Time to Get Your Flu Shot

Who should get a flu vaccine this season?

Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk of serious complications from influenza. Flu vaccination has important benefits. It can reduce flu illnesses, doctors’ visits, and missed work and school due to flu, as well as prevent flu-related hospitalizations and deaths.

Different flu vaccines are approved for use in different groups of people.

- There are flu shots approved for use in children as young as 6 months old and flu shots approved for use in adults 65 years and older.
- Flu shots also are recommended for pregnant people and people with certain chronic health conditions.
- The nasal spray flu vaccine is approved for use in non-pregnant people who are 2 years through 49 years of age. People who are pregnant and people with certain medical conditions should not receive the nasal spray flu vaccine.

There are many vaccine options to choose from. CDC does not recommend any one flu vaccine over another. The most important thing is for all people 6 months and older to get a flu vaccine every year. If you have questions about which flu vaccine to get, talk to your doctor or other health care professional.

Most people should be vaccinated for influenza each year, but some people should not be vaccinated, or should not receive some types of influenza vaccines, depending upon things such as their age, health (current and past) and whether they have certain allergies.
**People who CAN get the flu shot:**

Flu shots are appropriate for most people.

- Different flu shots are approved for people of different ages. Everyone should get a vaccine that is appropriate for their age.
- There are standard-dose inactivated influenza vaccines that are approved for people as young as 6 months of age. Some vaccines are only approved for adults. For example, the recombinant influenza vaccine is approved for people aged 18 years and older, and the adjuvanted and high-dose inactivated vaccines are approved for people 65 years and older.
- Pregnant people and people with certain chronic health conditions can get a flu shot.
- People with egg allergy can get a flu shot.

**People who SHOULD NOT get a flu shot include:**

- Children younger than 6 months of age are too young to get a flu shot.
- People with severe, life-threatening allergies to any ingredient in a flu vaccine (other than egg proteins) should not get that vaccine. This might include gelatin, antibiotics, or other ingredients.
- People who have had a severe allergic reaction to a dose of influenza vaccine should not get that flu vaccine again and might not be able to receive other influenza vaccines. If you have had a severe allergic reaction to an influenza vaccine in the past, it is important to talk with your health care provider to help determine whether vaccination is appropriate for you.

**People who SHOULD talk to their health care provider before getting a flu shot:**

If you have one of the following conditions, talk with your health care provider. He or she can help decide whether vaccination is right for you, and select the best vaccine for your situation:

- If you have an allergy to eggs or any of the ingredients in the vaccine. Talk to your doctor about your allergy.
- If you ever had Guillain-Barré Syndrome (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get a flu vaccine. Talk to your doctor about your GBS history.
- If you had a severe allergic reaction to a previous dose of any other flu vaccine, talk to your health care provider.
- If you are not feeling well, talk to your doctor about your symptoms.

**People who CAN get a nasal spray flu vaccine:**

The nasal spray vaccine is approved for people 2 years through 49 years of age. Many people in this age group can receive the nasal spray vaccine, including people with egg allergies. The nasal spray vaccine is not recommended for some groups.

**People who SHOULD NOT get a nasal spray vaccine:**

- Children younger than 2 years of age.
- Adults 50 years of age and older.
- People who have had a severe or life-threatening allergic reaction to any ingredient in the nasal spray vaccine (other than egg proteins).
- People who have had a severe allergic reaction to any flu vaccine.
- Children and adolescents 2 through 17 years of age who are receiving aspirin- or salicylate-containing medications.
- People with weakened immune systems (immunosuppression) due to any cause, including (but not limited to) immunosuppression from medications, congenital or acquired immune disorders, HIV infection, or asplenia.
**People who SHOULD talk to their health care provider before getting a nasal spray vaccine:**

If you have one of the following conditions, talk with your health care provider. He or she can help decide whether vaccination is right for you, and select the best vaccine for your situation:

- People with asthma 5 years and older.
- People with other underlying medical conditions that can put them at higher risk of developing serious flu complications. These include conditions such as chronic lung diseases, heart disease (except isolated hypertension), kidney disease, liver disorders, neurologic and neuromuscular disorders, blood disorders, or metabolic disorders (such as diabetes).
- People with moderate or severe acute illness with or without fever.
- People with Guillain-Barré Syndrome after a previous dose of influenza vaccine.

**Who Should be Prioritized for Flu Vaccination During a Vaccine Shortage?**

When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to the following people (no hierarchy is implied by order of listing):

- Children aged 6 months through 4 years (59 months).
- People aged 50 years and older.
- People with chronic pulmonary (including asthma) or cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus).
- People who are immunosuppressed due to any cause, including immunosuppression caused by medications or by human immunodeficiency virus (HIV) infection.
- People who are or will be pregnant during the influenza season and people up to two weeks after delivery.
- People who are aged 6 months through 18 years who are receiving aspirin or salicylate-containing medications and who might be at risk for experiencing Reye syndrome after influenza virus infection.
- People who are residents of nursing homes and other long-term care facilities.
- American Indian or Alaska Native persons.
- People with extreme obesity (body-mass index [BMI] is 40 or greater).
- Health care personnel.
- Household contacts and caregivers of children under 5 years and adults aged 50 years and older; and
- Household contacts and caregivers of people with medical conditions that put them at increased risk for severe illness and complications from influenza.

Among adults, complications, hospitalizations, and deaths due to influenza are generally most common among people 65 years and older. However, adults 50 years and older are a priority group for vaccination because they may be more likely to have chronic medical conditions that put them at higher risk of severe influenza illness.

People with egg allergies can receive any licensed, recommended age-appropriate influenza vaccine (IIV4, RIV4, or LAIV4) that is otherwise appropriate. People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting, supervised by a health care provider who is able to recognize and manage severe allergic reactions.

For more information, visit: [https://www.cdc.gov/flu/prevent/whoshouldvax.htm](https://www.cdc.gov/flu/prevent/whoshouldvax.htm)

**CDC Director Adopts Preference for Specific Flu Vaccines for Seniors**

CDC Director Rochelle P. Walensky, M.D., M.P.H., adopted the Advisory Committee on Immunization Practices’ (ACIP) recommendation to preferentially recommend the use of specific flu vaccines for adults 65 years and older, including higher dose and adjuvanted flu vaccines. The preference applies to Fluzone High-Dose Quadrivalent, Flublok Quadrivalent and Fluad Quadrivalent flu vaccines.

While flu seasons vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease, accounting for most flu-related hospitalizations and deaths. Additionally, changes in the immune system with age mean that older adults often do not have as strong an immune response to vaccination as younger, healthy people.

“Given their increased risk of flu-associated severe illness, hospitalization, and death, it’s important to use these potentially more effective vaccines in people 65 years and older,” said José R. Romero, M.D., Director of CDC’s National Center for Immunization and Respiratory Diseases. Additionally, data has shown that racial and ethnic health disparities exist in populations that receive a high-dose flu vaccine compared with standard-dose flu vaccines. “This recommendation could help reduce health disparities by making these vaccines more available to racial and ethnic minority groups,” said Dr. Romero.
Last Thursday, ACIP voted to preferentially recommend the use of higher dose flu or adjuvanted flu vaccines over standard-dose unadjuvanted flu vaccines for people 65 years and older. This recommendation was based on a review of available studies which suggests that, in this age group, these vaccines are potentially more effective than standard dose unadjuvanted flu vaccines. Dr. Walensky’s adoption of the ACIP recommendation makes this recommendation official CDC policy, which will be further detailed in an upcoming Morbidity and Mortality Weekly Recommendation Report later this summer.

In recent years, CDC has not recommended any one flu vaccine over another for any age group, and there is still no preferential recommendation for people younger than 65. People 65 and older should try to get one of the three preferentially recommended vaccines, however, if one of these vaccines is not available at the time of administration, people in this age group should get a standard-dose flu vaccine instead.

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CDC works 24/7 protecting America’s health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

For more information, visit: https://www.cdc.gov/media/releases/2022/s0630-seniors-flu.html
Increasing Influenza (Flu) Vaccination Rates Among US Black Adults
NFID Survey and Partner Consultation Summary
May 2022

Background

In the US, communities of color are disproportionately impacted by both influenza (flu) and COVID-19. Racial and ethnic disparities in flu vaccination coverage continue across the lifespan, contributing to overall poorer health outcomes in communities of color. According to the Centers for Disease Control and Prevention (CDC), compared with flu vaccination coverage for White adults, coverage was 16.3 percentage points lower for Black adults and 17.4 percentage points lower for Hispanic adults during the 2021-2022 flu season.

In December 2021, the National Foundation for Infectious Diseases (NFID) conducted a national survey assessing Black adult (age 18-49 years) knowledge and attitudes toward flu and COVID-19 vaccination, including changes since the 2020-2021 flu season as well as a deeper look into the factors that influence vaccine uptake among younger adults. NFID developed a subsequent strategy to leverage the survey results as formative research to develop targeted communications to help raise awareness of the importance of flu prevention and to increase flu vaccination rates among US Black adults age 18-49 years during the 2022-2023 flu season.

Key Survey Results

- Among Black adults age 18-49 years, a greater number reported getting vaccinated against flu and COVID-19 during the 2021-2022 season compared to the 2020-2021 flu season survey.
- More than 8 in 10 of those who have or who plan to get vaccinated think it is the best way to avoid flu-related deaths and hospitalizations.
- Among those who have received or plan to get a flu vaccine, top reasons reported were to protect themselves and/or their families.
- Among those who do not plan to get a flu vaccine or who are unsure, the most common reasons cited were concerns about side effects, never getting sick with flu, or vaccine efficacy.
- Approximately 4 in 10 Black adults under age 50 years say they would be more likely to get a flu vaccine if their mother or a Black healthcare professional recommended it.
- Only 20 percent say the recommendation of a religious leader would make them more likely to get vaccinated.
- Among parents who were not planning to get their child vaccinated against flu or COVID-19, about half say it is because they are concerned about side effects of the vaccines.
- When receiving information about flu vaccines, healthcare professionals were the most trusted source of information for nearly half of Black adults under age 50 years.
Consultations

In March-April 2022, NFID conducted consultations with potential new partners with deep connections to US Black audiences, to inform them about the survey results and NFID efforts to elevate the importance of flu vaccines among this population, obtain feedback, and discuss potential collaboration.

NFID conducted outreach to 34 organizations whose missions range from facilitating public health, eliminating health disparities, promoting the interests of professionals, and mentoring within the US Black community. A consultation guide deck was used to summarize the key findings of the survey and provide opportunities for open discussions.

To date, calls have been conducted with the following leading national organizations: BlackDoctor.org, the Center for Black Equity, National Black Nurse Practitioner Association, National Coalition of Ethnic Minority Associations, National Minority Quality Forum, and the People’s Institute for Survival and Beyond.

By building relationships and receiving feedback from these organizations, NFID hopes to maximize the reach of targeted messages in increasing flu vaccination rates among US Black communities.

Summary of Key Themes

Increase in vaccine acceptance: Most organizations corroborated NFID survey data about self-reported vaccination rates, having observed increased acceptance for both flu and COVID-19 vaccines in the Black community. One organization leader shared that while they have not seen an increase in vaccination rates, they have noticed an increase in testing behaviors, such as for COVID-19.

“Prevention is becoming a part of the everyday lifestyle.”
Focus on risk mitigation: According to many of the organizations, the Black community has wholeheartedly embraced risk mitigation behaviors—testing, mask wearing, social distancing (when possible)—and has continued to adhere to these, even while other communities begin to de-emphasize such behaviors. This positive behavior, combined with increased public education and news coverage about the benefits of vaccination and continued risk mitigation behaviors is contributing to a shift from vaccine hesitancy to vaccine acceptance. In addition, according to many of the organizations, the Black community increasingly believes the best option is to get vaccinated to avoid risks including hospitalization and death.

Community engagement and personal stories are critical: Multiple organizations shared that engaging community leaders as trusted messengers is important because they often know their communities best and can provide information directly to community members. While only 20 percent of NFID survey respondents said a religious leader would influence their vaccination intention, organization leaders reported that teaming pastors with clinicians can help spread accurate information within the community. Organizations also cited examples such as workshops held in beauty salons and barber shops since relevant conversations often take place in these settings. Leaders also report that testimonials and personal stories from real people can play an important role in encouraging vaccination.

Side effects and not getting sick among most common barriers to flu vaccination: Organizations corroborated NFID survey findings that among those who do not plan to get a flu vaccine or who are unsure, one of the key barriers is a concern that the vaccine would cause adverse reactions. They also shared that parents are less likely to get their children vaccinated due to concerns about side effects from the vaccine.

Black healthcare professionals have the greatest influence on flu vaccination behaviors: Organizations agreed with NFID survey findings that when it comes to receiving information about flu vaccination, healthcare professionals were the most trusted source of information. There are many Black adults who are aware of and still refer to historical events (e.g., the Tuskegee Experiment and Henrietta Lacks), that influence current vaccine decisions. Organizations emphasized that patients feel more comfortable when receiving care from a Black healthcare professional because the patient feels understood and heard. Organizations recommend that Black healthcare professionals inform their patients that they themselves have received their flu vaccine and their other Black patients also get vaccinated. Two organizations pointed out that this may not be true for all communities including the LGBTQIA+ community who may be less likely to trust a healthcare professional.

“We know that we win when we take care of ourselves and continue to follow risk mitigation behaviors.”

“If the messenger does not look like us, we won’t retain the information.”
Reaching younger populations through online influencers: Consultations revealed that younger Black adults are more likely to trust information obtained from social media and may not believe healthcare professionals as much as older people do unless they are on social media. Identifying, and working with healthcare professionals who have a strong social media presence can help develop stronger connections with younger audiences and build a peer-to-peer network.

The Black community is becoming primed for scientific information: While some organizations shared concerns about lower levels of health literacy and limited access to educational materials about vaccination within Black communities, others noted that the COVID-19 pandemic has led the Black community to be more knowledgeable and primed for scientific information. COVID-19 has allowed communicators, healthcare professionals, and influencers to have more in-depth conversations about topics like vaccination. However, one leader also indicated that there is a need to ensure that the medical community addresses vaccine hesitancy to be able to effectively convey messages to community members. Others pointed out that advocates of natural remedies play a role in spreading misinformation, and they also need to be better educated on this issue.

Family members and tradition influence vaccination rates: Organization leaders noted that concerns about getting a vaccine sometimes stem from family tradition and other members of their family not wanting to be vaccinated. This logic is consistent with NFID survey results which found that mothers had a significant influence on vaccination decisions. One leader emphasized that it is important for people to follow the science and not solely the advice of their family members.

The importance of tailoring messages: Organizations shared how COVID-19 emphasized the need to tailor messages for the Black community. For example, early in the pandemic, many Black adults still needed to be at work in person, so the idea of staying home and social distancing had to be repositioned to “how do you stay safe, while still going to work?” One leader shared that including a Black person in materials like advertisements is not enough. Key messages must also be tailored to reach the audience effectively.

“You cannot just put a Black person in an advertisement—you must change your messaging and emphasis points.”

The need to focus on ‘whole health’ for the Black community: One leader shared that there should be equal concern and investment in treating and preventing diabetes, high blood pressure, and other chronic health issues in the Black community. Vaccination should be included in holistic conversations about health.
Next Steps for Partnering

1. NFID invites stakeholder organizations to partner in the NFID Leading by Example initiative, which calls on organizations/companies to make a commitment to flu prevention, through the following activities during the 2022-2023 flu season:
   - Support and promote the NFID Commitment to Influenza Prevention
   - Share photos and/or videos of key organization leaders getting vaccinated to help #FightFlu
   - Encourage followers to share Leading by Example social media posts on Facebook, Twitter, Instagram, and other social media channels

2. Join NFID for the 2022 NFID Flu/Pneumococcal Disease News Conference in early October to receive key updates about the upcoming flu season from leading medical experts. The NFID news conference serves as agenda-setting media event that reflects changing medical, scientific, and public health priorities relevant to the upcoming flu season. For 20+ years, NFID has partnered with government, industry, and leading non-profits to reach wide-ranging audiences about influenza and pneumococcal disease. NFID will also work with certain partners to test messaging and materials for specific audiences.

3. Through these consultations, NFID has gained valuable insights on how to better reach the Black community with appropriate flu vaccination messages. We hope that these new relationships will set the foundation for future partnerships and meaningful collaboration. We welcome opportunities to work together to continue to raise awareness about flu and increase flu vaccination rates within the Black community.
Did You Receive a Letter from the Social Security Administration? Here’s What You Need to Know

Key Takeaways

• The Social Security Administration (SSA) mails letters each spring to people who might be able to save money on Medicare costs.
• Get help from a local Medicare or benefits counselor to see whether you’re eligible for these cost savings.
• Did you just get a letter from SSA? Here’s what you need to know and what you should do next.

You open your mail to find a letter saying you may be able to get help paying for the costs of Medicare. It appears to be from the Social Security Administration (SSA) ...but is it for real? Here’s what you need to know and what you should do next.

Is this letter from the Social Security Administration (SSA) a scam?

No. Every year in May and June, SSA sends letters (see example letter on pages 11-12) to people with Medicare who may be eligible for two money-saving programs that can help them afford their prescriptions and health care costs.

What are these money-saving programs?

• The Medicare Part D Extra Help program (also known as the Part D Low Income Subsidy, or LIS) helps pay your Part D drug plan premium and saves you money on medications at the pharmacy. If you qualify for Extra Help, you will pay no more than $9.85 for your prescriptions for each drug your plan covers.

• The Medicare Savings Program (MSP) pays your Part B premium each month. It also may help pay for other costs in Medicare, such as your Part B deductible and co-pays at the doctor’s office.

Why did I get a social security letter?

Social Security sent you this letter because you are enrolled in Medicare and, based on your monthly Social Security benefit, you appear to have an income that qualifies you for these programs.

Getting this letter does not mean you automatically qualify for these programs. You still need to fill out an application for each program.

Where can I get help with an application?

To get in-person help with an Extra Help/MSP application:

• Contact your State Health Insurance Assistance Program (SHIP). SHIPs are federally funded to provide free, objective assistance to people with Medicare and their families. Find your SHIP at www.shiphelp.org or call toll-free 1-877-839-2675.

• Find out if there’s a Benefits Enrollment Center (BEC) near you. BECs help people with Medicare apply for all the programs they may be missing out on. You can also apply for Extra Help online through BenefitsCheckUp® website by visiting https://benefitscheckup.org/medicare-rx-extra-help-application/. It’s free, confidential, and can screen you for thousands of other benefits programs at the same time.

How do I know if other letters I receive are a scam?

Scammers are known to pose as agents of the federal government. If you receive a letter from Social Security and are not sure if it is real or not, you can verify it by calling 1-800-772-1213. SSA also encourages people to set up an account at My Social Security to be able to check notices and your benefits at any time.

For more information, visit: https://www.ncoa.org/article/did-you-receive-a-letter-from-social-security-heres-what-you-need-to-know
You may be eligible to save $2,041.20 or more in Medicare costs through a Medicare Savings Program or Extra Help.

If you can’t afford Medicare premiums or other medical costs, you may be able to get help through Medicare Savings Programs or Extra Help.

- Medicare Savings Programs can help pay for costs under Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), which could include help with premiums, deductibles, coinsurance, and/or copayments.
- Extra Help is a program that can help pay for costs under Medicare prescription drug coverage (Part D), which could include help with deductibles, premiums, and copayments. You need to enroll in a Medicare Part D plan to get Extra Help.

**Medicare Savings Programs**

The type of help you may qualify for depends on your income and total resources. To qualify for a Medicare Savings Program, your monthly income and total resources (like money in a bank, stocks, or bonds) must be at or below the amounts shown in this table:

<table>
<thead>
<tr>
<th>Medicare Savings Programs</th>
<th>2022 Monthly Income Limit*</th>
<th>2022 Total Resource Limit**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$1,549</td>
<td>$8,400</td>
</tr>
<tr>
<td>Married (living together)</td>
<td>$2,080</td>
<td>$12,600</td>
</tr>
</tbody>
</table>

* The income limits are higher in Alaska and Hawaii. Many states let you have more income than the figures listed above. If you or your spouse work, some of your earned income won’t be counted toward your eligibility.

** Some states let you have more resources and some states may have no resource limit at all. Your house, car, and up to $1,500 per person in burial expenses don’t count as resources.
You can visit ssa.gov/extrahelp to get more information and apply for Extra Help online. You can also call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) to apply over the phone or request a paper application. Visit ssa.gov/locator to get the telephone number for your local Social Security office.

Note: If you apply for Extra Help, you may not have to apply again for a Medicare Savings Program. Social Security will send your information to your state so they can start your application for a Medicare Savings Program, unless you tell us not to.

Have questions about Medicare or Medicare drug plans?

Your State Health Insurance Assistance Program (SHIP) can help answer any Medicare questions you may have. To get the phone number for your local SHIP office, visit shiphelp.org or look in your “Medicare & You” handbook. For more information about Medicare, visit Medicare.gov or call 1-800-MEDICARE.

Social Security Administration

Centers for Medicare & Medicaid Services
job loss during the early months of the pandemic were among those with the highest job gains during this recovery, with leisure and hospitality leading the way, followed by professional and business services. Financial activities and retail were also back to their pre-pandemic employment levels.

While among the major industry groups only utilities saw a negative year-over-year change in employment in 2021, some parts of the economy have not yet fully recovered. A few industries, such as health care and social assistance industries, made progress in reaching their pre-pandemic employment levels but could not fully make up for the ground lost in the last two years.

More recent and detailed industry data reveal that the hospital and nursing and residential care facilities sub-sectors of the health care industry had notably fewer jobs in May 2022 compared with May 2021. In some industries, the slower recovery of jobs is being driven by lower demand. However, staffing declines in hospitals, nursing, and residential care facilities largely stem from recruiting challenges and worker shortages as opposed to a shortage of available jobs—ultimately resulting in declining employment in these areas.

**Gains on the Demographic Side**

Labor force participation rates (LFPR), which dropped sharply after the start of the pandemic, have also recovered across many worker demographics. For example, May 2022 data show that among workers ages 25 to 34, the LFPR was 83.8 percent compared with 83.7 percent in February 2020, pre-pandemic. The LFPR for workers ages 55 to 64 was 65.4 percent in May 2022, compared with 65.5 percent in February 2020. A more buoyant labor market drew many workers back into the job market, especially as some employers responded to increased recruiting difficulty with more flexible work options and higher wages.

Yet despite these trends, in May the seasonally unadjusted LFPR among workers ages 65 and older was 19.2 percent, remaining below the pre-pandemic rate of 20.8 percent in February 2020. A return to the job market after traditional retirement age is generally less likely than it is among younger workers; nevertheless, workers in the 65+ age group can be drawn back into the workforce under certain conditions. For some, the financial need to work in retirement is the main driver, and thus rising inflation could influence the decision to return to work.

For others, better working conditions offered by employers with more flexibility and teleworking or higher wages could encourage some to reenter the workforce.

**Historic Cross-Industry Gains**

The CES data show that total nonfarm payroll employment in the United States continued to recover in 2021 from the job losses of 2020, with employment increasing by 6.7 million jobs last year. This was the largest calendar-year gain in the history of the CES employment series and the strongest relative gain (+4.7 percent) since 1978.

The CES data show that nearly all major industries experienced employment gains. Industries that experienced high levels of

A new analysis of Current Employment Statistics (CES) industry survey data by Bureau of Labor Statistics (BLS) economist Maria Ramos shows that employment levels have recovered across many industries. Meanwhile, the latest monthly employment data show that labor force participation rates have also recovered to pre-pandemic levels among many demographic groups, including workers ages 55 to 64. Yet the same cannot be said of the 65+ workforce. Underpinning the dynamics for this age group is that many of these workers who retired during the pandemic were already at or beyond retirement age. This makes it less likely that they will return to the workforce—though larger numbers returning is not an impossibility, especially considering certain economic trends as well as if employers take more steps to promote an age-diverse workforce.
Employers may also increasingly shape their recruiting efforts to appeal to a more age-diverse talent pool, resources.

For more information, visit: https://blog.aarp.org/thinking-policy/labor-force-participation-65-remains-below-pre-pandemic-levels

FACT SHEET: Biden-Harris Administration’s Monkeypox Outbreak Response

For years, the United States has invested in research on monkeypox and in tools to effectively respond to the disease. Monkeypox is a virus that is generally spread through close or intimate contact, with symptoms that include a rash and fever. It is much less transmissible than fast-spreading respiratory diseases like COVID-19, and this outbreak has not caused any deaths in the United States.

The virus, however, is spreading in the United States and globally, and requires a comprehensive response from federal, state, local, and international governments, and communities. Since the first United States case was confirmed on May 18, President Biden has taken critical actions to make vaccines, testing, and treatments available to those who need them as part of its whole-of-government monkeypox outbreak response.

Today, the Biden-Harris Administration announced the first phase of its national monkeypox vaccine strategy, a critical part of its monkeypox outbreak response. The vaccine strategy will help immediately address the spread of the virus by providing vaccines across the country to individuals at high risk. This phase of the strategy aims to rapidly deploy vaccines in the most affected communities and mitigate the spread of the disease.

This announcement is a critical component of the Administration’s broader public health response, which includes rapidly scaling up and decentralizing testing alongside continued provider education and community engagement across the country.

The Administration’s monkeypox outbreak response is also informed by the multiple times over the last twenty years that the United States has effectively responded to the virus. The United States government’s response is coordinated by the National Security Council Directorate on Global Health Security and Biodefense – more commonly known as the White House Pandemic Office – which President Biden restored on day one of his presidency, in collaboration with the Department of Health and Human Services (HHS).

Collectively, the Administration’s efforts aim to expand vaccination for individuals at risk and make testing more convenient for healthcare providers and patients across the country. The Biden-Harris Administration remains committed to working with urgency to detect more cases, protect those at risk, and respond rapidly to the outbreak.

Scaling and Delivering Vaccines to Mitigate New Infections: Thanks to prior investments in health security and the nation’s prior experience responding to the monkeypox virus, the United States has effective vaccines and treatments that can be used against monkeypox. To date, HHS has received requests from 32 states and jurisdictions, deploying over 9,000 doses of vaccine and 300 courses of antiviral smallpox treatments. With today’s national monkeypox vaccine strategy, the United States is significantly expanding deployment of vaccines, allocating 296,000 doses over the coming weeks, 56,000 of which will be allocated immediately. Over the coming months a combined 1.6 million additional doses will become available.

Making Testing Easier: The new national monkeypox vaccine strategy builds on the Administration’s efforts to make testing more widely available and easier to access. On day one of this outbreak, providers had access to a high-quality, FDA-cleared test to detect monkeypox. The CDC has since scaled testing capacity to 78 sites in 48 states, primarily at state public health laboratories, with spare capacity to conduct nearly 10,000 tests per week nationwide.

Last week, CDC began shipping tests to five commercial laboratory companies, including some of the nation’s largest reference laboratories, to further increase monkeypox testing capacity and access in every community. This action will dramatically improve convenience for patients and health care providers across the nation.

Activating Community Leaders and Stakeholders: The response to monkeypox requires a whole-of-society effort between federal, state, territorial, and local governments and communities. The Biden-Harris Administration is communicating with healthcare providers, public health officials, and affected communities on a daily basis to share information on what the virus is, how to treat it, and which communities are most at risk.
Administration is also sharing information on how to access testing, treatments, and vaccines, and how to prevent transmission with local, government, and community leaders in geographies and communities where transmission rates have been the highest. The Administration is grateful for the leadership and activism of advocates in the LGBTQI+ community who have thus far been most affected and have quickly mobilized to promote information and awareness.

The Biden-Harris Administration is providing vaccines to protect high-risk groups across America

As part of the monkeypox outbreak response, the Biden-Harris Administration is launching a national strategy to provide vaccines for monkeypox for individuals at higher risk of exposure. The strategy aims to mitigate the spread of the virus in communities where transmission has been the highest and with populations most at risk. This plan distributes the two-dose JYNNEOS vaccine, which the Food and Drug Administration (FDA) approved for protection against smallpox and monkeypox in individuals 18 years and older determined to be at high risk for smallpox or monkeypox infection. States will be offered an equitable allotment based on cases and proportion of the population at risk for severe disease from monkeypox, and the federal government will partner with state, local, and territorial governments in deploying the vaccines.

The goal of the initial phase of the strategy is to slow the spread of the disease. HHS will immediately allocate 56,000 vaccine doses currently in the Strategic National Stockpile to states and territories across the country, prioritizing jurisdictions with the highest number of cases and population at risk. To date, vaccines have been provided only to those who have a confirmed monkeypox exposure.

With these doses, CDC is recommending that vaccines be provided to individuals with confirmed monkeypox exposures and presumed exposures. This includes those who had close physical contact with someone diagnosed with monkeypox, those who know their sexual partner was diagnosed with monkeypox, and men who have sex with men who have recently had multiple sex partners in a venue where there was known to be monkeypox or in an area where monkeypox is spreading.

In the coming weeks, HHS expects to receive an additional 240,000 vaccines, which will be made available to a broader population of individuals at risk. HHS will hold another 60,000 vaccines in reserve. As additional doses are received from the manufacturer, HHS will make them available to jurisdictions to expand availability to the vaccine for individuals with elevated risk. HHS is increasing the availability of doses by leveraging its long-standing partnership with the manufacturer of JYNNEOS to expand vaccine supply and by accelerating completion and shipment of doses to the United States. HHS expects more than 750,000 doses to be made available over the summer. An additional 500,000 doses will undergo completion, inspection, and release throughout the fall, totaling 1.6 million doses available this year.

To supplement the supply of JYNNEOS, states and territories may also request a second vaccine, ACAM2000. ACAM2000 is FDA-approved for protection against smallpox, caused by the variola virus. ACAM2000 is also believed to confer protection against monkeypox and is available under an expanded access investigational new drug protocol sponsored by CDC for vaccination of individuals at risk of monkeypox infection. However, ACAM2000 carries greater risk of certain serious side effects than JYNNEOS and cannot be provided to individuals who are immunocompromised or who have heart disease. The CDC will work with state, territorial, and local health departments requesting the ACAM2000 vaccine to ensure that individuals are fully informed on the benefits and the risks before receiving the vaccine.

HHS will work closely with local and state partners and health providers to continuously evolve and strengthen its vaccine strategy to ensure that vaccines are being made available to communities most at risk and where transmission has been highest.

The Administration is expanding testing supply and availability.

Last week, CDC began shipping its FDA-cleared orthopox test to five major commercial laboratory companies to rapidly increase monkeypox testing access across the country. This action will dramatically expand testing capacity nationwide and convenience for patients and health care providers. These laboratories will begin to come on board for testing in early July and increase capacity through the month.

This expansion reflects the latest, most significant increase in testing accessibility, building on the capacities already available within the Laboratory Response Network (LRN). CDC has worked with the LRN to increase public health testing capacity by more than 50% since the start of the outbreak, increasing testing capacity from 6,000 tests per week to approximately 10,000 test per week.
This network continues to provide spare testing capacity to jurisdictions across the country. CDC is working with state, territorial, and local health departments to make the monkeypox testing process more accessible to health care providers.

To further expand access to testing early in the outbreak, CDC published its protocol from their FDA-cleared test on June 9, 2022 for any laboratory to test for monkeypox. The FDA is exercising enforcement discretion regarding CDC’s tests, which permits the use of tests beyond the current network. FDA has also authorized the use of additional reagents and automation to increase the capacity of laboratories using the CDC test.

Since the start of the monkeypox outbreak, the number of days from average symptom onset to test has decreased by approximately 35%, enabling patients to more quickly learn their diagnosis, access care, and prevent spread to others. The expansion of testing aims to facilitate further reductions in the gap between symptom onset and test result, maximizing access to treatment and vaccines for patients and high-risk contacts early in the course of disease.

The Administration has launched a robust community and stakeholder engagement strategy

The most effective response to infectious disease outbreaks is a community-based response. The Biden-Harris Administration is communicating with healthcare providers, public health officials, and communities on a daily basis to raise awareness of the monkeypox outbreak and educate the public and local and community leaders about what the virus is, how it is transmitted, and which populations are most at risk of the virus. As part of its robust engagement strategy, the Administration is facilitating access to vaccines, treatments, and tests.

The Administration will also continue to engage directly with leaders and stakeholders in the LGBTQI+ community to work together to prevent and combat stigma and bias and promote testing and vaccine access and health equity for LGBTQI+ communities. Through its comprehensive stakeholder engagement strategy, the Administration is also creating a critical feedback loop – learning from the experiences of those most at risk and responding based on their insights and needs.

HHS has provided a range of public health information to inform providers and high-risk communities, including:

- Updating and expanding the monkeypox case definition by June 14th to encourage health care providers to consider testing for all rashes with clinical suspicion for monkeypox;
- Releasing emergency information on May 20th and June 14th covering clinical testing, treatment, contact tracing, and other topics to health providers, sexual and community health centers, and public health officials across the nation;
- Providing over 570 case consultations to healthcare providers and health departments;

Clarifying how to transport and dispose of medical waste that allowed healthcare facilities and waste management companies to operate confidently and safely; and, Regularly speaking with global, community, clinical, and public health stakeholders to solve challenges and answer questions. HHS and CDC will continue to engage with the public and communities most impacted and at risk on a daily basis throughout the response.

The Administration is leading efforts to combat monkeypox globally

There is no domestic-only response to a global outbreak. The Biden-Harris Administration is committed to combatting monkeypox in the United States and around the world, including in countries where it has been historically endemic. The United States has also supported international efforts to combat monkeypox in endemic countries for years, including in Nigeria and the Democratic Republic of the Congo. The Biden-Harris Administration is dedicated to assisting endemic and non-endemic countries combat their outbreaks and is exploring options to further support the international response.

The Administration is also developing key U.S. monkeypox research and evidence priorities, led by the White House Office of Science and Technology Policy, to drive efforts to improve our arsenal of medical countermeasures, strengthen real-time monitoring, enhance our understanding of the monkeypox virus, and energize the broader U.S. and global scientific community around urgent monkeypox research and evidence challenges.

The Biden Administration has been responding to the outbreak since the first domestic case was identified with urgency, humility, and transparency, adapting our approach as we learn more about how this virus is spreading. It will continue to ensure a whole-of-government response to the monkeypox outbreak moving forward and will lead the government in adapting our response as the situation develops.

To learn more about monkeypox, signs and symptoms, treatments, and prevention, please visit the CDC page at https://www.cdc.gov/poxvirus/monkeypox/index.html
The findings of a Journal of the American Medical Association study published May 31 show that pulse oximeter oxygen level readings were often overestimated for Asian, Black, and Hispanic patients in comparison to white patients. This inaccuracy led to the delay of COVID-19 treatment for many.

Dr. James Rogan has experienced firsthand the impact of a flawed pulse oximeter reading.

The family physician did not encounter the issue with one of his patients, however. He saw it with his mother.

When Rogan’s mother, Clara Mae Rogan, 88, was admitted to the hospital in his hometown of Gallatin, Tennessee, for cardiovascular issues, she received an oxygen reading of 98% from a pulse oximeter — a normal reading.

Rogan was immediately skeptical of the accuracy of the reading because of his mother’s history of chronic illnesses. He said he felt that she needed oxygen from the way she was breathing.

Rogan voiced his concerns to his mother’s cardiologist, who he considers as a family friend. But the physician still did not give his mother oxygen, pointing to the pulse oximeter’s reading.

Only when the cardiologist left for vacation did Rogan find another doctor willing to provide the oxygen treatment. Rogan said his mother immediately began to feel better. However, she is still recovering today.

“It is something that I think needs to be looked at intently and evaluated by the companies that make pulse oximeters,” said Rogan, who practices in Atlanta.

“Why is it not functioning right?”

A pulse oximeter works by using a beam of light to detect oxygen carried in red blood cells after being attached to the tip of the finger or ear. It provides a reading of the oxygen saturation level, usually presented as a percentage, and a pulse rate. Oxygen saturation values are between 95% and 100% for most healthy people.

Besides skin pigment, poor circulation, cold skin and nail polish can interfere with the accuracy of readings.

In the early stages of the pandemic, health officials advised people to buy over-the-counter pulse oximeter machines to monitor their oxygen levels without having to go to a health care facility.

Following an earlier study that was published in The New England Journal of Medicine in December 2020, the FDA issued a safety communication in February 2021 cautioning against relying on pulse oximetry alone to determine oxygen levels.

Dr. Camara Phyllis Jones is a family physician, epidemiologist and adjunct professor at the Rollins School of Public Health at Emory University and Morehouse School of Medicine who has devoted much of her work to combating racism in medicine and at large.

Jones noted the original study was based on patients’ self-described race rather than their actual skin tones — a more variable measurement that would apply to more people.

“They (researchers) didn’t have skin tone, which would have been the perfect measure in terms of really understanding the faults in pulse oximetry and how we are using it now,” Jones observed.

“They have identified an important problem, and all they had was self-identified ‘race’ as a proxy for a group of skin tones .... This is about light absorption, so it has to do with skin tone.”

She said the study’s focus on race fails to capture the biology surrounding the oximetry problem.

“We have to abandon our notion of ‘race’ as something that is biological,” she said.

Jones, like many other doctors, feels as though something should be done on a foundational level about the issue found in pulse oximeters.

“Structural racism often shows up as lack of action in the face of need,” Jones remarked. “Now, we had better see the manufacturers of pulse oximeters trying to address this issue that they have known about since the New England Journal paper in 2020.”
HOW TO USE A PULSE OXIMETER

■ When placing the oximeter on your finger, make sure your hand is warm, relaxed, and held below the level of the heart. Remove any fingernail polish on that finger.

■ Sit still and do not move the part of your body where the pulse oximeter is located.

■ Wait a few seconds until the reading stops changing and displays one steady number. Oxygen saturation values are between 95% and 100% for most healthy individuals but sometimes can be lower in people with lung problems.

■ Pay attention to whether the oxygen level is lower than earlier measurements or is decreasing over time. Changes or trends in measurements may be more meaningful than one single measurement.

For more information, visit:
https://epaper.ajc.com/popovers/dynamic_article_popover.asp?artguid=ad3f5671-49bb-4e36-ad05-3b9dc3994579&utm_source=app.pagesuite&utm_medium=app-interaction&utm_campaign=pagesuite-epaper-ipad_share-article&appcode=AJC379&eguid=8822cf07-3326-4c84-a2a3-5ddccbf01baf&pnnum=15

HIV and Aging

In 2008, Janice Barton was vacationing at Serenbe, a biophilic, or nature-centered, community in the Chattahoochee Hills about 30 miles outside of Atlanta. She fell in love with the village's English-style cottages, outdoor artist studio, nature trails, local shops and café all within walking distance, and decided to buy her forever home there.

"In a typical suburb, you drive into your garage, shut the door and that is it," explained Barton, who at 73 is a solo ager. "Maybe you know your neighbors on either side or across the street but you don't have anything in common, so you don't want to invest the time and energy. At Serenbe, I feel younger because I am engaged and I'm living a more vibrant life."

Serenbe and other new amenities-laden retirement communities illustrate how the senior living industry is going through a transformation that has accelerated since the COVID-19 pandemic. Pre-pandemic Americans age 65+ expressed the desire to stay living in their homes as long as possible; the social isolation imposed by the pandemic has solo agers — the 12% of the population who, according to AARP, are widowed, divorced or without adult children to care for them — rethinking the desire to age alone at home.
Changing Designs, Changing Minds

Meanwhile, families have become more concerned about congregate living after pandemic-related health threats and mandatory isolation from loved ones occurred in most long-term care communities.

Overcoming ageist perceptions of retirement living and assisted living developments will be challenging.

In addition, the interests and needs of residents over 55 are changing, requiring existing communities for older adults to resuscitate their appeal to ever-younger prospective residents (the oldest of the millennial generation turns age 50 in just eight years).

Overcoming ageist perceptions of retirement living and assisted living developments will be challenging. Many people feel these communities are destinations for physical decay, disability, devastating diseases, and death instead of communities that promote thriving and better quality of life well into residents' 80s and 90s.

According to James Balda, president and CEO of Argentum, the leading national trade association for what the industry refers to as "senior living" communities, 7 out of 10 people will require assisted living care in their lifetime. The number of people in assisted-living accommodations today is expected to more than double to about two million by 2040.

However, most older adults only opt for senior living the last five years of life, making the amenities more about medical care than quality of life. Active 55+ communities and independent living cater to an older population but many boomers are looking for curated amenities and universal design homes within multigenerational neighborhoods.

Bob Kramer, co-founder and strategic advisor of National Investment Center for Senior Housing and Care (NIC), wrote in an article for Boston Hospitality Review, "Innovative housing communities focused on engagement and delivering quality lifestyle experiences will attract millions of seniors many years before they need today's care-focused products, which they actively avoid."

The first hurdle is that 42% of older adult communities are more than 25 years old and need upgrades in infrastructure and design aesthetics as well as reconfiguration of dormitory-style living. After the economic realities of the pandemic on how to keep both residents and staff healthy and safe, many operators realize they must invest significant capital in creating more yet smaller buildings that also have a more indoor/outdoor open floor plan design.

Whether it is a redesign or simply building a whole new community, the senior housing industry is hoping, "If you build it, they will come."

Wellness is now the biggest trend and No. 1 selling point for older adults and their family caregivers to consider a 55+ community. The Global Wellness Institute 2022 report estimates the North American wellness real estate market at $118 billion and says "people are becoming increasingly aware of how lifestyle and external environmental factors impact their well-being and are seeking health-and-wellness enhancing solutions in their daily lives."

This is why many communities seek to incorporate biophilic design into their marketing efforts. Advocates of biophilic-designed communities say they help promote physical and emotional health of older adults by creating environments that respond to humans' neuroscientific need for contact with nature (biophilia means "love of life or nature").

The Call of the Wild in Biophilic Communities

One study found patients in hospital rooms with a view of trees and greenery were discharged twice as fast and needed less pain medication than those in hospital rooms with no windows. Another study found a decreased risk of dementia and Alzheimer's in adults over age 60 who lived in biophilic-designed environments.

"Wellness has always been part of the model for senior living with a focus on nutrition, fitness and social health," noted Balda. "But it is boomers who are driving the need for a broader definition of wellness."

Steven Nygren, founder of Serenbe, describes his community as purposely biophilic and said it has also been called an "agrihood." This farm-style living movement includes more than 150 neighborhoods across the U.S., according to the Urban Land Institute. The appeal to escape the traffic, noise and stress of cities and live more simply within steps of community gardens and orchards is driving older adults to these nature-centered communities.

After the housing market crash in 2008, "the first communities to step out of the recession were walkable communities and those focused on environmental or biophilic design," Nygren said. "Suddenly people started showing up to see what Serenbe was all about."

Additional agrihoods designed to attract older residents into multigenerational living are in development, including Kallimos in Colorado and Texas, developed by aging pioneer Bill Thomas.
Creating Communities with Cultural Connections

"A lot of the models in assisted living are broken, mostly because we have taken away people's purpose," said Dwayne Clark, founder and CEO of Aegis Living, which uses scent diffusers and reminiscence therapy to evoke pleasurable memories in residents and reconnect them to their past.

Clark said Aegis intends to incorporate wellness design in the more than 35 assisted-living and memory-care communities it runs in three states. The company also operates properties tailored to residents’ cultural backgrounds. For example, Aegis Gardens near San Francisco is designed with feng shui principles in mind and serves authentic Asian cuisine and offers activities such as mah-jongg, calligraphy and tai chi.

"I'm a momma's boy and I didn't want to do this in the beginning," said Ed Weissberg, 58, who lives in Washington state and moved his 91-year-old mother, Isonio, into an Aegis Gardens near Seattle when she began showing signs of dementia and reverted to speaking in her native Japanese. "But moving her into this community was the smartest thing I have ever done because she is happy."

Other companies are creating communities based on lifestyle. Latitude Margaritaville 55+ communities in Florida and South Carolina are built around the lyrics, music and laidback island culture of the singer-songwriter Jimmy Buffett.

Not to be outdone, The Walt Disney Co. is planning active 55+ neighborhoods within the larger Storyliving community, designed to appeal in a similar way as its theme parks and cruise ships. "We're expanding beyond guests to residents and replicating the joy of those vacation times into everyday life," said Michael Hundgen, portfolio creative executive of Disney's Imagineering team.

Wellness and Longevity, at What Cost?

Affordability is a concern at all of these communities, where homes can run from $250,000 to one million dollars, depending on home size, community type and local property market. The Genworth Cost of Care Survey reports the nationwide average monthly cost for a bed in an assisted living facility is $4,500.

That exceeds the median income of people 65 or older in the U.S., according to Census Bureau data. Some multigenerational communities are trying to address this. Homes in one agrihood in a depressed Detroit neighborhood average $25,000 and offer a solution to the food insecurity that has long been a problem in the area. Building homes for the lowest-income retirees is not economic, developers say, although some see an opening in the middle of the market.

"The biggest opportunity for growth in senior living is the middle market who can afford $3,000 a month but not $4,500 a month for the higher-amenity communities," said Balda. "By 2050, 27 million seniors will need some care with a variety of needs and wants; it is our job to deliver those choices from active senior living to memory care."

Contributing Author: Sherri Snelling is a corporate gerontologist, author, speaker and consultant in aging and caregiving. She is the host of the "Caregiving Club On Air" podcast.
**NCBA Supportive Services**

Founded in 1970, The National Caucus and Center on Black Aging, Inc. (NCBA) is a national 501 (c) (3) nonprofit organization. Headquartered in Washington, DC, NCBA is the only national aging organization who meets and addresses the social and economic challenges of low-income African American and Black older adults, their families, and caregivers.

**NCBA Supportive Services include:**

**Job Training & Employment**

NCBA administers Senior Community Service Employment Program (SCSEP) with funding from the U.S. Department of Labor (DOL) to over 3,500 older adults, age 60+ in North Carolina, Arkansas, Washington, DC, Illinois, Missouri, Michigan, Ohio, Florida, and Mississippi. SCSEP is a part-time community service and work-based job training program that offers older adults the opportunity to return or remain active in the workforce through on the job training in community-based organizations in identified growth industries.

Priority is given to Veterans and their qualified spouses, then to individuals who: are over age 65; have a disability; have low literacy skills or limited English proficiency; reside in a rural area; may be homeless or at risk for homelessness; have low employment prospects; failed to find employment after using services through the American Job Center system.

Annually, NCBA and CVS partner to host job fairs to orient SCSEP participants about the benefits of working at CVS as a mature worker.

**To learn more about the Senior Community Service Employment Program (SCSEP), visit:** [https://ncba-aging.org/employment-program-resources](https://ncba-aging.org/employment-program-resources)

NCBA administers the Environmental Employment (SEE) Program with funding from the U.S. Environmental Protection Agency.

Agency (EPA) to older adults, age 55+ with professional backgrounds in engineering, public information, chemistry, writing and administration the opportunity to remain active in the workforce while sharing their talents with the U.S. Environmental Protection Agency (EPA) in Washington, DC, and at EPA Regional Offices and Environmental Laboratories in NC, OK, FL, and GA. **To learn more about the Senior Employment Environment Program (SEE), visit:** [https://www.ncba-aged.org/environmental-employment-program-resources](https://www.ncba-aged.org/environmental-employment-program-resources)

**Health and Wellness**

NCBA administers a health and wellness program with funding from the U.S. Department of Health and Human Services, Administration for Community Living to advance the principles of activity and vitality at a mature age; works to decrease access barriers to healthcare; and reduce or eliminate health disparities among racial, ethnic minority, and LGBT older adults.
The NCBA Health and Wellness Program offers continual education, resources, and technical assistance either in-person, online, or through self-paced learning opportunities. The program offers a wide variety of social and economic services and support including, the delivery and coordination of national health education and promotion activities, and the dissemination of and referral to resources. To learn more visit https://ncba-aging.org/health-and-wellness

Housing
Established in 1977, the NCBA Housing Management Corporation (NCBA-HMC) is the organization’s largest program and service to seniors. NCBA-HMC provides senior housing for over 500 low-income seniors with operations in Washington, DC, Jackson, MS, Hernando, MS, Marks, MS, Mayersville, MS and Reidsville, NC. To learn more about NCBA Housing Program, visit https://www.ncba-aged.org/affordable-housing/

Upcoming Events

The Black Male Caregiver Study
The Black Male Caregiver Study is a research study at George Washington University in Washington, DC is investigating the cognitive and physiological effects of Black American caregivers. Specifically, the study is designed to examine the cognitive, physical, and physiological effects of stress derived from providing care for a family member or loved one diagnosed with Alzheimer’s disease or Dementia.

This study is focused on the impact of stress on Black American males caring for loved ones. The aim of the study is to highlight any key areas that are affected by this form of caring with a hope of addressing any needs or issues that are currently under met by paid care.
The Black Male Caregiver Study is looking to recruit participants from communities in the District of Columbia, Maryland and Virginia (DMV) area who are:

- Black males
- Between ages 30yrs and 85yrs old
- Both unpaid caregivers (for persons with dementia or Alzheimer’s Disease) and
- non-caregivers (Black males in the community that do not provide care)

**How is the study conducted?**

George Washington University is administering cognitive tests and questionnaires as well as taking biological samples from study participants. The information gleaned will be analyzed and added to a growing body of knowledge regarding brain health. The study involves:

- Questionnaires and surveys about health, sleep, and stress
- Saliva samples
- Memory and thinking tests
- Compensation of up to $125 and travel reimbursement
- Majority of the study can be completed over the telephone

**How to get involved:**

We are recruiting black men between the ages of 30-85 that are the primary caregivers for a family member or close friend with Alzheimer’s or dementia. See the flyer below for more information on the study and how to get involved.

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**NCBA Presents Free Tool Kit and Recorded Webinar for Dispelling Fears and Myths about COVID-19 Vaccines**

Rather than a live webinar, we have linked a recorded webinar for you to view at your convenience to help in your outreach to older African Americans in your community who are still wary about the Covid-19 vaccines or have trouble accessing services. The webinar runs less than 20 minutes.

Not only does this video include practical suggestions and "lessons learned" about organizations seeking to educate their members and facilitate vaccinations, but it also includes a Tool Kit with an infographic, tip sheet, a brief informational video that addresses myths and facts about the vaccines, and appointment cards to help recipients keep track.

**Here is the link to the Recorded Webinar and the Tool Kit.**

We strongly encourage you to download the informational video in the Tool Kit for public showings, to email it to members, or to share with other organizations and individuals who are engaged in Covid-19 education. There is no copyright on the video, so feel free to distribute it far and wide.

We would very much appreciate your feedback about this webinar, the Tool Kit and your distribution numbers. Please let us hear from you at cvided@ncba-aging.org.

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**NCBA social media**

To learn more about NCBA programs, services, and upcoming events, follow us on Facebook, Twitter, and Instagram!

Facebook @NCBA1970
Twitter@NCBA1970
Instagram@NCBA_1970

You’re also welcome to learn more about NCBA by visiting aging.org. We look forward to hearing from you!