Helping Your Facility Adjust to a Rainbow World

Dr. Jeff responds:
Of course, every facility will have to comply with legal changes as they occur. Married couples, regardless of gender, will have the rights granted already to share rooms or utilize spousal impoverishment exemptions in state Medicaid regulations. Ethics policies may need a brief re-examination but will probably not require any modifications beyond the occasional correction of pronouns. Visiting rights are already universal, so improved understanding of gender and sexual orientation issues should not change the opportunities your facility already offers. Although the Centers for Medicare & Medicaid Services has not extended the absolute nondiscrimination requirements to nursing homes that already apply to hospitals, this will undoubtedly come soon.

These are changes already endorsed by multiple professionals, including the 2012 White Paper from AMDA. Nondiscrimination clauses that already exist in a variety of areas from admissions to medical staff membership should be expanded to include sexual orientation and gender identity. Although employment discrimination against lesbian, gay, bisexual, and transgender (LGBT) applicants or staff is not illegal in many states, there seems little doubt that it will be legally forbidden within the next decade in most, if not all, jurisdictions. Moreover, in an industry with chronic labor shortages serving extraordinarily diverse populations, formal elimination of discriminatory employment practices is both the right thing to do and a potential benefit to your facility and residents.

Although on the surface this may seem to be everything needed to achieve regulatory compliance (and all-too-often compliance is mistaken for quality), there is much deeper and more profound change required to transform LTC facilities into homes where “person-centered” care is able to recognize the diversity in our residents. Certainly one’s sexual identity, sexual desires, and who one loves or loved are key elements of one’s personhood. Gender issues and gender identities are key personality elements from early childhood. And even if sexual interest and desire decrease somewhat with age, they certainly do not disappear, and lifelong interests and concerns have already helped formulate major aspects of who we are as individuals.

Complex Relationships
Most of our residents spent the majority of their adult lives in the era when LGBT individuals remained in the closet. When I first started my geriatrics practice, I was surprised how many of my elderly patients were living with “cousins” who were often individuals with different last names and no obvious physical similarities. Others had “boarders” or “roommates” with whom they shared living expenses. As I made home visits or came to know them better, it was apparent that they shared bedrooms, and the nature of lifelong relationships became clearer.

The landmark Supreme Court case for marriage equality (United States v. Windsor) concerned an elderly woman and her desire as a surviving spouse to benefit from preferential inheritance taxes for widows and widowers. Thea Spyer and Edith Windsor considered themselves engaged, but never used the same last name and did not wear wedding rings for fear that the rings would lead to questions at work, even though they lived together in Greenwich Village. After the opportunity to marry in Canada became available, they were married by Canada’s first openly gay judge. Ms. Windsor had previously married and divorced a man.

Several years prior to the Windsor-Speyer engagement — after Franklin Roosevelt’s death — Eleanor Roosevelt lived a few blocks away in the Village with a lesbian friend to whom she had written daily letters while living in the White House. The exact nature of their relationship remains a matter for conjecture. The point is that standard nursing home social histories would probably have identified Windsor as divorced and Eleanor Roosevelt as widowed, without any real respect for the complexity of their relationships.

Public acceptance (and family acceptance) of LGBT individuals and relationships is still quite variable. Homophobic violence persists and survivors still have reason to fear being “out.” It is safer to identify oneself as an elderly bachelor or “spinster” rather than acknowledge a life lived in hiding. Unless your facility makes it clear that it is safe to be open, residents will continue to hide, living a lie and perhaps being denied opportunities to continue long-term relationships or openly mourn lost loves. Of course, the desire of a resident to preserve confidentiality and privacy about their status must also be respected.

There are varying statistics regarding the size of the LGBT population in the United States. Estimates of the adult population suggest that somewhere between 3.5% and 10% of the population fall into one of these categories. Transgender individuals in varying states of physiologic and anatomic transition are estimated at 0.3%. The lower estimates would still suggest about 9 million LGBT seniors and 700,000 transgender adults. More than 130,000 people have requested name and sex reassignment acknowledgment from Social Security.

In fact, your facility probably has multiple LGBT residents already. Declining estrogen, progesterone, and testosterone levels in the elderly often blur secondary sexual characteristics. Identification of transgender individuals can be difficult, and visual identification of gender identity can be problematic, with facilities cited by surveyors for failure to shave female residents. Residents who failed or were unable to inform the hospital about hormonal support may come to the nursing home experiencing hormonal withdrawal. Skilled nursing facilities that admit large numbers of post-acute patients should be prepared to provide medically appropriate and emotionally sensitive care.

Building Respect
Fifteen years ago, the nursing home where I was medical director initiated a joint project with SAGE (Services and Advocacy for GLBT Elders). At that time, the organization existed only in New York, but it has now become national, and it preceded legalization of gay marriage in New York. We proposed to explore measures that might be needed to make our facility more respectful to our LGBT residents. They were pleased (and perhaps surprised) that an institution sponsored by a Catholic religious order would reach out to them. Initial changes included modifying admissions procedures and forms to include options to self-identify in diverse ways. Offering choices other than “male” and “female” was possible without major paperwork modifications and acknowledged the variety of human sexual expression. Similarly, there were clearly more choices than married, single, divorced and widowed under what was labeled “marital status.” Even offering “other” as a choice in each category allowed the resident an option to be open from the onset.

In-services for social work staff assisted them with sensitive areas with which they might be unfamiliar, and informed them about community resources available for LGBT residents after discharge. Education for other staff included sensitivity training and reinforcement of facility policies regarding patient respect. There was remarkably little pushback from staff, perhaps because almost all had gay family members or friends. There were no issues with other residents or families, but of course this was New York City, where acceptance of diversity is more normative. If your facility isn’t located in a progressive city or state, you may be required to explain and defend facility policies to those residents and family members who may feel discomfort.

At least one nursing home has proposed the development of a “neighborhood” for LGBT residents. Although SAGE has endorsed this, and it certainly allows residents to be out and proud, it seems to shift LGBT status to a sole-defining identity. Just as I would not wish to live in an all-white neighborhood, I wouldn’t want to be on the “straight” floor of a nursing home. And certainly a transgender female should be accepted on regular floors along with other residents, rather than separated and effectively stigmatized.

Modifications of procedures regarding sexual identity and marital status also benefit heterosexuals. Relationships can often be complex. When my parents were active in upstate New York politics 25 years ago, they helped persuade their city to adopt a domestic partnership statute to allow legal recognition for same-sex relationships. To their surprise, the majority of couples coming forward for legal recognition were heterosexual couples. These included many couples who had chosen not to marry and many divorced older couples whose religious affiliations or finances did not allow them to remarry but who wished to have their relationships formalized.

The one certainty in PA/LTC seems to be constant change. Fortunately, changes offering increased diversity and the opportunity for our residents (and staff) to be open about who they are and who they love are changes for the better. Your facility should be happy to embrace them, and your role as a medical director should be to encourage the process.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”