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ADMINISTRATION FOR COMMUNITY LIVING
U.S. ADMINISTRATION ON AGING
DEPARTMENT OF HEALTH AND HUMAN SERVICES
WASHINGTON, DC

Request for New Information Collection for a Program Instruction on Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and the Intrastate Funding Formula	)	FR Doc. 2016-14612

COMMENTS OF SERVICES AND ADVOCACY FOR GAY, LESBIAN, BISEXUAL AND TRANSGENDER ELDERS ("SAGE")

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COMMENTS OF
SERVICES AND ADVOCACY FOR GAY, LESBIAN, BISEXUAL AND TRANSGENDER ELDERS ("SAGE")

STATEMENT OF INTEREST

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders ("SAGE") is the country's oldest and largest organization dedicated to improving the lives of LGBT older adults. In conjunction with 30 affiliated organizations in 20 states and the District of Columbia, SAGE offers supportive services and consumer resources to LGBT older adults and their caregivers, advocates for public policy changes that address the needs of LGBT older people, and provides training for agencies and organizations that serve LGBT older adults. SAGE was honored to serve as the Administration for Community Living's co-host at the historic Aging Services Network Convening held in Denver, Colorado on November 17, 2015 ("Denver Convening"), which brought together consumers and influential stakeholders from State and local aging programs, the LGBT community and LGBT older adults, data and research experts, and Federal aging officials, to analyze available research and data and identify next steps for enhancing the Aging Services Network's outreach to LGBT older adults.

Pursuant to a grant from the Administration for Community Living, SAGE – in collaboration with 18 leading organizations nationwide – operates the National Resource Center on LGBT Aging, which is the country's first and only technical assistance resource center aimed at improving the quality of services and supports offered to LGBT older adults. The NRC provides training, technical assistance, and educational resources to aging providers, LGBT organizations, and LGBT older adults. To date, the NRC has trained 12,648 professionals, representing 1,783 aging organizations located in every State and the District of Columbia. The NRC has published, and made widely available, best practice guides, including: *Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity*; *Inclusive Services for LGBT Older Adults: A Practical Guide to Creating Welcoming Agencies*; *Age-Friendly Inclusive Services: A Practical Guide to Creating Welcoming LGBT Organizations***;** and *LGBT Programming for Older Adults: A Practical Step-by-Step Guide*.[1]

[1] *See* National Resource Center on LGBT Aging, Our Best Practices Guides, *available at* www.lgbtagingcenter.org/resources/resources.cfm?s=35.

INTRODUCTION AND SUMMARY

SAGE is pleased to file these comments in response to the Notice published in the Federal Register on June 21, 2016.[2] SAGE commends the Administration for Community Living/U.S. Administration on Aging ("ACL") for initiating this proceeding, and appreciates ACL's ongoing efforts to address the needs of Lesbian, Gay, Bisexual and Transgender ("LGBT") older adults.

In the Notice, ACL seeks comments regarding the inclusion of a new provision in the template used to prepare the information collection requirements contained in the Program Instruction on Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and the Intrastate Funding Formula. The provision would provide guidance regarding the obligation of State Units on Aging ("SUA") that receive funding under Section 307(a) of the Older American's Act ("OAA") to target resources to all older adult populations that have the "greatest economic and social need."

The proposed targeting guidance would make clear that:

> Numerous factors can contribute to 'greatest economic and social need' . . . including (but not limited to) being an American Indian (regardless of membership in a Federal or state-recognized tribe); one's sexual orientation/gender identity (LGBT); being a Holocaust survivor; status as a refugee; or discrimination and/or persecution (past or present) based on religious/social/political beliefs. Such factors can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports.[3]

In order to "ensure effective targeting of resources to all older adults with greatest economic and social need," ACL proposes to require State Units on Aging to "describe," in their State Plans, "their approaches for assessing and addressing the needs of such populations of older adults."[4]

ACL seeks comments regarding whether the proposed collection of information is "necessary for the proper performance of ACL's functions" and on "ways to minimize the burden" on those who will be required to collect the information.[5] ACL further asks whether the proposed targeting guidance is "feasible and likely to ensure maximum inclusion of all populations of seniors, including older American Indians, LGBT seniors, Holocaust survivors

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[2] Request for New Information Collection for a Program Instruction on Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and the Intrastate Funding Formula, 81 Fed. Reg. 40311 (June 21, 2016) ("Notice").

[3] Standard Template, AoA Program Instruction: Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and the Intrastate Funding Formula, 5-6, *available at* www.aoa.acl.gov/AoA_Programs/OAA/Aging_Network/pi/docs/template-PI.pdf ("Proposed Template").

[4] *Id.* at 6.

[5] Notice, 81 Fed. Reg. at 40311-12.

living in the U.S., and other isolated groups of older adults."[6] In particular, ACL requests comments "on the extent to which the direction provided is sufficient for states to fully assess the existence of, and develop plans for serving, these individuals and their families."[7] ACL also has invited commenters who "believe the proposed direction is insufficient," to state "the specific guidance desired as well as the practical means and data available to implement" the proposed direction.[8]

ACL's proposed targeting guidance is a significant step forward. The proposed guidance resolves any lingering doubt that States must give preference to "all older adult populations" – not just those populations specifically enumerated in the statute – with "greatest economic and social need."[9] The proposed guidance also expressly recognizes that sexual orientation and gender identity "can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports"[10] – and, therefore, that LGBT older adults can be targeted as a greatest social need population. Finally, and perhaps most significantly, the proposed targeting guidance requires States to "describe," in their State Plans, "their approaches for assessing and addressing the needs of such populations of older adults."[11] SAGE believes that this requires States to describe how they will assess the needs of the populations specifically enumerated in the targeting guidance, including LGBT older adults.

Requiring States to provide information regarding their efforts to assess the needs of LGBT older adults is "necessary for the proper performance of ACL's functions"[12] because it will enable ACL to fulfill its statutory obligation to ensure that States are targeting *all* older adult populations with greatest economic and social need. Substantial evidence demonstrates that LGBT older adults have a heightened risk of greatest economic and social need. As a group, LGBT older adults have poorer physical and mental health outcomes than their non-LGBT contemporaries.[13] At the same time, LGBT elders are often isolated: they are twice as likely to

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[6] *Id.* at 40312.

[7] *Id.*

[8] *Id.*

[9] Proposed Template, *supra* n.3, at 6.

[10] *Id.*

[11] *Id.*

[12] Notice, 81 Fed. Reg. at 40312.

[13] Soon Kyu Choi and Ilan H. Meyer, *LGBT Aging: A Review of Research Finds, Needs, and Policy Implications* 3 (Williams Inst. Aug. 2016), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Aging-White-Paper.pdf ("Williams LGBT Aging Report") (citing Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C.P., Goldsen, J., Petry, H., Seattle: Institute for Multigenerational Health, *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults* (2011); Fredriksen-Goldsen, K.I., Cook-Daniels, L., Kim, H., Erosheva, E.A., Emlets, C.A., Hoy-Ellis, C.P., Goldsen, J. & Muraco, A., The Gerontologist 54(3), *Physical and Mental Health of Transgender Older Adults: An At-Risk and Underserved Population* 488-500 (2013)) (A copy of the Williams LGBT Aging Report is attached as Appendix One.).

live alone, half as likely to have close relatives to call for help, and four times less likely to have children to assist them.[14] LGBT older adults also are more likely to live in poverty than other older adults.[15] However, many LGBT elders are not receiving the services and supports that they need to live independently. Indeed, LGBT older adults are 20 percent less likely than their non-LGBT peers to access government services such as housing assistance, meal programs, food stamps, and senior centers.[16]

Notwithstanding this evidence, 29 States do not appear to have made *any* effort to assess and address the needs of LGBT older adults – and only nine States (and the District of Columbia) appear to be making a significant effort to do so.[17] In essence, LGBT older adults are the victim of an insidious "Catch-22": Because many States Units on Aging do not know that LGBT older adults have a heightened risk of greatest economic and social need, they do not collect data about the needs of LGBT older adults in their State. And, because States Units on Aging do not collect data about the needs of LGBT older adults, they do not know that many LGBT older adults in their State have greatest economic and social need. As a result, the vast majority of States do not target LGBT older adults for services under the Old Americans Act.

In order for the targeting guidance "to ensure maximum inclusion of all populations of seniors," including LGBT older adults "and other isolated groups of older adults,"[18] SAGE proposes four carefully crafted modifications to the proposed targeting guidance. These modifications would:

- acknowledge the substantial evidence that LGBT older adults not only can, but often do, face social and cultural isolation;

- require States to describe the actions taken to assess the needs of all populations that have a heightened risk of "social, cultural, or geographic isolation," expressly including LGBT older individuals;

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[14] Lesbian, Gay, Bisexual & Transgender Elder Initiative, Facts, *available at* www.lgbtei.org/p/facts.html.

[15] *Williams LGBT Aging Report*, *supra* n.13, at 10 (citing Goldberg, N.G.,The Williams Institute, *The Impact of Inequality for Same-Sex Partners in Employer-Sponsored Retirement Plans* (2009); LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (MAP & SAGE), *Improving the Lives of LGBT Older Adults* (2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf.

[16] *Id.* at 6 (citing LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (MAP & SAGE), *Improving the Lives of LGBT Older Adults* (2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf; Czaja, S.J., Sabbag, S., Lee, C.C., Schulz, R., Lang, S., Vlahovic, T., Jaret, A., & Thurston, C., Aging & Mental Health, *Concerns About Aging and Caregiving Among Middle-Aged and Older Lesbian and Gay Adults* 1-12 (2015)).

[17] *See* State Plan Chart (attached as Appendix Two).

[18] Notice, 81 Fed. Reg. at 40312.

- require States to describe the ways in which they intend to use the planning resources identified by ACL, such as the National Resource Center on LGBT Aging ("NRC"), to assess and address the needs of those populations most likely to be eligible for targeting; and

- direct States to focus on identifying and providing services to populations with "greatest economic and social need."

If ACL accepts these modifications, the revised targeting guidance would read as follows:

> 6. **Targeting** – The Older Americans Act (OAA) requires that states give preference to serving older individuals with greatest economic and social need, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. (Sec. 305(a)(2)(E)). Numerous factor can contribute to "greatest economic and social need," including (but not limited to) being an American Indian (regardless of membership in a Federal or state-recognized tribe); one's sexual orientation/gender identity (LGBT); being a Holocaust survivor; status as a refugee; or discrimination and/or persecution (past or present) based on religious/social/political beliefs. ~~Such~~ These factors ~~can~~ often limit the degree to which older adults experience full inclusion in society and are able to access available services and supports. To ensure effective targeting of resources to all older adults with greatest economic and social need, states should describe their approaches for assessing and addressing the needs of ~~such~~ the populations enumerated above and any other populations of older adults that have a heightened risk of cultural, social, or geographic isolation, including (but not limited to) conducting statewide environment scans and needs assessments, ensuring broad representation on advisory committees, holding public hearings, utilizing the "diversity and aging" planning resources identified in Section V of this Program Instruction, and conducting targeted outreach to ensure that all populations with greatest economic and social need are aware of and able to access services.

SAGE wishes to emphasize that requiring the States to *assess* the needs of LGBT older adults does not pre-judge the question of whether LGBT older adults have greatest economic and social need and, therefore, are entitled to be *targeted* under the Older Americans Act. Rather, it would merely require that the States inform ACL as to how they assessed the needs of LGBT older adults, what conclusions they reached, and what actions they took.

SAGE recognizes that collecting data about LGBT older adults may raise challenges. However, the alternative – not collecting data – is worse. If States do not try to assess the needs of LGBT older adults, they will have no basis on which to determine the extent to which State and area agencies should target resources to this population. Given the significant evidence that LGBT older adults have a heightened risk of cultural and social isolation, requiring States to assess the needs of this population is not only *consistent* with the Older Americans Act, it is *necessary* to implement Congress' intent that OAA-funded services be targeted to *all* older adults with greatest economic and social need.

Concerns about the availability of census data do not preclude adoption of a Federal requirement that States assess the needs of LGBT older adults. The Census Bureau does not collect data about a number of groups that Congress has directed the States to target. For example, while the Older Americans Act requires States to target "older individuals with Alzheimer's disease" and their "caretakers,"[19] the Census Bureau does not collect information about this population. In any case, significant information is available that can help Area Agencies on Aging ("AAA") identify LGBT individuals. For example, the Census Bureau's American Community Survey collects significant data about same-sex households. In addition, AAAs in every State in the Union can reach out to community partners, including SAGE affiliates, LGBT community centers, trusted community leaders, LGBT-friendly religious organizations, statewide equality organizations, Parents, Families and Friends of Lesbians and Gays ("PFLAG") chapters, or any other institution connected to the LGBT community.

Similarly, concerns that many older adults will decline to self-identify as LGBT, thereby rendering the data collected statistically invalid, are significantly over-stated. To the contrary, there is significant evidence that the use of carefully worded questions can yield valuable information, without adverse results. For example, 36 States now ask questions about sexual orientation and gender identify as part of the annual Behavioral Risk Factor Surveillance System ("BRFSS"), which is conducted by the Center for Disease Control ("CDC") in coordination with the U.S. Department of Health and Human Services ("HHS").[20]

SAGE and the National Resource Center on LGBT Aging have helped State and local aging agencies across the country identify and assess the needs of LGBT older adults. In particular, the NRC's best practices guides and trainings programs have helped State Aging Agencies to develop data collection procedures that include sexual orientation and gender identity. To date, the NRC has trained 12,648 professionals, representing 1,783 aging organizations located in every State and the District of Columbia. The NRC provides both web-based and in-person training sessions. This includes a one-hour training session titled "Asking Demographic Questions About Sexual Orientation and Gender Identity." The NRC also has developed effective outreach training materials. For example, the NRC has published *Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity*,[21] which has now been downloaded from the NRC website more than 45,500 times. The NRC's guide provides practical suggestions and addresses widespread misconceptions that have impeded collection of necessary data regarding the existence and needs of LGBT older adults.[22]

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[19] Older Americans Act of 1965, as amended, § 306(a)(4)(B)(i)(VI), 42 U.S.C. § 3026(a)(4)(B)(i)(VI) (requiring SUAs to "provide assurances that the area agency on aging will use outreach efforts that will . . . identify individuals eligible for assistance under the Act, with special emphasis on . . . older individuals with Alzheimer's disease . . . (and the caregivers for such individuals)").

[20] *See, infra*, § IV.B.2.

[21] Services and Advocacy for GLBT Elders and National Resource Center on LGBT Aging, *Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity* (March 2013), *available at* www.lgbtagingcenter.org/resources/resource.cfm?r=601.

[22] *Id.*

SAGE and the NRC are ready, willing, and able to expand their efforts to help the Aging Network assess and address the needs of LGBT older adults. In particular:

- The NRC will prepare a best practices guide and/or webinar training that highlights how SUAs and AAAs have successfully implemented effective LGBT outreach programs.

- The NRC will enhance its existing webinar training for collecting data on sexual orientation and gender identity.

- The NRC will make training sessions as concise and flexible as possible.

- The NRC will develop sample language regarding outreach to LGBT older adults in area plans.

- The NRC will provide technical assistance by identifying and providing AAAs with tools for assessing needs of LGBT older adults.

- The NRC will provide individual technical assistance to SUAs and AAAs in support of their efforts to assess the unique needs of diverse communities and, where needed, will help to connect the AAAs with LGBT groups such as SAGE Affiliates, LGBT Centers, LGBT employee/affinity groups, and welcoming faith communities that can help identity LGBT populations.

SAGE and the NRC welcome other suggestions and are committed to make every possible effort to help the Aging Network implement the new data collection requirements established by ACL.

FACTUAL BACKGROUND

The Older Americans Act requires State Units on Aging that receive funds under Title III of the Act to submit a State Plan to ACL.[23] Each plan must provide assurance that "the State agency will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on . . . older individuals with greatest economic need . . . [and] older individuals with greatest social need."[24] The OAA defines "greatest social need," in relevant part, as the need caused by "cultural, social or geographic isolation, including isolation caused by racial or ethnic status" that restricts the ability of an older individual to "perform normal daily tasks" or "live independently."[25]

2012 FAQ. In 2012, the Administration on Aging ("AoA") issued an FAQ that recognized that "[w]hile the definition of 'greatest social need' in the Older Americans Act includes isolation caused by racial or ethnic status, the definition is not intended to exclude the targeting of other populations that experience cultural, social or geographic isolation due to other factors."[26] To the contrary, AoA stated that, pursuant to the statutory requirement, "[e]ach planning and service area must assess their particular environment to determine those populations best targeted based on 'greatest social need.'"[27] AoA recognized that older LGBT individuals may be among the populations with "greatest social need" because "in some communities . . . isolation due to sexual orientation or gender identity may restrict a person's ability to perform normal daily tasks or live independently."[28] However, AoA did not expressly require the States to assess the needs of LGBT older adults, and imposed no reporting requirements.

SAGE's advocacy. As the Notice recognizes, SAGE has been "urging ACL to require States, in their State Plans, to provide assurances that they will assess all groups that may be eligible for designation as a 'greatest social need' population and expressly include LGBT older adults as one of those groups whose needs must be assessed by the State Unit on Aging."[29] Other organizations also have called on ACL to require States to reach out to isolated populations of older adults likely to have greatest economic and social need.

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[23] Older Americans Act § 307, 42 U.S.C. § 3027 (2016).

[24] *Id.* at § 307(a)(16)(A)(ii) & (iii), 42 U.S.C. § 3027(a)(16)(A)(ii) & (iii).

[25] *Id.* at § 102(a)(24), 42 U.S.C. § 3002(24).

[26] Administration on Aging, Frequently Asked Questions, *available at* www.aoa.gov/AOA_programs/OAA/resources/faqs.aspx ("AoA Frequently Asked Questions").

[27] *Id.*

[28] *Id.*

[29] Notice, 81 Fed. Reg. at 40312.

Denver Convening. On November 17, 2015, ACL, in collaboration with SAGE, hosted a convening of consumers and influential stakeholders from State and local aging programs, the LGBT community (including LGBT older adults), data and research experts, and Federal aging officials, to analyze available research and data and identify next steps for enhancing Aging Services Network outreach to LGBT older adults. The participants reflected the diversity of individuals both impacted by, and involved in, Federal aging policies. Participants presented evidence that LGBT older adults face significant isolation, but often have difficulty finding service providers who understand and can address their unique needs. Participants also noted that many States are not adequately assessing the needs of LGBT older adults. Finally, a number of participants stressed the need for a Federal mandate to ensure that States reach out to this vulnerable population.

Notice. On June 21, 2016, ACL published a Notice in the Federal Register.[30] ACL seeks comments regarding the addition of a new provision to the template used to prepare the information collection requirements contained in the Program Instruction on Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments, and the Intrastate Funding Formula.[31] The new provision would: (1) make clear that States must target "all older adults with greatest social and economic need"; (2) recognize that "[n]umerous factors can contribute to 'greatest economic and social need' . . . including . . . one's sexual orientation/gender identity (LGBT)" because they "can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports"; and (3) require State Units on Aging, in the State Plans, to "describe their approaches for assessing and addressing the need of such populations of older adults."[32]

NRC/n4a Executive Roundtable. In response to ACL's Notice, on July 26, 2016, the National Resource Center convened an executive roundtable with key stakeholders at the National Association of Area Agency on Aging ("n4a") National Conference. The meeting was attended by 18 board members and employees from AAAs, two representatives from n4a, and two representatives from ACL. The purpose of the roundtable was to discuss the types of technical assistance needed from the NRC to assist AAAs and SUAs in assessing the needs of LGBT older adults and to deliver targeted outreach and services where needed. Participants identified various types of technical assistance that the NRC can provide to SUAs and AAAs, including: (1) a best practices guide and/or webinar training that highlights how SUAs and AAAs have successfully implemented effective LGBT outreach and service programs; and (2) ideas as to how to improve the NRC's existing webinar training for collecting sexual orientation and gender identity data. The NRC confirmed that it is ready, willing, and able to support efforts by the SUAs and AAAs to implement ACL's targeting guidance, as soon as it is issued.

[30] *Id.* at 40311-12.

[31] *Id.*

[32] Proposed Template, *supra* n.3, at 5-6.

COMMENTS ON THE PROPOSED TARGETING GUIDANCE

I. THE PROPOSED TARGETING GUIDANCE IS A SIGNIFICANT STEP FORWARD

SAGE commends ACL for proposing to modify its Program Instruction on Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and the Intrastate Funding Formula to provide the States with guidance regarding their obligation to target "resources to all older adults with greatest economic and social need." SAGE also welcomes ACL's express recognition that "one's sexual orientation/gender identity . . . can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports."[33] The proposed guidance builds on – and is a significant step forward from – AoA's historic 2012 FAQ.

A. The Proposed Targeting Guidance Confirms That States Must Target "All Older Adults with Greatest Social Need"

The proposed targeting guidance resolves any lingering doubt that States must give preference to *all* older adult populations – not just those populations specifically enumerated in the statute – that meet the statutory definition of "greatest social need."[34] The AoA's 2012 FAQ stated that the definition of "greatest social need" was "not intended to exclude the targeting of populations that experience cultural, social or geographic isolation due to other factors" besides "racial and ethnic status."[35] The 2012 FAQ further stated that "[e]ach planning and service area must assess their particular environment to determine those populations best targeted based on 'greatest social need.'"[36] The proposed targeting guidance goes further, affirmatively providing that States must "ensure effective targeting of resources to *all* older adults with greatest economic and social need."[37] Moreover, while the FAQ was essentially advisory, because the targeting guidance would be contained in a Program Instruction, it would impose a binding requirement on the States.[38]

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[33] *Id.*

[34] *Id.*

[35] AoA Frequently Asked Questions, *supra* n.26.

[36] *Id.*

[37] Proposed Template, *supra* n.3, at 6 (emphasis added).

[38] *See* Administration on Aging, The Aging Network: Program Instructions, *available at* www.aoa.acl.gov/AoA_Programs/OAA/Aging_Network/pi/PI-Template.aspx ("To be eligible to receive a formula grant under Section 307 (a) of the Older Americans Act (OAA) of 1965, as amended, each State Unit on Aging (SUA) is required to develop a State Plan on Aging that conforms to requirements and priorities outlined by the Assistant Secretary for Aging. States receive guidance on the development of their State Plans on Aging via an annual Program Instruction (PI) entitled Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and the Intrastate Funding Formula.").

B. The Proposed Targeting Guidance Expressly Recognizes That Sexual Orientation and Gender Identity Can Limit the Degree to Which Older Adults "Experience Full Inclusion in Society and are Able to Access Available Services and Supports"

The proposed guidance also represents a meaningful improvement over the AoA's 2012 FAQ in its treatment of LGBT older adults. The FAQ recognized that "[i]n some communities . . . isolation due to sexual orientation or gender identity may restrict a person's ability to perform normal daily tasks or live independently."[39] The proposed targeting guidance goes further, expressly stating that sexual orientation and gender identity "can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports."[40]

C. The Proposed Guidance Imposes Reporting Requirements That Will Enable ACL to Monitor Whether States are Assessing the Needs of LGBT Older Adults

Finally, and perhaps most significantly, unlike AoA's 2012 FAQ, the proposed targeting guidance requires States to "describe," in their State Plans, "their approaches for assessing and addressing the needs of such populations of older adults."[41] As discussed further below, the term "such populations" is ambiguous. However, SAGE believes this term should be construed to require States to describe how they will assess the needs of the populations specifically enumerated in the targeting guidance, including LGBT older adults. The reporting requirement will provide ACL with an effective means to monitor whether, and how effectively, the States are doing so. That said, the proposed guidance would not pre-judge the outcome of the States' assessments. Rather, it would merely require that the States inform ACL as to how they assessed the needs of LGBT older adults, what conclusions they reached, and what actions they took.

[39] AoA Frequently Asked Questions, *supra* n.26.

[40] Proposed Template, *supra* n.3, at 6.

[41] *Id.*

II. REQUIRING STATES TO PROVIDE INFORMATION REGARDING HOW THEY WILL ASSESS THE NEEDS OF LGBT OLDER ADULTS IS NECESSARY "FOR THE PROPER PERFORMANCE OF ACL'S FUNCTIONS"

Requiring States to provide information regarding how they will assess the needs of LGBT older adults is necessary "for the proper performance of ACL's functions."[42] Congress directed ACL to ensure that the States conduct "outreach efforts that will identify individuals eligible for assistance under [the Older Americans] Act, with special emphasis on . . . older individuals with greatest social need."[43] Requiring States to provide information regarding their outreach efforts to LGBT older adults will enable ACL to fulfil its statutory obligation to ensure that the States are targeting *all* older adult populations with greatest economic and social need.

There is significant need for increased Federal oversight. Substantial evidence demonstrates that LGBT older adults have a *heightened risk* of greatest economic and social need. As many as four million American adults age 60 and over identify as LGBT.[44] LGBT older adults are found in every State in the Union – in urban, suburban, and rural areas. As a group, LGBT older adults have poorer physical and mental health outcomes than other older adults.[45] At the same time, many LGBT older adults have weaker social support systems than their contemporaries.[46] LGBT older adults also have higher rates of poverty than other older adults.[47] However, many LGBT elders are not receiving the services and supports that they

[42] Notice, 81 Fed. Reg.at 40311.

[43] Older Americans Act § 307(a)(16)(A)(iii), 42 U.S.C. § 3027(a)(16)(A)(iii).

[44] *Williams LGBT Aging Report, supra* n.13, at 2 (citing Administration on Aging, U.S. Department of Health and Human Services, Administration for Community Living, *Lesbian, Gay, Bisexual and Transgender (LGBT)* (2014), *available at* www.aoa.acl.gov/AoA_Programs/Tools_Resources/diversity.aspx#LGBT)).

[45] *Id.* at 24 (citing Fredriksen-Goldsen, K.I., Kim, H-J., Barkan, S.E., Muraco, A., Hoy-Ellis, C.P., American Journal of Public Health 103(10), *Health Disparities Among Lesbian, Gay, and Bisexual Older Adults: Results from a Population-Based Study* 1802-1809 (2013); Addis, S., Davies, M., Greene, G., MacBride-Stewart, S., & Shepherd, M., Health and Social Care in the Community 17(6), *The Health, Social Care, and Housing Needs of Lesbian, Gay, Bisexual and Transgender Older People: A Review of the Literature* 647-658 (2009); Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C.P., Goldsen, J., Petry, H., Seattle: Institute for Multigenerational Health, *The Aging and Health Report: Disparities and Resilience Among Lesbian, Gay, Bisexual, and Transgender Older Adults* (2011)).

[46] *Williams LGBT Aging Report, supra* n.13, at 8 (citing LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (MAP & SAGE), *Improving the Lives of LGBT Older Adults* (2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf; Barker, J.C., Herdt, G., & de Vries, B., Sexuality Research & Social Policy: Journal of NSRC. 3(2*), Social Support in the Lives of Lesbians and Gay Men at Midlife and Later* 1–23 (2006)).

[47] *Id.* at 10 (citing Goldberg, N.G.,The Williams Institute, *The Impact of Inequality for Same-Sex Partners in Employer-Sponsored Retirement Plans* (2009); LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Biseuxal and Transgender Elders (MAP & SAGE), *Improving the Lives of LGBT Older Adults* (2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf).

need to live independently. Indeed, the majority of States are still making no effort to assess the needs of this population.[48]

A. LGBT Older Adults Have a Heightened Risk of "Greatest Economic and Social Need"

The Older Americans Act contains specific criteria for determining whether an individual has "greatest social and economic need." The statutory definition of "greatest social need" includes need caused by "physical and mental disabilities" and by "cultural, social or geographic isolation, including isolation caused by racial or economic status" that restricts that ability of an older individual to "perform daily tasks" or "live independently."[49] "Greatest economic need" is defined as "the need resulting from an income level at or below the poverty line."[50] Significant evidence demonstrates LGBT older adults have a heightened risk of "greatest social need" and "greatest economic need," but often do not receive the services and supports they need to live independently.

1. As a group, LGBT older adults are more likely to have "physical and mental health disabilities" than other older adults

Poorer Physical Health. LGBT people – and especially LGBT older adults – tend to be in poorer physical health than their peers. Studies have found that there are "higher rates of diabetes, hypertension [and] disability . . . among aging gay men, lesbians, and bisexual people than among older straight adults."[51] Other "[s]tudies suggest higher levels of chronic and other health problems among LGBT older adults, including asthma, diabetes, HIV/AIDS, obesity, rheumatoid arthritis, and certain illnesses such as cancer."[52]

HIV/AIDS has had a disproportionate effect on the LGBT community. Thirty-five years after it was first recognized, "[t]he HIV epidemic . . . continues to have a lasting impact on the older generation physically, emotionally, and psychologically."[53] The Centers for Disease

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[48] *See* State Plan Chart (attached as Appendix Two).

[49] Older Americans Act at § 102(a) (24), 42 U.S.C. § 3002(24).

[50] *Id.* at § 102(a)(23), 42 U.S.C. § 3002(23).

[51] Erin Fitzgerald, *No Golden Years at the End of the Rainbow*, Nat'l Gay & Lesbian Task Force, 12 (Aug. 2013), *available at* www.thetaskforce.org/static_html/downloads/reports/reports/no_golden_years.pdf.

[52] Movement Advancement Project, et al., *LGBT Older Adults And Health Disparities*, 2 (Sept. 2010), *available at* www.lgbtmap.org/file/lgbt-older-adults-and-health-disparities.pdf.

[53] *Williams LGBT Aging Report, supra* n.13, at 27 (citing Friend, R. A., Journal of Homosexuality, 20(3-4), *Older Lesbian and Gay People: A Theory of Successful Aging*, 99-118 (1991); Emlet, C.A., Fredriksen-Goldsen, K.I, Kim, H., & Hoy-Ellis, C., Journal of Applied Gerontology, *The Relationship Between Sexual Minority Stigma and Sexual Health Risk Behaviors Among HIV-Positive Older Gay and Bisexual Men* 1-22 (2015) doi:10.1177/0733464815591210).

Control has estimated that one-quarter of those living with HIV in the United States are over 55.[54] A recent study found that 50 percent of those living with HIV in the United States are over 50.[55] Another study found that nine percent of the LGBT older adults surveyed were living with HIV, and that HIV rates are higher for African Americans and Hispanic LGBT older adults than other LGBT older adults.[56] "HIV positive older adults have worse mental and physical health, disability, poorer health outcomes (such as cardiovascular disease and rates of cancer), and a higher likelihood of experiencing . . . barriers to care."[57]

Worse mental health outcomes. As a group, LGBT people – and especially LGBT elders – also "have worse mental health outcomes than their heterosexual counterparts."[58] Indeed, according to one study, LGBT people are three times more likely than other people to have a mental health problem during their lifetime.[59] This reflects the fact that LGBT people have endured "stressors and challenges not experienced by heterosexuals," such as discrimination, rejection, difficulty accepting their sexual orientation, and the need to conceal their orientation from others.[60]

2. LGBT older adults are more likely to face "cultural, social or geographic isolation"

Scholarly studies have shown that "[i]solation and fear of loneliness are major concerns of LGBT older individuals."[61] In one study, nearly 60 percent of the LGBT older adults "reported feeling a lack of companionship, and over 50 percent reported feeling isolated from others.[62] Transgender older adults reported higher levels of loneliness than cisgender older

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[54] Centers for Disease Control and Prevention, HIV Among People 50 and Over, *available at* www.cdc.gov/hiv/group/age/olderamericans/index.html.

[55] S. Karpiak**,** Senior Director for Research and Evaluation, ACRIA Center on HIV and Aging, Implementing Research on Older Adults with HIV, 1.

[56] *Williams LGBT Aging Report, supra* n.13, at 27 (citing Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C.P., Goldsen, J., Petry, H., Seattle: Institute for Multigenerational Health, *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults* (2011)).

[57] *Id.*

[58] Richard Wright, Am. J. of Public Health 103(2), *Same-Sex Legal Marriage and Psychological Well-Being: Findings From the California Health Interview Survey*, 339 (Feb. 2013).

[59] National Alliance on Mental Illness, Find Support, LGBTQ, *available at* www.nami.org/Find-Support/LGBTQ.

[60] Richard Wright, Am. J. of Public Health, *Same-Sex Legal Marriage and Psychological Well-Being*, *supra* n.58, at 339.

[61] *Id.* at 6 (citing Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C.P., Goldsen, J., Petry, H., Seattle Institute for Multigenerational Health, *The Aging and Health Report: Disparities and Resilience Among Lesbian, Gay, Bisexual, and Transgender Older Adults* (2011)).

[62] *Id.*

adults.[63] As a group, LGBT older adults are more concerned about isolation that their non-LGBT peers. In one study, for example, 32 percent of LGBT older adults reported being very or extremely concerned about "being lonely and growing old alone," compared to 19 percent of non-LGBT older adults.[64]

Significant evidence of the isolation facing LGBT older adults was presented at the Denver Convening. For example, two participants, Kathleen Sullivan, who was then Director of Senior Services Department at the Los Angles LGBT Center, and Chris Kerr, Clinical Director of the Montrose Center in Houston, observed that "LGBT older adults who live outside cities or far from areas with LGBT populations are isolated from LGBT programs and services."[65] A transgender woman, Dana Wallingford, reported experiencing "isolation, marginalization, and a lack of culturally competent health services."[66]

Perhaps the most significant reason why LGBT older adults have a heightened risk of isolation is the fact that they often do not have as strong a social support network as their peers. As people age, many come to rely increasingly on family members, especially spouses and children, for assistance with medical and financial matters. Prior to 2003, no State allowed same-sex couples to marry, and it took another twelve years until the Supreme Court struck down the remaining State prohibitions. As a result, LGBT individuals are less likely to be married than heterosexuals. Roughly 16 percent of LGBT adults are currently married compared to about 50 percent of adults in the general public.[67] Further, many States continue to restrict the ability of LGBT people to adopt.[68] In addition, many LGBT elders remain estranged from their families of origin.[69] As a result, LGBT elders are twice as likely to live alone, half as likely to have close relatives to call for help, and four times less likely to have children to assist them.[70]

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[63] *Id.*

[64] SAGE, Out and Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual and Transgender Older Adults, Ages 45-75, 12, *available at* *www.sageusa.org/files/LGBT_OAMarketResearch_Rpt.pdf*.

[65] *Id.* at 5.

[66] *Id.* at 13.

[67] *Id.* at 6 (citing Pew Research Center, *A Survey of LGBT Americans: Attitudes, Experiences and Values in Changing Times (2013), available at* www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbtamericans/).

[68] Movement Advancement Project, Foster and Adoption Laws, *available at* www.lgbtmap.org/equality-maps/foster_and_adoption_laws.

[69] Williams LGBT Aging Report, *supra* n.13, at 6 (citing Movement Advancement Project, et al., *Improving the Lives of Older Adults* 6-7 (March 2010)).

[70] *See* Movement Advancement Project, *Improving the Lives of Older Adults* 6-7 (March 2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf. In one study, nearly one-quarter of LGBT older adults reported that they had "no one" to rely on when they are ill. *See* Still Out, Still Aging The MetLife Study of Lesbian, Gay, Bisexual, and Transgender Baby Boomers, at 15 (March 2010), *available at* www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-still-out-still-aging.pdf; *see also* SAGE, Out and Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual and Transgender Older Adults, Ages 45-75, *supra* n. 64, at 17-18 (collecting statistics comparing isolation experienced by LGBT and non-LGBT older adults).

Discrimination also continues to isolate many LGBT older adults from the larger society. For example, housing discrimination can adversely affect LGBT older adults' ability to be near the family, friends, and social services and supports that they need to live independently. There is significant evidence that such discrimination remains widespread.[71] Fear of physical abuse further exacerbates the isolation felt by many LGBT older adults. As the Department of Justice has recognized, animus towards LGBT people is the second most common motivation for hate crimes.[72] Despite the overall decrease in hate crimes, the number of hate crimes committed against LGBT people has continued to increase.[73] Moreover, events such as the recent massacre at an LGBT venue in Orlando are likely to make more LGBT people feel that they may be at risk even in places that the LGBT community has long considered to be "safe spaces."

3. LGBT older adults are more likely to have incomes "at or below the poverty line"

Contrary to popular belief, LGBT people – and especially LGBT older adults – are underrepresented at the top of the income pyramid and over-represented at the bottom.[74] One study reported that 15.9 percent of single gay men over 65 lived in poverty, compared to just 9.7 percent of single heterosexual men their age.[75] While older LGBT couples are less likely to live in poverty than LGBT singles, they are still more likely to be poor than their heterosexual peers. For example, 6.0 percent of lesbian couples 65 years of age and older have incomes below the poverty line compared to 3.5 percent for heterosexual married couples in the same age group.[76]

Lower incomes have made hunger an especially serious problem for LGBT individuals, including LGBT older adults. According to one study, 29 percent of LGBT adults did not have enough money to feed themselves or their family at some point during the last year. Even after

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[71] In a nationwide study, two older adults – one who self-identified as lesbian, gay, or bisexual and another who self-identified as heterosexual – contacted the same senior housing community to determine availability. In 48 percent of the cases, the LGB-identified older adult was given less favorable information regarding the "availability of housing, pricing, financial incentives, amenities, or application requirements." *Williams LGBT Aging Report, supra* n.13, at 10-11 (citing Equal Rights Center. *Opening Doors: An Investigation of Barriers to Senior Housing for Same-Sex Couples* (2014), *available at* www.equalrightscenter.org/site/DocServer/Senior_Housing_Report.pdf).

[72] Brief for the United States, *Obergefell, et al. v. Hodges, et. al.* No. 14-556, at 6 (S. Ct. March 2015).

[73] *Id.*

[74] Gary J. Gates and Frank Newport ,GALLUP, *Special Report 3.4% of U.S. Adults Identify as LGBT,* 2 (Oct. 12, 2012), *available at* www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx (35 percent of LGBT adults had annual incomes under $24,000, compared to 24 percent of the total adult population; 16 percent of LGBT adults earned more than $90,000 a year, compared to 21 percent of the general population).

[75] M.V. Lee Badgett, et al., Williams Inst. 9-10, *New Patterns of Poverty in the Lesbian, Gay and Bisexual Community* (June 2013) *available at* http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-poverty-update-june-2013/.

[76] *Id.* at 15.

accounting for gender, age, racial/ethnic, and education level, LGBT adults are 1.7 times more likely than non-LGBT adults to experience hunger.[77]

B. Many LGBT Elders Are Not Receiving the Services and Supports That They Need to Live Independently

Despite the significant evidence that LGBT older adults are at heightened risk of greatest economic and social need, many LGBT elders are not receiving the services and supports they need to live independently. Indeed, LGBT older adults are 20 percent less likely than their heterosexual peers to access government services such as housing assistance, meal programs, food stamps, and senior centers.[78] There are two primary reasons for this. First, there is a scarcity of culturally competent service providers. And, second, fear of discrimination makes many LGBT elders reluctant to access available healthcare and housing services and supports.

1. Many LGBT elders have difficulty finding culturally competent providers

The Denver Convening found that many LGBT elders have difficulty finding service providers who understand and can address their unique needs. For example, Chris Kerr, Clinical Director of the Montrose Center in Houston, Texas, stated that many LGBT elders must travel long distances to find competent and welcoming service providers.[79] Moreover, as Director Kerr noted, even when service providers are interested in creating an LGBT friendly environment, they often prioritize "mainstream service offerings."[80]

LGBT elders face particular challenges "finding trained, qualified, and culturally sensitive health providers.[81] Troy Johnson of the Senior Pride Initiative/Center on Halsted in Chicago noted that health services friendly to LGBT older adults are particularly scarce in the South.[82] However, as Herbie Taylor, an active member of the Los Angeles, California LGBTQ Center observed, even in major urban centers "HIV/AIDS programs and support networks for

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[77] Williams Inst., Food Insecurity and SNAP (Food Stamp) Participation I LGBT Communities, 10 (Feb. 2014), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-in-LGBT-Communities.pdf.

[78] *Williams LGBT Aging Report*, *supra* n.13, at 6 (citing LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (MAP & SAGE*), Improving the Lives of LGBT Older Adults* (2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf; Czaja, S.J., Sabbag, S., Lee, C.C., Schulz, R., Lang, S., Vlahovic, T., Jaret, A., & Thurston, C., Aging & Mental Health, *Concerns About Aging and Caregiving Among Middle-Aged and Older Lesbian and Gay Adults* 1-12 (2015)).

[79] *Williams LGBT Aging Report*, *supra* n.13, at 5.

[80] *Id.* at 29.

[81] *Id.*

[82] *Id.*

LGBT seniors are almost non-existent."[83] Transgender people face particular challenges because "many health providers 'may lack knowledge about transgender and intersex anatomy . . . .'"[84]

Lack of culturally competent providers also deters many LGBT older adults from participating in the activities of their local senior center. Even today, some senior centers "may never even consider that their clients might be LGBT."[85] As a result, in one study, 72 percent of the LGBT respondents said they were reluctant to use available aging services due to lack of trust of service provider personnel, and only 19 percent reported involvement in a senior center.[86]

2. Fear of discrimination deters many LGBT older adults from using available services

Fear of discrimination deters many LGBT older individuals from using available services. As a result, according to Reynaldo Mireles, Program Manager at SAGE of the Rockies in Denver, many LGBT older adults wait longer to ask for help and feel they cannot reveal their sexual orientation or gender identity to providers.[87] Fear of discrimination is especially acute in situations in which an LGBT older adult requires long-term or advanced care.[88] Older lesbians and gay men often delay or decline to enter residential facilities because they believe that they would be discriminated against,[89] ostracized by other residents,[90] and in many cases forced to "go back into the closet."[91]

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[83] *Id.* at 27.

[84] Movement Advancement Project, Improving the Lives of LGBT Older Adults, at 25 (2010), 35 (*quoting* Public Advocate for the City of New York, *Improving Lesbian, Gay, Bisexual and Transgender Access to Health Care at New York City Health and Hospitals Corporation Facilities* (2008)) *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf.

[85] *Id.* at 48.

[86] *Id.*

[87] *Williams LGBT Aging Report, supra n.13,* at 5.

[88] *Id.* at 29 (citing Brotman, S., Ryan, B., & Cormier, R., The Gerontologist, 43(2), *The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada* 192-202(2003);
Stein, G.L., Beckerman, N.L., & Sherman, P.A., Journal of Gerontology of Social Work 53(5), *Lesbian and Gay Elders and Long-Term Care: Identifying the Unique Psychosocial Perspectives and Challenges* 421-35, (2010)).

[89] *Id.* (citing Johnson M, Jackson N, Arnette J, Koffman S., Journal of Homosexuality 49, *Gay and Lesbian Perceptions of Discrimination in Retirement Care Facilities* 83-102 (2005)).

[90] *Id.* at 30 (citing Stein, G.L., Beckerman, N.L., & Sherman, P.A., Journal of Gerontology of Social Work 53(5), Lesbian and Gay Elders and Long-Term Care: *Identifying the Unique Psychosocial Perspectives and Challenges* 421-35 (2010); Brotman, S., Ryan, B., & Cormier, R., The Gerontologist 43(2), *The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada* 192-202 (2003)).

[91] *Id.*

C. Despite the Evidence, Many States Have Not Made Any Effort to Assess the Needs of LGBT Older Adults

Despite the significant evidence that many LGBT older adults have greatest economic and social need, and that many LGBT older adults are not receiving the services and supports that they need to live independently, many States do not assess whether members of this population are eligible for targeting under the OAA. As one of the participants in the Denver Convening, Linda Evans, Executive Director of ElderSource in Northeast Florida, observed, "State data collection systems do not collect or track LGBT data and resources. Aside from anecdotal information, we do not have a good sense of what kind of services LGBT older adults need."[92]

In essence, LGBT older adults are the victim of an insidious "Catch-22": Because many States Units on Aging do not know that LGBT older adults have a heightened risk of greatest economic and social need, they do not collect data about the needs of LGBT older adults in their State. And, because States Units on Aging do not collect data about the needs of LGBT older adults, they do not know that many LGBT older adults in their State have greatest economic and social need. As a result, the vast majority of States do not target LGBT older adults for services under the OAA.

A study provided to SAGE (which is attached as Appendix Two) confirms this assessment. The study reviewed the State Plans filed by each of the fifty States and the District of Columbia. The study found that:

- The State Plans filed by 29 States make *no reference whatsoever* to LGBT older adults.[93]

- An additional 12 State Plans have isolated reference to LGBT older adults, but do not address specific actions being taken to reach and target this population.[94]

- Only nine States, and the District of Columbia, specifically address efforts to reach out and target LGBT older adults.[95]

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[92] *Id.* at 21 (quoting Linda Levin, Executive Director, ElderSource).

[93] State Plan Chart (attached as Appendix Two). The States are: Alabama, Alaska, Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Wisconsin, and Wyoming.

[94] *Id.* For example, the only reference to LGBT issues in one State's plan is in a paragraph about elder abuse in long-term care facilities, while another State's plan simply notes the expected increase in the number of LGBT older adults. A third State's plan summarizes recent research on LGBT aging.

[95] *Id.* The States are: Connecticut, Maine, Michigan, Mississippi, Nebraska, New York, Oregon, Rhode Island, and West Virginia. *See, infra*, § IV.A (discussing actions taken by these States).

Participants in the Denver Convening generally agreed that the States "need to collect data"[96] regarding the needs of LGBT older adults and to use the information to develop effective programs." A number of participants at the Denver Convening also stressed the need for a Federal mandate. For example, Director Levin of ElderSource in Northern Florida observed that one thing "that would help support a better LGBT older adult experience . . . is to mandate state agencies to collect LGBT data."[97]

III. ACL SHOULD MODIFY THE PROPOSED TARGETING GUIDANCE TO ENSURE THE "MAXIMUM INCLUSION" OF ALL "ISOLATED GROUPS OF OLDER ADULTS," INCLUDING LGBT OLDER ADULTS

As ACL recognizes, the targeting guidance that it issues should ensure "the maximum inclusion of all populations of seniors, including LGBT seniors and other isolated groups of older adults."[98] While the proposed targeting guidance is a significant step forward, SAGE believes that further refinements are necessary to ensure that the guidance is "sufficient for states to fully assess the existence of, and develop plans for serving," LGBT older adults. [99] In this section, SAGE proposes four carefully crafted modifications to the proposed targeting guidance which, we believe, will help ensure the maximum inclusion of isolated groups of older adults, including LGBT older adults. We then provide a redline of the proposed targeting guidance, as modified.[100]

A. The Targeting Guidance Should Recognize the Existing Evidence Regarding LGBT Older Adults

The proposed targeting guidance states that being a member of various populations, including being an LGBT older adult, "can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports."[101] Given the evidence that LGBT older adults are more likely to have physical and mental health disabilities[102] than other older adults, are more likely to face cultural, social or geographic

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[96] *Williams LGBT Aging Report*, *supra* n.13, at 35 (quoting Corinda Crossdale, New York State Office for the Aging).

[97] *Williams LGBT Aging Report*, *supra* n.13, at 21 (quoting Linda Levin, Executive Director, ElderSource).

[98] Notice, 81 Fed. Reg. at 40312.

[99] *Id.*

[100] SAGE believes that the proposed targeting guidelines should apply to *all* populations of older adults that have a heightened risk of cultural, social or geographic isolation. SAGE further believes that the evidence collected above plainly demonstrates that LGBT older adults have a heightened risk of cultural, social and/or geographic isolation. For purposes of these comments, SAGE assumes that the other populations enumerated in the proposed targeting guidance also meet this standard. However, we confine our comments to the application of the targeting guidance to LGBT older adults.

[101] Proposed Template, *supra* n.3, at 6.

[102] *Williams LGBT Aging Report*, *supra* n.13, at 3.

isolation,[103] and are more likely to have incomes at or below the poverty line,[104] SAGE believes that the targeting guidance should recognize the likelihood that sexual orientation and gender identify "*can*" cause social isolation is more than a theoretical possibility. The guidance should make clear that sexual orientation and gender identity "*often limit* the degree to which older adults experience full inclusion in society and are able to access available services and supports." Such a finding would provide the factual predicate for requiring States to assess the needs of this population.

B. ACL Should Expressly Require States to Describe the Actions Taken to Assess and Address the Needs of LGBT Older Individuals

After noting that sexual orientation and gender identify (as well as membership in other enumerated populations) "can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports,"[105] the proposed targeting guidance goes on to require States to "describe their approaches for assessing and addressing the needs of *such populations* of older adults."[106] The term "such populations" is ambiguous. While SAGE believes this term should be construed to require States to describe how they will address the needs of the populations specifically enumerated in the guidance – including LGBT older adults – the term could be read to mean populations "such as" those enumerated in the guidance. Under that reading, the enumerated list is merely illustrative, leaving States free to continue to ignore LGBT older adults.

In order to avoid any uncertainty, ACL should revise the proposed language to expressly require States to "describe their approaches for assessing and addressing the needs of *the populations enumerated above* and *any other populations of* older adults *that have a heightened risk of cultural, social, or geographic isolation*." SAGE wishes to emphasize that requiring the States to *assess* the needs of LGBT older adults does not pre-judge the question of whether LGBT older adults have greatest economic and social need and, therefore, are entitled to be *targeted* under the Older Americans Act. We believe – based on the substantial evidence already compiled – that most, if not all, States that properly assess the needs of LGBT older adults will conclude that LGBT older adults should be targeted. However, the final determination is for the States to make based on their assessments. The proposed targeting guidance would merely require that the States inform ACL as to how they assessed the needs of LGBT older adults, what conclusions they reached, and what actions they took.

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[103] *Id.* at 5-6.

[104] *Id.* at 10 (citing Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Biseuxal and Transgender Elders, *Improving the Lives of LGBT Older Adults* (2010), *available at* www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf).

[105] *Id.* at 6.

[106] *Id.* (emphasis added).

C. ACL Should Expressly Require States to Describe the Way in Which They Intend to Use the Planning Resources Identified By ACL, Such as the National Resource Center on LGBT Aging

The proposed targeting guidance requires States to "describe their approaches for assessing and addressing the needs" of populations that may have greatest social and economic need, and provides a non-exclusive list with several helpful examples, specifically "conducting statewide environment scans and needs assessments, ensuring broad representation on advisory committees, holding public hearings and conducting targeted outreach."[107] Each of these activities can help to assess the needs of LGBT older adults.

SAGE remains concerned, however, that some States may be reluctant to assess the needs of LGBT elders due to lack of knowledge and experience. Fortunately, as ACL recognizes in Section V of its Program Instruction, significant resources exist to assist States – including the National Resource Center on LGBT Aging, funded by ACL.[108] In order to ensure that States are using all available resources, ACL should revise the targeting guidance to expressly require States to describe the ways in which they intend to "*utilize[e] the 'diversity and aging' planning resources identified in Section V of the Program Instructions*."

D. ACL Should Direct States to Focus On Identifying and Providing Services to Populations with "Greatest Economic And Social Need"

The final clause of the proposed targeting guidance directs the States to "describe their approaches for assessing and addressing the needs of such populations of older adults . . . to ensure that *all populations* are aware of and able to access services."[109] SAGE recognizes the importance of trying to ensure that all eligible older adults are aware of and receive the benefits to which they are entitled. However, the purpose of the *targeting* guidance is to ensure that the States target populations with the "greatest social and economic need."[110] SAGE, therefore, proposes that the targeting guidance be modified to require States to describe their approach for conducting targeted outreach to ensure that "all populations *with greatest economic and social need* are aware of and able to access services."

E. Specific Targeting Guidance Requested

Taken together, the modification proposed by SAGE would require relatively limited revisions to the proposed targeting guidance. If ACL accepts SAGE's proposed edits, the guidelines would read as follows:

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[107] *Id.*

[108] *See infra*, Section V (discussing ways in which the NRC is prepared to assist States implement a requirement to assess the needs of LGBT older adults).

[109] Proposed Template, *supra* n.3, at 6 (emphasis added).

[110] *Id.* at 7.

6. **Targeting** – The Older Americans Act (OAA) requires that states give preference to serving older individuals with greatest economic and social need, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. (Sec. 305(a)(2)(E)). Numerous factor can contribute to "greatest economic and social need," including (but not limited to) being an American Indian (regardless of membership in a Federal or state-recognized tribe); one's sexual orientation/gender identity (LGBT); being a Holocaust survivor; status as a refugee; or discrimination and/or persecution (past or present) based on religious/social/political beliefs. ~~Such~~ These factors ~~can~~ often limit the degree to which older adults experience full inclusion in society and are able to access available services and supports. To ensure effective targeting of resources to all older adults with greatest economic and social need, states should describe their approaches for assessing and addressing the needs of ~~such~~ the populations enumerated above and any other populations of older adults that have a heightened risk of cultural, social, or geographic isolation, including (but not limited to) conducting statewide environment scans and needs assessments, ensuring broad representation on advisory committees, holding public hearings, utilizing the "diversity and aging" planning resources identified in Section V of this Program Instruction, and conducting targeted outreach to ensure that all populations with greatest economic and social need are aware of and able to access services.

IV. REQUIRING STATES TO ASSESS THE NEEDS OF LGBT OLDER ADULTS IS "FEASIBLE"

In the Notice, ACL requests comments as to the feasibility of the proposed targeting guidance,[111] and the "practical means and data available" to implement any proposed revisions.[112] The experience of the States that have done LGBT outreach demonstrates that assessing the needs of LGBT older adults can be done efficiently and effectively. Therefore, concerns about the availability of data (and, in particular, census data), and the feasibility and legality of collecting sexual orientation and gender identity ("SOGI") data do not preclude adoption of a Federal requirement to assess the needs of LGBT older adults.

A. A Number of States Have Successfully Assessed the Needs of LGBT Older Adults

While most States have not taken systematic action to assess the needs of LGBT older adults, a number of States have done so. Significantly, the States that appear to have made the most significant efforts to reach out to LGBT older adults are not concentrated in any particular geographic region. Rather, they are found in the North, the South, the Midwest, the Great Plains, and the West. The experience of these States demonstrates the feasibility of reaching out to LGBT older adults, and can provide a model for other States. We describe several examples below:

[111] Notice, 81 Fed. Reg. at 40312.

[112] *Id.*

District of Columbia. The District of Columbia Office on Aging has been working with the DC LGBT Center to "identify collaborations that would increase older GLBT access and inclusion." As a result, of these efforts, the use of support services by LGBT older adults has increased.[113]

Michigan. Michigan conducts "statewide needs assessment specifically for LGBT residents age 60 and older."[114]

Mississippi. In Mississippi, the Division on Aging and Adult Services makes "special efforts to engage . . . 'hard to reach' populations," including LGBT older adults.[115]

Nebraska. The Nebraska Department of Aging and Elder Services has provided training to more than three-quarters of the AAA staff focusing on "outreach to the LGBT population."[116]

New York. In New York, the State Office for the Aging provides "ongoing training and technical assistance focused on expanding outreach . . . to underserved populations including . . . LGBT . . . to ensure that these clients are served to the maximum extent feasible."[117] The agency has revised its "comprehensive assessment form to include LGBT questions to help collect data and use it to better serve the LGBT community . . . worked with local AAAs that had concerns about asking LGBT related questions in culturally competent ways and updated [its] annual implementation plan to include LGBT components and ensure those issues are included in the planning process for all programs."[118]

West Virginia. The West Virginia State Unit on Aging targets LGBT older adults and conducts workshops that specifically address issues of special concern to LGBT older adults.[119]

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[113] State Plan Chart (attached as Appendix Two) at 4 (citing District of Columbia State Plan Objective B-17).

[114] *Id*. at 1 (citing Michigan State Plan Issue Area V-B).

[115] *Id*. at 2 (quoting Objective 1.3 of the Mississippi State Plan).

[116] *Id*. at 3 (quoting Nebraska State Plan).

[117] *Id*. (quoting New York State Plan Expected Outcome 1.9).

[118] Williams LGBT Aging Report, *supra* n.13, at 22 (quoting Corinda Crossdale, New York State Office for the Aging, at Denver Convening); *see also* New York State Interagency Task Force, *Standing up for ALL New Yorkers* (describing the efforts of the New York State Office for the Aging), *available at* www.governor.ny.gov/sites/governor.ny.gov/files/archive/governor_files/StandingUpForAllNYers.pdf ("NYS LGBT Task Force Report").

[119] State Plan Chart (attached as Appendix Two) at 2 (citing West Virginia State Plan).

B. Concerns About the Availability of Census Data, and the Feasibility and Legality of Collecting Sexual Orientation And Gender Identity Data, Do Not Preclude Adoption of a Federal Requirement to Assess the Needs of LGBT Older Adults

While a number of concerns have been raised regarding the availability of census data, and the feasibility and legality of collecting sexual orientation and gender identity data, they do not provide a basis on which to oppose a Federal requirement to assess the needs of LGBT older adults. First, significant resources are available that can help AAAs identify LGBT populations. For example, the Census Bureau collects significant data about same-sex households.[120] Second, while some AAAs are reluctant to ask clients about their sexual orientation or gender identify, there is significant evidence that inclusion of carefully worded questions can yield valuable information without adverse results. Finally, there are no legal impediments to ACL requiring the Aging Network to collect this data.

SAGE recognizes that collecting data about LGBT older adults may raise challenges. However, the alternative – not collecting data – is worse. If States do not try to assess the needs of LGBT older adults, they will have no basis on which to determine the extent to which the State and area agencies should target resources to this population. Moreover, as discussed in Section Five, SAGE and the National Resource Center on LGBT Aging are ready, willing, and able to help SUAs and AAAs develop effective programs to assess the needs of LGBT older adults.

1. Sufficient data is available to assess the needs of LGBT older adults

Some observers have suggested that lack of adequate data – and, in particular, lack of census data – regarding LGBT older adults will make it difficult to assess the needs of this population. This concern is not well-founded.

As an initial matter, the Census Bureau does not collect data about a number of groups that Congress has directed the States to target. For example, the Older Americans Act requires States to target "older individuals with Alzheimer's disease" and their "caretakers."[121] However, while an estimated 5.2 million people over the age of 65 have Alzheimer's disease, the Census Bureau does not collect information about persons with Alzheimer's or their caretakers.[122] AAAs nonetheless are able meet their obligations using other sources of

[120] *See* U.S. Census Bureau, Same Sex Couples Main, *available at* www.census.gov/hhes/samesex/.

[121] Older Americans Act, § 306(a)(4)(B)(i)(VI) (requiring SUAs to "provide assurances that the area agency on aging will use outreach efforts that will . . . identify individuals eligible for assistance under the Act, with special emphasis on . . . older individuals with Alzheimer's disease . . . (and the caregivers for such individuals)").

[122] Even the American Community Living Survey, which is the Census Bureau's most detailed survey, contains only a single general question about whether an individual has a "physical, mental or emotional condition" that causes the individual to have "serious difficulty concentrating, remembering, or making decisions." 2016 American Community Living Survey, Question 18(a), www2.census.gov/programssurveys/acs/methodology/questionnaires/2016/quest16.pdf. Because many conditions can cause an individual to have serious difficulty concentrating, remembering, or making decisions, the data collected in response to this question would not enable AAA to target

information, such as local chapters of the Alzheimer's Association. In any case, an increasing amount of data regarding LGBT individuals *is* collected by the Census Bureau. While the Bureau does not specifically ask questions regarding an individual's sexual orientation or gender identify in the Decennial Census, it now collects significant data about same-sex households in the ongoing American Community Survey, including the relationship status of individuals of the same sex who live in the same household, which can provide useful information about the LGBT population.[123]

There are numerous other sources of data that States can use to try to assess the needs of LGBT older adults. For example, the Gallup Organization's daily tracking survey asks respondents in each State, "Do you, personally, identify as lesbian, gay, bisexual, or transgender?"[124] And UCLA's Williams Institute has done numerous studies regarding the demographics of the LGBT community in general, and LGBT elders in particular. [125] AAAs also can reach out to community partners, including SAGE affiliates,[126] LGBT community centers, [127] trusted community leaders, LGBT-friendly religious organizations,[128] statewide equality organizations,[129] PFLAG chapters,[130] or any other institution connected to the LGBT community. Finally, as discussed further below,[131] SAGE and the NRC have experience in addressing these concerns and are ready, willing, and able to assist States in developing effective outreach methods.

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persons with Alzheimer's. Moreover, the survey does not collect information that would identify the individuals who act as caregivers to persons with Alzheimer's disease.

[123] *See* U.S. Census Bureau, American Community Survey Data on Same Sex Couples, *available at* www.census.gov/hhes/samesex/data/acs.html.

[124] Gallup, Gallup Daily Tracking, *available at* www.gallup.com/services/170948/gallup-daily-tracking.aspx. Gallup reports that 3.4 percent of the individuals surveyed nationwide self-identify as LGBT. Hawaii is the State with the highest percentage of self-reporting LGBT individuals (5.1 percent), while North Dakota is the lowest (1.7 percent).

[125] Williams Inst., *LGBT Data &Demographics, available at* williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density.

[126] SAGE has affiliates in twenty States and the District of Columbia. *See www.sageusa.org/advocacy/sagenet.cfm*.

[127] *See* www.lgbtcenters.org/Centers/find-a-center.aspx (providing contact information for LGBT community centers in 42 States and the District of Columbia).

[128] The Metropolitan Community Church, whose membership is predominantly LGBT, has churches in 43 States and the District of Columbia. *See* http://mccchurch.org/overview/ourchurches/find-a-church/united-states-church-listing.

[129] The Equality Federation has chapter in 33 States. *See* www.equalityfederation.org/members/list/.

[130] *See* www.pflag.org/find-a-chapter (providing contact information for chapters in 49 States and the District of Columbia).

[131] *See, infra*, Section V.

2. Effective means for collecting SOGI data have been developed

Some members of the Aging Network have expressed reluctance to ask clients about their sexual orientation or gender identify. Given the stigma that some older adults still feel about these issues, and well-founded fears of discrimination, efforts to gather this information must be conducted with care and sensitivity. However, concerns that many older adults will decline to self-identify as LGBT, thereby rendering the data collected statistically invalid, are significantly over-stated. To the contrary, there is significant evidence that inclusion of carefully worded questions can yield valuable information without adverse results.[132]

The Behavioral Risk Factor Surveillance System, which is the largest ongoing health survey system in the world, provides an example of how State agencies can successfully identify LGBT individuals. The annual survey, which is conducted by the Center for Disease Control and Prevention ("CDC"), in coordination with the U.S. Department of Health and Human Services, surveys more than 400,000 American adults about health-related issues.[133] In 2013, the CDC developed a question module for BRFSS to collect data on sexual orientation and gender identity data.[134] The text of the module appears below:

CDC-approved SOGI module for BRFSS

The next two questions are about sexual orientation and gender identity.

Do you consider yourself to be:

- Straight
- Lesbian or gay
- Bisexual
- Other
- Don't know/Not sure
- Refused+

[132] A recent study showed that providers and clients have starkly different views regarding how patients would react to being asked for SOGI data. While 80 percent of healthcare providers surveyed said that they expected that patients would be offended if asked to provide information about their sexual orientation or gender identity, only 11 percent of the patients said that they actually would be offended. *See* Lau, Brandyn. Emergency Department Query for Patient-Centered Approaches to Sexual Orientation and Gender Identity: The Equality Study (June 2016). A summary of the study is available at http://www.equalitystudy.com/academyhealth-presentation.

[133] *See generally* www.cdc.gov/brfss/ (providing information about the BRFSS).

[134] Another approach to collecting information about gender identity, developed by the Gender Identity in U.S. Surveillance (GenIUSS) Group, is to first ask a person's assigned sex at birth and then to ask the person's current gender identity. This two-step approach has proven particularly effective. *See* Williams Inst., Best Practices for Asking Questions to Identify Transgender and Other Gender Minorities on Population-based Surveys, *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/geniuss-report-sep-2014.pdf.

Do you consider yourself to be transgender?

- Yes, Transgender, male-to-female
- Yes, Transgender, female-to-male
- Yes, Transgender, gender non-conforming
- No
- Don't know/not sure
- Refused

In 2014, the CDC gave states the option of adding this module to their BRFSS questionnaires. Twenty-five states and territories used the module in 2015.[135] Eleven additional jurisdictions asked about sexual orientation and/or gender identity using questions that differ from the CDC-approved module.[136] "States that have used this module report that it is well-received by respondents and does not negatively affect the quality of data collected." [137] For example, Missouri State BRFSS Coordinator Janet Wilson noted that the State's use of this module in its 2015 survey "did not result in any survey break-off and had very low rates of item nonresponse."[138]

The SOGI data collected has proven useful. States have used this data to "create more effective policies and direct limited resources to where they can do the most good."[139] For example, Massachusetts began using the CDC-approved module in 2015. Based on the data collected, which showed that LGBT State residents faced health-related risks far higher than non-LGBT residents, the State government developed a number of programs targeted to the LGBT population, including "suicide prevention programs, domestic violence prevention and services, homeless services, meals for LGBT elders, and LGBT youth services."[140] Similarly, in Colorado, the BRFSS data identified health disparities between LGBT and non-LGBT residents. This data enabled the State to develop the LGBT Health Outcomes Planning Project.[141] A number of other States – including Hawaii, Indiana, North Carolina, and Utah – have used BRFSS data to publish reports on LGBT health.[142]

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[135] Center for American Progress, Sexual Orientation and Gender Identity Data Collection in the Behavioral Risk Factor Surveillance System 1-2 (2016), *available at* www.americanprogress.org/issues/lgbt/report/2016/03/29/134182/sexual-orientation-and-gender-identity-data-collection-in-the-behavioral-risk-factor-surveillance-system/.

[136] *Id.*

[137] *Id.* at 6.

[138] *Id.*

[139] *Id.*

[140] *Id.*

[141] *Id.* at 7-8.

[142] *Id.*; HHS also has recognized the importance of collecting LGBT-specific data. For example, the U.S. Centers for Medicare and Medicaid Services ("CMS") has "established five initiatives to data collection integrate LGBT

State Units on Aging have successfully undertaken efforts to collect SOGI data from older adults. For example, the New York State Office for the Aging ("NYSOFA") operates a data system called COMPASS (Comprehensive Assessment for Aging Network Community-Based Long Term Care Services), which is used to assess older adults for seven different services, such as home care services and home-delivered meals. In order to ensure that LGBT older adults "receive adequate services," NYSOFA updated the COMPASS system "to better collect information about sexual orientation and gender identity." The data collected by the COMPASS system also is being used to "assist local AAAs in targeting their outreach efforts to ensure clients receive necessary services."[143] SAGE was pleased to assist NYSOFA by conducting three webinars designed to provide the cultural sensitivity skills needed to effectively collect this data from older adults.

3. SOGI data can be lawfully collected

Some members of the Aging Network have expressed concern that ACL cannot require States to assess the needs of LGBT older adults because: (1) the OAA does not expressly list LGBT older individuals as a group that should be targeted; (2) anti-discrimination laws in some States do not identify LGBT people as a legally protected class; and (3) some jurisdictions may prohibit collection of SOGI information. These concerns can be readily addressed.

Older Americans Act. SAGE recognizes that the OAA does not list LGBT older adults as one of the populations that must be targeted. However, in its 2012 FAQ, the Administration on Aging made clear that "[w]hile the definition of 'greatest social need' in the Older Americans Act includes isolation caused by racial or ethnic status, the definition is not intended to exclude the targeting of other populations that experience cultural, social or geographic isolation due to other factors."[144] To the contrary, AoA stated that pursuant to the statutory requirement "[e]ach planning and service area *must* assess their particular environment to determine those populations best targeted based on 'greatest social need.'"[145]

Given the significant evidence that LGBT older adults have a heightened risk of cultural and social isolation, requiring States to assess the needs of this population is not only *consistent* with the Older Americans Act, it is *necessary* to implement Congress' intent that OAA-funded services be targeted to *all* older adults with greatest economic and social need. That said, as noted above, requiring the States to assess the needs of LGBT older adults does not pre-judge the question of whether LGBT older adults have greatest economic and social need and, therefore,

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issues into the agency's data collection efforts. *See* Williams LGBT Aging Report, *supra* n.13, at 32 (comments of Samuel Haffer, Director of Data and Policy Analytics, GMS).

[143] NYS LGBT Task Force Report, *supra* n.118, at 4. The revision of the COMPASS system is part of a larger effort under taken by the State, covering eight separate agencies, "to systematically update data systems to include s sexual orientation and gender identity information . . . so they can be more responsive to the needs of the LGBT communities." *Id.* at 2.

[144] AoA Frequently Asked Questions, *supra* n.26.

[145] *Id*. (emphasis added).

are entitled to be targeted under the OAA. Unless Congress directs otherwise, that would remain a determination for each State to make.

State non-discrimination laws. SAGE also recognizes that while some States have extended legal protection to LGBT individuals under their anti-discrimination laws, many other States have not. However, the fact that a State has not extended protection under its anti-discrimination laws to the LGBT population does not preclude ACL from requiring that State to assess the needs of LGBT older adults in that State. The OAA and State non-discrimination laws serve different purposes. The OAA is intended to ensure that States target older adults with greatest economic or social need, while State non-discrimination laws are designed to protect specific populations from adverse treatment. While discrimination may contribute to greatest economic and social need, a population need not be protected by State anti-discrimination laws in order to be eligible for targeting under the OAA. For example, individuals in rural areas are eligible for targeting, even though they are not protected by State anti-discrimination laws.

State legal restrictions. SAGE is not aware of any State that has prohibited State agencies from asking individuals to *voluntarily* provide information about their sexual orientation and gender identity. Indeed, as discussed above, 36 States currently request such information as part of the BRFSS survey. [146]

V. SAGE AND THE NATIONAL RESOURCE CENTER ON LGBT AGING ARE READY, WILLING, AND ABLE TO HELP STATES DEVELOP "PRACTICAL MEANS" AND IDENTIFY "DATA AVAILABLE" TO ASSESS AND ADDRESS THE NEEDS OF LGBT OLDER ADULTS

SAGE and the National Resource Center on LGBT Aging have helped State Units on Aging and local Area Agencies on Aging in all areas of the country identify and assess the needs of LGBT older adults. SAGE and the NRC are prepared to continue, and expand, their efforts to help the Aging Network assess and address the needs of LGBT older adults to minimize any burden caused by the data collection requirements, and make the most effective use of the information collected.

The NRC's best practice guides and trainings programs have helped SUAs and AAAs to develop data collection procedures that include sexual orientation and gender identity. To date, the NRC has trained 12,648 professionals, representing 1,783 aging organizations located in every State and the District of Columbia. This includes a one-hour training session titled "Asking Demographic Questions about Sexual Orientation and Gender Identity." The NRC also has developed effective outreach training materials. For example, the NRC has published *Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity*,[147] which has now been downloaded from the NRC website 45,515 times. The NRC also has sent out more than 1,000 hard copies.

[146] *See, supra*, § IV.B.2.

[147] *See* www.lgbtagingcenter.org/resources/resource.cfm?r=601.

The NRC's guide provides practical suggestions and addresses widespread misconceptions that have impeded the collection of necessary data regarding the existence and needs of LGBT older adults, such as the following:

> *Misconception*: It is illegal to ask about a person's sexual orientation or gender identity.
>
> *NRC Response*: It is not illegal to ask about sexual orientation and gender identity but there are many laws that make it illegal to refuse services because someone is LGBT. In addition, while service providers and healthcare professionals should ask about sexual orientation and gender identity, they cannot force an individual to answer these questions. Remember, many LGBT older adults have profound histories of stigma and prejudice and might be less willing to disclose these parts of their identities, especially if they are accessing services for the first time. But asking these questions opens the door to future conversations and shows clients that your agency is LGBT-friendly.
>
> *Misconception:* Our clients will resist answering questions related to sexual orientation or gender identity.
>
> *NRC Response:* While some LGBT older adults will not want to self-identify as LGBT, they should be offered the opportunity to do so. Further, asking sets an important tone of inclusion. Also, remember that sexual orientation and gender identity are different concepts, so in some cases clients might disclose their sexual orientations but not their gender identities—or vice versa.
>
> *Misconception:* We treat everyone as equals, so we don't need to ask our clients about sexual orientation or gender identity.
>
> *NRC Response:* Treating everyone the same often discounts the particular challenges that LGBT older adults encounter; it often translates into treating everyone as heterosexual and non-transgender. This assumption can undervalue the life experiences of LGBT older adults, such as experiences of discrimination, physical and emotional stress, and violence. Understanding all aspects of your clients' identities will lead to better person-centered care.[148]

[148] National Resource Center on LGBT Aging, *Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity* 8-9 (2013) *available at* www.lgbtagingcenter.org/resources/resource.cfm?r=601.

The NRC also provides web-based and in-person training sessions. This includes a session on "Asking Demographic Questions about Sexual Orientation and Gender Identity." The NRC recognizes that AAAs face significant demands on their time, and has worked to make training sessions as concise and flexible as possible.[149]

The NRC is prepared to work closely with ACL, the National Association of States United for Aging and Disabilities, the National Association of Area Agencies on Aging, and other members of the Aging Network (including AAA-selected subcontractors) to help implement ACL's direction to States to assess the needs of LGBT older individuals.

The NRC will implement additional initiatives proposed at the July 26, 2016 Executive Roundtable. In particular:

- The NRC will prepare a best practices guide and/or webinar training that highlights how SUAs and AAAs have successfully implemented effective LGBT outreach programs.

- The NRC will enhance its existing webinar training for collecting data on sexual orientation and gender identity.

- The NRC will make training sessions as concise and flexible as possible.

- The NRC will develop sample language regarding outreach to LGBT older adults in area plans.

- The NRC will provide technical assistance by identifying and providing AAAs with tools for assessing needs of the LGBT older adults.

- The NRC will provide individual technical assistance to AAAs in support of their efforts to assess the unique needs of diverse communities and, where needed, will help to connect the AAAs with LGBT groups such as SAGE Affiliates, LGBT Centers, LGBT employee/affinity groups, and welcoming faith communities that can help identity LGBT populations.

SAGE and the NRC welcome other suggestions and are committed to make every possible effort to help the Aging Network implement the new data collection requirements established by ACL.

[149] For example, each of the following NRC webinars last for just one hour: Introduction to LGBT Aging; Embracing LGBT Older Adults of Color; Transgender Aging: What Service Providers Need (and Don't Need!) to Know; Respected and Whole: Preventing Anti-LGBT Bias between Constituents, Staff, and across Aging Services; and Asking Demographic Questions about Sexual Orientation and Gender Identity.

CONCLUSION

For the foregoing reasons, SAGE urges ACL to modify the proposed targeting guidance to: (1) acknowledge the substantial evidence that LGBT older adults not only can, but often do, face social and cultural isolation; (2) require States to describe the actions taken to assess the needs of all populations that have a heightened risk of "social, cultural, or geographic isolation," expressly including LGBT older individuals; (3) require States to describe the way in which they intend to use the planning resources identified by ACL, such as the National Resource Center on LGBT Aging, to assess and address the needs of those populations most likely to be eligible for targeting; and (4) direct States to focus on identifying and providing services to population with "greatest economic and social need."

SAGE and the NRC are prepared to provide every possible assistance to State Units on Aging, Area Agencies on Aging, and other member of the Aging Network to implement the revised Program Guidance in order to ensure that "all older adults with greatest economic and social need," including LGBT older adults, receive the OAA-funded services and supports that they need to live independently.

Respectfully submitted,

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August 22, 2016

APPENDIX ONE: WILLIAMS INSTITUTE REPORT

The Williams Institute

UCLA SCHOOL OF LAW

LGBT Aging: A Review of Research Findings, Needs, and Policy Implications

Soon Kyu Choi and Ilan H. Meyer

July 2016

LGBT Aging: A Review of Research Findings, Needs, and Policy Implications

Soon Kyu Choi and Ilan H. Meyer

The Williams Institute
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About the Williams Institute

The Williams Institute is dedicated to conducting rigorous, independent research on sexual orientation and gender identity law and public policy. A think tank at UCLA Law, the Williams Institute produces high-quality research with real-world relevance and disseminates it to judges, legislators, policymakers, media and the public. These studies can be accessed at the Williams Institute website.

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In this report, we provide a review of what is known about lesbian, gay, bisexual or transgender (LGBT) older adults. In doing so, we rely on previous reviews that have approached the study of LGBT older adults through various perspectives, such as through a life-course (Fredriksen-Goldsen & Muraco, 2010) or social historical perspective (Morrow, 2001). Some previous reports have focused on areas such as health and wellbeing or access and use of social services (Czaja, 2015; Addis et al., 2009; MAP & SAGE, 2010). We also rely on peer-reviewed articles, organizational reports, and books published regarding the experience of LGBT older adults in the U.S. and Canada (research focusing on populations outside of North American were not included in this report). We also draw upon expert and community members' perspectives as recorded in a special meeting convened by the Services and Advocacy for GLBT Elderly (SAGE) and the Administration of Community Living (ACL) in Denver, CO in November 2015. The meeting included 50 representatives from various organizations that study and serve LGBT older adults, including LGBT older adults themselves. Their perspectives are represented in text boxes throughout this report.

Although definitions vary, broadly LGBT older adults can be defined as the population of sexual and gender minority (SGM) individuals over the age of 50.[1] With no accurate census count of LGBT people, investigators used various methods to estimate the size of the population. Fredriksen-Goldsen, Kim, Shiu, Goldsen, and Emlet (2014) estimated that there are over 2.4 million LGBT older adults over age 50 in the U.S., with the expectation that this number will double to over 5 million LGBT adults over age 50 by year 2030. Other estimates suggest that 1.75 to 4 million American adults age 60 and over identify as LGBT (Administration on Aging, 2014).

The report suffers from lack of probability samples that can inform us about more accurate estimates of demographics, prevalence of diseases, conditions (e.g., disability), and health behavior and access to health care. Only two studies in this report used probability samples (both studies used state-level data) to characterize LGB older adults (Fredriksen-Goldsen et al 2013a; Wallace et al., 2011). To our knowledge, no representative data on transgender older adults exists. We rely on many studies that use various community-based sampling techniques (Meyer & Wilson, 2009). For that reason, we sometimes present findings that appear contradictory. As we do not have accurate national statistics, we are limited in our ability to judge which of the contradictory findings is correct and which is a function of the particular study's characteristics. Still, community-based studies provide invaluable data that enriches our knowledge about the variety of experiences that characterize LGBT aging.

[1] "Sexual and gender minority" is an all-inclusive term the U.S. federal government and National Institutes of Health has chosen to use that represents lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity, gender expressions, or reproductive development fluctuates from societal, cultural, or physiological norms (NIH SGM Research Coordinating Committee, 2016).

To date, most studies on sexual and gender minority older adults focus on the extent to which sexual orientation, rather than gender identity, affects the aging experience of individuals. Even within sexual minority older adults, we find that we know most about gay men or lesbian women, with less research on bisexuals. Bisexuals are often included in an LGB category but rarely examined on their own so even less is known about the unique experiences of older bisexuals. Gender minority older adults, including transgender individuals, share many of the challenges and experiences of sexual minorities, and are often analyzed and reported under the LGBT umbrella. However, transgender older adults encounter specific challenges and often need different types of support and expertise, such as transition related medical care, of which LGB cisgender older adults do not. Despite these differences, research specific to transgender older adults is limited. Throughout the report, when available, we include research on transgender older adult specific issues, such as isolation and loneliness related to transitioning (Cook-Daniels, 2006; Cook-Daniels, 2015), discrimination and abuse by healthcare system and inability to conceal gender history to health professionals (Cook-Daniels, 2006), or challenges with finding adequate transition related healthcare (Cook-Daniels, 2006).

We note disparities in life experiences between transgender and non-transgender older adults. Transgender older adults experience high rates of discrimination in the work place and in healthcare settings, and experience high rates of lifetime verbal and physical abuse (Grant et al., 2011; Fredriksen-Goldsen et al., 2013b). In terms of health, transgender older adults have poor mental and physical health outcomes compared to non-transgender older adults (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013b). When compared to their LGB cisgender counterparts, transgender older adults report higher rates of internalized stigma (Fredriksen-Goldsen et al., 2013b), which is associated with psychological distress, depression, and poorer health (Testa et al., 2015; Bockting et al., 2013; Fredriksen-Goldsen et al., 2013b). A higher proportion of transgender older adults also report suicide ideation compared to LGB cisgender older adults (Fredriksen-Goldsen et al., 2011) and are at higher risk for poor physical health and disability compared to non-transgender adults (Fredriksen-Goldsen et al., 2013b). Though we have some information, there remain many gaps in knowledge on transgender older adults and their aging experience. We recognize this, along with the gap in knowledge on bisexual older adults, as major areas of research need within the LGBT older adult population (See *Future Research and Policy Needs- Research Needs* section).

Like LGBT people in general, LGBT older adults are diverse with regard to many characteristics, such as gender, race/ethnicity, socioeconomic status, residential region, religiosity, and disability status. However, they share experiences of exposure to past and current stigma and prejudice and resiliency related to their sexual orientation or gender identity (Meyer, 2001). Studies of LGBT older individuals are typically not large enough to provide data into the influence of this great diversity on the lives of LGBT people at these different intersections. Thus, many gaps to our understanding of LGBT older adults' characteristics exist. This makes it

difficult to provide accurate information about demographic and other characteristics of the population.

In writing this report, we attempted to take an integrative approach to understanding LGBT older adults, the challenges they encounter, and their resiliency in addressing these challenges. Additionally, we provide recommendations on future areas of research. Finally, we suggest how to use this report in informing policy makers and stakeholders on issues pertinent to the LGBT older adult community.

Research Perspectives

The Institute of Medicine's report on LGBT health (2011) recommended that researchers consider four conceptual perspectives: The first perspective, *minority stress*, suggests that LGBT individuals experience stressors that stem from stigma and prejudice in social environments toward their sexual and gender minority identity (Meyer, 2003; Hendricks & Testa, 2012). Stressors include stressful major life events (e.g. assaulted because of being LGB), micro aggressions or everyday discrimination (e.g. receiving poor services in stores), expectations of rejections, concealment, and internalized stigma. The minority stress theory suggests that these stressors have adverse health effects on LGBT individuals. Against this stress, resilience from resources both at the individual and community level can ameliorate the impact of minority stress on health. The overall impact of minority stress is the balance of these negative and positive processes, which can lead to mental and physical disorders as well as growth and positive well-being (Meyer, 2015).

The second perspective, the *life-course* approach focuses on the principle stress and health needs and health outcomes that vary along ages and developmental periods. At the same time, the life-course perspective also takes a historical perspective, examining how events at each life stage can influence later stages, both from an individual (biological and social) and environmental (cultural and contextual) aspect (Cohler and Hammack, 2007; Elder, 1998). As a result of these different influences, the life course perspective teaches us to note important distinctions among different cohorts of LGBT older adults.

The third, *intersectionality* perspective alerts us to examine LGBT lives in the context of other important social identities and statuses, such as race/ethnicity, socioeconomic status, and areas of residence (e.g., urban vs. rural), and how these factors interact (McCall, 2009). For example, lesbian and bisexual Black women have unique experiences with stress, health, and identity associated with their sexual orientation, race/ethnicity, and gender that cannot be fully captured by considering race and gender separately (Bowleg, 2008; Brooks et al., 2009; Gamson & Moon, 2004; Moore et al., 2010).

The fourth perspective, *social ecology*, focuses our attention on understanding individual health and lives as influenced by factors outside of immediate environments such as families, relationships, community, and society (McLeroy et al., 1998). The social ecological perspective provides a framework to examine individual and population-level determinants of health (HHS, 2000, 2011). This framework can be used to think about the effect of environment on individual's health and different ways to approach health interventions.

Considering the life-course and social ecology perspectives, we note that the population of older LGBT people is distinct from the rest of the contemporary LGBT community in its social history. Today's older LGBT adults were born, and most came of age, before the 1969 Stonewall Inn Riots, considered the start of the modern Gay Liberation Movement (Morrow, 2001; Fredriksen-Goldsen & Muraco, 2010). The pre-Stonewall era was a time in which homosexuality was criminalized and considered a mental illness. Prejudice, stigma, violence, and discrimination prevailed throughout the social fabric and institutions of the U.S. Sexual minorities, especially gay men, were perceived as "interested in seducing innocent others" into their gay lifestyles (Morrow, 2001, p.155). This social environment led many LGBT individuals to conceal sexual and gender minority identities (Morrow, 2001; Fredriksen-Goldsen & Muraco, 2010; Kimmel et al., 2006).

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Social and physical isolation

Isolation has indirect effects on how LGBT older adults interact with others and seek health care. Reynaldo Mireles, Program Manager at SAGE of the Rockies, noted many LGBT older adults wait longer to ask for help and feel they cannot reveal their sexual orientation identity to providers. LGBT older adults also report feeling invisible at LGBT events such as pride festivals. Kathleen Sullivan, Director of Senior Services Department at L.A. LGBT Center and Chris Kerr, Clinical Director of Montrose Center in Houston Texas both shared that LGBT older adults who live outside cities or far from areas with LGBT populations are isolated from LGBT programs and services. Chris Kerr of Montrose Center in Houston, Texas also reported that many LGBT older adults travel long distances to find safe and friendly services and argued that peer outreach may be an effective approach to reaching aging LGBT populations.

As we study the population of older LGBT individuals in today's more accepting social environment, we ought to consider the influences of the social environment on their life experiences, exposure to stress and resilience, and health along their entire life-course.

Intersectionality gives this historical analysis greater definition. For example, one area that researchers explored is sexual identity development. Though lesbian and gay older adults share similar global historical experience, their identity development is influenced by subcultures, new outlooks, practical needs (such as help from church or neighbors in old age), individual life histories (such as a past heterosexual marriage), and point in life of coming out (Rosenfeld, 1999).

Social Issues affecting LGBT Aging People

As LGBT individuals age, they face unique challenges that their heterosexual peers do not. Aside from the challenges that all older adults face, such as physical limitations and changes in socioeconomic status or relationships, LGBT older adults confront discrimination from entities that are traditionally relied upon for support, and legal and financial barriers to preparing for older age (MAP & SAGE, 2010). A 2001 Administration on Aging study found that LGBT older adults are 20% less likely than their heterosexual peers to access government services such as housing assistance, meal programs, food stamps, and senior centers (MAP& SAGE, 2010; Czaja et al., 2015). LGBT older adults are also more likely to delay seeking health care and to avoid continuous care from the same health provider, partly due to fear of stigma and discrimination (Czaja et al., 2015). Below are areas LGBT older adults experience distinct challenges.

Isolation

LGBT individuals are less likely to be married than cisgender heterosexuals (Pew Research, 2013). Roughly 16% of LGBT adults reported being currently married compared to about 50% of adults in the general public (Pew Research, 2013). Specific to older LGB individuals, studies have found that a higher proportion of LGB older adults are single or tend to live alone compared to heterosexual elders (MAP & SAGE, 2010; Wallace et al., 2011). For transgender individuals, incidents of social isolation may be exacerbated by requirements set forth by medical professionals in the past to divorce one's spouse, move to a new area, and construct a new identity that fit with one's changed gender identity (Cook-Daniels, 2006). One activist stated "I have met people who were friends with transgender people prior to transition, who were told by their transgender friend that all contact had to cease as part of their treatment plan" (Cook-Daniels, 2015, p.195).

Isolation and fear of loneliness are major concerns of LGBT older individuals (Fredriksen-Goldsen et al., 2011). For example, nearly 60% of surveyed LGBT older adults in one study reported feeling a lack of companionship, and over 50% reported feeling isolated from others (Fredriksen-Goldsen et al., 2011). Among LGBT older adults, bisexual men and women were more likely to report loneliness than were gay or lesbian older adults (Fredriksen-Goldsen et al., 2011). Comparing transgender with cisgender older adults, transgender older adults reported higher levels of loneliness (Fredriksen-Goldsen et al., 2011). Looking only at sexual minorities, more often than heterosexual cisgender older adults, LGB older individuals live alone (Kim & Fredriksen-Goldsen, 2014; Wallace et al., 2011). Loneliness and isolation are associated with

poor health, while living with a spouse or partner and having a social support network mitigates the effects of loneliness among LGB older adults (Kim & Fredriksen-Goldsen, 2014; Grossman, D'Augelli, & Hershberger, 2000).

Access to Healthcare

For all aging adults, access and receipt of proper health care is critical. For LGBT older individuals, finding good healthcare can be especially challenging. Study results vary on whether LGBT older adults have less access to quality healthcare than heterosexual or cisgender older adults. Looking at LGB older adults compared with heterosexual older adults, some studies, based on probability samples, found no statistically significant difference in access to healthcare measured by whether respondent reported having delayed or not received medical care or prescription when felt needed, whether respondent visited the emergency room (ER), and number of doctor visits in the past year (Wallace et al., 2001), and no difference in prevalence of having a health care provider (Wallace et al., 2011; Fredriksen-Goldsen et al., 2013a). However, LGB older adults are less likely to have health insurance and more likely to face financial barriers to healthcare than do their heterosexual counterparts (Fredriksen-Goldsen et al. 2013a).

But other studies that use non-probability community samples, show that LGBT older adults may feel distrust toward health and social service agencies, and avoid or delay health care for fear of discrimination due to their sexual orientation or gender identity (Beeler, Rawls, Herdt & Cohler, 1999; Cahill, South & Spade, 2000; Brotman et al., 2003; Croghan, Moone, & Olson, 2012; Wallace et al., 2011, Cook-Daniels, 2006). Incidents of overt homophobia or transphobia from healthcare providers toward older sexual and gender minority adults are common (Brotman et al., 2003; Cook-Daniels, 2015; Czaja et al., 2015). One respondent recalled how "when he got into the nursing home and they found out he was gay, they refunded him his money and threw him out" (Czaja et al., 2015, p.6). Another respondent shared his experience of witnessing nurse aids provide sub-quality care to an older gay patient because of their homophobia (Czaja et al., 2015). In a different study, a transgender older adult reported "One Navy doctor refused me care when a suture site related to my sex reassignment surgery became infected" (Cook-Daniels & munson, 2010, p. 156).

Respondents in a study conducted in the Mid-West reported that even before experiencing any discrimination from senior services, they believed they would not receive friendly services if providers became aware of their minority sexual orientation or gender identity (Croghan, Moone, & Olson, 2014). As a result of fear of discrimination, LGB elders may conceal their sexual orientation from their health care provider (Harrison & Silenzio, 1996). In turn, concealment of one's sexual minority identity can be damaging to LGB older adults seeking health care, for both medical and psychological reasons. Gay and bisexual older adults who reported their providers are aware of their sexual minority identity reported better perceived health and lower depression compared to those who reported their providers are unaware of their sexual orientation (Ramirez-Valles, Dirkes, & Barret, 2014).

Different from LGB older adults, many transgender older adults do not have the option to conceal their gender history to health professionals as their body may reveal scars and other evidence that contradict their gender appearance when dressed (Cook-Daniels, 2006). Because of this, transgender individuals may be more susceptible to discrimination and abuse by health professionals, and this is particularly the case for transgender older adults who may seek more frequent and intimate health care due to age related physical conditions and disabilities (Cook-Daniels, 2006).

Caregiving

LGBT older adults have fewer options for receiving informal caregiving than their heterosexual peers. Heterosexual older adults typically turn first to their spouse or children, second to their parents or siblings, third to in-laws or spouse's family, and fourth to friends and other informal caregivers before finally seeking professional or institutional care for care and social support (MAP & SAGE, 2010; Barker et al., 2006). LGBT older adults are less likely than heterosexual adults to have children to help them (de Vries, 2009; SAGE & Hunter College Brookdale Center, 1999) and may also be estranged or continue to conceal their sexual orientation from their biological families for fear of lack of acceptance (MAP & SAGE, 2010). As a result, LGBT older adults tend to rely more heavily than cisgender heterosexual older adults on friends or "families of choice"—families composed of close friends—and do not have many intergenerational levels of support that heterosexual aging adults typically have (Grossman et al, 2000). One study of gay men in New York City found that gay men were not more isolated than heterosexual men, but were more likely than heterosexual men to call on friends and partners than family (Shippy et al., 2004). Though caregiving received through friends and partners is critical, Barker and colleagues (2006) argue that the same social expectations for long-term care and support that exists for biological kin do not exist within friends, possibly lending to less reliable care among sexual minority older adults.

Financial Instability and Legal Issues

Many LGBT older adults indicate they worry about financial stability as they age (Alliance Healthcare Foundation, 2003; de Vries et al., 2009). Though financial instability is a concern for all aging adults, LGBT older adults face additional challenges because of disparities in access to legal and social programs, particularly related to recognition of legal partnership, lifetime earnings, and opportunities to build savings.

Until recently, same-sex couples faced discrimination in accessing federal government benefits. In *U.S. v. Windsor* (2013), the U.S. Supreme Court held that the federal government must treat married same-sex couples the same as married different-sex couples for purposes of federal benefits. Prior to *Windsor,* members of same-sex couples were unable to access federal benefits programs built to provide financial assistance to older adults. For example, LGBT older adults in same-sex couples were unable to access benefits from federal programs such as social security,

Medicaid and long-term care, retirement plans, or retiree health insurance plans the same way adults in different-sex marriages could, even if their marriage was recognized at the state-level (MAP & SAGE, 2010; Funders for Lesbian and Gay Issues, 2004; Goldberg, 2009). After *Windsor*, married same-sex couples who lived in states that recognized their unions had access to all federal benefits that flow from marriage. However, couples who lived in states that did not recognize their marriages continued to have limited access to benefits. Couples who could not or chose not to travel out of state to marry did not have access to any federal benefits. The U.S. Supreme Court's decision in *Obergefell v. Hodges* (2015) extended marriage equality nationwide, ensuring that same-sex couples can access federal benefits related to marriage no matter where they live. LGBT older adults who are married are now included in the programs that they were denied previously, but some challenges may continue that affect recently married or currently unmarried LGBT older adults. For example, the 9-month duration of marriage to qualify for social security survivor benefits could be restrictive to an LGBT older adult who recently married but their spouse passed away in the interim (Marriage Equality FAQ).

Furthermore, many older same-sex couples may not choose to marry as they already made legal, financial, and other arrangements to formalize their relationships. Older same-sex couples also may have never developed an expectation or desire for marriage, as it was not an option for most of their lives. Additionally, many LGBT older adults rely on "families of choice" or alternative family structures, which could not be included under the definition of formal marriage because they comprise networks of friends of various sizes but not intimate couples. For unmarried same-sex couples or individuals in alternative family structures, some challenges that existed prior to marriage equality remain. For example, benefits that are automatically granted to the surviving partner of marriage are not granted to surviving unmarried same-sex partner (without extensive estate planning and legal processes), and can be financially devastating for the surviving partner, especially if a high-earning partner passes away. Similar issues can arise if a partner needs to enter long-term care. In terms of estate or tax laws, a surviving unmarried partner may be subject to various estate tax requirements to inherit shared property, and without a set of specific legal arrangements that are often very costly, LGBT older adults in same-sex relationships do not have the confidence that they will inherit the property and assets they shared with their partner (MAP & SAGE, 2010).

Aside from discriminatory social and legal programs, many LGBT individuals worked or currently work in an environment where discrimination based on sexual orientation and gender is legal. Though changes are happening on this front, such as the U.S. Equal Employment Opportunity Commission (EEOC) interpreting Title VII's prohibition of sex discrimination to include discrimination based on gender identity and sexual orientation (U.S. EEOC, 2016), legal discrimination based on LGBT status or perceived status persists. This can translate to limited job opportunities, lower income, fewer opportunities to build savings and accumulate wealth for older LGBT adults—all with serious ramifications in older age (MAP & SAGE, 2010).

Gender, gender identity, and sexual orientation affect earnings in different ways. Gay and bisexual men, on average, earned 10-32% less than heterosexual men (Badgett, Lau, Sears, & Ho, 2007). Lesbian and bisexual women, on the other hand, earned the same or more than heterosexual women, but less than men in general (Badgett et al., 2007). Badgett and colleagues (2007) also reported that transgender individuals had high rates of unemployment and low wages, but they did not have a cisgender comparison group. To our knowledge, there is no study on earnings and savings of transgender older adults, though we do have some insight into how same-sex couples fair compared to different-sex couples in older age. "Same-sex couples are disadvantaged in retirement assets, retirement savings, and the ability to pass on wealth" (Goldberg, 2009, p. 2). Same-sex couples also have a higher rate of poverty compared to heterosexual married couples (Goldberg, 2009 in MAP & SAGE, 2010). Lesbian older couples, in particular, are 10-20% less likely than different-sex couples to have retirement income or interest and dividend income, and are much more likely to receive public assistance (Goldberg, 2009).

The accumulated effect of disparities in access to government programs, earnings, and saving as well as the inability to seek legal protection from discriminatory practices can lead to financial instability among LGBT older adults. At the same time, awareness of these legal and financial challenges seems to have manifested in better preparation for later life for some. Sexual minority older adults, particularly those who are coupled, are more likely to be prepared for later life (i.e., setting up a will or a durable power of attorney) than their heterosexual counterparts (de Vries et al., 2009).

Housing

Housing discrimination is a primary concern among LGBT older adults (Equal Rights Center, 2014). Housing decisions can be even more critical for older adults as issues of mobility, limited income earning opportunities, and proximity to social support need to be considered (Equal Rights Center, 2014). Though not specific to LGBT older adults, one experiment conducted by the Michigan Fair Housing Center, found that 26% of houses tested treated same-sex couples differently by either quoting higher monthly rent or denying housing applications (Michigan Fair Housing Center, 2007). Another study that surveyed transgender adults found that 19% were refused a home or apartment and 11% were evicted because of their gender identity or expression (Grant et al., 2011).

Sexual minority older adults may also face discrimination when searching for retirement homes and senior housing (Cahill & South, 2002). In a nationwide matched-pair study, in which an LGB identified senior and heterosexual identified senior contacted the same senior housing community to determine availability, nearly half of the tests (48%) showed that the LGB identified senior experienced unfavorable differential treatment in terms of availability of

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In Search of Safe Spaces

On a panel of program managers and directors serving LGBT older adults through LGBT centers or aging service networks, creating safe spaces was indicated the most pressing need within the LGBT older adult community. LGBT older adults lack safe and affordable housing and a communal and safe space to share information or talk openly about their concerns. Without a shared safe space, LGBT older adults remain invisible, isolated, and ignored. Safe spaces are particularly a concern for transgender older adults. Gloria Allan, founder of a charm school program for transwomen at the Center on Halsted in Chicago, voiced a lack of safe environments for transwomen of color in medical offices, senior housing centers, and social services. Furthermore, she expressed that "security and safety responses from policy and other agencies often is insufficient" in providing a safe environment. With nowhere to go, transwomen of color can suffer from mental health, substance abuse and other social challenges.

housing, pricing, financial incentives, amenities, or application requirements (Equal Rights Center, 2014). In 2012, the U.S. Department of Housing and Urban Development (HUD) issued the "Equal Access Rule" which ensures that any HUD-assisted or insured housing is made available to individuals regardless of actual or perceived sexual orientation, gender identity or marital status (U.S. HUD, 2015). This is an important step toward recognizing discrimination exists and protecting LGBT older adults and individuals looking for government-subsidized housing. Additionally, LGB-friendly housing is available in some parts of the U.S., but such housing is mostly available to upper-income LGB older adults (Cahill & South, 2002).

Stressors

Minority stress theory suggests that sexual and gender minorities are exposed to unique stress related to stigma and prejudice and that this stress leads to adverse health outcomes (Meyer, 2003; Hendricks & Testa, 2012). Minority stressors include external events and conditions, such as major life events, everyday discrimination (smaller magnitude events, such as daily hassles, or micro-aggressions), as well as more proximal (internalized) stressors such as internalized stigma, expectations of rejection and discrimination, and concealment of one's sexual or gender identity. Research has shown that LGBT individuals experience more stress than cisgender heterosexual people and, in turn, this leads to health disparities based on sexual orientation and gender identity (IOM report, 2013). Research has shown that stressful experiences for LGBT individuals begin when they are children and impacts the school experience and health of LGB youth (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Ryan, Huebner, Diaz, & Sanchez, 2009; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Toomey, Ryan, Diaz, Card, & Russell, 2010). For

example, compared with heterosexual, cisgender, youth, LGBT youth experience higher levels of assault, violence, and harassment and feel unsafe at school (Safe Schools Coalition of Washington, 1999; GLSEN, 1999). Fewer studies have analyzed how LGBT older adults experience stressors generated by stigma and discrimination due to their sexual and gender minority status, particularly if stressors are experienced during older age.

Prejudice Events

Prejudice events refer to events stemming from antigay prejudice, discrimination, and violence. Prejudice events include the *structural* exclusion of LGB individuals from resources and advantages available to heterosexuals, including their exclusion from the institution of marriage discussed herein. Prejudice events also include *interpersonal* events, perpetrated by individuals either in violation of the law (e.g., perpetration of hate crimes) or within the law (e.g., lawful but discriminatory employment practices). There are numerous accounts of the excess exposure of LGB people to such prejudice events (Herek, 2009; Herek et al., 2009; Meyer 2003; Meyer, Schwartz, & Frost, 2008).

Hate crimes are a particularly painful type of event because they inflict not only the pain of the assault itself, but also the pain associated with the social disapproval of the victim's stigmatized social group. The added pain is associated with a symbolic message to the victim that he or she and his or her kind are devalued, debased, and dehumanized in society. Such types of experiences affect the victim's mental health because it damages his or her sense of justice and order (Garnets, Herek, & Levy, 1990 in Meyer, 2003; Herek, Gillis, & Cogan, 1999).

One example of a hate crime that reverberates well beyond the victims of the event is the June 12, 2016 mass shooting in an LGBT nightclub. It is the deadliest mass shooting in U.S. modern history, which took the lives of 49 people and injured 53 at the nightclub Pulse in Orlando, Florida (Zambelich & Hurt, 2016). The complex motives behind the attack remains unknown but it appears that the shooter knowingly targeted a gay club, a historically "safe" space within the LGBT community, and thereby attacked people based on their sexual orientation and gender identity (D'Addario, 2016). This hate crime directly targeted the LGBT community and was a reminder that despite the social and legal advancements in gaining rights for LGBT individuals, the community is still a targeted minority group (Lawrence, 2016).

It is not only the pain of the assault but the pain reverberated through the act of the entire community's disapproval, derision, and disdain. The added symbolic value that makes a prejudice event more damaging than a similar event not motivated by prejudice exemplifies an important quality of minority stress: Prejudice events or even everyday instances of prejudice (*everyday discrimination)* and non-events can have a powerful impact "more because of the deep cultural meaning they activate than because of the ramifications of the events themselves . . . a seemingly minor event, such as a slur directed at a gay man, may evoke deep feelings of rejection and fears of violence [seemingly] disproportionate to the event that precipitated them"

(Meyer, 1995, p. 41-42). Therefore, stress related to stigma is not assessed solely by its intrinsic characteristics but also by its symbolic meaning within the social context: even a minor event or instance can have symbolic meaning and thus create pain and indignity beyond its seemingly low magnitude.

In a national community-based sample study of LGB older adults across the U.S., Fredriksen-Goldsen and colleagues (2013c) reported that LGB older adults on average experience victimization and discriminatory events six times in their lifetime. Additionally, the researchers found that those who reported experience of victimization in their lifetime had poorer general health, a higher likelihood of disability, and a higher likelihood of depression (Fredriksen-Goldsen, 2013c). In another study analyzing 416 LGB older adults aged 60-91, Grossman and colleagues (2002) found that victimization due to minority sexual orientation status was an important risk factor for poor mental health.

Using the same sample of LGB older adults, D'Augelli and Grossman (2001) examined lifetime victimization experiences due to sexual minority status. LGB older adults who disclosed their sexual orientation at an earlier age and were open about their sexual orientation experienced more victimization (D'Augelli & Grossman, 2001). Physical victimization in particular was associated with longer time being open about one's sexual orientation and was tied to lower self-esteem (D'Augelli & Grossman, 2001). Regardless of time being out, however, 63% of respondents reported to have experienced verbal abuse and 30% reported being threatened with violence at some point in their life due to their sexual orientation (D'Augelli & Grossman, 2001). Some respondents also reported having been threatened with disclosure of their sexual orientation. Experiences with victimization and discrimination also differed by gender, as sexual minority older men reported higher incidences of being physically attacked in their lifetime than did sexual minority older women (D'Augelli & Grossman, 2001). Victimization and discrimination experiences between older and younger LGB adults have also been compared. Older adults, particularly older gay men compared to younger gay men, reported fewer incidents of victimization and discrimination than younger LGB adults and youth (Dean et al, 1992; Herek et al.,1997).

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Lived Experiences of LGBT Elders: Discrimination

As a transgender woman, Dana Wallingford, has experienced isolation, marginalization, and a lack of culturally competent health services. Dana shared her experience of being kicked out of a local recreation center restroom being told "you haven't had the surgery yet". She has not felt comfortable at that recreation center since, and feels self-conscious at the new recreation center she frequents. Dana reports suffering from depression and anxiety.

To our knowledge, however, no study provides data on current or recent victimization and discrimination experiences due to sexual orientation among older LGB adults. This knowledge gap demonstrates a research need to focus on the current or recent lived experiences of LGB older adults.

Studies on victimization based on gender identity are more limited. Fredriksen-Goldsen and colleagues (2013b) found that compared to an average of 6 lifetime incidents among cisgender older adults, transgender older adults experienced an average 11 incidents of victimization and discrimination including verbal insults, being threatened with physical violence, not being hired for a job, being denied or provided inferior health care, being denied a promotion, or being hassled by the police. Seventy-six percent of the 174 self-identified U.S. transgender older adults in the survey reported experiencing verbal abuse and more than 54% reported being threatened with physical violence. Over one-third of the transgender older adults reported experiencing discriminatory events such as denial of healthcare, denial of promotion, and unfair treatment from police. Professional or government officials are sometimes the source of abuse and mistreatment that transgender individuals experience (Grant et al., 2011), making it difficult for individuals to report to authorities in fear that authorities may respond with hostility or apathy (Cook-Daniels, 2006). One transgender older adult who was residing in a long-term care facility shared his experiences of sexual abuse and verbal harassment from nurse aids with his social worker. Though the social worker discussed options to report the harassment and abuse, the transgender older adult refused to report the incidents out of fear of retaliation from the nurse aids and disclosure of his transgender status to his family (Cook-Daniels, 2006).

Internalized Stigma (Internalized Homophobia and Internalized Transphobia)

Internalized stigma (also described as *internalized homophobia and internalized transphobia*) refers to the internalization of negative societal attitudes about LGBT people toward oneself. For example, internalized transphobia refers to the internalization of anti-trans attitudes and beliefs, such as the belief that people's gender is consistent with their biological sex assigned at birth and therefore trans individuals are imposters who are not truly who they say they are. Internalized transphobia manifests when transgender individuals feel negatively about their own gender identity and about the transgender community (Testa et al., 2015). Internalized stigma is an insidious stressor because it is unleashed by the person toward the self through years of socialization in a stigmatizing society (Meyer, 2003, Herek et al., 2009). Heterosexual cisgender people, just like LGBT individuals, internalize homophobia and transphobia, but the effects of this internalization is quite severe for LGBT persons who must learn to dissociate their sense of self from what they have learned as members of society about being LGBT.

Internalizing stigma has negative consequences for the health and well-being of LGBT people. Because internalized homophobia disturbs the gay person's ability to overcome stigmatized notions of the self and envision a future life course, it is associated with mental health problems and impedes success in achieving intimate relationships (Meyer, 1995; Meyer & Dean, 1998;

Frost & Meyer, 2009). Similarly, internalized transphobia is associated with overall psychological distress and other mental health problems (Testa et al., 2015; Bockting et al., 2013).

LGBT older adults spent their formative and much of their early adult years in a social, political, and medical environment in which homosexuality was considered a mental illness and same-sex sexuality (sodomy) was illegal (D'Augelli et al., 2001). Given this historical background, internalized stigma is an important concept to explore among LGBT older adults. However, the effect of internalized homophobia and transphobia on LGBT older adults is less clear because few studies have examined this question within this population. One study found that LGB older adults had high self-esteem levels and low levels of internalized homophobia, with 80% reporting they were "glad to be LGB" and 8% reporting feeling depressed with regard to their sexual orientation (Grossman, D'Augelli & O'Connell, 2002). The authors also found that men tended to report higher levels of internalized homophobia than women did. For gay men, in addition to internalized homophobia, internalized ageism leads to aging related-stress, which, coupled with internalized stigma, is associated with depressive symptoms (Wight et al., 2015) and mental health issues (Wight et al., 2012). Among older LGB adults, internalized homophobia was a predictor of increased disability and depression, but was not associated with poor general health (Fredriksen-Goldsen, et al., 2013c). In a more recent study, however, researchers found that internalized homophobia was associated with chronic physical health conditions (Hoy-Ellis & Fredriksen-Goldsen, 2016).

In the study mentioned above on transgender older adults, transgender older adults reported higher rates of internalized stigma than cisgender LGB older adults (Fredriksen-Goldsen et al., 2013b). Internalized stigma, along with other stressors, was associated with poorer health, higher degrees of depression, and perceived stress.

Concealment of Sexual and Gender Identity

Concealment refers to an LGB or transgender person hiding their sexual or gender identity from others. It is typically used as a coping mechanism, to prevent being subject to prejudice, discrimination, or violence. But concealment is also a stressor and can have negative health consequences (Meyer, 2003). First, people must devote significant psychological resources to successfully concealing their LGB identity. Concealing requires constant monitoring of one's interactions and of what one reveals about his or her life to others. Keeping track of what one has said and to whom is very demanding and stressful, and leads to psychological distress. Among the effects of concealing are preoccupation, increased vigilance of stigma discovery, and suspiciousness (Pachankis, 2007). The concealing effort, and the required cognitive efforts can lead to significant distress, shame, anxiety, depression and low self-esteem (Frable, Platt, & Hoey, 1998). Second, concealing has harmful health effects by denying the person who conceals his or her LGB identity the psychological and health benefits that come from free and honest expression of emotions and sharing important aspects of one's life with others (Pachankis, 2007).

Third, concealment prevents LGB individuals from connecting with and benefiting from social support networks and specialized services for LGB individuals. Protective coping processes can counter the stressful experience of stigma (Meyer, 2015). Coping processes include the group's effort to counter negative societal structures by creating alternative norms and values and providing role models and social support. Access to and use of such community resources is beneficial to stigmatized minority group members whose experiences and concerns are not typically affirmed in the larger community. For example, LGB communities have provided role models of successful same-sex intimate couples, have provided alternative values that support LGB families, and, in general, have countered homophobic messages and values (Weston, 1991). LGB people who conceal their sexual identity would avoid, in an effort to maintain secrecy, such organizations or venues (e.g., gay or lesbian media, a gay community center, and other gay or lesbian community venues such as a gay pride day celebration). In addition, LGB people who need supportive services, such as competent mental health services, may receive better care from sources in the LGB community (e.g., a specialized gay clinic; Potter, Goldhammer, & Makadon, 2008). But individuals who conceal their LGB identity are likely to fear that their sexual identity would be exposed if they approached such sources. More generally, concealing can lead to social isolation as the person who conceals his or her sexual identity may avoid contact with other LGB persons but also feel blocked from having meaningful honest social relations with non-LGB individuals. As mentioned above, while many LGB individuals have the option of "passing" or concealment, transgender people do not always have this option, particularly with health providers who have access to past medical records or can see transition related body scars (Cook-Daniels, 2006).

Concealment is intertwined in the stories of many LGBT older adults, and can become a central issue as long-term or advanced health care and end-of-life planning become imminent. In a study of LGB older adults, the median age of first awareness of sexual orientation was 12 and the median age of first disclosure of sexual orientation was 23, while some respondents spent little time in the closet, others spent almost their entire lives concealing their sexual orientation (D'Augelli & Grossman, 2001). More than half of the respondents reported that either one or both parents or siblings did not know their LGB status (D'Augelli & Grossman, 2001). Among LGBT older adults with children, a higher proportion of fathers than mothers reported concealing their sexual orientation from their children (D'Augelli & Grossman, 2001). Differences in concealment also exist by gender, as women reported more openness about their sexual orientation than men (Jacobs, Rasmussen, & Hohman, 1998) and women reported that more people knew of their sexual orientation than men did (D'Augelli & Grossman, 2001). The stress of concealment and disclosure for LGBT older adults is most prominent in the context of health services, particularly long-term care services (See *Health Services-Advanced care/End-of-life care* section).

Expectations of rejection

Expectation of rejection and discrimination is a stressor because of the almost constant vigilance required by members of minority groups to defend and protect themselves against potential rejection, discrimination, and violence (Meyer, 2003). Unlike the concept of prejudice events, where a concrete event or situation—a major or minor life event or a chronic stressor—was present, expectations of rejection and discrimination are stressful even in the absence of a prejudice event. "Because of the chronic exposure to a stigmatizing social environment, 'the consequences of stigma do not require that a stigmatizer in the situation holds negative stereotypes or discriminates'" (Crocker, 1999, in Meyer, 2003, p. 681).

Although research has not studied this extensively, it is likely that expectations of rejection will be a factor in concealing sexual or gender identity and may play out most prominently in employment, health care settings, residential care, and in seeking support from non-LGBT persons. Thus, about one-third of lesbian and gay older adults identified discrimination due to sexual orientation as their greatest concern about aging (MetLife, 2006). Older lesbians feel their job would be in jeopardy if their sexual orientation were known (Jacobs, Rasmussen, Hohman, 1998). Older LGBT people may also expect dealing with insensitive professionals and policies in hospitals and other organizations. Respondents in one study were especially apprehensive about in-home services and attending straight support groups. One respondent shared this anticipation and fear of discrimination by professionals, saying: "Even though I was not treated badly, I always had that fear that I could be treated badly . . . there is always a threat that you carry around in your heart that they can be bad to you" (Hash, 2008, p. 133).

Resilience Factors for Successful Aging

In the face of stressors such as those described above, LGBT people display resilience through coping and social support. The minority stress model predicts that the impact of stress on LGBT populations is ameliorated by resiliency so that the outcome of stress is determined by the efficiency of salutogenic coping and social support to counter the adverse impact of stress (Meyer, 2003). Thus, studies show that many LGBT older adults are well-adjusted, happy, and thriving (Fredriksen-Goldsen et al., 2014; Van Wagenen et al., 2013; Kimmel, Rose, & David, 2006). These results conflict with above study results that focus on the negative experiences and stressors of LGBT older adults. However, these conflicting results may be because the focus and approach of the studies is different, studies that examine resilience will have different approaches and constructs to measure than studies that look at victimization and discrimination experiences. To further explore how LGBT older adults are aging in terms of resiliency, a few studies have looked at *successful aging* in LGBT populations. Though the concept of successful aging and its many dimensions have been thoroughly examined in gerontology (Van Wagen, Driskell, & Bradford, 2013) and applied to studies on the general aging population, little research exists around subpopulations and minority groups (Phelan et al, 2004; Laditka et al, 2009; Van Wagen et al, 2013), particularly sexual and gender minority groups.

Of the few studies that have theorized or examined what "successful" aging looked like among LGBT older adults, ability to be resilient in the face of difficulties or "crisis competency" was an important theme (Friend, 1991; Van Wagen et al, 2013; Fredriksen-Goldsen, Kim, Chiu, Goldsen & Emlet, 2014). Resilience, the "behavioral, functional, social, and cultural resources and capacities utilized under adverse circumstances" (Fredriksen-Goldsen, et al. 2013c p.3), aside from the other traditional metrics of successful aging such as physical, mental, and emotional health, is a critical dimension to understanding how well LGBT older adults age.

The ability to cope with adversity is an indication of resilience. Coping mechanisms can be understood at the individual level and at the group level (Meyer, 2003). Individual coping is personal strengths or characteristics, such as having a positive outlook or determination when dealing with stressful situations (Branscombe & Ellemers, 1998 in Meyer, 2003). Group coping, common among minority groups, provides individuals with a sense of unity by creating a positive environment of support and protection (Branscombe & Ellemers, 1998 in Meyer, 2003). For LGBT older adults, much of the literature on coping focuses on group coping mechanisms or social support networks.

Social Support

Studies have found positive effects of social support among LGBT older adults (Ramirez-Valles, Dirkes, & Barret, 2014; Fredriksen-Goldsen et al, 2001; MAP & SAGE, 2010). A larger number of people in one's social network is associated with better health (Ramirez-Valles et al 2014). Social support not only serves as a function of support toward aging but also in dealing with lifelong stigma and discrimination of being LGB (D'Augelli & Grossman, 2001). Social support has been associated with better health outcomes (White et al., 2009), as a safeguard to stigma and effects of discrimination (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Silliman, 1986), better general health and higher quality of life (Fredriksen-Goldsen et al., 2015), and decreased depression and internalized stigma (Masini & Barrett, 2008). In a study using a national community-based sample of LGBT older adults, 67% of respondents reported they had someone to help with daily chores if sick, 82% reported they had someone to turn to for help with personal problems, and 71% said they had someone to love or who made them feel loved (Fredriksen-Goldsen et al., 2011). Older individuals who were supported by people who knew of their sexual orientation had higher levels of satisfaction with their support and felt in control of their loneliness compared to those who were supported by people who were unaware (Grossman et al., 2000).

The most common and most studied form of social support network among LGBT adults and LGBT older adults is "families of choice" (Barker, Herdt & de Vries, 2006; Croghan et al., 2014; Brennan-Ing et al., 2014; MAP & SAGE, 2010). Families of choice refer to partners, friends, and other individuals such as neighbors, who are considered and act in place of one's biological family. Many LGB older adults in particular who left or were kicked out of home as youth often

found support in large urban areas, among people like themselves (Barker, Herdt, & de Vries, 2006). LGB older adults turned to each other for the support that families were unable or unwilling to provide (Barker, Herdt, & de Vries, 2006). A survey of 495 older adults in the Twin Cities Metropolitan area found that 75% of older LGBT people reported having a chosen family (Croghan et al., 2012). Another survey based in the Midwest found that LGBT older adults on average received more types of care from families of choice than from their biological families (Brennan-Ing et al., 2014). In a study of older gay and bisexual men in New York City, among the 36% who were partnered, the majority (70%) reported relying on their partners for primary support (Shippy, Cantor, & Brennan, 2004). In the absence of a partner, about 40% reported counting on friends for support rather than any existing family, though not all friendships were functional in terms of providing instrumental and emotional support (Shippy, Cantor, & Brennan, 2004). Masini & Barrett (2008) also found LGB adults who got support from friends rather than family reported better mental health and lower levels of depression.

Few studies have also analyzed what individual characteristics are associated with social network size and the characteristics of one's social support network. In a New York City study, Frost, Meyer, and Schwartz (2015) found significant gender differences related to major support (e.g., help with money), with GB men relying mostly on other LGBT friends, and LB women relying mostly on family of origin. Using data from a large community-based sample across the U.S., Erosheva and colleagues (2015) found that certain demographic characteristics, such as being female, transgender, employed, with higher income, and having a partner/child were associated with having a larger social network. Many of the same factors were also associated with having a network that was diverse in terms of sexual orientation and gender identity. Consistent with minority stress theory, Meyer, Schwartz, and Frost (2008) found that race/ethnic minorities (Blacks and Latinos) had fewer resources than White LGB and heterosexual respondents.

For many LGBT older adults, families of choice seem to be a major source of social support. However, relying primarily on families of choice can be challenging as older adults may feel they have fewer opportunities to make new connections (Zians, 2011) as friends fall away or face their own physical challenges with aging or disease. Shippy and Karpiak (2005) found that while most sexual minority men with HIV relied on friends who were also HIV positive, nearly 30% reported that they have only themselves to rely upon or that wouldn't know where to turn for help. Another challenge for LGBT older adults and social support is that many of their families of choice belong to the same generation and cannot provide support (MAP & SAGE, 2010) such that younger friends could provide. Although 73% of respondents in a San Diego based survey on older LGBT people reported having younger friends, only 30% believed they could count on these friends for support (Zians, 2011).

Support from LGBT Community Organizations

Another source of support is through LGBT community organizations. Though disclosure of sexual orientation and gender identity can lead to experiences of victimization and

discrimination, one major benefit of disclosure is the opportunity to connect and become involved with the broader LGBT community and LGBT-specific organizations. Being part of a larger unifying community can serve as an important social network and 89% of LGBT older adults reported they were proud to be part of the LGBT community (Fredriksen-Goldsen et al., 2011). Additionally, in a recent report surveying LGBT community centers, 61% of the 105 community centers noted that they provided services tailored to older adults and many had programs focused on LGBT older adult outreach or physical and mental health programs (CenterLink & MAP, 2016).

Two empirical studies have analyzed LGB older adults' engagement and attitude toward LGB service organizations. Quam and Whitford (1992) found that gay and lesbian adults over the age of 50 living in the Midwest were more likely to engage in gay and lesbian social groups than in senior recreation center activities for the general population. Similarly, in a more recent study in San Diego County, Jacobs and colleagues (1999) found that LGB older adults believed LGB specific social and support groups better met their needs in times of crisis than non-LGB specific support systems. Furthermore, about 80% reported that LGB-specific social services provided adequate support, though 30% reported they could not locate a LGB support center when in need.

The two studies indicate that LGB older adults can benefit from and enjoy participating in the LGBT community and organizations. In fact, almost 50% of respondents from the San Diego County study reported they would not participate in LGB support services if they were provided by a non-LGB service organization (Jacobs et al., 1999). Despite this show of support, a common challenge LGBT older adults face is feeling unwelcomed by the larger LGBT community and organizations (MAP & SAGE, 2010).

Highlights from the 2015 Denver convening: Evaluating and Enhancing Aging Network Outreach to LGBT Older Adults

Current State of Services Provided to LGBT Older Adults by Aging Networks
Aging network representatives from Florida, Georgia, Hawaii, and New York discussed how their networks served LGBT older adults.

Jacksonville, Florida: LGBT older adult representation at aging networks is low but improving. While the aging community is aware of the LGBT community, they do not believe LGBT older adults have different issues often saying "we don't have a problem here." Many elder service providers also believe everyone should be treated equally, which can lead to isolation of LGBT older adults. Raising community awareness of LGBT older adult issues is necessary and Eldersource now requires culturally competent service training to all staff and contractors. Another issue is the lack of information on the extent to which LGBT older adults access aging

services. State data collection systems do not collect or track LGBT data and resources. Aside from anecdotal information, we do not have a good sense of what kind of services LGBT older adults need. Some things that would help support a better LGBT older adult experience in Florida is to mandate state agencies to collect LGBT data, train providers in LGBT issues, and encourage state-to-state sharing of best practices.

- Linda Levin, Executive Director, ElderSource

Atlanta, Georgia: Georgia has the 8th largest LGBT population in the country and while many statewide systems have been implemented, things move slowly and there is still much to do. The state has provided culturally competency trainings, worked with service providers to establish a database of LGBT friendly providers, and updated intake and other materials to include LGBT elements. However, there is some pushback internally on making LGBT elder services a priority, such as employees resisting including LGBT questions in client interactions. Additional funding to implement systematic improvements in training availability would help improve the experience of LGBT older adults in Georgia as there are many disparities for both aging and LGBT issues at the state and local level. LGBT issues need to be treated like a minority or disability element.

-James Bulot, Director, Georgia Department of Human Services, Division of Aging Services, Chair, NASUAD Board of Directors

Maui, Hawaii: Hawaii is a welcoming state, but during marriage equality debate, the dialogue was heart wrenching and it exemplified causes of isolation among LGBT elders. Even in a state as warm and welcoming as Hawaii, stigma and discrimination exists. Though Maui County has a HIV/AIDS program, there is no sense of what the LGBT community looks like. The County is trying to incorporate LGBT specific trainings, but barriers exist. In Hawaii, a common view is that we are all minorities so why does one specific demographic need special attention. More opportunities are needed for our citizens to tell their stories. Asking LGBT questions on all forms, starting at the federal level, is critical to increase visibility and to make informed decisions and will improve the experiences of LGBT older adults in Hawaii.

- Deborah Stone-Walls, Maui County Office on Aging

New York, New York: As an Area Agency on Aging (AAA) Director, it became obvious that training to raise awareness among mainstream population on the needs of LGBT elders was important. As a state agency, we adjusted our comprehensive assessment form to include LGBT questions to help collect data and use it to better serve the LGBT community. We also worked with local AAA that had concerns about asking LGBT related questions in culturally

competent ways and updated our annual implementation plan to include LGBT components and ensure those issues are included in the planning process for all programs. LGBT outreach is treated just like outreach to any other minority population. Inclusion in implementation plans is allowing the State to collect much more data on LGBT populations. To move ahead, leaderships on these issues need to start from top down. Every organization faces limited capacity and resources, which is why LGBT policies need to be put in place systemically to ensure equality. Advocates also have to stay the course to put pressure from the outside in and force us to collect the data and report back.

-Corinda Crossdale, New York State Office for the Aging

Religious Networks

Religious networks are also a source of social support among older LGBT adults. Fredriksen-Goldsen and colleagues (2011) found that 38% of older LGBT people attended a religious or spiritual service at least once a month. Religious service attendance differs by sexual orientation and gender identity, with bisexual older men more likely to attend service than gay older men, and transgender older adults more likely to attend service than cisgender LGB adults.

Although religiosity is related to better health in the general population (Ellison, 1991; Ellison et al., 2001), little empirical research exists about the effects of religious networks and LGBT older adults. One qualitative study of older LGBT adults in Chicago examined the quality and type of support LGBT older adults received from religious organizations (Brennan-Ing, Seidel, Larson & Karpiak, 2014). About 75% of 210 participants reported having some kind of religious affiliation and 38% reported that they have turned to their religious organization for support. Many of the respondents stated that they received not only emotional but also practical support, such as shopping and meal preparation, from their congregations. Though most respondents reflected positively on their religious affiliation and network, about 23% reported their sexual orientation and gender identity status negatively affected their religious association and reported using various coping mechanisms, such as changing churches or having less of a presence, to deal with the negative experiences. In general, LGB people are less religious than non-LGB people. White LGB people often switch their family religion to a more accommodating, gay-affirmative religion but this is less common for Black and Latino individuals. For Black and Latino LGB people, relationship with communities of color and church is significant for their sense of race/ethnic community identification and for maintaining social ties with their communities (Barnes & Meyer, 2012; Meyer & Ouellette, 2009).

Giving and Receiving Care

Given that LGB older adults are more likely than their heterosexual peers to live alone (Wallace, Cochran, Durazo & Ford, 2011), the role of primary caretaker often falls to families of choice (de Vries, 2011). Several studies have analyzed the extent to which LGB older adults have received or given care to others in their social network, particularly to other LGB older adults (Grossman et al., 2007; Shippy et al., 2004; Erosheva et al., 2015; Muraco & Fredriksen-Goldsen, 2011). In one study of LGB older adults in New York and Los Angeles, about 38% of respondents reported that they received care from someone other than a health-care provider in the past 5-years (Grossman, D'Augelli & Dragowski, 2007). Additionally, 65% of respondents reported they have *provided* care to another LGB older adult within the past 5-years (Grossman, D'Augelli & Dragowski, 2007).

In a study conducted in the Twin Cities Metropolitan Area of LGBT older adults, participants reported receiving primary care from a non-legal relation and were more likely to provide care to others they were not legally related to in the future (Croghan, Moone, & Olson, 2012). Other studies have found that between 21-27% of LGBT older adults reported they served as caregivers, of which close to 35% served a spouse and between 27-39% took care of a friend or non- related person (Fredriksen-Goldsen et al., 2011; Metlife, 2010). Sexual orientation and gender determine the likelihood of LGB older adults providing care to others: Females were more likely than males to provide care (Grossman et al., 2007), and bisexual women were more likely than lesbian women to provide care, though both bisexual and lesbian women were more likely to provide care than bisexual or gay men (Croghan et al., 2014). Lesbian and gay elders were also more willing to provide care to gay or lesbian older adults than they were to bisexual or heterosexual older adults (Grossman et al., 2007).

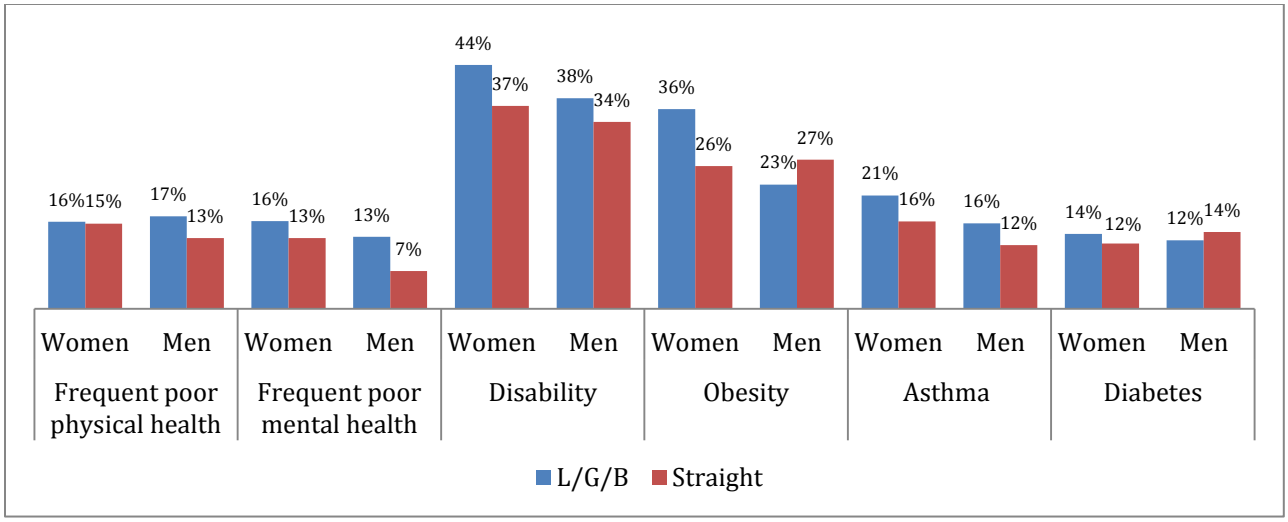
These results underscore the important role of families of choice and informal social networks as primary caretakers within the LGBT older adult population but also suggest that older LGBT adults may face extra burdens related to providing care to other older LGBT people (Muraco & Fredriksen-Goldsen, 2011). From a legal perspective, LGBT older adults who are the primary care for other LGBT older adults do not have the same state and federal privileges such as medical leave to care for a same-sex partner or medical decision-making processes for a terminally ill partner as heterosexual partners do (Krehely & Adams, 2010). Limited research is also available on the effect of caregiving among LGB older adults. Taking care of an older adult can be extremely taxing and burdensome. Muraco and Fredriksen-Goldsen (2011) examined the challenges LGB older adults face when caring for and receiving care from other LGB older adults. Through qualitative analysis of 18 care partners, the researchers found that relationships and boundaries were reevaluated and renegotiated as care receivers felt burdensome and care givers felt burdened. Expectations and social obligations to continue care are less clear for friends than they are for kin or spouses, adding complications and stress to the relationship of many LGB older adults (Barker et al. 2006). In fact, lesbian and gay older adults who provide

informal care and believe they will need support in the future from friends, have voiced a need for additional help in caring for other sexual minority older adults (Czaja et al, 2015). One study looked specifically at mid-life and older gay and lesbian caregivers' experiences after they provided care (Hash, 2008). As with any adult who has provided long-term care to a chronically ill spouse or friend, caregivers experienced loneliness, depression and physical and emotional strain. However, mid-life and older gay and lesbian caregivers also reported distress and difficulty in interactions with other forms of formal and informal support. For example, some respondents reported that ex-spouses or adult children were hostile or unaccepting of the caregiver or that health care providers refused to accept the caregiver as next-of-kin. Hash (2008) also reported incidents of caregivers dealing with whether to disclose or conceal the sexual identity of the care receiver and ultimately their own sexual orientation, upon death of the care receiver.

Health Outcomes

Compared to heterosexual older adults with similar demographic characteristics, sexual and gender minority older adults have worse mental and physical health (Fredriksen-Goldsen et al, 2013a; Addis et al., 2009; Fredriksen-Goldsen et al., 2011). LGB older adults have higher risks of mental health issues, disability, and higher rates of disease and physical limitations than heterosexual older adults (See Figure 1; Wallace et al., 2011; Fredriksen-Goldsen et al., 2013a). Below we examine studies on mental and physical health outcomes and determinants within the LGBT older population. However, most of the analysis compares health outcomes based on sexual orientation or gender identity, but do not classify different groups within LGBT populations and lack an intersectionality perspective.

Figure 1: Comparison of proportion of LGB and straight older adults' health outcomes, by gender and sexual orientation (Washington State BRFSS, 2003-2010)



*Source: Fredriksen-Goldsen et al., 2013a

Mental Health

Overall most LGBT older adults have rated their general mental health as good or satisfactory (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Fredriksen-Goldsen et al., 2011). However, when comparing overall mental health of LGB older adults with heterosexual older adults by gender, sexual minority adults have poorer mental health (Fredriksen-Goldsen et al., 2013a) and are more likely to have experienced psychological distress symptoms (Wallace et al., 2011). Though we do not have a comparison of transgender older adults' overall mental health with non-transgender older adults, we can examine differences within LGBT populations by sexual orientation and gender identity (Fredriksen-Goldsen et al., 2011). Bisexual older women reported a lower mental health score and showed a higher likelihood of frequent mental distress compared to lesbian women (Fredriksen-Goldsen, 2011; Fredriksen-Goldsen et al., 2010a). Bisexual older men also reported a lower mental health score than gay older men, and transgender older adults reported worse mental health than non-transgender adults (Fredriksen-Goldsen et al., 2011). Though the differences in perceived mental health disappeared when controlling for background characteristics for LGB older adults, they did not for transgender and cisgender LGB older adults (Fredriksen-Goldsen, 2011).

Research has measured the prevalence and factors that influence other mental health indicators such as depression, anxiety, and suicide ideation among the LGBT older adult population. Fredriksen-Goldsen and colleagues (2011) found that 31% of LGBT older adults reported depressive symptoms at a clinical level with transgender adults reporting the highest proportion of depressive symptoms. Similar results were also detailed in another study that compared transgender older adults with cisgender LGB older adults (Fredriksen-Goldsen et al., 2013b). In terms of suicide ideation, 39% of LGBT older adults reported they had at some point seriously considered taking their own life, with a higher proportion of transgender older adults (71%) reporting suicide ideation compared to cisgender LGB older adults (between 35-40%) (Fredriksen-Goldsen et al., 2011).

Mental health issues within the LGBT older population are linked to past experiences of victimization and discrimination, internalized stigma, barriers to health care, and poverty (Fredriksen-Goldsen, Emlet, Muraco, et al., 2012; D'Augelli & Grossman, 2001; Fredriksen-Goldsen et al., 2010). Among LGB older adults, victimization, internalized stigma, financial barriers to health care, and poor physical health were linked to depression (Fredriksen-Goldsen et al., 2013c). Experiences of victimization, particularly experiences of physical attack due to sexual orientation among LGB older adults, were associated with poorer mental health and more lifetime suicide attempts compared to adults who were not victimized or only verbally attacked (D'Augelli and Grossman, 2001). Difference in gender also exist, as gay and bisexual men who reported poor mental health reported higher levels of internalized homophobia, alcohol abuse, and suicide ideation than lesbian and bisexual women (D'Augelli et al., 2001). Suicidal behavior also seemed to differ by age range and is distributed across the lifespan among older adults with

the majority (69%) of suicide attempts occurring between ages 22-59, 27% at or before age 21, and 4% after age 60 (D'Augelli et al., 2001). In the same study, thirteen percent of the LGB older adult sample also reported a total 97 lifetime suicide attempts (Haas et al., 2011; D'Augelli et al., 2001). In turn, mental health problems are mitigated by protective factors such as social support (Fredriksen-Goldsen et al, 2013c). Ramirez-Valles et al (2014) found that fewer older gay men with support—e.g., they lived with another person and had a health care provider who knew of their sexual orientation—reported depressive symptoms as compared with peers with less support.

Physical Health

In general, LGBT older adults reported that they are in good physical health (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Fredriksen-Goldsen et al., 2011). Similar to mental health outcomes, there are some differences within LGBT older adults (Fredriksen-Goldsen et al., 2011). Bisexual older men and transgender older adults reported poorer overall physical health compared to gay older men and cisgender older adults, respectively. Results from a non-probability study showed that bisexual and lesbian women had similar levels of physical health (Fredriksen-Goldsen et al., 2011), but in probability sample comparing lesbian and bisexual women, Fredriksen-Goldsen and colleagues (2010a) found that bisexual women had poorer general health than lesbians.

Disability and health conditions among LGBT older adult populations have also been studied. About half of the participants in a study of over 2000 LGBT adults reported a disability and 44% reported they were they felt physically limited due to a physical, mental or emotional problem (Fredriksen-Goldsen et al, 2011). Comparing LGB older adults with heterosexual older adults, a higher proportion of LGB older adults reported a disability than heterosexual older adults (Fredriksen-Goldsen et al., 2013a) and older lesbian and bisexual women were 1.32 time more likely than heterosexual women to experience physical disability (Wallace et al., 2011).

Though many LGBT older adults self-report that they have good overall physical health, when comparing LGBT older adults with heterosexual older adults based on specific health outcomes, we find that both groups face similar health concerns and in some cases, LGBT older adults may be more at risk for certain health conditions compared to their non-LGBT counterparts. Obesity, high blood pressure, high cholesterol, asthma, cardiovascular disease and other health conditions are prevalent within the LGBT older adult population (Fredriksen-Goldsen et al, 2011). Two studies using representative samples provide some insight into how LGB older adults fare compared to heterosexual older adults. Within the Washington state population, Fredriksen-Goldsen and colleagues (2013a) find that lesbian and bisexual women are more likely to be obese than heterosexual women, while gay and bisexual men were less likely to be obese than heterosexual men. Lesbian and bisexual women also had higher risk for cardiovascular disease, and gay and bisexual men had higher risk for poor physical health compared to heterosexual older adults (Fredriksen-Goldsen et al., 2013a). Using data from a California probability sample

study, Wallace and colleagues (2011) found that although gay and bisexual men had similar rates of heart disease as heterosexual men, they had a higher ratio of hypertension, diabetes, psychological distress symptoms, and physical disability. The study did not find any statistical differences between sexual minority women and heterosexual women on key health conditions such as diabetes, hypertension, and heart disease.

Very little is known about transgender older adults and their physical health conditions. One study found that transgender older adults were at higher risk for poor physical health, disability, and depressive symptoms than non-transgender adults (Fredriksen-Goldsen et al., 2013b). Poor health outcomes were associated with gender identity, victimization and discrimination, lack of support, and health-related behaviors, though victimization and stigma explained poor health outcomes for most people.

HIV/AIDS

The HIV epidemic has had a profound impact on the LGBT population and continues to have a lasting impact on the older generation physically, emotionally, and psychologically (Friend, 1991; Emlet et al., 2015). While there are no national HIV prevalence data for older LGBT adults, Fredriksen-Goldsen and colleagues (2011) found that 9% of a nationally surveyed non-probability sample of LGBT older adults lived with HIV. Gay and bisexual men and transgender women, in particular, have high prevalence of HIV (Center for Disease Control, 2014; Herbst et al, 2008; Fredriksen-Goldsen, 2011). Furthermore, prevalence of HIV was higher for African Americans and Hispanics, compared to White LGBT older adults (Fredriksen-Goldsen et al. 2011). In a New York City study, the majority of LGB older adults living with HIV were White, followed by Latinos and African Americans (Karpiak & Brennan, 2009). Results of comparison analysis of HIV-positive LGBT older adults with HIV-negative LGBT older adults show that HIV positive older adults have worse mental and physical health, disability, poorer health outcomes (such as cardiovascular disease and rates of cancer), and a

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Social support for HIV positive seniors

HIV/AIDS programs and support networks for LGBT seniors are almost non-existent. This is true even in cities like Los Angeles, California where LGBT-specific centers and services are more common. Many elders do not think they can contract HIV and those that are HIV positive are heavily stigmatized. Given the lack of support and services, HIV positive LGBT seniors need to be taught spiritual, mental, and social tools, such as a buddy or referral system for newly diagnosed elders to function successfully.

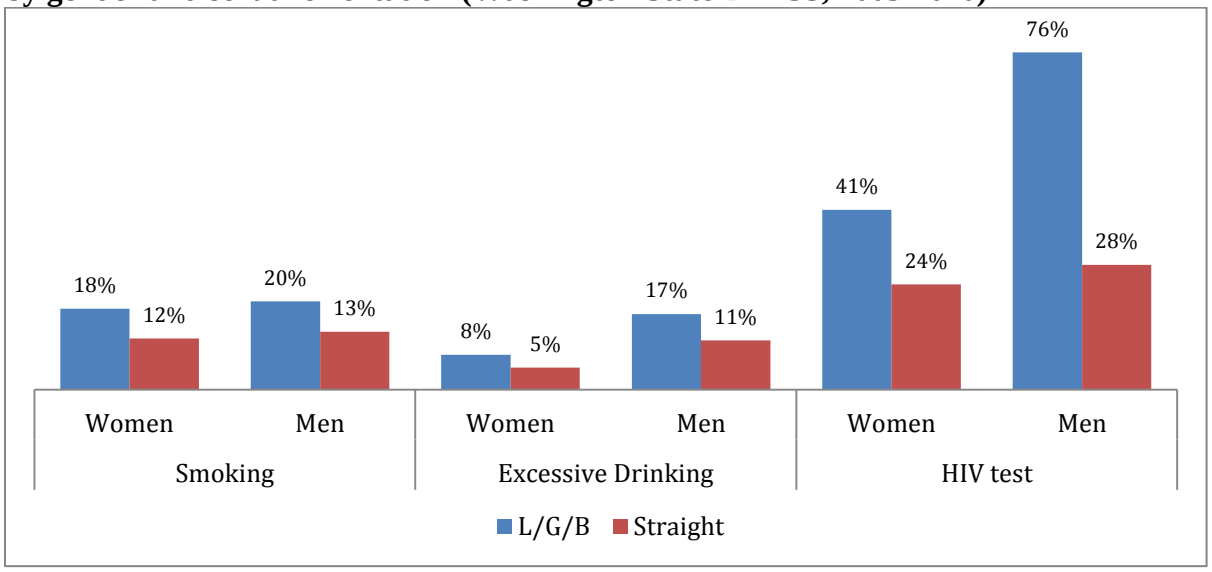
- Herbie Taylor, active member of L.A. LGBTQ Center

higher likelihood of experiencing stressors as well as barriers to care (Fredriksen-Goldsen et al., 2011). In particular, older gay men who are HIV positive experience multiple forms of stigma stemming from their sexual orientation, age, and HIV status and consequently report poor quality of life (Slater et al., 2015). Difficulties with finding social support and care are further exacerbated for many HIV positive LGBT older adults (Brennan-Ing et al., 2014; Shippy & Karpiak, 2005) and despite these additional challenges and fewer avenues for support, LGBT older adults living with HIV are often forgotten in discussions on LGBT and aging issues (Diverse Elders Coalition, 2014).

Health Behaviors

LGBT older adults also have a higher prevalence of engaging in risky health behavior, such as smoking and excessive alcohol consumption compared to heterosexual older adults (See Figure 2; Fredriksen-Goldsen et al., 2013a). Sexual minority women and men are more likely to smoke than their heterosexual counterparts (Fredriksen-Goldsen et al, 2013a). Some differences exist within the LGBT older population, as gay and bisexual men report higher levels of alcohol consumption than lesbian and bisexual women (Grossman, D'Augelli, & O'Connell, 2002). In another study, lesbian women reported higher rates of heavy drinking than bisexual women (Fredriksen-Goldsen et al., 2013c).

Figure 2: **Comparison of proportion of LGB and straight older adults' health behaviors, by gender and sexual orientation (Washington State BRFSS, 2003-2010)**



*Source: Fredriksen-Goldsen et al., 2013a

A high proportion of LGBT older adults also engaged in risky sexual behavior, with gay and transgender older adults reporting higher proportions of sexually risky behavior than bisexual men and sexual minority women (Fredriksen-Goldsen et al., 2011). On the other hand, LGBT older adults also reported higher rates of HIV testing, though between gay and bisexual men, bisexual men reported lower rates of being tested for HIV (See Figure 2; Fredriksen-Goldsen et

al., 2013c). Some studies looked specifically at sexually risky behavior among gay and bisexual men who reported HIV positive. A high proportion of HIV positive gay men and bisexual men reported engaging in sexually risky behavior (Golub et al., 2010; Emlet et al., 2015), and other health risks such as substance abuse were associated with sexually risky behavior (Brennan-Ing, Porter, Seidel, & Karpiak, 2014). Other studies found that internalized homophobia was associated with excessive drinking, drug use, and engagement in sexually risky behavior (Lelutiu-Weinberger et al., 2013; Emlet et al., 2015).

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Heterosexual framework impacts medical services for LGBT older adults

One common theme that emerged from the 2015 Denver convening was the challenge of finding trained, qualified, and culturally sensitive health providers. LGBT elders felt they were not represented within the healthcare system and that physicians still operated within a heterosexual framework. Many are not asked about their sexual orientation and assume patients are heterosexual. Some still operate under the idea that homosexuality is a mental illness: Pat Hussain, co-founder of GLAD in Atlanta, GA, recalled how a physician seeing a patient with PTSD asked "are you depressed because you are gay?" Pat advocates for training and materials to be updated in regards to LGBT older adult health issues. Troy Johnson of Senior Pride Initiative /Center of Halsted in Chicago brought to light how health services friendly to LGBT older adults are particularly scarce in the South and a major challenge for LGBT advocates is bridging the gap between the supply and demand of LGBT friendly service providers and LGBT older adults in need of care. Even among service providers who are interested in creating an LGBT friendly environment, mainstream service offerings are prioritized, according to Chris Kerr, Clinical Director of Montrose Center.

Health Services

Health services for LGBT older adults can be challenging as access and utilization of health services is complicated by fear of discrimination and poor treatment. In this section, we explore LGBT older adults and their attitudes about advanced-care or end-of-life care as well as the attitudes and experiences of providers who serve older adults.

Advanced-Care/ End-of-life Care

Fear and anxiety that LGBT older adults feel toward health care is further exacerbated in situations in which long-term care or advanced-care is needed (Brotman, et al., 2003; Stein, Beckerman & Sherman, 2010). Thus, older lesbians and gay men tend to delay entering residential care (Claes & Moore, 2000) and the majority believe health care providers would discriminate against them based on their sexual orientation (Johnson et al., 2005). Almost 75% of respondents in one study believed that residential

care facilities did not include anti-discrimination policies and 34% believed they would need to conceal their sexual orientation to live in the facility (Johnson et al, 2005). Other studies have recorded incidents of conflict and abuse of LGBT older adults in residential care due to displays of same-sex affection or of others' perception of residents' sexual minority status (Brotman et al., 2003; Bradford & Ryan, 1987). In fact, data from two qualitative studies of LGB older adults revealed a common concern of receiving long-term care was the fear of having to go back into the closet (Stein et al., 2010; Brotman et al, 2003). LGB older adults were also afraid of being neglected by their health care providers and of being ostracized by other residents due to their sexual orientation (Stein et al., 2010; Brotman et al., 2003).

To cope with this fear, many older LGB adults receiving long-term care reported that they conceal their sexual orientation for fear of mistreatment (Brotman et al, 2003). Possibly due to these stressors, one survey found that a higher proportion of LGBT adults reported wanting hospice care at home compared to heterosexual older adults (Metlife, 2010). Perhaps related to fear about old age care, in another study of lesbian and gay adults in New York City, a higher proportion of LG adults supported physician assisted suicide and palliative end of life care than did the heterosexual respondents, with most LG older adults over 60 preferring pain relief over life extension (Stein & Bonuck, 2001). Attitudes toward treatment at end-of-life, however, seemed more positive. Survey data results from two reports found that over 50% of the LGBT sample of older adults believed health professionals would treat them with respect at end-of-life (Metlife, 2010; Croghan, Moone, & Olson, 2012).

Provider Perspectives

Invisibility of LGBT elders was a theme voiced not only by LGB older adults receiving care but also by the providers and administrators providing senior health care (Brotman et al., 2003; Knochel, Croghan, Moone, & Quam, 2010). In a focus group study that included health administrators, Brotman and colleagues (2003) found that LGBT issues were avoided or ignored in agenda setting meetings. On the other hand, survey data assessing providers' readiness, attitudes, and experiences working with LGBT older adults in Michigan and the Midwest area showed that most providers were aware that LGBT older adults faced additional challenges from the general aging clientele and responded positively to providing or receiving training to work with LGBT older adults (Hughes, Harold & Boyer, 2011; Knochel, Croghan, Moone, & Quam, 2010). Providers believed their current services were appropriate for and environment welcoming toward LGBT older adults. However, almost half of the provider respondents in one survey reported that establishing separate services for LGB and T adults was not a good idea (Knochel, Croghan, Moone, & Quam, 2010). Additionally, few agencies reported that programs or efforts, such as outreach programs, existed to help LGBT older adults and few collected sexual orientation and gender identity demographics of their clientele. Agencies in urban areas or in the West had more requests for LGBT related services and more programs than did agencies in rural areas or the South (Knochel, et al., 2010).

The attitude and role of healthcare providers and organizations are integral to how services are sought and received. In a paper directed to health care providers and agencies, Fredriksen-Goldsen and colleagues (2014a) provided 10 core competencies to better serve the LGBT older adult population. Cultural competency was a major theme at both the provider and organization level with many of the recommendations focused on understanding the social history of LGBT individuals and conducting serious assessments of provider and organizational prejudices.

10 Core Competencies and Strategies to Providing Health and Human Services to LGBT Older Adults (Fredriksen-Goldsen et al., 2014)

1. Critically analyze personal and professional attitudes toward sexual orientation, gender identity and age, and understand how factors such as culture, religion, media, and health and human service systems influence attitudes and ethical decision-making
2. Understand and articulate the ways that larger social and cultural contexts may have negatively impacted LGBT older adults as a historically disadvantaged population
3. Distinguish similarities and differences within the subgroups of LGBT older adults, as well as their intersecting identities (such as age, gender, race, and health status) to develop tailored and responsive health strategies
4. Apply theories of aging and social and health perspectives and the most up-to-date knowledge available to engage in culturally competent practice with LGBT older adults
5. When conducting a comprehensive biopsychosocial assessment, attend to the ways that the larger social context and structural and environmental risks and resources may impact LGBT older adults
6. When using empathy and sensitive interviewing skills during assessment and intervention, ensure the use of language is appropriate for working with LGBT older adults to establish and build rapport
7. Understand and articular the ways in which agency, program, and service policies do or do not marginalize and discriminate against LGBT older adults
8. Understand and articulate the ways that local, state, and federal laws negatively and positively impact LGBT older adults, to advocate on their behalf
9. Provide sensitive and appropriate outreach to LGBT older adults, their families, caregivers and other supports to identify and address service gaps, fragmentation, and barriers that impact LGBT older adults
10. Enhance the capacity of LGBT older adults and their families, caregivers, and other supports to navigate aging, social, and health services

Future Research & Policy Needs

The growing population of LGBT older people is unique having experienced the spectrum of oppressive institutional stigma and discrimination in younger years, and unprecedented social change to understanding and acceptance of LGBT individuals in older adulthood. Still LGBT older adults are largely ignored in gerontology and sexual and gender minority research and by the agencies and stakeholder that serve these groups. Given the findings reported above, below are recommendations for future research and policy initiatives to deepen and broaden our understanding of LGBT older adults and address common barriers they face.

Research Needs

One of the biggest challenges to studying LGBT older adults is getting valid data. Most studies of LGBT older adults have used small sample sizes and community-based, non-probability sampling methods. While these studies have provided invaluable information, researchers, policy makers, and other stakeholders, findings from such studies are not generalizable to the overall LGBT older adult population (Addis et al. 2009). Policy makers who seek information from representative samples of LGBT older adults may find it difficult to characterize the population for several reasons. A prominent challenge is that sexual orientation and gender identity measures are not included in many U.S. probability-sampling based studies (Fredriksen-Goldsen et al., 2015). A second major challenge is that LGBT older adults are a small and, therefore, difficult population to reach. To achieve large enough number respondents, researchers who want to recruit probability samples would need to over-sample the LGBT older adult population (and, within this population, race/ethnic minorities). Such methods

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Recognizing diversity among LGBT older adults

Data collection, research, and developing data systems were important themes at the 2015 Denver convening. Researchers such as Drs. Karen Fredriksen-Goldsen, Naomi Goldberg, Ilan H. Meyer, and Samuel Haffer emphasized the lack of knowledge of disadvantaged communities within the LGBT older adult populations such as individuals living in poverty, people of color, individuals with disabilities, and other underserved groups. Ilan H. Meyer noted the need for NIH funding of population probability samples with large samples of LGBT individuals. Samuel Haffer, Director of Data and Policy Analytics Group at the U.S. Centers of Medicare & Medicaid Services (CMS) underlined how critical data collection is as the mindset among government agencies working with minority health populations is that if something cannot be measured, it cannot be improved. To improve data collection on LGBT individuals, CMS has established five major initiatives to integrate LGBT issues into the agency's data collection efforts. The initiatives aim to collect and analyze data in a standardized way at social and health service organizations that may serve LGBT older adults.

are costly and require larger funding sources than comparable studies of heterosexual cisgender populations. Despite these challenges, representative data are required for the study of health disparities because they allow comparison between LGBT and cisgender heterosexual older adults. Some recent policy changes are promising that LGBT older populations will be included in more federal and state surveys. Under the Obama administration, the Administration of Aging (now part of the Administration for Community Living) in the U.S. Department of Health and Human Services (HHS) stated in 2012 that the aging network has the discretion to consider LGBT older adults as a population of greatest social need (Tax, 2012). This could lead to increase attention and needed resources to the population of older LGBT adults.

Fredriksen-Goldsen & Kim (2015) found large surveys that include sexual orientation measurements often have a cut off age between age 50 and 60 for their samples because researchers incorrectly believe LGB older adults do not want to be studied and would not respond to surveys. Challenging this belief, Fredriksen-Goldsen & Kim (2015) reported that large numbers of LGB older adults were responding to questions and self-identifying with a minority sexual orientation and gender identity. (Although, the response rate was lower compared to that of younger LGB adults). Such limitations in data collection on LGB older adults may help explain why only two studies in this report used probability sampling data (both studies used state-level data) to characterize LGB older adults (Fredriksen-Goldsen et al 2013a; Wallace et al., 2011). To our knowledge, no probability sample data on transgender older adults exists. Despite this gap in knowledge, however, numerous studies using community-based sampling methods, reports, and reviews have provided important insight and knowledge about the lives of LGBT older adults and their shared challenges and resiliency.

Related to data collection and sample size, is the need to study subgroups within the population of LGBT older adults. Intersectionality perspective teaches us that there are important differences among intersectional subgroups, for example defined by gender and race/ethnicity, but knowledge about intersectional groups (e.g., older Black lesbians; Latina transwomen) is lacking. This can lead to misconceptions about a significant part of the LGBT elder population as policy makers assume that the knowledge gained from general, that is, mostly White LGBT populations, is representative of all subgroups of LGBT elders.

Bisexual and transgender older adults were particularly absent in many of the studies above. Even when studies and reports included bisexual older adults, their results were often folded in with results for gay and lesbian individuals. As bisexuals age, their sexuality may change to lesbian, gay, or straight, erasing their experience of aging (Dworkin, 2006) and leaving “no room for bisexuality within the older generation” (Kingston, 2002, p.4). Furthermore, bisexual older adults may experience different stressors compared to other sexual minorities as they are often stigmatized from both the heterosexual and homosexual communities (Dworkin, 2006).

Similarly, few studies include transgender older adults, and those that do use small sample sizes and conduct analysis on measures relevant to all LGBT older adults. There a serious lack of studies on the physical, psychological, and emotional process and effect of transitioning, an integral concept within the transgender community (Cook-Daniels, 2006). Similar to bisexual older adults, transgender older adults also face stigma from homosexual, heterosexual and gender-conforming communities (Cook-Daniels, 2006).

Another example of important subgroup analysis of LGBT older adults is age group-specific analysis (Czaja, 2015). In a recent study, Fredriksen-Goldsen and colleagues (2014) studied successful aging in the context of physical and mental health quality of life among LGBT older adults. Analysis was conducted by young-old (50-64), middle-old (65-79), and old-old (80 and older) groups. Results indicate that different factors influence quality of life by age group, with the most salient difference being that the effects of victimization and discrimination were most influential among the old-old group. Furthermore, factors that showed protective effects for the general LGBT older population, such as living with a partner, had a positive effect on the young-old and middle-old groups, but a negative effect on the old-old group (Fredriksen-Goldsen et al., 2014). Better understanding of different age groups could help policy makers and service agencies create more targeted interventions.

Life-course and intersectionality approaches to research would provide a more complete picture of the lived experiences of LGBT older adults (IOM, 2011). Though many life-course perspective studies have shown how historical and social context can affect LGBT older adults' health and general wellbeing (D'Augelli & Grossman, 2001; Fredriksen-Goldsen & Muraco, 2010), many gaps in knowledge remain. For example, little is known about chronic physical health, health outcomes measured through biomarkers, and cognitive health among LGBT older adults (Czaja, 2015). Longitudinal studies could help fill this knowledge gap as researchers can identify patterns over time and connections between determinants and outcomes can be better examined. Studies that take an intersectionality approach are even less available among LGBT older adults. The lived experiences of LGBT older adults who live in rural areas, are of different race/ethnicities, and are in lower socio-economic standing are particularly missing from the literature.

Finally, many areas studied in gerontology go unexamined among the LGBT older population. For example, little or no empirical research exists on family dynamics (older LGBT adults with children or grandchildren), caregiving patterns, workplace issues, bereavement and grief, cognitive health decline, mobility issues, chronic health issues, and program evaluations of health interventions among the LGBT older adult population.

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Lessons Learned from Serving LGBT Older Adults

- *Establishing public and private partnerships is key to providing comprehensive services to LGBT older adults. The Alzheimer's Association and American Association of Retired Persons (AARP) have been strong partners to the LGBT Center.*

  -Katheleen Sullivan, Director of Senior Services Department, L.A. LGBT Center, L.A., CA
- *Leadership on LGBT issues need to start from top down. Every organization faces limited capacity and resources, which is why LGBT policies need to be put in place systemically to ensure equality. We need to stay the course, collect data and report information to advocates.*

  - Corinda Crossdale, New York State Office for the Aging, New York, NY
- *Cultural competency and training seems to be an effective method to help service organization employees and providers overcome personal biases and stereotypes they may hold against LGBT individuals.*

  - James Bulot, Director, Georgia Department of Human Services, Division of Aging Services, Atlanta, GA
- *Aside from collecting and analyzing data, state funded organizations should be encouraged or mandated to look at results and take them into consideration when developing programs.*

  -Linda Levin, Executive Director, ElderSource, Jacksonville, FL
- *Raising awareness of LGBT older adults' unique issues is important. Many agencies do not believe LGBT older adults have unique barriers, story-telling, research, and information is critical to changing this dialogue.*

  -Deborah Stone-Walls, Maui County Office for the Aging, Maui, HI

Policy Needs

While research is important to increase our knowledge and educate policy makers and other entities involved with LGBT older adults, policy and program initiatives can provide more immediate and direct support and change (MAP & SAGE, 2010).

One major policy need is raising awareness and increasing advocacy about LGBT older adult needs and issues among LGBT and older adult service agencies and communities. LGBT older adults are part of both communities, yet many remain unaware of their needs (MAP & SAGE, 2010). Education and advocacy can instigate individuals and groups to develop targeted social service programs for LGBT older adults, funding for research, programs, and data collection, and formalize advocacy groups to represent LGBT older adults at different levels of government

(MAP & SAGE, 2010). Bringing visibility to these issues can also signal to LGBT older adults that organizations are welcoming and aware of their needs (Brotman et al. 2003).

At the federal level, an important overarching policy need is designating LGBT older adults as a population of "greatest social need" in the Older Americans Act (OAA) reauthorization. OAA is the biggest funding and service mechanism for older people in the U.S, yet few resources are designated specifically to LGBT older adults (Diverse Elders Coalition, 2014). Legal and administrative designation of LGBT older adults as a population of greatest social need would open important avenues for funding to prioritize LGBT older adults, and other subgroups that may experience additional forms of discrimination such as LGBT older adults of color and LGBT older adults living with HIV.

Other national policy recommendations include establishing legislation on anti-discrimination laws based on sexual orientation or gender identity and housing policy legislation to better protect LGBT older adults, particularly in healthcare, and access to retirement homes and senior centers. To help LGBT older adults adequately prepare for older life, expanding the definition of "family" to include families of choice and alternative family structures would be critical. Family structures are changing and broadening beyond the two-parent nuclear family structure and there are policy efforts to recognize these changes to include LGBT families and other family structures. Pertaining to paid sick leave for federal contractors the Department of Labor proposes that "[i]ndividual related by blood or affinity whose close association with the employee is the equivalent of a family relationship" means that any individual with a significant relationship with the employee is equivalent to family, regardless of biological or legal relationship (Executive Order No.13706, September 7, 2015). This broader definition of family would provide much needed time and support to LGBT older adults who provide care and receive care from families of choice. Finally, changing and implementing HIV testing guidelines to include adults over 65 and ensuring providers work with LGBT organizations to reach LGBT older adults who may have elevated levels of risk and are currently forgotten within the discussion of sexual health would be an important policy need (Diverse Elders Coalition, 2014).

At the service level, a major policy and program need is training of health professionals, agencies, and legal service providers to be culturally sensitive and knowledgeable of discriminatory practices or customs that overtly and inadvertently hurt LGBT older adults (MAP & SAGE, 2010; Fredriksen-Goldsen et al., 2014a). Given that fear of discrimination and actual discriminatory experiences have and continue to affect how LGBT older adults access and receive services, culturally sensitivity training may not be sufficient. Organizations and agencies should also consider instilling "anti-oppressive" practices—anti-oppressive practice recognizes structural inequalities and attempts to equalize power dynamics at an organization level (Preston-Shoot, 1995).

Another policy that service organizations can implement to help LGBT older adults is data collection of sexual orientation and gender identity measures of adults who utilize organization services. The feasibility of service organizations or service providers collecting sexual orientation and gender identity measures is highly debated, particularly in the healthcare setting (IOM, 2013; Cahill et al., 2016). Questions arise around provider competency and comfort in asking sexual orientation and gender identity questions, client's willingness to disclose such information, and even more damaging, whether simply asking about sexual orientation and gender identity would cause clients to delay or avoid healthcare (IOM, 2013). While examples of these situations exist, there are also many examples of healthcare service providers successfully collecting and storing sexual orientation and gender identity questions in electronic health record systems and of appreciation from LGBT individuals for being asked about their sexual and gender identity (IOM, 2013). Provider training, technical assistance from software vendors, and LGBT client training and education on why and how to best collect, store, and use LGBT data needs to happen for successful data collection by service organizations (Cahill et al., 2016; IOM, 2013). Though several measures to ensure confidentiality and remedy of disclosure would need to be in place to protect LGBT older adult identities, collecting service data can inform program managers and organizations of the prevalence and characteristics of LGBT older adults and their needs as well as identify any healthcare disparities based on sexual orientation or gender identity.

Finally, LGBT older adults need additional support systems. Many LGBT older adults may not have the time to wait for traditional service organizations to provide support (MAP & SAGE, 2010). Rather, policy makers need to think of alternative solutions to support this population. Programs such as "Share the Care", volunteer based networks composed of older adults' family, friends, neighbors or other informal networks who provide support during times of crisis, have proven helpful to many LGBT older adults (MAP & SAGE, 2010). Share the Care has been mobilized in small, non-urban areas that have a sizable number of LGBT people. Such support systems have provided intergenerational support to older adults (MAP & SAGE, 2010) and would allow the burden of caregiving to be shared among a larger community.

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APPENDIX TWO: STATE PLAN CHART

State	No	Yes	Verison	Comments	LGBT	GLBT	Lesbian	Gay	Bisexual	Transgender	Gender Identity	Sexual Orientation
Massachusetts			Current	Throughout	17	0	3	3	3	3	0	0
Michigan			Current	"This decision made Michigan one of the first states in the country to conduct a statewide needs assessment specifically for LGBT residents age 60 and older."; Issue Area V-B	16	0	5	5	5	5	0	0
Rhode Island			Current	RIDEA has begun outreach to older GLBT populations. In 2013 and 2014, RIDEA and SAGE coordianated helath fiars at the State House in Providence and in 2015 established an GLBT congregate meal "café" on a monthly basis in Providence and is expanding to a second location in Cranston.	10	0	0	0	0	0	0	0
Connecticut			Current	Inclusive goals & objectives; lists LGBT resource page; UNDER GOAL 1: SDA co-sponsored summits on aging in the lesbian, gay, bi-sexual and transgender (LGBT) Community, and Acquired Immune Deficiency Syndrome (AIDS) Awareness. A new LGBT resource page was developed and added to the SDA website. Objective 2.7: Ensure that programs and services are welcoming and effective for all consumers, including sensitivity to issues of race, disability, economic status, language, religion, sexual orientation, and gender identity. Strategies: Via SDA website, offer a visible message of inclusion, acceptance, and support to lesbian, gay, bisexual, and transgender individuals. Provide training to LTCOP staff and volunteers to strengthen competencies related to lesbian, gay, bisexual, transgender and questioning individualsthroughout the lifespan or aging-related issues.	6	0	3	3	3	3	3	2
Florida			Current	Paragraph under LTC Services; Objective 1.5 - Strategies: • Encourage individuals who identify with the LGBT community to plan for their elder years through education about long-term care options • Educate in-home and institutional care service providers about the special needs of individuals who identify with the LGBT community	6	1	1	1	1	1		
California			Current	One paragraph under "Race, Ethnicity and Cultural Factors" describing recent research on LGBT aging. Next section is "Gender and Marital Status" that lacks any integration of trans* issues. Still operating on heteronormative assumptions about gender and martial status. No intersectional lens.	5	0	1	1	1	1	0	0
Kentucky			Old	Listed on website. One paragprah abouth LTCO Elder Abuse and Training	3	0	1	1	1	1	0	0

West Virginia			Current	"WVSLA targets homebound, disabled, rural, minority, **LGBT**, and low-income seniors statewide." "WVSLA provided legal information to more than 660 workshop participants this year on topics including mental capacity and legal decision-making, special legal issues of **LGBT** seniors, dealing with debt, preserving autonomy through proactive legal planning, myths and realities of paying for long-term care, grandparent rights in West Virginia, and avoiding financial exploitation." "Additionally, workshops on financial exploitation and special legal issues of Lesbian, Gay, Bisexual and Transgender (LGBT) seniors have also been given."	3	0	1	1	1	1	0	0
Arkansas			Current	Aging Network Survey: Training Topics Needs LGBT issues (9 or 5.3%); Challenges in the Next 4 Years LGBT Client (7 or 3.9%)	2	0	0	0	0	0	0	0
Oregon			Current	Listed as an acronym. Objective 3: Increase use of nutrition and healthy aging programs by underserved populations and those at higher need/risk. Strategy: Identify and share person-centered models that have effectively reached targeted populations (e.g., rural, minority, LGBT, lowincome populations, people with disabilities).	2	0	1	1	1	1	0	0
Washington			Current	One paragraph under demographic trends reporting expected growth in population and access barrier of preceived fear of discrimination.	2	0	1	1	1	1		
Arizona			Current	Goal 2: Increase awareness and understanding of aging issues and help prepare Arizona for an aging population. Objective 2.1: Provide culturally appropriate information in a variety of formats to older adults and their families to promote a broad understanding of issues that arise as we age and how to address them. Question from the public: Would it be considered elder abuse if someone that falls under the LGBT category is being discriminated against? Answer by DAAS staff: In order for an act to be considered elder abuse it must be a knowing, intentional, or negligent act by a person that causes harm or a serious risk of harm to a vulnerable adult.	1	0	2	3	1	1	0	0
Mississippi			Current	Objective 1.3: Increase volunteer involvement by 5%. Make SPECIAL EFFORTS TO ENGAGE limited English speaking, and “hard to reach” populations (Native American, under 65, and LGBT) to present various opportunities of involvement and diversify the volunteer and outreach base	1	0	0	0	0	0	0	0

Nebraska			Current	National Family Caregiver Support Program: Strategy - "Develop outreach approaches for underserved populations, such as Lesbian, Gay, Bisexual, and Transgender families to be disseminated by FY19." Measurement - "Provide trainings to at least 75% of the AAA staff responsible for III-E programming focused on outreach to the LGBT population."	1	0	1	1	1	1	0	0
New Jersey			Current	APS Program Staff received training in working with individusals with the LGBT senior population.	1	0	0	0	0	0	0	0
New York			Current	**Objective 1.19 -** Increase cultural competency and understanding of Sexual Orientation and Gender Identity of older adults. **Strategies 1.19:** Continue training related to the recently developed questions pertaining to Sexual Orientation and Gender Identity that are a part of the Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS). **Expected Outcome 1.19:** Case Managers will be culturally and linguistically competent, and have skill and understanding of Sexual Orientation and Gender Identity of older adults. Provide ongoing training and technical assistance focused on expanding outreach and providing I & A services to underserved populations including minorities, low income individuals, frail individuals, and vulnerable individuals (this category includes rural residents, individuals with limited English proficiency, LGBT, persons at risk of institutionalization, caregivers of individuals with developmental disabilities, individuals with Alzheimer's disease and other forms of Dementia) to ensure that these clients are served to the maximum extent feasible. **Access Services -** Case management Objective 1.19 "Increase cultural competency and understanding of Sexual Orientation and Gender Identity of older adults."	1	0	0	0	0	0	3	6
North Carolina			Current	Expand training and educational opportunities to the aging network on the unique need of the aging lesbian, gay, bisexual, and transgender (LGBT) community. Measure: Conduct at least one provider training annually.	1		1	1	1	1	0	0

Tennessee			Current	Not in Non-discrimination Policy; "The growing “baby boomer” population appears to have different wants and needs than the current aging population being served. Overall, what are the four (4) most pressing challenges facing the State of Tennessee in providing services to this “baby boomer” population?" Under Healthcare: "HIV, AIDS, and LGBT issues in long term care"	1	0	0	0	0	0	0	0
Virginia			Current	**Objective 2.5:** Encourage individuals, inlcusing people under 60, to plan for future long-term care needs, incapacity, and end-of-life aoptions. **Stratgies:** Edcuate inidiviudals who identify with the LGBT community and their providers and the broader community about planning for long-term care needs.	1	0	0	0	0	0	0	0
Maine			Current	Included in paragrpahs about cultural factors and training of DCW. Listed in: Goal 3, Objective 1, Strategy 1.3 "Expand outreach and advocacy to Maine‘s Native American populations, Maine citizens living on coastal islands, Racial Ethnic Language (REL) communities, GLBT and those living in rurally isolated areas."	0	7	1	1	1	1	0	0
Minnesota			Current	One paragraph about Cultural Competenecy and Capacity to Serve	0	1	1	1	1	1	0	0
Washington, DC			Old	Objective B: Identify and link underserved, special needs populations to the appropriate home and community-based services by: B-3 Providing cultural competency training for service providers within the SSN on gay, lesbian, bisexual and transgender (GLBT) issues. B -17 Working with the DC Center to identify collaborations that would increase older GLBT access and inclusion to services; Issue: Make GLTB (Gay, Lesbian, Bisexual and Transgender) feel more comfortable when accessing programs and services? Recommendations: Service Providers to be more culturally competent and service friendly towards GLTB; In recent years, DCOA has noted trends in our evolving customer base that have influenced our choices regarding existing and proposed programs. For example, our staff throughout the District has reported stronger service- use by those who use English as a second language, gays and lesbians, veterans, the blind and hearing impaired and persons who are developmentally and mentally challenged.	0	4	3	3	2	2		
Alabama			Current		0	0	0	0	0	0	0	0
Alaska			Current		0	0	0	0	0	0	0	0

Colorado			Current		0	0	0	0	0	0	0	0
Delaware			Current		0	0	0	0	0	0	0	0
Georgia			Current		0	0	0	0	0	0	0	0
Hawaii			Current		0	0	0	0	0	0	0	0
Idaho			Current		0	0	0	0	0	0	0	0
Illinois			Old	No Approved Budget	0	0	0	0	0	0	0	0
Indiana			Current		0	0	0	0	0	0	0	0
Iowa			Old	Listed on website	0	0	0	0	0	0	0	0
Kansas			Current		0	0	0	0	0	0	0	0
Louisiana			Current		0	0	0	0	0	0	0	0
Maryland			Current		0	0	0	0	0	0	0	0
Missouri			Current		0	0	0	0	0	0	0	0
Montana			Current		0	0	0	0	0	0	0	0
Nevada			Current		0	0	0	0	0	0	0	0
New Hampshire			Current		0	0	0	0	0	0	0	0
New Mexico			Current		0	0	0	0	0	0	0	0
North Dakota			Current		0	0	0	0	0	0	0	0
Ohio			Current		0	0	0	0	0	0	0	0
Oklahoma			Current		0	0	0	0	0	0	0	0
Pennsylvania			Current		0	0	0	0	0	0	0	0
South Carolina			Current		0	0	0	0	0	0	0	0
South Dakota			Old	Link Broken on Website	0	0	0	0	0	0	0	0
Texas			Current		0	0	0	0	0	0	0	0
Utah			Current		0	0	0	0	0	0	0	0
Vermont			Current		0	0	0	0	0	0	0	0
Wisconsin			Old	Despite having a LGBT resource directory for youth and aging. (https://www.dhs.wisconsin.gov/lgbthealth/seniors.htm)	0	0	0	0	0	0	0	0
Wyoming			Current		0	0	0	0	0	0	0	0