

The Caucus Corner

The National Caucus and Center on Black Aging, Inc. (NCBA)
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Domestic Violence Awareness Month 2026



It's October. You know what that means, right? Pumpkins, apples, and **Domestic Violence Awareness Month (DVAM)**. Partners for Peace asks you to join us for a month full of opportunities to **spread awareness and take action** to support survivors of domestic violence.

Each October, communities across the nation join together to recognize the prevalence of domestic violence and honor those who have been affected by violence with vigils, walks, and other awareness-raising activities. DVAM was first recognized in October of 1987.

Frequently Asked Questions

1. What is Domestic Violence?

Domestic violence is a pattern of coercive, controlling behavior that can include physical abuse, emotional or psychological abuse, sexual abuse or financial abuse (using money and financial tools to exert control). Some abusers are able to exert complete control over a victim's every action without ever using violence or only using subtle threats of violence. All types of abuse are devastating to victims.

Domestic violence is a pervasive, life-threatening crime that affects millions of individuals across the United States. High-profile cases of domestic violence will attract headlines, but thousands of people experience domestic abuse every day, and they come from all walks of life.



In our annual [Domestic Violence Counts Report](#), the National Network to End Domestic Violence (NNEDV) finds that U.S. domestic violence shelters and programs serve thousands of victims and answer thousands of crisis hotline calls, chats, texts, and emails every day of the year.

Abusive partners make it very difficult for victims to escape relationships. Sadly, many survivors suffer from abuse for decades. It is important for survivors to know that the abuse is not their fault, and that they are not alone. [Help is available](#) to those who are experiencing domestic violence.

2. What Resources Are Available for Victims?

Survivors have many options, from obtaining a protection order, staying in a shelter, exploring options through support groups, or making an anonymous call to a local domestic violence shelter or national hotline. There is hope for victims, and they are not alone.

There are hundreds of local shelters across the United States that provide safety, counseling, legal help, and other resources for victims and their children. Information and support are available for victims of abuse and their friends and family:

Hotlines

If you are in immediate danger and feel comfortable involving law enforcement, please call 911.

- The [U.S. National Domestic Violence Hotline](#) provides confidential and anonymous support 24/7. Reach out by phone (1-800-799-7233), TTY (1-800-787-3224), chat ([TheHotline.org](#)), or text (START to 88788).
- [Loveisrespect](#) provides teens and young adults confidential and anonymous support. Reach out by phone 1-866-331-9474 and TTY 1-866-331-8453.
- [WomensLaw.org](#) (a project of NNEDV) provides legal information and resources for victims. Reach out by email through the [Women's Law Email Hotline](#) in English and Spanish.

Information

- Technology can be used by victims to increase safety and privacy; it can also be misused by perpetrators to harass, abuse, or harm victims. Find information, including resources and toolkits, related to technology safety at [TechSafety.org](#).
- [Financial abuse](#) is widespread. Learn more about rebuilding from financial abuse from [The Moving Ahead Curriculum](#).
- Find state- and territory-specific legal information on [WomensLaw.org](#) related to custody, protection orders, divorce, and more.
- Find your state or territorial domestic violence coalition (NNEDV's trusted members, supporting thousands of local programs) by visiting: <https://nnedv.org/content/state-u-s-territory-coalitions/>

TIP: Before using online resources, know that your computer or phone may not be safe. Some abusive partners misuse technology to stalk and track a partner's activities on a computer, tablet, or mobile device. (Learn more at [TechSafety.org](#).)

3. Why Do Victims Sometimes Return to Or Stay with Abusers?

The question is not "*Why doesn't the victim just leave?*" The better question is "*Why does the abuser choose to abuse?*" The deck is stacked against victims as they navigate safety: Abusive partners work very hard to keep victims trapped in the relationship. They may try to isolate the victim from friends and family, thereby reducing the people and places where the survivor can go for support.

Through various tactics of financial abuse, abusive partners create financial barriers to safety.

There is a real fear of death or more abuse if they leave, as abusers may perceive this act of independence as a threat to the power and control they've worked to gain, and they may choose to escalate the violence in response.

Through "gaslighting," abusive partners cause victims to feel like they are responsible for the abuse. Gaslighting is a form of emotional abuse that abusers use to confuse and shift blame onto the victim. This often causes the victim to doubt their sanity and feel like they are responsible for the abuse and, therefore, able to stop it.

Abuse takes an emotional and physical toll over time, which can translate to additional health issues that make leaving more difficult. Survivors often report that they want the abuse to end, not the relationship. A survivor may stay with or return to an abusive partner because they believe the abuser's promises to change.

4. Do Abusers Show Any Potential Warning Signs?

There is no way to spot an abuser in a crowd, but most abusers share some common characteristics. Some of the subtle warning signs include:

- They insist on moving quickly into a relationship.
- They can be very charming and may seem "too good to be true."
- They insist that you stop participating in your preferred leisure activities or spending time with family and friends.
- They are extremely jealous or controlling.
- They do not take responsibility for their actions and blame others for everything that goes wrong.
- They criticize their partner's appearance and make frequent put-downs.
- Their words and actions don't match.

Domestic violence is first and foremost a pattern of power and control. Any one of these behaviors may not be indicative of abuse on its own, until it is considered as part of a pattern of behavior. And remember: it's never your fault if someone chooses to hurt or abuse you, whether there were "warning signs" or not.

5. Is it Possible for Abusers to Change?

Yes, but they must first make the choice to change their behavior. It's not easy for an abusive partner to stop choosing abusive behavior, and it requires a serious commitment to change. Once an abuser has had all of the power in a relationship, it's difficult to transition to a healthy relationship where each partner has equal respect and power.

Sometimes an abusive partner stops one form of the abuse – for example, the physical violence – but continues to employ other forms of abuse, such as emotional, sexual, or financial abuse. It is important to remember that domestic violence includes one or more forms of abuse and is a part of an overall pattern of seeking power and control over the victim.

6. Are Men Victims of Domestic Violence?

Yes, men can be victims of domestic abuse. Domestic violence is a pervasive, life-threatening crime that affects millions of individuals across the United States.

According to the Centers for Disease Control and Prevention, more than four in 10 men (44.2% or 52.1 million) in the United States reported contact sexual violence, physical violence, and/or stalking by an intimate partner at some point in their lifetime.

Pervasive stereotypes that men are always the abuser and women are always the victim discriminates against survivors who are men and discourages them from coming forward with their stories. Survivors of domestic violence who are men are less likely to seek help or report abuse. Many are unaware of services for men, and there is a common misconception that domestic violence programs only serve women.

When we talk about domestic violence, we're not talking about men versus women or women versus men. We're talking about violence versus peace and control versus respect. Domestic violence affects us all, and all of us must be part of the solution.

7. How Does the Economy Affect Domestic Violence?

A bad economy does not cause domestic violence – and the only person responsible for abuse is an abuser – but economic stressors can worsen certain aspects of domestic violence.

The severity and frequency of abuse can increase when factors associated with a bad economy are present. Job loss, housing foreclosures, debt, and other factors contribute to higher stress levels at home, which can lead some people to choose to channel their frustration into violent, controlling behavior against partners or other family members.

As the abuse gets worse, a weak economy also limits options for survivors to seek safety or escape. Additionally, domestic violence shelters and programs may experience funding cuts right when they need more staff and funding to keep up with the demand for their services. Victims may also have a more difficult time finding a job to become financially independent of abusers.

8. What Can I Do to Help?

Everyone can speak out against domestic violence. Use our [10 Tips to Have an Informed Conversation about Domestic Violence](#) by visiting: [**https://nnedv.org/content/10-tips-informed-conversation/**](https://nnedv.org/content/10-tips-informed-conversation/) to help guide your conversations with friends, colleagues, and loved ones.

Every person can take individual action to create a supportive community for survivors. Get involved in your community – we’ve got ideas for creative ways to get involved in our [Get Involved Toolkit](#) by visiting: [**https://nnedv.org/resources-library/get-involved-toolkit/**](https://nnedv.org/resources-library/get-involved-toolkit/).

Members of the public can donate to local, statewide, territorial, or national anti-domestic violence programs or victim assistance programs, like [NNEDV](#) at [**https://nnedv.org/donate-now/**](https://nnedv.org/donate-now/).

Find your state or territory coalition by visiting: [**https://nnedv.org/content/state-u-s-territory-coalitions/**](https://nnedv.org/content/state-u-s-territory-coalitions/)

You can call on your public officials to support life-saving domestic violence services and hold perpetrators accountable.

For more information, visit:

[**https://nnedv.org/content/frequently-asked-questions-about-domestic-violence/**](https://nnedv.org/content/frequently-asked-questions-about-domestic-violence/)

Late Life Domestic Violence

Domestic violence, also called intimate partner violence, describes physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner. It can occur across the lifespan to victims of all ages, including older adults. An intimate partner is a person with whom one has a close personal relationship that can be characterized by emotional connection and regular contact, ongoing physical contact and sexual behavior, and familiarity and knowledge about each other’s lives.

Perpetrators include current and former spouses or partners, or other individuals with whom the victim has an ongoing, personal relationship. This problem occurs in all communities.

Although most victims are female, men can be harmed, too. Generally, abusers use a pattern of coercive tactics, such as isolation, threats, intimidation, manipulation, and violence, to gain and maintain power over victims. They often tell their victims where they can go, whom they can see, and how they can spend money—in other words, control their decisions.

Some abusers use their role and power to financially exploit their victims. Others feel that they are entitled to control because they are “head of the household,” or because they are younger and physically stronger than their victims. Some experts view late life domestic violence as a sub-set of the larger elder abuse problem. Elder abuse, broadly defined, includes physical, sexual and emotional abuse, financial exploitation, neglect and self-neglect, and abandonment.

The distinctive context of domestic violence in later life is the abusive use of power and control by a person known to the victim in a close, personal way. The domestic violence and aging networks are encouraged not to draw lines between the two service systems. So, the goal is not to answer, “Is this domestic violence?”, or, “Is this elder abuse?” Instead, efforts should maximize the capacity of both systems by partnering to meet older victims’ unique needs.

To learn more about the relationship between elder abuse and domestic violence, please read the National Center on Elder Abuse (NCEA) issue brief “[Late Life Domestic Violence: What the Aging Network Needs to Know \(PDF\)](#).”

Does an Older Adult in Your Life Need Help?

It is not always clear whether an aging parent or relative needs help. Sometimes a person will recognize that they need help and request it, or an emergency or sudden illness will make it clear. Others may not want to cause worry or admit they're struggling.

If you become aware of the signs that a loved one needs help, you will be better prepared to provide support for their safety and well-being.

How to tell if someone needs extra support

The best way to know what someone needs is to ask them directly. But a phone call, email, or text message is not always the best way to tell whether an older person needs help.

These signs may indicate that someone needs extra support:

Changes at home. When you spend time at the person's home, you might notice possible trouble spots. Some examples include:

- Can the person prepare meals on a stove safely?
- Are they bathing regularly and wearing appropriate clothing for the weather?
- Is the home relatively clean and free of clutter?
- Do they have the medications they need, and are they taking them regularly?

Mental health concerns. Changes in a person's mood could indicate a need for help. Sometimes depression in older people is confused with normal aging. An older person with depression might brighten up for a phone call or short visit, but it's harder to hide serious mood problems during an extended visit.

Seek immediate help if the person says they feel hopeless or have no reason to live, or if you're worried they may harm themselves. Call or text the 24-hour 988 Suicide & Crisis Lifeline at 988 or call 800-273-TALK (800-273-8255). For TTY, use your preferred relay service or dial 711 then 988.

Memory issues. Occasional forgetfulness is a normal part of aging. But more significant memory problems, changes in thinking ability or personality, or poor decision-making could indicate a serious condition that requires medical attention.

If you're concerned about the person's physical or mental health, suggest a visit to a health care provider. You might offer to make the appointment, give them a ride, or go with them to see the doctor.

You don't have to do everything yourself. In many communities, a variety of services are available to help older people. Depending on the person's needs, you might hire a home health aide to visit on a regular basis, arrange transportation so the person can run errands, or speak with a geriatric care manager to help coordinate care. You can also find ways to share caregiving responsibilities with other family members, neighbors, or friends.

Helping an aging parent or other relative plan for the future

The best time to plan is before the older person needs extensive help. Planning for the possibility of long-term care gives you and your family time to learn about services available in your community and what they cost. It also allows the older person to make important decisions while they are still able.

There may be a time when your older relative can no longer live independently at home. Learn as much as you can about housing options, which may include moving to a residential facility (such as a nursing home or assisted living) or living with a family member. These choices may depend on the person's health, ability to perform activities of daily living, financial resources, and personal preferences. Talk about the pros and cons of each option before making a decision.

You may also need to help the older person prepare for decisions about their future medical care — a process called advance care planning. It's important to know what they would want if they became seriously ill or unable to communicate their wishes. Having conversations about the person's preferences and making a plan makes it more likely that they will get the care they want.

For more information on how to help an aging parent or relative

Eldercare Locator

800-677-1116

eldercarelocator@USAging.org

<https://eldercare.acl.gov>

LongTermCare.gov

202-619-0724

aclinfo@acl.hhs.gov

<https://acl.gov/ltc>

Caregiver Action Network

202-454-3970

info@caregiveraction.org

www.caregiveraction.org

Family Caregiver Alliance

800-445-8106

info@caregiver.org

www.caregiver.org

For more information, visit:

<https://www.nia.nih.gov/health/caregiving/does-older-adult-your-life-need-help>

Call 211 for Help

In many states, dialing “211” provides individuals and families in need with a shortcut through what can be a bewildering maze of health and human service agency phone numbers. By simply dialing 211, those in need of assistance can be referred to, and sometimes connected to, appropriate agencies and community organizations.

Dialing 211 helps direct caller services for, among others, the elderly, the disabled, those who do not speak English, those having a personal crisis, those with limited reading skills, and those who are new to their communities. 211 is available to approximately 99 percent of the total U.S. population, according to 211.org. 211 covers all 50 states, the District of Columbia, and Puerto Rico.

To find out whether 211 services are offered in your area, and to obtain more information, visit 211.org. You can also connect directly to 211 by text or through this website.

How 211 Works 211 typically works a bit like 911.

Calls and texts to 211 are routed by the local telephone company to a local or regional calling center. The 211 center’s referral

specialists receive requests from callers, access databases of resources available from private and public health and human service agencies, match callers’ needs to available resources, and link or refer callers directly to an agency or organization that can help.

Types of Referrals Offered by 211

- Basic Human Needs Resources – including food and clothing banks, shelters, rent assistance, and utility assistance.
- Physical and Mental Health Resources – including health insurance programs, Medicaid and Medicare, maternal health resources, health insurance programs for children, medical information lines, crisis intervention services, support groups, counseling, and drug and alcohol intervention and rehabilitation.
- Work Support – including financial assistance, job training, transportation assistance, and education programs.
- Access to Services in Non-English Languages – including language translation and interpretation services to help non-English-speaking people find public resources (foreign language services vary by location).
- Support for Older Americans and Persons with Disabilities – including adult day care, community meals, respite care, home health care, transportation, and homemaker services.
- Children, Youth and Family Support – including childcare, after-school programs, educational programs for low-income families, family resource centers, summer camps and recreation programs, mentoring, tutoring, and protective services.

Suicide Prevention – referral to suicide prevention help organizations. Callers can also dial 988, the three-digit, nationwide phone number to connect directly to the 988 Suicide and Crisis Lifeline. Those who wish to donate time or money to community help organizations can also do so by dialing 211.

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For more information, visit:

https://www.fcc.gov/sites/default/files/dial_211_for_essential_community_services.pdf

The Silent Risk to Your Sight: Why Regular Eye Exams Matter More Than You Think

There is a quiet truth about vision loss that does not get talked about enough. It often happens slowly, without pain, and without obvious warning. Many people assume that if their eyes do not hurt, everything must be fine. In reality, some of the most common eye conditions, including glaucoma, macular degeneration, and diabetic eye disease, can progress silently and affect your sight long before you notice a change.

That is why regular eye exams are not just helpful, they are essential.

For many older adults, vision changes are often brushed off as a normal part of aging. Reading may feel more difficult. Driving at night may become more stressful. Faces across the room may not appear as clear as they once did. These changes can feel gradual and even expected, but they can also be early signs of conditions that can be treated or slowed when caught in time.

A comprehensive eye exam does much more than update your glasses prescription. It gives your eye doctor a clear view of your overall eye health and allows them to detect issues before they begin to affect your daily life. In many cases, early detection leads to simple treatments such as prescription eye drops, lifestyle changes, or routine monitoring that can help preserve your vision for years.

There are also times when your eyes send more obvious signals that something needs attention. Sudden flashes of light, new floaters drifting across your vision, eye pain, redness, or a shadow or curtain over part of your sight should never be ignored. These symptoms can point to serious conditions that require immediate care. Acting quickly can make a meaningful difference.

The encouraging news is that many causes of vision loss are preventable or manageable. Glaucoma can often be controlled with daily eye drops. Diabetic eye disease can be monitored and treated before it leads to permanent damage. Age related macular degeneration, one of the leading causes of vision loss, can often be slowed with proper care and regular follow up.

But none of this works without one key step. Showing up.

If it has been more than a year since your last eye exam, or if you cannot remember the last time you had one, now is the time to schedule one. If you are already receiving care for an eye condition, staying consistent with treatment and follow up visits is just as important as getting started. Vision care is not a one-time event. It is an ongoing partnership between you and your provider.

You can also play an important role in your community. If you have experienced the benefits of eye care, consider encouraging a friend, neighbor, or family member to schedule their own exam. A simple question like “When was your last eye check?” may be all it takes to help someone protect their sight.

Vision is closely tied to independence, confidence, and quality of life. It allows us to read, drive, recognize loved ones, and stay connected to the world around us. Protecting it does not require drastic action. It simply requires consistent and proactive care.

Finding an eye doctor is possible regardless of your insurance situation, and getting started is often easier than it seems. If you have Medicare, many plans cover annual eye exams for certain conditions such as diabetes, glaucoma risk, or macular degeneration.

Many Medicare Advantage plans also include routine vision benefits for exams and glasses. You can start by calling the number on the back of your insurance card or visiting your plan’s website to find in-network providers near you. If you have private insurance, your provider directory can help you locate optometrists or ophthalmologists in your area, often with low copays. A quick call to confirm your coverage can help you avoid surprises and make the most of your benefits.

If you do not have insurance, there are still options available. Community health centers, nonprofit organizations, and local programs may provide free or low cost eye exams and glasses, especially for older adults. Some clinics offer sliding scale fees based on income.

National programs such as EyeCare America, through the American Academy of Ophthalmology, can connect eligible seniors with volunteer eye doctors at no cost. You can also call 2-1-1 or check with your local health department to find services nearby. No matter your situation, there are resources available to help you access care.

Your eyes may not always tell you when something is wrong. But an eye exam will.

Schedule one. Keep it. And remind someone you care about to do the same.

Jon Lombardi, MPH, is the Program Director at the Prevention of Blindness Society of Metropolitan Washington, where he leads community-based vision care initiatives across the DC, Maryland, and Virginia region. Through mobile clinics and partnerships with local organizations, POB provides free eye exams, eyeglasses, and patient navigation services to help older adults and underserved communities access critical vision care.

Fall Vaccine Recommendations Updated for Flu, COVID, and RSV

Health officials have issued updated guidance for fall vaccinations, covering flu, COVID, and RSV. The new recommendations clarify who should get each shot and the best timing for protection.

Updated fall vaccine recommendations are now available for the flu, COVID-19, and RSV, according to a recent report from NBC Chicago. Health officials advise most people to plan for their annual flu shot and stay current with COVID boosters, while RSV vaccination remains targeted at older adults and certain high-risk groups. The goal is to offer protection before respiratory viruses begin spreading widely in the community.

Key takeaways

- The flu vaccine is recommended for nearly everyone aged 6 months and older.
- Updated COVID-19 shots are available and recommended for most people, especially those at higher risk.
- RSV vaccination is not for everyone. It is generally advised for adults aged 60 or older and for certain younger adults with chronic conditions.
- Timing matters. Getting vaccinated in early fall, before virus season peaks, provides the best protection.
- People can receive the flu and COVID shots during the same visit in many cases.

What the latest flu vaccine guidance says

The report highlights that annual flu vaccination continues to be the most reliable way to reduce the risk of influenza and its complications. Health authorities recommend that everyone aged 6 months and older receive a flu shot each season, barring specific medical exceptions.

For older adults, there are higher-dose and adjuvanted flu vaccines designed to produce a stronger immune response. These are often preferred for people aged 65 and up, though the standard shot remains a reasonable option if those are not available.

Flu activity typically begins to increase in October or November and can last through the spring. Because it takes about two weeks for the body to build protective antibodies, getting the shot in September or October is considered ideal. Getting it too early in the summer may result in waning immunity before the season ends, but late fall is still better than skipping it entirely.

Updated COVID-19 shots and who should get them

The updated COVID-19 vaccines are designed to match the virus variants that are currently circulating. The report notes that these shots are recommended for everyone aged 6 months and older. People who are older, immunocompromised, or living with chronic health conditions such as heart disease, diabetes, or lung disease have the most to gain from staying current on their COVID vaccinations.

Pregnant women are also encouraged to get vaccinated to protect both themselves and their newborns. For people who have never received a COVID-19 vaccine, the updated shot serves as the primary series. For those who have been vaccinated before, it acts as a booster. The timing of the COVID shot does not have to match the flu shot exactly but receiving them together is convenient and safe for most people. Health officials say there is no downside to getting both at the same appointment.

RSV vaccination is more targeted

Respiratory syncytial virus, known as RSV, is a common virus that can cause serious illness in older adults and infants. The new recommendations reflect a more focused approach. The RSV vaccine is recommended for adults aged 60 through 74 who are at increased risk of severe RSV disease. This includes those with chronic heart, lung, or kidney conditions, weakened immune systems, or those living in nursing homes. Adults aged 75 and older are advised to get the vaccine even without specific risk factors.

For infants, RSV protection can be provided through a maternal vaccine given during pregnancy or through a preventive antibody shot for babies born before or during RSV season. Parents should discuss these options with their child's healthcare provider to determine the best strategy, as recommendations may vary based on the baby's age and health status.

Why early fall timing matters

The report stresses that planning ahead is important because respiratory viruses often peak during winter months. Vaccination not only reduces the chance of getting sick but also lowers the severity of illness if a breakthrough infection occurs. This can mean fewer hospitalizations and less strain on healthcare systems.

While no vaccine offers perfect protection, the updated formulations are designed to match the strains expected to circulate this season, making them a valuable preventive measure.

Frequently Asked Questions

Can I get the flu and COVID shots at the same time?

Yes, in most cases it is safe and convenient to receive the flu and COVID-19 vaccines during the same visit. There is no evidence that getting them together reduces effectiveness, and it saves an extra trip to the pharmacy or clinic. If you have concerns about side effects, you can space them out by a week or two, but co-administration is generally approved and encouraged.

Is the RSV vaccine right for everyone over 60?

No, the RSV vaccine is not recommended for every older adult. It is specifically advised for adults aged 60 to 74 who have underlying health conditions that increase their risk of severe RSV. These conditions include chronic heart or lung disease, diabetes, kidney disorders, and weakened immune systems. Adults aged 75 and older are recommended to receive it regardless of their health status. If you fall into these categories, a quick discussion with your doctor can help clarify your personal risk.

How long does it take for the vaccines to provide protection?

Most respiratory vaccines, including flu and COVID, take about two weeks after administration for the body to build a meaningful immune response. That is why public health officials recommend getting vaccinated in early fall before virus transmission becomes widespread. RSV vaccines also require a similar period to reach full effectiveness. Getting vaccinated too late in the season is still better than not getting vaccinated at all, since protection can develop even as viruses are already circulating.

<https://medicalnewstoday.us/fall-vaccine-recommendations-updated/>



Vaccines Offer Our Best Protection Against Severe Illness from Respiratory Diseases

Vaccines help protect against more than 20 life-threatening diseases—including infectious respiratory diseases. For decades, vaccines have saved millions of lives and greatly reduced the spread of deadly diseases all over the world. Staying up to date with recommended vaccines is the best way to help protect yourself, those you love, and your community from infectious respiratory disease. Learn more about the vaccines available to protect against infectious respiratory disease.

COVID-19

Who needs to be protected?

FDA-approved 2025-2026 COVID-19 vaccines are recommended by the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) for those:

- 6 months to 64 years of age based on individual decision-making, also known as shared clinical decision-making.* Vaccination is most favorable for those at increased risk for severe COVID-19 disease.
- 65+ based on individual decision-making.

This recommendation does not require a prescription to receive a 2025-2026 COVID-19 vaccine, though encourages people to talk to a health care provider (e.g., doctor, nurse, pharmacist) to help them assess if the vaccine is right for them. COVID-19 vaccines should be available at your local pharmacy but call ahead to ensure availability.

COVID-19 vaccines are covered by both public (Medicaid and Medicare) and private insurance, including employer-sponsored insurance, without cost-sharing.

What COVID-19 vaccines are available?

Three COVID-19 vaccines are available in the U.S., including two mRNA vaccine options (Moderna and Pfizer) and one protein-based vaccine option (Novavax).

Many pharmacies offer a range of vaccines. Visit [vaccines.gov](https://www.vaccines.gov) to find a pharmacy near you.

Influenza (Flu)

Who needs to be protected?

Everyone is vulnerable to the flu, and the best way to help prevent it is by getting vaccinated. CDC recommends that **everyone—with rare exceptions—6 months and older** receive an updated flu vaccine each year. According to CDC, flu vaccines reduce the risk of severe disease by about 50%.

What flu vaccines are available?

Several types of flu vaccines are available. Depending on age and other factors, you may be recommended to receive a particular type of flu vaccine. Approved options include inactivated injectable, recombinant injectable, live attenuated nasal spray, high-dose, and adjuvanted flu vaccines.

Some types of flu vaccines are not recommended for older adults, pregnant women, or individuals who have certain health conditions, so check with a healthcare provider to choose the right option for you.

Pertussis (Whooping Cough)

Who needs to be protected?

CDC recommends that **everyone — including infants, children, preteens, adults, and pregnant women** — stay up to date with their whooping cough vaccines.

Because whooping cough is particularly dangerous for babies, vaccines are important for anyone who is around babies, including parents, siblings, grandparents, caregivers, and friends of the family.

What whooping cough vaccines are available?

There are two types of combination vaccines available to protect individuals from whooping cough and the vaccine you receive depends on age. Children younger than 7 years of age receive DTaP, while older children and adults receive Tdap. DTaP and Tdap vaccines also protect against diphtheria ("d") and tetanus ("t").

Respiratory Syncytial Virus (RSV)

Who needs to be protected?

The best way to help prevent RSV is to get vaccinated. The Centers for Disease Control and Prevention (CDC) recommends protection against RSV for the following groups:

- Infants and young children
 - CDC recommends either maternal RSV vaccination or infant immunization to help prevent severe illness from RSV in infants and young children.
 - CDC recommends that pregnant women receive an RSV vaccine between 32–36 weeks of pregnancy during RSV season (typically September through January*) to protect their infants at birth.
 - If a child's mother does not receive an RSV vaccine during pregnancy, CDC recommends giving a preventive antibody to the newborn after birth.
- Adults ages 50 and older
 - A single dose of RSV vaccine is recommended for:
 - All adults age 75 and older
 - Adults ages 50-74 who are at increased risk of severe illness from RSV (such as those with chronic heart or lung illness or those who are residents of long-term care facilities)

*RSV season can vary around the country. If you live in Alaska, Florida, or outside the continental U.S., talk to a healthcare provider about when RSV season is expected where you live.

What vaccine options are available?

- For adults ages 50 and older:
 - Three RSV vaccines are available to help prevent RSV.
- For infants:
 - **Maternal vaccine:** One maternal RSV vaccine is available. When given during pregnancy, it helps prevent RSV in infants after birth.
 - **Preventive antibodies for infants:** Two options, nirsevimab or clesrovimab, are available for infants under 8 months born during or entering their first RSV season if their mother didn't receive the RSV vaccine during pregnancy, their mother's RSV vaccine status is unknown, or their mother received the RSV vaccine less than 14 days prior to birth.
 - **Preventive antibody for some young children:** Nirsevimab is also available for young children 8–19 months who are at increased risk for severe illness from RSV and are entering their second RSV season.

For more information, visit: <https://cveep.org/vaccines/>

Key takeaways

- Older workers in AI-exposed jobs have been more likely to leave the workforce since ChatGPT's arrival, while jobs less affected by AI saw little change.
- Research suggests workers age 50 and older are adopting AI at lower rates than younger colleagues, often because the payoff from learning a new tool may seem limited late in a career.
- Experts say AI could eventually help extend careers and boost productivity, especially when older workers combine experience with newer technical skills.



5 Things a Year of Job Searching Has Taught Me

It's been about a year since I was laid off after 14 years at a job in medical writing that I had once loved, in an editorial career currently clocking in at 30 years. And it's been interesting ... somewhat humbling ... let's say "challenging"...

OK. Folks. It has sucked.

I was strangely excited by the layoffs, believe it or not — I'm generally invigorated by change, I'm an optimist, I wasn't burnt out, I was wholly ready to jump into another job. Let's do this! Here I am!

And here I am, a year later, fully employed in... nothing. Semi-employed in several situations I wouldn't have considered a year ago that have taught me some stuff about life, work and our unexpected paths in the world. And of course, I would love to tell you that this past year has been a crucible of personal growth. It has! Precisely because it has been crap. And crap equals fertile ground for growth. My blip of unemployment turned into a whole (second or third?) midlife crisis thing and I KNOW I'm not alone in that.

So, during this magical year of growth:

- I've been excited and optimistic.
- I've been persevering, tenacious, determined.
- I've been rejected thoughtfully and rejected blindly.
- I've been persistent.
- I've had a gradual, sustained loss of confidence.
- I've felt punched in the guts.
- I've reenergized over the belief in potential, opportunity, new realms.
- I've had an existential crisis. I've questioned my purpose and my worth.
- I've cried, I've been mad, resentful, hopeless.
- I've gained weight. I've lost sleep.

I've had an existential crisis. I've questioned my purpose and my worth.

I've cried, I've been mad, resentful, hopeless.

I've gained weight. I've lost sleep.

I've considered somewhat suitable to fully inappropriate alternative lines of work.

I've volunteered and worked for minimum wage.

I've regretted not going into a completely different, more durable career (maybe with a union?) and then circled back to knowing I've been in the right career because I love the work.

I've panicked.

I've read a lot of pep talk blog posts.

I've been given lots of annoying advice. I've been given a bit of really insightful advice.

But I HAVE learned: How to do needlepoint. So now I'm launching my freelance needlepoint business! I'm kidding. I never got past satin stitches.

But I did say I'd share what I really learned during this year of job searching, which starts with...

1. Sometimes You Need to Stop Job Searching

Surprise!

So maybe not what you expected. Like all the traditional advice says, I made job search my job — and it slid into being a soul-destroying endeavor with surprisingly little payoff. Which I didn't quite realize until I had a unique session with an intuitive [cognitive behavioral therapy](#) (CBT) counselor. She said: "You need to put job search in a box. It has not been valuable to you."

It struck me like a slap. I felt like I hadn't heard a truer thing in ages. I mean, no one sensible will tell you to stop job searching, right? We're all meant to keep looking until we land the job. But to hear that 1) I need to put it away in a box, and 2) it actually hasn't been valuable to me? That made my eyelids flap.

But when I looked back, I realized that job searching actually only demoralized me over time. It didn't even help me get networking contacts. It's generally been a black hole of my time, energy, hope and mental health. And more harmfully, the relentless, unfruitful job searching led me to this painful query: *Have I outlived my employable usefulness?*

This is actually an absurd and irrational question but forgive yourself if you've asked it. It's the way anyone could feel after repeatedly sliding down the job search rejection hole. This question starts to follow you around when you get rejection emails fizzing up at unexpected times — evenings, Sundays, holidays — even Christmas Day.

There seems to be nowhere to hide from these little daggers of rejection – crisp brush-offs that are blandly worded but still somehow prick right through your skin. These emails always deploy the phrase "we appreciate your interest" and usually contain the word "unfortunately" shortly after that. My eyes can now instantly spot the word "unfortunately" in any large gray field of text.

I almost prefer radio silence. (And there's been a lot of that.) But the moment I paused my job search, I felt in control of my life again. No longer suspended in mid-air, waiting for someone to pick me so I could live my life. Sometimes you need to just say *stop*.

So, I did some freelance work. It was just a little bit – it's harder to find than I anticipated – but it made me feel ALIVE because I love editing and writing. I got a part-time minimum wage job that was surprisingly tricky. And I worked with a career/life coach, because...

2. We All Need Some Help

It turns out that sometimes we need help!? Wow. This is pretty basic, I know, but isn't it funny how something so fundamental sometimes has to be relearned? Because how many times do you feel like, "I can work my way out of this on my own"?

Especially as we get older, we have more life skills and resilience – I have tons of resilience. Buckets of it! Absolute heaps and mounds! But that doesn't mean nothing affects me anymore. It does mean that I can call on my strengths and wisdom to move forward. And one of those bits of wisdom is knowing when it's time to ask for help.

My plan was to find a career counselor to work with. I had an amazing one in the past I always want to call, but she died suddenly a few years ago, leaving a strong legacy of compassion and wisdom that she shared with so, so many people. There was truly no one like Toni Littlestone. She's always a reminder to me that having helped others with compassion is the best legacy you can leave.

But my lovely friend Kim Moldofsky – who does life/career coaching, among many other creative and wonderful enterprises that engage people in so many positive ways – offered to chat about what I needed.

I told Kim, "I thought I would have a job by now. I'm losing hope. I don't know what I should be doing. I can't see my way out of this dark corner." And so, we started. It started with me "thinking expansively" and progressed over a six-week set of sessions and homework to a specific action plan.

With every session, she helped deliver me from despair, not only with sensitive listening, compassion, humor, empathy and cheerleading, but also Venn diagrams, colored pencils, collage-making and other things that may sound goofy to someone listening at the door but legitimately brought me back from despair and regenerated my elemental, precious optimism. And along the way, I was reminded of the following piece of wisdom.

3. The World Is Still Full of Possibilities

During my search for a stable, full-time situation, *freelance* was a word that kept popping up. And I kept batting it away. I wanted an employee-type job. I like a steady paycheck, paid vacation and holidays, and a team to get to know. Freelance is unstable and you have to keep hustling to get work so you can pay those bills.

However. The job listings got thinner and thinner. Companies seem less into adding headcount, but they still need work done, so freelancers are very much needed.

Kim and I talked about ways to look for possibilities that would generate work, not just look around for listings. And the more I looked around with a creative eye, the more opportunities I saw. And not just in my chosen field, but other ideas to try out – part-time situations, new business sectors, new training to enter other types of editorial work.

So, I started a freelance business instead. It's a bit better – I feel somewhat more in charge of my life again – but of course, it's not like the work just rolls in. I'm working on my business mentality. I have to figure out my rates and chase projects. But it's borne of energy and optimism again. I have a fat repertoire of skills to farm out. Because...

4. We Have Lots of Good Things to Offer - But Not 'Too Much'

Younger people sometimes get more attention in the work realm, but holy hell, the rest of us are full of incredible amounts of skills, valuable insights and ideas, and things that time and experience teach you: patience, prioritizing, how to manage time and stress, how to work with all types of personalities, under all types of pressures and deadlines.

It's strangely easy to forget how much you definitely have to offer as an over-50 when you're deeply demoralized by job searching and, ahem, perhaps also easy to forget when you're the one hiring?

I'm still doing some job searching amidst my freelance hustling (although job searching still sucks mightily) so I'd like to take a moment to tell recruiters and hiring managers: THERE IS NO SUCH THING AS "OVERQUALIFIED."

If we're applying for your job and have a lot of experience, it's not too much. *It's awesome.*

We want to help your company/team/project with all of this fantastic experience! That's a good thing!

5. I'm Pretty Sure I'm Not Alone

So, if any of this sounds familiar or relatable, take solace in knowing that you have a lot of company. Job searching is a wretched undertaking, and I think there are a fair few of us on LinkedIn having a pretty rough time with it. We'll get through this, too.

I have NOT outlived my employable usefulness. But I may never progress with my needlepoint skills.

Sincerely yours,
Brooke



Breast Cancer Awareness Month 2026



Breast Cancer Awareness Month 2026 takes place globally from 1–31 October, with the World Health Organization highlighting the theme “Every story is unique, every journey matters,” emphasizing early detection, equitable care, and personal experiences.

Breast Cancer in the Elderly: Treating this Growing Patient Population



How the disease affects aging Americans—and what additional research is still needed to improve care and outcomes

Breast cancer, like most cancer, is a disease of aging. The median age of a breast cancer diagnosis is 63 and nearly 20 percent of women diagnosed are over the age of 75, according to the Surveillance Epidemiology and End Results registry. Women in their 70s have the highest risk of breast cancer diagnosis and women in their 80s have the highest risk of death. Of the more than 42,000 patients who die from the disease each year, more than half are over 70.

While older adults represent a significant portion of breast cancer patients, there are still few standardized guidelines for how best to treat and screen this population. The first mammography guidelines for survivors of early-stage breast cancer who are over age 75, for example, were only just published in early 2021.

Here, we highlight some of the ways elderly people experience breast cancer differently—and the importance of further research to improve outcomes.

How breast cancer affects the elderly

Based on current knowledge, the biology of breast cancer in the elderly is not much different from breast cancer at younger, post-menopausal ages. Up to 80 percent of cases are ER-positive. A 2014 analysis showed that the percentage of luminal breast cancers increase with age, while the percentage of aggressive basal-like tumors decrease. While more favorable breast cancer subtypes are prevalent in older women, more aggressive breast cancers are not uncommon.

Older patients can respond to treatment differently. Chemotherapy, for example, requires a balance of providing the standard of care at recommended doses while monitoring potential toxicities (such as congestive cardiac failure and osteoporosis) and impact on quality of life. While elderly people with breast cancer are at a greater risk of side effects and treatment-related mortality, *undertreatment* at any age is linked to poor outcomes.

Regardless of breast cancer subtype and prognosis, patients over 75 years do not always receive appropriate treatment. Improper assessment of functional age as well as a lack of available data in older adults with cancer contribute to this disparity. It is important for patients and their caregivers to clearly define the goals of treatment with their oncologists, along with the potential side effects of treatment.

Functional age is different for individual patients. One 75-year-old person may be very independent and active, while another may be confined to home and require daily assistance. How cancer treatment affects the individual patient will very much depend on functional status. Incorporating a few basics of geriatric assessment (Has the patient had any falls? Can he/she walk one block?) into practice could better evaluate older patients and guide treatment and care. A geriatric assessment is now recommended for almost all older patients with breast cancer and is especially important in older women considering chemotherapy. The Cancer and Aging Research Group has a chemo-toxicity calculator and geriatric assessment for patients [online](#).

The need for more research into breast cancer in the elderly

Older adults are often excluded from clinical trials, which form the basis of standards of care. This can be based on an eligibility cutoff age or a restriction to only include healthier patients. The result is a lack of clear, evidence-based guidelines on how to treat breast cancer in this group.

“Understanding how toxicities of cancer therapies will affect older patients remains an unanswered question,” said [Dr. Hyman Muss](#), BCRF investigator and director of geriatric oncology at the Lineberger Comprehensive Cancer Center at the University of North Carolina.

“New drugs are not tested in adequate numbers of older patients,” he added. “We don’t know if they will have the same benefit or side effect profile as they do for a younger, healthier population. We have just started studies in breast and other cancers to explore these issues.”

The doctors who dedicate their practice to older patients, are a special group of individuals who often view their diagnoses through the lens of a life’s journey.

“The geriatric oncologist is a rare breed,” said Dr. Muss.

One such oncologist, the late BCRF investigator Dr. Arti Hurria, [who tragically passed away in 2018](#), once said of her profession: “I am so blessed to work with this population. Because of their life’s experiences and wisdom, they can somehow appreciate and accept the boundaries of our knowledge. I advise them on their cancer, and they advise me on life. I become part of their family and vice versa. Hugs and kisses are a big part of my clinic day.”

In addition to adequate treatment guidelines for older adults with breast cancer and further study of how standards of care affect this population, there is a critical need for more oncologists who specialize in treating this population—especially as the U.S. population continues to age.

For more information, visit: <https://www.bcrf.org/about-breast-cancer/breast-cancer-elderly/>



The Emotional Impact of Downsizing

Earlier this year, I made the difficult decision to sell the home where my husband Jim and I lived together for 31 years, the place where we raised our two children. Jim died in July 2023, and it became clear the time had come for me to move on. And so, the downsizing began – one of the most difficult and emotionally challenging projects I have ever undertaken.

I could write an entire essay – or ten – about my experience and maybe someday I will. However, as I was going along filling bags and boxes, throwing away bags and boxes, making multiple trips to Goodwill, holding a garage sale, deciding what to keep, changing my mind and changing it again, what repeatedly occurred to me was that "getting rid of stuff" is as layered as the overfilled bookshelves, closets and drawers I was navigating – and I realized other people likely feel the same way.

Cris Sgrott is the founder and owner of Organizing Maniacs, based in the Washington, D.C. area, and as a Certified Professional Organizer, she understands that the "emotional baggage" – the stuff we all carry (and store in closets) – is profound. Along with her sister Vanessa, they help clients get to the root of this monumental task.

The Role of Storytelling

The key, Sgrott says, is to arrive at a place of "storytelling" for your items. "One of the reasons that people hire professional organizers to help them is that we can create a safe space for storytelling," she explains. "We can honor the memories of say, a vase, and hear someone when they tell the story out loud." One of the biggest mistakes people make when they dive into downsizing is starting with the hard items – the drawing that your now 35-year-old child did in kindergarten, the photo albums – all of the things that are guaranteed to bring up feelings of sadness or melancholy about a previous time.

"Start with the dining room. Go through the plates and silverware," Sgrott says. "They probably won't hold as much emotional value."

If you happen to be working on a downsizing project with a spouse, make the experience into a "date night" – when you have the emotional bandwidth – and tell those stories of the important items together.

Oftentimes, downsizing happens between an older parent and their adult child – this can come with its own set of challenges. For example, what if one person is a keeper and the other is a [thrower](#)? (More often than not, it's the younger one in the pair who favors tossing, especially if a move is pending for their parent.) That's where the project can turn sour, but it doesn't have to, according to Sgrott.

"We all get unreasonable when we feel we aren't being heard," she says, relaying the story of a mother downsizing her own home with her daughter, who was in her 40s, and how both were holding their ground on what to keep and what to throw. "I left them alone and before long, there was a softening between them. There was laughter. One was sharing a story. Out of what had started as two or three bins of things the mother wanted to keep, there ended up being two or three single items," said Sgrott. "Their stories about the things were honored and then they could let go."

Faced with bulging closets and overflowing desks, it's very easy to assume that it's all just clutter and needs to be eliminated, but according to Sgrott, that's not true.

"Not everything is clutter. There is a percentage of things that you do want to keep, and that's good," she says. Maybe it's a collection of photos, for instance. "I think it's fun to find pictures of myself when I was in my 20s," she says. "Looking at them validates who I was, who I am now... that's not clutter."

With that said, here comes the practical advice: "There are only so many bowls you need. You know which ones you love and which ones you use. There *are* things you need to make decisions on."

One of Sgrott's mantras when it comes to downsizing is "be ruthless, don't be reckless." This is especially true of those sentimental items we all have because once they are gone, [they're gone](#).

The Challenge of Three Houses

Downsizing one house is enough of an emotional landmine, but what about downsizing three concurrently? For Sara Beth and Michael Weller, who live in a suburb of Washington, D.C., this has been their ongoing project of the past few months, involving the homes of their parents and their own home.

Both sets of parents lived within a mile of each other, with the Wellers' home about five miles away from each house. Michael's parents, who lived in his childhood home, died first, about four years ago. Sara Beth's mother died not long after that and her father came to live with Sara Beth and Michael, since the layout of their house was conducive to his needs. However, he lived for only six months.

"So we had three houses, and started to have the conversations – 'do you want stuff from your parents' house?'" said Sara Beth. "We realized we both did."

The house belonging to Michael's parents (he was an only child) was the largest of the three, so the couple decided to move there to accommodate everything they knew they wanted to keep.

"My parents bought their house in the early 80s and his parents bought theirs in 1979," she said. "Plus we had 15 years worth of stuff from our own house."

As they started to make headway through all of it, the couple discovered that their parents had similar tastes – "there were quadruplicates of so many things," laughs Sara Beth, who said her parents' home proved harder to sort through.

In general, Sara Beth says, "We discovered that I'm more attached to memories and Michael is more attached to items." They established 'yes, no, maybe later' piles to help them work through the three housefuls of items.

Although it can be difficult to get there, ultimately many people come to the realization that items they don't want any longer may make someone else really happy, Sara Beth remembers Sgrott telling her.

It's easy to be fearful of letting things go. Now that I have been through my downsizing, I recognize that I frequently confronted those feelings. Overall, I feel I made good choices. In my new space, I have things that make me happy, that remind me not only of my husband and our family, but of my parents and his parents.

I have a lovely print of Notre-Dame de Paris that my late mother-in-law Joyce gave me about seven years ago, when she downsized, that had belonged to her mother. I think of Joyce, who knew of my fondness for [Paris](#), every time I look at it. And I can truly say that about many items I chose to bring with me.

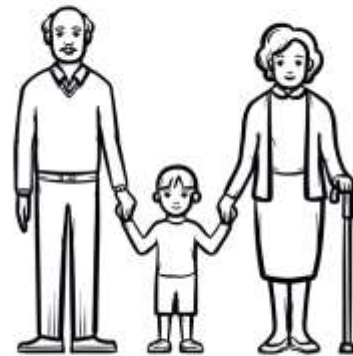
"The goal," says Sgrott, "is to surround yourself with the things you love and that bring meaning to you."

Contributing Author: Julie Pfitzinger is the managing editor for Next Avenue and senior editor for lifestyle coverage. Her journalism career has included feature writing for the Star-Tribune, as well as several local parenting and lifestyle publications, all in the Twin Cities area.

GrandFamilies

Family and Kinship

Exes? No, Co-Grandparents



After a divorce, one couple navigates the roles of grandparents in a unique way

Divorces have a way of creating a snowball of effects beyond a fractured relationship. If the parties involved had children, things are often messier, and if those children also had children, the divorcees no longer face only the challenges of being exes and parents, but also of being grandparents.

Naturally, grandparents under these circumstances might have to interact and — depending on their locations — see each other at holidays or birthday parties. It could be many years since they last had to see one another or communicate. Jennifer Taitz, a clinical professor of psychiatry at UCLA, recently presented an interesting interpretation of how this conundrum could play out for some divorced grandparents: co-grandparenting.

One Family's Story of Co-Grandparents

In a [column for The New York Times](#), Taitz told her own family's story. Her parents divorced when she was in elementary school and didn't exactly have the most amicable split.

"For years, my parents' contact was limited to kid-related events, like parent-teacher conferences," Taitz wrote. "Yet their tension remained, my mother occasionally whispering damning words about my father within earshot, inevitably beginning with 'He never...' For his part, my father would more directly and angrily announce, 'Your mother always...'"

But when Taitz's first child Sylvie came into the world, she "became the first person to truly bring [Taitz's] parents into a respectfully shared territory in decades." Things changed between Taitz's parents — slowly.

It wasn't a seamless transition. At first there were glares, insults and passive-aggressiveness, but eventually to the author's amazement, the article noted, "the tension between [her] parents began to abate, particularly when they both zoomed in on Sylvie, a magnet with her bright red hair and contagious giggle."

Taitz eventually had a second child and moved from New York to Los Angeles where her parents lived.

The light that their grandchildren brought into the world seemed to minimize the disdain the former couple had toward one another. Jo and Emanuel began to coexist peacefully and even made kind gestures to one another. They cordially spent the same holiday together with the grandchildren, and Taitz's father purchased her mother a ticket for a benefit at Sylvie's school. They began to work together not as a couple, but as grandparents.

Exposure Therapy?

Non-traditional relationships like these are not realistic for everyone, but it's a unique and thought-provoking concept that got Taitz thinking about how her parents were able to fall into a working co-grandparenting relationship.

"As a psychologist, I know about the profound therapeutic impact of exposure therapy — when a person chooses to repeatedly face an uncomfortable stimulus rather than avoid it," she wrote. "For example, if someone hates public speaking, rather than dodging opportunities to grab a microphone, she would actively pursue chances to perform."

Was exposure therapy at work here? Maybe. But it's impossible to say for certain whether forced discomfort could ultimately turn positive for every divorced couple. What worked for Taitz's parents is somewhat miraculous and definitely won't bring every family together in the same way, but perhaps the moral is: If we all strive just a little more to meet each other halfway, there's a lot to gain. Especially for those grandchildren.

For more information, visit:

<https://www.nextavenue.org/exes-become-co-grandparents/>

NCBA Supportive Services



Founded in 1970, 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 Programs

The Senior Community Service Employment Program (SCSEP)

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>

The Senior Environmental Employment Program (SEE)

NCBA administers the Senior 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://ncbainc.org/see/>



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://ncbainc.org/the-ncba-health-and-wellness-program/>

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://ncbainc.org/affordable-housing/>



Samuel J. Simmons NCBA Estates located in Washington, DC

Carl F. West Senior Estates --Now Open

Carl F. West Senior Estates and Grandfamily Apartments are now OPEN!

NCBA is proud to announce the opening of the Carl F. West Senior Estates and Grandfamily Apartments, a 179-unit community in D.C.'s Columbia Heights. Thirty-six units are reserved for "grandfamilies"—older adults raising grandchildren or young adults. Carl F. West Senior Estates includes a fitness center, library computer lab, and playgrounds for children. Our 36 grand family units are thoughtfully designed to offer comfort, stability, and built-in support—creating a safe, nurturing environment where both generations thrive.

For more information, call 202-289-1700 or visit:
info@ncbacfw.com.



Social Media



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

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You're also welcome to learn more about NCBA by visiting our website at www.ncbainc.org. We look forward to hearing from you!



Grandfamilies Housing Opportunity

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Comfort & Convenience in Your New Home

**Thoughtfully designed apartments
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- Modern, newly built three-bedroom apartments
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- **Supportive Services Onsite**
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 - Resource navigation
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Secure and Family-Friendly

- **24-hour security on-site**
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 - Secure residential parking spaces



Have questions about availability, eligibility, or the application Process? Our team is happy to guide you

Phone: (202) 289-1700

Email: info@ncbacfw.com

Address: 1370 Harvard Street, NW, Washington, DC 20009

Office Hours Monday- Friday 8:00 AM- 5:00 PM, Saturday, 8:00AM to 2:00 PM (Closed on federal holidays)

Eligibility for Grandfamilies



✓ Who is Eligible?

- Grandparents aged 55+ who are the primary caregivers of grandchildren
- Income- qualified to meet affordable housing guidelines
- Bright, open floor plans
- At Least one child aged 26 or younger in the household

✓ Convenient Location

- Metro station is just a few blocks away
- Close to schools, grocery stores, and local shops
- Nearby playground and outdoor courtyard for children to play



How to Apply

For more information, please contact:

Call (202)289-1700

Visit: ncbacfw.com

1370 Harvard Street, NW,
Washington, DC 20009



Office Hours Monday- Friday 8:00 AM- 5:00 PM, Saturday, 8:00AM to 2:00 PM (Closed on federal holidays)

MEDICARE 2027: Fall Open Enrollment Begins



Starting today, October 15, and until December 7, people with Medicare have an opportunity to make changes to the way they access their Medicare coverage. During Fall Open Enrollment, people can switch from Original Medicare to Medicare Advantage (MA) and vice versa, pick a new standalone Part D prescription drug plan, or choose a different MA plan with or without Part D coverage.

A Guide for Fall Open Enrollment

Choosing coverage can be intimidating and complex. Medicare Rights offers [Your Guide to Medicare Open Enrollment](https://www.medicareinteractive.org/) to help inform successful decision-making through details about what options you have during open enrollment, timelines, and questions to ask before enrolling. This resource is available for free through our online educational platform [Medicare Interactive](https://www.medicareinteractive.org/) by visiting: <https://www.medicareinteractive.org/> (requires registration).

Comparing Options Is Vital

Every year, we urge people with Medicare to assess how their current coverage works for them and compare it to other options. Financial and health circumstances can change from year to year, and health plans change, too. Even if the plan someone is enrolled in is not changing dramatically, changes to other offerings may mean that changing plans is wise.

Does Original Medicare Fit Your Needs?

Everyone with Medicare should review the 2027 *Medicare & You* handbook. All Medicare households should have received this handbook in late September, but you can also [download it from Medicare.gov](https://www.medicare.gov). Callers to 1-800-MEDICARE (1-800-633-4227) can also request a copy. The handbook explains Medicare's coverage for the coming year. For those with Original Medicare, the handbook is a primary source of information for costs and coverage for the upcoming year. People with Medicare Advantage should know that although MA plans must cover all services covered by Original Medicare, costs and rules (like network or prior authorization restrictions) may be different. Everyone with Medicare should review the 2027 *Medicare & You* handbook.

Reminder: For those who have Original Medicare and a Medigap who are considering an MA plan, switching to an MA plan may make it difficult or impossible to re-enroll in Medigap. Check with your local [State Health Insurance Assistance Program \(SHIP\)](#) to learn about your state's rules.

Does Your MA or Part D Plan Fit Your Needs?

If you have MA or a standalone Part D plan, you should read through any Annual Notice of Change (ANOC) and/or Evidence of Coverage (EOC) documents. You should have received these documents in late September, either as a hard copy or via email.

The ANOC or EOC identifies plan changes for 2027:

- Benefits and coverage rules
- Costs
- Formulary (list of drugs covered) and coverage restrictions
- Network changes

If you have providers you want to keep, make sure your doctors and/or pharmacies are still in the plan's network. It's helpful to double-check with providers to be sure they accept that plan, or with plans to be sure they contract with that provider.

Need to Make a Switch?

The questions to consider are much the same if you need or want to make a switch to a new plan.

For MA plans, be sure your providers are in the network and compare costs, coverage, and benefits.

For Part D plans, whether standalone or part of an MA plan, you should look at the formularies to be sure your prescriptions are covered and check if your preferred pharmacies are preferred and in-network.

It is important to look beyond premiums and compare costs associated with accessing care—deductibles, coinsurances and copays—as well as other restrictions that may limit access to needed and preferred care.

Where to Go for Help

Your local State Health Insurance Assistance Program (SHIP) provides one-on-one unbiased Medicare assistance. There are 54 SHIPs (one in each of the 50 states, Puerto Rico, Guam, the District of Columbia, and the U.S. Virgin Islands).

Visit www.shiphelp.org and click on the blue “Find local Medicare help” button in the upper right corner to contact your SHIP.

You can also go directly to Medicare through [Medicare Plan Finder](#) or by dialing 1-800-MEDICARE (1-800-633-4227). And Medicare Rights can provide additional assistance, answering your questions and troubleshooting issues you may be having during open enrollment. Call our national helpline at 800-333-4114.

2027 Medicare and Medicaid Changes You Need to Know

The 2027 Medicare and Medicaid changes are beginning to take shape, and some could affect how Americans qualify for health coverage and how healthcare providers are paid for treating Medicare patients.

A recent update from the [American Medical Association](#) highlighted two developments worth watching. New Medicaid work and community engagement requirements are scheduled to take effect in 2027, while lawmakers and the Centers for Medicare and Medicaid Services continue to consider changes involving Medicare physician payments.

With headlines about Medicare and Medicaid changing quickly, it is important to separate rules that are becoming law from proposals that are still being considered.

Here is what you need to know and what you may need to do to prepare.

WHAT IS CHANGING WITH MEDICAID IN 2027?

One of the most significant 2027 Medicare and Medicaid changes for consumers involves Medicaid eligibility. Under federal law, states will be required to implement new community engagement requirements for certain Medicaid recipients beginning in 2027. These requirements generally mean that individuals who are subject to the rules will need to demonstrate that they are working or participating in another qualifying activity to maintain Medicaid eligibility.

For applicable individuals, the requirement generally calls for at least 80 hours per month of qualifying activities. Depending on the individual and program, qualifying activities can include employment, community service, education or participation in certain work programs.

Not everyone receiving Medicaid will be subject to these requirements. There are exclusions and exemptions for certain individuals and circumstances, making it important to understand how the rules apply to your specific situation.

For the most current information about Medicaid eligibility and upcoming requirements, visit [Medicaid.gov](#).

WHY THE NEW MEDICAID REQUIREMENTS MATTER?

The American Medical Association has raised concerns about how the new requirements will be implemented.

In its August 7, 2026 [National Advocacy Update](#), the AMA discussed its request that CMS significantly rework proposed rules implementing the Medicaid work requirements. One of its concerns is that administrative and reporting requirements could result in eligible people losing coverage because of problems documenting compliance or an exemption.

That distinction matters. Someone could potentially meet the underlying eligibility requirements but still experience coverage problems if required information is not submitted or processed correctly.

For Medicaid recipients who may be affected, paying attention to notices from your state Medicaid agency will become especially important as implementation approaches. You can read more about the AMA's concerns and the other healthcare policy developments it is following in its August advocacy update.

WHAT MEDICAID RECIPIENTS CAN DO TO PREPARE

If you currently receive Medicaid, you do not need to assume that your coverage is ending in 2027. The new requirements do not apply to every Medicaid recipient. You should, however, be prepared for additional communication about eligibility and renewal requirements. Make sure your state Medicaid agency has your current contact information, so you do not miss important notices. Read renewal and eligibility notices carefully and respond by any deadlines provided.

If you are required to meet a community engagement requirement, keep records that qualifying employment, education, training, community service or other eligible activities. If you believe you qualify for an exemption or exclusion, pay close attention to what documentation your state requests.

Most importantly, do not ignore a notice because you believe you are still eligible. Administrative requirements can be just as important as meeting the underlying eligibility criteria.

WHAT HAPPENS IF YOU LOSE MEDICAID COVERAGE?

If your Medicaid eligibility changes, losing Medicaid does not necessarily mean going without health insurance. Depending on your household, income, age and other circumstances, you may have other coverage options available. These could include an Affordable Care Act Marketplace plan, employer-sponsored insurance or private health insurance.

The right option will depend on your individual circumstances.

If you receive notice that your Medicaid coverage will end, it is a good idea to begin reviewing alternatives before your termination date. Waiting until after coverage ends could create an unnecessary gap in health insurance. If your Medicaid coverage is ending, we can help you compare available health insurance options, including private health insurance and Affordable Care Act plans, so you can find coverage that fits your needs and circumstances.

WHAT IS CHANGING WITH MEDICARE IN 2027?

The Medicare portion of the 2027 Medicare and Medicaid changes requires a little more explanation because several of the developments being discussed are not final changes to Medicare beneficiary coverage. The AMA's August 7 update highlighted the introduction of the Provider Reimbursement Stability Act in the U.S. Senate. The legislation is a companion to a House bill that previously advanced unanimously through the House Ways and Means Committee. The legislation is intended to change how Medicare's physician fee schedule is updated.

This is primarily an issue involving what Medicare pays physicians for providing care rather than a direct change to the benefits included in an individual's Medicare plan. That distinction is important for Medicare beneficiaries.

News about changes to Medicare physician reimbursement does not mean that your Medicare benefits have suddenly changed or that you need to switch plans because of this legislation.

WHY MEDICARE PHYSICIAN PAYMENTS STILL MATTER TO PATIENTS

Although physician reimbursement may sound like an issue that only affects doctors and medical practices, it can matter to Medicare patients over the long term. The AMA has argued that Medicare physician payments have not kept pace with the increasing costs of operating a medical practice. The [2026 Medicare Trustees Report](#) also raised concerns about the long-term sustainability of physician payment rates and potential implications for access to Medicare-participating physicians.

That is why organizations such as the AMA continue advocating for changes to the Medicare physician payment system. However, proposed legislation and proposed federal rules can change considerably before they become final. For Medicare beneficiaries, the practical takeaway is to stay informed without assuming that every Medicare headline requires immediate action.

WHAT MEDICARE BENEFICIARIES SHOULD DO NOW

For most Medicare beneficiaries, the physician payment developments highlighted in the AMA update do not require an immediate change to your current Medicare coverage. You should still review your Medicare coverage regularly, particularly during the Medicare Annual Enrollment Period. Medicare Advantage plans, Part D prescription drug plans, provider networks, formularies and out-of-pocket costs can change from year to year. Your healthcare needs can change as well. Rather than making a decision based on a national headline, review how your specific coverage is changing and whether your current plan continues to meet your needs.

We can also help you evaluate [Medicare Advantage, Medicare Supplement and Part D plan](#) options to determine which coverage best fits your healthcare needs and budget.

WHAT YOU SHOULD KNOW ABOUT THE 2027 MEDICARE AND MEDICAID CHANGES

The most important thing to remember is that Medicare and Medicaid are different programs, and the changes currently being discussed affect them differently. The new Medicaid community engagement requirements could directly affect eligibility for certain Medicaid recipients beginning in 2027. People who may be subject to those requirements should watch for official notices and be prepared to provide requested information.

The Medicare developments highlighted by the AMA are more heavily focused on physician reimbursement and proposed policy changes. They should not be interpreted as an announcement that Medicare beneficiaries are automatically losing benefits or need to change their coverage. Healthcare policy can also continue to evolve as federal agencies issue additional guidance and states implement new requirements.

That makes reliable information particularly important. Before changing coverage based on something you read or hear about Medicare or Medicaid, determine whether the change actually applies to you.

FREQUENTLY ASKED QUESTIONS ABOUT 2027 MEDICARE AND MEDICAID CHANGES

When do the new Medicaid work requirements begin?

States generally must implement the new Medicaid community engagement requirements beginning in 2027. Implementation details can continue to develop, so Medicaid recipients should watch for information from their state Medicaid agency and CMS.

Will everyone on Medicaid have to work 80 hours per month?

No. The community engagement requirements do not apply to every Medicaid recipient. Federal law provides exclusions and exemptions for certain individuals and circumstances. If you receive Medicaid, check official information from your state Medicaid agency to determine whether the requirement applies to you.

What activities can count toward the Medicaid requirement?

For people subject to the requirement, qualifying activities can include employment and certain education, work programs and community service activities. The specific rules and documentation requirements should be confirmed through your state Medicaid program.

What should I do if I receive a Medicaid eligibility notice?

Read it carefully and respond by the deadline provided, even if you believe you remain eligible. Keep copies of any information or documentation you submit and contact your state Medicaid agency if you do not understand what is being requested.

What happens if I lose Medicaid in 2027?

You may have other health insurance options depending on your circumstances. Those could include Affordable Care Act Marketplace coverage, employer-sponsored insurance or private health insurance. Because eligibility and costs vary, review your options before your Medicaid coverage ends whenever possible.

Are Medicare benefits being cut in 2027?

The Medicare developments highlighted in the AMA's August 7 advocacy update primarily concern physician reimbursement and proposed Medicare policy changes. They should not be interpreted as an across-the-board announcement that Medicare beneficiaries are losing their existing benefits.

Should I change my Medicare plan because of these changes?

Not solely because of the physician payment proposals discussed in the AMA update. Medicare beneficiaries should review their individual coverage, costs, prescriptions and provider needs when evaluating whether to keep or change a plan.

For more information, visit: <https://ictinsurance.com/2027-medicare-medicaid-changes/>

1 Tax season is here: You can access your Benefit Statement tax form through your personal my Social Security account.

 An official website of the United States government [Here's how you know](#) ▼



Social Security

Benefits ▼

Medicare ▼

Card & record ▼



 Español

 Account

Learn about changes we're making to your personal my Social Security account

Go Digital! Create your personal my Social Security account today

An online my Social Security account provides you with personalized tools, whether you receive benefits or not. With this free and secure account, you can request a replacement Social Security card, check the status of an application, estimate future benefits, or manage the benefits you already receive.

When you create your account, opt in to receive your notices online, faster and more securely than by mail. Choose the online notice option to get your annual Cost of Living Adjustment (COLA) benefit amount and tax forms up to three weeks earlier than by mail!

Create an Account

Sign In



To create a personal my Social Security account, first you'll need to decide whether to create a Login.gov or an ID.me account. There is no wrong choice, it's just a matter of which account is the best fit for you. Watch the [How to Choose Your Sign-in Account for my Social Security](#) video for more information.

For step-by-step instructions for creating each account type, watch:

- [How to Create Your Login.gov Account with SSA](#)
- [How to Create Your ID.me Account with SSA](#)

If you need additional assistance in creating your account, call **1-800-772-1213** and say "Help Desk" for priority service between 8:00 a.m. – 7:00 p.m. local time, Monday through Friday.



VACCINES YOU NEED TO TAKE OR AT LEAST CONSIDER

It may not dominate the news anymore, but Covid and other serious respiratory infections still threaten the U.S. public, especially Older Americans.

For most people over age 65—or anyone with a weakened immunity system—the Centers for Disease Control and Prevention (CDC) recommends two **Covid** vaccinations a year, about six to nine months apart, to keep the sometimes-deadly disease at bay.

That's because, like most viruses, Covid continually mutates, finding new ways to survive and thereby requiring medical science to change the formula for vaccines to stop it.

Likewise, **influenza vaccines** have to be altered each season to match the strains that emerge each year, mainly around fall. Flu may cause not only misery for weeks or longer, but can trigger existing conditions, like heart disease, to worsen.

The CDC also recommends that Older Americans consider taking shots aimed at **pneumococcal pneumonia**, a potentially fatal infection that often goes undetected until its late, harder-to-treat stages. It is particularly difficult to treat in young children and older adults. One shot usually confers lifelong immunity.

The **respiratory syncytial virus (RSV)** also requires only one vaccination for lifelong protection in most cases. The virus attacks the lungs and bronchial passages, making it difficult to breathe and producing a persistent cough.

The cost of all four vaccines are covered by Medicaid and patients enrolled in Medicare Part D plans are eligible for free or discounted shots.

As with all medical treatments and procedures, people with preexisting conditions such as diabetes or heart, liver, or kidney disease should double-check with their physician before taking any vaccine.

DATE CHANGE



VACCINE CLINIC

NCBA and CVS Pharmacy

Working together for a healthier community

**TUESDAY**
OCTOBER 20, 2026

**Time:**
10:00 AM – 2:00 PM
Eastern Time

Contact NCBA
(202) 637 - 8400

**Protect Yourself. Protect Your Community.**
Stay up to date on your vaccines and help keep our community healthy and safe.

Vaccines Available

No appointment needed | Walk-ins welcome
For more information, please contact NCBA.



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