00:00:09:22 - 00:00:35:06
Unknown
Cecilia Hardaker is the director of education at Howard Brown Health, an LGBTQ+ centric community health center in Chicago. She's an expert in the education and training of healthcare, best practices for LGBTQ+ individuals and communities, with a specialization in trans healthcare and aging. We're thrilled to have Cece here as a part of this certificate.

00:00:35:06 - 00:00:36:08
Unknown
In this module.

00:00:36:08 - 00:01:13:07
Unknown
She asks us to consider one of the least research aspects of all our lives and our healthcare aging. This is likely a surprising and fresh topic for most of you. The United States is a profoundly youth centered culture that exhibits phobias about aging in almost all aspects of mainstream popular culture, whether it's the exaltation of youth as beauty ideals or the maelstrom of anti-aging marketing a marketing that notably includes the widespread use of hormone therapies for all individuals and communities.

00:01:13:09 - 00:01:46:14
Unknown
The contemporary culture of the United States is adamantly youth centered. If we take mainstream popular culture as the metric, it's as if no one ever ages here. As Hardaker brings to light across an array of topics and practices, this ageism presents considerable barriers and even harms to the healthcare of elderly, LGBTQ+ individuals and communities. I frame Hardaker interventions along four axes.

00:01:46:16 - 00:02:21:21
Unknown
First, the fast paced transformation and expansions of the cultural meanings and identities of sexuality and gender. Hardaker explicitly explains the shifting terrain around preferred pronouns, for example, as a kind of generational gap. Hardaker also explicitly calls for patient driven care and cultural humility, offering that the example that the word queer may sound offensive to some LGBTQ+ elders.

00:02:21:23 - 00:02:59:12
Unknown
The second axis is the problematic histories of LGBTQ+ medical practices and experimentations, which Hardaker lays out in great detail. She goes back to the mid 20th century practices of electroshock therapy, insulin therapy, and frontal lobe lobotomies. She tracks the evolution of sexuality and gender in the all the DSM volumes, and she also speaks a bit about the anti-trans campaigning of Donald Trump, which in 2025 has now become federal policy.

00:02:59:14 - 00:03:40:08
Unknown
The third axis is the particular relationship to family that so many LGBTQ+ individuals and communities have. Post-World War Two culture in the United States witnessed the mass marketing and construction of what is known as the nuclear family across the nation. The patriarchal gender binary took hold, buoyed by middle class and thus largely white race status, to create the ideal family as as made up by the breadwinning husband, the bread baking wife, two children, and perhaps a dog.

00:03:40:10 - 00:04:15:12
Unknown
As this became naturally as the ideal family. Homophobia became the absolute weapon to guard its borders. Consequently, in this contemporary, up until this contemporary time of the 2020s, LGBTQ+ children and adolescents continue to be evicted from their biological families of origin. There are two crucial points here for the healthcare of

LGBTQ+ elders. First, the longstanding practice of reclaiming one's chosen and sustaining circles of love as family.

00:04:15:17 - 00:04:39:17
Unknown
In LGBTQ+ communities, these networks of care are often vibrant and sustaining. However, these networks of care are also often within the same age bracket. This means that LGBTQ+ elders are often without any younger family that is able to provide care to older persons.

00:04:39:17 - 00:05:10:04
Unknown
The fourth axis is that LGBTQ+ individuals and communities hold a specific relationship to death and dying. Let's be clear. At the heart of the rampant cultural ageism is a profound fear of death for LGBTQ+ individuals and communities. However, death is often not held at a safe distance. The Aids epidemic brought death directly into almost all our lives.

00:05:10:06 - 00:05:41:15
Unknown
We are also often cast out of our families and communities of origins as if we were dead. That is, we know and often experience what it is to cease all contact, almost as if we're dying. We also know what it is to be treated as if we were dead. And finally, especially for trans persons and communities, we experience death through the hateful acts of dead naming and misgendering.

00:05:41:17 - 00:06:36:19
Unknown
This module is jam packed with data, terms, practices and details about how to learn cultural humility, dismantle your implicit and explicit biases, and improve your healthcare practices for LGBTQ+ elders. As Hardaker makes clear, the entire population of the United States is aging by 2030. 20% of the population will be over 65 years old. So while you learn specific aspects of caring for LGBTQ+ elders, in this module, you will also learn invaluable practices for caring for all elders, as Hardaker emphasizes how to move into and through your discomforts to practice cultural humility, you will learn practices that will benefit all who come into your care.

00:06:36:21 - 00:06:39:04
Unknown
Enjoy this fantastic module.

[Cec Hardacker] Welcome everyone,
thank you for joining our session on

primary care best practices for LGBTQ
plus older adults.

Part of the original Nurses Heal Health
Education about LGBT Elders curriculum

that was developed in 2010.

Today's module has been updated several
times with the most up to I use she/her,

and AIAS pronouns.

I'm a nurse and the director of education
at Howard Brown Health in Chicago.

I've been presenting this content for 14
years,

and I'm always excited to share this
critical information with healthcare

providers.

So I'm very happy to be with you today.

Now we know that this can sometimes be
difficult content for people and so I

really encourage you to be with us in
whatever capacity you may have.

I invite you to practice self-care.

If you need to take a break,
put this on pause.

You have that advantage because it's
recorded material and take a pause,

do a grounding exercise,
do some deep breathing,

whatever you need to do to make it
comfortable for you to continue.

These are our objectives.

Obviously, we have quite a lot to cover.

This wasn't originally a six to eight hour curriculum that we have condensed

into an hour.

So as you might imagine, there's a lot of content that we're going

to cover, but keep in mind, in a very short amount of time,

we are going to cover this information, focusing always on our little orange

boxes, which are best practices.

And those are the things that you can easily incorporate into your daily

practice.

We've identified these as universal practices,

meaning that you don't just need to do this with LGBTQ people.

This is something you can do with all of your patients and we encourage you to do

that, to take away from today's recording, from today's lecture,

that information that you can use immediately in your daily practice.

So to begin with, we always have to think of ourselves as

establishing foundations, a framework of care.

And in our case, we want to really emphasize an

intersectional approach that's most effective.

And as you see here, this approach takes into account multiple

issues that older LGBTQ folks deal with on a regular basis.

It seems obvious,
but we always have to say it first,

do no harm.

We know that no one wants to do this in
the beginning,

but we do know that we have to address
these barriers specifically.

We also follow a practice of low
threshold care.

How do we make it as easy for individuals
to join us?

We do our best to address that access
issue.

It's always best to assume.

We rarely ask you to make assumptions,
but in this case, we do.

We want you to assume that our patients
have dealt with a modicum of trauma

throughout their life's experience.

Research tells us very clearly that 70 to
80% of the people who come and engage

with community health have been through
some type of trauma, Big T trauma,

little T trauma.

They have experienced trauma and as a
result will be more successful in

building a trusting relationship with
them by practicing trauma informed care.

Harm reduction asks that we work very
closely with the patient,

providing a shared decision making and
supporting incremental change.

Harm reduction is a fabulous way of
working with folks.

It allows them to move and grow at their

pace,

which is something that is not always
been supported by historically in medical

and medical medical systems.

We know there for years we've been saying
that there was a need for research.

There wasn't enough research,
We didn't have enough data,

We didn't have the statistics to tell us
about the health of LGBTQ plus older

adults.

But I have to say that we've seen that
gap closed in the last 10 to 15 years.

Very,
very important for us to always say that

what we're doing is based on evidence.

It's based on research.

And so evidence based practice is really
our guide and a best practice here.

Recognize an individual's lived
experience.

They are the expert in their lives.

We want to meet them where they are,
to provide them the best care,

the care that is going to really move
them to a place of health and well-being.

In addition,
the patient-centered care framework is

based on cultural competence theory and
more updated cultural humility,

which is that lifelong learning that we
will all need to continue to grow as

providers and working in the healthcare
field.

In the recent years,
we've moved beyond this more passive

approach,
cultural competence to a more active

approach in terms of this compassionate
learning that I'm I'm referring to.

That is in essence remaining open,
self-aware, self-reflective,

and for each of us to remain willing to
receive constructive critique,

not just from outside,
but for us to have that self reflection.

So very, very important.

And all of this is in response to the
inherent power imbalance that exists

within our medical system.

It I doubt it's a surprise to anyone that
older LGBTQ adults are slower to trust

providers, reluctant to disclose,
and have a rational fear of being treated

poorly in medical settings.

It's happened to them before.

It's happened to their friends.

Overall,
these folks are fearful about having to

return to the closet and people of color,
in particular Black and Latinx people are

worried about race affecting their care
as well.

So think about the overlap,
as we said before,

the intersectionality of these identities,
they're older,

they're part of the LGBTQ communities,
they may be a person of color.

All of these things will compound their concern about engaging with healthcare

systems.

It's a very important that we keep that in mind as particularly for older adults

now we've broken our content into 6 sections and at the end it'll be followed

by some legal concerns and many advocacy and policy suggestions that we think are

critically important to supporting older LGBTQ folks.

[Cec Hardacker] So we always start with terminology.

We want to know the language that we're using is appropriate.

I always like to ask people, do you speak gay?

You may or may not, but this is information that is

critically important for us to have at least the basics in our back pocket.

I'm not suggesting for a moment that you need to memorize all of this and know

this all by heart, but you do need to be open to learning

more about it.

Now, I'll go through this fairly quickly and

highlight the best practices.

As I said, the vast majority of people have some

understanding, but we do know that there are some things

that may be new to you.

So here on this slide, the one that might be new to you is this

SOGI.

SOGI, that actually stands for an acronym that

refers to sexual orientation and gender identity.

You may see this changing.

Our colleagues at Northwestern University here in Chicago have added an S to this.

So it would be SSOGI.

And this is our practice of asking people very,

very important information about their sexual orientation and gender identity.

And that added S refers to sex or biological sex.

And that you might start to see that in some academia or other places where

you're looking, you know, you're doing some of your study.

So keep that in mind.

Asking these questions is critically important to understanding the identity

of your patients, to knowing how to refer to them.

Always ask these questions and always be open to asking clarifying questions.

If you're if a patient shares a term with you that you're unfamiliar with,

it makes no sense to gather that information if you don't know what it

means or how it applies to their day-to-day life.

And my favorite example is to say if someone discloses to you that they

identify as a bear, well, they're not talking about grizzly bear.

They're talking about how they relate to other men in their life.

And so it's important for you to know that if you don't know to ask,

and if someone is going to be candid enough to say that they identify as a

bear, they're going to take a minute to explain

to you what that means.

So just be open to that.

Always ask those clarifying questions.

It'll make the rest of your conversation
go even more smoothly.

So this is some of the basic terminology
that people know.

I think most people are familiar with
most of this, the term bisexual.

People will see that more and more.

There are other folks who may identify as
pansexual.

They're very similar,
but they that's a more broad

understanding of sexual emotional,
intellectual attraction to other people.

The term asexual may be less familiar to
folks.

And again,
this is a person who does not really

experience a lot of sexual attraction or
experiences it rarely or in a different

way.

This is also a spectrum and some people
may feel some attraction or choose to

have sex or not have sex.

Again,
this is something that is you want to

specifically ask your patient,
tell me about this.

How does this affect you in your life?

How is this important to your
relationships?

Very,

very important to get clarification on

something if you're not sure exactly what
someone is talking about.

And as I mentioned earlier,
that added S has to do with sex assigned

at birth.

And this is a determination that happens
when a new human comes onto the planet

and the person that is witnessing that
birth makes a determination based on that

person's external genitalia.

This is a question that we can ask very
simply.

If someone doesn't understand what you,
what you mean when you say what was your

sex assigned at birth,
then a simple question is what did it say

on your birth certificate?

Tell me what that said so that we can get
that information added to your chart.

And again,
when we're talking about biological sex,

we're not just talking about anatomy,
the external genitalia,

but we're also talking about internal
reproductive organs.

We're talking about a person's
chromosomal makeup.

We're talking about a person's hormones
that they have when they are born.

And that gives us more information for
that individual as we learn more about

them.

And again,
how does this focus on their health?

And that's why we would ask those
questions of someone when we're visiting

with them, you know,
in whatever capacity we have a patient.

Now we want to talk a little bit about
gender identity.

And so these terms may be the least
familiar to some of you,

more than likely because this can,
this is terminology that continues to

change day-by-day, continues to grow.

I'd like to briefly look at the term
cisgender.

It's very important to state that this is
not an identity, OK?

This is a very important.

This is just an adjective that aligns
with an individual who's who has already

stated their identity.

All of gender identity is a
self-disclosed, self-determined,

self-stated identity.

And that's what we're that's why we ask
the question.

We don't want to make any assumptions
based on what we see externally from a

person that is may or may not align with
their internal sense of gender.

So it's very important that we keep that
in mind.

So the term cisgender, as I mentioned,
is a term that was developed as a

comparative term to the term transgender.

The root trans obviously means to change

and gender.

And so for the if we have to adhere to
our binary world,

what's the opposite of that?

Well, that's a person,
cis being the Latin root for same,

meaning that this person's current gender
identity aligns with that sex that was

assigned at birth.

So you may see those terms and it's
important to understand the difference

between the two.

Now, gender non conforming,
gender diverse, gender expansive,

genderqueer, there are many,
many other genders that we can identify.

But in this case,
I'm going to leave that for another.

You have another discussion about that,
but all of those terms fall squarely

under the transgender umbrella and are
self-determined and obviously will be

more fully described to you by your
patient.

So to briefly summarize about this
gathering SOGI information critically

important.

Do it in a respectful way.

Do it in a discreet way if you need to
explain why you're asking those questions.

Very, very simply,
I ask this of all my patients.

This is important health information I
need for you,

and I think it's important that we get established this baseline so that we can

go forward.

Always introduce yourself with your name and pronoun.

Always ask permission and get consent for asking sensitive questions.

More than anything, allow ample time for older adults when

filling in forms or answering questions that they might not understand.

Use common language as much as possible and always be open to new terminology as

it is always evolving.

And the thing for older adults, there may be some terms,

newer terms that they just don't they just aren't ready to accept yet.

The term queer is kind of split these days.

There are some older adults who completely embrace it and really enjoy

the empowerment of utilizing that term in a way that can be seen as positive.

But there are also adults who still feel very stigmatized by that term and so

they're not comfortable using it.

So very important to just keep in mind, there's terminology that we may

understand one way, but the person in front of us may not and

may not want to use it.

So it's a very important that we keep that in mind.

[Cec Hardacker] So the next section we're going to consider the earlier years that

LGBTQ people have lived through the historical context that really adds to

the precedent for mistrust in our medical system here in the United States.

I always like to take a pause here just to really explain.

We really have to think about this when we're talking about our patients,

particularly these patients, because this history that they've lived

through, the period of time has had a profound

effect on them.

So if you can imagine an older person, I mean a person at this point in their

80s or 90s, living through a period of time when the

only reference to what you were, who you loved, how you felt,

was perceived as criminal.

It was perceived as a medical or psychiatric illness,

fully stigmatized and pathologized.

You might say it's similar to our current time.

However, at the time, there were no legal protections.

There were no resources.

There was no Lambda Legal.

There was number Trevor Project.

There was nothing that people could reach out to.

It was a period of time when you could be
publicly outed and lose your job,

your family,
your entire way of life could easily be

threatened.

And there were individuals who made it
their sole purpose to persecute gay

people in government,
universities and schools.

When you think of the medical community
as one of the greatest inflictors of

trauma through those years,
it might be surprising.

But a person could be committed to a
psychiatric institute and have multiple

cures intended to rid them of their
homosexuality of their same sex

attractions.

So things like electroshock therapy,
insulin therapy,

where they gave them an individual a
bolus of sugar and then another bolus of

insulin to raise their sugar high and
then drop it back down.

And in the most egregious cases,
they would do surgery and do a frontal

lobotomy to completely remove any any
sensual feeling at all.

It wasn't until 1973 when homosexuality
was removed from the diagnostics and

Statistics Manual.

1973, I was 14 years old.

That's something to really keep in mind.

And it wasn't until 2013 when gender

identity disorder was removed from the

DSM.

One of the few bright lights in the 1950s
was The Kinsey Report that stated it was

a great research study that asked men and
a good sized group.

I think around 7000 men from the
northeast.

It's probably important to say if they
had ever had a same sex experience and

fully 1/3 of them said that they had.

They had had a same sex experience that
was consensual,

pleasurable and led to orgasm.

So he was the first scientist to say that
same sex physical relationships may not

be abnormal at all,
that we may be looking at this all in the

wrong way.

He also did a study up for women many
years later with the similar results.

In the 60s and 70s we see the rise of
public protest and activism for racial

equality,
rights for women and the start of the gay

rights movement.

It wasn't until the 80s when we really
began to see a very profound move in the

development of activism within the LGBTQ
community,

primarily in response to the AIDS
epidemic.

Now there are many survivors from this
area who witnessed one of the greatest

losses of life within their community who
continue to suffer from historical trauma,

community trauma,
and family trauma that has made them

justifiably wary of the healthcare system
that blatantly ignored them during that

really, really horrible time.

So there's one thing to think of it.

Keep building this idea in your head that
there's they have absolutely every reason

to be suspicious, cautious,
and fearful of engaging with the medical

system.

As we move closer to now,
the public landscape focuses more on

legislation that has both added rights
and eliminated rights.

In the 90s,
it was best just not to talk about it.

Don't Ask,
Don't Tell kept LGBTQ people in the

military in a painful limbo that provided
neither support nor rights.

We saw multiple horrific murders that
induced action to add sexual orientation

and gender identity to hate crimes
legislation.

The legal landscape is currently a mix of
state and federal laws that often

conflict and cause great hardship to
individuals and their families.

We are currently in a particularly
challenging time when anti trans

legislation is abundant.

As of this year,

652 bills were introduced in 43 states

anti-trans legislation.

Many of them failed,
but 45 of them passed and there are still

123 active cases.

So this is something that is ongoing and
all of this is tied to whatever

administration is in power.

So it's very,
very important to understand that even

with the change of administration,
the the fear level,

the anxiety that people may be
experiencing can, can go up, can be made,

can be exacerbated by what is happening
in the public.

So this is what I really want you to come
to.

How do you imagine this is affected an
individual's engagement with healthcare?

And think about the country we live in
today.

We're very, very youth focused,
very ageist.

My favorite question to ask people is,
I don't think anybody reads People

magazine anymore,
but they used to have who is the sexiest

man alive and who is the last person on
that cover that had Gray hair?

Everybody says Clooney,
and I think that's right,

But it's still not something that
regularly happened, right?

It seems like that person seems to get

younger and younger.

We have so many stereotypes,
beliefs and attitudes that are

microaggressions,
silly jokes that we take for granted,

but they can potentially be very,
very harmful people.

Talk about senior moments, right?

That's something that can being forgetful
is something that concerns people

tremendously or referring to somebody as
a dirty old man.

It's been identified that implicit bias
of providers is one of the really one of

the greatest issues that we see.

So here's where I'll tell you a story,
one of the best ways to truly understand

how bias might affect an individual.

And I will share a story about myself.

I may not look like the most active
person to truly understand how this bias

has affected something,
but I work with my hands all the time.

I play guitar, I paint, I'm an artist,
I even do construction on my own home.

And so one fine morning,
I am washing out a milk crate and I was

tearing it apart to break it down,
to put it in the recycling and I

dislocated my finger.

And I'm sure I dislocated my finger.

I saw it snap horizontally to the left
and then snap back to the right.

It swelled up a little bit,

but I'm a nurse.

And so I put ice on it and took care of
it during the day and it began to feel

better.

But soon I noticed that when the swelling
went down that my knuckle was out of

alignment.

And after about a month,
I thought I should really go see some an

orthopedic surgeon,
have somebody really check it out and

make sure.

So lovely resident came in, spoke to me,
asked me some questions.

We waited for the surgeon to come in.

Surgeon came in,
took a look at my hand and without asking

me one question said, well,
this is what happens when you get to be

your age.

At which point I've lost function in my
brain.

And when he suggested that I go
downstairs and get a splint for my finger,

I literally could say nothing to him.

I just left and I never went back.

And that's what patients do when they
have a bad experience.

They feel discounted or in my case,
100% I felt dismissed.

They just go to a different provider,
a provider, or they don't go back.

So how can I encourage you?

Please consider our own biases.

We all have them.

It's human, it's common,
but it is for each of us to find a way to

move beyond.

So I highly recommend the project
Implicit as an exercise every week can do.

It's easily found online and it is a
series of tests that you can do.

Takes 10 minutes,
but you'll learn an awful lot about

yourself as it relates to multiple
different characteristics,

sexual orientation, skin color, age,
gender, ability.

It's a really very useful thing for
everyone to do, so I highly,

highly encourage it.

So let's look at some statistics.

By the end of 2030,
which is just five years away now, very,

very close,
the number of adults over the age of 65

will represent 20% of the US population
for the first time ever,

the first time in our history, every day,
10,000 post World War 2 babies,

we're not supposed to call them boomers
anymore.

Turn 65. 10,000 a day.

It is expected that the number of older
LGB adults will double by that time to 5

million.

And the number of trans people continues

to grow as well, approximately 1.

3 million adults estimated by 20-30.

So it's very,
very important that we keep in mind,

no matter what field you plan to go in,
no matter what work you plan to do,

unless you plan on just bringing new
humans into the world and working with

the little ones,
you will have older adults in your care

and you will have older LGBTQ adults in
your care.

[Cec Hardacker] Now I get to talk about
one of my favorite subjects,

the myths about older adults and
sexuality and the impact of ageism.

Years ago I had some buttons made that
said my silver hair is sexy that was laid

over the top of the pride flag and I gave
them out to all my friends to wear.

We really suffer from the assumptions and
lingering stereotypes,

many of them listed here.

As you can see on this slide,
sexuality of older adults is invisible.

They're not seen as desirable.

And I used to make a joke.

Let's talk about older adults and
sexuality,

but don't think about your parents
because we don't want to arouse the ick

factor.

But what we really need to think about is
how healthy it is for people to have

sexual desire,
a partner that cares for them.

It becomes a very part important part of
people's lives as they age that we cannot

ignore.

So here's another story and I have to
tell this one because I made a promise

years ago.

I was doing a one hour training on sex
and sexuality at a nursing home for all

the staff.

I did it three times over the course of
the day of an 8 hour shift so that I

could bring it to everyone.

And it was done in the shared cafeteria
space.

Right next door was a room where the
residents could go and smoke.

It had glass.

They could see what was going on in the
cafeteria at the end of the day.

I'm packing up my projector and a tiny
man with white,

white bushy hair under a camouflage hat
and shirt that said veteran across the

top of his hat stopped me as I was
getting ready to go.

Now I'm an Air Force brat,
so I know to be respectful.

Immediately.

I stood up straight and answered, yes Sir,
how can I help you?

And he said,
I've been watching you all day.

And I thought, oh, here it comes.

I'm in big trouble.

He said, I just want to tell you,
I'm so glad you're teaching them about

this.

They don't think of us as sexual beings.

It's really sad.

And it's I'm so,
really glad that you came to do this

class.

And he kept going.

And he said,
just because there's snow on the

mountaintop doesn't mean there's not fire
in the oven.

And I laughed and laughed and I said,
I love it.

I said,
is it OK with you if I share this story

with other people?

And he said, yes, yes,
I want you to do it.

So I've shared that story from that day
till this.

I thought it was, first of all,
so brave of him to come up to me,

perfect stranger, and say,
I'm so glad that you're doing this.

But he also let me know that what I was
saying was true and that it was important

for the staff to hear and understand that
this was something we didn't want to take

away from them,
that this is something that we wanted to

maintain so that it helped them with
their health and Wellness.

And it's a very important because it does,
it makes a big difference for people who

are older.

So we really focus on sex positivity as a
way to support various sexual practices,

but it's also important for older adults.

Research tells us that older adults
continue to have intimate relationships

later in their years.

And there's an abundance of evidence that positive sexual health,

being in an intimate relationship protects against the stressors of chronic

illness.

And for gay identified men, research has shown us that their sexual

health and sex life is a function of their quality of life overall correlated

with sexual satisfaction.

So the best practice here more than anything is to ask people about their

sexual health.

Allow extra time for these honestly, these rich conversations that you will

have, asking questions like, can you tell me about your sexual life?

Can you tell me how that's changed over time?

Tell me about the quality of that very, very important conversations to have. Now,

There are very specific health issues related to sexual activity.

This chart points out just two of them.

Erectile dysfunction is something that receives plenty of media time,

primarily to promote those medications that can help with this issue.

But the truth of the matter is that this is not a normal part of aging.

Difficulty achieving and maintaining an erect penis is generally due to a chronic

health condition that affects at its most simple, understanding blood flow.

So atherosclerosis, diabetes,
side effects of other medications,

and a lack of physical exercise are
primary causes.

So when this conversation comes up,
more often than not the person is

interested in getting the pill to help
with their problem instead of other

simple interventions that can help.

Exercising, losing some weight,
reducing or stopping smoking can be

something that will help the situation
before jumping right to prescribing a

medication.

Now for people with post menopausal
vaginal tissue,

they may experience dyspariunia which is
painful vaginal pain during penetrative

sex.

And again,
this is definitely in most cases a result

of those post menopausal changes
consisting of vaginal dryness can be

because of fibroids or chronic urinary
tract infections.

UTI's.

Again,
the solutions for this can be very simple.

It can be something as simple as using a
water based water soluble lubricant that

so many people don't even know about.

I remember giving this talk at that same
nursing home where the older gentleman

approached me.

At the end of the day, several of the,
the staff walked up to me and said can

you tell me a little bit more about that,
that water soluble lubricant?

Where where can I find that?

And I thought, gosh, this is great.

We're providing help to the folks,
even the folks that work here was

absolutely was very satisfying.

You can also do a low dose estrogen cream
to help with elasticity of vaginal tissue

or provide a direct treatment for
whatever physical disorder that may be if

you can,
if they need to remove the fibroids,

if you need to treat those,
those chronic infections.

But more than anything,
and this is something that is a bit

controversial,
but I think incredibly important,

is to perform HIV testing with older
adults.

Older adults have a higher risk than
their middle-aged counterparts,

mostly because they're not aware of their
risk and providers don't educate them

about that.

Not just the risk for HIV,
but also sexually transmitted infections.

And we'll talk about that again when we
talk about HIV and aging.

But if it's a policy that you can do even
just asking every time,

would you like me to do an HIV test for

you today?

We'll start quite a conversation if somebody is not aware that they may be at

risk for it.

So finally, include that sexual health intake is part

of a routine process for health assessment and physical exam.

While this can be uncomfortable for an untrained provider,

it's incredibly important conversation to have with your patients.

So once again, normalize the process.

Ask for consent at the beginning of the conversation.

Let them know that you're going to maintain the confidentiality of whatever

you talk about and establish a mutual understanding of language and body parts.

It's so critical that we are aware of our body language.

Do we feel relaxed?

Are we showing any bias?

Are there any nonverbal cues or any judgment that we may have personally

about what we're hearing?

These are some great sample questions to ask.

As I mentioned a little bit earlier, ask an open-ended questions and then wait

for this conversation.

It can really be useful close ended questions to get started.

How many times have you been physical in

the last month?

And then tell me more about that.

Is that typical for you?

Can you share more about that with me?

I always like this because this is
something you're going to ask other

people in other situations.

So consider a patient coming back with a
heart condition who's just had a major

surgery,
who wants to be sexual with their partner

again.

But it's a shame to ask the question.

What do providers say before the last
thing that they say before they walk out

the door?

Do you have any other questions for me?

That's when people will ask the question
that they're reluctant to ask at the

beginning of their appointment or that
they're a little embarrassed about or

they're a little ashamed about.

So it's so important that we can
normalize these conversations so patients

expect it and we'll be prepared to ask
those questions.

So some of these questions, as I said,
for how would you describe your overall

satisfaction with your sex life?

And has that changed over time?

That's a conversation.

So keep in mind,

but be aware of your own biases.

Now,
there's been a handful of people that

I've worked with who said,
what if I just can't do this?

And my response to them is,
Are you sure you're in the right field?

You should be able to ask anything.

You really should.

It's something that we need to,
you might need to practice,

you might need to get some extra training
on it,

but it's important that we ask these
questions.

So please add this to your toolbox.

[Cec Hardacker] So now I'd like to talk about HIV and aging.

Earlier, I mentioned that we lost an entire

generation of young people to this voracious virus.

But thanks to the initiation of antiretroviral therapy,

people are living healthy lives and living with HIV well into their older

years.

Now, as I mentioned earlier, most older adults are unaware of their

risk to acquire the HIV virus.

We know that older adults are much more likely to have a late diagnosis,

primarily, again, because it's not a question that

providers ask regularly.

As the statistics show, there's still a significant number of new

infections among people over the age of 55.

Half the people living with an HIV diagnosis are over the age of 50,

but at the same time only 5% of people over the age of 55 actually know what

their HIV status is.

So we do see a large number of people, over 18,

000 in 2020 of people living with HIV passing for a variety of reasons.

It may not necessarily be that they had developed an AIDS diagnosis and had died

because of some opportunistic infection,
we don't know.

But that's still a significant number of
people who had been living with HIV who

had passed in that year now because of
the exceptional treatments that are

available.

And we continue to develop salvage
treatments for individuals who have

resistance to multiple medications.

More older adults are living longer
because of these treatments.

At the same time,
stigma is still a particular concern for

older adults.

They're already dealing with isolation
due to loss of friends and family,

but further stigmatization could lead to
even greater separation from their

community and family and really increase
their sense of isolation.

Now, not everyone has this experience.

I attended an HIV training at our local
Midwest AIDS Training and Education

Center and was privileged to hear a woman
tell her story about how she became HIV

positive.

She was an older black woman in her 60s.

Her husband had passed a couple years
prior, and her daughters, her elder,

her older daughters, her grown daughters,
encouraged her to get out there and find

some companionship.

At that time she was in her early 60s,

so she agreed and she set her eye upon a

Deacon in her church.

They had coffee, they had dinner,
and eventually they had sex.

Within about a month she began to have
symptoms and she thought it was the flu,

so she went to her doctor.

They performed all kinds of tests.

He asked all kinds of questions,
but it was many,

not for many months until her provider
asked,

is there any possibility you could have
been exposed to the HIV virus?

She said her initial response was she was
shocked, she was angry.

She said,
what kind of woman do you think I am?

And his response was simply that it's a
possibility based on your symptoms.

So she went home and she thought about it,
and she thought about it,

and she thought about it.

She realized that she had had sex with
her new friend,

and they did not use any protection.

So she went back and asked for the test,
and sure enough, she was HIV positive.

And when she brought in her friend,
he was HIV positive.

Now,
you might imagine that she'd be

devastated by this diagnosis,
but the story she shared was far from it.

She said her response was, well,
what can we do about this?

And she spent the rest of her time
sharing her story,

talking to people in her church,
talking to her friends, her family,

to her healthcare providers so that they
could learn from her experience.

She's a powerful advocate for opt out HIV
testing for older adults.

She said had her provider asked her in
her first appointment if she thought she

may have been exposed to HIV,
she may have saved herself months of

trying to determine was what was wrong
and experiencing those symptoms and

having her viral load get higher and
higher and have her CD4 count drop to the

point where she did not achieve an AIDS
diagnosis.

But she was very close.

She was truly an amazing woman and I
still to this day feel a very profound

sense of humility because of what she
taught me.

Our research shows us that older adults
have similar risk factors as younger

people,
including a lack of knowledge about HIV

prevention and the increased risk from
having multiple partners.

Older women are less likely to use a
condom.

There's no concern about pregnancy.

So they're probably thinking why do I
need one?

It's been years and years,
but there are physical changes as I

mentioned before,
thinning and dryness of the vaginal wall

that can allow for micro tears to occur
during penetrative sex,

which increase the risk for passing the
virus.

And we've established older people are
less likely to discuss their sexual

behaviors,
potentially drug use behaviors with their

doctors and unfortunately providers are
less likely to talk to them about their

sexual behaviors.

So again, making the argument,
at least open the door,

at least start a conversation,
if it's not something they need to talk

about at the time, then that's fine.

But you've opened the door.

They know that they can talk to you about
this if they need to.

So these statistics refer to people over
the age of 50.

The CDC,
Centers for Disease Control and

Prevention use this age as the cutoff
point for older adults.

Many of the disparities that exist in
younger adults,

younger individuals remain in older
adults.

For men who have sex with men over the
age of 55,

there's been a slight decrease and then a
slight increase over the span of the

years shown here.

We continue to see a deplorable disparity
in black Americans whose diagnosis have

remained stable,
while Hispanic and Latinos,

their numbers have increased.

For white Americans,
those numbers have decreased by 10%,

yet continue to remain a significant
number of diagnosis in the United States.

[Cec Hardacker] So now I'd like to talk
about the health of transgender older

adults.

And then again,
this is just going to be an overview

overview.

I know you have other content that
focuses on the transgender communities,

but again,
we want to start by laying a foundation

of inclusion.

Communication is the most essential part
of working with these patients.

If it's an inpatient space,
A-Team approach is vital.

Everyone on the care team needs to have a
clear understanding of terminology.

They need to be skilled and using gender
inclusive and gender appropriate language.

It's important that they only collect
information that is essential and they

are to work together and instruct the
team to avoid asking unnecessary

questions,
always focusing on their Primary Health

concern.

We do not want to rely on the patient to
educate us about their care.

Now these patients have great
understanding of their own lived

experience and we absolutely want to know
about that.

But it is not their job to teach us about
how to care for them.

We must absolutely respect their
self-selected gender identity and

instruct their caregiving team to do the
same.

And for providers,
screen and treat the body parts they have.

All of these best practices that team
approach,

screen and treat the body parts they have
and respect their self selected gender

identities are critically important for
us to follow.

Now,
hormone replacement is something that

people think, oh,
only young people do that.

And they start, you know,
as soon as they understand their gender

identity there that they're clear about
their self-determination.

But this is something that older adults
can start as well.

And this information comes from the
through WPath,

the World Professional Association for
Trans Health,

and from the University of California San
Francisco Center for Trans Health

Excellence.

Medical management of hormone use is well
within the scope of any provider.

You do not need to be an endocrinologist
to provide hormone therapy to an

individual.

It is an off label use,
but following the guidelines from the the

sources that I mentioned are absolutely
simple and very simple to follow.

So beginning with an assessment,
discussion of the risks and benefits of a

treatment,
utilizing that shared decision making,

in this case clinical decision making and
using an informed consent model is the

framework that you want to follow.

Utilizing a biopsychosocial approach that
explores the impact of hormone therapy is

significant and you must devote some time
to doing this before an individual starts

hormones.

As I mentioned earlier,
they have done all the research before

they come to you.

Believe me,
they've spent and invested a lot of time

in understanding what might happen.

So for older adults,
it's important to know that there are

very few health conditions that pose an
absolute contraindication to initiating

hormones.

They will be tolerated well by an older
adult provided that any chronic medical

condition that they have is being well
managed.

So it is something that they can do.

They may not see the changes as
dramatically as a younger person would,

takes longer to see the changes.

They may not fully get the changes that
they were hoping for had they started

this when they were younger.

But again,
in that informed consent process,

that's a discussion that you're going to
have with them so that they understand

the expectations and potential outcomes
that may happen for them.

When we talk about gender affirming
surgery, again, people think, oh,

older adults are not going to be
interested in doing that,

but that is absolutely not the case.

This type of of surgery is more common
than you would think.

Recently Medicare has added it as a
procedure that they will cover.

But ultimately this decision is made
between the individual and their surgeon.

So long as any serious medical issue is
well managed,

the surgeon may agree to performing the
requested surgery.

And a lot of people,
what they will say is if an older adult

is able to Well-tolerate anaesthesia,
they should be able to tolerate a surgery.

Individuals in their late 70s,
some of them have waited their whole

lives to ask for this procedure.

One of the probably the most touching
stories that I ever heard was a trans

woman was asking her surgeon if she could
have,

if they could consider doing a
vaginoplasty creation of a neo vaginal

space.

And she was very thin.

She was older.

She had, you know, she had very,
very fragile tissue.

You know, her skin was very fragile.

And the surgeon said, oh, I'm so,
so sorry.

I would love to say I can do this for you,
but I can't you,

you just will not have the outcome that
you want and that you need that I want to

give you.

So I'm so I can't.

And she said,
but I don't want to die with a penis

since he said,
well we can remove your penis.

And so they made a decision to do a
different surgery,

not the one that she wanted,
but something that could affirm her and

give her what she wanted in her later
years.

So it's so,
so important that that people find as a

surgeon who's willing to work with them
again, this patient-centered approach,

this shared decision making so that they
can get to a place where they can feel

their absolute best self.

So that's a critically important for us

to keep in mind.

For older adults,
it is still possible with some exceptions,

provided that they have any medical issue.

Pretty well managed.

Since we discussed isolation earlier,
I think it's important to know some of

these other frightening statistics about
trans older adults.

the US Transgender Survey reported that
more than half of trans people have

experienced some type of intimate partner
violence throughout their lives.

Trans people having the highest risk of
anyone in the LGBTQ community.

Black trans women experience a violent
death at roughly five times that of the

general population.

Think about that five times that
contributing to challenging challenges

interfacing with healthcare.

Trans folks have had the highest rates of
housing instability,

have the highest rates of suicide
attempts within the LGBTQ plus

communities,
and there are a few sensitive supports

around.

You know,
one program that we had at Howard Brown

for years was called In Power was a
sexual assault response program for LGBTQ

people.

It was something that we knew was

important because the disclosure rate was

incredibly high at our clinic.

And so this was a great program that was
put in place in response to that.

But these are rare.

You know,
I would challenge you to even start to

look for other places that have something
like that.

That is an immediate response to someone
disclosing that they've experienced

sexual assault.

There's significant substance use.

Again, that is due in part to isolation,
stigma, discrimination,

that people are experiencing a variety of
minority stressors.

As we may expect for older adults dealing
with their physical health and chronic

pain, social supports are limited.

Aging services, community support,
employment and housing.

We have an image of someone here that is
a remarkable woman.

This is Miss Gloria,
and she worked at our local center on

Halsted.

We have an amazing older adult program
there and she spent the last years of her

life teaching young trans women how to
survive in the world.

She taught an etiquette class and she was
one of the most amazing role models that

I've ever known.

And her work was truly selfless.

She passed just a couple years ago,
but it was it.

She's just was such a tremendous example
to the community and was such a wonderful

role model to young people who were who
were coming out.

But again,
these types of programs are far and few

between.

There's just not enough to help support
people, particularly older adults.

Now, I mentioned briefly pronouns.

We were talking about introducing
ourselves with our names and pronouns.

Here's a small table with some examples
of how pronouns are used.

Again,
you may have this information in another

in another course,
but it's just so critically important.

We've said for years that using the
appropriate pronouns for an individual is

suicide prevention.

You just don't know what that person has
endured and for them to come to us,

for us to use,
inflict harm by using a dead name or an

incorrect pronoun.

The most,
the easiest way to be sure that we're not

that making that mistake is just to ask
every person every time,

will you share with me your name and

pronoun today?

That's the simplest thing you can do.

And most people,
people will providers and and healthcare

professionals will say, oh gosh,
I'm nervous.

You know, if I ask that question,
what are they going to say?

I said they'll probably just answer your
question.

He probably just going to get the answer
that you're looking for.

So keep this in mind.

There is a website called
Practicewithpronouns.com,

which is something that you can do if you
feel like you're going to need a little

extra time.

Practicing with your coworkers is really
the best way to make this a practice that

you do every day without even thinking
about it.

That's really where you want to get.

You want it to just be a normalized part
of what you do every day.

So we briefly touched on the importance
of using gender appropriate language as a

standard practice.

It's incredibly important to model that
behavior,

to establish that mutually understood
language,

to reduce that natural anxiety that
occurs with engaging with the healthcare

system.

Microaggressions,
comments or actions that are subtle and

unconscious and many times unintentional
can really communicate prejudice towards

another individual or marginalized group.

And above all,
we want to do everything we can to avoid

misgendering trans and gender diverse
people.

[Cec Hardacker] So I want to talk a
little bit now about health disparities

and a particular type of health
difference that are closely linked to

social, economic,
and environmental disadvantage.

The CDC goes further to state that these
are preventable differences in the burden

of disease, injury or violence.

So opportunities to achieve optimal
health that are experienced by socially

disadvantaged population or what we like
to say is historically excluded.

Healthy People 2020 goes on to say that
these disparities adversely affect groups

of people who have been who have
systematically experienced greater

obstacles to their health based on their
group, based on their group.

So these health disadvantages are not of
their own making.

They're based on what we can,
what we call non bond,

non modifiable variables, skin color, age,
etcetera.

So the factors listed here,
characteristically,

characteristics historically linked to
discrimination or exclusion,

really contribute to these health
disparities.

So in this final content section,
we'll take a look at the health

disparities and barriers to care loosely
based,

loosely based on how individuals identify themselves, right?

This LGBTQ+ is not a monolith.

We cannot ascribe the same characteristics.

We cannot treat everyone the same just because they're part of this group.

So this gives us a chance to broaden our the way that we look at it.

And you'll notice as we go through these next few slides that the best practices

are the same for each group.

To acknowledge known barriers and address the inequities to care.

I always include the social determinants of health as part of your

patient-centered care.

Remember that the frameworks we spoke about at the beginning of the session,

we're looking for shared decision making, developing plans of care that take into

account as many of those factors as possible.

So this is a general list for health disparities for lesbians and bisexual

women.

For women who have sex with women, you may hear the term now

sapphic-identified individuals.

The disparities listed here, help me have been the same for the past

20 to 30 years.

So which in and of itself is a horribly sad statement.

It means that not enough research has
been done,

that not enough prevention is in place,
and we just haven't done enough to change

these statistics.

This group reports poorer overall health
and data shows us increases in diabetes

and carrying more weight,
experiencing fat phobia, asthma,

cardiovascular disease,
higher rates of smoking,

substance use notably depression,
anxiety and increased rates of breast and

lung cancer and increased risk of
cervical and ovarian cancer primarily

because of infrequent visits for cervical
screenings,

particularly trans men who retain a
cervix.

Again, remember,
screen and treat the body parts they have.

These folks have similar risks for STI's

as their heterosexual counterparts with
an increased HIV with a lower, excuse me,

HIV risk still a risk.

Over 44% of lesbian-identified women and
over 60% of women have experienced some

type of sexual violence by an intimate
partner.

So important for us to bear all of that
in mind for bisexual and pan identified

individuals.

Current research tells us that these
folks experience even more increased

rates of discrimination.

Then we call it double discrimination for
both lesbian and gay individuals and

their heterosexual counterparts,
so they experience it from both sides.

Data showed an increased rate of
headaches, osteoarthritis,

gastrointentional intestinal problem
problems, depression, anxiety,

and a significant increase in substance
use, particularly binge drinking.

So these are important.

The reason that I mention these is
because these are important things for

you to have in your back pocket.

What are greater health concerns for
Latino people?

You're going to be doing screening for
diabetes.

You're going to be doing screening for
cardiovascular disease.

Why do we know that?

Because there's plenty of research that
shows us that those are health issues for

those groups.

These are health issues for these groups.

And so it's important that we have at
least a basic,

some type of foundation to work from when
we have patients who come to us,

who share with us and disclose to us that
they are part of these groups.

For men who have sex with men,
gay and bi identified men,

it's important to maintain an open

discussion about their sexual health and

plan for regular STI testing once we
determine that they are sexually active.

Testing should include screening for
hepatitis A, B,

and C It's important to know with these
folks that there is an increased

substance use including smoking,
higher rates of depression and anxiety,

and particularly of note,
increased rates in lung and liver cancer.

Now screenings for anal cancer include an
anal pap smear,

which is a simple procedure can also be
done as a self swab.

Many people don't know that you can even
do an anal pap smear.

They only know about cervical cervical
pap smears.

But these men are also at higher risk of
intimate partner violence than their

heterosexual counterparts.

For black trans women,
the top issues are listed here.

They go way beyond chronic health issues.

These are directly related to violence
perpetrated against them.

These are a couple of the support
organizations for trans people in the

Chicago area, Brave Space Alliance,
Black Trans Women Incorporated.

There are others across the country,
but it's important that we know what

supports are out there and how to connect
people to those resources.

In general, for trans people,
they deal with multiple chronic

conditions listed here.

It's important to establish open
communication to support

transition-related therapies and their
sexual health.

Now I was talking with a group of nurses
in Nebraska and one of them raised their

hands and said, gosh, it's,
it can't be all doom and gloom right then,

to which I responded, you know what,
you're right,

we should had some information that
supports and really outlines the

resilience and strengths of older LGBTQ
people.

We know that compared to younger people
in the LGBTQ communities,

older adults are less likely to be
unhappy because they have seen so much

change and they've seen so much growing
acceptance in the last decades.

They have also built chosen families,
have strong social support networks that

they've developed over time,
and many of them will say that the fact

that they've experienced discrimination
in their youth,

that this experience has prepared them
for growing old.

As Betty Davis said,
growing old isn't for sissies,

and that would be something that LGBTQ+
older adults would absolutely agree with.

[Cec Hardacker] So as many of you heard,
I mentioned earlier that Lambda Legal is

an organization that advocates for the
rights of LGBTQ people,

including older adults and people living
with HIV.

They focus on legislation that supports
families, adopted children,

access to affordable healthcare,
fair and compassionate services for

everyone in the communities.

How can we advocate for our patients?

I often say to nurses,
and I know that there may be some of you

who are nurses,
some of you and other public health

fields,
advocacy is our greatest tool to support

our patients,
to be able to try to connect them with

the services that are available to them.

And they may be limited in different
areas.

So more and more it's important for us to
understand what is out there and what is

available.

We begin to wind up.

I want to cover some final
recommendations.

Financial security is one of the most
critical supports as we age.

I was giving this talk to a group of home
health care workers.

And when I started to talk about the

threat to people's financial security

when they were older,
it's kind of when I finally got their

attention was when I finally could say,
you do know that this is that the laws

that are in place can literally strip an
individual of all their financial

security.

And they were,
they were shocked to hear that most

people went to age in place,
staying in their homes as long as it's

safe for them to do so.

For older LGBTQ people,
this is highly desired because of the

incidence of discrimination in long term
care.

Only recently,
within the past 10-12 years has there

been legislation that protects LGBTQ
people in long term care or nursing home

settings.

In addition, long term care,
long term caregivers are not always

trained to provide the culturally safe
care that we need.

Older LGBTQ people have reported that
they're afraid of potential abuse and

discrimination that has occurred in long
term care settings.

And I'm sorry to say that it's very,
very common.

Most LGBTQ older adults have a peer
caregiver group.

Now,

these are people that are probably close

to their own age,
part of their chosen family,

who they prefer to have as their social
supports.

And now there are other social supports
out there.

A lot of them are faith-based,
but that can be concerning for older

adults too,
as these services may treat them in a

particular way or require them to behave
in a certain way.

Again,
the possible threat of going back into

the closet,
something that nobody wants to do as they

get older.

For those of you who intend to do
research, please, please,

please include asking questions about
sexual orientation and gender identity,

and when appropriate,
include older adults.

I'm currently working on a Pokhori grant
that's focusing on capacity building for

older adults in research.

We're hopeful that in the next two years
to discover what older LGBT people are

really interested in so we can develop
some research questions that will focus

on them and provide much needed data and
information to help support them as they

age.

And if you don't know,

for those of you who don't know,

we do have a sexual and gender minority research office at the NIH.

You're able to reach out to them at any time and ask questions.

I highly recommend getting on their listserv to get those announcements and

research opportunities and funding that may be coming out in the future.

Very, very important.

For those of you working in a university or educational setting,

please take note of the fact that there are there is minimal education that

focuses on LGBTQ people, older adults particularly.

And this course is one of the few that exist across the nation.

So the fact that you're able to participate and be part of this is

incredibly beneficial.

It's just not available across the country.

We have a drastic shortage of geriatric nurses,

geriatricians focused on the care of older adults needing specialized care.

In the 14 years that I've been doing this, we have seen the number of hours of LGBTQ

plus content increase from 2 1/2 hours of undergraduate medical training now up to

six hours.

Six hours is barely a mini series.

I mean, it's not much time at all, and most of that is typically focused on

HIV and sexually transmitted infection,
so it leaves an awful lot out.

The thing that still breaks my heart is
nursing programs are not required to

provide any training on LGBTQ health
issues.

My recommendation to you is to advocate
for any increased content that you may

want.

Now, probably after this class,
you won't need a whole lot.

But in another situation,
in any other situation where it might be

important for you to advocate for more
education, please, please do.

One of the most important things I say to
people is once you know what you don't

know,
it's now your responsibility to find out

how to add that knowledge.

It's now your job.

It's your responsibility to figure out
how do I find what I need to know?

How am I going to learn about that?

Because if you're not getting it from the
course that you're in,

you need to find a way to get it.

And lastly, as a healthcare professional,
I really count on your allyship and

advocacy for policy changes,
not just all the practices that we've the

best practices,
we've been talking about the policy

changes that will support older adults.

Now,
this can require you to be courageous in

some situations,
especially where there's a,

a power imbalance.

I often say to nurses that you're the
patient advocate that we rely on to

communicate and to do the best for your
patient.

And keep that in mind.

And these are the statistics that I will
leave you with.

Older adults are twice,
four times less likely to have their own

children.

They're twice as likely to be single,
three to four times less likely to have

children.

And many of them have been estranged from
their their biological families.

So in many cases,
it falls to us to be their support.

And I am truly counting on you to fill
that role so that they feel less isolated

and more supported.

So we have a number of references for you.

There's more work that you want to do,
and I hope that you do.

So I'll slowly scroll through these just
so you can have a peek.

But these are things that this is where
we hold most of our information and our

data.

And we'll come to the end momentarily to
tell you to share with you a quote that I

have kept by my side.

I even have this framed in my office so I
can look at it anytime that I want to

give me some encouragement.

This is a quote by Audre Lorde,
a black lesbian writer who often spoke

about the challenges of being a vocal
activist.

This really captures the heart of what it
means to be an advocate.

I think when I dare to be powerful,
to use my strength in the service of my

vision,
then it becomes less and less important

whether I am afraid.

So thanks everyone.

I hope you've enjoyed this course
presented by Ohio State University

College of Arts and Sciences.

Thanks so much.