Health Disparities Experienced by LGBTQ+ Older Adults

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Executive Summary

LGBTQ+ older adults experience health disparities at higher rates than their heteronormative peers. This memo explores interventions aimed at improving health outcomes for LGBTQ+ older adults in long-term care facilities. Specific options include maintaining the status quo, mandating cultural competency trainings for both staff and peers within long-term care facilities, and expanding upon the definition of sex discrimination within Section 1557 of the Affordable Care Act.

Utilization of analytical tools, specifically a causal loop diagram, problem definition framework, market failure frameworks, a logic model equipped with assumptions and risks, as well as an outcomes matrix, assist the reader in both understanding specific vulnerabilities that contribute to poor health outcomes for this population, as well as the rationale behind the suggested policy options.

It is predicted that cultural competency training is the most effective policy to reduce the rate of Sexual Orientation and Gender Identity (SOGI) based discrimination from both staff and peers, increase SOGI reporting from queer older adults themselves, and ultimately improve health outcomes. Although expanding the legal definition of sex discrimination provides enhanced legal protections that would both reduce discrimination rates and increase SOGI reporting, this option does not equip staff with the education needed to develop tailored health services for queer older adults.

Introduction: Problem Definition and Market Failures

Despite the significant number of LGBTQ+ older adults, as well as future estimates for increased growth, this population remains invisible to much of society (Fredriksen-Goldsen & Kim, 2017, p. 3). Existing research indicates that older adults who identify as LGBTQ+ have poorer health outcomes than their heteronormative peers. Specifically, LGBTQ+ older adults experience "increased prevalence of smoking, poorer mental health and increased functional limitations" (Emlet & Fredriksen-Goldsen, 2017, p. 1). Health disparities result in poorer quality of life and shortened life expectancies for this population.

LGBTQ+ older adults live in communities across the United States; researchers estimate that 2.4% of older Americans identify as lesbian, gay, bisexual, or transgender (LGBT). This percentage encompasses 2.7 million people over the age of 50, with 1.1 million over the age of 65 (Molinari & McSweeney-Feld, 2017, p. 481). U.S. Census data denotes an increase in LGBT older adults: "by 2060, the number of older adults who self-identify as LGBT will reach 20 million" (p. 473).

'LGBTQ+ older adult' is an umbrella categorization; failing to divide this heading into smaller subcategories prevents the reader from understanding behavioral factors that contribute to poor health. It is important to understand that various identities within the LGBTQ+ umbrella are more vulnerable than others, with trans, bisexual (Emlet & Fredriksen-Goldsen, 2017, p. 1), and older adults of color (SAGE; Movement Advancement Project;, 2017, p. 3) experiencing the greatest health disparities. The historical events experienced by older adults, dictated in large part by government action and corresponding societal stigma, contribute to an LGBTQ+ older adult's level of trust pertaining to healthcare providers, peers, and society at large (Fredriksen-Goldsen & Kim, 2017, p. 3).

Discrimination in long-term care settings has profound implications on the health of LGBTQ+ older adults. Amongst existing research, survey data indicates that 20% of LGBT older adults have been denied medical care (LGBT Older Adults, 2010, p. 9) due to SOGI. Research suggests that fear of discrimination within a healthcare setting is linked to "poorer general health and an increase in disability and depression"

(Emlet & Fredriksen-Goldsen, 2017, p. 1). The healthcare industry's inability to address the needs of LGBTQ+ older adults exemplifies the market failure of barriers to entry; this failure prohibits a significant market from accessing healthcare services needed to prevent both the onset and severity of illness.

Research conveys that 23% of LGBTQ+ older adults have experienced physical or verbal abuse from their peers, while an additional 14% reported experiencing abuse from staff (LGBT Older Adults, 2010, p. 9). Due to fear of discrimination, LGBTQ+ older adults are less likely to disclose their sexual orientation to both peers and healthcare providers. Underreporting of identity results in the market failure of information asymmetry; as a result of this failure, LGBTQ+ older adults are less likely to receive the services and support they need for their specific identities. Additionally, because they have not disclosed their status, the LGBTQ+ older adult population remains difficult to quantify. The government's failure to target this population, due to the population's invisibility, makes advocating for research funding and systemic change increasingly challenging.

LGBTQ+ older adults experience heightened levels of financial insecurity. Prior to the repeal of the Defense of Marriage Act (DOMA) in 2015, LGBTQ+ older adults were unable to access benefits such as a partner's Social Security or pension. If a partner passed away prior to 2015, the surviving spouse still may not be able to access their partner's benefits. Many LGBTQ+ older adults, due to discriminatory workplace practices, suffer from lower than average earnings (SAGE; Movement Advancement Project;, 2017, pp. 10-12). Approximately 26% of older adults ages 65 and older live at or below 200% of the federal poverty line (Emlet C. A, 2016, p. 3).

LGBTQ+ older adults have less social and familial support than their peers; "population studies indicate that LGBTQ+ older adults have more limited family ties; lesbian, gay, and bisexual elders are less likely to be married than heterosexual adults, less likely to have a child, and more likely to live alone" (Molinari & McSweeney-Feld, 2017, p. 481). Due to limited social support, this population experiences high levels of social isolation, which research suggests is a direct link to increased levels of cognitive decline and depression. As a consequence of morbidities associated with social isolation, combined with limited income, LGBTQ+ older adults experience increased risk of nursing home placement (Molinari & McSweeney-Feld, 2017, p. 481).

LGBTQ+ older adults encompass one of the most vulnerable population groups within American society. Lack of equal opportunity, caused by discrimination, has resulted in the distributive justice failure of inequity of outcome for LGBT older adults. Research shows that LGBTQ+ older adults experience higher rates of mental illness and morbidities than their peers. This inequity is caused by the negative health implications of poverty, inadequate accessibility measures on behalf of service providers, and fear-based behavioral modifications from LGBTQ+ older adults themselves.

Policy Options

The outcomes matrix is an evaluative tool utilized by policy analysts to directly compare potential policy options; criteria within the matrix, composed of both conceptual and operational measures, provide targets for option comparison. The first policy option, maintenance of the status quo, acts as a control to better understand the impact of proposed policy interventions. The status quo would introduce no additional interventions to reduce health disparities amongst LGBTQ+ older adults. For the purposes of this memo, due to the severity of the health disparities discussed, the status quo was not considered as a realistic policy option.

The second policy option would expand upon existing legal protections defined within Section 1557 of the Affordable Care Act. Federal law does not explicitly prohibit discrimination based upon gender identity and sexual orientation (Prohibited Employment Policies/Practices, n.d). However, specific to healthcare, Section 1557 of the Affordable Care Act (ACA) establishes "that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination" due to sex by any federally funded or monitored health program (Office for Civil Rights, 2018). The existing law

prohibits discrimination based upon gender identity, an individual's sex, and sex stereotyping. The law indicates that discrimination based upon sexual orientation is a potential form of sexual stereotyping; cases are evaluated on an individual basis to determine whether they meet the criteria for sex stereotyping, which the law prohibits (Office for Civil Rights, 2018). In order to ensure adequate protections, the law must be amended to explicitly include sexual orientation as a form of sex discrimination.

The third policy option will mandate that both direct care workers and residents within long-term care facilities participate in audience specific, cultural competency training about SOGI and the unique needs of LGBTQ+ older adults. Although Section 1557 of the ACA prohibits discrimination based upon gender identity, reporting from LGBTQ+ older adults indicate that discrimination continues to occur within long-term care settings (LGBT Older Adults, 2010, p. 9). To ensure adequate protections, this policy option expands upon existing training requirements for direct care workers within Centers for Medicare and Medicaid (CMS) contracted facilities; previous requirements did not explicitly include materials on the unique needs of LGBTQ+ older adults (CMS, 2016, p. 502).

SAGECare is the training and consulting division of Services and Advocacy for GLBT Elders (SAGE), the country's largest and oldest advocacy organization on behalf of LGBTQ+ older adults. SAGECare has championed the use of cultural competency trainings to improve quality of life for queer older adults (SAGECare, 2019). SAGECare trainings focus on improving interactions with queer older adults, and subject specific topics such as the health needs of queer older adults, prevention of bullying between older adults, information about minority populations within the LGBTQ+ umbrella, and overall bias prevention. It is important to note that the existing SAGECare trainings directly address areas previously outlined within the problem definition. Due to the organization's comprehension of the challenges faced by queer older adults, is suggested that cultural competency trainings follow best practices established by SAGECare.

Policy Evaluation

The logic model, an additional tool used by analysts, depicts the best-case scenario of an intervention. In combination with the option's associated assumptions and risks, the logic model assists analysts in understanding potential policy pitfalls. The accompanying logic model shown in Appendix B outlines the use of cultural competency training as a method to improve health outcomes amongst LGBTQ+ older adults.

The logic model asserts that recipients of cultural competency training will learn the material, and as a result of their learning, will provide inclusive health services to LGBTQ+ older adults. The model also determines that trainings will reduce SOGI based discrimination, as ideally, previous prejudice will be addressed, internally grappled with, and dispelled.

The model assumes that as a result of cultural competency training, that trainees will pay attention, retain, and modify their behaviors. It is assumed that recipients possess the evaluative skills needed to identify their own prejudices, and then have the motivation to integrate the material into their daily lives. If risks surrounding the training are actualized, recipients will fail to learn, and/or act upon learned material, resulting in a lack of behavioral change. As a result, rates of discrimination will not decrease, and healthcare services will not become more inclusive. Because a behavioral change must occur for discrimination rates to be reduced, this critical and evaluative measure has been included as an effectiveness criteria within the shell of the corresponding outcomes matrix.

If behavioral modifications do occur, the logic model assumes that these will benefit queer older adults. It is possible, however, that the training could produce a negative backlash; instead of benefiting older adults, training recipients could deepen their prejudice towards the target population, and levels of

discrimination could increase. Therefore, the potential for increased discrimination is considered a side effect and is captured within the evaluative shell of the outcomes matrix.

The logic models states that if healthcare services become more inclusive, due to a positive behavioral change, then LGBTQ+ older adults will not be denied services due to SOGI. The model also asserts that if LGBTQ+ older adults get the specific services required by their identities (a feat made possible by a positive behavioral change amongst trainees), then morbidity rates amongst the target population will decrease. Yet another evaluative tool of a policy's impact, the measure of decreased morbidity rates is included as an effectiveness criteria within the outcomes matrix shell.
Decreasing morbidity rates hinges on the assumption that long-term care staff are the sole determinants of care provisions for residents. Insurance companies are one of the key determinants of care, as they have the ultimate ability to decide which services will be covered. This is especially true for low income populations. Because the insurance provider is outside the scope of the training recipient population, it is possible that services will be denied even if the healthcare facility is making an earnest effort to provide inclusive care.

If discrimination rates decrease, the logic model states that LGBTQ+ older adults will be more likely to disclose their sexual orientation and gender identity to healthcare providers. The model assumes that discrimination is the sole factor of lower disclosure rates amongst queer older adults. This assumption negates the fact that other factors, such as lived experience, could have a greater impact on one's decision not to disclose their sexual orientation and gender identity. The risk associated with this assumption is continued underreporting of SOGI.

Theoretically, if risks surrounding reporting are not actualized, increased availability of SOGI data will equip researchers and advocates with the quantitative material needed to enhance advocacy efforts. Reporting of SOGI data, an effectiveness criteria, will allow researchers to gain a more comprehensive understanding of the population's needs. Utilizing this data, researchers will be able to focus their analysis on methods for improved quality of care. Availability of data will demonstrate to politicians that queer older adults live within their jurisdictions, and consequently need their advocacy. Even if the data becomes available, the logic model assumes that researchers and advocates will use the data to improve conditions for queer older adults. The model functions under the assumption that researchers will analyze the data to improve health outcomes for this population group. This model also assumes that, upon receipt of the data, politicians and people in power will alter their own behaviors and advocacy priorities. Unfortunately, even with the existence of data, politicians may not alter their advocacy priorities and researchers may choose not to analyze the needs of queer older adults.
People of color, bisexual, and transgender persons experience the greatest health disparities amongst LGBTQ+ older adults. The equity criteria of the outcomes matrix shell include operational measures aimed at capturing this policy's effect on vulnerable populations.

Policy Comparison

Predicting the potential effectiveness of cultural competency training requires an understanding of the cultural competence field. Within healthcare, cultural and linguistic competence are considered essential to "access, utilization, and quality of care" (Goode et al., 2016, p. 7). However, existing research on the effectiveness of culturally competent care to improve health outcomes is limited (Truong et al., 2016, p. 2). A review of published articles on cultural competency from 2000 through 2012 established a weak association between cultural competence interventions and improved patient outcomes (Truong et al, 2014, p. 15). Evaluative challenges, specifically a lack of a standardized definition of cultural competent care and inadequate evaluative tools, hinder researchers' ability to understand whether intervention methods (trainings) are effective (Henderson et al., 2018, p. 1) for reducing health disparities.

Therefore, it is challenging for analysts to predict whether cultural competency trainings will reduce discrimination rates and improve health outcomes.

However, researchers discovered a positive relationship between cultural competence interventions and improved patient satisfaction and health outcomes among the few studies that possess data both before and after interventions, and have participated in thorough evaluations (Truong et al., 2014, p. 8). Using this research as a foundation for future predictions, training models, such as those already established by SAGECare, will both decrease overall discrimination rates and improve health outcomes for LGBTQ+ older adults (SAGECare, 2019). Specifically, if a patient's overall satisfaction is a direct reflection of the patient's evaluation of both staff and services received, it is understandable that increased satisfaction would include decreased discrimination rates from both staff and peers. And if discrimination rates decrease, it is believed that SOGI reporting will increase amongst queer older adults. Additionally, as a result of cultural competency trainings, staff will be educated about the specific health needs of queer older adults and therefore better equipped to deliver tailored health services for this population.

Analysis of annual reports to Congress from the Office of Civil Rights was conducted to predict the potential impact of an expanded definition of sex discrimination. The Office of Civil Rights is responsible for investigating discrimination reports, and if criteria are met, opening cases that constitute the legal definition of discrimination (HHS, 2016). Prior to implementation of the ACA, an Office of Civil Rights annual report from year 2012 noted that a mere thirteen discrimination cases were opened (Department of Homeland Security, 2012, p. 33). Following the implementation of the majority of the ACA in 2014, opened discrimination cases increased to twenty-seven in 2014, twenty in 2015, thirty-one cases in 2016, and thirty cases in 2017 (Department of Homeland Security, 2013 p. 29, 2014 p. 24, 2015 p. 33, 2016 p. 31, 2017 p. 36). The nearly 225% increase in reporting between 2012 and 2017 demonstrates that Section 1557 of the ACA has increased discrimination reporting and is an effective means of protection.

Therefore, it is probable that by expanding the legal definition of sex discrimination to include sexual orientation, discrimination reporting would increase, and overall rates of SOGI based discrimination would consequently decrease. Due to decreased discrimination rates, denial of services because of SOGI will decrease, and health outcomes will improve for LGBTQ+ older adults. However, major limitations exist concerning expanding the definition of sex discrimination. Older adults experience gender discrimination at rates much higher than the reports opened by the Office of Civil Rights. Therefore, even if the definition of sex discrimination is expanded to provide more robust protections, accessibility barriers surrounding filing a discrimination complaint may prove to be insurmountable. It is feared that difficulties would be incurred at a disproportionate rate amongst the most vulnerable individuals within the LGBTQ+ older adult umbrella.

Although the expanded definition will provide enhanced legal protections that will ultimately reduce SOGI based care denials, this policy option will provide staff with no additional knowledge of the unique health needs of queer older adults. Therefore, although enhanced legal protection will decrease discrimination from staff and peers, nuanced care needs for this population may not be realized. As a result, health disparities will continue to exist.

Costs

Evaluative costs, both to establish and maintain the policy, are captured within the shell of the outcomes matrix. According to the most recent Centers for Medicare and Medicaid publicly available data, it is estimated that 15,634 nursing homes existed in 2015 (CMS, 2015, p. 1). On average, it is estimated that each nursing facility will need at least four hours of in person SAGECare training per year. With an understanding that four hours of training costs $2500 (Abrahms, 2016), this amounts to a total

start up cost of $39 million. Per existing nursing regulations, this option maintains the current practice of having long-term care facilities incur all costs associated with establishing and administering trainings (CMS, 2016, p. 502). For comparison, set up costs associated with expanding the existing ACA definition would include costs associated with lobbying, litigating, and advocating for the definition's augmentation. CMS is currently tasked with regulating and implementing regulation for CMS contracted nursing homes. State survey, licensing and certification agencies ensure compliance on a state level. These agencies frequently report to CMS about each nursing home's compliance. If adherence is a concern, CMS and the state agencies work together to mitigate the issue (Walshe, 2001). Similarly, the Office of Civil Rights is tasked with ensuring compliance for Section 1557 of the ACA. Therefore, additional staff for CMS, state level agencies, and the Office of Civil rights will be needed to ensure compliance with both policy options. The cost of additional staff would be incurred by both federal and state governments.

Conclusion / Recommendation

Cultural competency training should become mandatory for both peers and staff within long-term care facilities to reduce health disparities amongst LGBTQ+ older adults. Cultural competency training will reduce the rate of SOGI based discrimination from both staff and peers, increase SOGI reporting from queer older adults themselves, and ultimately improve health outcomes for LGBTQ+ older adults. It is believed that the SAGECare specific cultural competency training option most directly addresses the systemic factors that contribute to health disparities amongst LGBTQ+ older adults. Due to the limited amount of research surrounding cultural competence and improved health outcomes, there exists the need for more robust data and evaluative tools. Therefore, it will be required that data is gathered on both patient satisfaction and health status prior to the intervention. Once cultural competency training has been implemented, a standardized and inclusive evaluative tool should be utilized across all intervention sites to allow for further analysis of the intervention's effectiveness.

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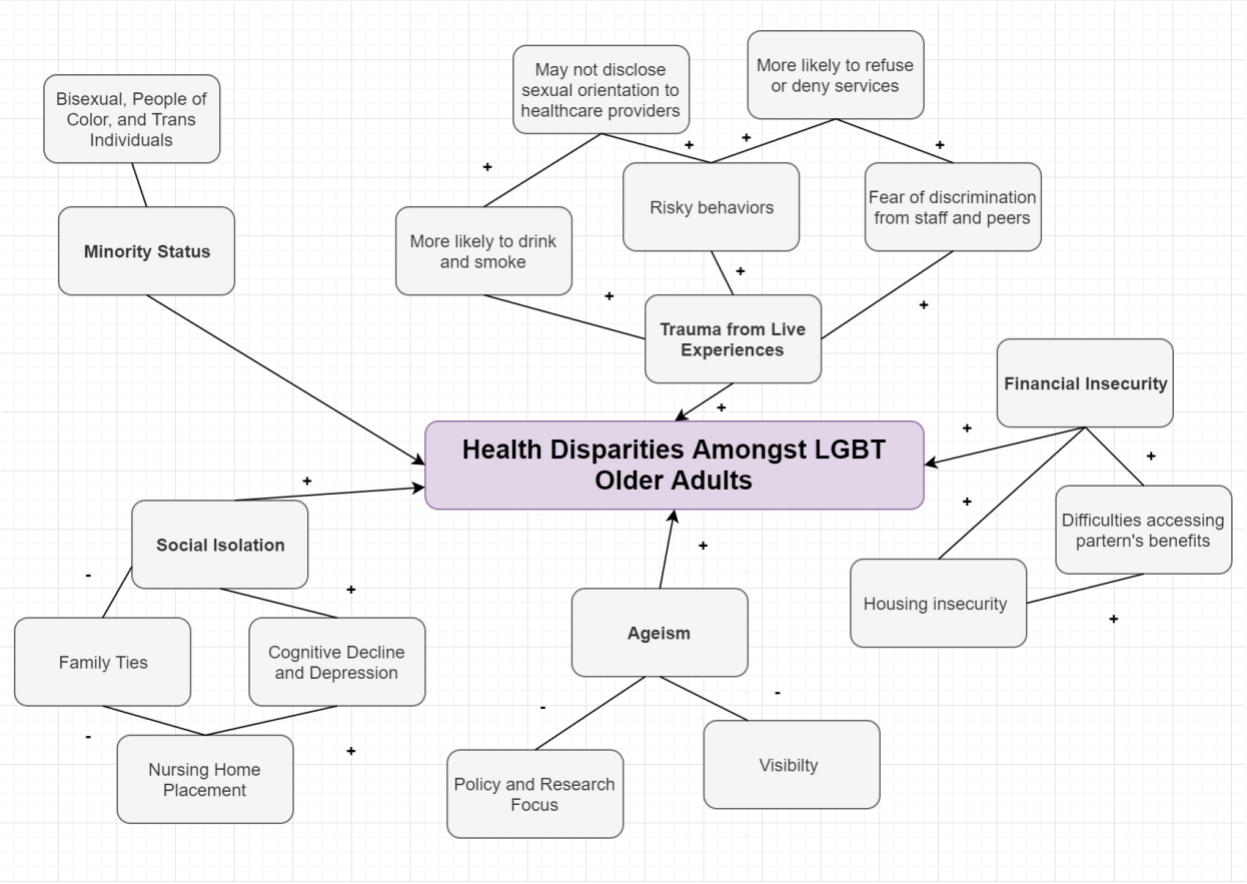
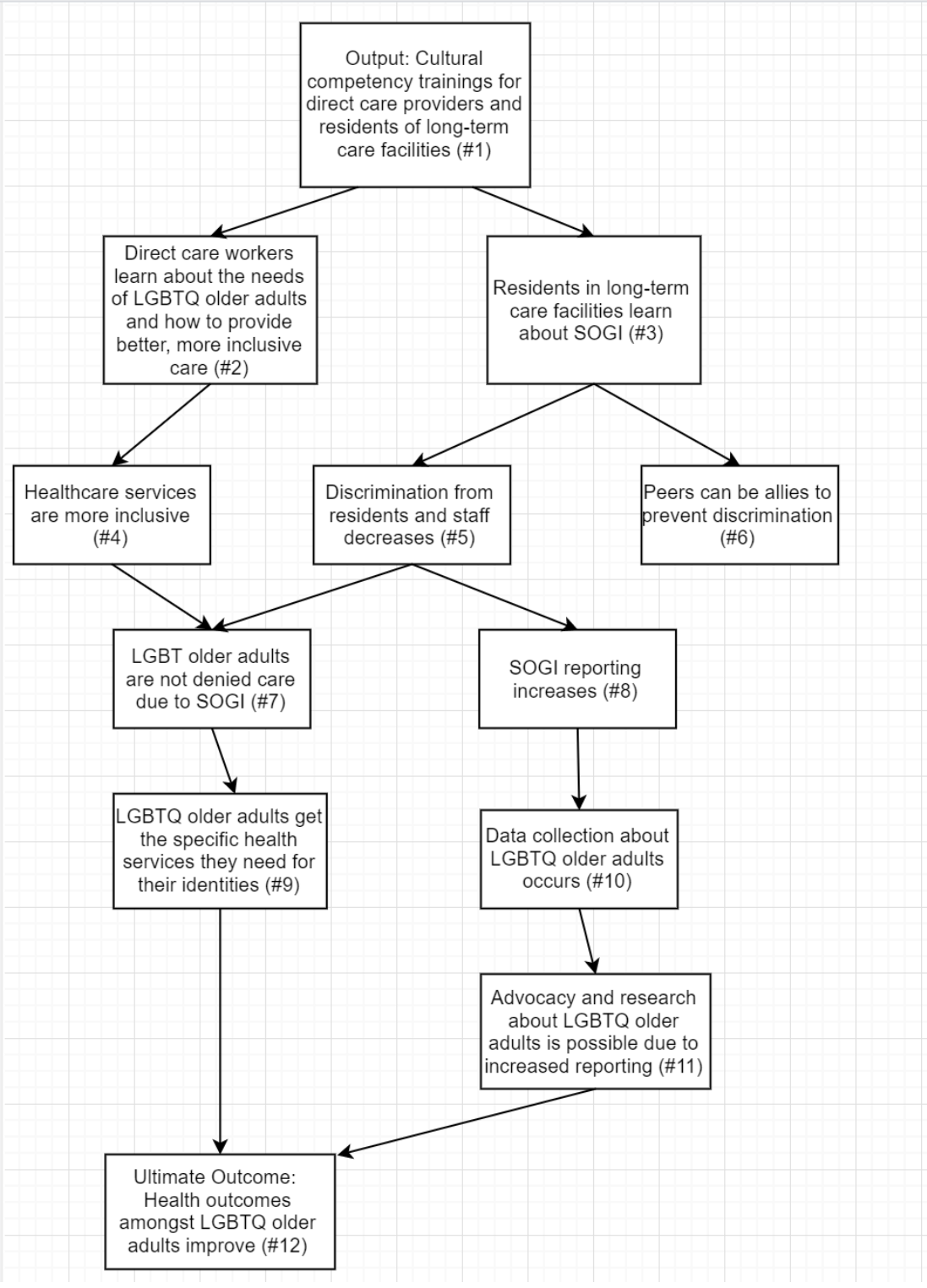
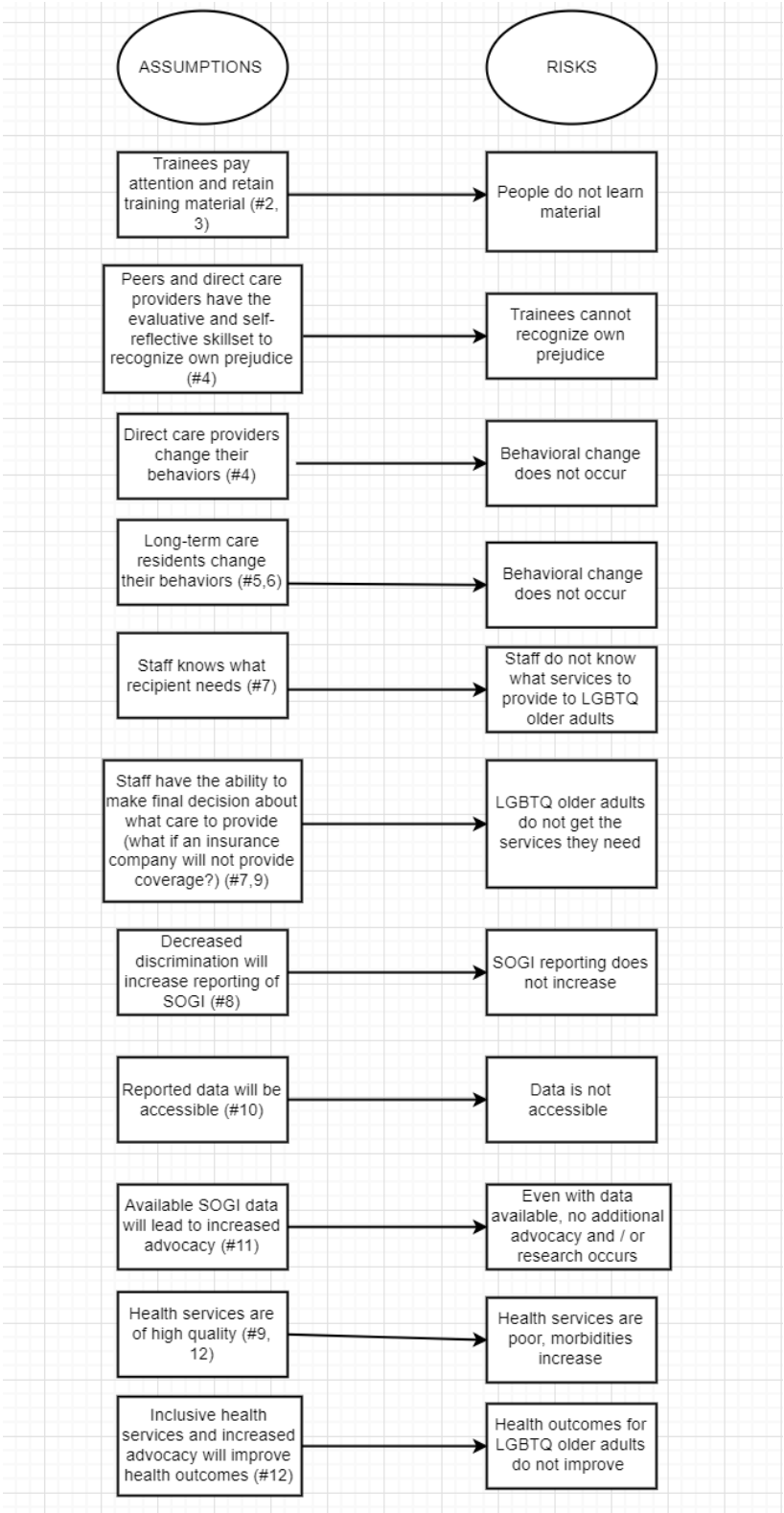
Appendix A - Causal Loop Diagram



Appendix B - **Logic Model for Cultural Competency Trainings**



Appendix B Continued - Assumptions and Risks for Logic Model



Appendix C - Outcomes Matrix

GOAL	CRITERIA	POLICY OPTION #1	POLICY OPTION #2	POLICY OPTION #3
		STATUS QUO	MANDATE CULTURAL COMPETENCY TRAININGS FOR DIRECT CARE WORKERS AND RESIDENTS OF LONG-TERM CARE FACILITIES	SEXUAL ORIENTATION AS A FORM OF SEX DISCRIMINATION WITHIN SECTION 1557 OF THE ACA
EFFECTIVENESS	SOGI DISCRIMINATION (-)	23% of queer older adults has experienced SOGI based discrimination from peers; 14% from staff	Discrimination (-)	Discrimination (-)
	SOGI REPORTING (+)	Underreporting of SOGI information	Reporting (+)	Reporting (+)
	MORBIDITY RATES (-)	Increased prevalence of smoking, poorer mental health, and increased functional limitations	Morbidity Rates (-)	Uncertain May decrease due discrimination (-). Effectiveness Limited due to lack of additional knowledge for staff
EQUITY	Effect on people of color, trans older adults, and bisexual older adults	Marginalized populations most vulnerable to discrimination and receipt of insufficient care	Morbidity Rates (-) due to tailored health services specific to individual's identities	Enhanced legal protections Effectiveness limited by accessibility challenges
COST	SETUP COSTS	None	15634 (# of nursing homes) x $2500 (cost of 4 hours of SAGECare training)= $39 million	Lobbying, litigating, and advocacy costs
	MAINTENANCE COSTS	None	Additional staff for CMS and state survey, licensing and certification agencies	Additional staff for Office of Civil Rights
SIDE EFFECTS	DISCRIMINATION (-)	No change	Initial backlash could discrimination (+) Fear of CMS penalty will reduce rates overtime	Initial backlash could discrimination (+) Legal protections should decrease rates overtime
	# OF PEER ALLIES INCREASE (+)	No change	# of allies (+)	# of allies remains the same