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The Housing Needs of Sexual and Gender Minority Older Adults: Implications for Policy and Practice

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ABSTRACT

This study identifies the interconnected needs and concerns of sexual and gender minority (SGM) older adults, with a particular focus on housing, healthcare, transportation, and social support. Data were gathered through seven groups with a sample of SGM-identified adults age 55 and over (N = 50) and analyzed using thematic analysis. The participants seek affordable and inclusive housing options. They identified that access to transportation is paramount in maintaining social support and accessing healthcare. Findings underscore the need for strategies to serve the housing needs of low-income SGM-identified older adults in a nondiscriminatory way, train housing providers in culturally responsive care, meet transportation needs, and provide SGM-inclusive community-based services that reduce isolation.

KEYWORDS

LGBT; housing; transportation; social support; isolation; healthcare

Introduction

The older adult population in the United States is growing rapidly, with an estimated 10,000 individuals turning 65 each day through the year 2030. The elderly population will reach 88.5 million by the year 2050, more than double the population in 2010 (Cohn & Taylor, 2010; Vincent & Velkoff, 2010). Population-based estimates suggest that there were more than 2.4 million sexual and/or gender minority (SGM) adults over age 50 as of 2014, and that this population will surpass 5 million by 2030 (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015). Despite this unprecedented growth, SGM older adults have historically been overlooked in research, policy and services.

Currently, the existing housing stock is unprepared to meet the myriad needs of aging adults, and the high cost of housing directly affects financial security and the affordability of other necessities. Additionally, housing stability is impacted by physical accessibility, proximity to resources (*e.g.* transportation, stores, and community spaces), and connections between housing and

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healthcare systems (Joint Center for Housing Studies, 2017). For SGM-identified older adults, these concerns are compounded by disparities in income, fewer familial resources, and the absence of federal laws prohibiting discrimination in housing (The Equal Rights Center, 2014). Further, recent research has demonstrated that sexual orientation and gender identity impact experiences of housing discrimination, with transgender individuals experiencing a higher frequency of housing discrimination than their cisgender sexual minority peers. These experiences of discrimination appear to be magnified the longer a person has been out regarding their sexual orientation and gender identity, highlighting the urgency for considering housing-related needs of SGM older adults (Kattari, Whitfield, Walls, Langenderfer-Magruder, & Ramos, 2016). This paper contributes to the extant literature by amplifying the perspectives, needs, and concerns of SGM older adults, with respect to the intersection of housing needs, social support, transportation and healthcare access.

Background

Housing

There is a growing awareness of, and attention to, the difficulties SGM seniors face when searching for welcoming and affordable housing, including income disparities, fewer familial supports, lack of legal protection, fear of discrimination, and associated social isolation. The absence of federal laws prohibiting housing discrimination has made this population especially vulnerable to uncertainty regarding safe housing options, which is pronounced as they age (The Equal Rights Center, 2014). A national survey revealed that 48% of older same-sex couples were discriminated against when seeking senior housing (Espinoza, 2015). The same study reported that 44% of lesbian, gay, and bisexual (LGB) older adults were very interested in living in an SGM-friendly housing development (Espinoza, 2015). Those who seek SGM specific housing do so to attenuate worries about discrimination and homophobic sentiments (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009; Bradford et al., 2016; Brennan-Ing, Seidel, Larson, & Karpiak, 2014; Knochel, Quam, & Croghan, 2011; Kottorp, Johansson, Aase, & Rosenberg, 2015). Qualitative data collected from three SGM senior housing communities suggests that a need for acceptance of residents' sexual orientation and/or gender identity drove them to seek out these living arrangements. Moreover, these feelings of acceptance cultivated a strong sense of community that facilitated both caretaking and the creation of strong social bonds between residents, who believed that this would not have been the case in mainstream senior housing (Sullivan, 2014).

However, SGM specific housing developments are not the only solution, and are not preferred by all SGM older adults. Advocates for inclusive housing believe that SGM-exclusive communities might perpetuate the exclusion or discrimination that they experienced as sexual and gender minorities. Additionally, diversity in a broader sense (*i.e.* age, race, and health status) was identified as paramount in fostering a sense of community (Kottorp et al., 2015). Residents in SGM-focused senior housing communities shared that they would also feel comfortable living with their heterosexual and cisgender peers, with the stipulation that "everyone feel comfortable"; participants were opposed to living in predominantly heterosexual spaces (Sullivan, 2014). Inclusive environments can be created through hiring SGM-identified staff members, and with cultural competency trainings, staff in existing senior housing facilities can better serve the needs of SGM residents (Kottorp et al., 2015; Lim & Bernstein, 2012).

According to the AARP Public Policy Institute, nearly 90% of adults age 65 or older would like to remain in their home for as long as possible (2011). As the aging population grows and older adults are advocating to remain in their homes, service providers and policy makers are called to consider and address the needs of SGM older adults looking to age in place (Boggs et al., 2016; Kottorp et al., 2015). The Centers for Disease Control and Prevention define aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (Joint Center for Housing Studies, 2017). Preferences for aging in place for SGM older adults include acceptance, friendship and social network building, and drawing upon other SGM identified peers as a source of strength and hope (Bradford et al., 2016).

Identified barriers to successful aging in place for sexual and gender minorities include housing and community discrimination, stigmatization by providers, gaps in SGM competent and sensitive social and health services, and decreased access to social and community networks (Boggs et al., 2017). Successful aging in place for SGM seniors can be supported through a centralized resource center, increased advocacy efforts through existing older adult organizations to include the needs of SGM older adults, buddy programs to connect SGM elders with younger SGM individuals and straight allies, in addition to supporting providers' ability to respond to the needs of SGM older adults (Boggs et al., 2017).

Efforts to support community building across housing domains are particularly important for SGM-identified older adults. A purposive sample of lesbian-identified women age 60 and older in urban and rural communities in Massachusetts demonstrated that a majority of participants preferred to have peers in their social network assist them when needed, as opposed to engaging formal elder care services (Bradford et al., 2016). Among SGM older adults, social connections fueled by shared life experiences as LGBT people

facilitated connection to resources when health and other crises arose (Sullivan, 2014). It appears that strong communities of SGM older adults may not only mitigate the negative mental and physical health of social isolation; they also serve to enhance older adults' ability to access community services (Pantell et al., 2013).

Transportation

Transportation has been identified as a significant barrier to healthy aging, as it impacts aging adults' ability to consistently access healthcare services, community resources, and develop and maintain social supports that help prevent isolation (Choi & DiNitto, 2016; Choi, Mezuk, Lohman, Edwards, & Rebok, 2012; Curl, Stowe, Cooney, & Proulx, 2013; Dahlhamer, Galinsky, Joestl, & Ward, 2016; Gratwick, Jihanian, Holloway, Sanchez, & Sullivan, 2014; Hardman & Newcomb, 2015; Smith et al., 2017; Solway, Estes, Goldberg, & Berry, 2010; Syed, Gerber, & Sharp, 2013). The Joint Center for Housing Studies (2017) indicates that a majority of older adults live in lower-density suburban and rural areas, which can make access to social service providers difficult. The literature indicates that transportation is a barrier regardless of geographic location, but asserts that older adults in rural areas face unique transportation barriers to accessing supportive care (Smith et al., 2017). Because they need to travel long distances and have limited access to public transit systems, older adults rely heavily on social support networks for transportation (Choi & DiNitto, 2016; Syed et al., 2013). Older adults in urban areas may be located more closely to social and health supports, but utilizing public transit can be difficult due to physical limitations (Solway et al., 2010).

As both the older adult population and housing costs continue to rise in the United States, more older adults are having to cut back on a variety of expenditures to afford housing and healthcare, including transportation, which could further limit access to resources (Joint Center for Housing Studies, 2017). When older adults stop driving, whether because of physical necessity or economic need, productive engagement in activities such as working or volunteering is negatively impacted (Curl et al., 2013). This reduction in transportation access negatively impacts health and mental health outcomes as a result of lowered consistent healthcare utilization (Joint Center for Housing Studies, 2017; Solway et al., 2010; Syed et al., 2013). This forces older adults to increase their dependency on family and friends, which may already be limited for SGM seniors (Gratwick et al., 2014; Hardman & Newcomb, 2015).

Transportation problems can be associated with isolation among sexual and gender minority adults, especially among those with mobility barriers (Gratwick et al., 2014), but this is an area that is understudied. Among

a national sample that was representative of U.S. Medicare beneficiaries age 65 and older, feelings of isolation were further exacerbated when transportation was a barrier to visiting friends and family, which were associated with depressive symptomatology (Choi & DiNitto, 2016). SGM-identified older adults may be at increased risk of social isolation and its sequelae as a result of transportation barriers, given that they are more likely to live alone and are less likely to be married and have children than their heterosexual and cisgender peers (Choi & Meyer, 2016).

Gaps

While the research on housing related needs for older adults has been firmly established, those specific to SGM older adults are still emerging and warrant further exploration. Many of the recognized housing-related concerns of older adults are equally relevant to SGM elders, including affordability, access to resources, transportation, prevention of isolation, etc.; however, what is not fully understood are the ways in which sexual orientation and gender identity mediate these concerns. Policies and direct service efforts that address the specific housing-related needs of SGM older adults are nascent and require a thorough understanding of the complex needs and concerns of the population being served. In light of this, qualitative methods are uniquely positioned to gather nuanced views of a relatively hidden population, and to highlight the diverse and potentially unique concerns of older adults associated with their sexual orientation and gender identity.

Conceptual framework

The authors approached this study with the conceptual perspective of the social ecological model; namely, an SGM-identified individual's housing needs can best be understood within the context of multiple, interacting levels of influence that include the microsystem (families and families of choice), mesosystem (community resources), exosystem (lack of discrimination protection in federal housing policies), and macrosystem (heterosexism, racism, and transphobia) (Bronfenbrenner, 1979). The questions posed to respondents were therefore focused on elucidating an understanding of how several interconnected themes might relate to housing.

Methods

This paper presents findings from a qualitative study of SGM-identified adults age 55 and over who lived in urban, suburban, and rural areas of a state in the northeastern United States. Researchers at a school of social work collaborated with practitioners at a community-based organization that provides cultural

competency training, fosters community building, and facilitates civic engagement for SGM older adults. This study was driven by the following question: what are SGM older adults' current and anticipated housing needs and concerns, and how do those relate to social support, geographic location, access to healthcare, and access to supportive services?

Sampling and recruitment

Utilizing purposive sampling (Tongco, 2007), we recruited participants who self-identified as a sexual and/or gender minority and were age 55 and older. Participants learned of the study through announcements at local senior centers, aging service access points, and SGM-specific congregate meal sites. The sample (N = 50) was predominantly White (79% White; 13% Black; 7% multi-racial) and ranged in age from 55–87 (M = 67). Participants identified as female (n = 28; 56%), male (n = 19; 38%) and transgender (n = 3; 6%). Sixty two percent of the sample reported an annual household income of less than 50,000, USD with 30% of the sample reporting an annual household income between 10,000 USD—$30,000. The majority of the sample (54%) lived alone. Sixty two percent of the sample lived in a single family house, 28% lived in an apartment or room in a building for people of all ages, and 10% lived in senior housing. Approximately half (52%) of the sample was retired. Among those who were working, 10% were employed full-time and 22% were employed part-time. To include the perspectives of SGM older adults from racially, ethnically, financially, and geographically diverse backgrounds, researchers held focus groups in urban (3 groups), suburban (2 groups), and rural (2 groups) locations. Recruitment efforts stopped when data analysis revealed no new themes.

Data collection

Data were collected through seven focus groups, each of which lasted 1.5 hours, and included 4 to 10 participants. Researchers used a semi-structured guide to guide the focus groups. The housing-specific questions that are the focus of this paper included: What is your preferred housing arrangement as you age? What are some of the most important factors that influence where you would like to live? If you are currently in the geographic area where you want to stay, what do you value about it? If you plan to move, what do you value about your preferred location? In addition to the facilitator, a note taker recorded observations about themes that emerged during the focus group discussions. The audio of each focus group was digitally recorded and transcribed verbatim. Respondents completed an anonymous questionnaire that gathered demographic information as well as information about

Table 1. Comfort in seeking assistance among focus group participants.

	n	%
Comfortable asking for help from		
spouse/partner[a]	18	36
child or children	12	24
other family members	23	46
friends	38	76
neighbors	11	22
aging service providers	26	52
others	5	10
Has no one to ask for help	1	2

Participants were asked to check all responses that apply.
[a]Half of respondents (*n* = 26; % = 50) selected 'n/a' for this question.

their houshold income, current living situation, and the types of supports they would likely turn to if needs arise (Table 1).

Data analysis

An inductive, thematic analysis approach (Braun & Clarke, 2006) guided data collection and analysis. Two members of the research team independently conducted inductive first-cycle coding of each transcript, using descriptive coding, process coding, sub-coding, and simultaneous coding (Miles, Huberman & Saldaña, 2014). A third researcher compared the coded transcripts to identify similarities and inconsistencies in coding. All three researchers met to reconcile discrepancies in coding and finalize a three level codebook that included codes, categories, and overarching themes. The researchers identified new codes until the data confirmed the existing codebook (Putney, Keary, Hebert, Krinsky, & Halmo, 2018).

Human subjects

This study was approved by the Institutional Review Board at the first author's university. We sought, and were granted, a waiver of written informed consent. Upon receiving information about the purpose of the study, details of participation, possible risks and benefits, confidentiality, right to refuse participation, and how the findings will be used, focus group participants provided verbal consent. Respondents received a 25 USD gift card to thank them for their time and participation.

Findings

When asked about their housing-related needs and concerns, respondents identified three main themes: affordability, access to community, and access to healthcare. Each of these themes relate in complicated ways to each other,

and their perspectives illuminate the complexity of these relationships. These concerns were intricately linked to the respondents' identities as sexual and gender minorities, many of whom did not have familial support and who looked to inclusive housing spaces and networks of support as they anticipate health decline.

Affordability

One of the primary concerns that emerged in the focus groups was the affordability of housing options. Respondents addressed that in the setting of diminishing finances in later life, the need to find affordable options becomes ever more critical. Although an overwhelming majority of respondents reported a clear preference to age in place, in their current living situation, these wishes were accompanied by fears of not being able to afford to do so. This is reflected by one respondent, who said, "I guess when I had the fantasy of growing older, I did see myself growing older like my mom. She stayed in her own house and I came to take care of her when she was dying, and she was a member of the community her whole life long. I don't see myself as that different from her except I don't have her resources."

Among those respondents who were working, pressing concerns emerged about how they will manage when they can no longer work. In one case, a respondent retired early from her ministry because she was concerned that she would be forced out of her church because of her sexuality. This had cascading effects of her ability to afford housing and rendered living in her preferred location (in an urban setting close to friends and healthcare) impossible. The respondents lamented the lack of truly affordable housing and underscored the need for more subsidized units, especially in a city where housing costs are rising and what is considered "affordable" is often not for those on fixed incomes. One participant summarized, "We have a major shortage of affordable housing." Another respondent summarized the relationship between affordability and community: "What comes to my mind is affordable housing where someone who is retired can manage to live decently and participate in everything that they're able to get to in a community." This brings us to the next themes related to fears of health decline, fears of isolation and the related need for social support.

Health decline

Respondents' housing needs were driven not only by worries related to affordability but also by fears of health decline and how those two concerns intersect. This is captured by one respondent who had fractured her hip shortly before the focus group. She shared,

> Because I'm not sure I can, I'm going to be able to go back to work. So, that's huge for me right now. And I was in the ER and my concern was the rest of it you know. OK, so I broke my hip, but the rest of it. Am I going to go back to work? And if I don't, I can't afford to stay where I am. So, in a two second accident, sorry guys, it changes everything. And you don't know when that's coming. So, yes I'm having to really spend a lot of time thinking about senior housing. I don't know if I'm ready for that.

Isolation and need for community

In light of health decline, some voiced fears of being alone and verbalized uncertainty about how they would access support. This was cast in light of the fact that many sexual and gender minorities later in life do not have children to turn to for support, as reflected by one participants who said, "A lot of LGBT people do not have kids or anyone to look on them, and that's one of the biggest problems. As we get older, who will look on, take care of us, even if we're in our home or if we're in a nursing home or whatever?" Another respondent added, "I'm terribly afraid of being alone. [My partner] goes first, my mother will be gone, and everybody will be gone, and here I am in my house just sitting there, and that's, sort of, the scenario." One respondent poignantly described a fear of being "marooned in a broken body or marooned in a place where nobody knows anything about things that matter to me." And another said, "I have no family, what is going to happen to me when I can't do it for myself?"

One respondent had a recent health crisis and described it as a "rude awakening" because she lived alone and suddenly realized how vulnerable she was to an unpredictable change in health. Another respondent reflected on the potential isolation of staying in one's home alone, along with a wish for community: "I love my house, yet I don't necessarily want to be someone who is living alone in her house indefinitely, because I do admire the way in any kind of group's facility, even a hospital, there are people who are trying to make a sense of community there, and I think that can be really isolating to live by myself." And another summarized this concern by asserting, "When you get older, you don't necessarily want to be isolated just because you're older and you're sick." The critical role of social support emerged at the intersection of discussions about housing, isolation, and health decline.

Some of the focus group participants were connected to an LGBT-identified peer group through Area Agencies on Aging. One of the themes of the focus groups was that in the context of not being able to count on family, the newly formed peer connections had proven invaluable. One person said, "Most people get a sense of community from the town they're living in or friends, but I think the LGBT community in our age group missed that opportunity and are kind of discovering it late in life. The friends I've met here in this senior group we have, were tremendous help to me over the last few weeks. And I'm so thankful for that." Please refer to Table 1 for more information

about the people to whom the respondents felt comfortable reaching out to for help.

Inclusive housing

There was a shared sense of wanting to connect with other SGM-identified peers in housing settings, which was illustrated by one participant who shared, "I currently live in senior housing, and I love where I live. I wish it had more gay people in it . . . .I would love if there were gay people in there to be friends with." Although some wanted to live in settings that were exclusively designed for SGM-identified older adults, most sought inclusive settings. This wish for inclusivity is captured by one participant who shared, "My preferred housing would be a facility that is LGBT friendly, but I don't necessarily say just LGBT friendly period. Open to anyone that understands me as an African-American, LGBT, HIV." In the same group, another participant voiced a similar preference, "I think it's good to have contacts with other gay people, but I think it wears thin living in a complex where everyone around you is gay."

Participants yearned for a safe space that appreciates and celebrates all of their identities, and welcomed a housing arrangement that allowed for "as much diversity as possible." One respondent talked about his experience of discrimination. He reported, "A year or so ago, my husband . . . emailed and called assisted living places . . . and identified himself in two different ways. One, as a straight man with a wife. The second time was a gay male with a husband. The first time the information was entirely different for the straight male than it was for the gay male. For the straight male there were opportunities for the couple to move in and to live happily ever after. For the gay male and his husband there were not. Or, if there were they were priced differently than the straight male and his spouse." Other respondents who reported incidents of discrimination in their housing settings echoed this sentiment. Ultimately, their need to be surrounded by SGM-identified peers and desire for diversity seems to underscore the significance of kinship in later life and creation of safe community as a means of decreasing social isolation.

Transportation

The theme of transportation emerged in the focus groups across several domains, with implications for SGM-identified older adults in both rural and urban settings. Participants spoke directly to the connection between transportation and their support system. Access to transportation appears to facilitate and maintain connections with peers, chosen family, and their community of SGM older adults, while the robustness of one's social support

network can directly impact access to transportation, particularly when faced with a lack community resources or family support.

One participant captured the importance of being able to access connection with her lesbian-identified peers while still living at home, "Thank God. It's an intangible. I don't know what it is, but just to be with my people, my tribe. It's just a wonderful thing. There's joy." Another participant expressed concern about how they would maintain their connection to their support system should they lose access to a car and or driving, for financial reasons or as a result of cognitive or physical decline.

In suburban and rural communities, participants underscored the importance of cultivating a support network as a means of accessing transportation to and from healthcare and other community resources, due to a lack of publicly available transportation services. "No public transportation with the exception of the senior bus and that has to be arranged ahead of time. Either that or you have to, if you're sick you have to call an ambulance really. So, even our network of people here that we've met is very helpful for everybody I think. Because if somebody needs a ride, I'll be there in a minute." Further, when resources are available, such as through the a local council on aging, some participants expressed a preference for relying on friends for transportation; reasons for this included a need to be respected and treated with dignity, lack of reliability of more formal services, and a perception that reliance on formal services constituted a form of helplessness. One participant even described taking vacation days off from work to drive her companions to medical appointments given the lack of options available to them. Participants in focus groups from rural and suburban communities expressed a desire to be closer to urban centers to help alleviate transportation burdens, though agreed that financial barriers to doing so were too great.

In urban settings, participants voiced concerns unique from their peers in rural and suburban communities, while still underscoring the important connection between transportation and community. They stressed the importance of available and proximal transportation options, such as public transit, medically arranged cab services, and state-subsidized paratransit services. Some participants expressed a desire to utilize these available transportation options instead of relying on others, though there was a consensus that transportation in any form was paramount to facilitating connection with social support networks and access to community resources.

For all groups, community played a particularly crucial role in how transportation facilitated access to healthcare services and participants' anticipated ability to age safely in their own homes. One participant who lived in an urban setting summarized the connection between healthcare access, transportation, and community. He shared that when he first moved to the city he was unable to secure transportation for a surgery through existing public services and sought volunteer support through his church community. When undergoing

a second surgery several years later, he was required to bring someone with him and again sought volunteer support through the church and paid a taxi service to transport them. A second participant from one of the rural focus groups shared that in the absence of available transportation through her senior center, she relied on a neighbor to transport her to the hospital for rehabilitation services after she broke her ankle and shoulder on separate occasions, which she would not have been able to access otherwise.

Discussion

The experiences of the individuals sampled validate prior research examining housing preferences of SGM older adults and the importance of transportation in maintaining social connection and accessing competent, inclusive healthcare services. This paper expands on the existing literature in important ways. These results illuminate the complex relationships between housing, finances, social support, transportation, and access to healthcare among SGM-identified older adults. The participants sought affordable and SGM-inclusive housing options where they feel welcomed and can foster a sense of community. They spoke to the importance of community in developing social support networks, and their reliance on networks of informal support for transportation and by extension, access to healthcare and community events. Additionally, these results illuminate that access to transportation for SGM older adults is paramount in creating and maintaining social support and accessing community by supporting existing peer connections, and facilitating access to LGBT congregate meal sites and other LGBT community events. Moreover, the participants' fear of unpredictable health decline appears to be moderated by access to tangible services such as affordable, accessible, and inclusive housing, reliable transportation, as well as the intangible benefits provided by a supportive community.

The results point to three main implications for policy and practice: 1) access to affordable, LGBT-friendly housing, 2) ways elder service systems can promote and sustain social support networks for older SGM-identified people, and 3) innovations to address transportation needs for SGM-identified older adults.

Access to affordable, LGBT-friendly housing

Sexual and gender minority older adults require a range of housing options to enable them to age in place. Local and state officials can ensure that public and subsidized housing is available to low-income SGM older adults in a nondiscriminatory way. The federal Department of Housing and Urban Development, which provides housing assistance to support 4.9 million affordable units across the U.S. (HUD User, no date), guarantees access to

its programs regardless of "actual or perceived sexual orientation, gender identity or marital status (Equal Access Rule, 24 CFR 5.105(a)(2), cited in HUD, no date)." Twenty states have nondiscrimination laws that explicitly ban discrimination in employment, public accommodations, and housing on the basis of sexual orientation and gender identity (Movement Advancement Project, 2019). Many counties, cities and towns have also adopted similar laws. Federal HUD policy and municipal or state laws in about half of the U.S. prohibit anti-LGBT discrimination in low-income and subsidized housing.

Local housing authorities and state housing agencies can ensure that housing nondiscrimination laws are enforced by training all staff, educating tenants and other residents, and surveying residents to identify problems. They can also collect voluntary, confidential data on sexual orientation and gender identity (SOGI) from housing residents to ensure that LGBT people are accessing housing proportionate to their share of the population.

In the state where this study was conducted, the Special Legislative Commission on Lesbian, Gay, Bisexual and Transgender Aging has issued recommendations to the state government related to housing for LGBT elders (Massachusetts Special Legislative Commission on LGBT Aging, 2015). The recommendations were based on multiple data points, including the findings from this study. The recommendations addressed future policy, housing development, research, provider training, and practice, and are included here.

The first set of recommendations addressed the need for an LGBT-friendly housing development. As of December 2018, there were 12 such projects in the United States and 16 additional ones in development, including one in the state where this study was conducted. In addition to a housing development, the recommendations included examining the development of an LGBT-friendly Naturally Occurring Retirement Community (NORC) in a geographic area that has a high relative concentration of SGM-identified older adults. Another recommendation was to create LGBT-friendly small group homes through a pending 1915(c) Medicaid waiver for home and community-based services to the Centers for Medicare and Medicaid Services. These waivers allow Medicaid to reimburse such services to allow older adults to age in place in their homes instead of in an institutional setting. One local Aging Service Access Point (ASAP) has recently developed an LGBT-friendly housing option based on the Village Model. This service enables members to age in place with services and social programs that are screened to be LGBT-friendly and provided through their membership in the program. Participants get to know each other through social and educational programming, which breaks down the barriers that have separated SGM-identified older adults and their heterosexual peers.

The second set of recommendations addressed the needs of low-income SGM older adults. For example, the Department of Housing and Community

Development's Low-Income Housing Tax Credit Qualified Application Plan (QAP) could prioritize funding projects that address the housing needs of underserved populations, including SGM elders. Additionally, SGM older adults could be designated as an "underserved population" under the Qualified Allocation Plan for Low Income Housing Tax Credits. Finally, there is a need to develop best practices for safely and affirmatively sheltering homeless SGM-identified elders.

The final set of recommendations focused on training elder service providers. As noted above, training elder housing management staff and residents in the unique life experiences of SGM older adults could reduce prejudice and stigma in elder housing. It is imperative to integrate the themes of housing, healthcare and social engagement into future SGM cultural competency trainings for anyone working with older adults. Trainings for elder service providers can educate area agency planners and outreach workers to critical unmet needs. Funding can be redirected to address specific areas connected to these needs. Examples include developing LGBT Friendly Visitor Programs to address concerns with social isolation and LGBT Medical Escort Services to address disparities in transportation and healthcare access.

Social support networks for SGM-identified older adults

Elder service providers should promote and sustain social support networks for SGM older adults. This can be done through Gay-straight alliance (GSA)-like support groups based in elder housing complexes, similar to the school-based support groups for SGM youth. This can also be accomplished through congregate meal programs for SGM older adults and their friends, which, have been shown to help LGBT elders develop and sustain social support networks (Porter, Keary, Van Wagenen, & Bradford, 2016). Participants in the present study, some of whom were connected to one of the now 23 existing LGBT-friendly congregate meal sites in the state where the study was conducted, report a strong sense of community, caregiving and social engagement that is developed through participation in these programs. One study found that only five states used Older Americans Act Title III-c Nutrition Funds for LGBT-friendly meal programs (Porter & Cahill, 2015). Many more states could use this existing funding stream to better serve LGBT older adults and support them in aging in place.

The LGBT friendly congregate meal model of practice addresses many of the social concerns raised by participants in this study. However, the breakdown occurs when a participant at a meal site can no longer attend the site due to health concerns or transportation issues. This leaves a gap in caregiving and fosters increased social isolation. The findings from this study can impact the congregate model in several ways: establishing LGBT-friendly meals on wheels service that delivers meals to the homes, providing an uninterrupted

connection to nutrition services when participants cannot access the sites; and in-home social engagement through video conferencing platforms and in-person visitation through an LGBT friendly visitor program.

Innovations to address transportation needs

Unmet transportation needs adversely affect SGM older adults. In urban and metropolitan areas, subsidizing public transportation passes for older adults is one way to make it easier for LGBT elders to get around. In areas with fewer public transit options, more creative solutions are needed. We recommend that local and state aging departments, and Area Agencies on Aging, conduct needs assessments and incentivize creative solutions to meet the transportation needs of SGM older adults in these areas. Some solutions include developing a network of SGM older adults who drive or SGM-friendly volunteer drivers to support continued access to healthcare appointments and community events. Taxis and ride share companies may provide pro bono services or grants. Additionally, grant funding could be established to provide transportation to and from congregate meal sites and other community events supporting SGM older adults. Not having a car should not mean that LGBT older adults are condemned to living in isolation.

Limitations

The results of this study must be interpreted in light of its limitations. The focus groups were conducted in community-based settings with SGM-identified older adults who had access to transportation necessary to participate in the study. Therefore, the voices of those who did not have access to transportation and therefore might have even more pronounced concerns about isolation are not reflected in the findings. Future inquiry ought to include home-based interviews such that SGM-identified older adults with mobility barriers, transportation barriers, and health problems that might preclude travel can offer their perspectives on their housing needs and concerns. The sample also included many participants who were connected to SGM-specific congregate meal programs and peer support groups; therefore the findings do not include the perspectives of those who might not have such opportunities for social support available or accessible.

Conclusion

This study aimed to understand the perspectives of SGM-identified older adults with respect to housing needs and concerns. The picture that emerged captures the complex relationships between housing, finances, need for a safe and affirming community, transportation, and healthcare access. Some of the

concerns voiced by the participants might resonate for all older adults, for example the fear of isolation, but those fears have unique dimensions for SGM-identified older adults who might not have family to rely on and who are more likely than their non-SGM peers to live alone. The need for inclusive, affordable housing is critical, as is the need to cultivate community through initiatives such as congregate meals for SGM older adults. So, too, future efforts ought to focus on strategies to address transportation such that SGM older adults in urban and rural areas can age in place and access healthcare and social support.

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