ABSTRACT

EDUCATION FOR PROFESSIONALS ON SEXUALITY AMONG OLDER ADULTS:

A GRANT PROPOSAL

By

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The purpose of this project was to write a grant to implement an educational program for healthcare professionals employed by Kaiser Permanente (e.g., physicians, nurses, and social workers) on older adult sexual health. Topics would include the increased transference of sexually transmitted infections among the older adult population. The professionals would also acquire the tools needed to enhance their comfort levels when engaging in sexual health discussions with older adult patients.

The goals are to increase (1) the professionals' knowledge of sexuality and sexual behaviors among older adults and (2) their comfort levels when discussing sexual health with their older adult patients. A total of 2,100 healthcare professionals would participate during the funding period. The program would be evaluated by means of pre/post-testing of knowledge and comfort levels, as well as a satisfaction survey. The actual submission and/or funding of this grant were not requirements for the successful completion of this project.

EDUCATION FOR PROFESSIONALS ON SEXUALITY AMONG OLDER ADULTS: A GRANT PROPOSAL

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To my 9:01 crew...you all hold a special place in my heart and I thank you for loving me through this process. There is no one else I respect more than all of you, and whether you know it or not, you have kept me strong throughout these last 3 years. This is for us, the 2%!!!

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moment I was accepted into grad school, but you were able to provide such guidance that the fear dissipated. I do not know how you did it, but it worked! Many thanks to you and to my committee members for all your hard work over the past months.

It would not be right to end this without mentioning a friend and classmate that we lost in a tragic event during our 2nd year of this program. As a class, we mourned his death and searched for an understanding that never revealed itself. To Devin, you are remembered and missed.

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CHAPTER 1

INTRODUCTION

The older adult population in the United States is rapidly growing as the generation known as the "baby boomers" continues to age. According to the U.S. Census Bureau (2014), the number of older adults increased from 281,421,906 to 308,745,538 between 2000 and 2010. This is a change of 9.7% within a 10 year period.

Along with the rise in the older adult population, there has also been a rise in sexually transmitted infections (STIs) being contracted by older adults. According to the Centers for Disease Control and Prevention, in 2010, there was a 5% increase from the previous year of HIV infections in adults over the age of 55 and the incidence of other STIs in older adults has also been gradually increasing from 2008 to 2012 (Centers for Disease Control [CDC], 2012). The CDC reported that per 100,000 cases, the number of older adults who contracted syphilis in 2008 was 563; however, in 2012, that number increased to 737. The number of those who contracted gonorrhea in 2008 was 3,277 and in 2012, it rose to 3,874. The largest growth in STIs in the older adult population in the United States was 2,133 cases of chlamydia contracted between 2008 and 2012 (CDC, 2012).

Ageist attitudes are common when thinking about older adults and their sexual behavior. Family members, healthcare workers, and society in general may believe the myth that older people are neither interested in nor participate in sex (Rheaume & Mitty,

2008) and/or that the idea of them engaging in sexual activity is disgusting and unnatural (Bentrott & Margrett, 2011). However, the desire for sexual contact and closeness can last a lifetime (Rheaume & Mitty, 2008). The denial of senior sexuality by society, including healthcare personnel, and the reality of continual sexual behavior later in life, leaves seniors in a vulnerable position related to the spread of STIs including HIV/AIDS, often without their knowledge.

Purpose of Project

The purpose of this project was to develop a grant to fund the implementation of an educational program for healthcare professionals (e.g., physicians, nurses, and social workers) on older adult sexuality and sexual health. The proposed program aims to inform healthcare professionals about the increased risks, and transference of STIs within the older adult population, as well as provide them with tools that will help increase their own comfort levels when engaging in sexual education discussions with their older adult patients.

This educational program will take place over a year and be implemented at Kaiser Permanente facilities throughout Southern California. In fact, Kaiser has 106 facilities within their Southern California region (Kaiser Permanente, 2014). These facilities include medical offices and hospitals in which primary care physicians are seen. The program will take place up to three times a week, changing office locations each time. By doing so, staff at each of the 106 locations will have the opportunity to partake in the educational program, without having to leave their facility. This will allow for the maximum number of healthcare providers to be in attendance.

Definitions of Terms

S*exually transmitted infections (STIs):* Are defined by the CDC (2014a) as diseases or infections that are passed from one person to another through sexual contact. These diseases include chlamydia, gonorrhea, genital herpes, human papillomavirus (HPV), syphilis, and AIDS.

The CDC (2014a) also defines *HIV* as "a virus spread through body fluids that affects specific cells of the immune system, called CD4 cells, or T cells. Over time, HIV can destroy so many of these cells that the body cannot fight off infections and disease. When this happens, HIV infection leads to AIDS" (Definition of HIV).

Older adults/seniors: Persons 65 years of age and older, according to the American Psychological Association (2014).

Healthcare professional: For purposes of this project, physicians, nurses, and social workers will be targeted.

Relevance to Social Work and Multiculturalism

It is the job of social workers to improve the lives of the populations with whom they are working. The National Association of Social Workers (NASW) Code of Ethics states:

> Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability. (NASW, 1999)

Since STIs are present among all age groups, it is unethical to deny services and assistance based on these characteristics.

The Administration on Aging (2012) has shown that in 2011, 21% of people over the age of 65 identified themselves as members of one or more racial or ethnic minorities. Of these older adults, 9% identified as African American, 7% as Hispanic, 4% as Asian or Pacific Islander, less than 1% as American Indian, and 0.6% as biracial or multiracial. Although some of STIs are more prevalent in some ethnic groups than others, everyone is still at risk, regardless of their ethnicity. According to the CDC (2013), statistics show that African Americans have a higher rate of contracting chlamydia, gonorrhea, and syphilis than any other ethnic minority. Asians and Pacific Islanders prove to have the least amount of newly contracted STIs, followed by Caucasians, then Hispanics (CDC, 2013). If unprotected sex occurs or if needles are being shared, STIs are oblivious to race; all they see is a host to infect. As social workers, it is imperative that all ethnic groups receive the same amount assistance in order to prevent the spread of HIV/AIDS.

Finally, as social workers, it is essential to provide preventive services as early as possible. Since the older population is growing as the baby boomers age, it is vital that they are informed of the rise in STIs in their age group as well as educated about the signs and symptoms of STIs and their right to be tested. With greater education now, it is less likely that interventions will be needed later.

CHAPTER 2

LITERATURE REVIEW

An Aging Population

The U.S. Census Bureau (2014) reported that in 2013, the population of the United States had reached 316 million people. Of that 316 million, 14.1% or 45 million were over the age of 65, which is an increase of almost 5 million since 2010 and 12 times the number since 1900. As the population gets older, their need for resources increases. These resources include housing, medical services, transportation, and activities. At each stage within older adulthood, there are new challenges and strengths to discover, both medically and psychologically. The basic psychological needs of older adults can be examined based on various theories.

Theories of Aging

Throughout the years, theorists such as Sigmund Freud and Erik Erikson have developed theories of aging and the processes through which people reach older adulthood. Freud's (1923) theory was based on the early stages of psychosexual development, while Erikson (1963) focused on psychosocial development throughout a person's lifespan. Each theory provides a unique perspective on the psychological stages constituting the "normal" development of the 45 million older adults in the United States.

According to Freud (1923), the genital stage occurs during adolescence and is when young adults and teens begin to explore the idea of romantic relationships with

others. He stated that this stage continues throughout adulthood with the ultimate goal of balancing all aspects of life. Freud did not differentiate between adulthood and older adulthood, as did Erikson. Freud also discussed the various aspects of personality. He believed that there are three main components of the personality: the id, the ego, and the superego. The id is relevant to the topic of older adult sexuality as it is the component of the personality that includes the sex life and libido. According to Freud, the id is an unconscious and impulsive personality characteristic. It demands immediate gratification and experiences pain when it is not satisfied. Every person is born with an id, which perpetuates the need and desire for pleasure and sexual satisfaction. The id does not disappear during older adulthood but continues to look for gratification throughout life (Freud, 1923).

Freud's theory is dramatically different from Erikson's view of older adulthood. Erikson (1963) believed that at the age of 65, adults begin to look back on their lives and feel one of two ways. They may look back and feel fulfilled because of how their life has evolved and begin to accept death without fear or regret, knowing that it may happen soon. This satisfaction with one's life was conceptualized by Erikson as ego integrity. On the other hand, if older adults look back at their lives and feel unfulfilled or view themselves as a failure, they begin to feel a sense of despair as they believe that it is too late to fix what went wrong or to begin working in a new direction or toward a new goal (Erikson, 1963).

Erikson's (1963) stages of psychosocial development stopped at the eighth stage of development (ego integrity versus despair), which he stated takes place at about age 65. However, modern medicine is helping adults to live longer, fuller lives well into their

80s and 90s. If based solely on the work of Erikson, older adults would reflect on their life with a sense of fulfillment leaving feelings of peace and wisdom during their end of life stage, or they would find themselves in despair because they are not happy with their life accomplishments. Research has shown that older adults continue to seek out love, relationships, companionship, and friendships regardless of the level of satisfaction with their lives (Lindau & Gavrilova, 2010).

As alternatives to the theories of Freud and Erikson, Cumming and Henry (1961) developed the disengagement theory of aging and Havighurst and Albrecht (1953) developed activity theory as it pertains to aging. The theory of disengagement suggests that as adults age, they begin to withdraw from certain roles, social events and relationships (Cumming & Henry, 1961). This suggests that the older the adult, the less time he or she spends fulfilling roles and engaging with others in the community. Cumming and Henry believed that the disengagement of the older adults is both normal and should be expected. They also believed that the disengagement of these older adults positively affected the community, as it minimized the disturbance to the community once the older adult finally passed away (Cumming & Henry, 1961). Disengagement theory and Erikson's stage of ego versus despair are compatible in that the older adult is viewed as withdrawing from society and beginning to contemplate either satisfaction or despair with his/her life. Disengagement theory further suggests that sexuality in later life is unusual, since the role of sexual partner is no longer relevant.

Conversely, activity theory suggests the opposite of disengagement theory. Havighurst and Albrecht (1953) stated that aging should be focused on continued well-being and the creation of new experiences. They believed that each role, relationship, or

activity that is lost due to old age should be replaced with a new one that increases current happiness and well-being. They wrote that disengagement is not natural, nor does it encourage positive or successful aging (Havighurst & Albrecht, 1953). The notion that older adults continue to seek these new roles, relationships, and activities parallels research by Lindau and Gavrilova (2010) showing that older adults continue to seek out love, intimacy, and sexual partners. Researchers have also shown that it is not uncommon for older adults to participate in weekly sexual activity (Janus & Janus, 1993), which shows that partners are being sought after to fulfill the roles of spouses who have previously passed.

Sexuality in Older Adulthood

There is a common belief that older adults do not have sex; however, according to Fisher (2010), most of them view sex and intimacy as important parts of life and often feel as though it is critical for a good relationship. Fisher also maintained that older adults have become more open minded in their attitudes toward sex, stating that they are approving of sex outside of marriage and accepting of the view that sex is not only for procreation.

Data has shown that 54% of men and 21% of women between 70 and 80 years old have had intercourse within the last year and that 25% of older adults were participating in intercourse more than once a week (Hillman, 2008). It also has been stated that many older adults engage in a wide spectrum of sexual activities well into their 90s (Letvak & Schoder, 1996). This spectrum includes masturbation, foreplay (e.g., kissing and caressing), and vaginal intercourse (Schick et al., 2010).

Research has shown that intimate partnerships have positive health benefits among older adults (Cohen & Janicki-Deverts, 2009). These health benefits include increased longevity, as well as an increase in positive health behaviors, increased relaxation, decreased stress, decreased pain sensitivity, improved cardiovascular health, and decreased depression (Brody, 2010; Davison, Bell, LaChina, Holden, & Davis, 2009; Heiman et al., 2011). Intimacy has also been found to be related to increased self-esteem and relationship satisfaction.

Medical Advances and Sexuality in Older Adulthood

The ability to have sex later in life is often due to pharmaceutical drugs. According to the Food and Drug Administration (FDA; 2013), sildenafil, otherwise known as Viagra, was introduced to the public on March 27, 1998. It was marketed by the FDA as the very first oral pill to treat impotence, an erectile dysfunction which affects millions of men in the United States (FDA, 2013). Within the first 3 months of its availability to the public, Viagra earned over $400 million in sales, with more than 2.9 million prescriptions filled (Keith, 2000; Lamberg 1998). The number of Viagra prescriptions continued to rise over the next 3 years. By 2001, there were more than 14 million prescriptions being written for men over the age of 60 (Wysowski & Swann, 2003).

In women, hormone replacements such as estrogen have dramatically increased the desire for sexual activity (Ambler, Bieber, & Diamond, 2012). Estrogen promotes the pelvic resiliency needed for comfortable intercourse by women (Ambler et al., 2012). As women age, their estrogen levels decrease; even small doses of hormone replacement, mainly estrogen cream, can increase lubrication of the vagina, thus decreasing the pain

that might be contributing to the lack of sexual desire (Ambler et al., 2012). If lubrication is increased and pain is decreased, older adult women are more likely to want to participate in sexual activity. However, the growing popularity and accessibility of both Viagra and estrogen therapy have also increased the opportunities for new STIs within the older adult population.

Risk Factors for Sexually Transmitted Infections Among Older Adults

Older adults often believe that STIs are a problem for young people and that they are not at risk. These older adults are taught that sex and sexual behaviors are for the young and beautiful, while sexuality among older people is shameful, disgusting, or nonexistent (Bitzer, Platano, Tschudin, & Alder, 2008; Hillman 2008). The denial of senior sexuality by society, including healthcare personnel, along with the reality of continual sexual behavior later in life, leaves seniors in a vulnerable position related to the spread of STIs.

There was a study conducted in Ohio, which consisted of 50 older adults living in a densely populated urban county. Although the percentage of members was not revealed, the study reported that many of the participants admitted to engaging in at least one of two risky behaviors that put them at risk for STIs, these being having sex with prostitutes and drug use (Small, 2010). The participants were over the age of 50 and from a variety of ethnic groups. The high-risk behaviors of having sex with prostitutes and drug use were found to be more frequent at the beginning of the month when social security checks are disbursed (Small, 2010). Some of the older adults in this study claimed that they were still doing at their current age whatever they did when they were

younger, including disbursing drugs within subsidized senior housing facilities (Small, 2010).

In addition to the social factors of denial and stigma associated with sex and the elderly, other factors contribute to their increased risk of infection. Biological factors include a decline in immune system functioning and thus the ability to fight disease. In addition, the thinning of the vaginal walls in women may lead to easier tearing and rupture, thus increasing their susceptibility to infection (Letvak & Schoder, 1996; Levy-Dweck, 2005).

Research has found that older men have a greater desire for sex, participate in sex more frequently, and have more sexual partners than older women (Smith & Christakis, 2009). Older men have higher motivation for seeking out a new partner once they have lost a spouse and the new partner is often younger than themselves, which puts them at an increased risk as well (Smith & Christakis, 2009).

HIV/AIDS and Other Sexually Transmitted Infections (STIs)

Syphilis and chlamydia are the most frequently reported STIs among adults over the age of 65 (CDC, 2014a). According to the CDC (2012), there was a 5% increase from 2009 to 2010 in the number of HIV infections in adults over the age of 55. The number of new STIs contracted by older adults has also been gradually increasing from 2008 to 2012 (CDC, 2012). The CDC reported that per 100,000 cases, the number of older adults who contracted syphilis in 2008 was 563; however, in 2012 it was 737; the number of those who contracted gonorrhea in 2008 was 3,277 and in 2012 it was 3,874. The largest growth in new STIs in the older adult population was 2,133 cases of chlamydia contracted in between 2008 and 2012 (CDC, 2012).

Although some STIs, such as syphilis or chlamydia, can be treated and cured through medication, there are others that cannot and are thus, more dangerous once infected. If a viral STI is contracted, such as herpes/genital warts and HIV, there is no cure (Freedom Network, 2005). Older adults are more susceptible to HIV infection and experience a higher rate of death due to it, as their bodies are physically less able to battle the infection and they are less likely to get tested for it in the first place (Levy-Dweck, 2005).

Common STIs, if left untreated for too long, can have lasting effects on the body, especially in older adults. STIs such as chlamydia and gonorrhea are often asymptomatic, but can lead to pelvic inflammatory disease and can also facilitate transmission of an HIV infection; can cause damage to internal organs, the brain, nerves, and eyes; and may cause death (CDC, 2014a). Similarly, certain strains of the Human Papillomavirus (HPV) can lead to cervical cancer, while Hepatitis-B attacks the liver and may cause liver cancer or death (CDC, 2014a). Because many STIs show few or no symptoms or are confused with other illnesses, the only way to identify them is through regular testing.

HIV/AIDS

In order to contract or transmit HIV, bodily fluids must be exchanged. These bodily fluids include blood, semen, pre-seminal fluids, breast milk, vaginal fluids, and rectal fluids. The most common methods of transmitting these bodily fluids are through activities such as unprotected sexual intercourse, sharing needles during drug use or blood transfusions, childbirth, breast feeding, or contact between broken areas of skin (U.S. Department of Health & Human Services [USDHHS], 2009). There are many

misconceptions about how HIV is transmitted. It is not spread through air or water. It cannot be transmitted through any type of casual contact (e.g., shaking hands, hugging, sharing dishes, or from toilet seats), nor can it be passed through saliva, sweat, or tears (USDHHS, 2009). Many falsely believe that HIV can be passed through insects such as fleas, ticks, or mosquitoes (USDHHS, 2009).

An HIV infection attacks cluster of differentiation 4 (CD4) cells within the immune system (National Institute of Health [NIH], 2013). Once the virus is attached to a CD4 cell, it injects the virus into it and begins the process of replicating itself within the body (USDHHS, 2009). Once the CD4 cells have been injected with the virus, they are no longer able to fight infections and certain types of cancer (NIH, 2013). Once infected with HIV, there are several stages that occur within the body. The first stage is the acute stage.

The acute stage happens within 2 to 4 weeks after being infected with HIV. During this stage, most people develop very severe flu-like symptoms (NIH, 2013). These symptoms are known to include fevers, sore throats, swollen glands, rashes, muscle and joint pain, and headaches. These symptoms are said to be the natural response of the body when it comes in contact with HIV. The acute stage is when large amounts of the virus are being replicated and produced within the body. Since the viral load is so high during this stage, the possibility of infecting others is increased. It is suggested that extra precautions be taken to reduce the risk of transmission, as well as taking antiretroviral therapy (ART; NIH, 2013).

The clinical latency stage follows the acute stage. During this stage, those who are infected with HIV experience no symptoms (NIH, 2013). It is in this stage that the

virus continues to multiply, however at low levels. ART increases the chances of remaining in this stage for up to 10 years; however, some people progress through the clinical latency stage at a faster rate. Although there may be decreased symptoms in this stage, the virus can still be transmitted to others. The use of ART does decrease the risk of transmission; however, it is still possible when the proper precautions are not followed (NIH, 2013).

A diagnosis of AIDS is the final stage of the infectious process, during which time life expectancy is typically 1 to 3 years without treatment (USDHHS, 2009). The body's immune system has been badly damaged, which has left it susceptible various types of cancers and opportunistic infections. There are two ways to determine if the body has progressed into the AIDS stage: (1) if one or more opportunistic infections have occurred and (2) if the CD4 cells fall below 200 cells per cubic millimeter of blood. If ARTs are taken, and a low viral load is maintained, it is possible to continue a normal life and live a normal lifespan with the possibility of never progressing to AIDS.

Syphilis

Syphilis is transmitted through direct contact with a syphilis sore (CDC, 2014b). Syphilis sores can be located in a person's mouth, on the lips, on the penis, or in and/or around the vagina, as well as the anus and rectum. Syphilis can also be spread between an infected mother and her unborn child (CDC, 2014b). Syphilis is frequently mistaken for other illnesses. When first infected, a painless syphilis sore may be mistaken for an ingrown hair or a harmless bump (CDC, 2014b). Within the first year, the infected person is at the highest risk of transmitting the infection to a sexual partner. Syphilis is easily cured with the right antibiotics and is easily detected through a blood test.

Treatment does not decrease the chances for re-infection nor does it correct any damage to the body (CDC, 2014b).

An early case is generally when a person has been infected for a year or less, which is known as the primary stage. The primary stage begins immediately after a person has been infected. It usually consists of a single sore, although it is possible to have multiple sores, around the area in which the syphilis first entered the body (CDC, 2014b). These sores are generally painless and may go unnoticed. They typically last 3 to 6 weeks and heal on their own with or without treatment (CDC, 2014b). It is during this stage that treatment is crucial in order to prevent the infection from moving into the secondary stage.

It is within the secondary stage that the infection begins to become more apparent and noticeable. A rash will begin to develop around the same area in which the sores appeared in the primary stage (CDC, 2014b). The rash will often present itself several weeks after the sore has healed (CDC, 2014b). The rash is typically red/reddish brown, with rough spots that generally either do not itch at all or are not bothersome (CDC, 2014b). Other symptoms include fevers, sore throats, headaches, weight loss, hair loss, swollen lymph glands, fatigue, and muscle aches (CDC, 2014b). These symptoms may last over a wide range of time but will disappear whether or not medical treatment has been sought. Without medical treatment, however, the infection moves into the latent/late stages.

During the latent stage of the syphilis infection, all symptoms experienced during the primary and secondary stages have ceased (CDC, 2014b). Symptoms re-appear during the late stage, sometimes developing 10 to 30 years after the initial infection if it is

left untreated (CDC, 2014b). The symptoms of the late stage are much more destructive than those of the first two stages. The symptoms include paralysis, numbness, difficulty with the coordination of muscle movement, blindness, and dementia. Late stage symptoms begin to damage the body's internal organs and can result in death (CDC, 2014b).

Gonorrhea/Chlamydia

Gonorrhea and chlamydia can be contracted by both men and women as long as they are sexually active. The symptoms and treatment of gonorrhea and chlamydia are the same. For many men, there are often no symptoms of either infection, which means that they can go untreated for long periods of time. When men do have symptoms, they generally include a white/yellow discharge from the penis, a burning sensation during urination, and (less commonly) painful or swollen testicles (CDC, 2014c).

It is more difficult to tell when a woman has been infected with gonorrhea or chlamydia, as the symptoms often appear to look like a bladder or yeast infection. These symptoms include increased vaginal discharge, vaginal bleeding between regular periods, and painful or burning sensations during urination (CD, 2014c). Rectal infections are common in both men and women as well. The symptoms of rectal infections include anal itching, discharge, soreness, and bleeding and pain during bowl movements (CDC, 2014c).

Similar to syphilis, gonorrhea and chlamydia can be treated through prescribed medication. Left untreated, either can cause permanent damage, such as spreading to the blood or joints, as well as increasing the chance of contracting or transmitting HIV. In

women, these STIs can cause pelvic inflammatory disease (CDC, 2014c). In men, they can cause pain in the tubes attached to the testicles (CDC, 2014c).

Herpes

Herpes is caused by two types of viruses, herpes simplex virus-1 (HSV-1), typically known for causing cold sores, and herpes simplex virus-2 (HSV-2), typically known as genital herpes. Both viruses can be contracted by both men and women; however, HSV-1 is typically caught by children, while HSV-2 can be contracted by anyone who is sexually active. According to the American Academy of Dermatology (AAD; 2014), approximately 20% of all sexually active persons in the United States are infected with HSV-2. There are certain factors that put people at a greater risk for catching HSV-2 than others: being female, previous STI, weakened immune system, having sex at a young age, and having many sexual partners.

Both herpes viruses are spread easily through physical or other close contact with an infected person. The infected person does not necessarily have to have an open sore in order to infect another person, which is referred to as "asymptomatic viral shedding" (AAD, 2014). HSV-1 is generally passed to others through contact such as kissing, sharing certain objects (e.g., razors, utensils, and chapstick), or touching someone else's skin. HSV-2 is generally contracted through sex, including oral sex (AAD, 2014). The difference between herpes and other infections such as chlamydia or gonorrhea is that once a person has been infected with the herpes virus, it never leaves the body and there is no cure (AAD, 2014). After the first outbreak, the virus transfers from the skin cells into the nerve cells and remains there forever (AAD, 2014).

Once the virus transfers into the nerve cells, it is dormant; however, it is possible for it be become active again (AAD, 2014). There are triggers that alert the virus into activation, including illness and the weakening of the immune system, stress, fever, sun exposure, surgery, and menstruation. Antiviral medication can be taken orally or intravenously. Although the antiviral medication does not cure or remove the virus from the body, it can alleviate symptoms and decrease the frequency and duration of outbreaks (AAD, 2014).

Human Papillomavirus

The National Institute of Allergy and Infectious Diseases (NIAID; 2010) stated that there are approximately 6 million new cases of the human papillomavirus (HPV) each year in the United States and that at least 20 million are infected. The HPV is easily caught, as there are over 100 types of the virus, most of which are said to be harmless (NIAID, 2010). There are approximately 30 types that are of concern. These 30 types are transferred through sexual contact with an infected person, and although some are low risk, others put both men and women at high risk for various cancers in the cervix, vagina, vulva, penis, or anus areas (NIAID, 2010).

The HPV can cause genital warts, which are highly contagious. If none are present, an abnormal pap smear is a possible sign of infection in women. It is important for women to get annual pap smears to check for the HPV virus. The longer it is untreated, the higher the possibility of contracting a form of cancer.

Lack of Knowledge and Need for Education

In general, older adults know less about HIV/AIDS and other sexually transmitted diseases than younger age groups, mainly because the elderly have been largely neglected

by those responsible for education and prevention messages (NIH, 2009). Research has shown that sex education, as well as preventative programs, have historically targeted and have been made readily available to teens and young adults, as well as high-risk groups such as gay men and drug users (Karlovsky, Lebed, & Mydlo, 2004). Older adults have seldom been a part of the targeted population as many professionals do not believe that they are significantly at risk. Only 15 of 50 state health departments in the United States are known to provide HIV/AIDS publications targeted specifically toward older adults (Heath, 2000).

According to the CDC, in 2007, the guidelines for the U.S. Preventative Services Task Forces HIV screenings were revised (CDC, 2012). According to these revisions, clinicians were recommended to provide HIV screening for all adolescents and young adults and for those who presented an increased risk (CDC, 2012). There were no recommendations, however, for any type of screening or assessment on older adults.

In one study of adults over the age of 50, the results showed that 95% of the participants had never been tested for HIV or other STIs, while 92% had never used condoms (Inelmen, Gasparini, & Enzi, 2005). In another study, consisting of a focus group of 14 individuals over the age of 65, the participants stated that they received most of their information regarding sexual issues from television and radio, more specifically "those doctor shows where doctors give general medical advice" (Slinkard & Kazer, 2011, p. 345). Researchers have discovered that many older adults avoid seeking advice regarding their sexual health (Slinkard & Kazer, 2011). They often view themselves as lacking in knowledge when it comes to their own sexual problems, which may cause them to feel uncomfortable or embarrassed when discussing sex. In addition, most

believe that there is a stigma attached to older people engaging in sexual activity, of which magnifies their embarrassment (Taylor & Gosney, 2011). In a study conducted in Chicago, only 38% of older adult men and 22% of women had discussed sex with their primary physician since the age of 50 (Lindau et al., 2007).

In another study conducted in the United Kingdom, 22 general practitioners and 35 nurses were interviewed to determine the barriers to sexual health discussions with their older adult patients. The providers reported their main barriers to be "differences between the patient and the provider, specifically related to gender, ethnicity, sexual orientation, and age discrepancies" (Gott, Galena, Hinchliff, & Elford, 2004, p. 530). In a survey conducted in the United States, 163 females over the age of 65 were asked about their feelings when discussing their sexual health with their healthcare professional. They stated that although they did not want to be the ones to initiate a discussion of sexuality with their healthcare provider, they were open to having the discussion if brought up by their doctor or nurse first (Nusbaum, Singh, & Pyles, 2004). One of the participants in this study shared that none of her physicians had ever asked questions or discussed anything with her pertaining to sex. She stated that "they look at the white hair and stopped asking" (Slinkard & Kazer, 2011, p. 345). When asked what the provider did to help them learn about sexually transmitted diseases, the nearly unanimous response was "nothing." This lack of prevention education is a growing concern as these adults continue to age and continue to participate in sexual activity, largely unaware of the health risks involved.

Current Successful Educational Programs

This writer conducted research to find educational programs that have been evaluated and shown to be effective in increasing healthcare providers' knowledge and comfort levels when discussing sex with older adults patients; however, the search was unsuccessful. The educational programs located in the literature were directed specifically at the older adults themselves, with an emphasis on techniques for having a healthy sex life or living with and managing HIV.

In 2010, Widener University implemented a consortium focused on the sexual needs of older adults within the Bronx community of New York (Roberts, 2013). This was an outreach effort within their human sexuality studies program. The consortium consisted of various types of professionals throughout the nation who provided services including sex education, counseling, and resources for the older adults themselves, as well as their families and/or caregivers (Roberts, 2013). The older adult members of the consortium also offered their expert advice to the professionals. Trainings, consulting, and policy development were conducted as well. The founder of the consortium worked with several assisted living facilities to develop policies to assist them in dealing with residents who develop intimate relationships with other residents (Roberts, 2013).

The National Center for Gerontological Social Work Education offers teaching modules on their website, including those containing information on various aspects of sex and sexuality among older adults (Council on Social Work Education [CSWE], 2014). These modules include topics such as myths about sexuality, contributing factors to sexual dysfunction, and facts on sex after 60, as well as sexual response phases, older adults and HIV/AIDS, and LGBT baby boomers (CSWE, 2014). Along with these

topics, tools are available which are helpful when facilitating educational programs. These tools include sexual health assessments, quizzes, video recommendations, discussion prompts, homework suggestions, sample test questions, and in-class exercises and discussion guides, as well as a valuable reference and resource guide. These modules are frequently used by professionals, such as educators and social workers, but are not considered training material, but rather are viewed as informational for the targeted professionals. Several materials within the modules are appropriate for inclusion in the proposed program.

Conclusion

As shown, the population of older adults has increased and will continue to increase over the next few years. Research has shown that these older adults are seldom receiving proper information or medical treatment regarding safe sex practices and awareness of their risk for STIs. Physicians seldom address sexuality with them and many do not know the signs and symptoms of STIs. This is an increasingly significant problem as the rate of STI transmission among older adults continues to rise. In order to prevent the continued increase of STIs in older adults, they need to be educated and tested by their healthcare providers. Educational programs for healthcare professionals are an important step in the process of enhancing awareness and thus prevention among these older adults.

CHAPTER 3

METHODOLOGY

Potential Funding Sources

In order to begin searching for potential funders for this grant, the writer was able to utilize multiple sources and speak to several experts to get advice. These experts made suggestions that identified funding sources from federal, state, and local governments, as well as private funders. There were also suggestions of places not to attempt to go to in order to find funders. Once these suggestions were made and a list was compiled, an internet search was utilized in an effort to gain more knowledge about each of the funders suggested. The writer utilized the Google.com search engine to look up information and guidelines for writing grants. The grant writer was informed that local nonprofit libraries were unable to support individuals looking for grant funders, as they are mandated to assist organizations only. Instead, the writer continued to look up the various websites from the suggestions provided by the experts consulted.

The first option was Grants.gov, which is a website managed by the U.S. Department of Health and Human Services. Grants.gov describes over 1,000 grant programs awarding over $500 billion each year as it serves as a centralized site for grant seekers to learn about and apply for federal funding. It allows a researcher using key words to sort through all grants that may be of relevance and apply for funding directly rather than submit a paper application. This is fast and direct. While utilizing

Grants.gov, the writer used key terms such as *older adults*, *sex education*, *STIs*, and *healthcare professional education*. Many of the available grants revealed during the search were not appropriate for the target population of older adults. Many of the fundable sex education grants located were directed toward other populations, such as teenagers and gay males.

The California Wellness Foundation was another possible funding source. Their mission is to improve the health of all Californians, with the majority of their grant money being allocated based on community needs, which are determined by community partners (California Wellness Foundation [CWF], 2014). Their main goal is to improve the lives and health of the populations who are underserved and in need (CWF, 2014). Sexual health and education aimed toward the older adult population fit their parameters; however, at the time research was conducted, they were not accepting applications for funding until the fall season. Thus, this source was eliminated as a potential funder.

The John A. Harford Foundation, whose mission is to help improve the health of older adults, was examined at as a possible funder as well. The Harford Foundation bases it funding on three main criteria. The first is that the program must focus on the older adult population (John A. Harford Foundation [JAHF], 2014). The second is that it must include geriatric expertise and the third is that is must have a potentially national impact, as well as carry a potential for leveraging other initiatives and funding sources. In order to be considered for funding by the Harford Foundation, a one to two page letter of intent must be submitted which will be reviewed by staff members and outside reviewers. Within this letter of intent, the writer must include the purpose and activities of the proposed program, qualifications for funding, estimated cost of the program, and a

time frame (JAHF, 2014). Although the Harford Foundation was a feasible option for funding, after continued research, the writer felt as if there would be a better option. This was the Archstone Foundation, based on their commitment to improving the lives of older adults specifically within the Southern California region.

Archstone Foundation

The Archstone Foundation was established in 1985 after a nonprofit health maintenance organization combined with a for-profit corporation. It is a private foundation that has become a nonprofit grant making organization. The Archstone Foundation's main focus is on the broad issues of health and healthcare delivery. The mission of the Archstone Foundation is to prepare society to meet the needs of the aging population. Over the last 20 years, this foundation has funded over 800 grants, with over $86 million awarded. The foundation accepts unsolicited letters of intent or inquiry on an ongoing basis throughout the year and there are no deadlines to meet in order to apply for funding. Priorities are given to those who are applying within the Southern California region. After the letter of intent has been read and it is determined that the funding request falls within the priorities and guidelines of the foundation, the submitting person/organization will be asked to submit a full proposal (Archstone Foundation, 2014a, 2014b).

The full proposal is required to be no more than eight pages long and is to be written in the third person. Written within the proposal, 16 bullet points of information are required. The application is to be submitted by regular mail and will be reviewed by the Review Committee. The Review Committee meets only once per quarter and refers its top-rated proposals to the Board of Directors. Like the Review Committee, the Board

of Directors meets quarterly. Once the proposals have been submitted, the expected time frame for funds to be disbursed is within 4 months (Archstone Foundation, 2014c).

Needs Assessment

A comprehensive literature review was completed in order to determine the need for the proposed sex education program for healthcare professionals. The literature review showed that healthcare professionals often fail to ask questions about their older adult patients' sexual activity and sexual health due to a variety of reasons, such as lack of knowledge, misconceptions about older adult sexuality, and feeling uncomfortable. Letvak and Schoder (1996) suggested that in order for healthcare professionals to be able to recognize and treat STIs in the older adult population, they must be comfortable enough to obtain an accurate sexual history from the patient.

The research also explained that there is a substantial gap in the provision of sex education classes for the older adult population (Pardini, 2014). Many older adults in the current century missed out on sexuality instruction in the schools and sexuality discussions with parents and friends. They grew up in an era during which sex was seldom talked about in schools, in homes, or within social groups. It was not until 1940 that there was a strong push from the U.S. Public Health Service toward sex education in schools. The response to what they considered to be an "urgent need" was a nationwide family life education program, as well as five pamphlets known as the Sex Education Series, printed by the American School Health Association (Pardini, 2014). The children and teens of these years were done a disservice because these pamphlets were the primary sources of sex education in the 1950s and 1960s but contained no information on the transmission and prevention of STIs (Ebscohost, 2014). Many states considered

contraceptives illegal at that time as well, so condoms were seldom used. Instead, what they were taught in the 1950s were gender role expectations. Part of their sex education was to learn that a woman stayed at home, cooked, cleaned, and took care of her husband as well as her children (Ardinger, 2012). As the 1960s approached, one would think that significant changes would be made in sex education materials; however, people did not begin to see a change until the years leading into the 21st century. It was at that point that sex education materials began to reflect changes in the view that women were expected to stay at home and raise children and to include the fact that they were joining the workforce and engaging in successful careers (Ardinger, 2012). It was not until the 1980s and the beginning of the HIV epidemic that sex education was offered in 90% of schools (Ebscohost, 2014).

The grant writer also co-facilitated a sex education class with a group of older adults within a nursing facility. There were 25 participants who participated in the class, which was assessed using a pre-test, post-test, one-group design. Based on the results of the pre-test, it was very clear that none of the participants knew what STIs are, how to contract them, how to prevent them, their symptoms, or how to treat them. The findings thus suggested that their physicians were not having conversations about sexual health with these older adults. It is the writer's goal to educate physicians and other healthcare providers on these issues in order to help reduce the spread of STIs within the older adult population.

CHAPTER 4

GRANT PROPOSAL

Executive Summary

The purpose of this project is to develop and implement an educational program for healthcare professionals (e.g., physicians, nurses, and social workers) on older adult sexuality and sexual health. The target population for this educational program is healthcare professionals who work with older adults (i.e., those who are 65 years old or older) as patients in a medical setting. The host agency for this program is Kaiser Permanente; therefore, participants will be medical staff of that organization. These professionals work in hospitals, clinics, and offices where they have access to older adult patients daily. The program will focus on the increase, risks, and transference of STDs within the older adult population, as well as provide participants with tools that will help increase their own comfort levels when engaging in sexual education discussions with their older adult patients.

The Archstone Foundation's mission is to prepare society to meet the growing needs of the older adult population. A major need of this population is education about healthy sexual behaviors in order to reduce the spread of STIs, including HIV/AIDS. This would provide a safer future for older adults, along with lower medical costs for society. Healthcare professionals are in need of greater awareness of older adult

sexuality, as well as the skills required to provide education on this topic and thus promote health aging.

Host Agency

The Kaiser Permanente Foundation will oversee the management of the program. Kaiser Permanente was established in 1945 and provides a wide variety of services to all demographic groups (Kaiser Permanente, 2014). They have 656 facilities throughout the country, including hospitals, vision centers, and medical offices, along with behavioral health centers and many more. Working within the 656 facilities are 17,425 doctors/ physicians and 48,701 nurses (Kaiser Permanente, 2014). The proposed program is designed to begin throughout the 106 Southern California locations, but it is hoped that it could be extended to other areas with further funding.

Kaiser Permanente has a long history and a solid record of high-quality patient services. They are clearly a credible organization, thus assuring the successful implementation of the proposed program.

Background Literature

The National Campaign to End Teen and Unplanned Pregnancy evaluated various sex education programs and concluded that with these programs in place, 40% of teenagers have increased condom and/or contraceptive use, while 60% have reduced the number of times they participated in unprotected sex (Kirby, 2007). This shows that sex education programs for teenagers have been successful in helping them make better choices that decrease their risks of contracting an STI. Similarly, older adults need to be educated about safe sexual behaviors, along with the risk of contracting and spreading STIs.

With a 9.7% increase in the older adult population within the last 10 years (U.S. Census Bureau, 2012) and the knowledge that older adults are continuing to live a healthy sex life well into their nineties (Letvak & Schoder, 1996), the need to address sexual health with this population is becoming more apparent. However, the question of responsibility when it comes to educating older adults on sex and sexual health can become a guessing game. They are no longer in the age range that would allow them to be educated in school, and when they were in that age range, sex education was not promoted. They were typically provided with simple pamphlets that they were not required to read. These pamphlets did not provide enough information that would promote a healthy sex life 60 or more years later.

Notably, Inelmen, Gasparini, and Enzi (2005) studied 50 older adults and found that 95% had never been tested for STIs. They are not in a high-risk category for STIs, such as drug users, gay men, and young adults (Karlovsky et al., 2004). Moreover, old adults who visit their primary care providers regularly are seldom asked about their sexual health (Slinkard & Kazer, 2011). Many primary care providers find it embarrassing to discuss sex with a patient who might be in the same age range as their parents. Yet, this is this logical place to provide such discussions and thus the best care possible.

Goals, Objectives, and Outcomes

Goal 1: Increase the knowledge of healthcare professionals regarding older adults and their sexuality.

Goal 2: Increase the comfort levels of healthcare professionals when discussing sexual health with older adults.

Objective 1: Two or three sessions will be held per week during months 3 to 11, depending on holidays and facility closure days.

Objective 2: A minimum of 20 healthcare professionals will attend each of 106 educational sessions.

Objective 3: The program will educate a minimum of 2,100 healthcare professionals throughout the year.

Outcome 1: Each healthcare professional will demonstrate knowledge of sexuality, sexual behaviors, and sexual health among older adults by scoring 95% or higher on the post-test.

Outcome 2: At least 95% of the healthcare professionals will indicate high comfort levels when discussing sexual health with older adults by scoring 5 on a 1-5 point scale included in the post-test.

Program Description

Each session of the program will take place in a different Southern California Kaiser Permanente facility. A room will be provided by Kaiser Permanente in each of these facilities and will be set up for a minimum of 20 participants. The program will be 90 minutes long and will be interactive, consisting of information provided through PowerPoint presentations, as well as case studies, vignettes, and role playing. PowerPoint outlines will be provided so that participants can take notes. The attendees will also have the opportunity to practice their skills on each other in order to gain confidence in interacting with their patients. Vignettes will be provided for group discussion, enabling attendees to consider how they would respond in certain challenging situations, allowing ample time for feedback and the expression of differing opinions.

The attendees will also have a chance to break into small groups or pairs to role play situations they may face. The participants will be able to ask questions, voice their concerns, and provide examples to the group in order to facilitate group discussion.

Specific topics will include the following: sexuality among older adults, their lack of knowledge, medical advances, factors increasing their risk, and what can be done to prevent the future spread of STIs. Once the session has ended, the presenter will remain on site for several minutes to answer further questions and/or clarify information.

Program Evaluation

While implementing this educational program, process and outcome data will be gathered throughout the year. To begin each session, all attendees will be required to sign in and indicate their job title (e.g., nurse or physician). A brief instrument will be developed for the purpose of testing the participants' knowledge and comfort levels prior to the program and again at its conclusion.

In order to determine whether the material was presented in such a way that the participants were able to learn and feel comfortable, they will be given a satisfaction survey to complete at the conclusion of the session. This survey will give the participants the opportunity to rate the effectiveness of the content and delivery, as well provide suggestions for improvement.

The project manager will review the findings of the satisfaction survey after each session. The project manager will also summarize the findings and prepare interim and final reports to submit to the Archstone Foundation.

Risk Analysis

Although the risks are perceived as minimal in the implementation of this educational program, one challenge might involve scheduling. The healthcare professionals must be relieved from their usual work activities in order to attend the program. The best day and time for the program would need to be determined with administrators at each facility. To enhance participation, advertisements will be made far in advance of the program.

Timeline

Month 1:

Hire project manager.

Develop schedule with each facility to determine date and time for each session.

Advertise program through flyers and email announcements.

Month 2:

Develop curriculum and all materials.

Create pre/post-tests and satisfaction survey.

Purchase equipment and other materials needed for sessions.

Secure rooms, tables, and chairs at each facility for each session.

Months 3-11:

Program implementation (two or three sessions per week).

Ongoing curriculum revision as needed.

Preparation of interim report (Month 6).

Month 12:

Final program evaluation.

Preparation of final report.

Budget Narrative

The total projected budget for this grant is $144,000. This amount is needed to fund the development and implementation of the proposed program for one year. The proposed program costs include personnel costs, direct and indirect operational costs. A detailed account of the proposed program budget may be found in the appendix section.

Personnel Costs

Program Manager: This position requires a Masters of Social Work (MSW) degree. The program manager will be responsible for all aspects of the development and implementation of this program. This person will be responsible for developing the educational curriculum, including all handouts, vignettes, and role play scenarios, as well as the evaluation measures. This person will also be responsible for organizing all sessions and presenting the material. The program manager will be responsible for data collection and analysis and preparation of reports to the funder. This is a full-time position, compensated at $60,000 per year.

Direct Program Costs

Refreshments: refreshments will be provided for the participants at each educational session. Approximately $50 has been allocated for each session, totaling $5,300 per year.

Office Supplies: Office supplies include paper, pens, paper clips, staplers, and folders. There is $200 a month allocated for this, with paper for the printing of educational materials the majority of costs in this category.

Equipment: There has been $2,400 set aside for program equipment which includes $1,000 for a laptop in order to show the presentation, $1,000 for a projector to hook up to the laptop, and $400 for a printer.

Telephone: A total of $1,200 per year has been allocated for a cell phone to allow the program manager to access email, text and voice messaging, and GPS.

Printing/Duplicating: In order to be able to provide all the participants with copies of the PowerPoint outlines, vignettes, and role play situations, $500 per month or $6,000 per year has been allocated for printing purposes.

Travel: Approximately $5,000 per year has been allocated for mileage reimbursement and any other travel expenses. The program manager will be driving to several facilities that are over 100 miles away from his or her office and will be reimbursed at the California mileage reimbursement rate of $0.56 per mile.

In-Kind Contributions

Kaiser Permanente will provide a training or conference room for each of the sessions at approximately $100 per use, including tables and chairs for each session at approximately $100 per use. Utilities are estimated at $50 a month. Kaiser Permanente will also supply the program manager with an office for the year, costing $100 per month.

CHAPTER 5

LESSONS LEARNED

The process of developing this grant and completing this project allowed the writer to gain invaluable knowledge on this particular topic. This knowledge will be useful in the field of geriatric social work in the future. The writer first realized the need for the proposed program during her community projects class while in graduate school. The writer, along with four other students, was curious to know how STIs affected the older adult population. Through extensive research and an educational program provided in a nursing home, the group soon realized the need for these older adults to be educated on the topic of sexual health. Through two surveys, one completed by older adults and a separate one completed by healthcare professionals, it was evident by the responses that the older adults, on average, knew very little about STIs, while most of the healthcare professionals admitted to not asking about their older adult patients' sexual health. The group decided to learn more about how STIs were affecting the health of older adults, as well as the needs of this population. The more research that was conducted on the topic, the more obvious the needs became.

At this time, the writer developed the idea for the proposed program. The writer realized that it would be difficult to facilitate an educational program for a large number of older adults in an attempt to educate each person about the risks of STIs, what to look for, and how to prevent them. The writer then determined that by educating their

healthcare providers, they could provide this information and recommend testing for their older adult patients in a confidential setting, thus avoiding the discomfort older adults might feel when considering sexual matters in an educational group setting. This realization seemed reasonable as it was assumed that the majority of older adult patients visit their doctor at least annually. In conclusion, the writer wanted a way to help the intended beneficiaries, (i.e., the older adults); however, it became apparent that it would be easier and perhaps more effective to educate the healthcare professionals first since they in turn, could educate many older adults.

The process of writing this grant was much different from what the writer originally thought it would be. There were some aspects that were simpler than expected, while others were much more difficult and time consuming. The writer did not expect that the literature review would take as long as it did. Locating articles relevant to the program presented the most challenges. Few sources addressed STIs within the older adult population, which made the process more complicated. Trying to develop a good plan for time management was difficult during this process. The time needed for pieces such as the literature review threw off the writer's time table, based on the initially suggested due dates from her advisor, as it took much more time than expected.

The writer initially had reservations about writing the grant, but the components seemed to fall into place much more easily than expected. The overall goals of the program were fairly simple, as the writer had those in mind since the beginning. Identifying specific objectives and creating a time line that would ensure the fulfillment of the program's goals throughout each session, as well as the entire year, were a little more challenging.

Locating Potential Funding

Finding possible funders took extensive research as well. Originally, there were many that seemed like a possibility; however, after looking closely, they were found not to be appropriate for the target population or were interested only in programs that educated older adults on safe sex techniques in response to various health conditions. The proposed program is unique in that although the older adults are the indirect target population and the ones expected to benefit from the education, the healthcare professionals are targeted directly. They are the ones to implement the education and dialogue with their older adult patients.

The Archstone Foundation was chosen for two reasons. First, they fund programs with overall benefits for older adults but do not require them to be the direct target population. Second, they focus on Southern California, which is where the proposed program would be piloted.

In order to increase the likelihood of funding, the writer conducted extensive research on the topic. The literature review provided documentation of the increasing rates of STIs among older adults and the extent to which healthcare providers fail to address their sexual behaviors and safe sex practices. In addition, no other programs such as the one proposed here were located in the Southern California area.

Relevance to Social Work Practice

Due to the increase in cases of older adults contracting STIs within the United States, it is important to ensure that they are properly educated about ways to keep themselves safe. Having healthcare professionals who are not embarrassed to begin a dialogue about sexuality with them is essential to their health and safety. Implementing a

program that enables healthcare providers to feel more comfortable with such important discussions may reduce the spread of STIs in this population, thus reducing their need for treatment in the future.

There are currently many gerontological social workers who assist the aging population with numerous services. These services will most likely expand as the older adult population grows. By implementing the proposed program and helping to prevent the spread of STIs, the number of social workers needed to treat them might be reduced. Thus, they could be utilized for other essential services.

It is also important for social workers to address the attitudes of healthcare professionals and others by informing them that many older adults live active and healthy sex lives. Social workers are often the ones responsible for advocacy, so they would be the perfect group of people to begin breaking down the current ageist attitudes about older adults and sex.

There are many different types of social workers who work in and are experts in a variety of areas and services. The more skills one possesses, the more one can have an impact on clients and larger communities. Whether a social worker specializes in some form of direct service, program development, or project management, it is important to have at least a basic knowledge of evidence-based research, grant writing, and budgeting. By completing this project, the writer gained knowledge and skills in these areas. The more social workers attain a variety of skills, the more marketable they will be when employment opportunities are decreased due to budget cuts and the more services they can offer to vulnerable populations.

APPENDIX:

PROPOSED PROGRAM LINE ITEM COSTS

Expenses for 1 Year of Proposed Program	
Personnel	
Program Manager/MSW/FTE/100%	$60,000
Benefits and taxes @ 31%	$18,600
TOTAL PERSONNEL COSTS	$78,600
Direct Program Costs	
Snacks for Program Participants	$5,300
Office Supplies	$8,400
Equipment	$2,400
Telephone	$1,200
Printing & Duplicating	$6,000
Travel	$5,000
TOTAL DIRECT PROGRAM COSTS	$28,300
In-Kind Donations	
Rent	$10,600
Utilities	$5,300
Tables/Chairs	$10,600
Office for Program Manager	$10,600
TOTAL IN-KIND PROGRAM COSTS	$37,100
TOTAL PERSONNEL COSTS	$78,600
TOTAL DIRECT PROGRAM COSTS	$28,300
TOTAL IN-KIND PROGRAM COSTS	$37,100
TOTAL PROGRAM COSTS	$144,000
TOTAL AMOUNT REQUESTED	$106,900

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