LGBT Patients Seek Open Arms in Long-Term Care
By Randy Dotinga

"LGBT people experience real discrimination in nursing homes and long-term care settings," said Jamison Green, PhD, a transgender author and activist in Vancouver, WA. Dr. Green will turn 72 this year, and the expensive prospect of long-term care is on his mind. "I'm winging it like most Americans do," he said. But his concerns are wider than those of the typical aging person. "I worry that I will be denied my hormonal support, that I will be ridiculed and neglected," Dr. Green told Caring.

The reasons for discrimination and mistreatment of LGBT seniors are varied. Medical and personal care staff may be careless, prejudiced, or untrained. But whatever the explanation, LGBT patients and their advocates say the result can be devastating on mental, spiritual, and physical levels. "My biggest concern is that people will completely invalidate me and decide to start treating me like some other person that I'm not," Dr. Green said. "I've been in medical settings where people won't look me in the eye if they find out I'm trans. They reduce communications, they're not interested, they're disrespectful."

According to SAGE, an advocacy organization for older LGBT adults, the number of LGBT people over the age of 50 in the United States is expected to grow to 7 million by 2030 ("The Facts on LGBT Aging," SAGE, 2018; https://bit.ly/3lfrDUy). Long-term care facilities have been evolving to become inclusive and culture change in long-term care.

Ageism and Complacency: Lessons From COVID-19
By Roberta Meyers, MD, MPH

As I write this here in Minnesota, 78% of those who have died from COVID-19 have been men and women living in long-term care or assisted living facilities. As of mid-July, this is well over a thousand people (Minnesota Department of Health, “Situation Update for COVID-19,” 2020, updated daily; https://bit.ly/3gpeghZ). I have been a geriatrician for 30 years at a public safety-net hospital in a practice where people are vulnerable not only because of years of chronic illness but also because of poverty and lack of social support. I know bias in almost all its variations, but COVID-19 has reacquainted me not only with ageism but with its evil twin: complacency.

I will remember April 2020 as the month I started watching death numbers. In Minnesota, the reporting was described by two categories, private residence versus congregate living. I watched the numbers rise and realized nearly all the deaths were occurring in congregate living settings, defined as skilled nursing or assisted living facilities, or group homes with more than 10 residents. Why wasn’t anyone talking about this? Where was the plan? By May, my confusion had turned to horror as
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more welcoming to the LGBT community. They’re implementing training, getting certified by the national advocacy organization, and adopting new policies about everything from pronouns to posters.

“Education is the key,” Dr. Green said. “People need to be educated well, and they need to be open to be educated.”

Care facilities that fail to evolve may fall behind. Creating an LGBT-friendly environment in long-term care has four keys aspects.

Meet the Unique Medical Needs of LGBT Patients

Lesbians, gay men, and transgender people face unique disparities in care, and it’s important for medical professionals to understand these issues. According to SAGE, older LGBT adults have higher rates of disability and mental and physical illness than the general population.

Income also may be a crucial factor. Studies have pointed to lower incomes in the LGBT community (Dayana Yochim, “By the Numbers: Being LGBTQ+ in America,” HerMoney, June 15, 2020; https://bit.ly/3hJlM6j). Economic constraints are one reason lesbians often don’t get proper preventive and screening care, said Seattle internist Peter Shalit, MD, PhD, PACP, an advocate for LGBT patients.

Another contributor to health disparities is “incorrect provider preconceptions that [lesbians] are at lower or no risk of conditions affecting heterosexual women.” In fact, some research has suggested that lesbian women may have a higher risk of breast cancer, possibly because they’re less likely to have had children. According to the American Cancer Society, “studies suggest that some lesbian and bisexual women get less routine health care than other women, including breast, colorectal, and cervical cancer screening tests” (“Cancer Facts for Lesbian and Bisexual Women,” American Cancer Society, July 30, 2020; https://bit.ly/2D6nSxJ).

“All that means is that lesbians, like all other women, deserve breast cancer screening,” Dr. Shalit said. “It doesn’t mean that lesbians deserve more breast cancer screening than other women — just not less screening.”

As for gay men, they’re especially vulnerable to sexually transmitted infections such as human immunodeficiency virus (HIV), hepatitis B, and syphilis. “It’s important to ensure that every gay man has been screened for these conditions at least once after their period of risk — sexual activity,” Dr. Shalit said. “There are numerous anecdotes of older men in long-term care developing complications from one of these conditions that had not been screened for or recognized on entry.”

Advocates urge also medical professionals to take special care with transgender patients during medical exams. “Sometimes their bodies may look different, and it’s important to react in a professional and sensitive manner,” said Tim R. Johnston, PhD, senior director of national projects at SAGE. Practitioners should be careful about language, he suggested, and should consider asking these patients how they refer to parts of their body. “Someone may not refer to their breast tissue as breasts but instead call it their chest,” he said.

Dr. Shalit noted that “many transgender men have had breast surgery meaning they have had their breasts removed. There may be residual tissue that can be a cancer risk, but mammograms would not be possible after a mastectomy. So the person should be aware of any changes and bring them to the attention of their provider. If a transgender man retains his breasts, then breast cancer screening is the same as prior to gender transition.”

Almost all transgender women have prostates, Dr. Shalit added, so they should receive screening for prostate cancer.

Ask Open-Ended Questions, and Don’t Make Assumptions

Medical professionals can damage the practitioner–patient relationship when they make assumptions about gender identity and romantic relationships. Rabbi Erica Steelman, MAHIL, MPP, staff chaplain and director of LGBT+ initiatives at the Madlyn and Leonard Abramson Center for Jewish Life in North Wales, PA, offered the example of an experience that happened to a female friend of hers. While it did not take place in a nursing home, it is an example of how within seconds a clinician can unintentionally harm a therapeutic relationship and cause it to end.

Rabbi Steelman’s friend had made it clear on her intake forms that she had a female partner. “The doctor either didn’t read what she wrote or forgot, and asked her about her husband,” Rabbi Steelman recalled. “That was a deal breaker for the patient. She was not going to continue to see this doctor.”

Rabbi Steelman’s advice is simple: “For any person you meet as a patient or client, don’t make assumptions about their sexual orientation or gender identity. Ask open-ended questions.”

Forms and applications shouldn’t have just two responses to questions about gender, Rabbi Steelman said. Practitioners should ask about partners, not just spouses. Patient should be asked about their preferred pronouns and preferred names, and the staff should be made aware that a client’s name on an insurance card may differ from the name they use.

Jennifer Serafin, RN, MS, GNP, a nurse practitioner with Kaiser Permanente of Northern California, pointed to the case of a transgender patient in a large long-term care facility
who was being treated for a staph infection while Ms. Serafin was working there. “The staff really had a hard time taking care of them,” she said. “Some of the staff wouldn’t call the patient their chosen pronoun, and some called them their original name instead of their chosen name. The facility hired an outside agency to conduct company-wide cultural training on LGBT elders and say, ‘We’re not going to tolerate how you are talking about this patient.’”

Practitioners and staff should always follow a patient’s wishes, Ms. Serafin added, even if it’s a desire for complete privacy. “Never out a patient. It’s not your right to do that,” she said. “If a patient wants to be in the closet in the facility, that’s their choice.”

Create a Welcoming and Inclusive Environment

Nondiscrimination policies aren’t the only way that long-term care facilities can show that they welcome LGBT patients. Rainbow flags and posters can send a message, too. “People may not recognize how significant signs and symbols can be — some sort of signal that affirms that the people here welcome you,” said Jeffrey Kwong, DNP, MPH, a professor of nursing at Rutgers University in Newark, NJ. Rabbi Steelman put it this way: “Convey openness and respect and affirm dignity.”

It’s also helpful to make it clear that loved ones — including those who are welcomed to take part in activities and visitation — don’t have to be relatives. “When people talk about visitation in long-term care, it’s often the nuclear family — the kids or other biological relations. LGBT older folks are more likely to be supported by families of choice, people who aren’t legally related to them,” said Dr. Johnston.

Indeed, according to SAGE, 21% of older LGBT adults have provided care for friends, compared with just 6% of heterosexuals. “Let’s say you’re having a Family Day. If I’m an LGBT resident, I might just assume family means biological/nuclear family,” said Dr. Johnston. “Maybe have the wording say ‘family/ friends/loved ones.’”

To avoid conflicts, Ms. Serafin urged colleagues to work with LGBT patients early to choose medical decision-makers. “Make sure the person’s wishes are known so they’re followed,” she said. “Sometimes LGBT patients are ostracized from their family, and suddenly family members come out of the woodwork when they’re not doing well or even dying, and they haven’t been part of the person’s life for 50 years.”

Conduct Staff Training, and Don’t Stop

For a 2015 report, researchers at San Francisco State University surveyed 268 nurses in the Bay Area and asked whether they’d been educated or trained about the needs of LGBT patients.

Even though the Bay Area is one of the most liberal areas of the nation, with a famously high LGBT population, fewer than 20% of the nurses answered “yes” (J Prof Nurs 2015;31:323–329).

“Never in all my years of nursing — 37 years in nursing — I’ve never been educated in that subject,” said one nurse. Another said, “I believe a lot of nurses are uncomfortable working with a LGBT patient, especially if they live in a city that has a very limited population of LGBT.”

SAGE offers a cultural competency training program known as SAGECare for facilities that treat older LGBT adults. More than 87,000 people have been trained, and 35 providers now have SAGECare certification (https://bit.ly/2FpewQF). SAGE and the Human Rights Campaign also are developing an assessment tool — the Long-Term Care Equality Index — to “encourage and help residential long-term care communities to adopt policies and best practices that provide culturally competent and responsive care to LGBT older adults” (https://bit.ly/2H0QNH7).

Rabbi Steelman cautioned that education and training are an ongoing process. “It’s important to think of this as a commitment to continuing to do the work. No human or organization will be perfect, so there will always be more work to be done.”

Randy Dotinga is a San Diego-based freelance writer.