Healthy Aging and Special Considerations for Lesbian, Gay, and Transgender Older Adults in rural settings

Kathleen M. Nokes, PhD, RN, FAAN
kathynokes@aol.com

Objectives

• Analyze how stigma impacts on aging for LGT persons living in rural settings.
• Identify how key social determinants of health (Social and Community context and Neighborhood and Built Environment) impact on health status of LGT persons living in rural settings.

• Identified Gap:

• Although persons have lived as sexual minorities for centuries, the later part of the 20th century and the AIDS epidemic resulted in increased visibility and rights for LGT persons.
• Aging brings new challenges for all persons including limited choice due to functional and economic status.
• These limited choices can impact on whether a person can live openly as a gay man, lesbian, or transgender person especially in rural settings.

Definitions

• LGBTQ = Lesbian; Gay man; Bisexual; Transgender; Queer/Questioning

• Take-home points:
  • the person will self-identify and then you can ask for clarification
  • Distinct cultural groups within sexual minority communities and subgroups with unique language and norms – can get confusing so focus on “need-to-know”

• Heterosexual, cisgender populations
Definitions (cont):

RURAL

• The Census Bureau does not actually define “rural.” “Rural” encompasses all population, housing, and territory not included within an urban area. Whatever is not urban is considered rural.
• Office of Management and Budget (OMB) estimates that about 17% of the population was Non-Metro; 74% of the land area; 46.2 million people; and about 15% of the total population.
• The HRSA website has a Rural Health Grants Eligibility Analyzer where you can search for eligible counties, or eligible census tracts inside Metro counties. You can also download complete lists of rural areas by County, Census Tract and ZIP code on the FORHP Data Files page.

Healthy Aging

• The Healthy Aging Data Portal provides easy access to Centers for Disease Control and Prevention data on a range of key indicators of health and well-being, screenings and vaccinations, and mental health among older adults at the national and state levels.
• These indicators provide a snapshot of currently available surveillance information, and can be useful for prioritization and evaluation of public health interventions.
• Usually measured by the item:
  • Self-rated health (good to excellent health). Age groups 50 and older

Social Determinants of Health

• Are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
• Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.”
• In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live.
• Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.
Stigma

- Enacted stigma: experiences of discrimination from others in the past or present
- Internalized: endorsement and application of negative beliefs and feelings about people like you* and applying them to the self
- Anticipated: expectations of experiencing discrimination from others in the future

* Model created for people living with HIV and adapted for this presentation.

Health disparities: LGB populations not based on geographic location

LGB persons are more likely than heterosexuals to:
- smoke currently
- use alcohol and other drugs
- experience poor mental health and self-directed violence.
- obesity issue - lesbians

LGB persons are more likely to be at risk for chronic conditions including:
- cardiovascular disease and certain forms of cancer
- asthma and respiratory diseases
- headaches
- allergies
- osteoarthritis
- serious gastrointestinal problems.

LGB persons are more likely to delay or avoid getting healthcare services care than their heterosexual counterparts.

LGB living in urban compared to rural place

- LGB persons living in rural areas or areas with a lower density of LGB persons may:
  - feel less comfortable disclosing their sexual orientation
  - have fewer supports from families and friends
  - may lack access to an LGB community (IOM)

- OR
- They may NOT
What is the evidence?

• Aging sexual minorities often face hardships including isolation, financial stress and social inequities that make managing their healthy/medical and mental health problems challenging
• Risk of suicide is estimated to be two to four times higher than that of heterosexual individuals
• The health care climate—including culture, economy, and traditional practices—is complex and culturally sensitive practices are by no means consistently integrated.
• Aging LGBT adults often do not disclose their sexual orientation for fear that they will be confronted with prejudice and biased treatment by their providers—anticipated stigma
• Past discriminatory practices against LGBT patients leads to perceived and actual homophobia that perpetuates problems with accessing adequate health care

Research exploring the intersection of geography and sexual orientation: LGB and heterosexuals in rural and nonrural settings

• Used a multistate and population-based data, specifically the Centers for Disease Control and Prevention’s (CDC) Behavioral Risk Factor Surveillance Surveys (BRFSS)
• FINDINGS:
  ▫ among rural women, lesbians and bisexual women were less likely to be married/coupled than heterosexual women
  ▫ lesbians were more educated and more likely to have served in the military than other women.
  ▫ gay and bisexual men were less likely to be married/coupled than heterosexual men and gay men were less likely to have served in the military.
  ▫ no differences were observed between rural lesbian and heterosexual women on any health indicator
• Summary: there were fewer differences on key health indicators between rural LGB persons and their rural heterosexual counterparts

Take home points from Farmer’s research

• If sexual orientation questions are asked (and only states chose to ask those questions—not the national government in 2010), meaningful data can be collected
• Living alone is more common and this has implications for social support when functional status becomes impaired
• Lesbians were more likely to have served in the military which opens up the possibility of access to the Veterans Administration facilities. That gay men had less service is probably due to the policies that did not allow gay men to serve.
Healthy People 2020 (new topic for HP)

• **Goal:** Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.

• **Specific objectives related to LGBT persons:**
  
  • LGBT-1 Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, bisexual, and transgender populations
  
  • LGBT-2 Increase the number of states, territories, and the District of Columbia that include questions that identify sexual orientation and gender identity on state level surveys or data systems

BUT, the Census Bureau’s 2020 survey will **not** ask about respondents’ sexual orientation or gender identity

• An initial draft showed that respondents would be asked about their sexual orientation and gender identity, among the 51 other categories of questions.

• But a final version did not include the sexual orientation and gender identity questions — SOGI, in Census parlance — among the proposed topics.

• Had been voluntary question in 2010.

SO WHAT – why should nurses consider sexual orientation of older populations?

• **Identification of risk.** Social isolation can be higher in persons who live alone and sexual minorities are more likely to live alone – for many, this is a continued impact of the HIV epidemic in the 1980’s when so many of the cohort died. Implications for discharge planning and determining safety. Also, especially for lesbians, finances might be limited since women in general earn less than men.

• **Legal issues.** Advanced directives and the naming of preferred persons. Not assuming biological relationships are primary. Asking, and not assuming “Mrs X”. Advising clients to ensure that advance directives are in order and reflect preference when the persons are competent.
Living in community settings: Justice in Aging findings

- A majority of LGBT seniors living in long-term care settings believed they would face discrimination from housing staff if they were open about their sexual orientation.
- The report, that was written in 2010, captured hundreds of stories of problems encountered by L.G.B.T seniors with housing staff, ranging from harassment to refusals to provide basic services or care.

Eight years later and a Supreme Court decision on right to marry – may have changed the legal landscape. The anecdotal evidence is that staff know that there are consequences but the issues are coming from other residents.

http://www.justiceinaging.org/our-work/focus-populations/lgbt-older-adults/


Strategies

Create a safe, welcoming environment

- Post LGBTQ-positive visual representations, for example, images of people/families of differing gender/sexual, cultural, ethnic/racial backgrounds, in lobbies/examination rooms
- Use culturally appropriate, culturally specific terms on intake forms; that is, recognize that some patients may prefer local terminologies such as Native American use of "Two-Spirit," patient preference for "queer" over "lesbian," "gay" or "bisexual," and/or use of "they" as a preferred gender pronoun by people across the sexual/gender minority spectrum
- Include gender/sexual difference in displayed antidiscrimination policies


Evolving case: Marsha Wetzel

- Ms. Wetzel had lost her life partner of 30 years to colon cancer, as well as her home in Skokie, Ill., a suburb of Chicago.
- Moved to a senior living community, specifically Glen St. Andrew, a private senior living facility in Niles that houses low-income people without many options
- In the suit, she accuses the housing center and its managers of failing to protect her from hostile residents who have insulted and verbally abused her. The suit says that she has been pushed, shoved and spit on, and that she was injured, including bruises on her arm, a bump on her head and a black eye.

Staff are being specifically named in Martha’s lawsuit

- Marsha repeatedly complained about the sex- and sexual orientation-based harassment she has experienced to the administration of GSALC, including Executive Director Alyssa Flavin, Director of Supportive Services Carolyn Driscoll, and Regional Director of Operations Sandra Cubas (collectively, “the Administration”). Other GSALC staff and residents witnessed some of the incidents and reported them to the Administration. **Defendants have taken no meaningful action to stop the harassment**, but instead have marginalized and alienated Marsha and retaliated against her for complaining about the harassment.

Summary

- Addressing the interface between two minority populations: sexual and geographic (place) and, perhaps, an overlay of race/ethnicity, means that the “patient” has to be proactive to self-identify since the assumption is that s/he is not part of a minority.
- Healthcare providers need to create an environment that not only supports disclosure but also intervenes when stigmatizing behaviors are occurring – in other words, the risk associated with disclosing needs to be outweighed by the benefits gained through disclosure.
- Not much evidence, nor political climate in the United States currently, to support exploration of need

Questions/Comments