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| 😊   |  |  |  |  | | --- | --- | --- | --- | | **CUSTODIAL CARE VERSUS SKILLED CARE**   |  |  |  | | --- | --- | --- | | **What care will Medicare Cover?** | Vector female caregiver giving glass to senior woman semi flat color vector characters | By the GWAAR LEGAL SERVICES TEAM  Submitted by Alice Ackerman, Elder Benefit Specialist of ADRC of Monroe County |   If you are a Medicare beneficiary who needs care outside the home, you will have many questions about what type of care is needed and whether Medicare will cover it. **Medicare does not cover custodial care but will cover skilled care under specific circumstances.** Knowing the differences between custodial care and skilled care will help you better understand your medical care choices and financial obligations.  **CUSTODIAL CARE**  First, it is important to know what custodial care is. Custodial care encompasses assistance with activities of daily living (ADLs), including bathing, dressing, eating, repositioning, and oral care. The ADLs are non-medical care that can be done reasonably and safely by a non-skilled or non-licensed caregiver. Custodial care can also be done at home, in a nursing home, or in an assisted living facility. This type of care consists of activities you need to do daily to care for yourself.  **SKILLED CARE**  Next, it’s essential to understand skilled care. Skilled care must be provided by or under the supervision of a skilled or licensed medical professional. The care must be medically necessary and can only be safely performed by a skilled or licensed person. Examples of skilled care include physical therapy, occupational therapy, wound care, and intravenous injections. This type of care often happens in a skilled nursing facility. This care is usually more expensive than custodial care due to the complexity of the care and the need for a skilled or licensed provider to safely administer the care.  **DIFFERENCES**  The most significant difference between custodial care and skilled care is the person providing the care.  Skilled care must be performed by or under the supervision of a skilled or licensed person, while any caregiver can give custodial care.  Custodial caregivers are not required to hold a formal license or complete medical training and are less costly to hire.  If you are in a skilled nursing facility, skilled care should be covered, and custodial care will not be covered in that setting.  In an assisted living facility, you most likely receive custodial care that Medicare will not cover. In virtually all instances, custodial care will not be covered under Medicare.  **BEING INFORMED**  Being informed about medical care choices that Medicare covers and your financial responsibility with those choices will help you be better prepared to meet your needs. Knowing the difference between custodial care and skilled care can help you prepare for decisions about long-term care choices. It will also help you advocate for yourself if you find yourself in a skilled nursing facility. It is essential to know what type of care Medicare will cover and what kind of care you will receive. Being informed will help you navigate your medical care and ensure you receive the care you need without financial surprises. |   😊  😊Page 04 | 😊😊😊 | 😊 **FOR YOUR INFORMATION…**   |  |  |  |  | | --- | --- | --- | --- | | **THE PANDEMIC TURNS 5**   |  |  |  | | --- | --- | --- | | **We Are Still Not Prepared for the Next One.** | mask-on-ground  A mask lies on a sidewalk.  Peter Kneffel/picture alliance-Getty Images | By Simon Williams  TIME The Brief March 11, 2025  Simon Williams is a lecturer in psychology and a public health researcher at Swansea University in the U.K. |   It’s hard to believe it’s been five years since the start of the COVID-19 pandemic. **Since 2020, the disease has killed more than 1.2 million Americans – more than in any other country.** That accounts for more than 1 in 7 reported COVID-19 deaths in the whole world (*Although the true global death toll is likely much higher due to under-reporting)*. Don’t be fooled by some social-media revisionist historians who would have us believe that COVID-19 was “mild” – **it was one of the most lethal infectious disease outbreaks in human history, ranking only behind the 1918 Spanish Flu and the Bubonic Plague** *(not including the ongoing HIV/AIDS epidemic)*.  Thankfully, in 2025, the days of lockdowns and quarantines now seem a distant memory for many – even though the physical, mental, and emotional impacts of the pandemic persist in many ways. However, the question remains: Are we better prepared for the next time?  Sadly, if anything, we are less prepared than before.  Pandemics ae not necessarily once-in-a-lifetime events. We already saw in 2009 a swine flu pandemic that killed up to half a million people globally. H5N1 bird flu continues to spread in poultry, wild birds, and mammals in the U.S., with each case increasing the risk of further spillover into humans – making the U.S. a possible epicenter of any new flu epidemic, should the virus evolve further to spread easily among humans. Mpox, MERS *(another coronavirus with a high fatality rate)*, and Ebola are just some of the currently circulating pathogens with pandemic potential. And, of course, “Disease X” *(a potential virus that could emerge in the future that we don’t know about)* is always a possibility.  What should we be doing that we’re not?  **First**, **we should be making investments, not cuts, in pandemic preparedness. The U.S. has withdrawn funding from the World Health Organization.**  Working alongside local and national health authorities, the WHO is a key “first responder,” identifying and containing infectious-disease outbreaks before they spread. The U.S. contributed approximately $120 million in 2023-2024 on responding to acute health emergencies and to preventing pandemics and epidemics, so our step back leaves a massive hole in resources designed to tackle emergencies and stop outbreaks from spreading. Also, recent funding cuts or freezes to agencies like USAID are already having ramifications on the ground, with public-health professionals concerned that progress in tackling diseases like tuberculosis will stall or regress. With less funding, pandemic preparations also slow down, and the U.S. Ceasing negotiations for the Pandemic Agreement and amendments to the International Health Regulations makes matters worse.  Nationally, purported plans to de-prioritize infectious-disease research and defund some CDC training programs are a recipe for having a public-health workforce that is under-resourced and under-skilled to deal with future pandemic threats. Although some employees have since been rehired, sweeping and hasty cuts to key staff involved in potential pandemic response will mean a loss of invaluable experience of those working on the public-health frontlines during COVID-19.  **Second**, **the ideologies and track records of some of those with the greatest responsibility for protecting public health in the U.S. would suggest that, if a new pandemic were to emerge in the next few years, the response would be hands-off**. Robert F. Kennedy Jr. recently endorsed *(albeit weakly)* the measles, mumps, and rubella vaccines to fight the measles outbreak in Texas. While that was a welcome move, he has a long history of spreading misinformation on vaccines. RFK Jr. has lobbied against and opposed COVID-19 vaccines.  *Continued on page 2* |   😊Page 01 |

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| 😊   |  | | --- | | **THE PANDEMIC TURNS 5,** continued…  The Trump Administration is said to be re-evaluating nearly $600 million funding for H5N1 mRNA vaccine research. Dr. Jay Bhattacharya, the likely new head of the National Institutes of Health (NIH), held views on COVID-19 that deviated from the scientific mainstream, which included arguing in favor of a herd-immunity approach that thousands of scientists argued would have led to preventable deaths. While the U.S.’s COVID-19 policies were far from harmless and perfect, and while some of the more draconian and harmful measures like extended school closures could hopefully be avoided in the future, doing too little during the next health emergency would be reckless. How much would pandemic measures like vaccines be promoted next time?  Third, we should be helping to rebuild public confidence and trust in science – which declined during the pandemic – not continuing to undermine it. Recent rhetoric used not just by Trump and Kennedy but also highly influential social media personalities and podcasters are cultivating a conspiracy mindset toward science and health organizations, who are being pegged as “corrupt” and inefficient. We know from five years of COVID-19 research that one of the biggest predictors of whether people will follow public-health guidance is how much they trust science and health authorities. Can the new administration restore trust in science and health organizations? If not, will people trust public-health guidance during future health emergencies, including infectious disease outbreaks?  If the answer isn’t “yes” by the time the next pandemic arrives, the risks will be grave. |   😊   |  |  |  |  | | --- | --- | --- | --- | | **MEASLES IS BACK**   |  |  |  | | --- | --- | --- | | **Measles is back… and a lot more people are at risk.** | measles-vaccine  A health worker prepares a dose of measles vaccine at a health center in Lubbock, Texas on Feb. 27, 2025.  Ronaldo Schemidt/AFP-Getty Images | Time Daily Spotlight March 10, 2025  By Dr. Ashish K Jha  Dr. Ashish K. Jha |   A friend recently asked about measles. She’s the mother of four very young kids and wanted to know if she should be worried. She’d heard about the large measles outbreak in northwest Texas.  Since January, more than 159 people are known to have been infected, and the outbreak has resulted in two deaths and dozens of hospitalizations. Now, this measles outbreak has spread into nine other states, and there’s an alert to travelers passing through the Los Angeles Airport.  Contrary to statements by Health Secretary Robert F. Kennedy Jr., outbreaks of this deadly disease are highly unusual. The U.S. declared measles eliminated more than 20 years ago, thanks to an exceptionally safe and effective vaccine. But efforts to undermine confidence in that vaccine have contributed to these recent outbreaks. There are things we can do, individually and collectively, to protect our most vulnerable and hopefully eliminate measles in this country again.  My friend understands the settled evidence behind the safety and efficacy of vaccines. She’s following the vaccine schedule her pediatrician recommended. Measles vaccines are among the most protective shots we have, so when she gets her kids vaccinated, they are protected. But the large outbreaks we are starting to see are still creating risks, including among our very youngest kids, our immunocompromised kids, and even among vulnerable adults.  *Continued on page 3* |   😊Page 02 | 😊😊😊 | 😊   |  | | --- | | **MEASLES IS BACK**, continued…  **Measles vaccines are highly effective: 93% after the first dose, 99% after the second dose.** The problem is the timing. The first dose is not recommended until a child is 12 to 15 months old, and the second dose usually between the ages of 4 and 6. Infants have some passive immunity from their mom’s antibodies for the first 6 months, but not enough to be fully.  protective, which is why the U.S. Centers for Disease Control and Prevention strongly recommends that parents of children too young to be vaccinated avoid travel to areas with measles outbreaks  All children under the age of 1, before they get their first measles vaccine, are at risk if they come near someone with measles. Given that **measles is one of the most contagious diseases on Earth**, outbreaks mean we are likely to see more infections among children in this age range, including kids whose parents fully intend to vaccinate. And while the first dose is highly protective, the best protection comes after the second dose, which is usually given when a child is ready to start school. Between those two doses, children may still be at some risk, especially if they come into repeated contact with measles from others refusing or unable to be vaccinated.  Beyond the youngest kids, two other groups need special attention. The first is children who are immunocompromised. Some of these children, such as those undergoing cancer treatment, cannot get measles vaccine because the vaccine is a weakened form of the live virus, and in someone who is immunocompromised, it can actually cause the disease. Therefore, these immunocompromised kids rely on high levels of population immunity to protect them. When population vaccination rates fall below 95%, the virus can begin to circulate, and vulnerable children can become infected and will get very sick if they do.  The second potentially vulnerable group are elderly and immunocompromised adults. Most elderly people should have some immunity against measles; people born before 1957 likely had measles, and starting in the 1960s, people started getting vaccinated (though through 1968, the available vaccine was a little less effective). In general, we assume that everyone has lifelong immunity, whether from an infection or vaccines. But we don’t really know for sure. If a senior in her 80s had measles when she was 5, is she still protected? What about an adult undergoing chemotherapy? Immunity in these two populations may hold up fine – but we urgently need  studies to better understand the risks of being exposed to measles for these types of individuals.  Measles in an elderly or immunocompromised adult who isn’t protected – wither because they cannot be vaccinated or because their immunity has not held up over time – is likely to be quite severe. And it is possible that the elderly may need an additional shot to protect them if they live in a high breakout area. We don’t know, and we can’t make recommendations without data.  Years of scaremongering about vaccines have ed to low vaccination rates in many communities across America. A now-standard refrain is that parents are simply putting their own kids at risk but not harming anyone else. **The truth is this: low vaccination rates create risks for others**.  They create risks for kids who are still too young to get vaccinated. They create risks for kids who are immunocompromised, who can’t get vaccinated. They may also create risks for older or immunocompromised adults whose immune systems are not robust enough to protect them.  So, when my family friend with a child under one called about protecting her children, my advice was clear. Stay away from areas with outbreaks. Get your child vaccinated as soon as they are eligible, and encourage your friends and others in your community to do so, too – because while she can eventually get all of her children protected, no such option exists for all those who are immunocompromised or at risk because of waning immunity. **We owe it to all of them to make sure we stamp out measles in the U.S. again.** |   😊  😊Page 03 |