subjects, such as family coping strategies.

All patients participating in the specific rehabilitation program are evaluated at the end of the program, and will be evaluated again six months after the end of the program.

The effects of the special multidisciplinary rehabilitation program are encouraging, and the work continues.

Dr. Meiner states that this is the first study trying to identify the needs of polio survivors in Israel as compared to the general population. "The results are important in order to develop preventive interventions and rehabilitation programs in order to improve the quality of life of polio survivors.

"Our study showed, as we already expected, that polio survivors, through their immense struggle, succeeded to gain even higher education and almost the same rate of employment as the general population," said Dr. Schwartz. "Unfortunately, in the last years, many of them are suffering from the devastating effect of PPS. Therefore, it is of utmost importance to determine the risk factors



Drs. Schwartz and Meiner

for this syndrome and to prevent or ameliorate its effect."

Post-Polio Health International will report to our Members when information from these studies is published in peer-reviewed professional journals.

PHI's Research Fund

The Research Fund was established in 1995 to support the work of researchers investigating the late effects of poliomyelitis and/or neuromuscular respiratory disease. The Fund's priorities are to provide funds to initiate new research, to continue notable projects or to combine with other resources to complete research into post-polio and neuromuscular respiratory research. For details, go to www.post-polio.org. ▲

had health insurance for six months and either that they have a pre-existing medical condition, which a medical professional will certify prevents them from getting insurance, or documentation of an insurer denying them comparable insurance coverage within the past year.

In most instances, individuals who had polio and those contending with post-polio symptoms will meet the criteria of the prior health condition. By checking with the authority managing the program in your state you can get more specific information which would pertain to you.

The Illinois Plan

I am managing the Plan on behalf of the State of Illinois and can share some of the information about our Plan that is similar to most. We provide a maximum \$5,000,000 lifetime benefit and in 2011 offered two alternative plans. One provided for a \$1,000 deductible while the other called for a \$2,000 deductible.

For those unfamiliar with health insurance this means that covered individuals would pay the first either \$1,000 or \$2,000, depending upon their election, for medical care out of their own pocket. After paying that amount, medical and health care for covered services is reimbursed at the rate of 80 percent of approved charges for in-network care.

The Illinois Plan, like many insurers, uses a preferred provider network. If care is rendered by a

medical practitioner who is not within the network, coverage is provided at the rate of 60 percent of the charges with the individual responsible for the other 40 percent.

Similar coverage applies for prescription drugs. After meeting the deductible, the maximum out-of-pocket payment for medical or hospital care is \$2,350 if you are in the \$2,000 deductible Plan or \$3,350 if you are in the \$1,000 deductible Plan.

“In most instances, individuals who had polio and those contending with post-polio symptoms will meet the criteria of the prior health condition.”

Thus, regardless of Plan, in addition to paying your monthly premium, the maximum out-of-pocket anyone would spend in Illinois if covered by this Plan for medical or hospital care is \$4,350 in the network. For prescription drugs the maximum out-of-pocket is \$1,650. Thus, the maximum that one would pay, other than for premiums, out of their own pocket for covered services would be less than \$6,000 per year.

For 2012 we will be adding two additional Plans, a \$500 deductible Plan with terms similar to those discussed above and a \$5,000 deductible plan in which 100 percent of medical or pharmaceutical expenses for covered services above \$5,000 will be covered. As with most insurance products, the

lower your deductible, the higher your premium. In this way individuals who qualify can determine their ability to pay out-of-pocket and the cash flow which works best for them.

Other States' Plans

Most states offer comparable Plans although there are variations in each state.

The rates charged are not permitted to be more than what is termed 100 percent of the Standard Risk Rate in the state in which the Plan is offered. Standard Risk Rate is an insurance term that means the amount charged to a person for an individual insurance policy if that individual has no health conditions that would move them to a higher rate class. Thus, for those of us who have dealt with prior health conditions, the rates charged in these Plans is much lower than we would otherwise experience.

Many states have, for a number of years, offered their own so called high-risk pools for which those of us who had had polio would likely qualify. These federal plans differ in that the rates charged tend to be lower and there is no waiting, or pre-existing conditions, clause.

Again, however, you have to have been without insurance for six months first. In many insurance policies if one is covered, that coverage would not apply to any condition which you had on the date the policy was issued until periods of six or twelve months



▷ had passed. In these new federal plans, one can get a full range of medical care the day the policy is issued including for any previous condition.

Income Not a Qualification

This program was meant to be a bridge for people who previously could not secure health insurance and did not qualify for other government programs such as Medicare or Medicaid. There are no income tests to qualify for the program and a great many enrollees are working or have worked in the past and have assets, but could not secure insurance coverage.

“For those of us who have dealt with prior health conditions, the rates charged in these Plans is much lower than we would otherwise experience.”

The Plans are scheduled to go out of existence December 31, 2013, because the Affordable Care Act provides that as of January 1, 2014 insurance companies will be prohibited from denying coverage to people because of a pre-existing medical or health condition.

It is anticipated that individuals securing coverage from these Plans will be able to transition into a privately offered or state insurance exchange provided insurance plan in 2014.

How to Find Out More

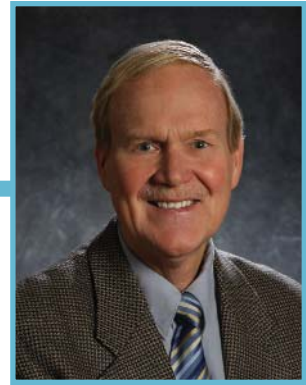
Anyone who has not had health insurance for six months and otherwise meets the qualifications for participation is encouraged to either contact your state Department of Insurance or go online to the website of the Department of Health and Human Services (www.hhs.gov) and to look for the terms “Pre-Existing Condition Insurance Plan” or “PCIP”. There you will find information about these Plans and links or phone numbers to the Plan offered in your state.

Our experience in Illinois, after less than 14 months of operation, is that with little fanfare or marketing we have provided in excess of \$25,000,000 of health care to approximately 2,500 people. Some have been in the Plan since it became operational, September 1, 2010, while others may be insured for a period of months and then drop out. Regardless, we have found this program to be a wonderful alternative for so many of us who could never secure health insurance in the past on our own. ▲

Saul J. Morse has been an attorney in the Springfield, Illinois, community for 30 years, concentrating his practice in governmental regulation, health care and lobbying. He has served as legislative counsel for a variety of organizations from the Illinois State Medical Society to the Chicago Cubs. He has served on a number of Illinois state commissions and boards, and in 2010, was appointed Program Director of the Illinois Pre-Existing Insurance Plan, a pool providing health insurance to individuals unable to secure insurance due to their health conditions.

Morse holds Adjunct Assistant Professor positions in Medical Humanities at the Southern Illinois University School of Medicine and in Legal Studies at the University of Illinois. He has been named by his peers as a Leading Lawyer of Illinois in the areas of municipal law, government affairs and health care.

A polio survivor, he contracted polio in 1949 at the age of 21 months. He is a member of the Post-Polio Health International board of directors and currently serves as treasurer.



Frederick M. Maynard, MD

Question: *I have been having a LOT of pain through my butt into my lower back. I looked up muscle groups and think I see what is causing the problem. I sit at my desk nine or so hours six days a week in order to survive financially. I never realized sitting in a wheelchair could atrophy some muscle groups. Do you have any words of wisdom for PPSers who use wheelchairs? At night I lie down after supper to watch TV and unwind.*

A: Sitting eight hours or more in a wheelchair – or any chair – can lead to lower back pain. The primary reason is tightness of back muscles and joints from remaining so long in a constant position, especially if the muscles are under constant low-grade contraction in order to hold and maintain the sitting position.

While it is true that prolonged sitting postures can lead to atrophy of the gluteal muscles that make up the buttocks, and atrophy can be associated with the development of back pain, in my experience atrophy is rarely the cause of that pain. This is true for ambulatory people as well as people with neuromuscular disabilities.

If you are sitting in a wheelchair, I presume you do not walk much, if at all. Do you do some standing and walking for even short periods? For how many years have you been using a wheelchair? Part-time or exclusively? Did you ever have much bulk to your gluteal muscles since acute polio?

Your answers to these questions and the duration of your problem with back pain are pertinent to the most likely cause of YOUR

back pain after long sitting and the best solutions.

Based on my experience with post-polio sitters who are developing new back pain after long sitting, especially as they are getting older and are doing more sitting than ever, I would recommend three primary management strategies:

1) Stretching exercises can be very helpful in reducing this type of back pain. You may require a good, detailed examination of your sitting posture, strength and flexibility by a physical therapist to identify exactly what type of stretching exercises and positions will best help your unique tightnesses that are contributing to your pain.

2) Posture breaks every one to two hours, for even five minutes each, can help minimize back pain from prolonged sitting. Standing up and arching your back, if possible, is one simple option. At the end of a long period of continuous sitting, lying down in a horizontal position and doing some simple stretching of the spine and hips is another option. This option may be quite difficult for some people with severe disabilities because of

SEND YOUR QUESTIONS
FOR DR. MAYNARD TO
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the help needed to do this, but it can be very helpful, even if only done once at the end of a long day of work-related sitting.

3) Ergonomic seating is another useful strategy. It may require a certified seating specialist (usually a PT or OT) to evaluate your sitting position in your usual chair. The amount of back support, the firmness/softness of the seat interface, the need for differential height of the seat to correct for asymmetry of buttock size and pelvic obliquity, the depth of the seat and the height of the seat from the floor or footrests are the most commonly needed changes to create an optimal sitting posture for long, pain-free sitting periods.

I hope you will find these suggestions helpful. Please get professional help if the simple suggestions don't help enough.

Question: *Can post-polio syndrome (PPS) be the cause of a nerve ending problem over the stomach region? I have annoying, tingling pains over the stomach region at about skin level or just below. It continues on and off throughout the day but not serious enough to wake me at night. The doctors I have visited can't seem to find a reason for the problem and suggested it may be PPS but don't know enough about PPS so I end up with no solution for the continuing mild pain. Also, temperature appears to affect me and brings the pains on.*

A: A tingling feeling over the stomach would not be a direct result of PPS, because polio never affects sensory nerve function. The only possibility that I can think of that might relate to your post-polio condition is if you have developed a problem in your back that is pinching any sensory nerve that comes out of the spine and runs along the ribs toward the upper abdomen. This is not uncommon

in people with long-existing scoliosis who undergo age-related changes in their vertebrae.

It could be addressed by a physiotherapist with special skills for mobilizing thoracic vertebrae and ribs. It could also represent a "referred pain" from a problem with your stomach or other abdominal organ. It should not simply be attributed to PPS. ▲

Dear Dr. Maynard:

Thank you for responding to my earlier letter about possible rotator cuff surgery. I write to tell you about two things that worked for me in regards to my rotator cuff pain.

One: A PT told me to always push up from a chair with my fingers pointing out. Doing the opposite with my fingers pointing in on the chair arm would damage my rotator cuff. I have found this to be true.

Two: I saw an article by Jane E. Brody in the *New York Times* (August 2, 2011) entitled "Ancient Moves for Orthopedic Problems." After three days of thirty seconds of a yoga exercise recommended by Loren Fishman, a rehabilitation specialist at New York-Presbyterian/Columbia hospital, the pain was almost all gone. Fishman's move is called the "triangular forearm support" and is an adaptation of the yoga triangular headstand.

I rest my forearms and head against the wall with my hands clasped making a triangle and gently push. The explanation as to why it works is that the maneuver trains the subscapularis (a muscle below the shoulder blade) to take over the job of the supraspinatus (muscle that raises the arm from below chest height to above the shoulder).

-Clara Reiss, New York, New York

Editor's Note: Go to www.nytimes.com/2011/08/02/health/02brody.html for a diagram of the "triangular forearm support."



Morton Freilicher and his wife Yseult.

Honoring Morton Freilicher on His 80th Birthday

The Edouard Foundation recently acknowledged the exemplary life of Morton Freilicher by donating \$5,000 in honor of his 80th birthday to support the activities of Post-Polio Health International.

Born in Brooklyn, New York, Freilicher received his law degree from Columbia Law School as a Harlan Fiske Stone scholar eight years after he contracted polio at age 17, which left him with total paralysis in his right arm and partial paralysis in his left arm, neck and diaphragm.

During his professional career, specializing in trusts and estates, he was a partner in the New York-based law firm of Phillips Nizer LLP. He authored a book on estate planning and taught as an adjunct professor at Fordham Law School.

After retirement, Freilicher donated his services to the work of the Edouard Foundation, which supports disaster relief, medical care and research and aid to the impoverished throughout the world.

Due to the effects of polio, he has used nighttime ventilation for more than 25 years. He says he credits his continuing survival to “staying active, exercising my usable muscles, benefiting from the nighttime ventilator, a wonderfully loyal wife and plain old-fashioned good luck!” ▲

More Research About Bisphosphonate Treatment in Polio Survivors

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if bisphosphonates are the cause, these unusual femur fractures have been predominantly reported in patients taking bisphosphonates.”

And, lastly they report that “the optimal duration of bisphosphonate use for osteoporosis is unknown.” Current data support fracture reduction efficacy through at least three years of treatment and, in some cases, through five years. Because of this data, many physicians suggest a “drug holiday.”

Another unknown is how often should women be re-screened using BMD. A study, *Bone-density testing interval and transition to osteoporosis in older women*, (ML Gourlay, et. al.) published in the January 19, 2012, issue of *The New England Journal of Medicine* suggests that women with a very good baseline bone density at 67 may not need screening again for 5 to 15 years.

What to Do?

So, how can an individual polio survivor decide what decision to make about bisphosphonate use?

Experts suggest that we individually educate ourselves and work with a trusted primary care physician. As we concluded in the first article, decisions can be guided by your individual fall risk and individual fracture risk, your response to previous therapies and your remaining life expectancy. ▲

Thank you

For recognizing your friends and loved ones with contributions to support the unique mission of PHI and IVUN. PHI strives to publish an accurate list. Please contact us if we made an error.

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The Chervenak-Nunnallé Foundation	ResMed Corporation
Alan Fiala Estate	Mildred Annice Smith Estate
Helen H. Ford	

Did You Know?

You can use Post-Polio Health International's secure "shopping cart" on our website, post-polio.org, where you can:

- Renew your Membership to PHI and IVUN.
- Become a Member of PHI or IVUN for the first time.
- Purchase PHI or IVUN publications.
- Donate to PHI or IVUN to support its ongoing mission.
- Donate to PHI's Research Fund.
- Donate to PHI or IVUN in memory or in honor of a loved one.

Visit us soon and start shopping!

Inside *Post-Polio Health* (Vol. 28, No. 1, Winter 2012)

Is a Pre-existing Condition Insurance Plan the Right Fit for You? p.1 ■ More Research About Bisphosphonate Treatment in Polio Survivors p.3 ■ and more.

WE NEED YOU! To Help PHI Find Researchers For Post-Polio Studies

PHI's Research Fund will award a \$25,000 grant in the fall of 2012 to the successful applicant whose project aims to improve the lives of polio survivors and/or users of home mechanical ventilation.

We are looking for new and creative research projects: Projects that will examine post-polio problems from a unique perspective. Or, projects that will move beyond the identification and quantification of known problems and will provide solutions.

PHI will also consider funding for pilot studies that will generate data to be used in obtaining larger grants.

We encourage you, our Members, to help spread the word about this opportunity to your circles of colleagues and friends. Or, send us names of researchers and we will send the "Call" directly to them.

The "Call for Proposals," which includes detailed criteria and submission requirements, can be accessed at www.post-polio.org/res/rfcall.html

DEADLINES:	Postmark deadline for Phase 1:	Friday, May 4, 2012.
	Invitation to submit for Phase 2:	Friday, July 13, 2012
	Postmark deadline for Phase 2:	Friday, October 5, 2012.
	Final decision:	Friday, December 14, 2012.



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