5-2016

Health Care Matters: Perspectives from LGBT Older Adults

Mary Hoffman

St. Catherine University, hoff5696@stthomas.edu

Recommended Citation
Hoffman, Mary. (2016). Health Care Matters: Perspectives from LGBT Older Adults. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/598

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.
Health Care Matters: Perspectives from LGBT Older Adults

Mary S. Hoffman, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members
Mari Ann Graham, MSW, PhD, LISW (Chair)
Carol Ashwood, MSW, LICSW
Barbara Satin

The Clinical Research Project is a graduation requirement for the MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master’s thesis nor a dissertation.
Abstract

This qualitative research study was conducted to describe more clearly the barriers to care that LGBT older adults perceive in medical care settings and explore how social work professionals in these settings can effectively provide more culturally competent services. Previous literature indicates common concerns include: discrimination, receiving care from providers who are not LGBT-friendly, and the cultural competence of providers. This study interviewed 16 LGBT adults over age 62 to learn more about their perspectives and experiences using health care. The results indicated participants had concerns similar to what previous studies suggested. An unexpected finding was that participants overwhelmingly experienced positive experiences with health care providers and settings. Implications for social work practice are discussed at micro, mezzo, and macro levels. Recommendations for future research include: long-term care needs of LGBT older adults, hearing the perspectives LGBT older adults of color, transgender men, and bisexuals, the effects of long-term hormone use, reevaluating data collection methods to address the complexities of sexual preference, gender identity, and relationship structures. Future research efforts should include exploring the aging experiences of gay men who survived the AIDS crisis in the 1980s, and learning more about LGBT aging in rural areas and other geographic locations in the United States.
Table of Contents

Introduction………………………………………………………………………p.5

Literature Review………………………………………………………………p.9

Research Lenses………………………………………………………………..p.23

Methods…………………………………………………………………………p.25

Findings…………………………………………………………………………p.31

Discussion………………………………………………………………………p.47

References………………………………………………………………………..p.54

Appendices

- Appendix A. De-identified letters of approval……………………………p.61
- Appendix B. Consent Form…………………………………………………p.65
- Appendix C. Schedule of Interview Questions…………………………p.68
- Appendix D. Research Flier…………………………………………………..p.70
Acknowledgements

I would like to extend heartfelt appreciation to my family, friends, and an assortment of other individuals who provided me with inspiration, love, and support throughout this project. I also want to say thank you to Mari Ann Graham, Carol Ashwood, and Barbara Satin for providing me with invaluable guidance and mentoring. Additionally, I would like to acknowledge the following persons for their significant contributions during my academic career: George Baboila, Diane Bauer, Nancy Black, Monte Bute, Karen Carlson, Marilyn Cooper, Marci Gerulis-Darcy, Janet Enke, Teresa George, Jean Gregg, Kari Fletcher, Colin Hollidge, Jane Hurley-Johncox, Wesley Longhofer, Elizabeth McLemore, Rajean Moone, Jessica Peterson, Lance Peterson, Rebecca Phil, Tanya Rand, David Roseborough, Shelly Rottenberg, Eva Solomonson, Amanda Thooft, Jessica Toft, Elaine Walsh. Lastly, I would like to express my deep appreciation to the research participants of this project for their time and willingness to share their perspectives on health care.
An important factor in the growth of the aging population began in 2011, when members of the baby-boom generation (persons born from 1946 to 1964) began turning 65 (United States Census Bureau, 2014). According to 2012 statistics, 43.1 million people in the United States were over the age of 65. Projected figures indicate that by 2029, over 20 percent of the population will be over the age of 65. The increase of aging adult minorities is also projected to grow by 217 percent between 1999 and 2030 (Administration on Aging, 2014).

Although not reported by United States census data, the Williams Institute (2011) estimated nearly nine million persons identify as Lesbian, Gay, Bi-sexual, and Transgender (LGBT). The number of LGBT adults over the age of 50 living in the United States is estimated to be over two million (The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011). By 2030, figures for the LGBT older adult population are expected to double (SAGE, 2014). Gathering figures for the LGBT population is difficult because the U.S. census does not include options for indicating LGBT status; other complications including the following: the lack of standardized definitions about LGBT identities, varying methods of data collection, and concerns about stigma or discrimination that can result from survey participation (Williams Institute, 2011).

As sexual minorities and as aging adults, members of the LGBT population may have a higher likelihood of not accessing services due to perceived barriers to care linked to lifelong discrimination that may lead to increased risks for poorer health and well-being (Administration of Aging and Services, 2013; Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE), 2014). A national research study conducted to better understand the lives of LGBT older adults indicates this population is more vulnerable than heterosexuals as they age, which impacts their health and well-being (The Aging and Health Report: Disparities
and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). For example, stress-related illnesses such as heart disease, high blood pressure, and elevated rates of obesity are found more often in older LGBT older adults than their heterosexual peers. Research indicates that nearly 25 percent of LGB and 33 percent of transgender older adults describe their overall health as poor. (The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011).

The increased risks of mental health disorders such as higher rates of depression, increased substance abuse, and greater risk for suicide, which are correlated to experiencing long-term social and institutional marginalization, also makes LGBT older adults more vulnerable than their heterosexual peers as they age (The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011; SAGE, 2014). For example, research suggests feelings of depression are indicated by nearly one-third of LGB older adults and almost 50 percent of transgender persons. More alarmingly, 39 percent of LGBT older adults report they have considered suicide at some time during their lives. (The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011).

The limiting health capacities resulting from medical conditions and the deleterious effects of comprised mental well-being may lead to increased social isolation, further impacting the well-being of the LGBT aging population. Since older LGBT adults may have experienced strains in family relationships because of sexual orientation and/or gender identity, their biological families or children may not be an available source of emotional or financial support to the same extent that non-LGBT seniors experience (Philantrofund, 2010). As a result, older
HEALTH CARE MATTERS

LGBT adults may need to depend more on public programs and services (The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011).

Economic resources plays an important role in LGBT older adults having access to services connected to addressing health and wellness matters. Research from SAGE (2014), suggests having enough financial assets to live on is a greater concern for older LGBT adults than their heterosexual peers. MetLife Mature Market Institute (2006) reports that nearly 75 percent of LGBT older adults express concerns about financial solvency as they age and are less able to depend on traditional family supports for help. For over 15 percent of LGBT older adults living at or below the poverty level, having fewer opportunities for financial support causes increased disparities in all aspects of living (The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults, 2011).

The challenges related to physical and mental health, social support, and aging-related financial concerns for LGBT older adults are apparent. These challenges are significant to address as a social justice issue and with the growing increase of the aging population. For the field of social work, to effectively deliver culturally competent services to LGBT older adults requires gaining a clearer understanding of how their experiences of oppression and discrimination have led them to perceive barriers to care. The professional standards applicable to working with LGBT older adults are clearly outlined in the National Association of Social Workers Code of Ethics (2008) as follows:

1.05 Cultural Competence and Social Diversity
(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability (Ethical Standards).
HEALTH CARE MATTERS

Therefore, the purpose of this study is to describe more clearly the barriers to care that LGBT older adults perceive in medical care settings, and to explore how social work professionals in these settings can effectively provide more culturally competent services.
Literature Review

Medical and social history has tempered the life experiences of LGBT older adults and impacted their lives significantly. In the 1930s, homosexuality was deeply stigmatized and classified by medical professionals within the realm of a “psychopathic personality” (Mendelson, 2003, p. 681). In the early 1950s, the American Psychiatric Association (APA) published its first book as a method to classify diagnoses, the *Diagnostic and Statistical Manual of Mental Disorders (DSM I)*, and homosexuality was categorized as a “sexual deviation,” which was included in the range of “sociopathic personality disturbances” (Mendelson, 2003, p. 681). According to the *DSM I*:

“Sexual deviation” is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenia and obsessional reactions. The term includes most of the cases formerly classed a ‘psychopathic personality with pathologic sexuality.’ The diagnosis will specify the type of pathologic behavior, such as homosexuality, transvestism, paedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation). (as cited in Mendelson, 2003, p. 681).

Further, in 1968, the *DSM II* modified the term “sexual deviation” to be used:

… for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances such as in necrophilia, pedophilia, sexual sadism and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behaviour for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them (as cited in Mendelson, 2003, p. 681).

The *DSM II* removed homosexuality as a disorder in 1973, but reclassified it in yet another stigmatizing manner by calling it a “sexual orientation disturbance” (Mendelson, 2003, p.681).

In the early 1900s and until the 1920s, homosexuals and transgender individuals were commonly placed in the same category, not distinguishing sexual orientation from gender identity (Dresher, 2010). Gender identity disorder first appeared in the *DSM III* as a diagnosis in 1980 after nearly 30 years of debate concerning those who did not identify with or conform to
their biological gender (Dresser, 2010). The DSM IV made modifications to the diagnosis in 1994 and gender identity disorder was eventually removed from the DSM V, and has been replaced with the term “gender dysphoria.” This is explained as follows:

[The] DSM-V aims to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender. It replaces the diagnostic name “gender identity disorder” with “gender dysphoria,” as well as makes other important clarifications in the criteria. It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition (American Psychiatric Association, 2013).

Presently, the term gender identity is clearly distinct from sexual orientation:

[Gender Identity] is the gender you feel you are inside (man, woman, neither or both). For transgender people, their birth-assigned gender and personal sense of gender identity do not match. Gender identity and sexual orientation are not the same. Transgender people may be heterosexual, lesbian, gay, or bisexual. For example, a transgender woman who was assigned a male gender at birth and is attracted to other women may self-identify as a lesbian (National Resource Center on Aging, 2013, p. 26).

Socially, LGBT older adults have lived through an era of increased visibility. The events of Stonewall Riots in the late 1960s, the civil rights movement, the gay rights movement of the 1970s, and the AIDS epidemic in the 1980s, have led to greater public awareness of the LGBT population (Fredriksen-Goldsen et al., 2011; MetLife Mature Market Institute, 2006). More recently, the Obama Administration has enacted several measures to advance the rights of LGBT individuals at federal and state levels by addressing issues concerning hate crime legislation, military service, same-sex marriage, hospital visitation rights, access to housing, access to health care coverage, employment, and military service (The White House, n.d.). Yet, many individuals born prior to and during the baby-boom era may have different experiences and perceptions about their sexual preference and gender identity; accordingly, these generations of LGBT older adults may be reluctant to disclose this information because of past experiences of social and institutional disparagement and discrimination (Fredriksen-Goldsen et al., 2011; SAGE, 2014).
HEALTH CARE MATTERS

Therefore, the barriers that are perceived in health care settings and the diminished confidence in receiving competent care are something that needs be addressed in order to increase positive outcomes for LGBT older adults (National Gay and Lesbian Task Force, 2013). The rest of the literature review will focus on the following three areas: discrimination, lack of affirming and welcoming environments, and the need for increased cultural competence.

**Discrimination**

As a culturally diverse group, the LGBT population has unique needs that are often overlooked in health care settings and by service providers (Institute of Medicine, 2011). Research on LGBT aging adults suggests fear of discrimination based on sexual orientation and gender identity are common (Fredriksen-Golden et al., 2013; Justice in Aging, 2010; MetLife Mature Institute, 2006; Philanthrofund, 2012). In a survey conducted by the Philanthrofund Foundation (2012), results showed twice as many LGBT participants were confident they would not experience discrimination in care environments compared to a similar study 10 years earlier. Although the study’s numbers suggest significant growth in LGBT older adult’s perceptions of receiving respectful services from care providers, confidence levels are still less than 20 percent. In long-term care environments, similar findings indicate that less than 20 percent of respondents feel secure in being open with staff members about their sexual preference or gender identity (Justice in Aging, 2010).

Despite findings that suggest LGBT older adults are becoming more confident they will be treated more respectfully in care environments, discrimination is still a significant concern (Philanthrofund, 2012). Research indicates that health-care settings conveying heterosexuality and heteronormativity, homophobia, transphobia, racism, and religious bias create perceived barriers to care for LGBT older adults (Justice in Aging, 2010).
HEALTH CARE MATTERS

**Heterosexualism and heteronormativity.** A contributing factor in discriminatory treatment and perceptions toward the LGBT population is the pervasive influence of heterosexual dominance, which maintains that heterosexuality is the defining standard of social and institutional behaviors, norms, and values. According to UC Davis LGBTQI Resource Center (2015),

Heterosexualism is the assumption that all people are or should be heterosexual. Heterosexualism excludes the needs, concerns, and life experiences of lesbian, gay, bisexual, and queer people while it gives advantages to heterosexual people. It is often a subtle form of oppression, which reinforces realities of silence and invisibility.

Another characteristic of heterosexualism it that supports the subjugation of LGBT individuals and is dismissive of their needs. This system of heterosexual privilege advances the behaviors, norms, and values of the binary classification of male and female biological gender assignments, which further reinforces the marginalization of the LGBT population. According to UC Davis LGBTQI Resource Center (2015),

Heteronormativity is a set of lifestyle norms, practices, and institutions that promote binary alignment of biological sex, gender identity, and gender roles; assume heterosexuality as fundamental and natural norm; and privilege monogamous, committed relationships and reproductive sex above all other sexual practices (2015).

Similar to heterosexualism, heteronormativity is oppressive and exclusionary to the LGBT population, which is diverse in gender identities, sexual orientations, and relationship models and practices.

In health care research and education, heterosexualism and homophobia are common. A study conducted to examine public health research from 1980 to 1999 found that LGBT issues were overwhelmingly excluded from research efforts (Boehmer, 2002). In a large-scale national study conducted to create equity in health care treatment, over 50 percent of LGBT participants report their care providers were uninformed of their health care needs (Lambda Legal, 2010).
The Center for Disease Control and Prevention (2014), emphasizes the need for public health institutions to include the needs of the LGBT persons in their research to reduce the health and wellness deficits that are experienced as a result of social and institutional discrimination. According to Zuzelo (2014), the pervasive influence of heterosexism and homophobia by medical researchers and providers across the care spectrum negatively impacts service delivery.

**Homophobia.** Homophobia is commonly described as the irrational fear and hatred of gay men, lesbians, and bisexuals and these biased attitudes contribute significantly to perceived barriers to care. A national study found that 27 percent of LGBT older adults are significantly concerned about discrimination and lack confidence that providers in health care settings will treat them with consideration (MetLife Mature Institute, 2006). Many participants in the study reported lacking confidence that health care settings will treat them with “respect and dignity” and 12 percent of lesbian respondents in the study report having “absolutely no confidence that they will be treated respectfully” (MetLife Mature Institute, 2006, p. 5).

**Transphobia.** Transphobia is closely related to homophobia and is the irrational fear and hatred of transgender persons, which is another type of perceived barrier to care that can be experienced by LGBT persons. Research suggests transgender persons are fearful of discrimination in care settings and common concerns include: being demeaned, shamed, and stigmatized by providers, and experiencing other forms of discriminatory treatment (Fredriksen-Goldsen et al., 2011; SAGE, 2014). Further, many transgender persons avoid seeking care, are denied services, and are provided with inferior care (Fredriksen-Golden et al., 2013; Philanthrofund Foundation, 2010; SAGE, 2014).

Since transgender individuals can be in various stages of gender transition and/or have variances in body modifications, a significant number of transgender persons express concerns
related to providers treating their bodies with respect and care (Philanthrofund, 2010). In addition to concerns about physical safety, transgender persons report being mistreated by health care providers and settings for even seeking out health care services (Lambda Legal, 2010).

Compared to other members of the LGBT community, transgender individuals experience discrimination in health care settings at considerably higher rates than LGB persons (Lambda Legal, 2010; Fredriksen-Golden et al., 2013). For example, research suggests that compared to their LGB peers, over 50 percent of transgender persons are provided with inferior care in health care settings (Lambda Legal, 2010). Another disturbing finding indicates that 26.7 percent transgender individuals are refused care altogether in health settings compared to 7.7 percent of LGB identified persons (Lambda Legal, 2010).

**HIV and AIDS.** LGBT persons living with HIV and AIDS may experience perceived barriers to care through discriminatory attitudes and/or substandard care based on a providers’ personal beliefs and values related to sexual orientation, gender identity, and religious identification (Lambda Legal, 2010). According to the Center for Disease Control and Prevention (2015), nearly 25 percent of the total population living with HIV are persons over 55 years old. Some of these individuals are gay men who lived through the AIDs crisis in the 1980s and have routinely experienced biased attitudes in care settings (Isacco, Yallum, & Chromik, 2010). However, HIV-based discrimination is not exclusive to gay men. Research suggests that over 55 percent of lesbians and bisexuals receive negative treatment in care settings because of being HIV positive and over 70 percent of transgender persons have experienced HIV-related discrimination (Lambda Legal, 2010).

**Racism.** The intersectionality of race, sexual orientation, and gender identity creates other perceived barriers to care for LGBT racial minorities who face multiple layers of systemic
social and institutional oppression (Lambda Legal, 2010; Philanthrofund, 2010; SAGE, 2014; VanSluytman & Torres, 2014). For example, compared to white people, a higher percentage of Hispanics and African Americans LGBT older adults are concerned that if their providers know about their sexual preference, the quality of care they received will be negatively impacted (SAGE, 2014). These concerns are notable since research suggests that people of color show greater incidences of biased and inferior care than whites (Lambda Legal, 2010). Any opportunities to better understand the experiences, needs, and perspectives of people of color to improve deficits in care are greatly lessened since a common limitation of research studies is that sample is predominately white (Jenkins-Morales, King, Hiler, Coopwood, & Wayland, 2014; (Philanthrofund, 2010; Philanthrofund, 2012; SAGE, 2014).

**Religious bias.** Religious discrimination is a further perceived barrier to care LGBT older adults may encounter in care settings. For instance, findings suggests there is a correlation between religious beliefs and negative biases toward LGBT persons for clinicians working in substance abuse settings (Eliason & Hughes, 2004). Other research reports that staff members felt it was necessary to inform several LGBT older adult residents that they were praying for them because they were LGBT (Justice in Aging, 2010). However, despite various forms of social and institutional religious bias, religion and spirituality is important to LGBT older adults and many participate in religious and spiritual activities in some capacity one or more times per month (Frederiksen-Golden et al., 2011).

**Lack of Affirming and Welcoming Environments**

In addition to discrimination, practice settings and environments that are not affirming and unwelcoming create perceived barriers to care for LGBT older adults. Research indicates that apprehension about being treated differently in care settings by providers who are
unwelcoming is a concern for almost 50 percent of LGBT older adults (Jenkins-Morales, King, Hiler, Coopwood, & Wayland, 2014). Having LGBT specific literature and programs in place in care settings is an important factor to feeling recognized and affirmed by the larger culture since the LGBT population has experienced ongoing discrimination and stigma, (National Resource Center on LGBT Aging, 2013; Metlife Mature Institute, 2006). Therefore, this section of the literature review will discuss the lack of affirming and welcoming environments in the context of care environments, providers’ perspectives, and LGBT older adults’ perspectives.

**Care environments.** The aesthetic of a practice environment plays a significant role in developing trust between a provider and patient (Flemmer, Dekker, & Doutrich, 2014). For example, a setting’s exterior, lobby, and practice spaces can evoke many feelings or perceptions for a person including: safety, confidence, wariness, or a lack of hospitality (Gutheil, 1997). Research indicates having easily identifiable visual cues that are synonymous with LGBT culture such as the rainbow symbol or brochures depicting families with same-sex parents are beneficial in creating an LGBT-friendly environment (Philanthrofund, 2010; SAGE, 2013). Also, the feelings of being in an affirming and welcoming environment can be heightened for LGBT persons when the settings’ intake forms include a wide-range of sexual orientations, gender identity designations, and use non-gender specific language (Philanthrofund, 2010; SAGE, 2013). A study examining the needs of caregivers suggests many lesbians are concerned about finding providers who are welcoming and that the importance of recognition and receptivity of same-sex partnerships is critical to their sense of comfort and safety when seeking out care services (Valenti & Katz, 2014). Other research indicates the potential for positive care outcomes is significantly improved when persons feel safe, open, and authentic in health care settings (National Research Center on LGBT Aging; MetLife Mature Market Institute, 2006).
Provider’s perspectives. According to Dickman-Portz et al. (2014), a large number of health care providers recognize the importance of creating welcoming and affirming environments for the LGBT community. Yet, the service ethics of many agencies puts an emphasis on treating all clients equally regardless of cultural differences and do not make provisions specific to the LGBT population (Brotman, Ryan, & Cormier, 2003; Dickman-Portz et al. 2014; Knochel, Quam, & Croghan, 2011). However, the idea of treating everyone alike in care settings only serves to highlight LGBT lack of visibility and dismisses the unique historical contexts that have caused marginalization and barriers to care for LGBT individuals across the social and institutional spectrum (Brotman, Ryan, & Cormier, 2003; Hughes, Harold, & Boyer, 2011; Willging, Salvador, & Kano, 2006).

LGBT older adults’ perspective. Responses from LGBT persons in regard to settings that cater exclusively the community are mixed (Philanthrofund, 2012). Some community members state a preference for all-inclusive LGBT service settings (Fredriksen-Goldsen et al., 2011). However, many older LGBT adults would prefer care settings that cater to the needs of the entire aging community but are also welcoming and affirming of the LGBT population (Philanthrofund, 2012). On the other hand, another study suggests that close to 10 percent of older LGBT adults feel afraid to access care from LGBT community providers, which may be related to fears of discrimination and stigma (Fredriksen-Goldsen et al., 2011).

For some LGBT older adults, having issue-specific groups is important. For example, research indicates participants would prefer to have support groups and grief and loss groups that are specific to the needs of LGBT older adults (Stein, Beckerman, & Sherman, 2015). These findings are consistent with other research, which suggests that over 60 percent of participants are concerned about having accessibility to support groups that are inclusive to LGBT aging
HEALTH CARE MATTERS

persons (Jenkins-Morales et al., 2014). However, LGBT all-inclusive settings of any kind are very limited in numbers and are not well-funded (SAGE, 2012-2014).

**Increasing Cultural Competency**

In addition to discrimination and lack of affirming and welcoming environments, research suggests LGBT older adults are concerned about cultural competency (Administration on Aging, 2104; Centers for Disease Control and Prevention, 2014; Lambda Legal, 2010). Research indicates LGBT older adults are concerned about having access to educated, knowledgeable, and trained LGBT-specific practitioners in health care settings (Jenkins-Morales et al., 2014). A key finding indicates many participants report the need for competently trained professionals in any type of care setting (Valenti & Sands, 2014). However, despite the critical need for culturally competent providers, information gathering processes, lack of education in academic settings, LGBT-specific service training for providers, and providers who lack knowledge about LGBT relationships and family structures have made a significant impact on the LGBT aging populations’ ability to receive culturally competent services.

**Information gathering.** As a measure to provide culturally competent care, having a comprehensive overview of the varying characteristics that make up the population is important. Research indicates that in order to effectively meet the health care requirements of the LGBT population, collecting data on sexual orientation and gender identity information on surveys is an important factor in providing successful service delivery (Institute of Medicine, 2011). A study conducted to examine aging and sexual activity, found that questions related to gender identity were absent, which eliminates the opportunity to gain valuable data about the needs of transgender population. A further analysis of study’s findings emphasized the need to generate and improve existing data collection related to the LGBT population to meet their aging needs.
more effectively (Brown & Grossman, 2013). In other contexts, the importance of gathering information on data collection forms is recognized to further identify and improve programs, policies, and services delivered to LGBT older adults (Brown & Grossman, 2013; Institute of Medicine, 2011).

**Educational curriculum and training.** In addition to using information gathering as a measure to inform providers how to more effectively provide culturally competent services to LGBT older adults, academic education plays major role and is often scarce in graduate social work programs, and medical and nursing school curriculums (Logie, Bridge, & Bridge, 2007; Maliver-Obedin et al., 2011; Zuzelo, 2014). For example, research conducted to assess graduate-level social work students’ perceptions about LGBT persons suggests that informed cultural competency is not necessarily related to the sensitivity students have toward the population. Overall, social work students in the study have positive attitudes about LGBT people though more than 42 percent report having limited knowledge of the population’s needs and potential difficulties despite the profession’s emphasis on cultural competency and ethical practice (Logie, Bridge, & Bridge, 2007).

A similar example is found in the medical profession, which also values cultural competence when working with patients. A study conducted to assess medical education and curriculum specific to the LGBT population, suggests that roughly five hours of program content is devoted to LGBT concerns, which is noted as being increase from previous years (Maliver-Obedin et al., 2011). Educators in the nursing profession indicate that their curriculums mostly focus on gay men’s issues and that medical educators need to put more efforts into including the health care needs lesbian, bisexual, and transgender women in their programs (Zuzelo, 2014). From a community perspective, LGBT older adults consider educating healthcare
professionals on needs specific to the LGBT population is an important measure to feeling like they are receiving supportive and competent care (Brotman, Ryan, & Cormier, 2014).

**Service training and provider knowledge.** From the perspective of LGBT older adults, the apprehension of working with providers who were inexperienced or untrained in LGBT specific issues is significant (Jenkins-Morales et al., 2014). Although research overwhelmingly suggests LGBT older adults have a higher likelihood of seeking out services from providers who are specifically trained in meeting the needs of the LGBT community, less than 20 percent of providers feel like they are capable of delivering a high-level of culturally competent care to this population (Croghan, Moone, & Olson 2013; Dickman-Portz et al., 2014).

Providers’ interest on receiving training specific to LGBT older adults is mixed. According to Philanthrofund Foundation (2010), 75 percent of service providers are willing to offer LGBT specific training to their employees. Interestingly, the study’s findings also report agencies are more willing to offer training related to the needs of LGB older adults and are less open to providing training that includes the needs of transgender people. Another study suggests that almost two-thirds of survey participants would like to receive training specific to LGBT older adults; however, more than one-third of respondents report not having any interest (Harold, & Boyer, 2011)

Despite there being signs of interest from members of the LGBT community, some service organizations indicate they are not willing to provide practitioners with LGBT specific training due to lack of funding or deem it unnecessary (Philanthrofund Fund Foundation, 2010; SAGE, 2014). National and local outreach efforts by organizations to reach LGBT older adults are less than 15 percent and are attributed to lack of interest from the LGBT community, agency inclusiveness of all persons regardless of sexual orientation or gender identity, and the political
philosophy of the state in which the agency is located (Hughes, Harold, & Boyer, 2011; Philanthrofund, 2010). Research suggests that providers’ level of knowledge and feelings toward the LGBT aging population are positively impacted by participating in LGBT aging specific trainings (Porter & Krinsky, 2013). Yet, results from another study indicates staff education about cultural competency may not eliminate negative perceptions of the LGBT population and strategies for effecting long-term change need to be put into action (Eliason & Hughes, 2004).

**Family and relationship structures.** LGBT older adults often have diverse family and relationship structures and are concerned practitioners lack cultural competency in their knowledge of LGBT family systems (SAGE, 2014). A study conducted to examine the caregiving experiences of LGBT mid-life and older adults suggests while over nearly two-thirds of participants’ report that family members are overwhelmingly or mostly accepting of their sexual orientation, 10 percent of participants report family members are completely unsupportive or show very little support by (Croghan, Moone, & Olson, 2013). Though the study’s findings are generalized to persons living in the Midwest, they are supported by a national survey that suggests LGBT older adults’ support systems are frequently diverse and often are made up of persons other than biological family members because of marginalization due to sexual orientation and/or gender identity (Fredriksen-Goldesen et al., 2011). These diverse formal and informal support networks are made up of persons many LGBT describe as their family of choice, which is a term used to describe persons who are not biologically or legally recognized as family members but are considered as such (Croghan, Moone, & Olson, 2013). For LGBT older adult caregivers, the need for care settings and providers to have training specific to the needs of the population is critically important. A study by Valenti & Katz (2014), suggests that
having care providers recognize same-sex relationships is especially relevant in end-of-life care and planning.

**Summary and Research Question**

The literature shows that LGBT older adults have perceived certain barriers in medical settings related to fears of discrimination, concerns about environments that are not affirming of or are unwelcoming of their needs, and the cultural competence of providers. This literature also suggests that LGBT older adults are underserved and not well-researched. These are important factors that contribute to the impact of LGBT older adults’ well-being in care settings. This research study seeks to add to the existing body of literature and further explore LGBT older adults’ experiences in health care settings. Therefore, the question for this research study is: how can health care systems be more responsive to the needs of LGBT older adults?
Research Lenses

To demonstrate integrity and lend credibility to the study, this section of the project will discuss how relevant perspectives have influenced the organization of the project. Here, I will articulate the lenses or frameworks that I used to formulate the theoretical perspectives, concepts, and ideas of the study. First, the lenses were used as a means for developing the research. Second, the lenses played an important role in guiding the researcher’s interpretation of the data and as a means to critically evaluate the study. More specifically, lenses of conflict theory and the minority stress model were used to develop the research and interpret the data, and to provide the reader with a context to critically evaluate the study. These frameworks were also used as an instrument to discuss how they influenced the project from a personal standpoint.

Theoretical Lenses

Conflict theory and its focus on systemic power and how its distribution affects people’s lives, was used to provide a conceptual lens to explain the human behaviors that influenced the researcher’s orientation toward the study. The key emphasis of conflict theory is how the dynamics of power privileges the interests of dominant groups, while oppressing and disregarding those in minority groups (Hutchinson, 2008). Discrimination based on sexual orientation and gender identity can be used as examples to illustrate how power can be used to advance the interests of some groups while disparaging the interests of others, which made conflict theory useful to demonstrate how heterosexuality and heteronormativity are privileged over the LGBT population.

In addition to conflict theory, the minority stress model was used as a more specific theoretical lens that influenced my approach to the research. Conflict theory is defined as “the damaging physical and mental health effects of being stigmatized and/or the focus of prejudice
and discrimination, which create a hostile and stressful environment” (National Resource Center on LGBT Aging, 2013, p. 27). The main concept of the minority stress model proposes that individuals in minority groups encounter chronic stressors that are not experienced by those in dominant groups (Meyer, 2010). The terms “distal to proximal” are used to describe the objective, larger social and institutional values that impact a person’s distinct and immediate psychological experience, suggesting that for sexual minorities, perceived expectations of negative social and institutional biases such as homophobia, violence, and other forms of mistreatment can lead to varying coping strategies, which may include not disclosing one’s sexual preference or gender identity (Meyer, 2010, p. 244). Therefore, the minority stress model was used as another guiding lens to illustrate how prejudicial social and institutional values can significantly influence an LGBT person’s view of how they may be perceived in health care environments.

Personal Lens

In addition to the aforementioned theoretical lenses, I will provide a brief description of how my perspective as a LGBT-identified person was relevant to this study and how it impacted my analytical approach to the project. From a personal perspective, I viewed the research from the lens of a LGBT-identified person and as a consumer of the health care system, which gave me insight about the topic. However, since I was also the instrument the data was analyzed through, the risk of researcher bias was heightened. Consequently, to reduce the possibility of bias, the data was coded in multiple contexts to identify common themes and then analyzed from a number of perspectives to safeguard the study’s objectivity and strengthen its rigor.
Method

This research study used a qualitative design for data collection to answer the research question, “How can health care systems [primary care clinics, hospital settings, and residential and nursing facilities] be more responsive to the needs of LGBT older adults.” A qualitative method was well-suited for this project because the data was studied from the standpoint of an insider and was useful for obtaining a deeper understanding of each participant’s perspective on the questions or topics (Padgett, 2008). More specifically, this study used the participant interview method to collect data from LGBT older adults. The proposed methodology for the research included the following: sampling procedures, protection of human subjects, instrumentation, data collection, and data analysis procedures. This section of the study concludes with a brief discussion of the strengths and limitations of the research design.

Sampling

The sample taken for the study was 16 LGBT older adults aged 62 and older living in the Twin Cities area. Research participants were recruited using purposive sampling, which was way for the researcher to obtain participants that were the most accessible and specific to the age category of the population needed for the study (Monette, D.R., Sullivan, DeJong, C.R., & Hilton, T.P. 2014). Additionally, snowball sampling was used to recruit additional participants using participants’ knowledge of other persons who may have also met the criteria for participating the study (Monette et al., 2014). To recruit participants, a flier created by the researcher provided the following information about the study: a description of the research study, the age-range of participants needed for the research, the approximate length of the interview, and a statement explaining that interviews are completely confidential and anonymous.
The flier was sent to a number of organizations specific to the LGBT population with a letter that provided details about the study and posted at locations around the Twin Cities including: a library, a church, and other facilities that LGBT older adults frequented (see Appendices A & D). In addition, an LGBT social organization posted a copy of the flier on their website. Snowball sampling was also used to recruit participants; a flier was given to participants who passed the flier on to persons they knew who may have been interested in being part of the study.

**Protection of Human Subjects**

To ensure the research was conducted ethically, the research investigator took number of measures to protect participants from any potential harm associated with participating in the study (Monette et al., 2014). A consent form for this study was created by the researcher based on a template used by the University of Saint Thomas Institutional Review Board and reviewed by researcher investigator’s research chair. The content of the consent form discussed the following: background information regarding the purpose of the study, the procedures involved in the study, the risks and benefits of participating in the study, confidentiality issues, and the voluntary nature of the study (see Appendix B). The contact information of the researcher, the research chair supervising the study, and the University of Saint Thomas Institutional Review Board was provided to each research participant. The researcher reviewed the form with each participant and provided an opportunity to address any questions or concerns the participant had before obtaining written consent.

There were minimal risks associated with participating in the study.

To ensure confidentiality, the researcher requested that the meeting took place in an area that was conducive to privacy. Participant confidentiality was further protected by storing the
HEALTH CARE MATTERS

research records in a locked filing cabinet in the researcher’s home. Electronic copies of transcripts were stored in a password protected laptop computer. A transcriber signed confidentiality agreements and any potentially identifying information in the transcripts was deleted.

The voluntary nature of study was clearly explained to each participant. Participants were told they could skip any questions or stop the interview at any time. Also, participants were informed that their decision participate would not affect their current or future relations with Saint Catherine University, the University of Saint Thomas, and the School of Social Work. Participants were free to withdraw from the study without penalty up to one week after the interviews was conducted.

Instrumentation

The instrument used to obtain the data for the research was a single, semi-structured interview schedule. The schedule consisted of 12 primary questions, which were informed by literature and created by the research investigator. The interview questions were open-ended, which allowed for nuances, spontaneity, and variances in participants’ responses. Utilizing open-ended questions gave the researcher opportunities to ask participants to respond in a manner that permitted added depth and exploration. The 12 question interview schedule asked participants the following: demographic information, how they sought out services from health care providers or facilities, how they could tell health care providers were affirming, trained, and knowledgeable specific to the needs of the LGBT population, how they described their comfort level in accessing and utilizing the health care system, what barriers they had, if any, in terms of the health care system, information about a time the health care system was responsive to their needs, what changes they would like to make the health care system make, what needs they
prioritized as being the most important in health care systems, and how they think social work professionals in health care settings effectively could provide more culturally competent services. The researcher also used probe questions to gather clarifying information to capture more nuances and subtleties in the data (Monette et al., 2014). To increase the rigor of the data, all persons on the researcher’s committee reviewed the questions to ensure face validity (see Appendix C for a complete list of research interview questions).

**Data Collection and Data Analysis**

The data collection for the study occurred via single, semi-structured interviews conducted by the researcher at a date, time, and location chosen by each research participant. The length of the interviews averaged 40 minutes and were audio-recorded. The audio-recordings were transcribed verbatim. Field notes were taken by the researcher after each interview as a secondary measure to document observations made by the researcher.

Since the design of the study was qualitative, the researcher was also an instrument of data collection. Meaning, the interviews that were conducted with participants were reported through the individual lens of the researcher (Seidman, 1991). As a result, the data collected by the researcher was subjective to the researcher’s individual level of experience and knowledge related to creating the interview schedule and interviewing participants, which would impact the researcher’s analytic stance and make subsequent efforts to reduce bias.

To analyze the data, the researcher used a descriptive phenomenological approach, which utilizes a first-person or subjective perspective of the world (Padgett, 2008). Since the nature of this qualitative research study was exploratory, the researcher utilized a phenomenological approach as a means to hear about the participants’ experiences and to find meaning and subsequent themes in their responses. An open-coding system was used first by the researcher to
HEALTH CARE MATTERS

identify and record initial themes found in the data which included: key words, phrases, and ideas described by participants. A focused-coding scheme was then developed to further identify and to provide a deeper analysis of the main concepts and relationships that were established during the open-coding process (Monette et al., 2014). Because the researcher was the instrument the data was collected through, the data was analyzed from a number of different perspectives to provide increased rigor and accuracy. The data was examined the following ways: age ranges (ages 69 and under, and ages 70 and older), sexual preference (gay, lesbian, and gender fluid), participants receiving transgender-related health care services, and responses to individual interview questions,

Strengths and Limitations

This research design had both strengths and limitations worth mentioning. One strength of the study was that qualitative data collection process allowed for more flexibility because participants were free to respond in their own ways to the questions. This method also allowed participants to respond with further depth and with more nuanced and exploratory responses. A further strength of the research design is that the interview questions were reviewed and pre-tested by multiple persons to ensure their face validity. Another strength of the study was that it captured some of the breadth of the LGBT population rather than being specific to only one age group, gender identity, or sexual preference of participants. Lastly, the data analysis was conducted in a number of different formats to strengthen the rigor of the data and reduce researcher bias.

A limitation of the research design was its small sample size, which limited its ability to be representative. Another limit of the study’s design is that the sample’s location was specific to the Twin Cities metro area of the Midwest, therefore excluding LGBT older adults’ perspective
from rural areas and other urban areas from the East or West coasts. A further limitation of the study was the sample consisted entirely of Caucasian individuals and did not include the perspectives of persons of color. The study was also limited by a sample that was not representative of bisexuals or transgender men. Additionally, the researcher as an instrument of data collection and analysis limited the study’s objectivity. Lastly, although the sample of the study provided some breadth, it was limited in not providing more depth specific to a particular age, gender identity, or sexual preference.
Findings

The findings section of the study will begin with a description of the research participants and relevant demographic data. Next, relevant observational data will be presented. Finally, the themes and subthemes that emerged from the data will be presented. These include: relationships with providers, LGBT-friendly care, training, long-term care, and perspectives on aging.

Description of Participants

The participants of the research study were self-identified lesbian, gay, and transgender adults over the age of sixty-two who were using health care services [primary care clinics, hospitals and/or residential/nursing care] at the time of the study or had within the past five years.

The participants ranged from ages 62 to 83. Eight participants identified as female, seven as male, and one person as transgender (male-to-female). Two of the eight participants that identified as female were receiving transgender-related care and services. One participant that identified as female described herself as “being in between,” which she explained meant that according to medical tests, genitally and chromosomally, she was neither female nor male. Eight participants identified as lesbian, six identified as gay, one identified as gay/queer, and one identified as gender fluid, which was described as a sexual preference rather than the person’s gender.

Ten participants reported having partners and four stated that they were married, three were single, and three did not specify a relationship status.

All research participants lived in the Twin Cities metropolitan area of Minnesota.

Observational Data
The interviews lasted an average of 40 minutes. Interviews with participants that identified as female and lesbian lasted an average of 38 minutes; participants that identified as male and gay and gay/queer spoke for an average of 42 minutes; the interview with the participant who identified as male-to-female transgender and gender fluid lasted 44 minutes.

Participants appeared to be engaged, pleasant, and thoughtful. In addition to providing answers to the questions, the interview process was balanced by laughter and good humor.

**Relationships with Providers**

Provider relationships was significant theme that emerged from the data. Participants discussed the importance of the relationships they had with their health care providers. Most participants discussed this theme in the same way. A number of subthemes also emerged. These include: long-term relationships with provider and/or care network, LGBT provider preferences, level of comfort with provider and accessing care, and potential barriers to accessing care.

**Long-term relationships with providers.** Twelve participants reported they had long-term relationships with the same providers and/or care networks. This was a commonality across the continuum of age, gender identity, and sexual preference. To describe the length of their relationships with their providers and/or care network participants used words and phrases such as *many, many, many years, a long time, 20 years, 20 or 25 years ago, can’t even remember, a number of years, probably thirty-some years*. Most participants said they had found their provider(s) through *a friend, a referral from an LGBT organization, researched online, and a referral from another provider.*

**LGBT-friendly provider preferences.** While discussing care providers, participants indicated varying preferences for having providers who were LGBT-friendly. The preference for having an LGBT-friendly provider was most important for persons that received transgender-
related care. For example, the transgender participant and both participants who received transgender-related care described the significance of having an LGBT-friendly provider as it related to their care:

"[The provider] was a person that dealt with transgender folks and hormones. Not necessarily trained, but who didn’t have an issue with transgender people or our community.

When I started my gender therapy, I sought somebody out that knew what they were doing as far as counselling, and would be able to write subsequent letters and help me out as I moved along with my transition. So that was part of the...where I looked and the reasoning that I used behind that.

I’m being treated for gender dysphoria, so sure I see a specialist who was recommended to me. Apparently, she handles a lot of us trans[gender] women.

Other participants described mixed preferences for LGBT-friendly providers. Three participants indicated that it was an important factor, and maybe nice, but not a primary concern:

Well, I’d rather have somebody who is gay-friendly, LGBT-friendly. And since I’ve been in Minnesota that’s always been my first criteria.

Before the days of the internet, I would be asking around within the [LGBT] community. You know, who feels comfortable, who can I talk to without having to explain [about being a lesbian].

[When looking for a provider]... And I would go back online again, to the various clinics that I thought would be close enough, and read the profiles of the doctors. And then this past spring, late winter, I did it again. And oh, this clinic has a gay doctor. And in his profile, he and his husband live in the Twin Cities and he’s the... one his specialties is transgenderism and he’s the go-to physician for that you know. And I just thought, oh wow. So I set up a meeting with him and was impressed and very happy. And he referred me to a lesbian doctor for another medical issue I have, who I’ve met a couple of times now and she’s fantastic.

I guess that’s not my primary concern, but it’s always nice. And my providers who are gay have always told me they are gay. They shared that with me. And the nurses all great too and they’re all gay-friendly.

Another three participants stated that having an LGBT-friendly provider was not an important aspect to consider when seeking services from a care provider:
I did that early on [sought out an LGBT-friendly doctor], I did that and didn’t think it was any better medicine or worse medicine anywhere else.

That is never a consideration. But, I think using referrals of other health people who I trust is how I choose.

I’ve never looked for that or thought it was important. The places I go to help everybody and I happen to be an LGBT person that’s there.

**Feeling comfortable.** Fifteen participants described feeling comfortable with their providers and accessing care settings and services. For example, almost every participant described their comfort level and satisfaction with their provider and accessing care as **comfortable, totally comfortable, at a ten and very, very comfortable, never had a bad experience, [my care provider] has my back, he was so kind and caring, very satisfied, took plenty of time to answer my questions, is very understanding, I never feel rushed.** One participant described herself as being **not as comfortable** as she had been in the past with a lesbian provider because she did not know what her new provider’s attitude would be toward her sexuality.

A number of participants noted how changes over time have impacted their comfort levels with health care providers and accessing services:

I’ve never had an issue with a caregiver that was negative. It just hasn’t happened. I’ve been lucky, I guess. Although... you know in a way I have to take that back a little bit. Cause when I found out I was HIV positive, I had a partner and we were living in Texas at the time. It was 1989 and we went to a clinic. I had some symptoms so I went to this clinic that was advertised in the local gay paper. They were the worst doctors I’ve ever seen. [...] Then, shortly after that we moved back to Minnesota and my first doctor was not gay but very gay-friendly. Everybody at the clinic was good. But not as good as, again, now.

I have to admit, back when I first came out in the 70s, when I had to go to a doctor I wouldn’t say anything. And I think that’s why I called a gay services organization for a referral and was fortunate in finding the doctor I had for many years. Well, I had him through all the years that I was still maturing, being a little less concerned about who
knows whether I’m gay or not. And the public is changing. I think the whole health care system is changing.

I am pleased with the changes over the years and I feel relatively comfortable. But I also want folks to know that I have a history that’s kind of a nightmare sort of thing. I actually subjected myself to reparative therapy at the urging of my family. The medical professionals were part of that. Obviously, it didn’t go well.

Potential barriers. Participants had mixed responses across the ranges of age, gender identity, and sexual preference about whether they faced any potential barriers in accessing or receiving care. For example, eight participants reported that they could not identify any barriers, which they conveyed by using words and phrases such as I honestly don’t see any, none, I don’t feel like I’ve run into any barriers

Another participant explained he could not imagine a provider not being welcoming:

It would really surprise me if they weren’t. I mean, how could you do that? I mean, how would they not be? Would they say they’re not [LGBT] welcome here? I can’t imagine anybody being in the medical profession, not welcoming people. Are there still people that don’t?

One participant reported though he was not experiencing barriers he could see how they barriers potentially exist because of how a provider may perceive a person’s sexual preference:

I’ve never felt any barriers, but I can see where some people who… I’ve been queer for a long time. The older I get, the less I care about what I say. And I think there are people that, some older people who’ve come out late in life, and are still having trouble dealing with that. They might not want to say, ‘I’m gay.’ Or, if a question comes up about sexual activity.

Three participants described barriers in more institutional contexts such as having access to restrooms or having care options being limited by insurance coverage:

You know, there’s always the issue of restrooms. I just use the ladies room but it takes some getting used to at first but now I’m used to it. [Asking providers] are you thinking about trans[gender] people? It [not having gender neutral restrooms] can be more or less of a barrier.
The insurance company is a huge barrier because I don’t have the option of picking a hospital.

Well, it’s upcoming. I’m not on Social Security yet. I’m 66, I know that not all providers take people who are on Medicare and so that will limit the providers and so I have some concerns if I need too…

Two participants shared anecdotal stories that suggested other LGBT persons experienced barriers to accessing or receiving care:

I felt like I was always treated respectfully. It doesn’t always happen that way, there are plenty of stories. There was a story about a guy that, or a trans woman that… this was in the last year or so, he was in a very well-known health care system and the emergency room doctor refused to treat her. So, now you’re a freak. We don’t treat you. And the person’s mother was along with her and it got into the news. It was a traumatic experience... to be denied care.

You know, I’m sure there are lots of people out there that have had horrible experiences and particularly now that our marriages are legal and they can’t really discriminate against you for visiting in hospitals and that kind of thing. That takes a big load off our minds about that. But there have been horrible experiences where a person’s partner is dying and they can’t even visit them at the hospital. I mean, how sad is that?

LGBT-friendly Care

Another significant theme that emerged in the data was LGBT-friendly care. For all participants, LGBT-friendly care meant various indications that signaled providers and facilities were supportive of the LGBT population. The most common indicators of LGBT-friendly care include: provider reactions, environmental cues, recognition of one’s intimate partner, and receiving LGBT-informed care.

**Provider reactions.** An indicator of an LGBT-friendly provider is the way providers respond to them. Participants described these responses in terms of the provider’s facial expressions, body language, behavior, and general comments. For example, words and phrases used to indicate welcoming and affirming care from providers included: *general expressions, no wincing, non-judgmental, non-invasive, open body language, easy to talk to, and open-ended*
questions, a matter of fact manner, a business as usual approach. Some participants described other ways providers responded to them that made them feel welcomed:

And sometimes I’ll say, “Well as an older gay man”… nobody flinches. I still get the same kind of treatment from people. And it’s not just care, it’s kind of loving care. It’s kindness, kindness that I feel from the people I get care from.

In general there’s other affirming ways that I call my little sparkles, you know when somebody says... I mean when somebody will find some reason to compliment me on my presentation as a woman.

Visual cues. Participants reported that visual cues in health care settings was another way they were able to sense they were in a LGBT-friendly environment. Seven participants noted that seeing a rainbow sign or flag, a well-recognized symbol of the LGBT population, was the most obvious indicator that an environment was welcoming. Other common cues mentioned by participants were having LGBT specific magazines/literature, and anti-discrimination signs prominently posted. Two participants spoke about conveying a sense of welcome to people via visual cues:

Well, I do like the about the safe place concept of welcoming people into their offices and letting know people know that this is a safe place to be through signs, literature, or whatever.

Pay attention to what reading materials you have in your lobby. Pay attention to what photos or décor you have. I mean, if all of your photos show white families and you are not a member of a large family or whatever is depicted and you are not white, well, you don’t feel as welcome.

Recognition of partner. Having providers that recognize their partners was another important sign of a LGBT-friendly provider. Participants described feeling supported when their providers acknowledged their partner or spouse:

My partner had surgery and beyond the initial signing papers and who’s giving information and all that, it wasn’t even an issue of if I could be present, or what would be shared with me. It was just really settled and it was really subtle that if I needed to stay there overnight... cool. It just felt very normal.
I was seeing my provider for an issue and I said that I wanted to make sure that it healed up before I got married. So I told her [my provider] that my female spouse and I were getting married and she was very supportive and kind of curious about the whole situation.

She said, “So are you two related?” And we said, “Yes.” And she said, “Are you brothers?” We said, “No, we’re not, but we’ve been partnered for thirty years.” She said, “Oh congratulations!” That was the county hospital saying, a person working the desk saying, “Yeah, I get it. We understand here.” And it was very comfortable, very nice.

**LGBT-informed care.** Twelve participants reported suggestions that they receiving LGBT-friendly care was related to a number of factors: language and pronoun awareness, having gender neutral restrooms, administering LGBT-related tests and procedures, and having a transgender specific department at the facility. Two participants explained that when a facility used inclusive and gender non-specific language they thought it was more likely that the facility would be an LGBT-informed care provider:

You know when the doctors are talking to me about my own personal stuff, are they being inclusive in their questions and in their information that they’re giving me? So, those are what I look for.

The facility I use now is real upfront. They ask me if I am partnered and that sort of thing. And they use the right kind of pronouns. Even from the first person you meet does that and that feels real important.

When their doctors specifically addressed the health concerns of gay men, participants felt like they were LGBT-friendly and informed:

Well, he certainly was familiar with HIV, STDs, and that sort of thing. And then he asked if I was sexually active and made sure I took the blood tests that were necessary.

Because I have identified myself as a gay man, he’s asked me to take a series of shots for Hepatitis C. He wanted to make sure I wasn’t going to contract that disease if it could be avoided.

Participants receiving care at facilities who had specific providers for LGBT-related care was also an indicator of being LGBT-friendly:
They have a doctor and now it’s become two other doctors in practice that specifically work with transgender patients. So, these are people that intentionally and specifically work with transgender people.

Provider Training

Another significant theme that emerged from the data was the importance of provider training. Eleven participants across the spectrum of age, gender identity, and sexual preference emphasized the importance of training care providers to help them be sensitive and knowledge about the needs of the LGBT population. A number of subthemes emerged that include: recognition of cultural diversity, knowledge of resources, and receiving academic and ongoing educational training.

Recognition of diversity. Participants identified cultural diversity training as a significant component of providing quality health care. Participants discussed diversity in a number of contexts. For example, participants mentioned providers need to recognize cultural diversity in the domains of gender identity, sexual preference, family structure, race, and cultural practices:

But they [providers] have to be trained to have their diversity radar out for a whole bunch of stuff. And it’s like that checklist of here’s something else that we do here is the way we treat LGBT... LGBT is a spectrum by itself. You know, it’s one thing to be a gay man or lesbian or bi or trans, or gender queer, nonconforming, or...

Well, I think the primary thing is sensitivity training on the part of the staff. Thorough knowledge of what our needs are, how to treat us. Both the same as everybody else and from everybody else depending on our needs and so forth.

To not make assumptions that we’re all straight, white, Christians. I’ve seen this in situations where somebody’s in the hospital, like a lesbian let’s say is in the hospital, and aides come in and say we want to make you pretty for your boyfriend, or husband, or whatever... I mean, that’s okay but they’re being dumb.
Knowledge of resources. Participants also reported that knowledge of resources was an important part of provider training. Three participants noted the importance of having a broad base of resources and knowledge for them to draw from:

Well, I think they [providers] need to know the system. Know how everything works.

There’s a certain amount of teaching that providers can give to people and their families [about LGBT persons] and supply them with the resources and information that informs them about our lives or acts kind of like an interpreter for our needs.

[Provider training] means having experience in getting acquainted with the alternative communities that are out there enough so that you have some resourcefulness about who you can refer to and bring in for consult. It would mean increasing your background in the specialty of the GLBT person’s needs and then it’s a whole spectrum of resources. It’s not only medical, but a whole spectrum of resources, housing, and financial.

Academic and ongoing training. Participants reported that receiving formative academic training and ongoing training for provider settings were both important factors in providing quality health care. Some participants suggested academic training needed to occur so that future providers are educated about the needs about the LGBT populations:

I don’t know if there’s any kind class in medical school or nurses training or nursing assistants when they get trained in any kind of cultural things. If there is, GLBT needs to be in there. We just have to be part of that because we have different needs and live differently. It would be very important to know that I can be who I am and go in there and get the treatment I need.

I think it’s important that you just have a clue of what’s going on, it doesn’t have to be huge. I’m not sure they need a [whole] class in LGBT issues when they’re going through school, but it would be nice to have someone like me come and talk to them for an hour and a half. This is what it’s about. Now you know a little bit and you can go out and get more information.

Participants also suggested providers need to receive ongoing training to accurately access and respond to the changing needs of LGBT persons. Participants described the need for this kind of training:

Focus on continued training [for providers] ... I also think they can probably be more responsive if the system can quickly respond with the legal issues of consent and all that.
We have difficult families, so it’s important to get it right. So a family member doesn’t step in.

Do more in-service trainings to sensitize people to situations and people and stuff. Work with the hospital to come up with some ideas how to best serve the population and find out from the [LGBT] community what they are really looking for and not assume [the providers] they are meeting the needs of the LGBT people.

Long-term Care Facilities for LGBT

The topic of long-term care for LGBT was another theme that emerged from the data. Ten participants reported concerns about long-term care facilities across the continuum of age, gender identity, and sexual preference. Participants described their concerns most specifically to nursing home care related to discriminatory attitudes and poor treatment from staff and other residents. As a means to effectively respond to biased treatment from staff and residents, some participants spoke about having anti-discrimination policies in place to protect them. Participants also reported their thoughts about long-term care by stating their preferences and ideas about what long-term care environments would resemble.

Concerns. Participants conveyed concerns about long-term care facilities in various contexts. Some participants explained their perspectives were related to receiving care from persons who were from different parts of the world and cultures who may have negatively biased views of LGBT people. Several concerns are expressed:

The population that serves healthcare has changed so drastically. There are so many different cultures. I’ve been told by other elderly people that have gone to nursing homes in particular about able to understand the people [caregivers] because they have a heavy accent. Also, these people [caregivers] from different cultures, maybe they’ve grown up with very negative feelings about homosexuality and this doesn’t like disappear just because they’ve moved here. Even though they have been trained, they might still carry the feelings, the negativity and discrimination. So that might seem kind of scary. And also, not only different cultures but certain religions. You might have a Fundamentalist Christian [caregiver] who doesn’t believe in gay marriage and treats you poorly because of that. And I don’t know how, I know training is a big part of it but, people’s attitudes don’t change overnight and so I guess you would have to make sure you had some kind of ombudsman that you could speak to if you were receiving poor care, discrimination.
I volunteer at a nursing home and there’s all kinds of other nursing personnel from other countries. So you have the added issue that they don’t culturally experience where we’re coming from and understand us [LGBT people], let alone have any sensitivity toward discrimination practices.

Some of my [LGBT] friends are in nursing homes, and I think how the other residents are with things makes a big difference. They may be older and from a different world, but they can certainly be shaming and make you feel uncomfortable and all that. A friend of mine is living in one part of a facility and her partner is living in another part of the same facility. Most of the folks there are understanding of that relationship. But, there are some staff that struggle with it. Typically, the Africans, relatively new to this country, relatively religious, they go around with the bless you kind of thing. So, my concern [for a nursing home] is what their policy is and how they would handle something like that. The staff shouldn’t ignore it and they need to figure out a strategy for it.

Other participants reported they were not as concerned with the staff members of a facility as they are with being mistreated by other residents:

I still feel nervous about when I’m going to need a nursing home or assisted care or something like that. I may never end up in place like that but... if I’m going to be in place long-term, I’m not so much [nervous about] the facility or the staff, but other residents. There’s gonna be people there that are my age that haven’t changed with the times.

Well, I see problems in nursing homes more with my mom’s generation, for instance. She’s 86. I know there are people there who are gay. LGBT people and there in the closet because they’re afraid of their peers’ reactions. Not necessarily the workers, but the other people who live there, the other residents. I also think they [care providers] need to respect confidentiality more because not everybody wants to be out. A lot of people go back in the closet, as a matter of fact, when they go into nursing homes. I’ve heard a lot of that happening. There was a man that I know who had to go into a nursing home for a while. He said it was horrible because he had to go back into the closet because he was afraid his peers would treat him badly.

I would probably be concerned if I was thinking I was being faced with a nursing home soon. I know for me, it’s really scary that some transgender people have to go back to their original sex. You gotta be a boy again, you gotta be a girl again, you gotta be something you’re not in order to get service from us. That’s just tragic, a nightmare.

Suggestions and ideas. In addressing concerns about long-term care for LGBT, participants had a few ideas and suggestions. One participant suggested a long-term facilities specifically for LGBT persons, while two others suggested ways to alleviate isolation, and increase LGBT visibility and inclusiveness:
I’m hoping for more long-term care facilities that are geared toward LGBT people. I know there are some in this country but not many. I refuse to go into the closet. I’m not gonna do that.

I think care centers need to have a way for [LGBT] folks to connect more. I’m not aware of such a thing in a nursing home. Maybe a [LGBT] mentoring program or something like that because it’s got to feel awfully isolating. It’s probably essential in mental settings too. Not everyone feels as free as one would like them to be or supported.

It would be wonderful if nursing homes had other gays and lesbians there and that would make you feel really comfortable. They [nursing homes] could feel more inclusive because most of the time people are going to assume that you’re straight and they’re going to treat you that way. They’re going to ask you about your husband or kids or whatever. If you didn’t have that you wouldn’t feel very included. I know that they celebrate birthdays and holidays and stuff like that, but what about celebrating Gay Pride Week? They could have posters, videos, and other monumental events that people could see and everybody would recognize, ‘oh this is important to them.’

**LGBT Views on Aging**

All participants presented their views on aging in various contexts. Subthemes included: attitudes about aging, the importance of supportive connections, concerns about aging, and the need for self-advocacy.

**Attitudes about aging.** Participants reported a range of attitudes about aging. A number of participants expressed positive perspectives on aging that were optimistic, self-affirming, grateful, and enthusiastic. Some participants described that with aging there was a sense of freedom, growth, self-acceptance, and caring less about the expectations of others:

_The upside of aging is that I’ve reached an age where I say pretty much what I want to say. I don’t care if someone... well, of course, I care if people like me or not, but not enough to keep my mouth shut._

_I have evolved as I came out more and with age and decided that I didn’t give a rat’s ass what anybody thought about anything._

_I’m not going to chop off my hair and try to fit in with somebody else’s expectations anymore. This is who I am and I’m not here to hurt anybody, I’m here to be._
I think that’s the promise of aging, self-awareness, growth, um... that one thereby accepts the variability and wonder of just being who you are and sharing that. That’s all we could ever hope for.

Other participants conveyed similar positive outlooks on aging. For example, these participants felt youthful, enthusiastic, and gratitude about the aging process:

I haven’t even started looking at stuff for aging. I mean, I guess I’m aging to some people, but to me I’m not aging yet.

I can’t wait on see what’s gonna happen next. That’s what’s exciting about life. I’m an eternal optimist, so I can’t wait ’til tomorrow.

This is great [aging as a transgender woman]. And who knew? There have been other things in my life that have been hard, but this has been just a gift. I feel like I can bring that to the party [a being transgender aging person] and have a ball doing it.

Despite the many positive feelings on aging, two participants also reported some challenges about getting older. Both participants noted that the aging process brought decreased abilities and increased health issues:

I’m going to have someone come in and help with some housework that I’m not getting done. But that’s no issue with gender. That’s just because I’m getting old, too old to do all these things. I get by day after day, but everything is getting harder.

First of all, aging sucks. As they say, it’s not for sissies. I never felt that I was aging. Then suddenly, just like that, major health problems.

Importance of supportive connections. A number participants reported the significance of having supportive connections in their lives as they aged. Interestingly, more gay men noted this more than lesbians. For example, participants described these relationships in contexts of the LGBT community, having close friendships, supportive neighbors, and being active in their churches:

It’s been helpful to me to have a good, healthy gay community where they have all the support networks around.
I like that many of my neighbors are LGBT. We do look out for each other and like, if someone is sick, everybody chips in and we buy them food. If I don’t go out for a few days, they’re gonna check on me.

I don’t have a partner but I have wonderful friends.

We’ve got a lot of good home base places to be. We have some real close friend groups that we play cards with in the family, kind of. And, we’ve got the church.

One participant also acknowledged the absence of having meaningful connections and how important they are:

I have so much to be thankful for. I’ve had a good mind, I’ve had employment, and I have a comfortable retirement. I could make quite a list, but I don’t have people anymore. In the Prayer of Serenity, that’s the one thing I would change if could and I do have the wisdom to know the difference.

**Concerns about aging.** A number of participants reported concerns for LGBT aging persons and future generations, which were expressed across the continuum of age, gender identity, and sexual preference. Participants described their concerns in the contexts of overall well-being, accessibility, affordability, and ease of using the health care system, and housing.

What I’m concerned about is not so much people of my own age, but those who are a little older and are not... who did not come out in any kind of social movement of the 60s, 70s, and so on and tend to be more closeted. How will they be treated and have their own voices?

The younger generation, this whole idea of safe sex and all this. There are so many left [younger gay men]. They [younger gay men] seem to be unconcerned and think that’s sad that they’re not getting the support at younger ages about sexuality in general. The dangers and so forth. I think when I was sexually active, I never practiced safe sex or thought about. Then, in the early 80s, I saw all these guys dropping dead all around me. But it seems like this younger generation think they can just take a pill for something or whatever. You can’t do that anymore.

I think we have to pay attention to the generational stuff going on with all of this [LGBT aging]. It is really important that we think of all people when we’re doing things. We need to make life better for everyone we come in contact with. I think we kinda owe that to the coming population some help in this whole area.

Everyone needs quality care with respect, confidentiality, and coordinated services.
I’m concerned about figuring out Medicare, which is a common concern for people in our country. I find the whole system hard and I’m reasonably smart for crying out loud.

Housing for older, not just transgender people but LGBT, the whole acronym is going to become a larger concern. You know, it seems like people [LGBT] have a different circumstance in life when they come out as LGBT. They lose family, so they don’t have family support all of the time.

Self-advocacy. Several participants stated that self-advocacy was an important part of getting one’s health care needs met. Fifteen participants reported that taking a proactive approach to their health care was a collective and individual responsibility. Participants described various ways of self-advocacy such as being vocally assertive, researching providers, and taking action if their needs were not addressed properly:

I do a lot of my own research for my health care.

[As LGBT older adults] part of the responsibility is on us. To be able to be in a place where, in a place emotionally and intellectually I suppose where we can challenge people without having to yell and scream just to get our needs met.

We [LGBT older adults] have to speak up and talk about... first of all, determine what our needs are and then speak up.

We [LGBT older adults] need to make our feelings known. It’s up to us to indicate what our needs are.

I recognize that if somebody treats me wrong or doesn’t provide the right kind of care, there are regulatory bodies I can go to.

I’m not mean, but I don’t put up with any crap either. If I feel disrespected in any way, I’m very clear about it.
Discussion

The discussion section of this study will begin with findings supported by the literature. This will be followed by a discussion of unexpected findings of the data. Then implications for social work practice will be presented. Lastly, implications for future research will be suggested.

Findings Supported by the Literature

A number of this study’s findings are supported by previous literature. These include: the significance of LGBT-friendly care, importance of provider training, concerns about long-term care facilities, and perspectives on LGBT aging. The finding that LGBT older adults would desire LGBT-friendly care providers and settings is consistent with what several scholars have suggested (Croghan, Moone, & Olson, 2012; National Resource Center on LGBT Aging, 2013; PFund, 2012). Since LGBT older adults have a unique history, specific care needs, and are more likely to have non-traditional relationship and family structures, it is reasonable that the participants in this study would want care providers that were LGBT-friendly. As this study’s findings suggests, receiving care from LGBT-friendly providers increases comfort levels and satisfaction with providers, which would likely improve the potential for better care outcomes. These findings are also consistent with the minority stress conceptual framework used for the study (National Resource Center on LGBT Aging, 2013). For persons who are considered minorities and who have endured a significant amount of institutional and social stigma, it is not surprising that this study’s participants would find it important to receive care from LGBT-friendly providers and facilities.

The finding of participants noting the importance of care providers needing to be trained in meeting the needs of LGBT population supports what other studies have suggested (Croghan, Moone, & Olson, 2012; Institute of Medicine, 2011; Jenkins-Morales et al., 2014; Lambda Legal, 2010; Porter & Krinsky, 2013). The participants in this study noted that it is critical for
care providers to be trained and sensitive to the needs of LGBT older adults in the areas of
cultural diversity, familiarity with resources, and as part of academic curricula. In addition,
participants see LGBT-specific training as an important part of initial and ongoing professional
training. In part, this data speaks to the complex intersectionality of the LGBT population. The
demographic make-up of LGBT older adults, which includes a broad spectrum of racial, ethnic,
and socioeconomic backgrounds, makes responding effectively to care needs via increased
training relevant on that basis alone. In addition, the diversity of LGBT older adults as related to
gender identity, sexual preferences, and family structures adds further complexity and makes
provider training even more imperative in knowing what/where resources are appropriate.

This finding is also speaks to aspects of the conceptual lenses used for the study: conflict
theory and minority stress theory. First, conflict theory can be used to illustrate the advances in
civil rights for the LGBT population that have resulted from years of social and political activism
that has insisted that providers be educated and understanding of the needs of LGBT population
(Hutchinson, 2008). Second, the minority stress theory can be interwoven here to demonstrate
that this group of LGBT older adults are members of a marginalized population group that have
seen significant positive social and institutional changes, which are more likely to be sustained if
providers continue to receive training and education (National Resource Center on LGBT Aging,
2013).

The finding that the participants of study have concerns about long-term care is also
consistent with what a number of scholars have suggested (Justice in Aging, 2010; PFund, 2012).
This study indicated participants had serious concerns about LGBT-related discrimination from
long-term care staff members and residents alike. To mediate these concerns, participants had
suggestions and ideas about how to make these environments more inclusive for LGBT older
adults. Given the vulnerability older adults face due to potential declines of physical and cognitive capacities, having to spend time or live at a long-term care facility may be necessary for some. Older adults also may encounter increased isolation because of these declines, which may be paired with diminished social supports, resulting in even more vulnerabilities in long-term care environments. Accordingly, for LGBT older adults addressing concerns about mistreatment, safety, and inclusiveness is vital to their well-being in long-term care facilities given their history of social and institutional discrimination. These concerns have been addressed through various advances civil rights advances but remain something to be vigilant about for a population that still can face prejudicial treatment.

Participant perspectives on LGBT aging are also consistent with what several scholars suggest (Fredriksen-Goldsen et al., 2011; MetLife Mature Market Institute, 2006; PFund, 2010; SAGE, 2014). The participants of this study shared their attitudes, concerns, beliefs about self-advocacy, and the importance of social connections about aging in a ways that are likely to be true for both LGBT older adults and non-LGBT aging persons. However, the perspectives of LGBT older adults have about some of these common concerns are heightened when viewed through the conceptual lenses of conflict theory and minority stress. Because the participants of this study have been resilient despite enduring a significant history of marginalization, it is likely that strong feelings were expressed. In addition, the importance of social connections for LGBT older adults can be seen as a resiliency factor for a minority population being able to mitigate the differences of often times not having traditional support systems. Lastly, several participants noted having strong feelings of self-acceptance, which can be seen as integrity in aging but also as a testimony of their strength of surviving and thriving while facing challenging circumstances as a minority population.
Unexpected Findings

One unexpected finding of the data was that participants had overwhelmingly positive health care experiences, which challenges findings from other scholars (Justice in Aging, 2010). One possible reason for this is that most participants reported having long-term relationships with their care providers and facilities, and this may account for their positive experiences and high level of satisfaction with the care they receive. Another possible explanation is that the participant sample was made up entirely of Caucasian individuals, which would likely decrease bias based on racial or ethnic identity. A further possible reason for this finding is that Minnesota has offered more opportunities for provider trainings than other organizations in the Midwest and at the national level (PFund, 2010). Thusly, providers in Minnesota would have a better understanding of LGBT older adults and their needs, which would increase the potential for better care experiences and outcomes. Another potential explanation is that in 1993, the Minnesota Human Rights Act broadened its definition of sexual orientation, which largely prohibits discrimination based upon sexual preference or gender identity (OutFront Minnesota, 1999-2013).

Implications for Practice

This study’s findings suggests a number of significant implications for clinical social work practice. These implications can be addressed on micro, mezzo, and macro levels. At the micro-level of practice, clinical social workers need to engage in reflective practice so that they gain insights into how personal values and biases related to gender identity, sexual preference, and family structures can impact their work with LGBT older adults. In the area of direct practice, clinicians can promote a LGBT-welcoming atmosphere by making sure that visual cues (such as rainbow stickers, affirming literature, and anti-discrimination policies) are in easy to see
locations. Also, practitioners should be sensitive and aware of pronoun use and not assume a person’s gender identity matches their social presentation. In addition, practitioners can engage in ongoing self-initiated education efforts and training to further expand their knowledge of the LGBT aging population.

On a mezzo-level, the findings of the study suggests a number of implications for social work practice worth noting. First, providers in community settings can place visual cues such as signs, symbols, and literature that is LGBT-affirming and welcoming in their practice environments to support visibility and inclusiveness for LGBT persons. Also, community providers can place anti-discrimination information prominently in their settings to assert a clear message promoting equality, justice, and safe treatment of all people. In addition, agencies should have data collection and intake forms that are inclusive to LGBT people as related to sexual preference, gender identity, and relationship structures. Similarly, provider settings need to allocate funds for practitioners to be trained and educated on how to effectively work with LGBT older adults and their families. Also, in a further effort to better meet the needs of LGBT older adults, care settings need to make LGBT aging information and resources easily available for clinicians and patrons. Also, providers and facilities can better serve the LGBT population by making LGBT-specific groups available to older adults for matters related to aging support, illness, and grief and loss issues, especially to meet the needs of aging gay men who survived the AIDs epidemic in the 1980s and suffered profoundly complex losses. Lastly, agencies should promote the importance of clients/patients completing advanced health care directives for end of life issues.

On a macro-level of practice, the implications for clinical practice are significant. One important area of focus is maintaining lobbying efforts to uphold the recent civil rights advances
HEALTH CARE MATTERS

in government policies that continue to positively impact the LGBT aging population including: hate crime legislation, same-sex marriage, hospital visitation rights, and access to health care coverage. Another implication of the findings suggests the Council on Social Work Education should make aging and LGBT topics a required component of social work curriculum as a measure to provide basic education about these areas, both of which are critically important and underserved populations. A final implication for practice is that national organizations such as the National Board of Social Work make sure that LGBT people are well-represented to ensure that insider perspectives on professional development, ethical standards, and advocacy efforts are inclusive and culturally sensitive.

Implications for Future Research

This study suggests implications for future research in a number of key areas. First, more research is necessary to address the needs of LGBT aging adults, which should include not only the physical and psychological aspects of aging but also issues related to long-term care environments to address concerns related to discrimination and lack of LGBT inclusiveness. Relatedly, research needs to be conducted to better understand how we can respond effectively to transgender and gender nonconforming persons in long-term care facilities. In addition, data collection methods should be further researched to address the complexity of the LGBT population related to sexual preference, gender identity, and relationship structures. In addition, more research is required to better inform care providers about the perceptions and experiences of LGBT older adults of color, transgender men, and bisexuals, all of whom were not represented in this study and are not well-researched populations. Future research is also needed to understand how to effectively meet the needs of LGBT older adults living in other geographic locations of the country since this study’s sample consists of persons living in Minnesota where
providers and facilities have received training on LGBT health care at higher rates than what has been found at national levels and have policy provisions in place that prohibit discrimination based on sexual orientation. Correspondingly, since the participants of this study are living in a metropolitan area, future research efforts should examine the perceptions and experiences of LGBT older adults living in rural areas where access to resources may be more limited and social isolation more prevalent.

**Conclusion**

This research study provides some insights of the first generation of LGBT older adults who have lived openly and visibly as LGBT individuals, and their perceptions and experiences in health care. As one participant of this study said about aging, “it’s not for sissies.” To successfully respond to the needs of LGBT older adults a number of challenges will need to be met, which can be overcome through collective efforts of providers across the domains of micro, mezzo, and macro levels of practice and through future research efforts. The data of this study suggests that LGBT older adults take an active interest in their health and well-being and have a unique perspective to share. The principles of social justice demands that their voices are heard. It is the responsibility of the social work profession to answer the call.
References

http://www.aoa.gov/Aging_Statistics/Profile/2013/docs/2013_Profile.pdf

Administration on Aging. (2014). Diversity. Retrieved from:
http://www.aoa.gov/AoA_programs/Tools_Resources/diversity.aspx


http://www.sageusa.org/issues/general.cfm?&print=1


Appendix A.
De-indentified letters of institutional and organizational approval.

A1.

January 11, 2016

Dear Ms. Hoffman:

Our Board of Directors has approved providing our members with your information. It is our policy to have you supply us with an electronic copy of your flyer which we will then send out to our members via our weekly update system and monthly newsletter.

Based on the information you provided to us the study will be done through interviews and participation is voluntary. Your data will be protected and kept confidential.

The study will begin in January 2016 and end February 2016.

We wish you well and thank you for addressing this issue.

Respectfully,

[Name]
Outreach and Education Chair
Prime Timers Minneapolis/St. Paul
Dear Mary Hoffman:

I have reviewed your research proposal, entitled Perceived Barriers to Care for LGBT Older Adults, and grant permission for you to post materials for the purpose of recruiting subjects for your study. It is understood that your study aims at the barriers to care LGBT older adults perceive in health care settings and how health care settings can be more responsive to needs of lesbian, gay, bisexual, and transgender (LGBT) older adults. It is further understood that:

- Participation is completely voluntary and the participants may withdraw from the study at any time throughout the research process without consequence.
- There are risks for participants of the study, including experiencing emotional distress
- Confidentiality of data will be maintained by removing names from the study.
- The study will begin in January 2016 and end in May 2016.
December 30, 2015

Dear Ms. Hoffman:

I have reviewed your research proposal, entitled Perceived Barriers to Care for LGBT Older Adults, and grant permission for you to hang a flier at [redacted] to solicit participants for your study. It is understood that your study aims at exploring, through the use of interviews, the barriers to care LGBT older adults perceive in health care settings and how health care settings can be more responsive to needs of lesbian, gay, bisexual, and transgender (LGBT) older adults. It is further understood that participation is completely voluntary and the participants may withdraw from the study at any time throughout the research process without consequence.

There are risks for participants of the study, including experiencing possible emotional distress.

Confidentiality of data will be maintained by you.

The study will begin in January 2016 and end February 2016.
December 09, 2015
12/28/2015

Dear Mary S. Hoffman:

I have reviewed your research proposal, entitled “Perceived Barriers to Care for LGBT Older Adults,” and grant permission for you to recruit residents or obtain and use data—if data is to be gathered, to “explore the barriers to care LGBT older adults perceive in health care settings and how health care settings can be more responsive to needs of lesbian, gay, bisexual, and transgender (LGBT) older adults.” It is further understood that participation is completely voluntary and the participants and/or organization may withdraw from the study at any time throughout the research process without consequence. In addition, we understand that any resident that experiences emotional distress may end the interview, and or not answer specific questions as they choose. All names of participants are held confidential.

I look forward to learning more.
Appendix B

Consent Form

Health Care Matters: Perspectives from LGBT Older Adults

You are invited to participate in a research study I am conducting to explore the perspectives that lesbian, gay, bisexual, and transgender (LGBT) older adults have about accessing health care services, and how health care settings [such as primary care clinics, hospitals, and residential/nursing facilities] can be more responsive to needs of LGBT older adults. I invite you to participate in this research. You were selected as a possible participant because you are an LGBT adult age 62 or older and are currently using health care service settings [such as primary care clinics, hospital settings, and residential and nursing facilities] or have within the past five years. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Mary Hoffman, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas, and is supervised by Dr. Mari Ann Graham of the School of Social Work, St. Catherine University/University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to explore how health care service providers and facilities such as primary care clinics, hospital settings, and residential and nursing facilities can be more responsive to the needs of LGBT older adults.

Procedures

If you agree to participate in this study, I will ask you to do the following things: participate in an interview for approximately one hour on the date, time, and location of your choice. To protect your confidentiality, I will request that the interview takes place in enclosed area such as an office or in a room with a door that can be closed. Approximately 8 to 12 other persons are participating in the study. The interview will be audio-recorded by the researcher and transcribed by a paid professional transcriber. The transcriber has signed a confidentiality agreement. You are free to skip or not answer any questions while participating in the interview. I am planning on asking participants any clarifying questions during the interview and do not plan on following up with you after initial procedures and the interview is completed.

Risks and Benefits of Being in the Study

There is risk involved in being in this study. A risk involved in participating in the study includes the possibility of experiencing emotional distress. To safeguard against and use precautions to minimize the risk of possible emotional distress I will do the following: throroughly discuss the informed consent form with you before the interview and answer any questions about what possible types of emotional distress could arise. You may skip any questions you feel
uncomfortable answering or you may stop the interview at any time. During the interview, I will be observant of any indications of possible emotional distress and check-in to see if you are experiencing these feelings. If you say yes, I will ask you if you would like to skip the question or if you would like to stop the interview for a few minutes to allow these feelings to pass. I will also remind you that you may end the interview at any time without penalty. As an additional resource to safeguard against and minimize the risk of possible emotional distress, I will have the phone number of a mental health crisis line available.

There are no direct benefits for participating in this study.

Privacy

Your privacy will be protected while you participate in this study. I will protect your privacy by allowing you to choose the date, time, and location of your interview. For the purposes of preserving confidentiality, I will request that the interview takes place in enclosed area such as an office or in a room with a door that can be closed.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include consent forms, audio-tapes, notes that have been taken in a paper format, transcripts, and a master list that will be coded with a letter and number as a measure to collect data related each participant’s age, sexual orientation, and gender identity, which will be used for data purposes only. The names of participants will not be used. The principal research investigator will have access to the data which include: audio recordings, notes that have been taken in a paper format, transcripts, a master list of personal identifiers needed for data analysis purposes with the age, sexual orientation, and gender identity of each participant, and consent forms. A paid professional transcriber will have access to the audio recordings of the interviews and any personal identifiers will be deleted from the transcripts. The transcriber’s signed Transcriber Confidentiality Agreement is included on a separate document in the researcher’s application packet. The audio recorded interviews will be destroyed by the researcher within two weeks after transcription. To further preserve confidentiality, all forms of research data will be stored in a locked filing cabinet in the principal investigator’s home. The researcher is the only person who has a key to the filing cabinet and knowledge of where the key is kept. As an additional measure to preserve confidentiality, digital files of the transcripts will be encrypted and stored in a password protected laptop computer owned by the principal investigator. While traveling, all forms of research data and the researcher's password protected laptop with encrypted digital files of the data will be locked in the trunk of the principal researcher's automobile. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study
HEALTH CARE MATTERS

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the School of Social Work, or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used. You can withdraw by contacting me at xxx-xxx-xxxx or at hoff5696@stthomas.edu.

Contacts and Questions

My name is Mary Hoffman. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at xxx-xxx-xxxx or hoff5696@stthomas.edu or Dr. Mari Ann Graham at 651-962-5812. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

_______________________________________________________________
Signature of Study Participant Date

_______________________________________________________________
Print Name of Study Participant

_______________________________________________________________
Signature of Researcher Date
Appendix C

Interview Questions

1. Demographic questions:
   - What is your age?
   - What is your gender identity?
   - What is your sexual preference?

2. I would like you to describe how you seek out services from health service providers or facilities. I am thinking about three settings in particular: primary care clinics, hospital settings, and residential or nursing facilities. How do you do this? What is your process?

3. How can you tell if health care service providers or facilities [such as primary care clinics, hospital settings, and residential or nursing facilities] are welcoming and affirming?

4. How can you tell if health care service providers or facilities [such as primary care clinics, hospital settings, and residential or nursing facilities] are trained and knowledgeable about the needs of the LGBT population? LGBT older adults and their families?

5. How would you describe your level of comfort as an LGBT older adult in accessing and utilizing health care service providers or facilities [such as primary care clinics, hospital settings, and residential or nursing facilities]?

6. What barriers, if any, do you have in terms of accessing health care service providers or facilities [such as primary care clinics, hospital settings, and residential or nursing facilities]?
7. Tell me a story about a health care service provider or facility [such as primary care clinics, hospital settings, and residential or nursing facilities] that was responsive to your needs and the needs of LGBT older adults in general?

8. What changes would you like to see health care service providers or facilities [such as primary care clinics, hospital settings, and residential or nursing facilities] make in terms of how they provide services to older LGBT persons and their families?

9. What needs do you prioritize as being most important or urgent for older LGBT persons receiving health care services from providers or facilities [such as primary care clinics, hospital settings, and residential or nursing facilities]?

10. How do you think social workers in health care settings [such as primary care clinics, hospital settings, and residential or nursing facilities] might provide more culturally responsive services?

11. What recommendations (in general) do you have for making health care settings [such as primary care clinics, hospital settings, and residential or nursing facilities] more responsive to the needs of LGBT older adults?

12. What else would you like to tell me about this topic?
Appendix D
Research Flier

Seeking LGBT Research Study Participants
Age 62 and Older

Hello! I am conducting a research study to explore the perspectives that lesbian, gay, bisexual, and transgender (LGBT) older adults have about accessing health care services, and how health care settings [such as primary care clinics, hospitals, and residential/nursing facilities] can be more responsive to needs of LGBT older adults.

To be eligible to participate in the study you must be:

- LGBT and at least 62 years old
- currently using primary care clinics, hospital settings, and residential and nursing facilities the health care system or have within the past five years
- willing to be interviewed for approximately one hour at a location of your choice

Participation in this study is entirely voluntary and your interview is confidential. If you decide to participate in this study, you are free to withdraw at any time without penalty, up to one week after the interview. Should you decide to withdraw, data collected from your interview will not be used.

*If you are interested in volunteering as a participant in this research study or have any further questions, please contact Mary Hoffman at xxx-xxx-xxxx or hoff5696@stthomas.edu.

Thank you!