

## **WEBINAR VIDEO TRANSCRIPT**

Partnership for Care HIV TAC

### **Engaging and Retaining Older Patients in HIV Care**

23 Feb 2016

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STEVE LUCKABAUGH: Good afternoon, my name is Steve Luckabaugh and I'd like to welcome you to the Engaging and Retaining Older Patients in HIV Care webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance and Collaboration Center or HIV TAC.

The Partnerships for Care project is a three year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to, one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance and Collaboration Center, HIV TAC.

Our speaker today is Mr. Courtney Williams. Mr. Williams brings over 30 years experience in serving seniors in the District of Columbia. In his role as Community Planner for the DC office on Aging, Mr. Williams represented the agency as a liaison with public and private organizations serving seniors. He designed and implemented HIV prevention and education campaigns targeting older adults and seniors infected and affected by HIV/AIDS residing in the District of Columbia.

He has also served as an adviser to several community service and government organizations such as the Max Robinson Community Advisory Board, Duane Brown Foundation, Silent Partners, Impact DC, Inner City AIDS Network, KOB Mass Media Campaign, Grateful Inc., Faith Temple Ministry, and the DC Department of Health HIV Aging Workgroup.

He retired from the DC office on Aging in 2013, and has been providing consulting services to Silent Partners, a nonprofit organization whose mission is to provide HIV education to older adults in Washington DC and the MedStar at Washington Hospital Center. Mr. Williams holds a Master's degree in Urban and Regional Planning from the University of the District of Columbia. Please join me in welcoming Mr. Williams.

COURTNEY WILLIAMS: OK, good afternoon, my name is Courtney Williams. As Steve said I've previously worked for the DC office on Aging. In the District of Columbia we have a high HIV rate, which is considered epidemic. Like 3% of the population is living with HIV, which is more than double the national rate.

Previously I worked to educate and provide training to providers on HIV. The places that we've done were senior centers, health centers, housing building, long term care facilities, and daycare. This session is called Engaging and Retaining Older Patients and HIV Care.

Appropriate care for older adults living with HIV must take into account not only HIV specific psychological and social psychological effect, but also the effects of aging and comorbidities associated with HIV. As HIV persons get older and seek services outside of the HIV specific care, they find that the service are not tailored to their needs and they experience great stigma.

For instance, health care providers that traditionally care for older adults, for example, home care workers, rehab practitioners, gerontologists may not be accustomed to working with people who are HIV positive, older adults and seniors who are heterosexual, gay, bisexual, transgender, or have a long history of drug and mental illness. As such our providers must respond to increasing complex issues associated with HIV and aging.

For this particular webinar you can describe older adults in many terms. But for this particular webinar we're looking at older adults of being 50 years and older. Sometimes people refer to old adults and seniors, elders, matured adults, grown in sexy, older Americans, and the like. For this particular webinar when we use the term older adults most times we're referring to people who are 50 years and older.

Now these are some of the goals of this particular webinar-- review current epidemiology of HIV/AIDS among older adults, explore the stigma, be familiar with the conditions, review effective strategies in engaging and retaining older adults in care, and gain an understanding of the support in daily long term care that might be needed by older adults living with HIV through the aging continuum.

This is a quote that I always-- it kind of keeps me grounded-- I always look at this quote and just say it mean something to me, personally, that kind of keep me grounded and keep me doing what I do. It's a quote from George Washington Carver. It says, "How far you go in life depends on you being tender with the young, compassionate with the aged, sympathetic with the striving and tolerant of the weak and strong. Because someday in your life you will have been all of these." I call this quote-- it's really kind of inspiring to me. Because when it says that you're putting yourself in other's shoes, so to speak, on how we most often relate to other circumstances.

Mr. Carver says that many of us are sometimes in our life in these categories. And that's a good thing. It keeps us grounded in our lives compared to those around us. The word tolerant in the last item is interesting. To me it means showing respect for the rights, and opinion, and practices of other. It falls in line with the others on this list.

Before we really get started, I want you to answer one of our poll questions. So we want to find out who's on the line, and get some sense of what do you know about this type of training. Can you complete this for me-- yes and no? Poll question number one-- have you ever had any specific health care training in area of geriatric. OK, thank you so much.

MODERATOR: We have 64% say no and 36% say yes.

COURTNEY WILLIAMS: Before we really get started, let's kind of review what some of the numbers say. People age 50 years and older have many of the same risk factors as younger people, but may not be less aware of their risks. Older adults are more likely to be diagnosed with HIV infection later in the course of their disease.

And here's the CDC statistics from 2002 that people aged 55 and older accounted for one quarter, 24%, of the estimate of 1.2 million persons living with HIV infection in the country. Now look at this particular chart. Look at the numbers under Estimated Diagnosis of HIV Infection by Age. This was 2013.

Look at the numbers. Even though the numbers go down, they still are significant. Look in the higher numbers are over 50. The higher numbers is in the 50 to 59 age group. And over time it declines. If you think about it, those in the blue-- those numbers are going to make those ones in the 50 and older go up, particularly the ones from 35 to 49.

Well, this is where we are now in 2000-- recently in 2005. We have 1.25 million in over 50. In 2001 it was 37%. But now in 2005 it's 50%. And guess what? In four more years it's going to be 70% of the persons in this country will be over the age of--

Now this is a very interesting chart right here. Just look at the numbers itself in terms of the number of people who are been diagnosed, the number of people who are linked to care, and the number of people who retain in care. If you look at the number goes down slightly, when you are over 65. If you look at the numbers, right there, from 46% down to 35%, but in the numbers we were only comparing 45 to 54 and 55 to 64. Just look at the numbers, how they go down.

Here's the incidence of HIV for 50-- over 50. Look at the percentage for that. 2013 it was 18% of the new cases were 50 and older. And look at the numbers that went south from 2011 to 2012, slightly went down. Then now it's back up to 18%. Look where they've come from since 2005. And look at the actual incidence of full blown AIDS. The percentage who are over 50, look at the numbers. The numbers have come a long way from 2003 down to 17% now to almost 27%.

What do you know about older adults and HIV? Survival rate-- what we know now is that the survival rate for older adults is a lot less than much younger people. What we know in terms of dating, many widows and divorced persons are dating again. They may be less aware of the risks for HIV than younger people. Believe me HIV is not an issue for their peer group. This might result in them-- might less to protect themselves.

And for the first time we have a larger percentage of our 50 and older population who are single and never married. Now what you also notice is that the availability of erectile dysfunction, medication such as Viagra has increased the sexual activity of some over 50 and might have been contributing to an increase in the number of people over 50 who are first time become HIV positive.

Discussing sexual habits and drug use-- what do we know about that? Older people were younger people. But you know what? Sometimes people's habits don't change when they get

older. They still do some of the same things they did when they were 20 or at least attempt to anyway.

Now what we know is in Aging is that HIV in America they're living longer. They're living in the community. They're not living in senior buildings in this, that, any other day. They are living fully in the community, because most older adults live in the community not in some facility.

Chronic disabilities-- older people living with chronic disabilities. One thing about HIV, you find that older people now taking medications for other chronic diseases. But then you have to top it off with taking HIV medications, whatever. And that's kind of difficult sometimes because you have to manage that. You have to remember when to take your medications for certain things. And that might be very difficult for some people.

Now my second pole question to you is, what percentage of the HIV population is over 50 that's in your care? And this question really is directed to all, but I'm particularly interested in the health centers that are online.

MODERATOR: All right, so we have less than 10% is at 8%. And the 10 to 24 range is 31%. And 23% of the people said 25 to 40%. And more than 40% is 8% responded. And don't know, not sure is 31%.

COURTNEY WILLIAMS: OK, thank you for responding.

Now I'm going to give you some examples of people I've dealt with working, HIV over 50, give you a little story on each one of them-- a really short story. The first one is Donald. Donald's a 55-year-old, HIV positive, openly gay man. He switched from his family doctor that he had for years because he felt his doctor was not very proactive in his HIV treatment. He is now with an Internal Medicine doctor and is very happy.

Donna-- Donna is 57, is a working mother and has children and grandchildren to care for. It is hard for her to make appointments in adherence to her HIV regimen. She suffers from diabetes, which is more bothersome than HIV.

Joan-- Joan is a divorced woman. She's very proactive in her health and has been an active advocate for older adults with HIV. She changed her doctor and she challenges her doctor and brings him information.

Maxine-- Maxine is 59, church member and leader. She was infected by our husband. She is very bitter about it. She lives in a rural area and travels to the city for treatment because of the fear that someone in her small town will find out. She is making a decision not to continue with her HIV medications.

Dan-- Dan is widow. He's 74 years old and lives in a senior building. He started taking Viagra. He sometimes take his medication, but he drinks out of a sense of loneliness. He's been a patient in a particular practice for over 10 years. He faithfully make his regular visits, but is not

compliant with his regimen. He repeatedly explains the issue of noncompliance and on occasion he gets very ill and have to go to the emergency room.

Sam-- Sam is homeless and goes to the clinic for treatment. He has mental and substance abuse issues. He misses his appointment and when he's hospitalized that's when his doctor find out that he's not doing what he's supposed to do.

This is interesting one. Tony is a 58-year-old transgender woman. She's unemployed and has very little schooling. She has insurance for the first time because of the Affordable Care Act. But she gets her health care from the local AIDS clinic. That kind of has a high turnover rate. She has had several doctors since she's been going.

Now I want to talk a little bit about what I know dealing with a doctor and patient relationship. One thing we talk to doctors about when I'm done training with doctor is support your patient's interest in their health care, be flexible with your responses. Two, make sure that you describe both sides of the issue. Doctors always had their viewpoint, but there are two or more viewpoints on every issue.

Be prepared to describe the many sides of your medical issues that confront patients, but don't feel insulted if your patient choose something that you didn't recommend. We want people to be more engaged in their own decision making. Respond medically-- patient may use a treatment any way that they determine to do, and you may not be able to sway them.

One thing, don't push your patient. Don't push your patient to begin treatment before he or she is ready to commit. Starting a regimen is a big step and it will change many things in their lives. While, for example, taking pills every day is a constant reminder of the HIV situation. Disclosure is often an issue. Your patient may be reluctant to begin therapy, because they must be taken around their family or around work time.

There was a study done of doctors in Texas and they found out that shocking number of doctors rarely or never asked their patients older than 50 about HIV or even discuss how to prevent it. Almost 40% rarely or never ask their patient. Some of the doctors may be a lot younger than their actual patient. You might have a doctor who's in the 30's counseling or a dealing with someone in the 50's or their 60's. It's like talking with your mother or your grandmother. Now how many of us do talk to their mother and their grandmother about sexual issues? And I can say not many.

Adherence to Care-- look at these numbers. During the past decade, there has been an average annual increase of 2% in a number of people 50 years and older living with HIV. Look at the numbers. And of those 1.2 million infected with HIV in the United States, based on previous estimate, only 30% achieve viral suppression. Look at the number.

The 86% diagnosed, then linked to care-- of that-- 80% is linked to care. 40% is engaged in care. Because sometimes they might not go. You link them to care. They might not go. Then 37% are prescribed the medication. And only 30% achieve viral suppression.

Now just look at the numbers here. Look at the numbers there. The number of people-- I want you to take a look at the 55 to 64. 89% diagnosed and of that 74% is linked to care. 46% retained in care. Look at the numbers. The numbers a little-- the numbers are not that much different until you get to older adults, or whatever, which is what we call elderly sometimes at 65 and older.

Look at their numbers gone down significantly. The number who retained in care and prescribe in viral suppression. And look at 65 and other, viral suppression has gone down from 36% when they were earlier. And now when they get older it's less then.

What should older adults expect from their doctor? Well, one thing they told me-- what they expect from their doctor-- they want their doctor to be up to date on everything in terms about chronic diseases and also about HIV care. And what some of them also told me is that they like their doctor, but they don't want their doctor too young or they don't want their doctor too old. They want their doctor to be very knowledgeable. And also they want their doctors to have a list of culturally competent support groups or individuals, and peer counselor.

Having that information is very important with somebody that's recently diagnosed. Because the first thing is that, where do I go now? I mean you just told me something now. What is my next step? Who can I go for support, if you don't have it at home. Also doctors need to have information materials available about HIV in older adults. There are some information out there now. The face of HIV-- dealing with older adults-- there are some information out there that doctors can get now from different organizations. Making sure that doesn't appear judgmental and sympathetic. You want the doctor to be more sympathetic to them.

Now when I was saying older, who are the older adults? Well, right now, if you look at 50 and older, the older adults are what we call Baby Boomers. Those born 1946 to 1964 and they will be in their early 50's to their late 60's. And then those generations even beyond that is what we call the Traditionalists, or whatever, those born before 1946.

But, you know, Baby Boomers may have a view of their doctors. Baby Boomers, a generation that's nearing retirement and will soon face many challenges associated with aging such as changes in income level, health insurance coverage, health status, career development, social status. While a number of Americans will age in a relatively physical, and economic, psychological comfort, there are many of whom who medical, financial, and social limitations will lead to problematic consequences that will affect their health.

Effective communication with physicians and health care professional at all levels can serve as a vital link to health and adaptation to the aging process. In terms of views of physicians and clinicians, in the past the older persons held doctors in high esteem and treated him with great regard. This view may change over time as aging Baby Boomers are likely to be more active approach to their health care, more knowledgeable.

Today so many older persons don't want to waste their doctors time with concerns that they think that their clinician would deem unimportant. Patients sometimes worry if they complain too much about minor issues that they won't be taken serious later on. Or they are afraid of the diagnosis and treatment.

Views of aging-- ageism can work both ways. Doctor can make assumptions about their older patient. Older patient may unwittingly assume the stereotypes of old age. Expectations regarding health diminish with age, sometimes realistically, but often not. Older persons with treatable symptoms may dismiss their problems as inevitable part of aging and not get medical help. The process of aging may be troubling for older adults in other ways too.

The value of health care-- now although physicians typically focus primarily on diagnosing and treating disease, older persons generally care most about maintaining their quality of life. In fact many older persons are relatively accepting of the prospect of death and seek chiefly to make most of the remaining years.

One thing I say about doctors, what the doctors need to do-- make sure you have effective communications with your older patient. Let the older person know that you welcome their questions and participation. That will go a long way into having them want to stay with you. Encourage other older adults to voice their concerns. The doctor can do that. Be alert to the barriers to communication about symptoms such as fear, or lost of independence, or cost of tests. Expect those in the Baby Boomer generation to be more active in their health care.

Now this is a big problem here in terms of dealing with older adults in health care. There's been some assumptions always made that older people are not as sexually active as younger people. Yet, approximately 1/3 of all older adults with HIV today are expected, you know, the number is expected to increase. But sexual contact is the most common mode of HIV transmission in older adults over 50. And specific risk factors include the formation of new and multiple sexual relationships, as well as the popularity of sexual performance enhancing drugs-- i.e. Viagra.

Stigma is a big thing. It's a particular concern among older person because they may already face isolation due to illness or loss of family friend. Stigma negatively affect people's quality of life, self image, and behavior. And may prevent them from seeking HIV care and disclosing their status.

Ageism-- well, it's real. Ageism has been defined as negative attitudes towards aging based on the belief that aging makes people unattractive, unintelligent, asexual, unemployable, and mentally incompetent. Identifying numerous experience that could be considered an example of the ageism. These are what these are.

When I was talking to some respondents report feeling that they receive less compassion and sympathy from their doctor than younger person's. These are HIV positive older adults. This was a perception, felt blamed and judged more harshly, and felt that the medical providers were more motivated to help restore younger adults to optimum health. This lack of focus on older adults as being at risk for HIV suggests ageism. Assumptions concerning age, behavior, and sexuality. Many of the health care professionals are younger than the people that they're serving. And they might have already have some built in bias or stereotypes.

One thing for sure the social and cultural factors play a role in care. Decrease of social support, age-related stigma, and HIV stigma compromises the components of active engagement in life and also in a spiritual sense. Most older adults belong to some type of spirituality, or some

church, or whatever, and that will allow them gain the emotional support. Person older adults with HIV might be sitting very silent about in the church or the people that they consider their support system about HIV. If they don't know of any other sources, if they don't have a support group dealing with their population, whatever, they just kind of suffering in silence.

Now these are some things I think older adults in HIV care-- some considerations need to really look at. Mobility-- well, some people might have transportation problem to getting to the clinic. Maybe their transportation is not that good or the accessibility to transportation. Time and work-- some people might say they too busy to take off or they can't take off the time to go to the doctor.

Language barriers-- you have English as a second language. And other cultural barriers such as being gay or lesbian, or transgender, or whatever that may prevent them from coming back to you, whatever. Because you might not have one person can speak English as second language, or they feel-- people make assumptions about staff, and the way the staff treat them. The first person that when a person comes for care, they see the receptionist. They might develop a perception of you based on that, whatever-- how the receptionists the receiver. Then you see the nurse. Then you see the doctor, whatever. How that goes with all three of those whatever, might determine if they going to come back or not.

Access to health care-- cost and plans vary by state. As the Affordable Care Act is rolled out there is still hope that it can address some of these health disparity issues, if you don't have access to health care, or because of the cost, or in your jurisdiction.

One thing with older adults where maybe they might have a hearing or visual impairment that you might not necessarily recognized when you first get there. Some people have a lot of pride and they won't say if they can see it or not, or hear it.

Literacy and language, whatever-- be clear about when you're talking about HIV care, of the medications and stuff, use language that people can understand. Some people will say, yes, they understand or whatever and not really understand it.

Now mental health issue is the one where whatever getting the person to the mental health treatment, you have to recognize that it might take a minute because you just meeting that person for the first time. So you're not-- some people are very good at disguising their mental health. But as more and more as you treat them you start seeing things and you start asking questions.

Also in no small of way is considering-- find a little bit about the family and the community support that the person has, or whatever. After a while people will tell you. They comfortable with you, they will tell you well, no I don't really have support at home. I can't discuss this or anything. Be prepared to recommend some other resources where they can get that, if they're not getting it from home.

Considerations and the Antiretroviral Therapy for older adults-- one thing you need to-- that's important-- because the adverse drug reactions. A lot of older adults are taken stuff for arthritis and other things. And it might have an impact on the HIV drugs. And you really don't know



sometimes, because there's not been a lot of research done on the over 50 population. Now there's some studies and some things are being done now, but basically when someone was HIV positive they were just giving them the medications, whatever. But there was no sense or thought-- well, I won't say thought-- but they did not look the interaction between HIV drugs different kind of drugs for diabetes, arthritis and other conditions that many associated with aging.

One thing they need-- consideration of care among different providers. When HIV positive person come into your office they might need more. They might not only need medical care, but they need to be working with other provides particularly in the mental health area. There are other doctors that need to be engaged in their care. Early diagnosis is the key. Get them in there early and continually counsel.

These are some of the comments that I've heard from HIV positive persons over 50. The doctor doesn't have-- why they won't go back to their doctor. The doctor doesn't have a caring manner. Could not understand him or her, the language and the words. Didn't appear to be not very sympathetic. Appears to be judgmental. Transportation and access to the doctor was an issue.

Don't assume that everybody has a car that can get there, whatever, some people might have to take three or four buses to get to care. And particularly in rural areas where that's the big problem. One thing-- I've talked with several ones that they have known a doctor for a long time, but they're not really sure of his HIV knowledge, whatever. He's prescribing the drugs, but to them it does not appear that he knows a lot about HIV. He just knows what's out there. He doesn't know what the other resources out there, or community support.

Fear-- fear is a big thing. Fear that for some reason that the doctors going to disclose it to someone else. Fear that your family's going to find out, if you go to this doctor and this doctor treats a large number of HIV patients, or whatever. It is a big fear if you go to him, people going to find out.

Also, it's very hard to talk with your doctor about personal issue, including sexual behavior-- young or old, whatever. Doctor might be your age or he might be younger, but, yeah.

And there's still a lot embarrassment about how I contracted this. Well, one thing I can say, how can you support an older adult with HIV? One thing-- it's a very basic simple things is-- you need to know how to connect with them, listen to them, ask-- don't assume. Do not assume. Be honest. Don't lie. Be patient. Don't assume because they're older that they will change their behavior, that they did a lot of things when they were younger and then they want to continue that. And they still doing that behavior. Don't be fooled because of their age.

I'm thinking of a case I had with a 92-year-old man who was HIV positive. He has certain behaviors in his '80s, whatever, but they put him at risk. He became, his wife died. He was went-- back in the day he was taking Viagra in the 80's. I don't know how he lived so long, whatever. He was taking Viagra in his 80's whatever. He went to his doctor on many occasions.

Well, guess what? His doctor never gave him an HIV test until he thought because of his advanced age that it was age related. He did not want to-- he knew a little bit about the guys lifestyle, a little bit, but he never assume. And that was one the last thing on the list that he would even test him for, whatever. He finally got to that because he was thinking that well, because you're getting older you're getting weaker. Your having these kind of conditions, or whatever. He did not recognize that even though the person has told him about some of his behaviors the doctor really just in some way dismissed the idea that oh, you're 92 years old. You can't be HIV positive.

All their needs different than younger people. Yeah, sometimes they need different services. Connection to the aging network, it might be then they need transportation. They need family support. They need a lot of different things. Mental health is always a big issue, mental health and substance abuse. Don't assume because they older they going to stop using drugs, particularly certain types of drugs. If they were a heroin user in their 20's, they might be still a heroin user in their 60's and 70's.

Health complications-- because as a person age there's a chance that they might have one or more chronic disabilities that complicates things. Health status-- what kind of condition you are when you first went in there. You might be a healthy 50-year-old, you might not be. Adherence to their medication-- yes, older people are better adhering to their medication than younger people.

Clinical trials-- this is one thing that there's not been a lot of clinical trials done on older adults with HIV in combination with the other types of medications that they're doing. More clinical trials are needed to be done to kind of determine what are the adverse impact of the different drugs, when you mix diabetes drugs with certain type of HIV medications.

Testing and screening-- there are not all places that older adults will go for screening, or testing, or whatever. It's always encouraged for a younger population. Everywhere you go you see these pictures of younger people going to testing and also screening. The campaigns are geared around a much younger people, but still some older people have some behaviors.

Well, I call it the five methods in terms of working with older people with HIV. Advise, inform the patient about the importance of sexual health, adherence to regimen, effect on the quality of life, positive message about older adults living with HIV. Second thing was assess. Attain sexual history. Assess current problems. Design form of treatment that's suitable for them given that they may have other mobilities. Also assist, provide resources printed and online about older adults with HIV, videos and printed stories and profiles about older adults living with HIV. Arrange-- follow up, reinforce the importance of sexual health in adherence to treatment. And another A would be acknowledge-- risk factors in that age are determinist for HIV infection. Because a persons of a certain age does not mean that they will stop their risk behavior, OK?

Now this is what I call important messages that doctor and the health practitioner can do when you dealing with a older person with HIV. Some of the message you could say to him-- him or her. I want you to be well. I want you to be empowered. I want you to be aware. I want you not to be afraid. I want you to know that there are people here for you. I want you to have enjoyment

and pleasure. I want you to have a good quality of life. I want you to know that they're excellent treatments available. I want you to know that anyone at any age can get HIV.

Now who can help you with this? Help you as a health practitioner? AARP has a lot of information about dealing with older adults with different types of services that they may want. Also the area agencies on aging-- every jurisdiction has an area agency on aging that provides a lot of support to older adults, particularly those over 60. Now there's an organization that has a magazine put out monthly called Graying of HIV magazine-- wonderful resource. And it shows the face of HIV and the focus on the effect of HIV on the population over 50.

Of course your aging consultants, whatever, will be particularly the ones who do training. Your Geriatricians, those doctors who specialize in the care of older adults. And one person's in particular are care managers, people who follow, who work with, and connect older adults to services. Faith-based organizations-- there's some good faith-based organizations that are very good in dealing with HIV care, like Balm in Gilead. It's an organization. Social services-- they might be able to help because they might be able to connect you to the health department and other services that are out there. Of course the Centers for Disease Control, if you check on their website they have a lot of information that will be useful to you.

There's an organization called ACT Against AIDS that's developing a lot of materials to deal with AIDS when the focus of lately has been on older adults. Of course, ACRIA is an excellent , source because ACRIA has a whole session called Center on Aging. And they do a lot of training dealing with older adults and HIV all over the country. HIV over FIFTY organization-- that's a national organization that has an annual conference. And, well, they get the best minds, I consider, in HIV care for older adults. And they have a conference every year, and it's in Boston. Of course, HRSA-- HRSA funds and also HRSA provides a lot of information about people who are out there doing issues who are on the front lines and also people who have written papers and stuff dealing with HIV in older adult.

Now this is an excellent resource right here. For after this session is over I want everybody to go on the site. And this is a good resource, because as you want more information about HIV in older adults. It's called HIV-AGE.org and they can help you a lot in terms of some of the things that you can better improve your services to older adults.

Now what we want older adults to do when we get them into treatment, if they smoking, we want them to stop smoking, stop excessive drinking or drug abuse, exercise, eat better, reduce stress-- I think we want this for every one, but, you know, the focus here is of older adults-- reduce stress, address depression, and loneliness.

Barriers to continued treatment-- like I said earlier lack of clinical trials for older people, to even involve them in clinical trials. Chronic disease management-- you dealing with diabetes and other things. Side effects of the drugs. Transportation getting there. Support from family, friends in the community. And it's very important older people need that support.

And also continued barriers for doctors would be understanding those generational issues dealing with the older [INAUDIBLE]. Communication between doctor and patient, trust and confidentiality.

Solutions for Retention and Engaging Impact-- be sympathetic to the person, have empathy. Also the doctors need to know that there are the need for multiple providers out there. You are providing a medical care, but there's some other issues that the person might need. It might be simple things that-- transportation, or of mental health counseling, and other services out there. Be abreast of those different kinds of things for them.

I think the area agency on Aging, wherever you're located, is a good starting point, a good resource for those other kinds of support out there for older adults-- and also your health department too. Because they can identify you different organizations that they fund to provide educational and support.

Support to reduce isolation-- make sure that support groups, it's important that when a person's diagnosed with HIV that you have a good resource for them. They need to go to someone, if they don't have the support at home, they need to have a support in the community that they can go to. Because what happens is you become isolated. And many things happen when you're an isolated person out there in the community, which is not always positive.

Multilingual staffing-- that's extremely important. Sometimes you need staff that can speak different languages to make sure that the people really understand what you're saying.

Health literacy at the patient level-- be simple in your talk in terms of about what HIV is, and keep it simple. Keep it simple until you can gradually bring them up to a different level. You might say a few things, but you reinforce that by giving them materials to take to read.

One thing I also found, a solution, physical environment or location-- some people do not like to go to certain kinds of places because of-- I'm thinking about situations that-- there have been AIDS clinics and people won't go there or they like to sneak around the back or something like that because they don't want anyone to see them going in there. Also, physical environment, it has to look friendly. When you go in there, whatever, it has to have a feel of friendliness as opposed to anything, whatever. Because if the environment is not right, you can make some assumptions about the [INAUDIBLE], if it's very difficult to get to, it doesn't look good, it looks dirty or some kind of thing.

Aging awareness about HIV and sensitivity training-- in your practice you might need that. You might have a so many, maybe most of the people your staffing, maybe in their early '20s. And they might not be aware of specific aging and generational issues. Well, you might want to have someone come in and do some cultural competency training and sensitivity training.

Key is also prevented messages in social media. You can use that as a solution for retaining them. Positive messages I talked about earlier, whatever. But also if you have some resources dealing with social media, there are several people I know on Facebook who are HIV positive.

They're over 60, whatever, but they always talk about it and they give a lot of positive messaging. Find, connect with them.

Clinic testing and screening-- if the person has a certain kind of behavior that you should screen them no matter what age they are, even though some of the data says that you don't need to really screen anyone past a certain age, whatever. It's behavior that should drive that issue not age.

Well, lessons learned-- this is a quote I love for Maya Angelou. "I learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." And that's important when you go to a doctor's office.

I have one last question for you here. Can you answer for me? Do you face any social, cultural, or age barriers in serving an older HIV population? Can you answer that for me please? Wow, that's interesting, OK.

MODERATOR: So, we have 77% saying yes, 15% saying no, 8% not sure.

COURTNEY WILLIAMS: OK, we can take a few questions right now. You've given me something, because you say that a lot of people still need some more information or whatever. I'm hoping that I gave you some resources that you might want to tap into that could help you.

MODERATOR: OK, we have one comment that came through, a couple of points to raise. It says, "Good webinar. Two important key [INAUDIBLE] related points that could be reemphasized here in regard to Baby Boomer or older patients include-- number one, HIV testing. Baby Boomers fall within the USPSTF guidelines for routine HIV testing in clinical settings, patient's aged 15 to 65. Once in a lifetime testing should be provided to all patients in a way that removes the stigma associated with testing and is dealing from the assessment of sexual risk. Additional testing should be provided to those patients with identified sexual drug risk. And secondly, Hepatitis C infection-- Hepatitis C can lay dormant for decades, which is why many newly reporting cases are among those born between 1945 and 1965. There's a significant need to get these patients tested for Hepatitis C and a new highly effective treatment for those testing positive."

All right, I agree with you most heartedly. I agree with you on all those points, whatever. If I had more time, I would-- because I am actually working on a project dealing with Hep-C in older adults, also, whatever. I thoroughly agree with you. Thank you for your comment.

OK, if anyone else has any comments or questions, please enter them into the questions pane now, and we will address those. The slide with the resources can be downloaded, right now, on the handout section if you'd like to grab that. Are there any other resources out there? Like I was thinking, like reaching out to people in like retirement communities and that kind of thing? Are there any, like, campaigns or--

Yeah, there are campaigns. It varies among cities and places. I know DC, San Francisco, New York-- places like that-- have good campaigns targeting older adults. Contact the health department there and they will put you in touch with people who develop all these elaborate

materials that can be used and copied. ACRIA actually has a lot of good information that they can let you have in terms of the campaigns they've done putting the face of HIV on older adults. So look at the resource section that I had in there and those organizations could help you.

Anyone else have any questions?

VICTOR RAMIREZ: Thank you, Steve, and thank you Mr. [INAUDIBLE] for being with us today. This is Victor Ramirez, the P4C HIV TAC Collaborative Training Coordinator, I just want to remind all the health centers out there, please be willing to participate as a corporate center. We'll be sending out emails to all the health centers leads requesting participation at the health centers and some of our collaborative training webinars for this year. We feel that health centers can learn from each other. A lot of the challenges, a lot the successes that you have can be replicated by other health centers in the other P4C states.

So please, you can feel free to contact me at the email address that you see on your screen. And just let me know what are those areas that are your expertise and your health centers expertise, and again for the health center leads just be aware that I will be contacting you requesting for your participation in some of our webinars this year.

COURTNEY WILLIAMS: Thank you.

MODERATOR: All right, thank you for participating in today's webinar. We hope that you're able to find the information provided useful as you continue your P4C project. And ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar was recorded. On audio and video versions of the entire webinar, as well as the slides from today's webinar, will be made available on the P4C website within the next few weeks. Copies of our prior P4C webinars are currently available on the website on the P4C Resource Materials page at [P4CHIVTAC.com](http://P4CHIVTAC.com). You'll need to log in to access the materials.

If you need login credentials, send an email to [p4chivtac@mayatech.com](mailto:p4chivtac@mayatech.com). Thank you, again, for participating in today's webinar. And thank, you once again, for that excellent presentation. If you have any additional questions for the P4C project, please email us at [p4chivtac@mayatech.com](mailto:p4chivtac@mayatech.com). Take care everybody and we'll see you next time.