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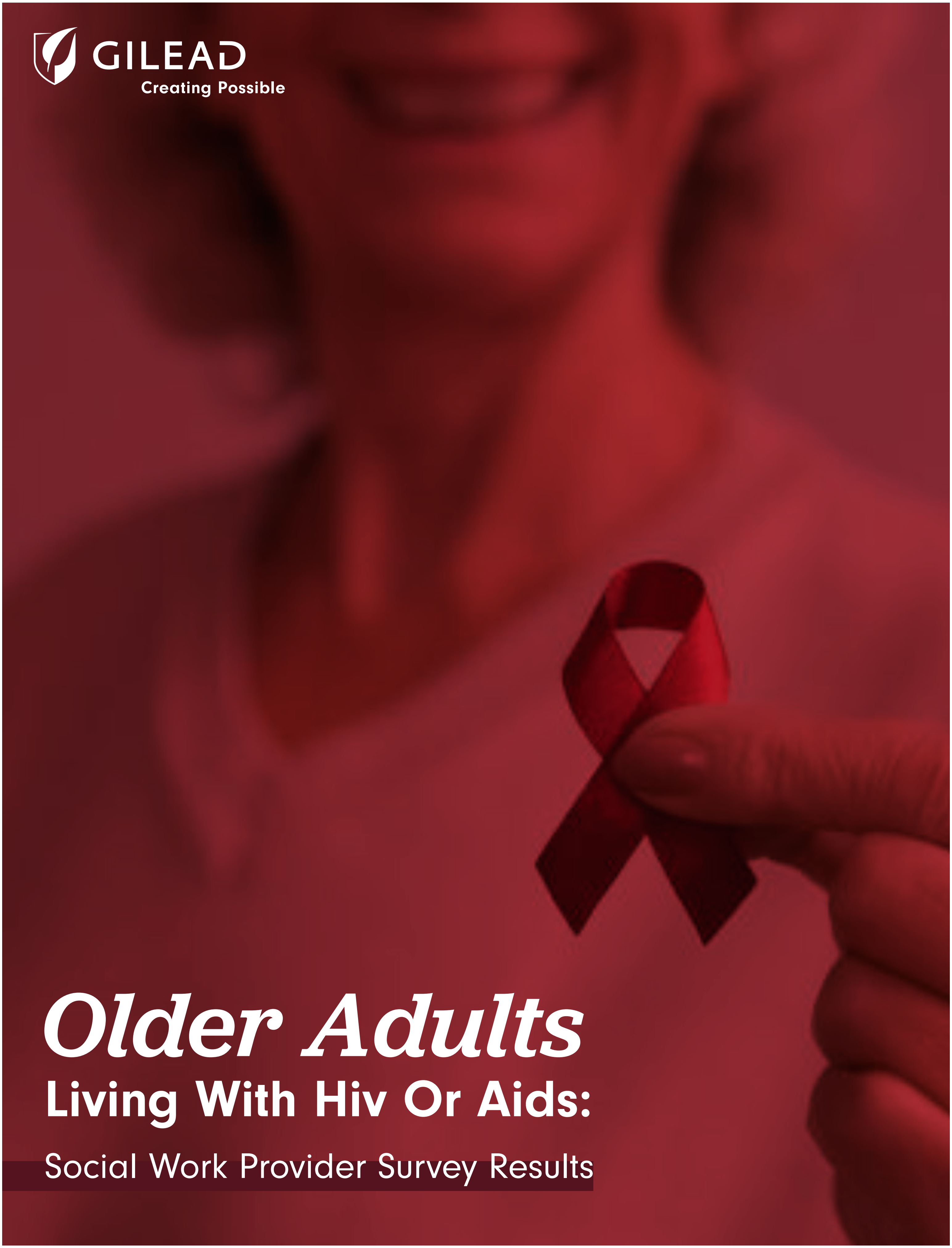


Older Adults
Living With Hiv Or Aids:
Social Work Provider Survey Results

Background

Background

Older Adults Living with HIV or AIDS: Social Work Provider Survey Results was developed by Collaborative Solutions, Inc. in August 2020 in collaboration with PASWH and Gilead Health. The survey was intended to understand capacity building needs for social workers to improve their support to adult clients, 50 years of age or older, living with HIV or AIDS. Results from this survey will help to drive the development of future professional development.

Methods

Survey participants were recruited through the Professional Association of Social Workers in HIV/AIDS existing national provider network, which includes # providers and partners across the US. Snowball sampling was used to reach out to providers to complete the survey. With this type of sampling, a provider can reach out to their own network of providers to extend an invitation to complete the survey AND pass the word on to other providers who may be interested in also participating. [ADD HERE.] Survey items were developed by several researchers and refined by the PASWHA Advisory Group to pilot test and revise. Surveys were completed online using SurveyMonkey between May 10 and June 28, 2021. Survey participants were entered into a drawing for a free membership to the Professional Association of Social Workers with HIV and AIDS and a conference registration to the National Conference on Social Work and HIV and AIDS. The data were downloaded from SurveyMonkey for analysis on July 7, 2021.

A total of 173 people responded to at least one survey question and were included in the analysis. Note that there was a large drop off in survey respondents at the start of the second section of the survey (starting with question 16.) 40 respondents (23%) stopped taking the survey at or before question 16, possibly due to the lengthiness of the questions beginning in that section.

Description of Survey Respondents

Note: demographic questions were asked at the end of the survey, so these data do not include descriptions of the 23% of survey takers who began, but did not finish, the survey.

Survey respondents were an average of just over 62 years old. Almost 70% of respondents were assigned female sex at birth with the remainder of those who answered the question reporting that they were assigned male. 68% of respondents stated their gender is female, 25% male, and one or two respondents stated their gender was one of the following: non-binary, fluid, cisgender, gay cisgender, or queer. In terms of racial and ethnic identity, 64% of respondents describe themselves as white, 24% as black or African American, 10% as Hispanic or Latino, and 2% as either Asian, multiracial or multiethnic, Native American or Alaska Native, or another race. Geographically, 29% of survey respondents are located in the mid-west, 17% in the northeast, 17% in the southeast, 12% on the west coast, and the remainder throughout the country with a handful also located outside of the United States.

Among those responding to the demographic questions, 41% are married, 22% are single (never married), 17% are divorced, 14% are in a domestic partnership, and the remainder are either separated or widowed. 60% of respondents have a graduate degree, 32% have a college or university degree, 6% have some college or university, and 3% have an MD or PhD. All but two respondents (98%) were currently employed at the time they took the survey and 95% work full time (more than 30 hours/week.) Almost half of respondents (46%) have a household income between $51-100,000, while about a quarter have a household income of $10-50,000 and another 20% have a household income between $101-150,000.

90% of respondents are currently working directly with aging clients living with HIV or AIDS and among them, 30% have worked with aging HIV/AIDS clients for 16 years or more, 10% have worked with them for 11-15 years, 19% have worked with them for 6-10 years, 28% have worked with them for 2-5 years, and 13% have worked with them for 0-1 year.

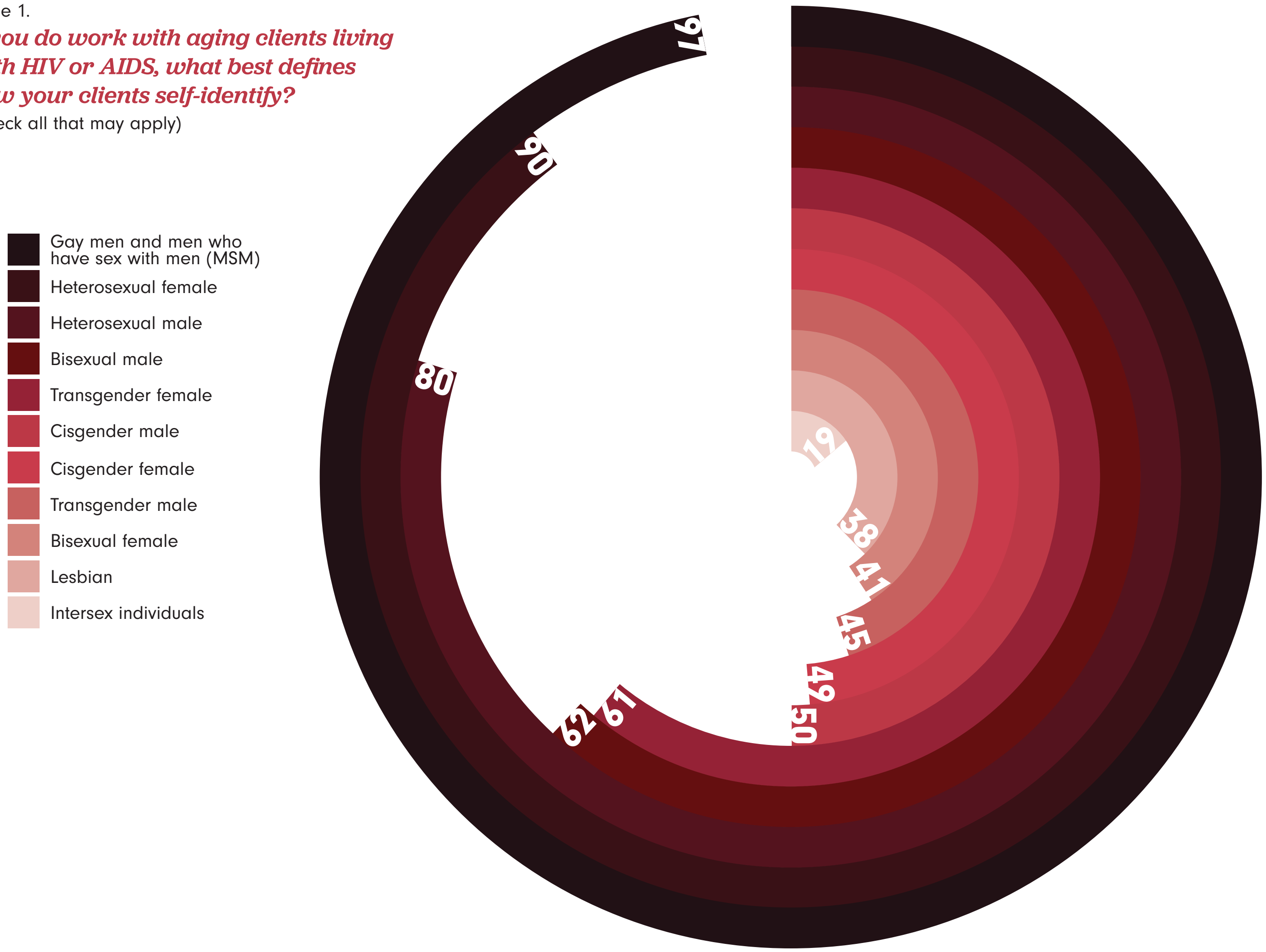
Most survey respondents serve clients along the age spectrum: 45% see clients less than 26 years old; 80% see clients ages 27-49; 94% see clients ages 50-64; 83% see clients ages 65-75; 51% see clients ages 76-84; and 26% see clients ages 85 and older.

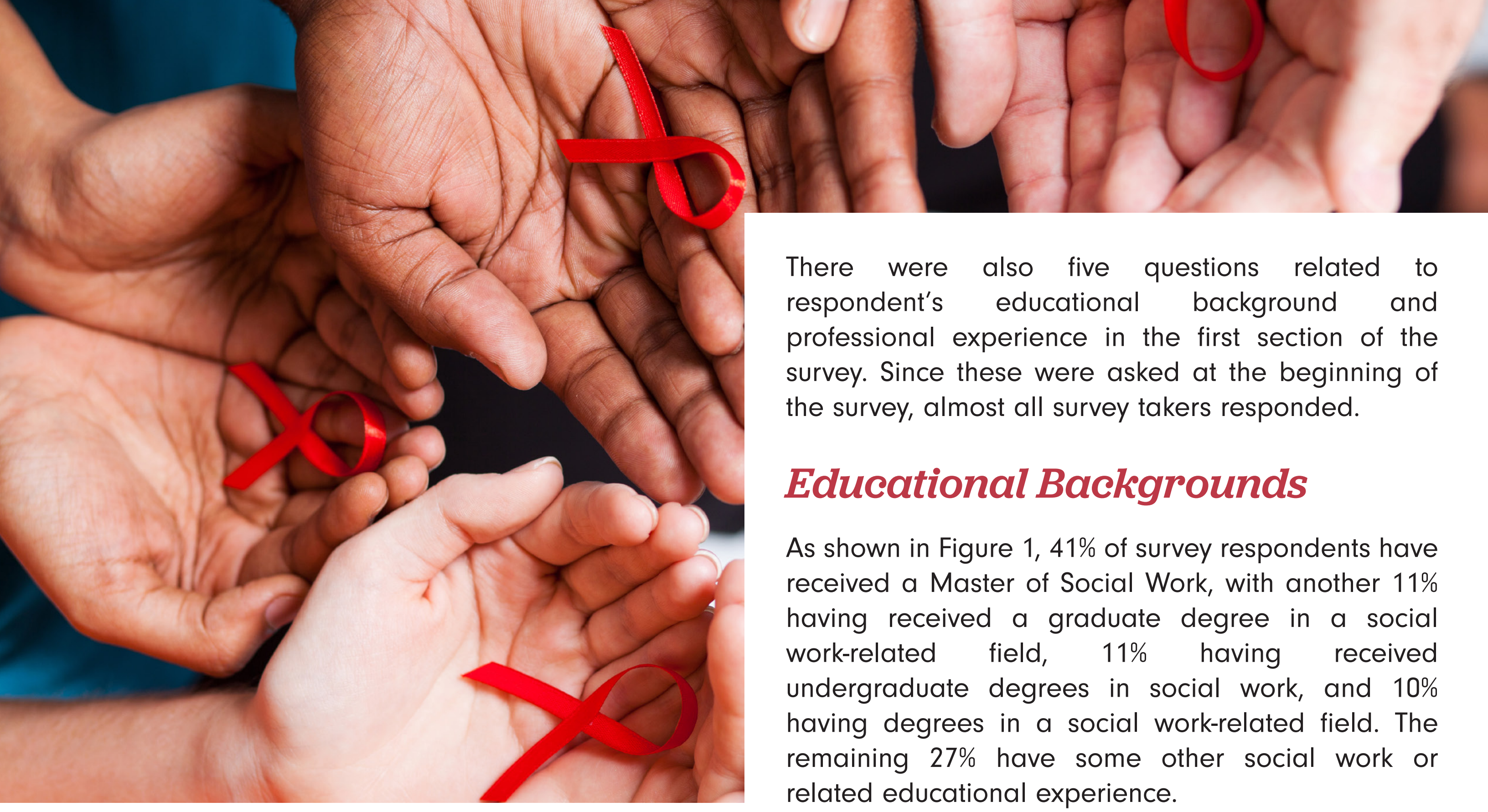
Survey respondents' clients self-identify in a variety of ways, see Table 1 below.

Table 1.

If you do work with aging clients living with HIV or AIDS, what best defines how your clients self-identify?

(Check all that may apply)





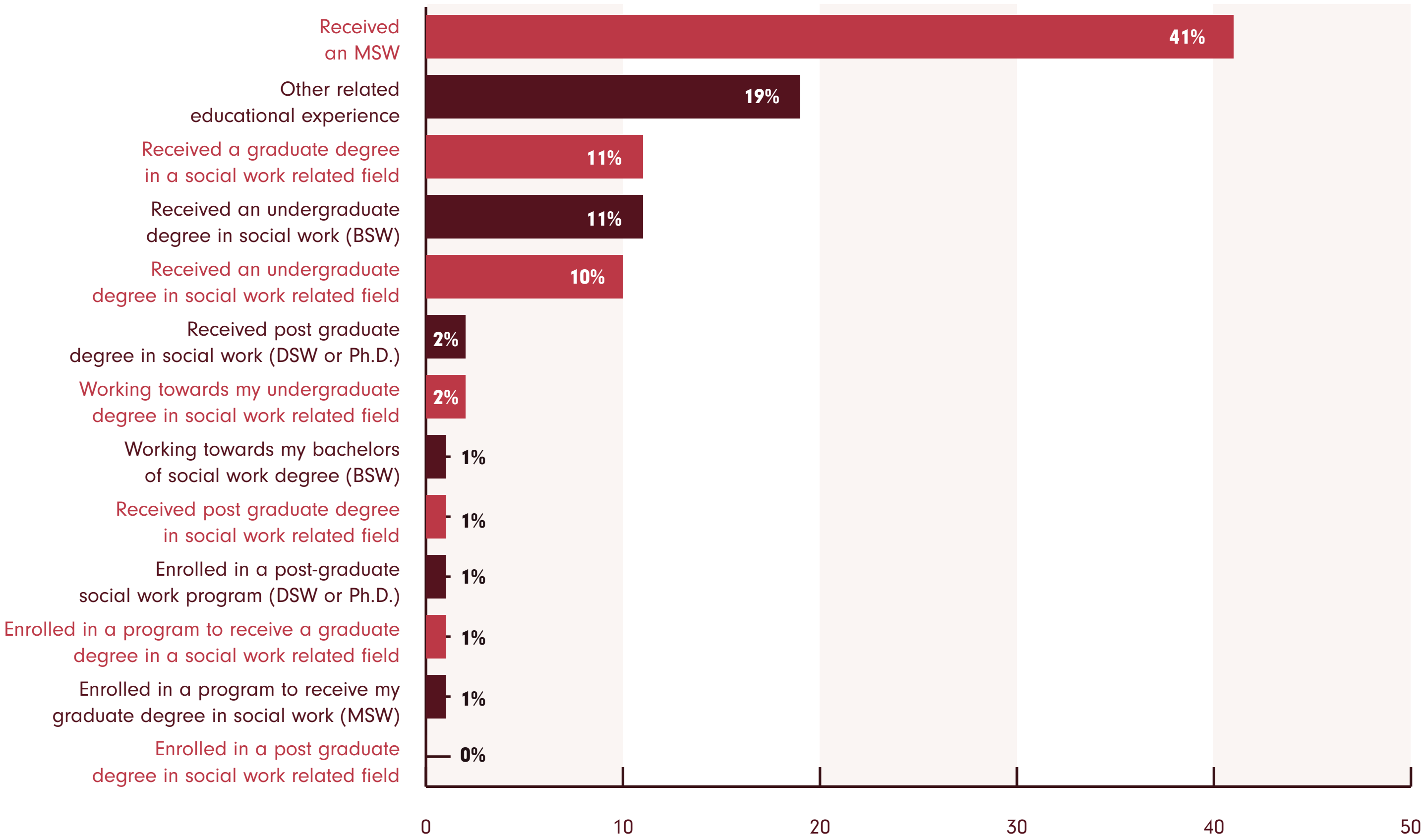
There were also five questions related to respondent's educational background and professional experience in the first section of the survey. Since these were asked at the beginning of the survey, almost all survey takers responded.

Educational Backgrounds

As shown in Figure 1, 41% of survey respondents have received a Master of Social Work, with another 11% having received a graduate degree in a social work-related field, 11% having received undergraduate degrees in social work, and 10% having degrees in a social work-related field. The remaining 27% have some other social work or related educational experience.

Figure 1.

Social Worker Educational Backgrounds
Which type of social worker best describes you?
(Check one. n=170)



Type of social work

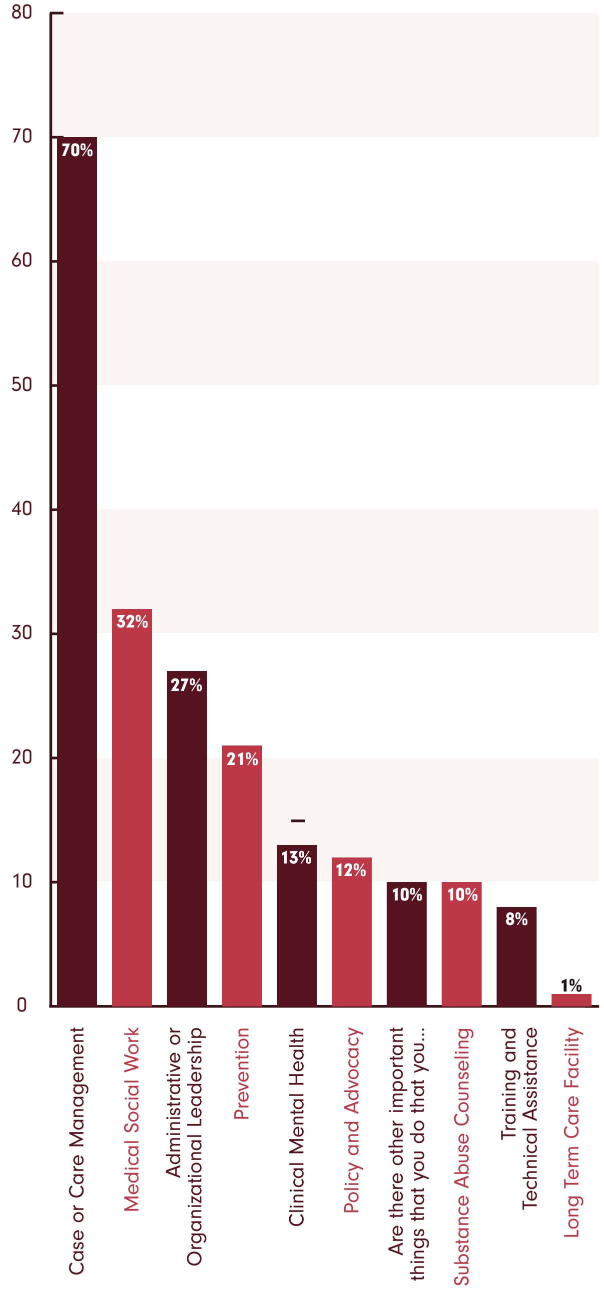
The vast majority (70%) of survey respondents report doing case or care management with people aging with HIV or AIDS on a weekly basis. Fewer report doing other types of social work on a weekly basis such as medical social work (32%), administrative or organizational leadership (27%), or prevention (21%). See Figure 2 for the full responses of the types of social work respondents are practicing.

Figure 2.

Types of Social Work

What type of social work are you doing on a weekly basis in Aging and HIV or AIDS?

(Check all that apply. n=173)



Practice settings

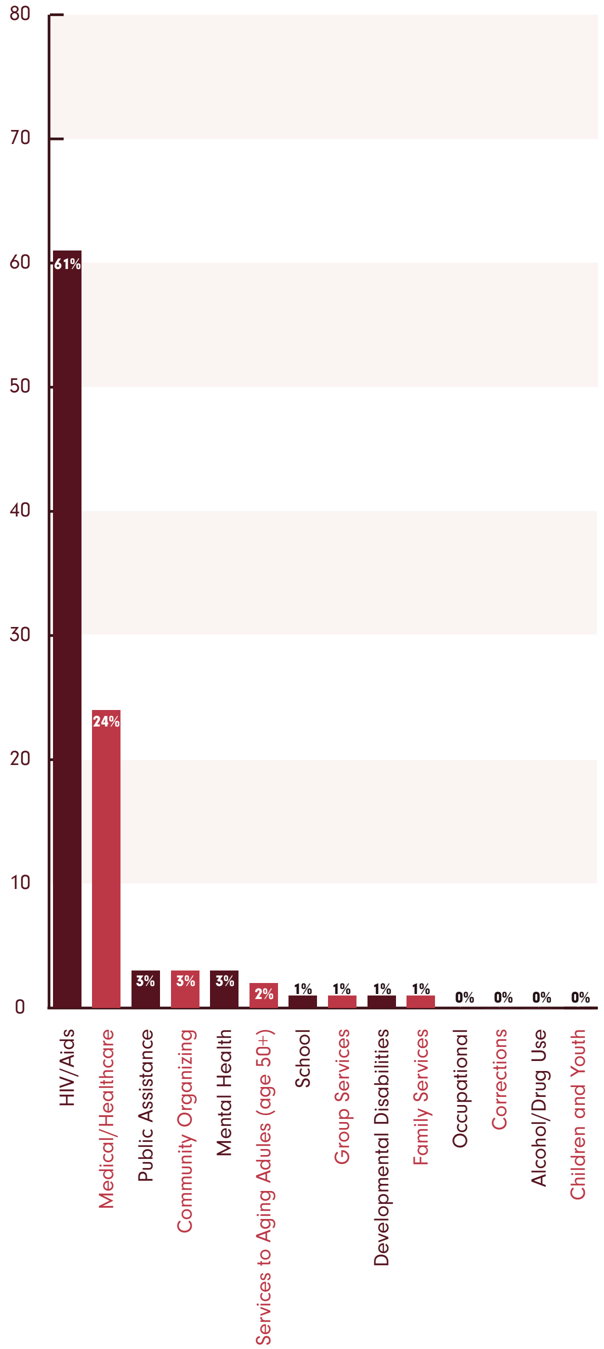
Over 60% of survey respondents report that their practice setting is HIV/AIDS with another 24% working in Medical/Healthcare. 3% or fewer of respondents selected other practice settings such as Public Assistance, Community Organizing, or Mental Health, see Figure 3.

Figure 3.

Practice Settings

My practice setting would best be desribed as:

(Check one. n=173)



Workplace settings

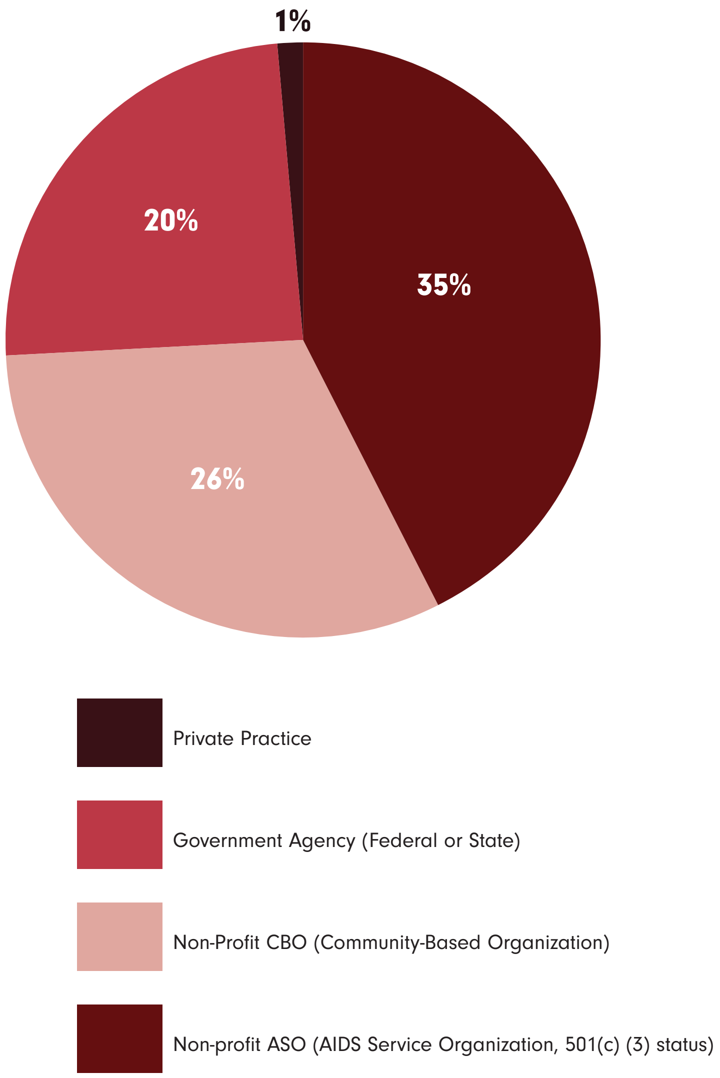
As shown in Figure 4, non-profit AIDS Service Organizations were the most common workplace setting where survey respondents reported they work with aging clients living with HIV/AIDS (35% of respondents). This was followed by non-profit community-based organization (26%) and government agency (20%). Only 1% of respondents stated they are in private practice. 18% of respondents selected other, including working at federally qualified health clinics, hospitals, or other healthcare settings.

Figure 4.

Workplace settings

In what kind of workplace setting do you work with aging clients living with HIV or AIDS?

(Check one. n=172)



Geographic area

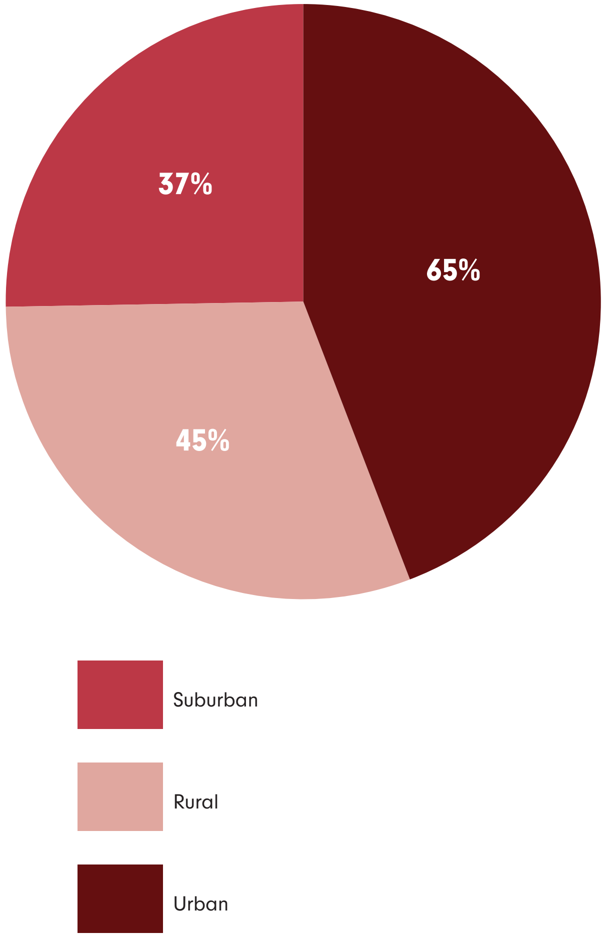
65% of respondents practice in urban areas, 45% in rural areas, and 37% in suburban areas, see Figure 5.

Figure 5.

Geographic area

Which geographic area is serviced by your practice?

(Check one. n=172)



Findings

Professional Development Knowledge

The survey (Q6) asked social workers about what type of professional development they have already acquired. The majority of respondents reported already acquired learning about Case/Care Management (82%), Assessing Social Supports and Loneliness (58%), Housing (56%), and Mental Health (50%), see Table 2.

However, less than 20% of respondents reported that they have already received professional development related to:

- Linking clients with meaningful work/“encore careers”: 19%
- Assessing religion/spirituality as a coping support: 18%
- Caregiving: 17%
- Dementia(s) vs. Delusion Assessment: 12%

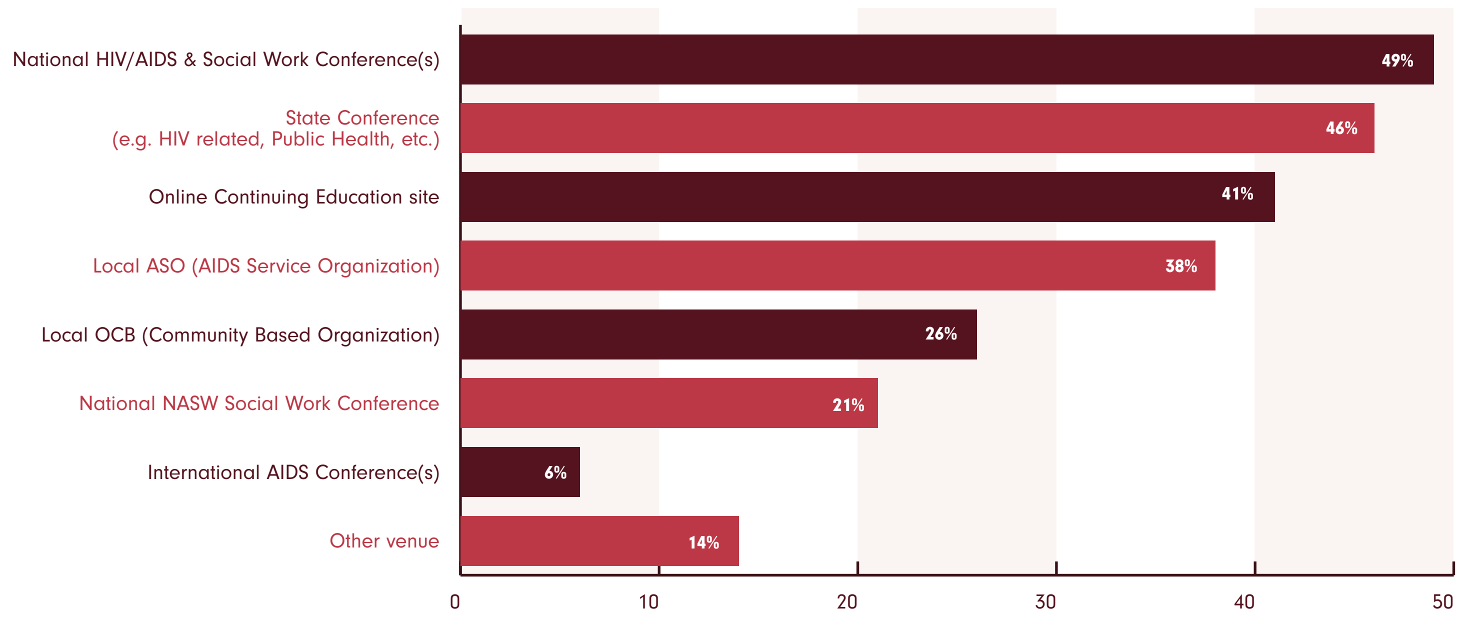
Table 2.

Professional Development Topics Already Acquired

Professional Development Already Acquired	Already Acquired (N)	Already Acquired (%)
Case/Care Management	138	82%
Assessing Social Supports (emotional, economic, tangible) and Loneliness	98	58%
Housing	94	56%
Mental Health (including discerning co-morbidities)	85	50%
Dismantling Stigma	72	43%
Brokering/Locating Resources (e.g. social services, entitlements...)	61	36%
Nutritional Assistance	59	35%
Teaching/Doing Self-Care	51	30%
Financial Stressors Assessment	44	26%
Long-term Care / Assisted Living / Home Health Care	34	20%
Linking clients with meaningful work / “encore careers”	32	19%
Assessing religion/spirituality as a coping support	30	18%
Caregiving	29	17%
Dementia(s) vs. Delusion Assessment	21	12%

Next, the survey asked where respondents acquired their knowledge. As shown in Figure 6, nearly half of respondents reported that they acquired social work professional development through the National HIV/AIDS & Social Work conferences with another 46% saying they acquired knowledge through their state conference, 41% through online continuing education, and 38% through a local AIDS Service Organization. Appendix A presents additional comments on where knowledge was gained from a local ASO, local CBO, online continuing education site, or other venue, along with the full text of all other open-ended comments.

Figure 6.
Where acquired knowledge
(Check all. n=168)



Impact of Covid-19 on Working with Aging Clients with HIV or AIDS

Question 8 asked respondents an open-ended question about how Covid-19 has changed the way in which they work with aging clients living with HIV or AIDS. 152 people responded to the question. By far the largest impact of Covid-19 on social worker's working with client was the necessity to move away from face-to-face visits and use telemedicine, including using Zoom or other video meetings, telephone, and text to communicate. 62% of respondents to this question mentioned moving from meeting with client in person to utilizing technology to do so during the pandemic. Other themes included awareness of an increase in isolation, mental health issues, and substance use during the pandemic, the need to take covid mitigation precautions to protect aging client's health, and discussion of clients deferring needs care and services.

A few people stated that there have been silver linings, such as expanding access through telehealth and virtual care. One discussed that their agency provided cell phones to clients and they are now able to connect with them more easily than before the pandemic. The full responses for this, and for all other open-ended questions, is available in Appendix A of this report.

Professional Development Interests

Survey question 9 asked respondents what type of professional development they would like in the future related to serving aging clients living with HIV or AIDS.

The top professional development topics of interest, with 40% or greater of respondents, include:

- Dementia(s) vs. Delusion Assessment – 56%
- Long-term Care / Assisted Living / Home Health Care Financial Stressors Assessment – 55%
- Mental Health (including discerning co-morbidities) – 44%
- Linking clients with meaningful work / "encore careers" – 44%
- Assessing Social Supports (emotional, economic, tangible) and Loneliness – 43%

Table 3.

Professional Development Topic of Interest in Future

(Check all)

Professional Development Topics of Interest	Interest (N)	Interest (%)
Dementia(s) vs. Delusion Assessment	96	56%
Long-term Care / Assisted Living / Home Health Care Financial Stressors Assessment	94	55%
Mental Health (including discerning co-morbidities)	76	44%
Linking clients with meaningful work / "encore careers"	75	44%
Assessing Social Supports (emotional, economic, tangible) and Loneliness	74	43%
Teaching/Doing Self-Care	60	35%
Housing	56	33%
Dismantling Stigma	50	29%
Assessing religion/spirituality as a coping support	49	29%
Brokering/Locating Resources (e.g. social services, entitlements...)	44	26%
Nutritional Assistance	42	25%
Caregiving	41	24%
Case/Care Management	34	20%

Respondents were also asked an open-ended question about additional areas they would like to learn about. Twenty-one people provided responses and outlined some additional areas including Medicare/Medicaid coverage, promoting racial justice and equity, comorbidities, substance use disorders, and others.

Professional Development Opportunities

One way to select which professional development topics to include is to look at the gap between the percent of people who have already acquired professional development in the topic and the percent who are interested in the topic. As shown in Table 4, the greatest difference is for the topic of "Dementia(s) vs Delusion Assessment" in which 56% are interested in the topic and only 12% have already acquired training in it. Similarly, "Long-term Care / Assisted Living / Home Health Care Financial Stressors Assessment[1]" has a 35-percentage point difference between acquired and interest. The third largest gap is between acquired and interest in "Linking clients with meaningful work/ "encore careers" with a 25-percentage point difference. This would suggest these are three topics that may be well-received and fill a gap in training.

[1] Note that this version, wording of Q9, includes "Financial Stressors Assessment" whereas Financial Stressors Assessment is asked as a separate item in Q6.

In contrast, Case/Care Management appears to be a training topic which has reached saturation. 82% of respondents report that they have acquired this topic and only 20% indicate interest in learning about it in the future, a 62-percentage point difference.

Table 4.
Comparing interest in and already acquired professional development topics

	Interest (N)	Interest (%)	Difference (Percentage Points)
Dementia(s) vs. Delusion Assessment	12%	56%	56%
Long-term Care/Assisted Living/Home Health Care Financial Stressors Assessment	20%	55%	55%
Linking clients with meaningful work / "encore careers"	19%	44%	44%
Assessing religion/spirituality as a coping support	18%	29%	11
Caregiving	17%	24%	7
Teaching/Doing Self-Care	30%	35%	5
Mental Health (including discerning co-morbidities)	50%	44%	-6
Nutritional Assistance	35%	25%	-10
Brokering/Locating Resources (e.g. social services, entitlements...)	36%	26%	-10
Dismantling Stigma	43%	29%	-13
Assessing Social Supports (emotional, economic, tangible) and Loneliness	58%	43%	-15
Housing	56%	33%	-23
Case/Care Management	82%	20%	-62
Financial Stressors Assessment	26%	Combined with above	NA

Other Topics of Interest

Question 10 asked respondents "what other information would you like to know more about?" As shown in Table 4, these topics received even higher ratings than many of the topics listed in Q9. Top interests include Psychology of Aging, Health Disparities, Biology of Aging, and Sociology of Aging. We again see lower interest in Case/Care Management.

Table 5.
Other areas of interest
(Check all)

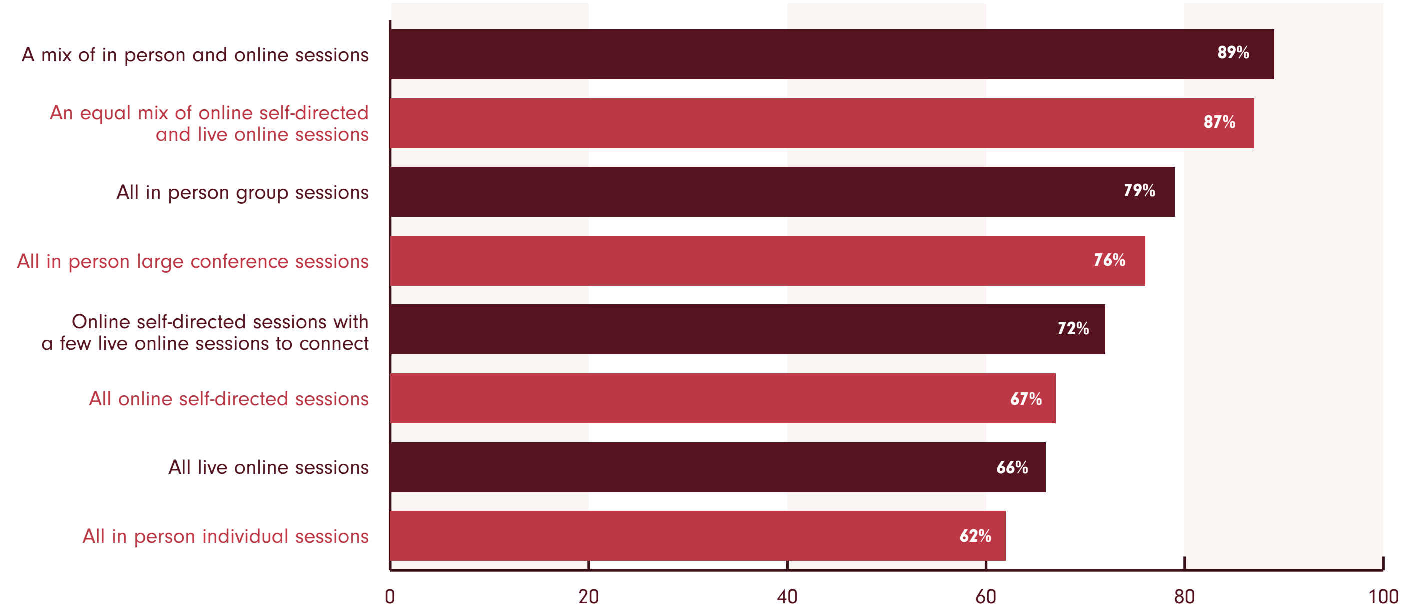
	N	K
Psychology of Aging Clients Living with HIV or AIDS (coping with physical and cognitive changes)	119	71%
Understanding / Managing Health Disparities of Aging Clients Living with HIV or AIDS	110	65%
Biology of Aging Clients Living with HIV or AIDS (assessing dementia, delirium, wear & tear)	104	62%
Sociology of Aging Clients Living with HIV or AIDS (assessing community & social supports)	100	60%
Mental Health Assessment of Aging Clients Living with HIV or AIDS	90	54%
Housing Resources for Aging Clients Living with HIV or AIDS	88	52%
Case/Care Management for Aging Clients Living with HIV or AIDS (information and referral)	70	42%

Learning Mode Preferences

The survey asked social workers how they would like to receive education and capacity building for meeting the needs of aging clients living with HIV or AIDS (Q11.) Favored by three-quarters or greater of respondents are a mix of in-person and online, a mix of self-directed and live online sessions, all in person group sessions, and all in person large conference sessions, see Figure 7.

Figure 7.

Learning Mode Preferences
% Favor (Strongly or Somewhat)



Telehealth Service Provision

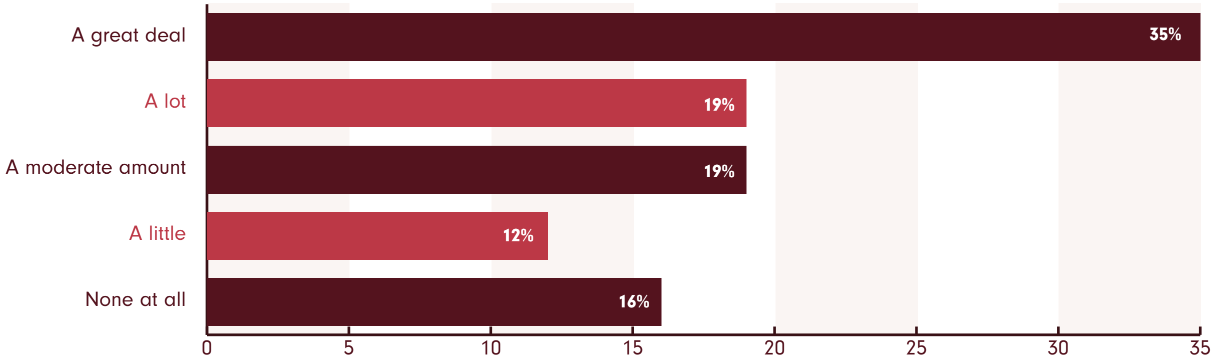
Next, the survey asked how often respondents are providing services via telehealth (phone, teleconference, or other platforms.) As shown in Figure 8, over half of respondents (54%) report that they are using telehealth "a great deal" or "a lot" with another 31% say they are using it "a moderate amount" or "a little" and 16% saying "none at all."

Figure 8.

Frequency of telehealth services

How often are you providing services via telehealth (on phone, on teleconference, on other platforms)?

(Check one)



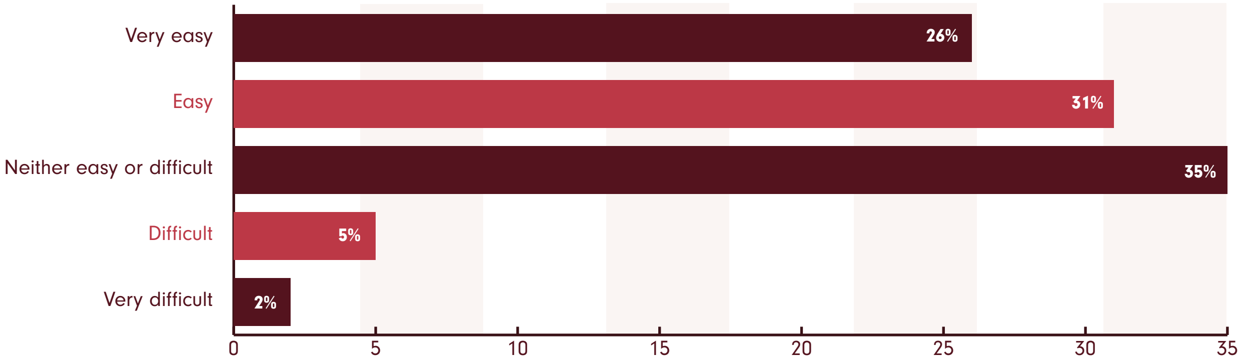
As shown in Figure 9, 57% of respondents find telehealth "very easy" or "easy" with another 35% finding it "neither easy nor difficult." Only a minority of respondents, 7%, feel it is "difficult" or "very difficult."

Figure 9.

Comfort with telehealth

How comfortable are you with using telehealth in your own practice?

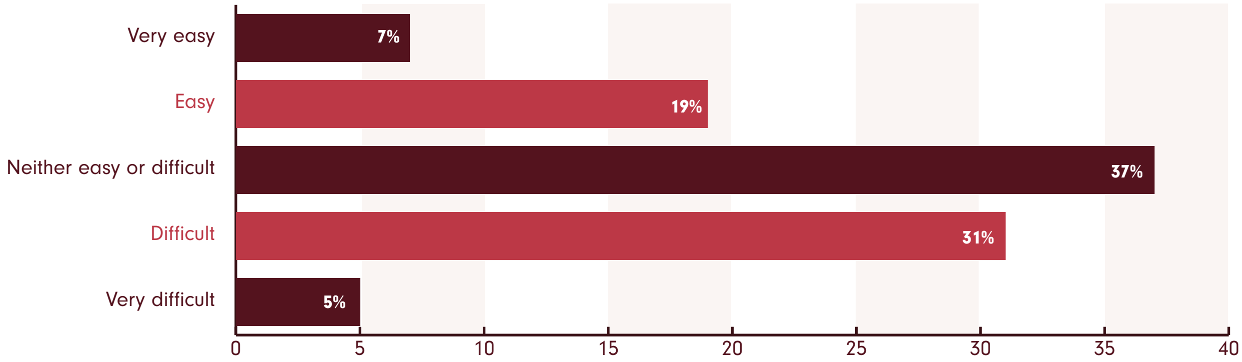
(Check one)



While providers feel generally comfortable with using telehealth, they report that their clients find it more difficult to use. Only about a quarter of respondents stated that telehealth is "very easy" or "easy" for their clients to use, while 37% stated their clients find it "neither easy nor difficult" and another 38% report their clients find telehealth "difficult" or "very difficult," see Figure 10.

Figure 10.

Client comfort with telehealth
How comfortable are your clients with the use of telehealth?
(Check one)



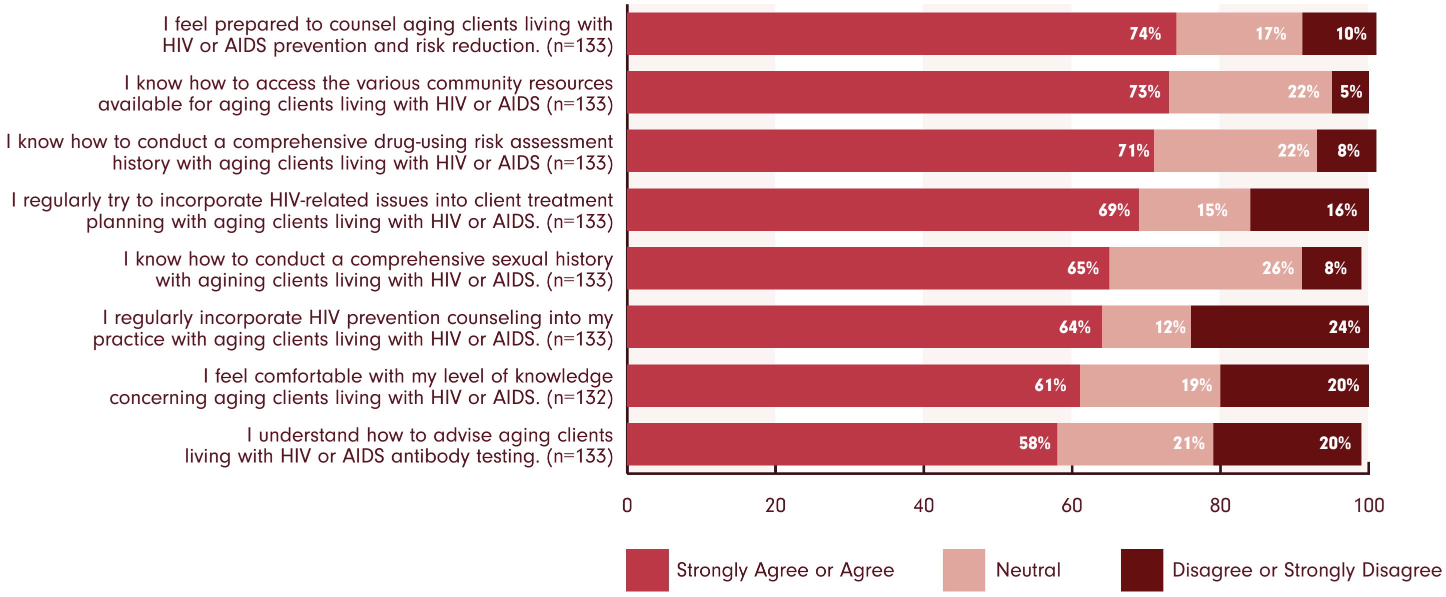
Question 15 asked an open-ended question, "what resources do you or your organization need to use telehealth more successfully?" 71 people provided responses. Over a third of responses reported that more and/or newer electronic devices such as computers or tablets were needed to use telehealth more successfully, although more of these responses said that their clients, not the clinic, needed the devices. Similarly, about a third of respondents stated that training and technical assistance was needed to better use telehealth, again with more saying that training was needed for clients rather than providers. A number of others mentioned the need for more reliable and faster internet was needed and others said that funding generally was needed to improve telehealth.

Knowledge of Topics Related to Aging with HIV or AIDS

The next section of the survey asked respondents to rate their level of knowledge on eight different HIV or AIDS related social work issues. As shown in Figure 11, 70% or greater of respondents strongly agree or agree that they feel comfortable with counseling about prevention and risk reduction, along with accessing community resources and conducting a drug-use risk assessment. The three areas in which 20% or greater of respondents strongly disagree or disagree that they feel comfortable include how to incorporate HIV prevention counseling into their practices, their level of knowledge concerning aging clients living with HIV or AIDS, and how to advise antibody testing.

Figure 11.

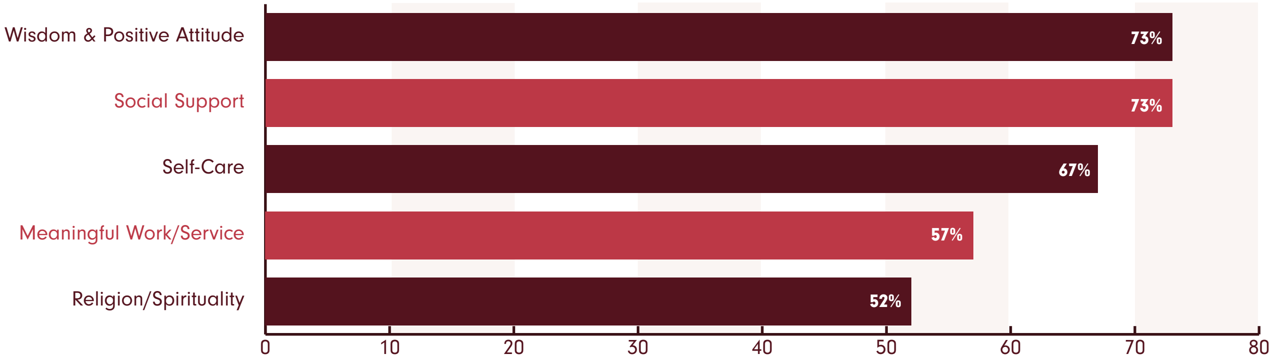
HIV or AIDS social work issue knowledge
Knowledge of HIV or AIDS related issues:



The next question (Q17) asked respondents to rate how knowledgeable they are on the strengths of aging clients living with HIV or AIDS (Very Knowledgeable, Knowledgeable, Somewhat Knowledgeable, Not Very Knowledgeable, or Not at all Knowledgeable.) As shown in Figure 12, almost three-quarters of respondents felt Very Knowledgeable or Knowledgeable about Wisdom & Positive Attitude and Social Support.

Figure 12.

Knowledge of strengths of aging clients
% Very Knowledgeable and Knowledgeable
(n=132 or 133)

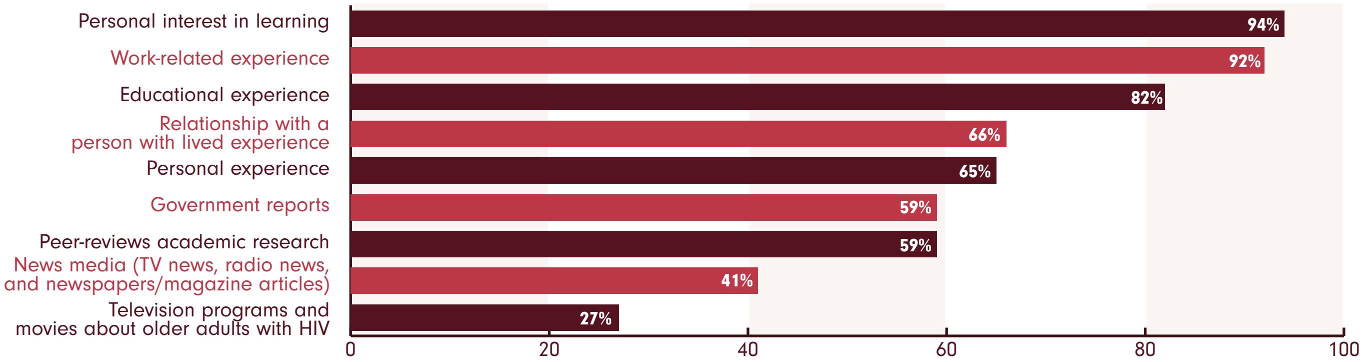


Next, respondents were asked to rate how much various sources contributed to their knowledge about aging clients living with HIV or AIDS, rated on a scale of Always, Often, Seldom, or Never. As shown in Figure 13, the top sources of knowledge included personal interest in learning (94% Always or Often), work-related experience (92% Always or Often), and educational experience (82% Always or Often). Rated as contributing the least included television programs new media (27% Always or Often) and governmental reports (41% Always or Often).

Figure 13.

Sources contributing to knowledge about aging clients living with HIV or AIDS
% Always or Often

(n=130 to 133)

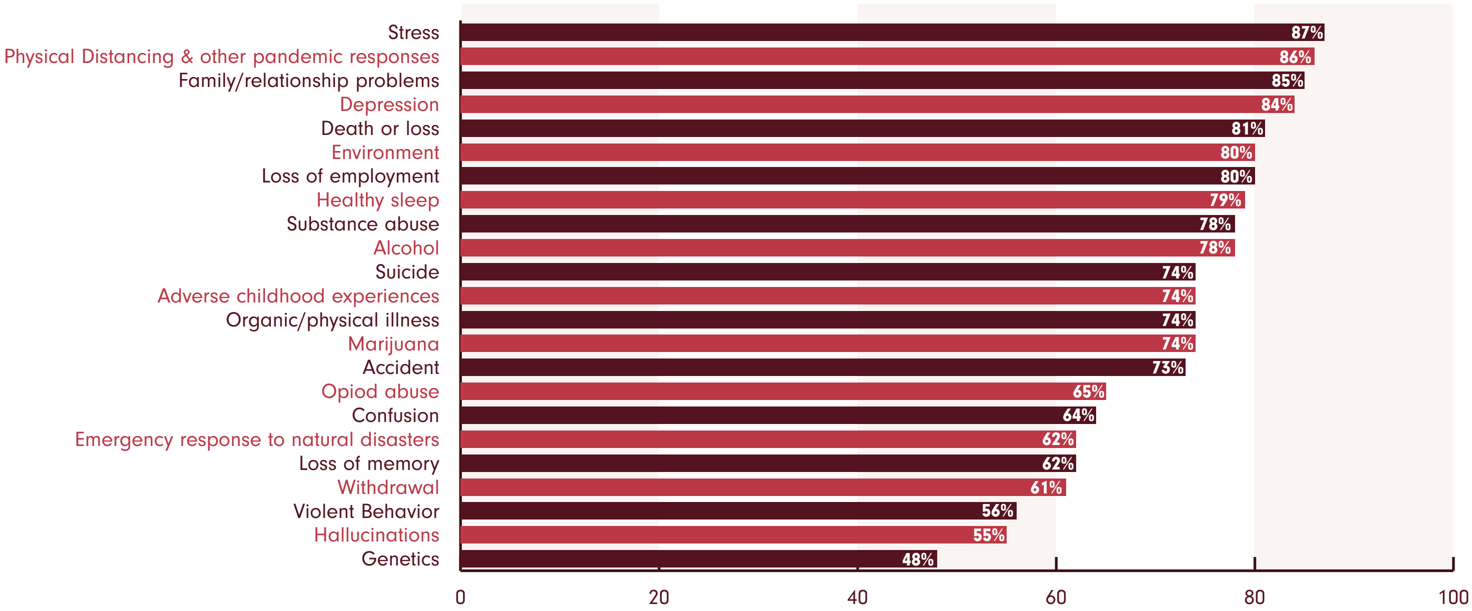


The next question on the survey asked how competent survey respondents feel about their ability to help aging clients living with HIV or AIDS with a number of different issues. Each issue was rated on a scale of Excellent, Very Good, Good, Fair, or Poor. In Figure 14 we combined Excellent, Very Good, and Good and rated the issues in descending order. Survey respondents felt most competent in their ability to help clients with stress (87%), physical distancing and other pandemic responses (86%), family/relationship problems (85%), and depression (84%). They felt least competent to help with genetics (48%), hallucinations (55%), and violent behavior (56%).

Figure 14.

Confidence in ability to help with the following issues
% Excellent, Very Good, Good

(n=132 to 133)



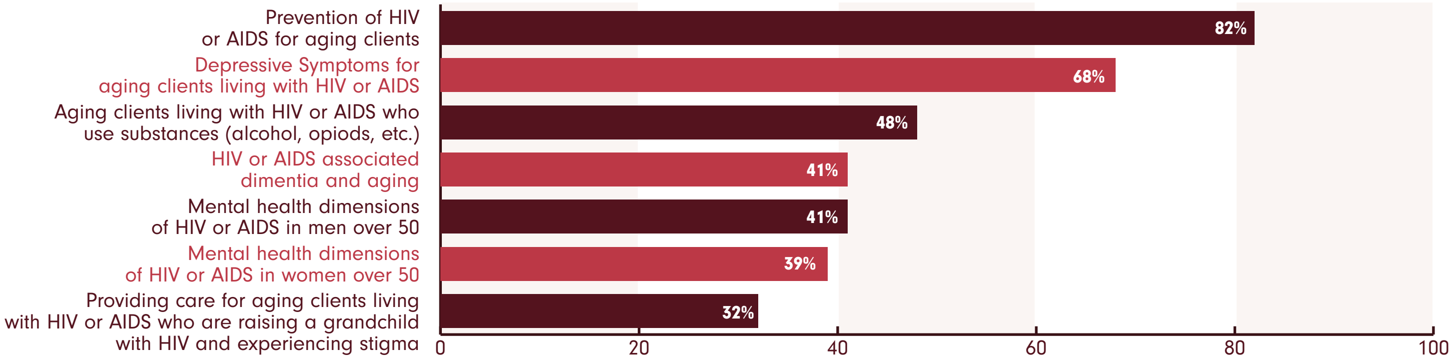
Survey respondents were asked to rate their level of knowledge of seven additional issues. As shown in Figure 15, 82% of respondents felt Very Knowledgeable or Knowledgeable about preventing HIV or AIDS for aging clients and 68% felt Very Knowledgeable or Knowledgeable about depressive symptoms for their clients, but fewer than half of respondents felt similarly knowledgeable about other topics, such as providing care for clients who are raising grandchildren living with HIV and experiencing stigma (32% Very Knowledgeable or Knowledgeable.)

Figure 15.

Knowledge levels

% Very Knowledgeable or Knowledgeable

(n=130 or 133)



Working Directly with Clients Living with HIV or AIDS

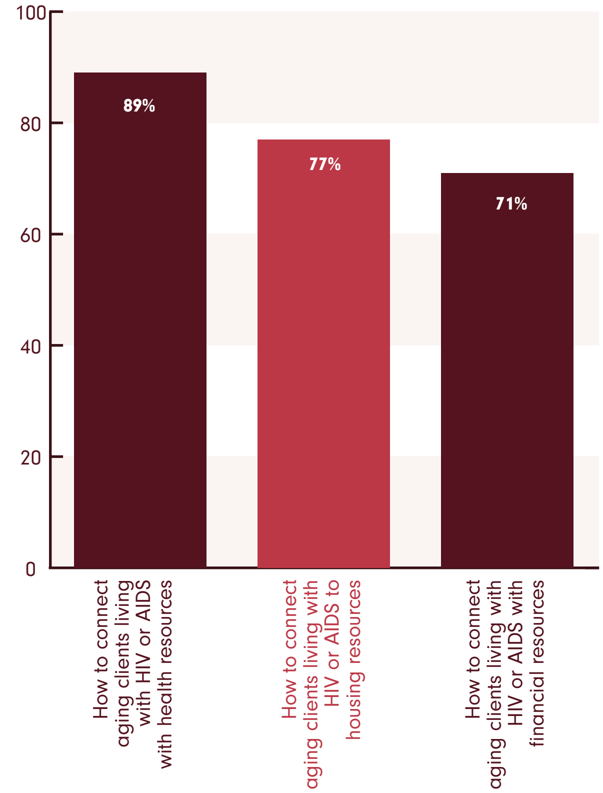
In the next section of the survey, respondents were asked questions about working directly with clients living with HIV or AIDS, of which 93% of respondents report that they do. Survey respondents, on average, report that while 80% of their job involves working with clients with HIV or AIDS, only 54% of their job involved working directly with aging clients living with HIV or AIDS.

Connecting Clients with Health, Housing, and Financial Resources

The survey next asked respondents to rate their understanding of connecting their clients with various resources. As shown in Figure 16, nearly 90% of respondents feel Very Knowledgeable or Knowledgeable about connecting their aging clients with health resources, while 77% feel the same about connecting clients with housing resources, and 71% feel knowledgeable about connecting clients with financial resources.

Figure 16.

Knowledge of connecting clients with resources
% Very Knowledgeable or Knowledgeable
(n=133)



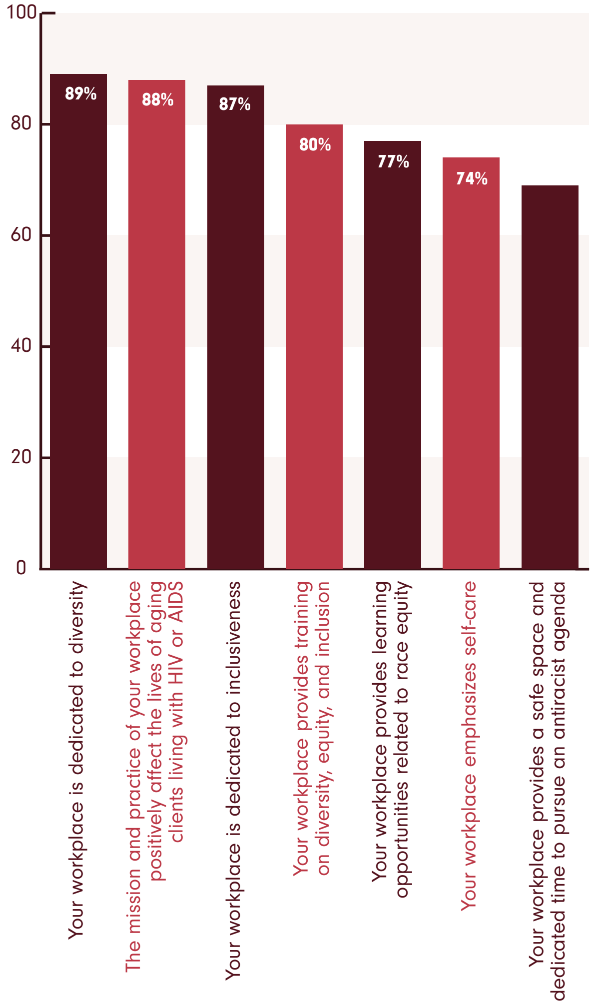
Additionally, 14 respondents listed what they feel are additional important resources for working with aging clients with HIV or AIDS, responses below, four of whom mentioned either Medicare or Medicaid:

1. How to connect clients with substance abuse or mental health resources
2. MEDICARE
3. How to access care homes/assisted living programs and how to pay for them.
4. Medicaid and Medicare; Ryan White ADAP
5. Medicare and other insurance resources
6. Social support and activities
7. Care homes/assisted living and convalescent homes, how they are funded and where to get help with funding.
8. Journals to read
9. Reducing housing costs
10. Technological resources, career resources, transportation resources
11. Navigating retirement
12. How to connect aging clients living with HIV or AIDS with substance use providers with limited coverage from Medicare.
13. Financial/Living Will etc.
14. Sexuality, Substance Use, Loss of Abilities

Workplace Culture

As shown in Figure 17, 80% or greater of survey respondents reported that their workplace environment was positive in terms of being dedicated to diversity, positively impacting the lives of aging clients, being dedicated to inclusiveness, and providing training on diversity, equity, and inclusion. The lowest rated among this group, still had nearly 70% of respondents Strongly Agreeing or Agreeing. That issue was that the workplace provides a safe space and dedicated time to pursue an antiracist agenda.

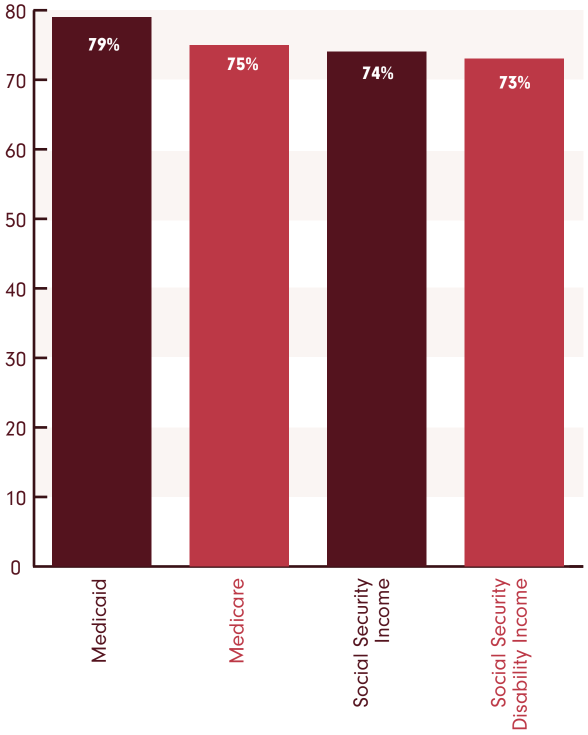
Figure 17.
Workplace culture
% Strongly Agree or Agree
(n=132 or 133)



Familiarity with Insurance and Benefits

Familiarity with Medicare, Medicaid, Social Security Disability Income, and Social Security Income varied little, with between 73% and 79% of respondents reporting they were Extremely or Moderately Familiar with them, see Figure 18

Figure 18.
Familiarity with insurance and benefits
% Extremely or Moderately Familiar
(n=133)



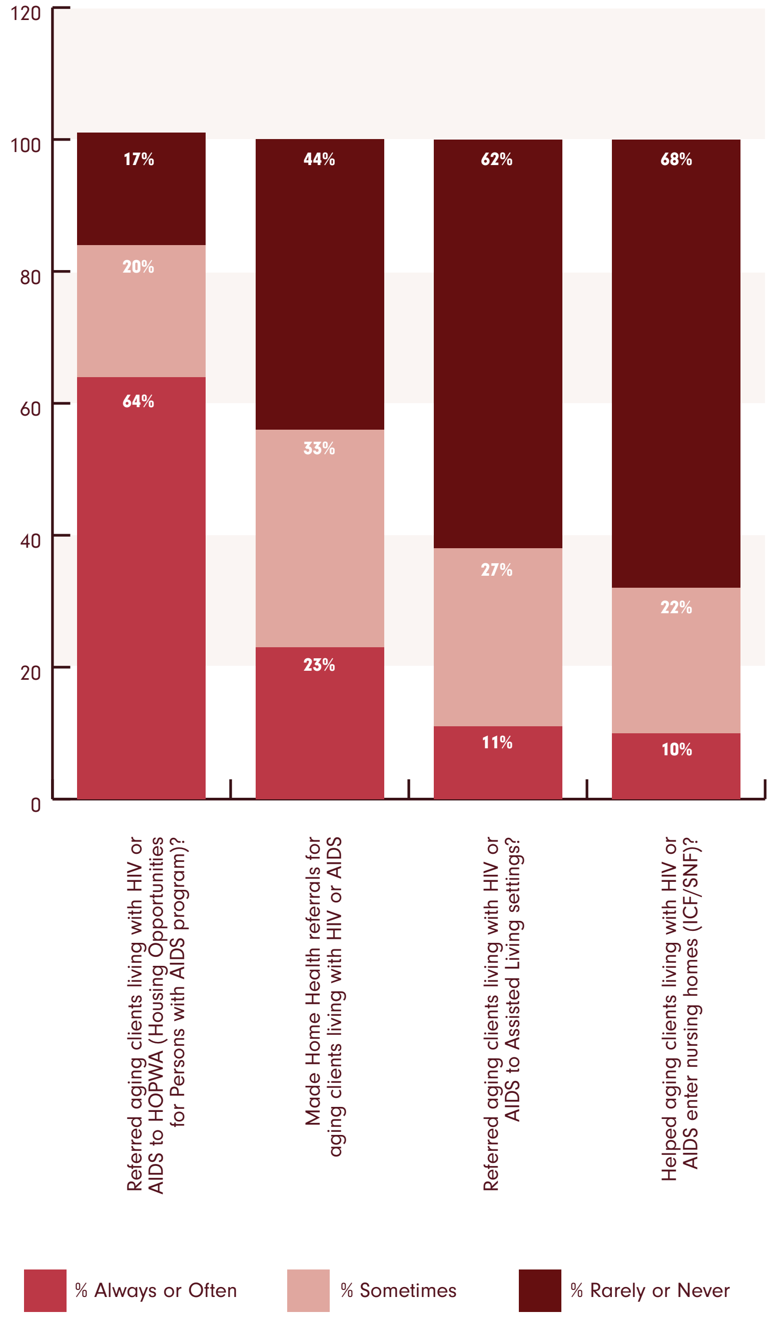
Referrals to Assisted or Supportive Living

The next survey question asked respondents how often they referred aging clients living with HIV or AIDS with referrals to home health, assisted living, nursing homes, or to HOPWA (Housing Opportunities for Persons with AIDS program.) As shown in Figure 19, the majority of respondents (64%) report they Always or Often refer their clients to the HOPWA program, however fewer than a quarter Always or Often refer to other settings. Instead, a plurality or majority report that they Rarely or Never refer to either home health (44%), assisted living (62%), or nursing homes (68%).

Figure 19.

Frequency of referrals

(n=132 or 133)



Question 28 asked an open-ended follow-up question about referrals, "how do you follow up with clients to find out if they had followed up on your suggested referral?" Of the 75 people who responded to this question, nearly 75% stated that they follow-up on referrals by phone calls to their clients. Fewer responded that they contact the referral agency, ask during a subsequent appointment, or work with case managers for follow-up.

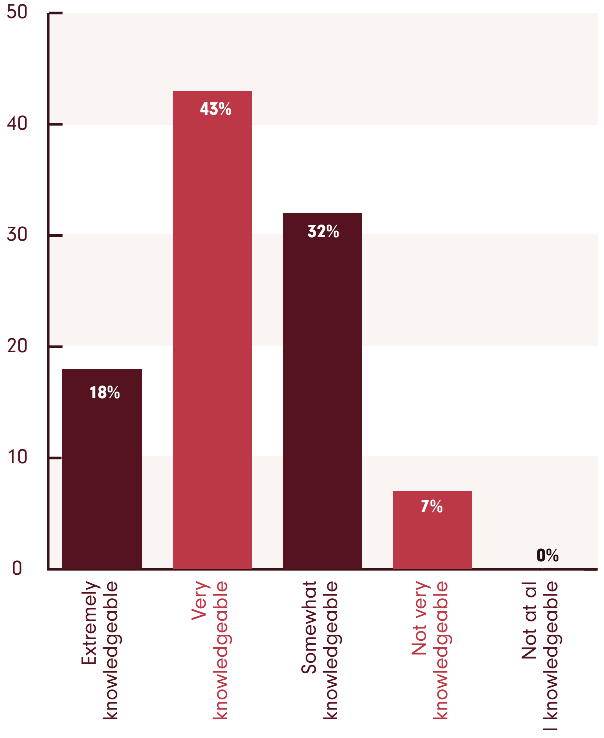
Knowledge of HIV Medications

Next, the survey asked respondents to rate their knowledge of HIV medications such as HAART and PREP. As shown in Figure 20, 61% of respondents state that they are Extremely or Very Knowledgeable about HIV medications with only 7% saying they are Not Very Knowledgeable and none said they were Not At All Knowledgeable.

Figure 20.

Knowledge of HIV medications
How would you rate your knowledge about HIV medications (HAART, PREP)?

(n=133)



Mental Health Intervention – Knowledge and Referrals

Survey respondents report lower levels of knowledge of mental health interventions than HIV medications. As shown in Figure 21, 38% of respondents feel Extremely or Very Knowledgeable about mental health interventions, with about half saying they are Somewhat Knowledgeable, and 16% stating they are Not Very Knowledgeable. Again, no one reported that they are Not At All Knowledgeable.

Figure 21.

Knowledge of mental health interventions
How would you rate your knowledge about Mental Health interventions for aging clients living with HIV or AIDS?
(n=132)

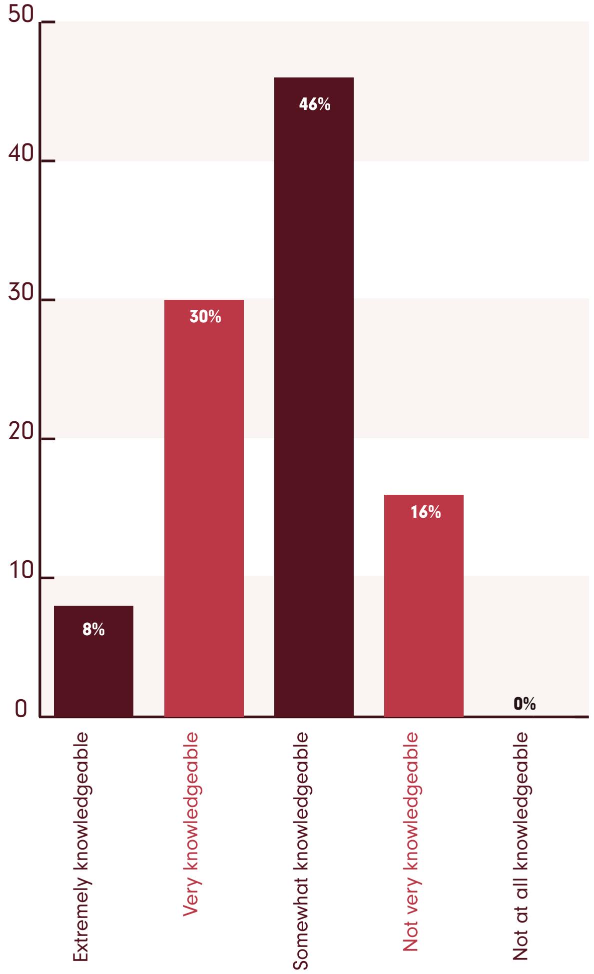
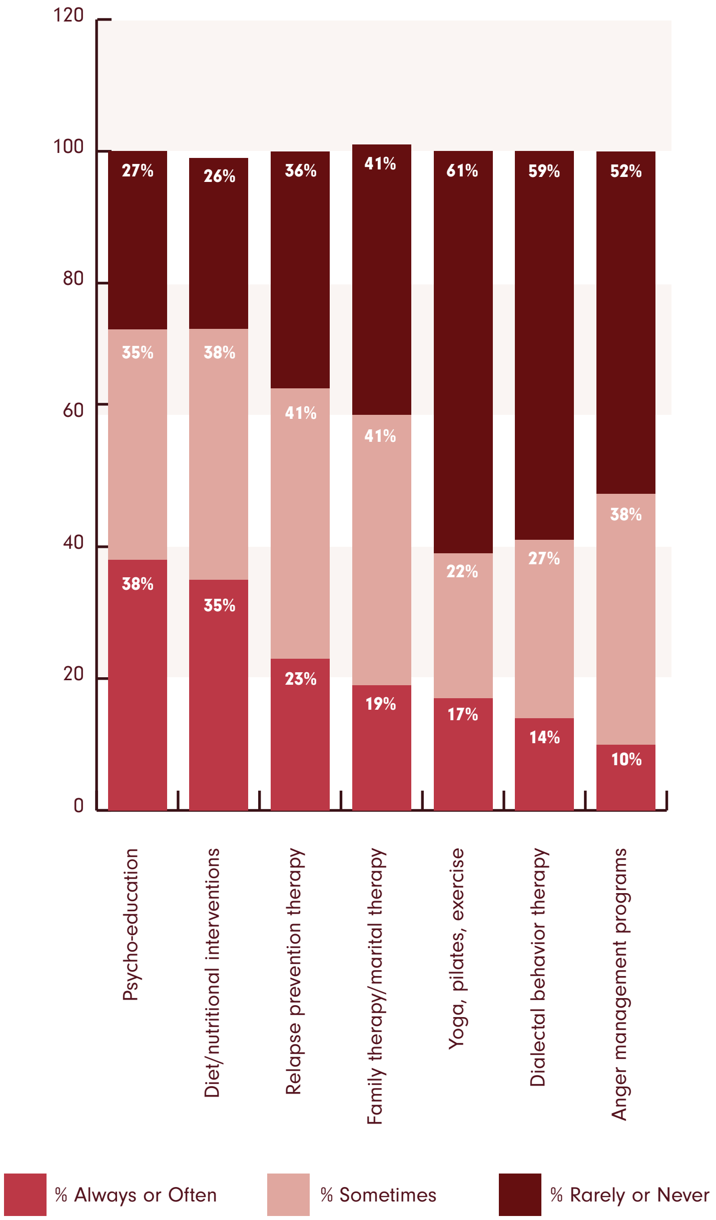


Figure 22.

Frequency of referrals to mental health resources
(n=133)

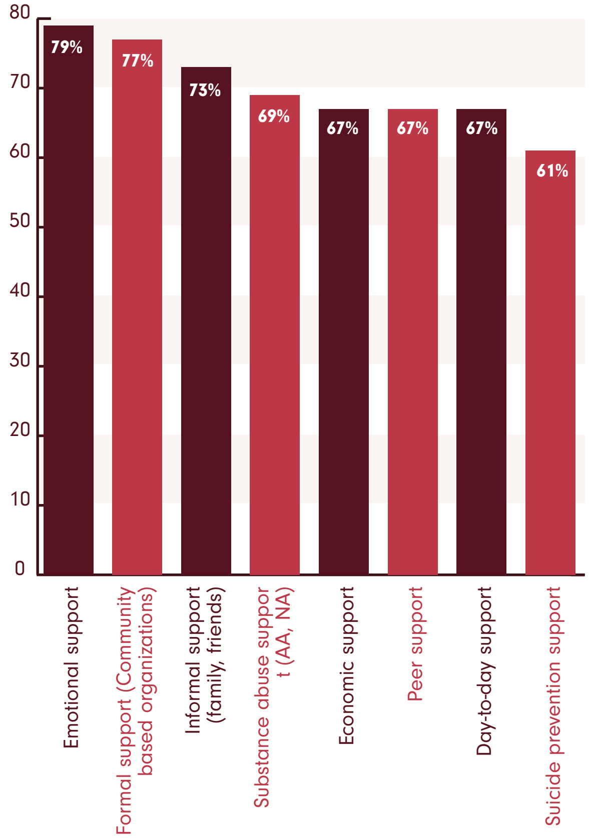


Respondents were also asked about how frequently they refer people to mental health resources. As shown in Figure 22, referrals to psycho-education, diet/nutrition interventions, relapse prevention therapy, and family/marital therapy were most frequently mentioned. However even about a third of respondents reported rarely or never referring to those services and supports. Even fewer respondents reported referring their clients for yoga/pilates/exercise, dialectical behavior therapy, or anger management programs. Between 52-61% of respondents report that they Rarely or Never refer to these programs or therapies.

Social Support Knowledge

In terms of social supports, 60% to 80% of respondents felt they are Extremely or Moderately Familiar with eight different components of support. The highest rated supports were Emotional Support (79% Extremely or Moderately Familiar) and Formal Support (Community based organizations) and the least highly rated support was Suicide Prevention (61% Extremely or Moderately Familiar), see Figure 23.

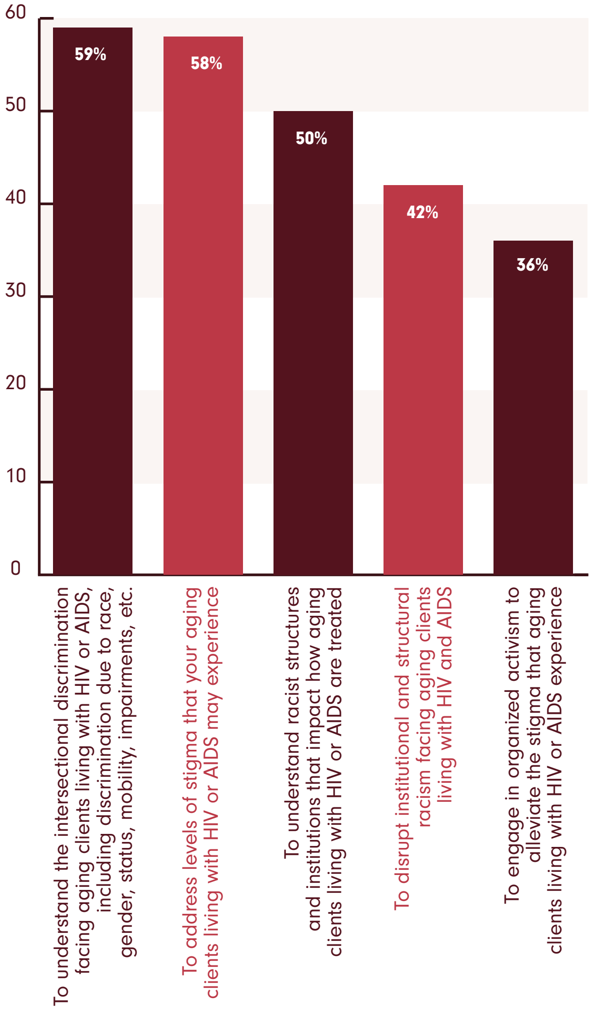
Figure 23.
Knowledge of social supports
% Extremely or moderately familiar
(n=131 to 132)



Stigma

Next, respondents were asked how prepared they are to help aging clients living with HIV or AIDS with five issues related to stigma. As shown in Figure 24, between 36% and 59% of respondents felt Extremely or Very Prepared to help clients. Respondents feel most prepared to help clients with intersectional discrimination (59% Extremely or Very Prepared) and addressing levels of stigma that clients may experience (58% Extremely or Very Prepared). They feel less prepared to disrupt institutional and structural racism (42% Extremely or Very Prepared) or engage in organized activism to eliminate stigma (36% Extremely or Very Prepared.)

Figure 24.
Preparedness to help clients with stigma
% Extremely or Very Prepared
(n=130 to 131)



The next question asked about places where clients face stigmatizing challenges. Churches, medical institutions, housing organizations, and government institutions were rated as being places where clients faced stigma to a higher extent than employers, businesses, and schools, see Figure 25.

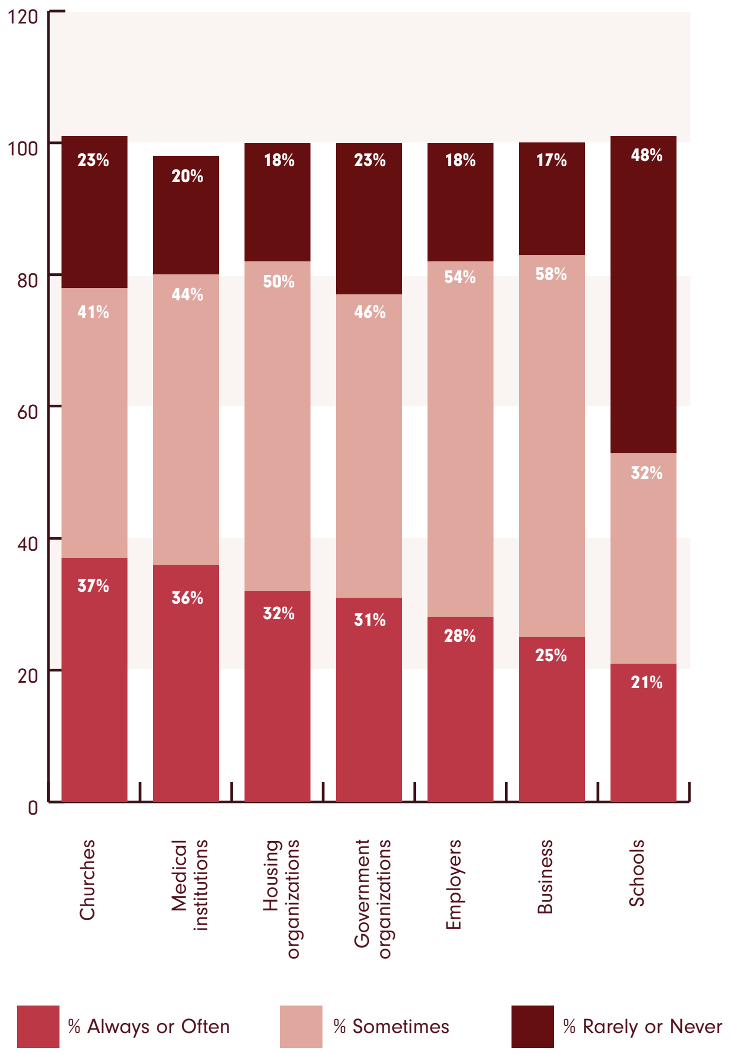


Figure 25.
Where clients face stigmatizing challenges
(n=127 to 130)

Spiritual or Religious Resources & Practices

The next few questions asked about social workers comfort connecting aging clients living with HIV or AIDS to spiritual resources. As shown in Figure 26, a little over 1/3 of respondents were A Great Deal or A Lot comfortable, another third were A Moderate Amount, and the remaining third stated they were comfortable A Little or None At All.

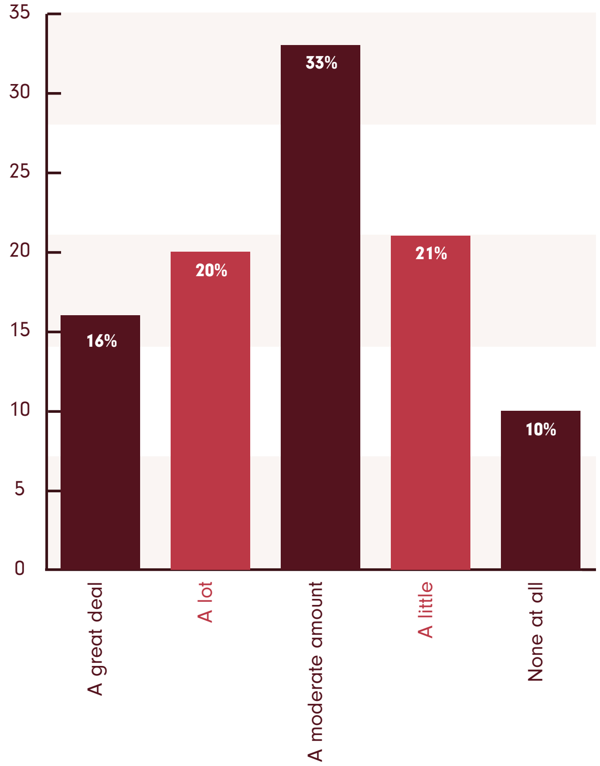


Figure 26.
Comfort connecting to spiritual resources
How comfortable are you at connecting aging clients living with HIV or AIDS to spiritual resources?
(n=131)

Question 36 followed up by asking an open-ended question about how respondents' own spiritual or religious beliefs influence how they care for themselves and help others. A total of 94 people responded to the question and among those about a third responded that their own spiritual and/or religious beliefs have little to no influence. Among those who said it was influential, the most common type of response was that religion and spirituality provides them with compassion, empathy, a desire to serve others, or love for their neighbors. A few described that their beliefs bring them peace, calm, or positive energy, and couple stated that religion provides them or their clients with a supportive community. Full text of the open-ended responses is in Appendix A.

Continuing Education Course Description

Question 38 asked "If you could only attend ONE continuing education course on aging clients living with HIV or AIDS, what would it look like?" A total of 95 people responded to the question, although 6 responded that they didn't know.

Responses fell into two categories. The first type were suggestions for specific continuing education topics, such as mental health, resource identification, addressing stigma and racism, long-term medication impacts, dementia, and others. A second category of responses were suggestions for the format of the continuing education. Several people requested that panels and presentations include people who themselves are aging with HIV or AIDS and can share their lived experiences. A couple respondents requested that the session be live and interactive. Others requested a mixture of ages and cultures while one specially asked to include aging women of color living with HIV or AIDS. Several used words like "comprehensive" and "in-depth." See Appendix A for the full responses.

Professional Rewards

The next open-ended question asked, "What is the most rewarding thing about working with aging clients living with HIV or AIDS?" There were a total of 97 responses, the full text is shared in Appendix A. The most frequent response was that respondents value hearing the wisdom, stories, and experiences of aging clients, followed closely by feeling rewarded by being able to help clients live better lives. Others mentioned that they appreciate feeling appreciated by their clients and like witnessing the long lives of those living with HIV. Some sample quotes include:

> *"Hearing their stories of survival and helping them look forward to a continued healthy life."*
>
> *"Being able to see positive impact on the client's lives when receiving support and referrals."*
>
> *"I love that people living with HIV are living longer and that it's not a death sentence. People are being given an opportunity to grow old and age gracefully."*

Experience of Racism

The next open-ended question asked, "How do you experience racism working with aging clients living with HIV or AIDS?" Out of the 91 responses, only a two people shared that they personally have experienced racism working as a social worker. One wrote, "I had a couple of clients were against working with me due to I am a Black woman." Another shared, "As a black female, I try to be objective and not take racism personally. I also will not tolerate abuse of staff."

Over one-third responded that they don't experience racism themselves, don't witness it affecting clients, or that they believe ableism and ageism are bigger factors than racism. As one person wrote, "Really, AGEISM is and ABELISM are experienced much more than just racism.... Today's culture (post George Floyed, BLM and CRT) is over emphasizing DEI / racism to society's detriment and division."

The remaining responses shared examples of how their clients experience racism, through discrimination in housing, barriers to healthcare, incarceration, or just daily as living in a racist society. A few others described how the intersection of disability, race, and other identities increase stigma and barriers to health.

One person discussed that their clients' racist attitudes impact their own ability to receive needed services. As they wrote, "Some clients may face racism themselves, but most often I experience racist attitudes that clients may have which impact their access to resources (i.e., don't want to access a service due to staff speaking a particular language). Opportunity to talk about assumptions."

Impact of the Covid-19 Pandemic

Respondents were asked an open-ended question about how the Covid-19 pandemic has impacted the lives of aging clients living with HIV or AIDS. The responses from 94 individuals primarily fell into three categories. The first theme in the responses is that aging client living with HIV or AIDS are feeling isolated and lonely due to the pandemic and quarantining. About two-thirds of respondents mentioned their clients feeling like this. About one-third of respondents shared that their clients felt anxious, fearful, or threatened, or that their mental health suffered during the pandemic. Other respondents discussed that their clients were unable or had difficulties receiving medical care of other services during the pandemic. One person's comment summed up these three themes:

> *"Clients have become more isolated in fear of getting sick, mental health issues due to constant fear and isolation. Not going to medical/lab visits and medication adhereance (sic)."*

Summary & Discussion

The Social Workers Helping Older Adults with HIV survey provides information about the experiences, practices, and knowledge of social workers who work with older adults with HIV or AIDS. While 173 people began taking the survey, about a quarter ended the survey mid-way, likely due to its length. This limitation should be kept in mind while interpreting the results.

Nearly all survey respondents currently work with aging clients living with HIV or AIDS – and about a third have worked with them for 16 years or more. Almost all survey respondents were employed fulltime, and tended to be nearing retirement age, female, and white, with geographic diversity. Over half of respondents have an MSW or a graduate degree in a social-work related field. 60% report that their practice setting is HIV/AIDS.

It isn't surprising, given the education and experience levels of survey respondents, that they generally report high levels of knowledge related to working with aging clients living with HIV or AIDS. However, there are some specific areas in which respondents would like to learn more. One topic area is the psychology of aging with HIV, including learning to differentiate between delusions and dementia among older adults with HIV or AIDS, mental health issues generally, and social supports and loneliness. Some of these issues may be top of mind due to the impact of the Covid-19 pandemic, which respondents report has led to loneliness, isolation, mental health concerns, and substance use among their clients.

Also of interest are other topics related to the biology of aging with HIV, including how HIV affects long-term physical health and the impact of medication use long-term. There's also need for additional learning related to long-term care, assisted living, and home health care related topics. Topics related to health disparities were mentioned throughout the survey as well.

Telehealth was another topic explored in the survey. Over half of respondents are using telehealth frequently, and over half also say that it's easy to use, with very few reporting that telehealth is difficult. That said, survey respondents report that their clients find telehealth more difficult to use than they do. In open-ended responses, this appears to be related to lack of access to devices that work with telehealth and also a need for training and support to clients who need extra help using technology.

In terms of continuing education format, respondents were most interested in a mixture of in person and online, and within online – mixing live and self-directed sessions. There were calls for panel presentations of older adults living with HIV to share their lived experiences to increase understand among social workers.

These are a few highlights from the lengthy survey, which should provide many interesting areas for exploration and inform future work with social workers caring for adults aging with HIV or AIDS.

Appendix A. Open-ended survey responses

Q7. Where did you acquire this knowledge? Asked to specify if selected local ABO, local CBO, online continuing education site, or other venture.

(n=53)

1. On-line webinars, in person seminars, where ever free training is available.
2. College courses; recent MSW graduate
3. MAEETC, PA DOH Trainings, other HRSA/HUD/CDC funded capacity building agencies
4. Washington State DOH provides some training to medical case managers
5. Maui AIDS Foundation
6. Workplace experience
7. Work with a Ryan White program in a Community Health Center
8. Nashville CARES; AETC Program; TCSW; National Conference on AIDS
9. University coursework in gerontology
10. Pharmaceutical community liaison training
11. MAF
12. Missouri MATEC
13. StonyBrook School of Public Health, webinars, other conferences, etc.
14. State online training courses
15. Treatment facility
16. AETC
17. NASW Spectrum HIV Traininig project
18. MDHHS
19. National Council on Aging
20. Hospital Based Ambulatory Clinic
21. Training from AACO and TPAC; online training for CEU's for my license.
22. Health HIV, HAHSTA/Ryan White, Housing Counseling Services Webinars
23. Evergreen
24. Hemophilia Foundation of Michigan
25. Working with a community based health services
26. PESI/Psychotherapy Network
27. Southeast AETC
28. AETC
29. Agency-provided trainings
30. CEU's where I work
31. College, Work Place Continued Ed, Other Jobs before Current
32. Book - 100 Questions and Answers by Joel Gallant
33. Learning on the job from my company Allies for Health and Wellbeing
34. Inner-Office agency trainings
35. MDHHS
36. On the job
37. Lifelong
38. Justice in Aging, National Center for Elder Law, Triage Cancer, AIDS Education Training Center
39. Parkland Amelia Court
40. on the job experience
41. NO/AIDS Task Force, Crescent Care Health
42. Developed our own bureau aging group and organized several webinars with experts for our providers
43. various conferences and ceu's and various additional college classes
44. Trainings, education, work experience
45. No
46. Hospital / Clinic training, education and experience
47. Reading articles and Books
48. Peer support groups
49. SF Dept. of Public Health
50. Legacy Counseling Center
51. Previous work with older adults
52. Several
53. On the job experience in the community after 4 years of HIV CM practice

Q9. What other areas would you like to learn more about?

(n=21)

1. Promoting racial justice and equity (this should be front and center for all SW practice).
2. Medicare
3. I want to learn all I can about every area and stage of life to help people living with HIV.
4. Linkage to services (assisted living/care home) without losing independence and integrity.
5. Medicaid medicare coverages how to apply, best options, nursing home vs assisted living, senior communities, age related comoebidites (sic), resources for seniors
6. Meditation, holistic services.
7. Substance used. Services related to HIV/AIDS and aging
8. I feel I am knowledgeable in regards to that population as for I worked with the aging for 18 yrs prior to entering the social work profession
9. Program development, policy, macro social work
10. Medicare/Medicaid navigation
11. Helping patients with several comorbidities find meaning to their current lives–especially those on dialysis.
12. Sexual health
13. Any
14. Teaching clients how manage finances and to learn how to budget.
15. Any opportunities that would support a "HIV Geriatric Social Work" certification
16. More information about medical related issues that medical case managers need to be aware of (comorbidities)
17. Substance use disorders and HIV
18. ICT that regards to awareness because everything have been digitize
19. Sexuality and gender stigma reproductive and sexual rights
20. This should also include the aging Trans population as well.
21. Reducing Apathy. Increasing Self-Worth. Harm Reduction/Substance Abuse Coping Skills.

Q15. What resources do you or your organization need to use telehealth more successfully?

(n=71)

1. More up to date equipment
2. Reliable internet/servers/platform.
3. Education to staff on availability of service options. Appropriate equipment and tools to provide these type of services.
4. We are not a direct service provider. Having additional training and information resources for our providers and clients would be helpful.
5. A lot of our clients, especially the 60+ clients don't always have access to or know how to use technology.
6. Different telehealth options to ensure confidentiality at a reduced cost.
7. More telehealth "rooms" in hospitals for distance/rural to connect with urban hospital sites
8. We have systems set up
9. Devices for workers to safely connect to patients
10. Not applicable to my position
11. Electronic devices
12. Cannot think of any at this time.
13. Best practice development, resources summarizing HIPAA compliant platforms that are accessible (IE clients can access without buying software and smaller nonprofits can afford)
14. Clients having access
15. Ensuring clients have equitable access to technology
16. Smart phone, laptops, data to get on line
17. Utilize personal equipment - such as phone or tablet
18. IT
19. Doxy.me, Zoom, Apple FaceTime.
20. Technical Assistance for Clients, particularly aging clients.
21. None I can think of atm
22. I believe we added policies and can make things available as per the clients need. We did get some ipads to help with telemed meetings, as well as opened up more funding for phones to help with keeping clients connected and give them the ability to use telemed at home.
23. Financial support and or technical support
24. Education on how to implement services via telehealth
25. Faster wireless internet
26. Accessibility of stable internet connectivity
27. As an organization, our staff is proficient, the challenge we have is client being able to connect with us. Many are not familiar with zoom, teams or simple practice, much time is spent attempting to teach

clients how to access services consistantly.
28. Staff cell phones
29. Financial support to pay for devices and internet for patients who would benefit from telehealth but do not have access.
30. Willingness of those on-site to provide patients with iPad for virtual meetings
31. Organization sets all telehealth resources
32. Living in a rural community, access to equipment and internet needed for telehealth are limited. Some customers are also not skilled in the use of computer devices or the internet. Some still don't have email addresses that are often needed to support some platforms.
33. This is difficult when working with older adults that may not like or are knowledgeable of technology
34. The electronic health record has features to simplify the process
35. The resources needed to perform telehealth
36. Integration with our emr
37. Being able to help clients secure reliable internet servers and internet-capable phones, tablets, PCs to connect to providers.
38. Training and access on technology for our aging clients
39. Tech support
40. More tablet or other device resources for clients
41. N/a
42. WIFI accessibility for all clients.
43. Assessable training to clients
44. Equipment for clients. Resource to train clients in the use of technology.
45. Clients do not have reliable equipment and WiFi.
46. Information on connecting and keeping clients engaged via telehealth.
47. Trainings on how to successfully set up, schedule, and assist clients in this kind of communication.
48. None
49. Tablets and data
50. Unsure at this time. Most likely more training on ways to enhance connection / engagement via telehealth.
51. Laptops/tablets for our patients
52. Phones for the clients
53. n/a
54. Multiple platforms and ways of contact - (email, phone, text, in person) added video during COVID
55. IT capacity, especially help with the expense of it.
56. none
57. Due to the CARES Act, we were fortunate to get the supplies to knock down any barriers.
58. Nothing at this time. we have been offering office to office telehealth, prior to the pandemic. Once EPIC solidified the platform, things have been going very well.
59. We have the necessary resources
60. Finances and mobility
61. Assistance in management of sessions and adequate equipment for all parties
62. We do not use telehealth because we are Medical Case Managers that connect our clients to their medical providers. We assist clients with accessing telehealth via our computers when needed.
63. We have no computers with cameras or microphones.
64. hardware - laptops, ipads, etc.
65. Financial support to increase tech capacity
66. Older Adult Friendly
67. Access is fairly easy to come by for most people. The outliers are those who are experiencing extreme poverty and/or homelessness.
68. Telehealth access for Case Managers to meet with clients.
69. Funding for assistance with phones/internet costs
70. Latinos, Asians, Africans have all experienced a great deal of difficulty with telehealth visits and virtual medical appointments due to lack of experience, lack of adequate equipment, and lack of cultural acceptance utilizing said technology.
71. Technical assistance to PWH over 50 on use of virtual technology and financial assistance for PWH for internet and cell phone plans.

Q36. How do your own spiritual or religious beliefs influence how you care for yourself and help others?

(n=94)

1. I am a Pagan. I care for myself using positive energy techniques. I surround myself with positive energy before entering a client's home.
2. none
3. Play a role

4. I believe in "love thy neighbors as myself". I use compassion and empathy in my services.
5. My beliefs has a great impact on how I interact with others. I believe do unto others what you would like done to you. Love your neighbor.
6. My belief system is that all people are deserving of care and consideration. Having HIV or AIDS or any other illness does not stop them from being people who deserve and need love and compassion.
7. It doesn't
8. I feel that all people are equal in God's eyes and maybe even more special if they suffer a lot here on earth. I like to think that everybody was a little baby in their mother's arms at one time and I like to think I would treat them like I would want my family treated. I especially try to think of this with difficult patients.
9. It doesn't.
10. I believe in doing good for and to others and being a good servant
11. Church offers a social connection, in addition to hope and meaning. Spiritual and religion can be a huge support for self care.
12. I recognize that there is concern for some community members living with HIV having to go to religious based organizations to access resources especially is they have had negative experiences with the religious community
13. I don't mix religion that much
14. Promotes stress reduction, comfort in talking about spirituality
15. I'm a spiritual person but not religious so religion does not influence how I care for myself or others. I believe in collective growth and spirituality.
16. higher power
17. helps me relate to their needs
18. I believe in being non-judgmental, love and help whomever I can.
19. Love and service
20. I understand the importance of it to some folks and encourage exploration of this topic
21. I see the benefits of connection
22. I am a Christian believer. I think that viewpoint allows me to care for myself and others well
23. Not at all- what’s best for the client
24. I use my lens so it involves a bias
25. I use and suggest to willing clients spiritual sources as a coping mechanism (as I do). Only if assessment suggests that they are willing and believe.
26. I try to remain neutral regarding spiritual
27. It is what guided me into my position.
28. Faith perspective reminds me of the importance of peace and calmness amid life stressors
29. A lot
30. My spiritual believe are a great part of the support that I offered some of my clients that are believers.
31. Not at all
32. they dont
33. It doesn't because I treat people the way I want to be treated.
34. Empathy
35. Never
36. I feel my spiritual beliefs assist me in working with my client with compassion and empathy.
37. I have no personal religious or spiritual beliefs.
38. It allows me to be ground everyday when doing this work
39. they don't at all
40. I practice radical grace and believe that identifying purpose can guide us in treating ourselves and others with kindness and compassion. This drives my interactions.
41. I never impose my spirituality into my work with others.
42. I believe they allow me to consider all forms of spiritualty/religion in assisting patients. I have seen the value of my own learnings/self care during the pandemic.
43. I am very aware that I am called to serve and help my fellow citizen, to be a voice for those who can not for themselves. To meet others were they are and encourage others to be their best.
44. No way it influences me; each client is individual and their beliefs has no bias response or services from me
45. A great deal - part of who I am
46. I don't consider it.
47. My beliefs help me with self-care by providing me with additional support through prayer and reading to help me work through secondary trauma. Since many of my clients have been hurt by churches and faith-based organizations, I encourage them to lean on their own spiritual beliefs. I do struggle when clients state they have no belief system of any type.
48. I try to not have any personal beliefs intercede or affect patient care

49. it doesn't influence as i keep my own beliefs to myself and work with the client individually meeting them where they are.
50. They don't.
51. it frames how I view the world so it limits different views
52. recognize the importance that spiritual or religious belief can be in terms of support and "belonging"
53. My faith guides my life, however, I am able to understand, how religion has devastatingly hurt some PLWH.
54. I am a practicing Episcopal and I use my spirituality for self care. I won't ever push religion on my clients but use it as a "background" for my work or if they ask for it
55. no often
56. My religion allows me to love and help all, so it is my duty to help.
57. In helping and be kind to all mankind.
58. My spiritual beliefs tell me that everyone is my brother and sister.
59. It gives me the understanding that spiritual health is just as important as mental and physical health.
60. Regular practice
61. n/a
62. I understand not everyone has the same beliefs
63. N/A
64. I am strongly guided by my spirituality and it provides me with guidance and meaning on my path to be of service. I do not push my beliefs on others, but I allow my clients to speak freely about how they view spirituality.
65. none
66. strong influence
67. I believe strongly in the ability to integrate trauma, and heal in other ways, through spiritual pursuit. When I interact with a client who discloses that spirituality is important to them, I encourage them to pursue and benefit from whatever spiritual practices they find most meaningful.
68. Support for their belief systems
69. Probably too much, in my animosity towards the topic in general.
70. Love of self
71. Does not
72. They don't.
73. positively
74. They are the reason for my doing this work.
75. My personal religious beliefs inluence me to be the best version of myself, however I do not allow my perosnal religious beliefs to reflect on my work.
76. I make it a practice to not let my personal beliefs influence the care I provide to clients.
77. not too often
78. It gives me the knowledge for services that are out there.
79. Having a base belief system that all humans deserve respect guides my practice.
80. Can encourage spiritual practices that may be helpful
81. Big part of what I do
82. Help them to know that there is hope that something must kill a man
83. I follow a servant leadership model
84. Accepting and appreciating everyone's own belief and assisting them with connecting to their preference of religion or spirituality.
85. I try to bond with them if they bring it up.
86. Na
87. I'm an atheist but feel like if someone's spirituality is important and a good support for them, I'm happy to explore this and provide resources. I myself don't use spiritual or religious beliefs.
88. I put in more effort to care for others less so for myself
89. Respect for self and others. Service oriented. Help others develop desire to live and experience peace. Have peace in my own life.
90. I am a true believer of treating others like I would like to be treated if I was in their shoes.
91. Never.
92. I am open to helping clients with their spiritual beliefs
93. It keeps me committed to the work
94. I believe in the power of having spiritual beliefs in the healing process and day to day coping

Q38. If you could only attend ONE continuing education course on aging clients living with HIV or AIDS, what would it look like?

Continuing education topic

suggestions

(n=73):

1. Life-stage planning
2. Overview of resources for support, medicare ins and outs
3. I cannot choose one... mental health would be probably top choice.
4. Something that addresses how to help people who have a little money but not enough for self pay, but too much to get all the free benefits.
5. Financial resources
6. Working with clients to gain knowledge regards health power of attorney, will and final arrangements,
7. Long term care how to find apply estate planning to qualify etc
8. Medicare, long-term care planning
9. Motivational interviewing focused on the aging client
10. anything that offers more info on hiv related dementia
11. Biology of aging with HIV
12. understanding mental health and trauma
13. Mental health diagnosis
14. Care and support
15. addressing stigma & racism
16. I think just "what to expect". Encompassing changes to their medical care, transitioning to assisted living as needed, insurance, co-morbidities, etc.
17. Comprehensive Overview of Aging of those living with HIV
18. Neuro/HIV
19. Addressing Housing needs for the aging homeless. This is a very vulnerable and fearful population. I wish I could help more.
20. How to best serve and help the aging client base
21. Hopefully it would be discussing the long-term effects of taking the HIV medication and the body's reaction to those medications.
22. A biopsychosocial approach to counseling and intervening with older HIV+ people
23. Learning about community resources
24. Case Manager Training for Older Adults Living with HIV/AIDS
25. The direct changes associated with HIV, how HIV can change the body as you age, depression, dementia HIV or age related
26. It would be a combination of learning meds and their affects along with how to stay physical and mentally fit.
27. Self-care and education
28. I would like to learn more about spirituality and cultural impacts of our clients as our clients present with many diverse cultures.
29. Subverting racist or anti-LGBTQ organizational practices for my own and other CBOs
30. Sexual health
31. mental illness, independent living
32. How to instill meaning and purpose to those with comorbidities that leave them drained.
33. Would want to attend a Aging well course. What does this look like and how is it achieved.
34. One that provides information and skills to address MH / D&A
35. How HIV meds affect aging folks
36. More about connecting to resources
37. Talking about supports
38. mental health
39. Home Care. Medicaid/Medicare/Insurance.
40. Aging with dignity.... Supporting the needs/desires of those that are aging with HIV
41. How to help client through isolation and giving hope.
42. a class that explains the physical decline with aging that is affected directly by HIV, exactly how HIV affects health when aging
43. Mental health
44. How to best assess, screen, and serve medication resistant individuals.
45. Understanding the day to day life. From Medical compliance to stigmas to geriatric care.
46. How to access in home health supports. How to determine if client is in need of a nursing home and how to facilitate that move while maintaining clients right to direct their care.
47. Continuing medical care
48. Stigma
49. Stigma/Advocacy
50. How to access housing options for low/limited income clients in clear and graceful way.
51. SSI, SSDI, medicare, resources in community to assist with these services and how to ensure the client I am working with is accessing everything they are eligible for.
52. Physiology on HIV and Aging
53. Emotional support needs

54. on mental health
55. 1 part biology/physiology, 1 part psychology/psychosocial and 1 part resource identification
56. planning end of life
57. One addressing holistic needs.
58. I am not well versed in resources for aging population needing long term care/nursing home care/etc.
59. On dementia and assessment.
60. Focus on HIV Or AIDS and the church
61. Computer base knowledge
62. Trends and advances in peer support
63. How to work with family members of our client when the client's wishes don't match what the family would like to do–re: care, end of life decisions. Addressing the discrimination, stigma re: HIV/AIDS when trying to place a client in assisted living or nursing homes for care.
64. Complementary care.
65. Dementia care/resource
66. Cognitive changes of aging and HIV
67. Neurology/How HIV and the blood brain barrier can create neurological problems earlier etc for those living with HIV Perhaps ways to help prevent these problems.
68. Course on overcoming difficulties associated with death and dying, desire to live, and participating in society.
69. How to effectively serve the aging population of TransWomen and TransMen.
70. HIV/ADIS related dementia.
71. Mental health issues
72. Developing social support networks
73. mental health and aging

Suggestions for continuing education format

(n=16):

1. A presentation with people living with HIV/AIDS and that are aging along with Social Work professionals that are seeing aging clients
2. Comprehensive training to address key social/emotional needs
3. It would include panels with actual aging PLWH who would benefit from our services.
4. It would be well rounded touching on what to expect in working with aging clients and how to move forward in their best interest.
5. in depth schooling on the most important issues they face
6. A live interactive session
7. In person, interactive.
8. run for and by people living with HIV/AIDS that are aging
9. A general overview of the topic so I could then identify areas of interest for further education
10. A mixture of students; ages & cultures
11. Much like today's, I would prefer to hear from those with lived experience on how I could best assist them, what is most important to them in a mental health services provider and what issues they most want to see addressed in their care.
12. speaker is well-versed in the field and can speak to best practices with this community; would like the course to spend ample time on assessment
13. Aging Women of color living with HIV/AIDS
14. Research opportunities
15. A comprehensive course leading to a certification as a "HIV/AIDS Aging/Geriatric Social Worker" sanctioned and approved by PASWHA, NASW, Ryan White Care Act.
16. Free.

Q39. What is the most rewarding thing about working with aging clients living with HIV or AIDS?

(n=97)

1. Hearing their stories of survival and helping them look forward to a continued healthy life
2. The wisdom they share.
3. Hearing their journeys
4. Their resilience
5. Helping them live a full life.
6. The independence and support they feel
7. they have been through enough and I feel blessed to be able to help even if its just having a smile and a kind word.
8. Seeing that they have survived the disease better than ever expected. I love the stories and the varied personalities.
9. Acknowledging that their needs matter.

10. Assuring that all their basic needs are met.
11. Knowledge about HIV history experience lbgt history and experience
12. They are living proof that a long life is possible with HIV and HAART
13. Hearing about their stories, and how resilient they are. Interacting with the clients is the most rewarding
14. the knowledge base of long term survivors
15. The way they appreciate
16. A very resilient population
17. being able to see positive impact on the client's lives when receiving support and referrals
18. that they have lived through decades of hardships yet are still amazing individuals.
19. All of it
20. The stories they have, their experiences and how humble they are for what I would consider something small.
21. Contribution to their healing
22. With long-term survivors hearing the life stories of living with HIV through most of the epidemic
23. connection
24. Their knowledge and own lived experience
25. Hearing the words / Thank you fir caring
26. Diversity
27. The fact that they can count on my services, as I learn from them.
28. Providing help they need
29. Sharing some truly special moments of time with the clients.
30. Their acquired wisdom and life experiences transmit stories that usefully inform how to life one's best life
31. Keeping them independent
32. Life experiences.
33. giving hope
34. Their gratitude
35. helping them live their best healthiest lives
36. Seeing the joy they have about life
37. Client satisfaction.
38. The most rewarding things about working with my aging clients are that many are long term survivors and they bring a certain amount of wisdom through their lived experiences.
39. Successfully connecting clients with financial support or stability resources.
40. seeing thriving with HIV/AIDS
41. As I am also living with HIV (and aging) , my reward is assisting everyone who is experiencing life with HIV
42. I have found that older adults are more likely to acknowledge and communicate their appreciation of the work we do with them.
43. being able to give support and get to know their stories/life experiences
44. Seeing them thrive and remain as healthy as possible.
45. Seeing people thrive and helping those who have not quite gotten their yet, achieve their highest quality of life.
46. Being able to help them find stable housing and fulfilling their needs
47. Attempting to remind them that they are more than their diagnosis -step away from the shame and stigma
48. Their wisdom and internal fortitude having survived
49. Knowing you can make a difference for someone, get them into housing, get them meals, medical care, medication. Hearing their stories.
50. Building relationships with the clients and being someone who enjoys listening to their stories and experiences.
51. I love that people living with HIV are living longer and that it's not a death sentence. People are being given an opportunity to grow old and age gracefully
52. learning from their experience as i help others and grow in the HIV/AIDS field
53. Their rich history.
54. Helping them find what gives them peace/joy in their golden years
55. learning from the clients how their life experiences have impacted them and what they deem to be important qualities in their medical providers
56. Learning something every day and the perseverance and enduring strength they have.
57. Helping them to be "seen" and helping them in whatever way they need
58. Hearing the changes that have occurred in HIV care over the last 30 years.
59. Helping those that didn't see a way out.
60. Letting them know they have a change to live a full and health life.
61. It is a humbling experience to get to witness the consistent resilience and strength many of these individuals have.
62. Connecting with them on a personal level.

63. Seeing growth
64. Making a direct impact on their physical and financial well-being.
65. Helping them get linked to care and know they are can still be successful
66. Witnessing their long term successes and longevity.
67. Currently, it is the emerging opportunities for connection and community that make exciting possibilities for the future.
68. Their experience
69. helping people period
70. The histories that clients share about their lives
71. Facilitating provision of much needed support services
72. Witnessing resilience , strength, and courage en vivo.
73. Being able to help
74. That they are now older people living with HIV
75. I do not work with aging clients living with HIV.
76. seeing them happy
77. Witnessing their courage and strength.
78. to experience the life they have been gifter, so many thought they received a death wish with the diagnosis
79. LEARNING from THEM!
80. It has been a pleasure working with HIV/AIDS patients for the past 22 years
81. Successfully making the transition from private insurance or employment income to Medicare and social security
82. It is extremely rewarding to work with aging clients - they often have amazing life experience to share.
83. Giving folks hope, to live the best they can and find joy
84. Helping them teach their goals
85. Make you learn so many things
86. Successful treatment plan outcomes
87. Like with any other aging individual, an aging person has a lot to offer re: history, what they've experienced, memories. It is reassuring them that the aging process does not have to strictly be re: HIV/AIDS. It can be a process of aging in real life for everyone. Empathize with their experiences, stories, memories.
88. They are appreciative.
89. Advocacy
90. The wisdom of living through the early stages of HIV and LGBTQ+ civil rights
91. Resiliency/All they have overcome and experienced
92. Having the opportunity to embrace the dying process with individuals as they cope with death. Saying goodbye is good when everyone is prepared.
93. Wisdom
94. Being able to provide support to those people who lost a lot of their peers/supports/friends/partners during the height of the AIDS epidemic.
95. The wisdom and experience that they share
96. Their life experience and stories
97. Witnessing their tenacity to keep going in spite of hardships and health issues

Q40. How do you experience racism working with aging clients living with HIV or AIDS?

(n=91)

1. As a white female with privledge, I recognize when my minority client's are being treated differently. I provide support for speaking up and referrals as appropriate.
2. I am learn from those who have experienced.
3. Not a great deal unless they are undocumented
4. Policies that cause racial and economic disparities
5. Different ethnicities and races treat their elderly in different manners. Some take in the older population, living among their younger loved one.
6. stereotyping, hate crimes associated to their lifestyle choices and work places etc.
7. Have not experienced that.
8. I really don't see this related to aging so much. I see it more related to age than race and to the hIV.
9. I haven't
10. Health disparities
11. As a black female, I try to be objective and not take racism personally. I also will not tolerate abuse of staff.
12. Within the community, housing particularly, the discrimination is more towards the aging aspect, since most people don't know about the client's HIV status
13. frequent community reports of negative experiences while trying to access health care and medical resources
14. Rarely, not that much

15. Some clients may face racism themselves, but most often I experience racist attitudes that clients may have which impact their access to resources (i.e., don't want to access a service due to staff speaking a particular language). Opportunity to talk about assumptions.
16. racism and ageism overlaps in the older population, which perpetuates isolation
17. some landlords have assumed they are drug users just because they are black, skinny and receive assistance
18. Racism is imbedded in the healthcare system
19. Most of the clients do not disclose their status to anyone.
20. It's rare in my country but we avoid it.
21. As with all things, intersections of non-majority identities (like race with gender, sexual orientation, HIV status etc) increases stigma and barriers
22. All of my clients have been incarcerated at some time during their lives
23. N/A
24. World of difference dealing with economic levels among clients
25. Don't
26. n/a
27. Sometimes clients of color are defensive because I am not a person of color
28. I haven't
29. Really, AGEISM is and ABELISM are experienced much more than just racism.... Today's culture (post George Floyed, BLM and CRT) is over emphasizing DEI / racism to society's detriment and division.
30. Not sure
31. Some of the patients sometimes express frustration because they can't understand a medical provider whose first language is not English. Some expressed that because of their origin they are not care or received the same care than those that are English speaking and or white.
32. AA hides the illness
33. aometimes
34. I haven't yet but I know it does exists
35. Privacy broken, Agency name association.
36. Many of my clients are African born immigrants and African American so we are able to discuss the shared experience of racism in America.
37. Black clients are less trusted by the organization (not explicitly obviously), programs are built and maintained by white administrators and inaccessible to Black clients as a result
38. By people not letting people of Color having meaningful involvement
39. Racism does exist however I don't experience it with the folks I work with. We have a great relationship and I focus on helping the human.
40. As a white woman, I experience other white aging clients to be open and forward with me in sharing their racist beliefs and I experience aging clients of color to be less likely to share their experiences with me.
41. it's a myriad of judgements and barriers
42. I see my patients have and still experience it–some doctors don't check their privilege's, and that is frustrating, but I call it out. Hasn't made me popular though.
43. Not sure if I have. The customers our program currently serve are a mixed race of primarily Caucasian and African American. Our program staff over the years has also been a mixed race and gender.
44. I had a couple of clients were against working with me due to I am a Black woman
45. Not sure I have been looking out for it... can't think of instances
46. I live/work in a very white area where most folks don't necessarily belive in instititional racism. This is an obstacle
47. I'm not sure.
48. Many we serve are POC and we have a large hispanic and Native American population in our area, so many of our clients have experienced racism on multiple levels. Listening to their experiences makes me work hard to be more self-aware of my language, actions and I've had to correct some things, especially in my speech/word choices. I don't mind being corrected, I see it as valuable in making me more aware of systemic/institutional racism that, as a white woman, I may not otherwise recognize.
49. The rw program itself is not set up for poc and their barriers to care.
50. normally when i do experience racism is with housing.
51. Through the patients stories and supporting them in addressing racism.
52. I don't experience it
53. I notice discrepancies when there should not be.

54. Have not experienced
55. N/a
56. Never have an experience.
57. I see it more in stereotypes. Society has a very cloudy perception of what HIV/AIDS looks like.
58. Non-white and/or uneducated and/or non english speaking clients may not have their medical needs evaluated as closely. They may have less access to potentially helpful treatment. Much more difficult time navigating support options.
59. prefer not to answer
60. n/a
61. I feel that rarely happens within out clinic
62. Language/cultural barriers for immigrants trying to connect with services. Mostly of African decent.
63. Patients of color often face more systemic barriers compared to their Caucasian counterparts.
64. none at all
65. I don't know how to answer this question. Systemic racism is the status quo, so it's experienced every day in practice and always has been.
66. None
67. Witness the impact of institutional racism in delivery of care across the spectrum, by design, intentionally and unintentionally.
68. Not sure
69. I do not work with aging clients living with HIV.
70. often
71. I can observe it and occasionally address it, but as a cisgender white male, I do not "experience it" as some of my clients do.
72. same as people who are not living with HIV
73. I witness how my clients are treated in various institutions.
74. no
75. I have not yet.
76. Unfortunately in our clinic we do not have much diversity among our providers. I would love to see more diversity among our providers.
77. I do not think this is just affecting aging clients. Racism is impacting everyone in this country at this time.
78. Often
79. Fair
80. Minimal
81. Accessing more medical care via assisted living facilities, nursing homes, etc. Once their diagnosis is known, there is significant hesitation to take a client in some cases.
82. Often
83. Usually landlords
84. I am a white woman so in a place of privilege so I don't experience racism. My BIPOC patients experience racism everywhere, every day.
85. Through those who are experiencing racism
86. This is not really an issue. Maybe when working with a large institution such as Social Security and a non-English speaking client.
87. NA
88. Patient's who we work with can experience racism at various organizations. All we can do at our organizations is listen to complaints and experiences, provide supportive listening, problem solve when needed, and assist with referrals to legal aid if that is required.
89. When they are self sufficient
90. We live in a racist and ageist society.
91. I see how it impacts my clients daily lives.

Q41. How has Covid-19 impacted the lives of aging clients living with HIV or AIDS?

(n=94)

1. They are dealing with isolation and feelings of trauma after living in a more open environment. Old feelings of stigma have resurfaced and feel very strong again.
2. It has intensified their experience of threat.
3. less in-person support from all avenues for the clients
4. Caused isolation
5. They are the most vulnerable of my patient population. They were unable to receive medical services for a portion of the pandemic.
6. Clients have become more isolated in fear of getting sick, mental heath issues due to constant fear and isolation. Not going to medical/lab visits and medication adhereance.
7. Covid 19 has impacted all clients not just the aging ones. They are terrified.
8. Rely more on family and community agencies for assistance obtaining food.
9. ISOLATION was the main issues I think, both those at home who feared for their health as well as those

in Nursing homes. Also I had a patient who was scammed out of her money.
10. It has been limiting due to clients being caucious and staying safe out of fear of contracting the virus.
11. Many are afraid of COVID 19 infection b/c of the rate of death in the aging population. They've lost many friends and loneliness affects them. Comorbidities also present additional fears.
12. Seclusion, and loneliness is worse
13. more housing funds resources from CARES funding being available has helped transition homeless clients into permanent housing.
14. It has impacted alot
15. I have noticed a lot of fear in the population and thus social isolation to a greater degree than general population
16. technical support is more difficult with the aging clients who don't have access to it. It has increased isolation in this population. It has also caused more trauma in this population, especially the long term HIV survivors.
17. it has forced them to utilize technology they normally would not have used.
18. for worse
19. The have become more shut in and unwilling to leave their homes or have visitors.
20. Hard to get treatment as movement is restricted
21. Less access to direct in-person supports
22. increased a sense of isolation & loss
23. Isloation
24. Loneliness
25. Isolation
26. I've seen Dimentia and Isolation issues come about just because of COVID-19. It's sad.
27. it has caused more withdrawal and seclusion due to health worries and concerns due to possible exposure
28. Depends on the person. I have maintained myself in reality, and try to keep them focused on taking care of themselves, and doing what feels right to them. No allowing ourselves to be riddled with fear about anything where there is misinformation being delivered around every corner and pushed in all media outlets that truly is wrong. It has been a disservice to humanity in general. These medical professionals have proven themselves lacking integrity.
29. COVID-19 has caused such isolation, fear of contagion and diminished feelings of support in so many!
30. Helpless
31. It has add to the anxiety, depression to the already changes that they are going through as they aged. The opportunities to interact with other has decreased, social life if any if not the same for them.
32. Mental Health
33. isolation, loneliness
34. It has kept may in there homes which took away there social contacts.
35. Homeless, loss of jobs, Food scarcity.
36. Many of my clients have felt the impact of COVID-19 as a threat to the overall health, some have stated that they have survived HIV for 20 + years only to die from COVID and the forced isolation have increased the numbers of clients with Depression.
37. This demographic has poor technological literacy in my experience and most do not have in home wifi. Having access to these resources has become an expectation during COVID, which particularly affects Black clients. Comcast, Verizon, and other tech stores are geographically distant from Black communities. Libraries and community centers that hold particular importance in Black neighborhoods in my city have been closed which further limits access to technology.
38. patient worry about getting sick from COVID
39. isolation, but this is getting better as the pandemic improves
40. financial, transportation, access to support services, access to supportive people/agencies, isolation, food shortage, putting off other medical care.
41. the isolation and fear mongering has been hard on them
42. More isolation, hopelessness, uptick in substance use, relapse of substance abuse of those previously sober for many years/decades.
43. I feel like customers have done well. This is a group that has had some experience with isolation. Those who were linked to needed health care prior to COVID 19 has maintained access to their health care. We saw very few loses with our customers.
44. Most lack social interaction with family and friends
45. Increased loneliness and isolation
46. More isolation, more frustration (dealing with telehealth)
47. Barriers that already exited have become worse.

48. I'm seeing a lot more anxiety, depression, substance use and suicidal ideations than pre-pandemic due to the confusion around the mis-information that was spread in the beginning and the isolation/loneliness related to how long this is going on. Many clients haven't had much contact in over a year now except for phone calls.
49. Isolation has caused many issues. Physical as well due to not getting out
50. extremely for there's an increase of mental health and loneliness.
51. I think especially for the ones living alone they feel very isolated. I have spoken with them much more often this past year on the phone. They cant attend the support groups they usually do.
52. Isolation and lack of supportive services that was available before the COVID pandemic
53. More Isolation.
54. The fear of contracting the virus because of underlying conditions and age brought much fear and anxiety for them
55. Feelings of isolation
56. Unknown
57. They have experience isolation, fear, and sadness.
58. It has sent many individuals into a harsher isolation leading to an increase in mental health concerns.
59. Open up more resources
60. We have had to temporarily transition to telehealth appointments with case managers and many of our aging clients are not comfortable with technology.
61. It has affected many aspects of their lives
62. Isolation, fear and PTSD from AIDS epidemic.
63. Isolation.
64. a great deal
65. I believe we live in a culture that promotes "elder neglect". The prioritization of professional success and individualism over caring for the family has made financial and social isolation of aging people a common occurrence. Aging people are extra vulnerable to financial exploitation, poverty, food insecurity, and inability to access medical necessities. COVID has amplified the degree to which aging people experience loneliness, isolation, and financial exploitation, plus all of the secondary effects of those conditions.
66. Medical home deliveries have been improved and on-line consultations have been initiated
67. Triggered a PTSD like response from the early days.
68. Increased isolation
69. Increased isolation.
70. COVID 19 impacted everyone.
71. increased isolation
72. lock down and isolation
73. It has been very isolating.
74. It has kept their butts inside and made them more aware of their health and safety. Blessed to have been gifted this life
75. Quarantining has created more isolation.
76. yes, they are were very fearful of catching the virus and dying.
77. They are much more isolated
78. It has further isolated many clients and increased anxiety.
79. Many client were more isolated than ever. Very challenging. Increase in AODA. If they dropped out of medical care, b/c of concern with leaving their home.
80. More difficult financially
81. It was a terrible
82. Increases trauma induced fears PTSD from dealing with AIDS pandemic
83. Isolation, depression, food disparities, lack of face to face medical care, fear.
84. They are more isolated.
85. Loneliness
86. They've become much more isolated than they already were. Many of them live alone and lost most social support when they couldn't really leave home or get together with friends and family.
87. Fear of getting another disease that could kill them-anxiety/lasting effects from having had COVID 19
88. Fewer visit with them, interruption in services and relationship.
89. Isolation
90. It has caused further isolation and for some, has disrupted their most consistent supports. Some already lived comfortably in a more isolated life style and have not been impacted at all.
91. causing extreme stress
92. Yes - clients facing isolation and fear of going out and/or getting the COVID vaccine
93. All have been affected but those who are single are the most isolate during this time.
94. more isolation,less connection

GILEAD
Creating Possible

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COLLABORATIVE SOLUTIONS

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