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Enhanced SNAP Benefits for Millions of Americans Are Gone
Here’s What You Need to Know

Extra SNAP payments added under a pandemic-era policy have been cut, reducing monthly grocery allocations for recipient households by $95 or more. The Supplemental Nutrition Assistance Program helps more than 41 million Americans cover food essentials. But pandemic-era enhancements to SNAP, formerly known as food stamps, have expired nationwide.

As a result, monthly benefits for March dropped by at least $95 for all households, with some seeing a reduction of $250 a month or more, according to the Center on Budget and Policy Priorities, a progressive think tank.

The cuts come as US families continue to face food inflation: Supermarket prices in January were 10% higher than at the beginning of 2022, according to the Bureau of Labor Statistics. Expanded SNAP benefits kept 4.2 million people above the poverty line at the end of 2021, according to the CBPP, disproportionately Black and Latino people. But pandemic-era enhancements to SNAP, formerly known as food stamps, have expired nationwide.

As a result, monthly benefits for March dropped by at least $95 for all households, with some seeing a reduction of $250 a month or more, according to the Center on Budget and Policy Priorities, a progressive think tank. The cuts come as US families continue to face food inflation: Supermarket prices in January were 10% higher than at the beginning of 2022, according to the Bureau of Labor Statistics.

Expanded SNAP benefits kept 4.2 million people above the poverty line at the end of 2021, according to the CBPP, disproportionately Black and Latino people.
How do you apply for SNAP benefits?

You must apply for SNAP in the state where you reside. The USDA Food and Nutrition Service website has links to state agencies and online applications, as well as relevant phone numbers for each area.

SNAP benefits are deposited onto an electronic benefit transfer card accepted at most supermarkets.

How much can you get in SNAP benefits?

While the emergency allotments are ending, changes to how the USDA calibrates the Thrifty Food Plan, which is used to calculate SNAP benefits, gave the average recipient an extra 27% beginning in October 2021. The agency added a 12.5% cost-of-living increase in October 2022. An other adjustment is expected this fall, NBC News reported. For now, a single person can expect to receive an average of $197 a month, with a maximum payout of $281. The average monthly benefit for a household of three is $586, with a monthly maximum of $740. SNAP recipients can contact their state social services agency if they recently lost income or if their expenses have increased due to housing, child care, medical expenses or other factors.

You can also connect with area food banks and relief organizations for additional resources.

For more information, visit: https://www.cnet.com/personal-finance/enhanced-snap-benefits-for-millions-of-americans-are-gone-heres-what-you-need-to-know/

What was the increase to SNAP benefits?

Temporary SNAP emergency allotments, or EAs, were originally approved by Congress in March 2020, shortly after President Donald Trump declared a COVID-19 public health emergency. As part of the larger stimulus package, EAs provided an additional $3 billion a month to SNAP.

States could request the extra funds as long as they had an emergency declaration in place and the federal public health emergency was still But Congress closed the purse strings in December 2022 as part of the Omnibus Appropriations Bill. By the end of January, 18 states ended their declarations and stopped issuing emergency allotments.

For the remaining 32 states -- as well as the District of Columbia, Guam and the US Virgin Islands -- February was the last month for the expanded benefits. President Joe Biden has announced the federal public health emergency will expire on May 11, 2023.

How Does the change in SNAP benefits affect recipients?

One in eight Americans receives SNAP benefits. While the amount each household will lose depends on its size, makeup, and income, all will see a decline of at least $95 a month.

Families with children are losing about $223 a month on average, according to the CBPP, and people 60 and older are facing an average decrease of $168 a month.

Many Social Security recipients have seen an additional drop in SNAP benefits because the 8.7% cost-of-living increase to Social Security in January raised their overall income. Other changes to SNAP, including expanded eligibility for low-income college students, will expire in May when the federal public health emergency ends.

Who is eligible for SNAP benefits?

To qualify for SNAP benefits under the US Department of Agriculture, your gross monthly income generally can’t exceed 130% of the poverty line. For a family of three in the fiscal year 2023, that equals $2,495 a month, or just under $30,000 a year.

Your net income must be at or below the poverty line and assets for most households must be no more than $2,750. (Households with a senior or disabled person must have assets of $4,250 or less.)

Adults under 50 who are not working and do not have children at home are limited to three months of SNAP benefits every three years. That requirement was paused during the pandemic but goes back into effect in May.
What Are Food Banks? (And How They Can Help Hungry People Eat Real Food)

SUMMARY

Millions of people around the world are hungry or starving, and the number has grown since the COVID-19 pandemic. Food banks have stepped up hunger-fighting efforts, even more, to provide food for those in need. So, what exactly are food banks, how do they work, and how do we help them serve real and nutritious food to the people who need them most?

Prior to the COVID-19 pandemic, food banks were already struggling to feed the numbers of people who were hungry. But now, many food banks are experiencing new obstacles, including rising costs of trucking, shipping, warehouse rental, and other factors involved in providing basic food necessities. Making things even more difficult, many senior citizens, who have historically comprised a large share of food bank volunteers, have put their participation on hold to avoid possible exposure to COVID-19.

All this is happening as more and more people require food assistance from food banks and pantries. Since the pandemic began, the number of people laid off from work, and filing unemployment claims, has surpassed anything ever seen before in the United States. Countless small businesses have closed. And many families now face impossible decisions about which bills to pay. Some people are having to choose between rent and food while struggling to pay for the internet service their children need for remote learning.

With more than 50 million Americans now at risk of going hungry, food banks and pantries are no longer second-tier players in the US food supply; they’re now front and center. While there should never be a stigma attached to using a food bank or relying on government assistance to pay for food, especially now, relying on a food bank for survival is no cause for shame or hesitation.

What are Food Banks?

Perhaps you, or someone you know, needs assistance from a food bank or food pantry, maybe for the first time ever. Or maybe you want to help out with donations of money or food, but you’re unsure where to start or how it works. We’re going to explore what food banks are, the difference between food banks and food pantries, how these resources impact both hunger and obesity, and where to find organizations in your area.

Feeding America describes food banks as nonprofit organizations that collect and distribute food to hunger-relief charities. In the United States, food banks typically store and distribute food for smaller frontline agencies who then provide that food to individuals suffering from hunger. In the UK, on the other hand, food banks often provide more frontline support directly to people in need.

Food banks typically store food in large warehouses, which are then used by community hunger groups. The collected food may be surplus from manufacturers, farms, grocery stores, and other nodes in the food supply chain. Additionally, in the US, food may come from The Emergency Food Assistance Program (TEFAP), which provides food to states who then pass it on to local food banks. Other food is donated to banks via food drives conducted by individuals, families, faith-based groups, volunteer organizations, and/or local corporations.

What are Food Pantries?

Many people assume food banks and food pantries are the same things, but there are several differences between the two. A food pantry is considered an emergency food program and is actually a distribution center that receives the majority of its food from a food bank. Food pantries can also receive food donations from the community.

There are a few different models for how food pantries are set up. Some are located in schools to reach kids and teens. Mobile food pantries, which travel to different areas in the community, help feed senior citizens, people with disabilities, Indian reservations, and rural communities.
During the pandemic, **drive-thru food pantries** have become the most common model, minimizing risky contact while still providing food to those in need. In this scenario, cars line up to receive boxes of food to take home. Each box is the same, and people utilizing the service have no control over what food they receive. It all depends on what the pantry has available. Any leftover food boxes can then be donated to local food banks to make sure they, too, reach someone in need.

**Who Can Use A Food Pantry?**

Some food pantries, like [this one in North Hollywood, CA](https://www.example.com), don't have any specific assistance qualifications for people who can use them, so you can just show up whenever you need food. However, if you're visiting a food pantry, you may be asked for identification just to prove who you are and that you live in the community.

Food pantries are typically open for limited hours and days of the week. Many will have websites that you can check to plan your visits. Some pantries require that you fall into a certain income bracket, which is more often the case if they're funded by a state's Emergency Assistance Food Program. For instance, here's an example of the temporary household eligibility guidelines for food assistance if you live in Ohio. In many cases, you can visit more than one food pantry in your area in order to meet your family's needs.

**What Kinds of Foods Do Food Banks and Food Pantries Have?**

Food banks and pantries focus primarily on providing **non-perishable food items** that have a long shelf life and don’t require refrigeration. Examples of food found at food banks and food pantries include:

- Canned fruits and vegetable
- Canned and dried beans and legumes
- Boxed and canned processed foods and meals
- Bags of dried grains, or boxes of instant versions like instant rice
- Processed foods like crackers, cookies, chips, etc.
- Condiments
- Canned nuts and jars of nut butters
- Cereals
- Canned meats

Some food pantries also are able to provide fresh produce, in addition to refrigerated or frozen food, but this isn't common in many places. They may also offer supplies for households, such as personal care items, paper products, pet food, diapers, and formula.

**Why is Hunger Such an Issue?**

Hunger is a global issue. **Recent estimates from the World Health Organization are that over 820 million people worldwide are suffering from hunger, and that number has been growing since COVID-19 began.**

It's important to understand that the root cause of global hunger isn’t actually a lack of food in the world. It’s a lack of access to food. Food distribution is uneven, so it isn’t getting to the people who need it most.

There are a number of reasons for the unavailability of food to those who need it. Wars and conflicts can prevent adequate food access to communities in strife-torn areas. Many locations around the world, such as remote rural areas, present a challenge when trying to supply food and other necessities. Climate change has led to drought and other natural disasters that can destroy crops that local families and villages rely on for food. Widespread chronic poverty also means there’s not enough money to buy food or supplies needed to grow food. Often, impoverished communities lack access to fertile land that can be dedicated to growing their food, leaving them hungry even in the middle of an agricultural area.
In addition, policies that have prevented wealth-building opportunities to generations of people of color (such as redlining and USDA loan discrimination against Black farmers) have contributed to wealth disparities along racial lines. This is one of the reasons that, in the US, African American households are more than twice as likely to experience hunger and food insecurity as white households. Indigenous communities in the US and Canada are also disproportionately affected by food and nutrition insecurity. Removed from their ancestral lands and forced onto reservations, their traditional diets have been colonized, leading to dependence on government assistance programs and to poorer health outcomes and higher rates of diet-related diseases.

The Human Face of Hunger

Feeding America estimates that one out of six Americans is currently facing hunger due to the COVID-19 pandemic. As a result, more people are seeking out assistance from food banks and pantries than ever before.

To put a human face on households struggling with hunger right now, The New York Times created this photo essay series about food insecurity. The images show some of the nutrient-poor types of foods that many families end up depending on. They also show how many food-insecure families are seizing any opportunity they might have to collect food when it becomes available. Hunger is increasingly a problem for kids in the United States, and it ultimately hits them the hardest, as the quantity and quality of food they receive affect their growth and development.

Struggling To Provide True Nourishment

In order to keep up with enormous demand, many depend heavily on donated and non-perishable food. And because their first priority is averting immediate hunger, they often focus on providing the cheapest calories available.

Many of the staple foods provided by food banks are high in calories, but low in nutrients — and are based around refined sugar, refined flour, and highly-processed ingredients. No wonder, then, that low-income individuals, who are most likely to utilize food banks and food pantries on an ongoing basis, are more likely to suffer not just from hunger but also from obesity, type 2 diabetes, heart disease, and other diet and lifestyle-fueled diseases. As a result, the very people who can least afford to get sick often suffer from chronic illness the most.

While it can be tempting to blame food banks for serving unhealthy food, I think that to do so misses the point. Food banks are doing heroic work under extremely challenging circumstances. Their goal is to provide enough calories to help people survive. The fact that food banks receive so much highly processed junk food isn’t a criticism of the food banks themselves, but of a society that produces and even subsidizes, for the profit of the few, these hyper-palatable and harmful foods.

Food Banks & Organizations Standing for Healthy Food

Yet even with these constraints, there are a growing number of food banks and organizations that are trying to improve the health of the communities they serve.

In 2004, the Food Bank of Central New York implemented a no-soda and no-candy policy. As a result, it prevented an estimated 3,300 pounds of weight gain among the population relying on food banks. Some other food banks have followed suit, rejecting junk foods in all forms to help improve the nutritional quality of their offerings.

For instance, the Capital Area Food Bank began refusing to provide baked sweets, sodas, cookies, candy, and foods like boxed mac and cheese in an attempt to supply the right food to people who need adequate nutrition.
Feeding America

Feeding America, which coordinates a network of 200 food banks across the United States, has opened a Hunger and Health initiative, aimed at providing education and resources to support healthy eating in the communities of greatest need.

Hunger Free America

And Hunger Free America is a US-based direct service and hunger awareness advocacy nonprofit group. They actively promote policies and programs that make healthy food available to all Americans in need.

Wholesome Wave

Another worthwhile hunger-relief organization is Wholesome Wave. They seek to eradicate not just food insecurity, but in their words, “nutrition insecurity.” Wholesome Wave sees the food status quo as a contributor to chronic disease among the poor, including the high rates of serious illness and death caused by COVID-19 among the already obese and sick. One of their contributions has been a movement to double the value of food stamps when spent on fresh produce. They have also innovated “produce credit cards,” and are now working to make grocery home delivery available in nutritionally challenged communities.

Ample Harvest

And finally, Ample Harvest is an organization that works with growers to get healthy, fresh produce to food banks and pantries. Their mission is to eliminate food waste, malnutrition, and hunger in local communities. Growers (whether commercial, small farms, or backyard gardeners) can donate their excess harvest to one of the registered food pantries in the Ample Harvest database. Although many food pantries aren’t set up to store fresh produce, Ample Harvest can make deliveries on distribution days to ensure healthy food reaches people relying on food pantries for their nutrition.
Indigenous communities across the United States have been particularly devastated by the COVID-19 pandemic, with infection rates three and a half times higher than the infection rate for white people. In response, there are a number of organizations aiming to serve indigenous communities specifically during this time.

**Food Banks Are a Lifeline**

Food banks and food pantries are vital lifelines for millions of people. And in the time of COVID-19, they have become more important than ever. Many of these organizations are working tremendously hard and under very difficult conditions.

**Find a Food Bank or Food Pantry**

If you find yourself in need of food assistance or want to volunteer or donate to a food bank, pantry, or other similar organization, below are some good places to start.

**Food Banks and Food Pantries:**

- **Community Solidarity** is a vegetarian/vegan food bank serving New York and the surrounding areas.
- **Feeding America** is a network of food banks and pantries around the US, with a database that can help you find your local options.
- **Trussell Trust** is a food bank database located in the United Kingdom, serving England and Wales.
- **Food Banks Canada** is a charitable organization serving food-insecure households in Canada by working to alleviate local hunger and reduce the need for food banks.

To find local food pantries, you can also go to your state or county food bank website or use the Feeding American database. For instance, here are links to the Los Angeles Regional Food Bank and the North Texas Food Bank. If you Google "food banks in my area," you should be able to find nearby options.

If you're in the US, you can also call the National Hunger Hotline at 1-866-3-HUNGRY or 1-877-8-HAMBRE to ask for direction.

More needs to be done to address the underlying causes of hunger, so that everyone who wants to work can earn enough to provide healthy food for their family. Hopefully, in time, food banks can become, once again, a safety net of last resort and not a fundamental part of our food supply chain. Until that day arrives, we can all give thanks for the lives they are saving, and for the heroic efforts some are making to provide not just calories, but also the kind of nourishment that helps people to live healthy lives.

**For more information, visit:**
https://foodrevolution.org/blog/what-are-food-banks-food-pantries/
Criminals continue to impersonate SSA and other government agencies in an attempt to obtain personal information or money.

Scammers might call, email, text, write, or message you on social media claiming to be from the Social Security Administration or the Office of the Inspector General. They might use the name of a person who really works there and might send a picture or attachment as "proof."

Four Basic Signs of a Scam

Recognizing the signs of a scam gives you the power to ignore criminals and report the scam.

Scams come in many varieties, but they all work the same way:

1. Scammers pretend to be from an agency or organization you know to gain your trust.
2. Scammers say there is a problem or a prize.
3. Scammers pressure you to act immediately.
4. Scammers tell you to pay in a specific way.

Know Tactics Scammers Use

Scammers frequently change their approach with new tactics and messages to trick people. We encourage you to stay up to date on the latest news and advisories by following SSA OIG on LinkedIn, Twitter, and Facebook or subscribing to receive email alerts.

These are red flags; you can trust that Social Security will never:

- Threaten you with arrest or legal action because you don’t agree to pay money immediately.
- Suspend your Social Security number.
- Claim to need personal information or payment to activate a cost-of-living adjustment (COLA) or other benefit increase.
- Pressure you to take immediate action, including sharing personal information.
- Ask you to pay with gift cards, prepaid debit cards, wire transfers, cryptocurrency, or by mailing cash.
- Threaten to seize your bank account.
- Offer to move your money to a "protected" bank account.
- Demand secrecy.
- Direct message you on social media.

It is illegal to reproduce federal employee credentials and federal law enforcement badges. Federal law enforcement will never send photographs of credentials or badges to demand any kind of payment, and neither will federal government employees.

Report the Scam

How to Avoid a Scam

Protect yourself, friends, and family — If you receive a suspicious call, text, email, social media message, or letter from someone claiming to be from Social Security:

1. Remain calm. If you receive a communication that causes a strong emotional response, take a deep breath. Talk to someone you trust.
2. Hang up or ignore the message. Do not click on links or attachments.
3. Protect your money. Scammers will insist that you pay with a gift card, prepaid debit card, cryptocurrency, wire transfer, money transfer, or by mailing cash. Scammers use these forms of payment because they are hard to trace.
4. Protect your personal information. Be cautious of any contact claiming to be from a government agency or law enforcement telling you about a problem you don’t recognize, even if the caller has some of your personal information.
5. Spread the word to protect your community from scammers.

What to Do if You Were Scammed

Recovering from a scam can be a long and difficult process. Here are some reminders:

- Do not blame yourself. Criminal behavior is not your fault.
- Stop contact with the scammer. Do not talk to them or respond to their messages.
- Notify the three major credit bureaus: Equifax, Experian, and TransUnion to add a fraud alert to your credit report.

For more information, visit: https://www.ssa.gov/scam/
Infrequent Social contact

Infrequent contact with people from outside one’s household in the past year was more common among those who reported fair or poor mental health (56% vs. 30% of those with better mental health) or physical health (41% vs. 31% of those with better physical health), having a health problem or disability that limits daily activities (39% vs. 30% of those without such limitations), and men (37% vs. 29% of women).

Implications

Chronic loneliness (persistent feelings of isolation and/or a lack of companionship) can adversely affect mental, cognitive, and physical health, general well-being, and even longevity. NPHA polls from 2018 to 2023 have consistently found that feeling isolated from others, feeling a lack of companionship, and having infrequent social contact were strongly associated with poorer physical and mental health among older adults.

The results of this poll show that for adults age 50–80, lack of companionship and infrequent contact with family, friends, or neighbors outside the home have decreased to close to 2018 levels, although those pre-pandemic rates were already notably high. While the proportion of older adults who felt isolated from others in the past year is now lower than in the first three months of the pandemic, a substantial number still report feeling socially isolated.

Measures of loneliness remain particularly high among those with poorer physical and mental health, a health problem or disability that limits daily activities, and those who are not working/unemployed, live alone, are age 50–64, and women. People aged 50–80 more likely to have limited social contact include those with fair or poor physical or mental health, an activity-limiting health problem or disability, and men.

Particularly notable are the high rates of measures of loneliness in 2023 among older adults with fair or poor physical health and mental health. Feelings of social isolation and lack of companionship were reported by more than seven in ten with fair or poor mental health and more than half of those with fair or poor physical health. In fact, measures of loneliness among those with fair or poor mental health were slightly higher in 2023 compared with the early months of the pandemic in 2020.

Addressing loneliness requires a multifaceted approach. Much like asking about diet and exercise, clinicians should identify and screen older adults at increased risk of feeling
isolated, lacking companionship, or being disconnected from others. Individuals could be referred to Area Agencies on Aging and other community resources, such as senior centers or local libraries, which may help address unmet social needs, including opportunities for social connection. Family members and friends are encouraged to check in and reconnect with older friends and neighbors with whom they may have had limited contact during the past few years.

Loneliness affects the health and well-being of older adults. It is critical for policymakers, clinicians, and family members to address what the U.S. Surgeon General has called an “epidemic of loneliness.”

Data Source and Methods

This National Poll on Healthy Aging report presents findings from a nationally representative household survey conducted exclusively by NORC at the University of Chicago for the University of Michigan’s Institute for Healthcare Policy and Innovation. National Poll on Healthy Aging surveys are conducted using NORC’s AmeriSpeak probability-based panel.

This survey module was administered online and via phone in January 2023 to a randomly selected, stratified group of U.S. adults age 50–80 (n=2,563). The sample was subsequently weighted to reflect population figures from the U.S. Census Bureau. The completion rate was 61% among panel members contacted to participate. The margin of error is ±1 to 3 percentage points for questions asked of the full sample and higher among subgroups.

Findings from the National Poll on Healthy Aging do not represent the opinions of the University of Michigan. The University of Michigan reserves all rights over this material.

Citation


For more information, visit: https://www.healthyagingpoll.org/reports-more/report/trends-loneliness-among-older-adults-2018-2023

Ask Beverly Jones, author of the valuable new book, "Find Your Happy at Work," to describe a time when she was happiest at work and Jones instantly smiles. It was, she says, when she was a grad student at Ohio University working as a paid assistant to its president and researching ways for more equal opportunity on campus for women.

"In those days, women couldn't take some courses, like engineering," Jones, now a Washington, D.C.-based executive career coach, recalled. "Many graduate programs didn't accept women. It was something I cared totally about. I had absolutely no idea how to go about it, so I had to make it up every day, but it was one of the most intensely enjoyable periods of my life.

The reason, says Jones (one of my go-to career experts, fellow Labrador retriever fan and longtime friend), is that "creating something and making a difference is a great strategy to go to if everything is feeling dull at work."
What's Your Personal Mission Statement?

She also firmly believes that you can find more happiness at work by having a strong, internalized personal mission statement.

"It's easier to love your job if you're working for something that matters more than just a paycheck," Jones says. "Even a tedious job can feel rewarding if you have a good reason for doing the work, like saving to put your kids through college." Your own mission statement "can be the mission of the organization you're working for and how it aligns with your values or it can be a very personal mission," Jones notes.

Contributing Author: Beverly Jones. For more information, visit: https://www.forbes.com/sites/nextavenue/2022/02/18/how-to-be-happier-at-work/?sh=3abf52e6b1fb

The Secret to Happiness at Work

But there's more to it. "A secret to success, and ultimately happiness at work, is often being comfortable with your own discomfort," Jones says. "I'm a naturally cautious person, and I've learned to ask myself: 'Am I afraid because this is foolish and dangerous or am I afraid because it's an opportunity and I've got to push forward through the discomfort?'"

In "Find Your Happy at Work," whose subtitle is "50 Ways to Get Unstuck, Move Past Boredom and Discover Fulfillment," Jones has tapped into a subject that many workers, me included, have been grappling with since the pandemic began. We're stressed, a little nervous about the future of our work and perhaps a little burned out.

I recently visited with Jones to learn about her refreshing and timely happiness insights in a free-ranging conversation that hit on some of the major themes of her latest book.

"Some of the people who have had the biggest struggles [lately] seem to me to be rising to the occasion and finding meaning in their work," Jones says. "You can have a kind of joy and meaning even in a difficult job, like working in a hospital emergency room or struggling to help people who are going through a mental or health crisis. It's not a fun, giggly, kind of happy. It's a sense that life matters and time is going fast, and it feels good."

Jones discovered through researching her book, as well as from her bi-weekly "Jazzed About Work" podcast on NPR.org and sessions with clients during COVID-19 "that there is a shared sense that work should be meaningful, and lifestyles should be healthy," she says. "There's is a new sense that we deserve to have a rewarding work life which meshes nicely with the rest of our lives — especially for people in their fifties and beyond."

One Way to Get Unstuck at Work

One essential way to get unstuck in your work, Jones notes: building new relationships with interesting people — whether they're connected to your job. "These human connections can bring energy into your life, but they also can make you aware of opportunities and inspire you by learning from others," she says.

That people power is "important for happy aging. It is important for anybody that has interest in continuing to work later in life. And it's important for people who really want to retire and are looking to find other paths, even unpaid work in a different field," Jones says.

Your Nose Knows: Smell Loss and Brain Health

Many may be surprised to learn that our sense of smell is linked to brain health. Although one in two people over age 60 may be living with smell loss, many do not know it until they are tested. Unlike temporary smell loss associated with COVID or a cold, ongoing smell loss can be a signal of cell damage associated with brain disease.

In fact, emerging results from The Michael J. Fox Foundation’s landmark research study show that smell loss may be one of the most important signals of risk for Parkinson’s disease (PD).

Parkinson’s disease occurs when brain cells that make dopamine — a chemical that coordinates movement — stop working or die. Because PD can cause tremor, slowness and walking problems, it is called a movement disorder. But constipation, memory problems, smell loss and other non-movement symptoms also can be part of Parkinson’s. The experience of Parkinson’s and its symptoms vary from person to person.
Search for a Clinical Trial

Search for clinical trials and studies on Alzheimer’s and related dementias, cognitive impairment, brain health, and caregiving by visiting Find Clinical Trials (alzheimers.gov) https://www.alzheimers.gov/clinical-trials. If you need additional help, contact NIA by phone at 800-438-4380.

What Kinds of Research Can You Participate In?

Research involving people is called clinical research. There are two types of clinical research studies: observational studies and clinical trials.

- **Observational studies** are designed to collect information from people and compare that data over time. This helps them learn how different behaviors or lifestyles relate to health and disease and to understand how a disease progresses over time.

- **Clinical trials** are a type of research that tests new drugs, medical devices, surgical procedures, or behavior and lifestyle changes, such as exercise. Clinical trials may also test ways to detect and diagnose diseases and to better care for those living with diseases. Researchers determine if what is being tested, called an intervention, is safe and effective by comparing results in the test group to those in the control group.

The Alzheimers.gov Clinical Trials Finder includes listings for both kinds of clinical research studies.

Who Can Participate?

Nearly everyone! When people think of clinical research for Alzheimer’s and related dementias, they may think that only people with dementia can participate. But that’s not true! To produce meaningful results, Alzheimer’s and related dementias researchers need a variety of volunteers, including:

- People who are healthy, without symptoms of dementia
- Both younger and older people
- People diagnosed with Alzheimer’s or a related dementia, such as Lewy body dementia, vascular dementia, or frontotemporal dementia
- People who are identified as at-risk, given their family history, genetic makeup, or biomarkers, which are measures that could signal very early stages of disease
- People with Down syndrome, who are at higher risk for Alzheimer’s disease
- Caregivers of people with dementia
- People from diverse and underrepresented groups, such as those who are Asian, Black/African American, Hispanic/Latino, Native American, and/or Pacific Islander

Anyone 18 or older can participate, including people with dementia or memory problems, healthy volunteers, caregivers, and family members.

How Can I Find a Clinical Trial Near Me?

To learn more about specific research studies, search below to find listings near you, review the enrollment criteria, and reach out to study coordinators to ask questions. Even if there isn’t a study happening near you, you may still be able to participate in a study online.

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Request a free scratch-and-sniff test today at mysmelltest.org/brainhealth.

If you are eligible, you will be mailed a test. The test takes about 15 minutes to complete. Then you’ll enter your answers online. Your results may mean you are eligible to join a brain health study.

Ensure your community is represented!

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Alzheimer’s Disease Clinical Trials

By volunteering for a clinical study or clinical trial, you can become a partner in helping researchers discover new ways to potentially diagnose, treat, and prevent Alzheimer’s disease and related dementias. You may also:

- Receive medical care and new treatments that are not yet available otherwise
- Learn about the disease and your medical condition
- Gain access to resources, such as educational materials and support groups
- Help provide others with better treatments and prevention strategies in the future

Anyone 18 or older can participate, including people with dementia or memory problems, healthy volunteers, caregivers, and family members.

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Search for a Clinical Trial

Search for clinical trials and studies on Alzheimer’s and related dementias, cognitive impairment, brain health, and caregiving by visiting Find Clinical Trials (alzheimers.gov) https://www.alzheimers.gov/clinical-trials. If you need additional help, contact NIA by phone at 800-438-4380.

What Kinds of Research Can You Participate In?

Research involving people is called clinical research. There are two types of clinical research studies: observational studies and clinical trials.

- **Observational studies** are designed to collect information from people and compare that data over time. This helps them learn how different behaviors or lifestyles relate to health and disease and to understand how a disease progresses over time.

- **Clinical trials** are a type of research that tests new drugs, medical devices, surgical procedures, or behavior and lifestyle changes, such as exercise. Clinical trials may also test ways to detect and diagnose diseases and to better care for those living with diseases. Researchers determine if what is being tested, called an intervention, is safe and effective by comparing results in the test group to those in the control group.

The Alzheimers.gov Clinical Trials Finder includes listings for both kinds of clinical research studies.

Who Can Participate?

Nearly everyone! When people think of clinical research for Alzheimer’s and related dementias, they may think that only people with dementia can participate. But that’s not true! To produce meaningful results, Alzheimer’s and related dementias researchers need a variety of volunteers, including:

- People who are healthy, without symptoms of dementia
- Both younger and older people
- People diagnosed with Alzheimer’s or a related dementia, such as Lewy body dementia, vascular dementia, or frontotemporal dementia
- People who are identified as at-risk, given their family history, genetic makeup, or biomarkers, which are measures that could signal very early stages of disease
- People with Down syndrome, who are at higher risk for Alzheimer’s disease
- Caregivers of people with dementia
- People from diverse and underrepresented groups, such as those who are Asian, Black/African American, Hispanic/Latino, Native American, and/or Pacific Islander

Anyone 18 or older can participate, including people with dementia or memory problems, healthy volunteers, caregivers, and family members.

How Can I Find a Clinical Trial Near Me?

To learn more about specific research studies, search below to find listings near you, review the enrollment criteria, and reach out to study coordinators to ask questions. Even if there isn’t a study happening near you, you may still be able to participate in a study online.
Each study has specific requirements for participants, called inclusion and exclusion criteria. Check the qualifications to see if you may be eligible to participate.

**Why Is Diversity Important in Clinical Trials?**
Researchers need participants who represent all types of races and ethnicities, genders, geographic locations, and sexual orientations. When research involves a group of people who are similar, the findings may not apply to or benefit everyone. When clinical trials include diverse participants, the study results may have a much wider applicability. Having diverse people in studies can help researchers understand how dementia affects certain groups, why some communities are disproportionately affected by certain dementias, and which treatments or prevention strategies may be most effective in particular groups.

**Find More Resources on Clinical Trials**
Explore more resources about clinical trials and research studies below. If you are a health care provider, you can also find tips on talking with your patients about clinical trials.
- People with Down syndrome, who are at higher risk for Alzheimer’s disease
- Caregivers of people with dementia
- People from diverse and underrepresented groups, such as those who are Asian, Black/African American, Hispanic/Latino, Native American, and/or Pacific Islander

Sponsored by AMGEN -- Join us on April 13, 2023, from 1:00-2:00 pm (EST) for Part 3 of Osteoporosis Fractures: Impact on Black and African American Older Adults.

You will learn how to age healthy with nutrition, supplements and exercise while living with osteoporosis. To register for this webinar, visit www.ncba-aging.org.

For more tips and action on bone health and osteoporosis, see page 14.
# Osteoporosis in the Black Community

## Practical Tips and Action

### Facts

<table>
<thead>
<tr>
<th>The Most Common Types of Osteoporotic Fractures* Are</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spine, Hip, Wrist</td>
</tr>
</tbody>
</table>

*Fractures increase with age

### Proper Nutrition

- Inadequate nutrition leads to significant loss of bone and place individuals at an increased risk of fracture
- Black Americans may be at an increased risk for osteoporosis due to lack of calcium and Vitamin D

<table>
<thead>
<tr>
<th>Calcium (Dietary Sources)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dairy: Cheese, Yogurt, Milk</td>
</tr>
<tr>
<td>Fish: Sardines or Canned Salmon</td>
</tr>
<tr>
<td>Beans: Lima Beans, Kidney Beans</td>
</tr>
<tr>
<td>Nuts: Almonds</td>
</tr>
<tr>
<td>Certain Dark Leafy Greens: Collard Greens, Spinach, Kale</td>
</tr>
<tr>
<td>Fortified Food: Bread, Cereal, Soy Products</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vitamin D</th>
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</thead>
<tbody>
<tr>
<td>Fatty Fish: Salmon, Trout, Tuna</td>
</tr>
<tr>
<td>Beef Liver</td>
</tr>
<tr>
<td>Egg Yolks</td>
</tr>
</tbody>
</table>

### Disparities in Osteoporosis Screening

- Black men and women often go undiagnosed
- The Black community is less likely to be screened: 8-20% less likely depending on age

### Reasons for Disparities in Fracture Outcomes

1. Screening
2. Treatment: 5-20% lower in the Black community
3. Greater time to surgical repair: 44% to 200% higher odds of surgical repair ≠ 2 days
4. Improper rehabilitation: 30% higher odds of not receiving PT
5. Risk factors in the Black community
6. Patient knowledge and awareness

### Risk Factors for Osteoporosis

1. High BMI
2. Poor Nutrition
3. Vitamin D Deficiency
4. Secondary Risk Factors
   - Diabetes
   - Stroke
   - Sickle Cell disease
   - Breast Cancer
   - Lupus

### Exercise/Balance

- Good balance will decrease your risk of falling
- Fall Prevention exercises will improve balance and reduce your risk of falling
- Work with a physical or occupational therapist for a detailed assessment of your needs

### Benefits of Regular Exercise

1. Increase muscle strength
2. Improve balance
3. Decrease risk of bone fracture
4. Maintain/improve posture
5. Relieve/decrease pain

### Make a Plan of Action

1. Start a conversation with your doctor if you have a family history of osteoporosis or other risk factors that may put you at increased risk for the disease.
2. Ask your doctor if a test to measure bone density is needed.
3. Have a conversation with your doctor or pharmacist about dietary supplements and medicines you take to identify your risk.
4. Live a healthy lifestyle including eliminating the risk factors you can change.
On this day and throughout the year, the campaign partners – 100+ non-profits, advocacy organizations, professional societies, foundations, hospitals, and heart centers – join forces to help spread the word about valve disease. While partners educate about heart valve disease awareness throughout the year, a dedicated day allows us to collaborate and amplify each other’s messages.

To bring awareness to heart valve disease, NCBA partnered with the Alliance for Aging Research at Samuel J. Simmons NCBA Estates to “Take the Challenge! Listen to Your Heart”.

Even though as many as 11 million Americans are affected by heart valve disease, public awareness of the disease is shockingly low. A 2017 survey of more than 2,000 adults found that three out of four Americans know little to nothing about valve disease.

The seriousness of the disease, combined with the fact that symptoms are often difficult to detect or dismissed as a normal part of aging, makes this lack of awareness dangerous. While heart valve disease can be disabling and deadly, it can usually be successfully treated in patients of all ages if treated in time, making education and awareness particularly important.

The Heart Valve Disease Awareness Day campaign was started to increase recognition of the specific heart valve disease risks and symptoms, improve detection and treatment, and ultimately save lives. Heart Valve Disease Awareness Day takes place every February 22 during American Heart Month.
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**

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](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/

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. The webinar offers practical 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 covided@ncba-aging.org.

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 our website at www.ncba-aging.org. We look forward to hearing from you!
Upcoming Events

THE AMERICAN RED CROSS: BEFORE, DURING AND AFTER

Learn about the American Red Cross and what they do for our communities nationwide.

March 29, 2023
1:00PM–2:00PM

TO REGISTER USE THE LINK BELOW
https://us02web.zoom.us/webinar/register/...WvyQOkAg

Stevens Amendment
The Health and Wellness Program is supported by a total funding of $26,463,855 of which the DOL funds 90% or 23,817,469 and 10% or $2,646,386 is funded by non-federal sources.
Atherosclerotic Cardiovascular Disease
in Older Black and African Americans: An Overview

#1 KILLER IN AMERICA

- Strokes
- Heart Attacks
- Peripheral vascular disease

Atherosclerosis can cause...
- High blood pressure
- Heart Attacks
- Thrombi or Embolisms
- Arrhythmias

To learn more about Atherosclerotic Cardiovascular Disease (ASCVD)
Join us for a live discussion on the importance of early testing, managing
the disease, and understanding additional risk factors.

Thursday
March 30, 2023
1:00PM - 2:00PM ET

To register click the link below.
https://us02web.zoom.us/webinar/register/WN_XFIHaTXT6yoE6W2HFeURA
Living Safe and Aging Well with Osteoporosis

Learn how to age healthy with nutrition, supplements and exercise while living with osteoporosis.

THURSDAY
April 13, 2023
1:00PM ET

Click here to register.
https://us02web.zoom.us/webinar/register/WN_lcbQggNTXSi4gcghZ

The Health and Wellness Program is supported by a total funding of $26,463,855 of which the DOI funds 90% or $23,817,469 and 10% or $2,646,386 is funded by non-federal sources.
Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap

Based on current COVID-19 trends, the Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, to expire at the end of the day on May 11, 2023. Our response to the spread of SARS-CoV-2, the virus that causes COVID-19, remains a public health priority, but thanks to the Administration’s whole of government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from the emergency phase.

Over the last two years, the Biden Administration has effectively implemented the largest adult vaccination program in U.S. history, with nearly 270 million Americans receiving at least one shot of a COVID-19 vaccine.

As a result of this and other efforts, since the peak of the Omicron surge at the end of January 2022:

- Daily COVID-19 reported cases are down 92%,
- COVID-19 deaths have declined by over 80%, and
- New COVID-19 hospitalizations are down nearly 80%.

We have come to this point in our fight against the virus because of our historic investments and our efforts to mitigate its worst impacts. Addressing COVID-19 remains a significant public health priority for the Administration, and over the next few months, we will transition our COVID-19 policies, as well as the current flexibilities enabled by the COVID-19 emergency declarations, into improving standards of care for patients. We will work closely with partners, including state, local, Tribal, and territorial agencies, industry, and advocates, to ensure an orderly transition.

What will not be affected:

It is important to note that the Administration’s continued response to COVID-19 is not fully dependent on the COVID-19 PHE, and there are significant flexibilities and actions that will not be affected as we transition from the current phase of our response. As described below, the Administration is committed to ensuring that COVID-19 vaccines and treatments will be widely accessible to all who need them. There will also be continued access to pathways for emergency use authorizations (EUAs) for COVID-19 products (tests, vaccines, and treatments) through the Food and Drug Administration (FDA), and major telehealth flexibilities will continue to exist for those participating in Medicare or Medicaid.
Access to COVID-19 vaccinations and certain treatments, such as Paxlovid and Lagevrio, will generally not be affected. To help keep communities safe from COVID-19, HHS remains committed to maximizing continued access to COVID-19 vaccines and treatments.

Partners across the U.S. Government (USG) are developing plans to ensure a smooth transition for the provision of COVID-19 vaccines and treatments as part of the traditional health care marketplace and are committed to executing this transition in a thoughtful, well-coordinated manner.

Importantly, this transition to more traditional health care coverage is not tied to the ending of the COVID-19 PHE and in part reflects the fact that the federal government has not received additional funds from Congress to continue to purchase more vaccines and treatments.

When this transition to traditional health care coverage occurs later this year, many Americans will continue to pay nothing out-of-pocket for the COVID-19 vaccine. Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are a preventive health service for most private insurance plans and will be fully covered without a co-pay. Currently, COVID-19 vaccinations are covered under Medicare Part B without cost sharing, and this will continue. Medicaid will continue to cover all COVID-19 vaccinations without a co-pay or cost sharing through September 30, 2024, and will cover ACIP-recommended vaccines for most beneficiaries thereafter.

Out-of-pocket expenses for certain treatments may change, depending on an individual’s health care coverage, similar to costs that one may experience for other drugs through traditional coverage. Medicaid programs will continue to cover COVID-19 treatments without cost sharing through September 30, 2024. After that, coverage and cost sharing may vary by state.

FDA’s EUAs for COVID-19 products (including tests, vaccines, and treatments) will not be affected. The ending of the COVID-19 PHE will not affect the FDA’s ability to authorize various products, including tests, treatments, or vaccines for emergency use. Existing EUAs for COVID-19 products will remain in effect under Section 564 of the Federal Food, Drug, and Cosmetic Act, and the agency may continue to issue new EUAs going forward when criteria for issuance are met.

Major Medicare telehealth flexibilities will not be affected. The vast majority of current Medicare telehealth flexibilities that Americans—particularly those in rural areas and others who struggle to find access to care—have come to rely upon over the past two years, will remain in place through December 2024 due to the bipartisan Consolidated Appropriations Act, 2023 passed by Congress in December 2022.

Medicaid telehealth flexibilities will not be affected. States already have significant flexibility with respect to covering and paying for Medicaid services delivered via telehealth. State requirements for approved state plan amendments vary as outlined in CMS’ Medicaid & CHIP Telehealth Toolkit - PDF. This flexibility was available prior to the COVID-19 PHE and will continue to be available after the COVID-19 PHE ends. Similar to Medicare, these telehealth flexibilities can provide an essential lifeline to many, particularly for individuals in rural areas and those with limited mobility.

The process for states to begin eligibility redeterminations for Medicaid will not be affected. During the COVID-19 PHE, Congress has provided critical support to state Medicaid programs by substantially increasing the federal matching dollars they receive, as long as they agreed to important conditions that protected tens of millions of Medicaid beneficiaries, including the condition to maintain Medicaid enrollment for beneficiaries until the last day of
the month in which the PHE ends. However, as part of the Consolidated Appropriations Act, 2023 Congress agreed to end this condition on March 31, 2023, independent of the duration of the COVID-19 PHE.

Access to buprenorphine for opioid use disorder treatment in Opioid Treatment Programs (OTPs) will not be affected. Early in the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) released guidance allowing patients to start buprenorphine in an OTP by telehealth without the required in-person physical examination first. This flexibility has proven to be safe and effective in engaging people in care such that SAMHSA proposed to make this flexibility permanent as part of changes to OTP regulations in a Notice of Proposed Rulemaking that it released in December 2022. SAMHSA has committed to providing an interim solution if the proposed OTP regulations are not finalized prior to May 11.

Access to expanded methadone take-home doses for opioid use disorder treatment will not be affected. Early in 2020, SAMHSA allowed an increased number of take-home doses to patients taking methadone in an OTP. Research and feedback from patients, OTPs, and states have demonstrated that this flexibility has allowed people with opioid use disorder to stay in treatment longer, supported recovery, and has not resulted in increases in methadone-related overdoses. SAMHSA announced it will extend this flexibility for one year from the end of the COVID-19 PHE, which will be May 11, 2024, to allow time for the agency to make these flexibilities permanent as part of the proposed OTP regulations published in December 2022.

What will be affected:

Many COVID-19 PHE flexibilities and policies have already been made permanent or otherwise extended for some time. However, HHS continues to review the flexibilities and policies implemented during the COVID-19 PHE to determine whether others can and should remain in place, even for a temporary duration, to facilitate jurisdictions’ ability to provide care and resources to Americans. Still, others will expire. Below is a list of some of the changes people will see in the months ahead.

Certain Medicare and Medicaid waivers and broad flexibilities for health care providers are no longer necessary and will end. During the COVID-19 PHE, CMS has used a combination of emergency authority waivers, regulations, and sub-regulatory guidance to ensure and expand access to care and to give health care providers the flexibilities needed to help keep people safe. States, hospitals, nursing homes, and others are currently operating under hundreds of these waivers that affect care delivery and payment and that are integrated into patient care and provider systems. Many of these waivers and flexibilities were necessary to expand facility capacity for the health care system and to allow the health care system to weather the heightened strain created by COVID-19; given the current state of COVID-19, this excess capacity is no longer necessary.

CMS developed a roadmap for the eventual end of the COVID-19 PHE, which was published in August 2022, and has been sharing information on what health care facilities and providers can do to prepare for future emergencies. This includes facilities returning to normal operations and meeting CMS requirements that promote the safety and quality of care they provide. CMS will continue to provide updated information and is also offering technical assistance to states and engaging in public education about the necessary steps to prepare for the end of the COVID-19 PHE.

For Medicaid, some additional COVID-19 PHE waivers and flexibilities will end on May 11, while others will remain in place for six months following the end of the PHE. But many of the Medicaid waivers and flexibilities, including those that support home and community-based services, are available for states to continue beyond the PHE, if they choose to do so. For example, states have used COVID-19 PHE-related flexibilities to increase the number of
individuals served under a waiver, expand provider qualifications, and other flexibilities. Many of these options may be extended beyond the PHE.

**Coverage for COVID-19 testing for Americans will change.** Medicare beneficiaries who are enrolled in Part B will continue to have coverage without cost sharing for laboratory-conducted COVID-19 tests when ordered by a provider, but their current access to free over-the-counter (OTC) COVID-19 tests will end, consistent with the statute on Medicare payment for OTC tests set by Congress.

The requirement for private insurance companies to cover COVID-19 tests without cost sharing, both for OTC and laboratory tests, will end. However, coverage may continue if plans choose to continue to include it. We are encouraging private insurers to continue to provide such coverage going forward.

State Medicaid programs must provide coverage without cost sharing for COVID-19 testing until the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. That means with the COVID-19 PHE ending on May 11, 2023, this mandatory coverage will end on September 30, 2024, after which coverage may vary by state.

Additionally, dependent on supply and resources, the USG may continue to distribute free COVID-19 tests from the Strategic National Stockpile through the United States Postal Service, states, and other community partners. Pending resource availability, the Centers for Disease Control and Prevention’s (CDC) Increasing Community Access to Testing (ICATT) program will continue working to ensure continued equitable access to testing for uninsured individuals and areas of high social vulnerability through pharmacies and community-based sites.

**Reporting of COVID-19 laboratory results and immunization data to CDC will change.** CDC COVID-19 data surveillance has been a cornerstone of our response, and during the PHE, HHS has had the authority to require lab test reporting for COVID-19. At the end of the COVID-19 PHE, HHS will no longer have this express authority to require this data from labs, which may affect the reporting of negative test results and impact the ability to calculate percent positivity for COVID-19 tests in some jurisdictions. CDC has been working to sign voluntary Data Use Agreements (DUAs), encouraging states and jurisdictions to continue sharing vaccine administration data beyond the PHE. Additionally, hospital data reporting will continue as required by the CMS conditions of participation through April 30, 2024, but reporting may be reduced from the current daily reporting to a lesser frequency.

**Certain FDA COVID-19-related guidance documents for industry that affect clinical practice and supply chains will end or be temporarily extended.** FDA published several dozen guidance documents to address challenges presented by the COVID-19 PHE, including limitations in clinical practice or potential disruptions in the supply chain. FDA is in the process of addressing which policies are no longer needed and which should be continued, with any appropriate changes, and the agency will announce plans for each guidance prior to the end of the PHE.

**FDA’s ability to detect early shortages of critical devices related to COVID-19 will be more limited.** During the PHE, manufacturers of certain devices related to the diagnosis and treatment of COVID-19 have been required to notify the FDA “of a permanent discontinuance in the manufacture of the device” or “an interruption in the manufacture of the device that is likely to lead to a meaningful disruption in the supply of that device in the United States.” This requirement will end when the PHE ends. While FDA will still maintain its authority to detect and address other potential medical product shortages, it is seeking congressional authorization to extend the requirement for device manufacturers to notify FDA of significant interruptions and discontinuances of critical devices outside of a PHE which will strengthen the ability of FDA to help prevent or mitigate device shortages.
Public Readiness and Emergency Preparedness (PREP) Act liability protections may be impacted. Currently, the amended PREP Act declaration provides liability immunity to manufacturers, distributors, public and private organizations conducting countermeasure programs, and providers for COVID-19 countermeasure activities related to a USG agreement (e.g., manufacturing, distribution, or administration of the countermeasures subject to a federal contract, provider agreement, or memorandum of understanding). That coverage will not be affected by the end of the PHE. However, PREP Act liability protections for countermeasure activities that are not related to any USG agreement (e.g., products entirely in the commercial sector or solely a state or local activity) will end unless another federal, state, or local emergency declaration is in place for area where countermeasures are administered. HHS is currently reviewing whether to continue to provide this coverage going forward.

The ability of health care providers to safely dispense controlled substances via telemedicine without an in-person interaction is affected; however, there will be rulemaking that will propose to extend these flexibilities. During the PHE, the Drug Enforcement Administration (DEA) and HHS adopted policies to allow DEA-registered practitioners to prescribe controlled substances to patients without an in-person interaction. These policies allowed for audio-only modalities to initiate buprenorphine prescribing. DEA is planning to initiate rulemaking that would extend these flexibilities under certain circumstances without any gap in care and will provide additional guidance to practitioners soon.

###